2027 Illinois Access Large Group 3 and 4-Tier Prescription Drug List

Please note: This Prescription Drug List (PDL) is accurate as of Jan. 1, 2027, 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 All previous versions of this PDL are no longer in effect.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.

The current PDL can also be accessed online at **uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists**. Scroll down to Illinois section. An example of a plan coverage document may be accessed online at **2026-IL-LrgGrp-SBC.pdf**.

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 coverage documents and pharmacy information specific to your benefit plan.

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

- Charter
- Choice
- Choice Plus
- Core
- Options PPO
- Navigate
- NexusACO R
- NexusACO OAP
- Non-Differential PPO

Updated 9/1/2026

9/26 © 2027 United HealthCare Services, Inc. All Rights Reserved. WF22413508-A

United Healthcare®

Contents

Understand your medication options 3

How do I use my PDL? 5

What are tiers? 6

When does the PDL change? 6

Additional programs and details 7

Your right to request access to a non-formulary drug 8

Requesting a prior authorization 9

How do I locate and fill a prescription through a retail network pharmacy? 9

Prescription delivery options 9

How do I locate and fill a prescription through the mail order pharmacy? 10

How do I get updated information about my pharmacy benefit? 10

Nondiscrimination notice and access to communication services . . . 11

Prescription drug list 15

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:

Allowed Amount is the maximum amount on which the health insurance issuer bases its payment for a covered health care service. This may be called "eligible expense", "payment allowance", or "negotiated rate". If your health care provider charges more than the allowed amount and is not part of the provider network, you may have to pay the difference.

Brand name drug is a drug that is marketed under a proprietary, trademark-protected name. The brand name drug must be listed in all capital letters.

Coinsurance is a percentage of the cost of a covered health care service, which you are responsible to pay. The cost of the covered health care service is generally deemed to be the allowed amount, which may differ from the retail price that you would pay for the same service without using insurance. Typically, a coinsurance does not apply until after you have met the deductible, unless the health insurance issuer has waived or lowered the deductible for the health care service in question.

Copayment is a fixed dollar amount that you pay for a covered health care service. Typically, a copayment does not apply until after you have met the deductible, unless the health insurance issuer has waived or lowered the deductible for the health care service in question.

Covered Individual is an individual enrolled in, subscribed to, or insured under a health product, whether directly or as a dependent or beneficiary.

Deductible is the amount you pay for covered health care services before your health product begins payment for all or part of the cost of the health care service under the terms of coverage. If your health product has a deductible, it may have either one deductible or separate deductibles for medical benefits and drug benefits. For some health care services, such as preventive services, the health insurance issuer might waive or lower the deductible to pay for costs of the health care service from the first dollar of coverage, but this tends not to happen for most other covered services.

Drug Tier is a group of drugs that corresponds to a specified cost sharing tier in the health product's drug coverage. The tier in which a drug is placed determines your portion of the cost for the drug.

Exception request is a request for coverage of i) a nonformulary drug, ii) a drug being removed from the formulary, or iii) a quantity of a drug above a quantity limit. If you, your designee, or your attending or prescribing provider submits an exception request for coverage of a drug, the health insurance issuer must cover the drug when the drug is determined to be medically necessary to treat your condition.

Exigent circumstances are when you are suffering from a health 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 nonformulary drug.

Formulary or Prescription Drug List (PDL) is the complete list of drugs preferred for use and eligible for coverage under a health product, and includes all drugs covered under the outpatient or pharmacy drug benefit of the health product. Formulary is also known as a drug list or prescription drug list.

Generic drug is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in this PDL in ***bold and italicized lowercase*** letters.

Non-formulary drug is a drug that is not listed on the health product's formulary as a covered drug, but may become eligible for coverage under an "exception request."

Out-of-pocket cost is copayments, coinsurance, and the applicable deductible, plus all costs for health care services that the health product does not cover.

Prescribing provider is a health care provider authorized to write a prescription to treat your health condition.

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

Prescription Drug Product is a drug that is prescribed by your prescribing provider and requires a prescription under applicable law.

Prior authorization is a health product's requirement that you or your prescribing provider obtain the health insurance issuer's authorization for a drug before the health product will cover the drug. The health insurance issuer must grant a prior authorization when it is medically necessary for you to obtain the drug.

Quantity limit – Amount of medication covered per copayment or in a specific time period. Medications with quantity limits may be dispensed in greater quantities if medically necessary and prior authorized by UnitedHealthcare.

How do I use my PDL?

When choosing a medication, you and your provider should consult the Prescription Drug List (PDL). It will help you and your provider choose the most cost-effective prescription drugs. This guide tells you if special programs apply. Bring this list with you when you see your provider. It is organized by therapeutic category and class. The therapeutic category and class are based on the 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 or, if only the generic equivalent is covered under the plan, then just by its generic name, 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 bold and italicized lowercase letters;
3. If a generic equivalent for a brand name drug is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all bold and italicized lowercase letters; and
4. If a generic drug is marketed under a proprietary, trademark-protected brand name, the brand name will be listed in all CAPITAL letters 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 ***(irbesartan)***	3/4	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	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. If you have a plan with 3 Tiers, Tier 3/4 drugs will be placed on Tier 3. If you have a plan with 4 Tiers, Tier 3/4 drugs will be placed on Tier 4.

Drug Tier 1	Your lowest cost medications
Drug Tier 2	Your mid-range cost medications
Drug Tier 3	Your mid-range to high-cost medications
Drug Tier 3/4	Your highest cost medications
PA	Prior authorization required
QL	Quantity limit
H	Part of health care reform
H-N	Part of health care reform preventive with confirmation of age and/or condition appropriate preventive use

SP	Specialty medication
CM	Orally administered anti-cancer medication
SMCS	Specialty medication cost share may apply
E	Excluded from coverage unless covered as part of health care reform preventive
SM	Cost-share cap by state mandate applies when 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 3/4, look to see if there is a Tier 1 option available. Discuss these options with your provider.

For orally administered anti-cancer medications, there are no separate cost-sharing requirements or treatment limitations that do not also apply to intravenously injected or administered cancer medications covered under your medical benefit.

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 brand name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
$$	**Tier 2** **Your mid-range cost**	Medications that provide good overall value. Mainly preferred brand name drugs.	Use Tier 2 drugs instead of Tier 3 or 3/4 to help reduce your out-of-pocket costs.
$$$	**Tier 3 and 3/4** **Your highest cost**	Medications that provide the lowest overall value. Mainly non-preferred brand name drugs.	Many Tier 3 and 3/4 drugs have lower-cost options in Tier 1 or 2. Ask your provider 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. Your cost-share will not exceed the lesser of the cost-sharing amount or the retail price of the medication without the drug coverage. 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 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 or coverage may be added at any time.
- Medications may move to a higher tier when a generic becomes available.
- Medications may move to a higher tier, become non-formulary, or the dosage form covered may change, most often on Jan. 1, May 1, or Sept. 1.
- Medications may be subject to new or updated utilization management requirements at any time. This includes prior authorization or quantity limits. These changes most commonly occur upon FDA approval of a medication or its generic equivalent, or on scheduled update dates: 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.

Additional programs and details

Based on your benefit, the following may apply.

Patient Protection and Affordable Care Act (PPACA) zero cost-share preventive care medication 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. PPACA zero cost-share preventive care medications can be obtained, free of charge, at network pharmacies with a prescription from a prescribing provider. A prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products. PPACA zero cost-share preventive care medications are obtained at a network pharmacy with a prescription order or refill from a provider and are payable at 100% of the prescription drug charge (without application of any Copayment, Coinsurance, Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

A complete list of PPACA zero cost-share preventive care medications covered under the outpatient prescription drug benefit can be found at **myuhc.com**.

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

- Abortion*
- Gender Dysphoria*
- Human Immunodeficiency Virus (HIV) Prevention
- Naloxone

These medications are mandated to have the cost-share capped:

- Insulin $35 max per one month supply
- Epinephrine injectors $60 max per twin-pack

***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.

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

Before certain Prescription Drug Products are dispensed to you, your prescribing provider or your pharmacist is required to obtain prior authorization from us. Your prescribing provider can submit a request by phone to Optum Rx® or electronically by contacting us at **ProviderPA.com**. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your prescribing provider 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 by going online at **myuhc.com** or by calling at the toll-free phone number on the back of your member ID card.

Approvals for maintenance medications used to treat a chronic or long-term condition will be valid for at least 12 months. All other approvals, except for benzodiazepines and Schedule II narcotic drugs, will be valid for the lesser of six months, the length of treatment determined by your prescribing provider, or the renewal of your plan.

In the case of a standard prior authorization, 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 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 > Find a pharmacy** for an up-to-date list.

Prescription delivery options

You have choices on where to fill prescriptions you take regularly. You have the option to fill at a retail pharmacy or have them mailed to your home. It's up to you. Optum® Home Delivery Pharmacy is one of your network options. There may be other options in your network. Sign in at **myuhc.com > Pharmacies & Prescriptions > Find a pharmacy.**

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

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

You can start a new prescription or refill an existing one in several ways:

- **E-prescribe:** Ask your provider to send prescriptions directly to Optum Home Delivery Pharmacy (usually up to a 90-day supply).
- **Online:** Visit **myuhc.com** > **Pharmacies & Prescriptions** > **Rx Account** to set up an account. Then choose which medication you want moved to home delivery.
- **Phone:** Call Optum Rx at **1-888-658-0539** / TTY **711,** any day, any time.

Most prescriptions arrive within about 5 business days once Optum receives the completed order.

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.

You will receive sixty days notice if one of the following changes impacts you:

- A medication is moved to a higher tier*
- A medication becomes non-formulary*
- A medication becomes subject to new or revised utilization management procedures

***Please note:** You may be able to continue coverage of the medication at the same cost-share if your healthcare provider provides notice of medical necessity.

Sign 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**.

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card. (TTY 711).

ማሳሰቢያ፦ አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملحوظة: اذا كنت تتحدث اللغة **العربية** (Arabic)، فإن خدمات المساعدة اللغوية المجانية والمعلومات المجانية بتنسيقات أخرى متاحة لك أيضًا. اتصل بالرقم المجاني الموجود على بطاقة هويتك.

দেখুন: আপনি যদি **বাংলায়** (Bengali-Bangla) কথা বলেন, তাহলে আপনার ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণে নমুনা অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্য পরিচয়পত্রের পিছনে টোল-ফ্রি নম্বরে কল করুন।

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ** (Cambodian-Mon-Khmer)
សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត
ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។
ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

請注意：如果您說**中文** (Chinese - Traditional)，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

ATTENTION : Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **ελληνικά** (Greek), υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον αριθμό χωρίς χρέωση στην κάρτα μέλους σας.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી વિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.

ध्यान दें: यदि आप **ि◌ंदी (Hindi)** बोलते हैं, तो आपके ल्लए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे व्क्क र्ब ` प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais l**us Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus thiab muaj kev sib txuas lus pab dawb ua lwm hom ntawv, xws li luam ua ntawv loj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

ATENSION: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

ATTENZIONE: se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

알림 사항: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

ໝາຍເຫດ: ຖ້າຫາກທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານໃນຮູບແບບອື່ນໆຟຣີ, ເຊ່ນ: ການພິມຕົວອັກສອນຂະໜາດໃຫຍ່.
ໂທຫາເບີໂທຟຣີຢູ່ທີ່ບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

ध्यान दिनु होस्: यदि तपाईंले **नेपाली (Nepali)** बोल्नुहुन्छ भने, न्म:शुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा न्म:शुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लाग्ग उपलब्ध छन्।. आफ्नो सदस्य पहिचान कार्डमा रहेको टोल फ्री नम्बरमा कल गर्नुहोस्।

توجه: اگر به زبان **فارسی** (Persian-Farsi) صحبت می‌کنید، خدمات رایگان کمک زبانی و اطلاعات به صورت رایگان در قالب‌های دیگر، مانند چاپ درشت، در دسترس شما هستند. لطفاً با شماره‌ای که روی کارت شناسایی عضویت شما درج شده است تماس بگیرید.

UWAGA: Dla osób mówiących po **polsku** (Polish) dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ਦਿਆਨ ਦਿਓ ਿ ਤੁਸ਼ੀਂ **ਪੰਜਾਬੀ** (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸ਼ਹਾਇਤਾ ਸ਼ੇਵਾਵਾਂ ਅਤੇ ਹੋ ਫਾ ਮੈਟਾਂ, ਜਿੰ ਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਵਿੱਚ ਮੁਫ਼ਤ ਸ਼ੰਚਾ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬ ਪਛਾਣ ਕਾ ਡ 'ਤੇ ਟੋਲ-ਫ੍ਰੀ ਨੰਬ 'ਤੇ ਕਾਲ ਕ ੇ।

ВНИМАНИЕ! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro. (TTY 711).

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

โปรดทราบ หากคุณ**พูดภาษาไทย (Thai)** ได้
คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น
การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

ЗВЕРНІТЬ УВАГУ! Якщо ви розмовляєте **українською** (Ukrainian), ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як от набрані великим шрифтом. Телефонуйте на безкоштовний номер телефону, зазначений на вашій ідентифікаційній картці учасника.

اردو (Urdu): اگر آپ اردو بولتے ہیں تو آپ کی زبان میں مفت زبان سے متعلق مدد اور خدمات دستیاب ہیں۔ آپ کے ممبر کارڈ پر موجود فون نمبر پر کال کریں، جو آپ کے لیے مفت ہے، اور ہمیں بتائیں کہ آپ کو کس مدد کی ضرورت ہے۔

LƯU Ý: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

State of Illinois

Table of Contents of Prescription Drug List

INFORMATIONAL SECTION 1
ANTIDOTE THERAPEUTICS 15
ANTIHISTAMINE DRUGS - Drugs for Allergy 17
ANTI-INFECTIVE AGENTS - Drugs for Infections 20
ANTINEOPLASTIC AGENTS - Drugs for Cancer 44
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES - DRUGS FOR THE IMMUNE SYSTEM 58
AUTONOMIC DRUGS 63
AUTONOMIC DRUGS - Drugs for the Nervous System 64
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood 76
CARDIOVASCULAR DRUGS 88
CARDIOVASCULAR DRUGS - Drugs for the Heart 90
CENTRAL NERVOUS SYSTEM AGENTS 118
CENTRAL NERVOUS SYSTEM AGENTS - Drugs for the Nervous System 118
DENTAL AGENTS 164
DENTAL AGENTS - Oral Care 165
DEVICES - Medical Supplies and Durable Medical Equipment 168
DIAGNOSTIC AGENTS 180
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants 181
ELECTROLYTIC, CALORIC, AND WATER BALANCE 181
ENZYMES 189
EYE, EAR, NOSE AND THROAT (EENT) PREPS. 191
GASTROINTESTINAL DRUGS 206
GASTROINTESTINAL DRUGS - Drugs for the Stomach 207
GOLD COMPOUNDS 216
HEAVY METAL ANTAGONISTS - Drugs to Reduce Iron 216
HORMONES AND SYNTHETIC SUBSTITUTES 217
HORMONES AND SYNTHETIC SUBSTITUTES - Hormones 217
IMMUNOMODULATORY AGENTS (90:00) 263
LOCAL ANESTHETICS - Drugs for Numbing 272
MISCELLANEOUS THERAPEUTIC AGENTS 273
NONHORMONAL CONTRACEPTIVES - Drugs for Women 297
OXYTOCICS - Drugs for Women 298
PHARMACEUTICAL AIDS 298
RESPIRATORY TRACT AGENTS 298
RESPIRATORY TRACT AGENTS - Drugs for the Lungs 299
SKIN AND MUCOUS MEMBRANE AGENTS 313
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin 314
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles 340
VITAMINS 342

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIDOTE THERAPEUTICS		
ACETAMINOPHEN ANTIDOTE		
acetylcysteine inhalation solution 10 %, 20 %	1	
ALCOHOL DETERRENTS (91:02)		
acamprosate calcium oral tablet delayed release 333 mg	1	
disulfiram oral tablet 250 mg, 500 mg	1	
naltrexone hcl oral tablet 50 mg	1	
ANTIDOTE THERAPEUTICS		
atropine sulfate ophthalmic solution 1 %	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	
ft naloxone hcl nasal liquid 4 mg/0.1ml	1	SM
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
iodine strong oral solution 5 %	1	
KLOXXADO NASAL LIQUID 8 MG/0.1ML (***naloxone hcl***)	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naloxone hcl nasal liquid 4 mg/0.1ml	1	SM
NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***)	1	SM
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
penicillamine oral tablet 250 mg	1	
phytonadione oral tablet 5 mg	1	
REXTOVY NASAL LIQUID 4 MG/0.25ML (***naloxone hcl***)	1	SM
REZENOPY NASAL LIQUID 10 MG/0.11ML (***naloxone hcl***)	3	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (***naloxone hcl***)	1	SM
ANTIDOTES (91:04)		
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naltrexone hcl 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***)	3	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	PA
sevelamer carbonate oral tablet 800 mg	1	
sodium polystyrene sulfonate combination suspension 15 gm/60ml	1	
sodium polystyrene sulfonate oral powder	1	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (***sodium polystyrene sulfonate***)	3	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (***sodium polystyrene sulfonate***)	3	
CHEMOTHERAPY ANTIDOTES/PROTECTANTS		
lederle leucovorin oral tablet 5 mg	1	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	
CYANIDE ANTIDOTES		
EXODERM EXTERNAL LOTION 25-1 % (***sod thiosulfate-salicylic acd***)	3	
FLUOROPYRIMIDINE ANTIDOTE		
VISTOGARD ORAL PACKET 10 GM (***uridine triacetate***)	2	PA
ANTIHISTAMINE DRUGS - Drugs for Allergy		
ANTIHISTAMINE DRUGS - Drugs for Allergy		
promethazine hcl oral tablet 25 mg	1	
ETHANOLAMINE DERIVATIVES - Drugs for Allergy		
CARBINOXAMINE MALEATE ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	3/4	
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
clemastine fumarate oral tablet 2.68 mg	1	
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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 ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	3/4	
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
clemastine fumarate oral tablet 2.68 mg	1	
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
CORPHENA ORAL SOLUTION 2 MG/5ML	3/4	
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA
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	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	3/4	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
promethazine hcl oral solution 12.5 mg/10ml, 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-codeine oral solution 6.25-10 mg/5ml	1	PA
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
RYCLORA ORAL SOLUTION 2 MG/5ML (***dexchlorpheniramine maleate***)	3/4	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	
OTHER ANTIHISTAMINES - Drugs for Allergy		
bepotastine besilate ophthalmic solution 1.5 %	1	
cimetidine hcl oral solution 300 mg/5ml	1	
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	
nizatidine oral capsule 150 mg, 300 mg	1	
olopatadine hcl nasal solution 0.6 %	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
PHENOTHIAZINE DERIVATIVES - Drugs for Allergy		
promethazine hcl oral solution 12.5 mg/10ml, 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-codeine oral solution 6.25-10 mg/5ml	1	PA
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
promethazine-dm oral syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
PROPYLAMINE DERIVATIVES - Drugs for Allergy		
CORPHENA ORAL SOLUTION 2 MG/5ML	3/4	
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
RYCLORA ORAL SOLUTION 2 MG/5ML (***dexchlorpheniramine maleate***)	3/4	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (***chlorpheniramine-codeine***)	3	
SECOND GENERATION ANTIHISTAMINES - Drugs for Allergy		
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (***desloratadine-pseudoephedrine***)	3	
desloratadine oral tablet 5 mg	1	
desloratadine oral tablet dispersible 5 mg	1	
epinastine hcl ophthalmic solution 0.05 %	1	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	1	
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	
cefaclor oral suspension reconstituted 250 mg/5ml	1	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	1	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
CEFIXIME ORAL TABLET 400 MG	3/4	
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	
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		
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
HUMATIN ORAL CAPSULE 250 MG (***paromomycin sulfate***)	2	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	1	
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
AMINOGLYCOSIDE ANTIBIOTICS - Antibiotics		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (***amikacin sulfate liposome***)	3/4	PA; QL (8.4 ml per day.)
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
HUMATIN ORAL CAPSULE 250 MG (***paromomycin sulfate***)	2	
neomycin sulfate oral tablet 500 mg	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (***tobramycin***)	3/4	PA; QL (280 ml (1 carton) per 56 days.)
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	3/4	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	
AMINOMETHYLCYCLINES - Antibiotics		
NUZYRA ORAL TABLET 150 MG (***omadacycline tosylate***)	3/4	
AMINOPENICILLIN ANTIBIOTICS - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
amoxicillin trihydrate oral suspension reconstituted 250 mg/5ml	1	
amoxicillin-potassium clavulanate er oral tablet extended release 12 hour 1000-62.5 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	
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	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED 125-31.25 MG/5ML (***amoxicillin-pot clavulanate***)	3/4	
PIVYA ORAL TABLET 185 MG (***pivmecillinam hcl***)	3/4	QL (9 tablets per course of therapy.)
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ANTHELMINTICS - Drugs for Parasites		
albendazole oral tablet 200 mg	1	QL (124 tablets per month.)
BILTRICIDE ORAL TABLET 600 MG (***praziquantel***)	3/4	
EGATEN ORAL TABLET 250 MG (***triclabendazole***)	3	
EMVERM ORAL TABLET CHEWABLE 100 MG (***mebendazole***)	3/4	QL (6 tablets per 3 days.)
ivermectin oral tablet 3 mg	1	PA; QL (20 tablets per 3 months.)
ivermectin oral tablet 6 mg	1	PA
praziquantel oral tablet 600 mg	1	
STROMECTOL ORAL TABLET 3 MG (***ivermectin***)	3/4	PA; QL (20 tablets per 3 months.)
ANTIFUNGALS, MISCELLANEOUS - Drugs for Fungus		
griseofulvin microsize oral suspension 125 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
griseofulvin microsize oral tablet 500 mg	1	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	1	
iodine strong oral solution 5 %	1	
ANTI-INFECTIVES (SYSTEMIC), MISC. - Drugs for Infections		
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
ANTILEPROSY AGENTS - Antibiotics		
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
ANTIMALARIALS - Drugs for the Mouth and Throat		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	
ARAKODA ORAL TABLET 100 MG (***tafenoquine succinate***)	3/4	QL (16 tablets per month.)
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	1	
AVIDOXY ORAL TABLET 100 MG	3/4	
chloroquine phosphate oral tablet 250 mg, 500 mg	1	
COARTEM ORAL TABLET 20-120 MG (***artemether-lumefantrine***)	2	
DARAPRIM ORAL TABLET 25 MG (***pyrimethamine***)	3/4	PA
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (***atovaquone-proguanil hcl***)	3/4	
mefloquine hcl oral tablet 250 mg	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
primaquine phosphate oral tablet 26.3 (15 base) mg	1	
pyrimethamine oral tablet 25 mg	1	PA
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	1	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
ANTIMYCOBACTERIALS, MISCELLANEOUS - Antibiotics		
dapsone oral tablet 100 mg, 25 mg	1	
ANTIPROTOZOALS, CRYPTOSPORIDIOSIS - Drugs for the Mouth and Throat		
nitazoxanide oral tablet 500 mg	1	
ANTIPROTOZOALS, MISCELLANEOUS - Drugs for the Mouth and Throat		
atovaquone oral suspension 750 mg/5ml	1	
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (248 tablets per 720 days)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
IMPAVIDO ORAL CAPSULE 50 MG (***miltefosine***)	2	QL (84 capsules per course of therapy.)
LAMPIT ORAL TABLET 120 MG (***nifurtimox***)	3/4	QL (7.5 tablets per day.)
LAMPIT ORAL TABLET 30 MG (***nifurtimox***)	3/4	QL (9 tablets per day.)
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG (***pentamidine isethionate***)	3/4	
nitazoxanide oral tablet 500 mg	1	
pentamidine isethionate inhalation solution reconstituted 300 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
SOLOSEC ORAL PACKET 2 GM (***secnidazole***)	3/4	
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	1	
ANTIPROTOZOALS,NITROIMIDAZOLE-DERIVATIVE - Drugs for the Mouth and Throat		
tinidazole oral tablet 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIRETROVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	3/4	PA; QL (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***)	3/4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
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	1	
PRETOMANID ORAL TABLET 200 MG	3/4	
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	
rifapentine oral tablet 150 mg	1	
SIRTURO ORAL TABLET 100 MG, 20 MG (***bedaquiline fumarate***)	2	
ANTIVIRALS, MISCELLANEOUS - Drugs for Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (***maribavir***)	3/4	PA; QL (4 tablets per day.)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (40 tablets per 365 days. 20 tablets per prescription.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (60 tablets per 365 days. 30 tablets per prescription.)
PREVYMIS ORAL PACKET 120 MG, 20 MG (***letermovir***)	2	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG (***letermovir***)	2	PA
TPOXX ORAL CAPSULE 200 MG (***tecovirimat***)	3/4	
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
AZOLE ANTIFUNGALS - Drugs for Fungus		
CRESEMBA ORAL CAPSULE 186 MG, 74.5 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	QL (180 capsules per 365 days)
itraconazole oral solution 10 mg/ml	1	QL (1800 ml per 365 days)
ketoconazole external cream 2 %	1	
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketoconazole oral tablet 200 mg	1	
ketodan external foam 2 %	1	
NOXAFIL ORAL PACKET 300 MG (***posaconazole***)	2	
posaconazole oral suspension 40 mg/ml	1	
posaconazole oral tablet delayed release 100 mg	1	
SPORANOX ORAL CAPSULE 100 MG (***itraconazole***)	3/4	QL (180 capsules per 365 days)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***voriconazole***)	3/4	
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (***oteseconazole***)	3	PA; QL (18 capsules per 84 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
voriconazole oral suspension reconstituted 40 mg/ml	1	
voriconazole oral tablet 200 mg, 50 mg	1	
BACITRACIN ANTIBIOTICS - Antibiotics		
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
CORONAVIRUS (COVID-19) - Drugs for Viral Infections		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (40 tablets per 365 days. 20 tablets per prescription.)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (22 tablets per 365 days. 11 tablets per copay.)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (***nirmatrelvir-ritonavir***)	2	QL (60 tablets per 365 days. 30 tablets per prescription.)
ENDONUCLEASE INHIBITORS - Drugs for Viral Infections		
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (***baloxavir marboxil***)	3	QL (1 tablet per month.)
ENTRY INHIBITORS - Drugs for Viral Infections		
HEPCLUDEX SUBCUTANEOUS SOLUTION RECONSTITUTED 8.5 MG (***bulevirtide acetate-gmod***)	3/4	PA; QL (30 vials per month.); CM
ERYTHROMYCIN ANTIBIOTICS - Antibiotics		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***erythromycin ethylsuccinate***)	3	
ERY EXTERNAL PAD 2 %	3	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (***erythromycin ethylsuccinate***)	3/4	
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	1	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	1	
GLYCOPEPTIDE ANTIBIOTICS - Antibiotics		
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (***vancomycin hcl***)	3/4	
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (***vancomycin hcl***)	3/4	
vancomycin hcl oral capsule 125 mg, 250 mg	1	
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml	1	
HCV POLYMERASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; QL (1 tablet per day and 28 tablets per month.)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; QL (84 tablets per 720 days.)
SOVALDI ORAL PACKET 150 MG, 200 MG (***sofosbuvir***)	3/4	PA; QL (1 packet of pellets per day and 84 packets of pellets per 720 days.)
SOVALDI ORAL TABLET 200 MG, 400 MG (***sofosbuvir***)	3/4	PA; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days)
HCV PROTEASE INHIBITOR ANTIVIRALS - Drugs for Viral Infections		
MAVYRET ORAL PACKET 50-20 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 tablets per 720 days)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HCV REPLICATION COMPLEX INHIBITORS - Drugs for Viral Infections		
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	2	PA; QL (1 tablet per day and 28 tablets per month.)
MAVYRET ORAL PACKET 50-20 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (5 packets per day and 280 packets per 720 days.)
MAVYRET ORAL TABLET 100-40 MG (***glecaprevir-pibrentasvir***)	2	PA; QL (168 tablets per 720 days)
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	3	PA; QL (84 tablets per 720 days.)
VOSEVI ORAL TABLET 400-100-100 MG (***sofosbuv-velpatasv-voxilaprev***)	2	PA; QL (84 tablets per 720 days)
HIV CAPSID INHIBITORS - Drugs for Viral Infections		
BIXLENVO ORAL TABLET 75-50 MG (***bictegravir-lenacapavir***)	3/4	
SUNLENCA ORAL TABLET 300 MG (***lenacapavir sodium***)	3/4	PA; QL (24 tablets per year.)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (***lenacapavir sodium***)	3/4	PA; QL (5 tablets per 365 days.)
YEZTUGO ORAL TABLET 300 MG (***lenacapavir sodium***)	3/4	QL (4 tablets per year.); SM
HIV ENTRY AND FUSION INHIBITORS - Drugs for Viral Infections		
maraviroc oral tablet 150 mg, 300 mg	1	PA
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (***fostemsavir tromethamine***)	3/4	PA
SELZENTRY ORAL TABLET 150 MG, 300 MG (***maraviroc***)	3/4	PA
HIV INTEGRASE INHIBITOR ANTIRETROVIRALS - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	QL (1 tablet per day.)
BIXLENVO ORAL TABLET 75-50 MG (***bictegravir-lenacapavir***)	3/4	
DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***)	2	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***)	3/4	QL (1 tablet per day.)
ISENTRESS HD ORAL TABLET 600 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL PACKET 100 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL TABLET 400 MG (***raltegravir potassium***)	2	SM
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (***raltegravir potassium***)	2	SM
JULUCA ORAL TABLET 50-25 MG (***dolutegravir-rilpivirine***)	2	QL (1 tablet per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
TIVICAY ORAL TABLET 50 MG (***dolutegravir sodium***)	3	SM
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (***dolutegravir sodium***)	3	SM
TRIUMEQ ORAL TABLET 600-50-300 MG (***abacavir-dolutegravir-lamivud***)	2	QL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (6 tablets per day.)
VOCABRIA ORAL TABLET 30 MG (***cabotegravir sodium***)	3/4	SM
HIV NONNUCLEOSIDE REV.TRANSCRIP. INHIB. - Drugs for Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
DELSTRIGO ORAL TABLET 100-300-300 MG (***doravirin-lamivudin-tenofov df***)	2	QL (1 tablet per day.)
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (***rilpivirine hcl***)	2	SM
efavirenz oral tablet 600 mg	1	
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	1	QL (1 tablet per day.)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	1	QL (1 tablet per day.)
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
etravirine oral tablet 100 mg, 200 mg	1	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
IDVYNSO ORAL TABLET 100-0.25 MG (***doravirine-islatravir***)	3/4	QL (30 tablets per month.)
INTELENCE ORAL TABLET 100 MG, 200 MG (***etravirine***)	3/4	SM
INTELENCE ORAL TABLET 25 MG (***etravirine***)	2	SM
JULUCA ORAL TABLET 50-25 MG (***dolutegravir-rilpivirine***)	2	QL (1 tablet per day.)
methocarbamol oral tablet 500 mg	1	
nevirapine er oral tablet extended release 24 hour 400 mg	1	
nevirapine oral suspension 50 mg/5ml	1	
nevirapine oral tablet 200 mg	1	
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
PIFELTRO ORAL TABLET 100 MG (***doravirine***)	3	
rilpivirine hcl oral tablet 25 mg	1	SM
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	2	QL (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	
abacavir sulfate-lamivudine oral tablet 600-300 mg	1	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (***bictegravir-emtricitab-tenofov***)	3/4	QL (1 tablet per day.)
CIMDUO ORAL TABLET 300-300 MG (***lamivudine-tenofovir***)	2	QL (1 tablet per day.)
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
DELSTRIGO ORAL TABLET 100-300-300 MG (***doravirin-lamivudin-tenofov df***)	2	QL (1 tablet per day.)
DESCOVY ORAL TABLET 120-15 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); H; SM
DOVATO ORAL TABLET 50-300 MG (***dolutegravir-lamivudine***)	2	QL (1 tablet per day.)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	1	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	1	QL (1 tablet per day.)
emtricitabine oral capsule 200 mg	1	SM
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.); SM
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H; SM
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
EMTRIVA ORAL CAPSULE 200 MG (***emtricitabine***)	3/4	SM
EMTRIVA ORAL SOLUTION 10 MG/ML (***emtricitabine***)	2	SM
EPIVIR ORAL SOLUTION 10 MG/ML (***lamivudine***)	3/4	SM
EPIVIR ORAL TABLET 150 MG, 300 MG (***lamivudine***)	3/4	SM
GENVOYA ORAL TABLET 150-150-200-10 MG (***elviteg-cobic-emtricit-tenofaf***)	3/4	QL (1 tablet per day.)
IDVYNSO ORAL TABLET 100-0.25 MG (***doravirine-islatravir***)	3/4	QL (30 tablets per month.)
lamivudine oral solution 10 mg/ml	1	SM
lamivudine oral tablet 100 mg	1	
lamivudine oral tablet 150 mg, 300 mg	1	SM
lamivudine-zidovudine oral tablet 150-300 mg	1	SM
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
RETROVIR ORAL CAPSULE 100 MG (***zidovudine***)	3/4	SM
RETROVIR ORAL SYRUP 50 MG/5ML (***zidovudine***)	3	SM
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
SYMFI ORAL TABLET 600-300-300 MG (***efavirenz-lamivudine-tenofovir***)	2	QL (1 tablet per day.)
tenofovir disoproxil fumarate oral tablet 300 mg	1	H-N
TRIUMEQ ORAL TABLET 600-50-300 MG (***abacavir-dolutegravir-lamivud***)	2	QL (1 tablet per day.)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	2	QL (6 tablets per day.)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (***emtricitabine-tenofovir df***)	3/4	QL (1 tablet per day.); SM
VIREAD ORAL POWDER 40 MG/GM (***tenofovir disoproxil fumarate***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (***tenofovir disoproxil fumarate***)	2	
ZIAGEN ORAL SOLUTION 20 MG/ML (***abacavir sulfate***)	3/4	
zidovudine oral capsule 100 mg	1	SM
zidovudine oral syrup 50 mg/5ml	1	SM
zidovudine oral tablet 300 mg	1	SM
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	1	SM
darunavir oral tablet 600 mg, 800 mg	1	SM
EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***)	2	
fosamprenavir calcium oral tablet 700 mg	1	
KALETRA ORAL SOLUTION 400-100 MG/5ML (***lopinavir-ritonavir***)	3	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (***lopinavir-ritonavir***)	3/4	
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg	1	
NORVIR ORAL PACKET 100 MG (***ritonavir***)	2	SM
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (***darunavir-cobicistat***)	2	
PREZISTA ORAL SUSPENSION 100 MG/ML (***darunavir***)	2	SM
PREZISTA ORAL TABLET 150 MG, 75 MG (***darunavir***)	2	SM
REYATAZ ORAL PACKET 50 MG (***atazanavir sulfate***)	2	SM
ritonavir oral tablet 100 mg	1	SM
VIRACEPT ORAL TABLET 250 MG, 625 MG (***nelfinavir mesylate***)	2	
INTERFERON ANTIVIRALS - Drugs for Viral Infections		
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
LINCOMYCIN ANTIBIOTICS - Antibiotics		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	3/4	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***)	3/4	
CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***)	3/4	
CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***)	3/4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***)	3/4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	1	
clindacin-p external swab 1 %	1	
CLINDAGEL EXTERNAL GEL 1 % (***clindamycin phosphate***)	3/4	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	1	
clindamycin phos (once-daily) external gel 1 %	1	
clindamycin phos (twice-daily) external gel 1 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
clindamycin phosphate external foam 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	1	
clindamycin-tretinoin external gel 1.2-0.025 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***)	2	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	3/4	
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	
MONOBACTAM ANTIBIOTICS - Antibiotics		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (***aztreonam lysine***)	3/4	PA; QL (84 vials per 56 days.); SP
MONOCLONAL ANTIBODIES (08:18) - Drugs for Viral Infections		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (***nirsevimab-alip***)	3	H
ENFLONSIA INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 105 MG/0.7ML (***clesrovimab-cfor***)	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	1	
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	1	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (***zanamivir***)	3	
NITROIMIDAZOLE DERIVATIVE, ANTI-LEISHMAL - Drugs for the Mouth and Throat		
IMPAVIDO ORAL CAPSULE 50 MG (***miltefosine***)	2	QL (84 capsules per course of therapy.)
NITROIMIDAZOLE DERIVATIVE, TRYPANOCIDAL - Drugs for the Mouth and Throat		
BENZNIDAZOLE ORAL TABLET 100 MG	2	QL (248 tablets per 720 days)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BENZNIDAZOLE ORAL TABLET 12.5 MG	2	QL (720 tablets per 720 days.)
NITROIMIDAZOLE DERIVATIVES, MISC - Drugs for the Mouth and Throat		
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 250 mg, 500 mg	1	
metronidazole vaginal gel 0.75 %	1	
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	3/4	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
NUCLEOSIDE AND NUCLEOTIDE ANTIVIRALS - Drugs for Viral Infections		
acyclovir external cream 5 %	1	
acyclovir external ointment 5 %	1	
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	1	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (***entecavir***)	2	
COMPLERA ORAL TABLET 200-25-300 MG (***emtricitab-rilpivir-tenofovir***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 120-15 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); SM
DESCOVY ORAL TABLET 200-25 MG (***emtricitabine-tenofovir af***)	3/4	QL (1 tablet per day.); H; SM
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	1	QL (1 tablet per day.); SM
emtricitabine-tenofovir df oral tablet 200-300 mg	1	QL (1 tablet per day.); H; SM
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	1	QL (1 tablet per day.); SM
entecavir oral tablet 0.5 mg, 1 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
famciclovir oral tablet 125 mg, 250 mg, 500 mg	1	
LAGEVRIO ORAL CAPSULE 200 MG (***molnupiravir***)	2	QL (80 capsules per 365 days. 40 capsules per prescription.)
ODEFSEY ORAL TABLET 200-25-25 MG (***emtricitab-rilpivir-tenofov af***)	3/4	QL (1 tablet per day.)
ribavirin oral capsule 200 mg	1	
ribavirin oral tablet 200 mg	1	
TEMBEXA ORAL SUSPENSION 10 MG/ML (***brincidofovir***)	3/4	
TEMBEXA ORAL TABLET 100 MG (***brincidofovir***)	3/4	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (***emtricitabine-tenofovir df***)	3/4	QL (1 tablet per day.); SM
valacyclovir hcl oral tablet 1 gm, 500 mg	1	
valganciclovir hcl oral solution reconstituted 50 mg/ml	1	
valganciclovir hcl oral tablet 450 mg	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***)	3	
ZOVIRAX EXTERNAL CREAM 5 % (***acyclovir***)	3/4	
OTHER MACROLIDE ANTIBIOTICS - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***fidaxomicin***)	3	QL (136 mL per 10 days.)
fidaxomicin oral tablet 200 mg	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	3/4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	3/4	
OTHER MACROLIDES (8:12.12.92) - Antibiotics		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (***fidaxomicin***)	3	QL (136 mL per 10 days.)
fidaxomicin oral tablet 200 mg	1	QL (20 tablets per 7 days)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (***azithromycin***)	3/4	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (***azithromycin***)	3/4	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (***azithromycin***)	3/4	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (***azithromycin***)	3/4	
OXAZOLIDINONE ANTIBIOTICS - Antibiotics		
linezolid oral suspension reconstituted 100 mg/5ml	1	
linezolid oral tablet 600 mg	1	
SIVEXTRO ORAL TABLET 200 MG (***tedizolid phosphate***)	3	
PENICILLINASE-RESISTANT PENICILLINS - Antibiotics		
dicloxacillin sodium oral capsule 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
POLYENE ANTIFUNGALS - Drugs for Fungus		
klayesta external powder 100000 unit/gm	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin oral tablet 500000 unit	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
nystop external powder 100000 unit/gm	1	
POLYMYXIN ANTIBIOTICS - Antibiotics		
colistimethate sodium (cba) injection solution reconstituted 150 mg	1	
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED 150 MG (***colistimethate sodium***)	3/4	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
PYRIMIDINE ANTIFUNGALS - Drugs for Fungus		
ANCOBON ORAL CAPSULE 250 MG (***flucytosine***)	3/4	
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***)	3	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (***ciprofloxacin***)	3	
CIPRO ORAL TABLET 250 MG, 500 MG (***ciprofloxacin hcl***)	3/4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
levofloxacin ophthalmic solution 0.5 %, 1.5 %	1	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
moxifloxacin hcl ophthalmic solution 0.5 %	1	
moxifloxacin hcl oral tablet 400 mg	1	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (***ofloxacin***)	3/4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin oral tablet 400 mg	1	
ofloxacin otic solution 0.3 %	1	
RIFAMYCIN ANTIBIOTICS - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (***rifapentine***)	2	
rifabutin oral capsule 150 mg	1	
rifampin oral capsule 150 mg, 300 mg	1	
rifapentine oral tablet 150 mg	1	
XIFAXAN ORAL TABLET 200 MG (***rifaximin***)	3	PA
XIFAXAN ORAL TABLET 550 MG (***rifaximin***)	3	PA; QL (62 tablets per month.)
SULFONAMIDES - Antibiotics		
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	
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	
TETRACYCLINE ANTIBIOTICS - Antibiotics		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
AVIDOXY ORAL TABLET 100 MG	3/4	
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
demeclocycline hcl oral tablet 150 mg, 300 mg	1	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
tetracycline hcl oral capsule 250 mg, 500 mg	1	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
TRIAZAACENAPHTHYLENES - Antibiotics		
BLUJEPA ORAL TABLET 750 MG (***gepotidacin mesylate***)	3/4	
URINARY ANTI-INFECTIVES - Drugs for the Urinary System		
BACTRIM DS ORAL TABLET 800-160 MG (***sulfamethoxazole-trimethoprim***)	3/4	
BACTRIM ORAL TABLET 400-80 MG (***sulfamethoxazole-trimethoprim***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fosfomycin tromethamine oral packet 3 gm	1	
MACROBID ORAL CAPSULE 100 MG (***nitrofurantoin monohyd macro***)	3/4	
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	
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	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	
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***)	3	
uretron d/s oral tablet 81.6 mg	1	
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***)	3	
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
ANTINEOPLASTIC AGENTS - Drugs for Cancer		
abiraterone acetate oral tablet 250 mg	1	QL (4 tablets per day.); CM
abirtega oral tablet 250 mg	1	QL (4 tablets per day.); CM
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (***niraparib-abiraterone acetate***)	3/4	PA; QL (2 tablets per day.); CM
ALECENSA ORAL CAPSULE 150 MG (***alectinib hcl***)	2	PA; QL (8 capsules per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ALTRENO EXTERNAL LOTION 0.05 % (***tretinoin***)	3/4	PA
ALUNBRIG ORAL TABLET 180 MG, 90 MG (***brigatinib***)	2	PA; QL (1 tablet per day); CM
ALUNBRIG ORAL TABLET 30 MG (***brigatinib***)	2	PA; QL (6 tablets per day); CM
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (***brigatinib***)	2	PA; QL (30 packs per year); CM
anastrozole oral tablet 1 mg	1	H-N
AUGTYRO ORAL CAPSULE 160 MG (***repotrectinib***)	2	PA; QL (60 capsules per month.); CM
AUGTYRO ORAL CAPSULE 40 MG (***repotrectinib***)	2	PA; QL (8 capsules per day.); CM
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (***avutometinib-defactinib***)	3/4	PA; QL (66 capsules/tablets per month.); CM
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (***avapritinib***)	3/4	PA; QL (1 tablet per day.); CM
BALVERSA ORAL TABLET 3 MG (***erdafitinib***)	3/4	PA; QL (3 tablets per day.); CM
BALVERSA ORAL TABLET 4 MG (***erdafitinib***)	3/4	PA; QL (2 tablets per day.); CM
BALVERSA ORAL TABLET 5 MG (***erdafitinib***)	3/4	PA; QL (1 tablet per day.); CM
BEQALZI ORAL TABLET 1 MG, 20 MG, 5 MG, 80 MG (***sonrotoclax***)	3/4	
BEQALZI STARTER PACK ORAL TABLET THERAPY PACK 1 & 5 & 20 & 80 MG (***sonrotoclax***)	3/4	
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM
bexarotene external gel 1 %	1	
bexarotene oral capsule 75 mg	1	CM
bicalutamide oral tablet 50 mg	1	CM
BOSULIF ORAL CAPSULE 100 MG (***bosutinib***)	2	PA; QL (3 Capsules per day.); SP; CM; SMCS

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BOSULIF ORAL CAPSULE 50 MG (***bosutinib***)	2	PA; QL (1 Capsule per day.); SP; CM; SMCS
bosutinib oral tablet 100 mg	1	PA; QL (4 tablets per day.); SP; CM
bosutinib oral tablet 400 mg, 500 mg	1	PA; QL (1 tablet per day.); SP; CM
BRAFTOVI ORAL CAPSULE 75 MG (***encorafenib***)	3/4	PA; QL (6 capsules per day); CM
BRUKINSA ORAL CAPSULE 80 MG (***zanubrutinib***)	3	PA; QL (60 capsules per month.); CM
BRUKINSA ORAL TABLET 160 MG (***zanubrutinib***)	3	PA; QL (60 tablets per month.); CM
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (***cabozantinib s-malate***)	2	PA; QL (1 tablet per day.); CM
CALQUENCE ORAL TABLET 100 MG (***acalabrutinib maleate***)	2	PA; QL (2 tablets per day.); CM
capecitabine oral tablet 150 mg, 500 mg	1	CM
CAPRELSA ORAL TABLET 100 MG (***vandetanib***)	2	PA; QL (2 tablets per day.); CM
CAPRELSA ORAL TABLET 300 MG (***vandetanib***)	2	PA; QL (1 tablet per day.); CM
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COMETRIQ ORAL KIT 20 MG (***cabozantinib s-malate***)	2	PA; QL (93 capsules per month.); CM
COMETRIQ ORAL KIT 3 X 20 MG & 80 MG (***cabozantinib s-malate***)	2	PA; QL (124 capsules per month.); CM
COMETRIQ ORAL KIT 80 & 20 MG (***cabozantinib s-malate***)	2	PA; QL (62 capsules per month.); CM
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (***duvelisib***)	3/4	PA; QL (2 capsules per day.); CM
COTELLIC ORAL TABLET 20 MG (***cobimetinib fumarate***)	2	PA; QL (63 tablets per 21 days); CM
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg	1	PA; QL (1 tablet per day.); CM
dasatinib oral tablet 20 mg	1	PA; QL (90 tablets per month.); CM
DAURISMO ORAL TABLET 100 MG, 25 MG (***glasdegib maleate***)	2	PA; QL (2 tablets per day.); CM
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (***hydroxyurea***)	1	CM
ENSACOVE ORAL CAPSULE 100 MG, 25 MG (***ensartinib hcl***)	2	PA; QL (60 capsules per month.); CM
ERIVEDGE ORAL CAPSULE 150 MG (***vismodegib***)	2	PA; QL (1 capsule per day.); CM
ERLEADA ORAL TABLET 240 MG (***apalutamide***)	2	PA; QL (1 tablet per day.)
ERLEADA ORAL TABLET 60 MG (***apalutamide***)	2	PA; QL (4 tablets per day.); CM
erlotinib hcl oral tablet 100 mg, 150 mg	1	PA; QL (1 tablet per day.); CM
erlotinib hcl oral tablet 25 mg	1	PA; QL (2 tablets per day.); CM
ETCAMAH ORAL TABLET 75 MG (***camizestrant***)	3/4	
etoposide oral capsule 50 mg	1	CM
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
everolimus oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
exemestane oral tablet 25 mg	1	H-N
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (***tivozanib hcl***)	3/4	PA; QL (0.75 capsules per day.); CM
FRUZAQLA ORAL CAPSULE 1 MG (***fruquintinib***)	3/4	PA; QL (84 capsules per 21 days.); CM
FRUZAQLA ORAL CAPSULE 5 MG (***fruquintinib***)	3/4	PA; QL (21 capsules per 21 days.); CM
GAVRETO ORAL CAPSULE 100 MG (***pralsetinib***)	3/4	PA; QL (4 capsules per day.); CM
gefitinib oral tablet 250 mg	1	PA; QL (2 tablets per day.); CM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (***afatinib dimaleate***)	3	PA; QL (1 tablet per day.); CM
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (***lomustine***)	2	CM
GOMEKLI ORAL CAPSULE 1 MG (***mirdametinib***)	3/4	PA; QL (42 capsules per 4 weeks.)
GOMEKLI ORAL CAPSULE 2 MG (***mirdametinib***)	3/4	PA; QL (84 capsules per 4 weeks.)
GOMEKLI ORAL TABLET SOLUBLE 1 MG (***mirdametinib***)	3/4	PA; QL (168 tablets per 4 weeks.)
HEPZATO W/50MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (***melphalan hcl***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HEPZATO W/62MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED 50 MG (***melphalan hcl***)	3	
HERNEXEOS ORAL TABLET 60 MG (***zongertinib***)	3/4	PA; QL (90 tablets per month.); CM
HYCAMTIN ORAL CAPSULE 0.25 MG (***topotecan hcl***)	2	PA; QL (20 capsules per three weeks.); CM
HYCAMTIN ORAL CAPSULE 1 MG (***topotecan hcl***)	2	PA; QL (30 capsules per 3 weeks.); CM
hydroxyurea oral capsule 500 mg	1	CM
HYRNUO ORAL TABLET 10 MG (***sevabertinib***)	2	PA; QL (120 tablets per month.); CM
IBRANCE ORAL CAPSULE 125 MG (***palbociclib***)	3/4	PA; QL (21 capsules per month.); CM
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (***palbociclib***)	3/4	PA; QL (0.75 tablets per day.); CM
IBTROZI ORAL CAPSULE 200 MG (***taletrectinib adipate***)	3/4	PA; QL (90 capsules per month.); CM
ICLUSIG ORAL TABLET 15 MG, 45 MG (***ponatinib hcl***)	3	PA; QL (1 tablet per day.); CM
IDHIFA ORAL TABLET 100 MG, 50 MG (***enasidenib mesylate***)	2	PA; QL (1 tablet per day); CM
imatinib mesylate oral tablet 100 mg	1	QL (6 tablets per day.); CM
imatinib mesylate oral tablet 400 mg	1	QL (1 tablet per day.); CM
IMBRUVICA ORAL CAPSULE 140 MG (***ibrutinib***)	2	PA; QL (4 capsules per day.); CM
IMBRUVICA ORAL CAPSULE 70 MG (***ibrutinib***)	2	PA; QL (1 capsule per day.); CM
IMBRUVICA ORAL SUSPENSION 70 MG/ML (***ibrutinib***)	2	PA; QL (7.2 ml per day.); CM
IMBRUVICA ORAL TABLET 420 MG (***ibrutinib***)	2	PA; QL (1 tablet per day.); CM
IMKELDI ORAL SOLUTION 80 MG/ML	3/4	PA; QL (280 ml (2 bottles) per month.); CM
INLURIYO ORAL TABLET 200 MG (***imlunestrant tosylate***)	2	PA; QL (56 tablets per month.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
INLYTA ORAL TABLET 1 MG (***axitinib***)	3	PA; QL (6 tablets per day.); SP; CM
INLYTA ORAL TABLET 5 MG (***axitinib***)	3	PA; QL (124 tablets per 30 days.); SP; CM
INQOVI ORAL TABLET 35-100 MG (***decitabine-cedazuridine***)	3/4	PA; QL (5 tablets per month.); CM
IRESSA ORAL TABLET 250 MG (***gefitinib***)	3/4	PA; QL (2 tablets per day.); CM
ITOVEBI ORAL TABLET 3 MG (***inavolisib***)	2	PA; QL (56 tablets per month.); CM
ITOVEBI ORAL TABLET 9 MG (***inavolisib***)	2	PA; QL (28 tablets per month.); CM
IWILFIN ORAL TABLET 192 MG (***eflornithine hcl***)	2	PA; QL (8 tablets per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); CM
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (***ruxolitinib phosphate***)	2	PA; CM
JAYPIRCA ORAL TABLET 100 MG (***pirtobrutinib***)	3/4	PA; QL (3 tablets per day.); CM
JAYPIRCA ORAL TABLET 50 MG (***pirtobrutinib***)	3/4	PA; QL (1 tablet per day.); CM
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (***ribociclib succinate***)	2	PA; QL (21 tablets per month); CM
KISQALI (400 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (42 tablets per 21 days.); CM
KISQALI (400 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (42 tablets per month); CM
KISQALI (600 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (63 tablets per 21 days.); CM
KISQALI (600 MG DOSE) TABLET THERAPY PACK 200 MG ORAL (***ribociclib succinate***)	2	PA; QL (63 tablets per month); CM
KOMZIFTI ORAL CAPSULE 200 MG (***ziftomenib***)	3/4	PA; QL (90 capsules per month.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
KOSELUGO ORAL CAPSULE 10 MG (***selumetinib sulfate***)	3	PA; QL (8 capsules per day.); CM
KOSELUGO ORAL CAPSULE 25 MG (***selumetinib sulfate***)	3	PA; QL (4 capsules per day.); CM
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (***selumetinib sulfate***)	3	PA
KRAZATI ORAL TABLET 200 MG (***adagrasib***)	3/4	PA; QL (6 tablets per day.); CM
lapatinib ditosylate oral tablet 250 mg	1	PA; QL (186 tablets per month.); CM
LAZCLUZE ORAL TABLET 240 MG (***lazertinib mesylate***)	3	PA; QL (30 tablets per month.); CM
LAZCLUZE ORAL TABLET 80 MG (***lazertinib mesylate***)	3	PA; QL (60 tablets per month.); CM
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); CM
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 & 4 MG, 2 X 10 MG, 2 X 4 MG (***lenvatinib mesylate***)	2	PA; QL (2 capsules per day.); CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG, 2 X 10 MG & 4 MG, 3 X 4 MG (***lenvatinib mesylate***)	2	PA; QL (3 capsules per day.); CM
LENVIMA ORAL CAPSULE THERAPY PACK 10 MG, 4 MG (***lenvatinib mesylate***)	2	PA; QL (1 capsule per day.); CM
letrozole oral tablet 2.5 mg	1	H-N
LEUKERAN ORAL TABLET 2 MG (***chlorambucil***)	2	CM
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; SM
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (1 carton (18 capsules) per 28 days.); CM
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (3 blister paks (18 capsules) per 28 days.); CM
LIFYORLI (125 MG DOSE) CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (9 blister paks (18 capsules) per 28 days.); CM
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (1 carton (27 capsules) per 28 days.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (3 blister paks (27 capsules) per 28 days.); CM
LIFYORLI (150 MG DOSE) CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG ORAL (***relacorilant***)	3/4	PA; QL (9 blister paks (27 capsules) per 28 days.); CM
lomustine oral capsule 10 mg, 100 mg, 40 mg	1	CM
LONSURF ORAL TABLET 15-6.14 MG (***trifluridine-tipiracil***)	3/4	PA; QL (100 tablets per month.); CM
LONSURF ORAL TABLET 20-8.19 MG (***trifluridine-tipiracil***)	3/4	PA; QL (80 tablets per 21 days.); CM
LORBRENA ORAL TABLET 100 MG (***lorlatinib***)	3	PA; QL (30 tablets per month.); CM
LORBRENA ORAL TABLET 25 MG (***lorlatinib***)	3	PA; QL (90 tablets per month.); CM
LUMAKRAS ORAL TABLET 120 MG (***sotorasib***)	3/4	PA; QL (240 tablets per month.); CM
LUMAKRAS ORAL TABLET 240 MG (***sotorasib***)	3/4	PA; QL (120 tablets per month.); CM
LUMAKRAS ORAL TABLET 320 MG (***sotorasib***)	3/4	PA; QL (3 tablets per day.); CM
LYNPARZA ORAL TABLET 100 MG, 150 MG (***olaparib***)	2	PA; QL (4 tablets per day); CM
LYSODREN ORAL TABLET 500 MG (***mitotane***)	2	CM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (84 tablets per month.); CM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (112 tablets per month.); CM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (***futibatinib***)	3/4	PA; QL (140 tablets per month.); CM
MATULANE ORAL CAPSULE 50 MG (***procarbazine hcl***)	2	CM
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml	1	
megestrol acetate oral tablet 20 mg, 40 mg	1	
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (***trametinib dimethyl sulfoxide***)	3/4	QL (17.4 ml per day.); CM
MEKINIST ORAL TABLET 0.5 MG (***trametinib dimethyl sulfoxide***)	3/4	PA; QL (2 tablets per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MEKINIST ORAL TABLET 2 MG (***trametinib dimethyl sulfoxide***)	3/4	PA; QL (1 tablet per day.); CM
MEKTOVI ORAL TABLET 15 MG (***binimetinib***)	3/4	PA; QL (6 tablets per day); CM
mercaptopurine oral suspension 2000 mg/100ml	1	CM
mercaptopurine oral tablet 50 mg	1	CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
MODEYSO ORAL CAPSULE 125 MG (***dordaviprone hcl***)	3/4	PA; QL (20 capsules per month.); CM
MYLERAN ORAL TABLET 2 MG (***busulfan***)	2	CM
NERLYNX ORAL TABLET 40 MG (***neratinib maleate***)	2	PA; QL (6 tablets per day.); CM
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	1	PA; QL (4 capsules per day.); CM
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (***ixazomib citrate***)	2	PA; CM
NUBEQA ORAL TABLET 300 MG (***darolutamide***)	2	PA; QL (4 tablets per day.); CM
ODOMZO ORAL CAPSULE 200 MG (***sonidegib phosphate***)	2	PA; QL (1 capsule per day.); CM
OGSIVEO ORAL TABLET 100 MG, 150 MG (***nirogacestat hydrobromide***)	2	PA; QL (56 tablets per month.); CM
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (***tovorafenib***)	3/4	PA; QL (96 ml per month.); CM
OJEMDA ORAL TABLET 100 MG (***tovorafenib***)	3/4	PA; QL (24 tablets per month.); CM
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (***momelotinib dihydrochloride***)	3/4	PA; QL (1 tablet per day.); CM
ONUREG ORAL TABLET 200 MG, 300 MG (***azacitidine***)	2	PA; QL (14 tablets per 24 days.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
ORGOVYX ORAL TABLET 120 MG (***relugolix***)	3	PA; QL (1 tablet per day); CM
ORSERDU ORAL TABLET 345 MG (***elacestrant hydrochloride***)	2	PA; QL (1 tablet per day.); CM
ORSERDU ORAL TABLET 86 MG (***elacestrant hydrochloride***)	2	PA; QL (3 tablets per day.); CM
pazopanib hcl oral tablet 200 mg	1	PA; QL (4 tablets per day.); CM
pazopanib hcl oral tablet 400 mg	1	PA; CM
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (***pemigatinib***)	3/4	PA; QL (31 tablets per month.); CM
PIQRAY ORAL TABLET THERAPY PACK 2 X 150 MG, 200 & 50 MG (***alpelisib***)	2	PA; QL (2 tablets per day.); CM
PIQRAY ORAL TABLET THERAPY PACK 200 MG (***alpelisib***)	2	PA; QL (1 tablet per day.); CM
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	1	PA; QL (21 capsules per 21 days.); CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
QINLOCK ORAL TABLET 50 MG (***ripretinib***)	3/4	PA; QL (3 tablets per day.); CM
RASONQUE ORAL TABLET 100 MG, 150 MG (***daraxonrasib***)	3/4	PA; CM
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (***selpercatinib***)	3/4	PA; QL (60 tablets per month.); CM
RETEVMO ORAL TABLET 40 MG (***selpercatinib***)	3/4	PA; QL (90 tablets per month.); CM
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % (***tretinoin microsphere***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
REVUFORJ ORAL TABLET 110 MG (***revumenib citrate***)	3/4	PA; QL (120 tablets per month.); CM
REVUFORJ ORAL TABLET 160 MG (***revumenib citrate***)	3/4	PA; QL (60 tablets per month.); CM
REVUFORJ ORAL TABLET 25 MG (***revumenib citrate***)	3/4	PA; QL (240 tablets per month.); CM
REZLIDHIA ORAL CAPSULE 150 MG (***olutasidenib***)	2	PA; QL (2 capsules per day.); CM
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (***vimseltinib***)	2	PA; QL (8 capsules per 4 weeks.); CM
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (***entrectinib***)	2	PA; QL (3 capsules per day.); CM
ROZLYTREK ORAL PACKET 50 MG (***entrectinib***)	2	PA; QL (84 packets (2 boxes) per month.); CM
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (***rucaparib camsylate***)	3	PA; QL (4 tablets per day.); CM
RYDAPT ORAL CAPSULE 25 MG (***midostaurin***)	2	PA; QL (8 capsules per day); CM
SCEMBLIX ORAL TABLET 100 MG (***asciminib hcl***)	3/4	PA; QL (120 tablets per month.); CM
SCEMBLIX ORAL TABLET 20 MG, 40 MG (***asciminib hcl***)	3/4	PA; QL (2 tablets per day.); CM
sorafenib tosylate oral tablet 200 mg	1	PA; QL (4 tablets per day.); CM
STIVARGA ORAL TABLET 40 MG (***regorafenib***)	2	PA; QL (84 tablets per 21 days.); CM
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	PA; QL (1 capsule per day.); CM
TABLOID ORAL TABLET 40 MG (***thioguanine***)	2	CM
TABRECTA ORAL TABLET 150 MG, 200 MG (***capmatinib hcl***)	3/4	PA; QL (4 tablets per day.); CM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (***dabrafenib mesylate***)	3/4	PA; QL (4 capsules per day.); CM
TAFINLAR ORAL TABLET SOLUBLE 10 MG (***dabrafenib mesylate***)	3/4	QL (420 tablets per month.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TAGRISSO ORAL TABLET 40 MG, 80 MG (***osimertinib mesylate***)	3	PA; QL (1 tablet per day.); CM
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (***talazoparib tosylate***)	3/4	PA; QL (1 capsule per day.); CM
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	1	CM
TEPMETKO ORAL TABLET 225 MG (***tepotinib hcl***)	3/4	PA; QL (2 tablets per day.); CM
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; CM
TIBSOVO ORAL TABLET 250 MG (***ivosidenib***)	2	PA; QL (2 tablets per day.); CM
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	3/4	
toremifene citrate oral tablet 60 mg	1	CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	
tretinoin external gel 0.01 %, 0.025 %	1	
tretinoin external gel 0.05 %	1	PA
tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin oral capsule 10 mg	1	CM
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
TRUQAP ORAL TABLET 200 MG (***capivasertib***)	2	PA; QL (64 tablets per month.)
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (***capivasertib***)	2	PA; QL (64 tablets every month.); CM
TUKYSA ORAL TABLET 150 MG (***tucatinib***)	2	PA; QL (4 tablets per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TUKYSA ORAL TABLET 50 MG (***tucatinib***)	2	PA; QL (10 tablets per day.); CM
TURALIO ORAL CAPSULE 125 MG (***pexidartinib hcl***)	2	PA; QL (4 capsules per day.); CM
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (***quizartinib dihydrochloride***)	3/4	PA; QL (2 tablets per day.); CM
VENCLEXTA ORAL TABLET 10 MG (***venetoclax***)	2	PA; QL (14 tablets per month.); CM
VENCLEXTA ORAL TABLET 100 MG (***venetoclax***)	2	PA; QL (4 tablets per day.); CM
VENCLEXTA ORAL TABLET 50 MG (***venetoclax***)	2	PA; QL (1 tablet per day.); CM
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (***venetoclax***)	2	PA; QL (42 tablets per year.); CM
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***abemaciclib***)	2	PA; QL (2 tablets per day); CM
VITRAKVI ORAL CAPSULE 100 MG (***larotrectinib sulfate***)	2	PA; QL (2 capsules per day.); CM
VITRAKVI ORAL CAPSULE 25 MG (***larotrectinib sulfate***)	2	PA; QL (6 capsules per day.); CM
VITRAKVI ORAL SOLUTION 20 MG/ML (***larotrectinib sulfate***)	2	PA; QL (10 mL per day.); CM
VORANIGO ORAL TABLET 10 MG (***vorasidenib***)	2	PA; QL (62 tablets per month.); CM
VORANIGO ORAL TABLET 40 MG (***vorasidenib***)	2	PA; QL (31 tablets per month.); CM
WELIREG ORAL TABLET 40 MG (***belzutifan***)	3/4	PA; QL (3 tablets day.); CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
XOSPATA ORAL TABLET 40 MG (***gilteritinib fumarate***)	3	PA; QL (3 tablets per day.); CM
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (***selinexor***)	3/4	PA; QL (0.26 tablet per day.); CM
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (***selinexor***)	3/4	PA; QL (16 tablets per month.); CM
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	3/4	PA; QL (0.29 tablet per day.); CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (***selinexor***)	3/4	PA; QL (1 therapy pack per month.); CM
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	3/4	PA; QL (0.86 tablets per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (***selinexor***)	3/4	PA; QL (0.29 tablet per day.); CM
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG (***selinexor***)	3/4	PA; QL (4 tablets per month.); CM
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (***selinexor***)	3/4	PA; QL (1.15 tablets per day.); CM
XROMI ORAL SOLUTION 100 MG/ML (***hydroxyurea***)	3/4	PA
XTANDI ORAL CAPSULE 40 MG (***enzalutamide***)	2	PA; QL (4 capsules per day.); CM
yulithira oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
yulithira oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
ZELBORAF ORAL TABLET 240 MG (***vemurafenib***)	2	PA; QL (8 tablets per day.); CM
ZENBEXUS ORAL CAPSULE 0.75 MG, 1 MG (***iberdomide hydrochloride***)	3/4	PA; CM
ZOLINZA ORAL CAPSULE 100 MG (***vorinostat***)	2	PA; QL (4 capsules per day.); CM
ZYDELIG ORAL TABLET 100 MG, 150 MG (***idelalisib***)	3/4	PA; QL (60 tablets per month.); CM
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***)	3/4	PA; QL (1 tablet per day.)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (***dust mite mixed allergen ext***)	3/4	PA; QL (1 tablet per day.)
ORALAIR ADULT STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (3 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ORALAIR CHILDRENS STARTER PACK SUBLINGUAL TABLET SUBLINGUAL 100 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (3 tablets per year.)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (***grass mix pollens allergen ext***)	3/4	PA; QL (1 tablet per day.)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (***short ragweed pollen ext***)	3/4	PA; QL (1 tablet per day.)
TOXOIDS - Vaccines		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	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	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	2	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	3	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
TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML (***tetanus-diphtheria toxoids td***)	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (***haemophilus b polysac conj vac***)	2	H
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	3	H
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (***rsvpref3 vac recomb adjuvanted***)	3	H
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***meningococcal b recomb omv adj***)	3	H
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (***tetanus-diphth-acell pertussis***)	2	H
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (***pneumococcal 21-valent conjuga***)	3	H
COMIRNATY 5-11 YEARS INTRAMUSCULAR SUSPENSION 10 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	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 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac a&b surf ant adj***)	3	H
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza virus vacc split pf***)	3	H
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac tiss-cult subunt***)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza virus vacc split pf***)	3	H
FLUMIST NASAL LIQUID (***influenza virus vaccine live***)	3	H
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza vac split high-dose***)	3	H
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***influenza virus vacc split pf***)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML (***hpv 9-valent recomb vaccine***)	3	H
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***hpv 9-valent recomb vaccine***)	3	H
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 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	H
INFANRIX SUSPENSION 25-58-10 INTRAMUSCULAR (***diphth-acell pertussis-tetanus***)	3	H
IPOL INJECTION SUSPENSION (***poliovirus vaccine inactivated***)	2	H
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML (***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
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML (***covid-19 mrna virus vaccine***)	3	H
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***dtap-hepatitis b recomb-ipv***)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PEDVAXHIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (***haemophilus b polysac conj vac***)	2	H
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (***mening acyw(tet conj)-b(rcmb)***)	3	H
PENMENVY INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	H
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (***dtap-ipv-hib vaccine***)	3	H
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (***pneumococcal vac polyvalent***)	2	H
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (***pneumococcal 20-val conj vacc***)	3	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
SPIKEVAX 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (***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 0.5 ML (***meningococcal b vac (recomb)***)	3	H
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (***hepatitis a-hep b recomb vac***)	3	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML (***hepatitis a vaccine***)	2	H
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML, 50 UNIT/ML (***hepatitis a vaccine***)	2	H
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML (***varicella virus vaccine live***)	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	H
AUTONOMIC DRUGS		
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	H
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (***varenicline tartrate***)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (***varenicline tartrate***)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (***varenicline tartrate***)	1	H
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine mouth/throat gum 2 mg, 4 mg	1	H
ft nicotine mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	1	H
goodsense nicotine mouth/throat gum 2 mg, 4 mg	1	H
goodsense nicotine mouth/throat lozenge 4 mg	1	H
goodsense nicotine policrilex mouth/throat gum 4 mg	1	H
habitrol transdermal patch 24 hour 21 mg/24hr	1	H
naltrexone hcl oral tablet 50 mg	1	
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	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, 7 mg/24hr	1	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (***nicotine***)	1	H
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (***varenicline tartrate***)	3/4	PA; QL (0.28 ml per day.)
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	1	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	H
varenicline tartrate(continue) oral tablet 1 mg	1	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, 0.15 MG/0.15ML, 0.3 MG/0.3ML (***epinephrine***)	2	SM
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (***desloratadine-pseudoephedrine***)	3	
droxidopa oral capsule 100 mg	1	PA; QL (90 capsules per month.)
droxidopa oral capsule 200 mg, 300 mg	1	PA; QL (180 capsules per month.)
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	1	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
NEFFY NASAL SOLUTION 1 MG/0.1ML, 2 MG/0.1ML (***epinephrine***)	3/4	
pseudoephedrine-bromphen-dm oral syrup 30-2-10 mg/5ml	1	
ALPHA-ADRENERGIC AGONISTS (12:12) - Drugs for Heart and Lungs		
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	1	
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	1	
JAVADIN ORAL SOLUTION 0.02 MG/ML (***clonidine hcl***)	3/4	PA
lofexidine hcl oral tablet 0.18 mg	1	
methyldopa oral tablet 250 mg, 500 mg	1	PA
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
ONYDA XR ORAL SUSPENSION EXTENDED RELEASE 0.1 MG/ML (***clonidine hcl***)	3	QL (120 mL per month.)
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	1	
ANTIMUSCARINICS/ANTISPASMODICS - Drugs for Parkinson		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (***umeclidinium-vilanterol***)	3	SM
atropine sulfate ophthalmic solution 1 %	1	
belladonna alkaloids-opium rectal suppository 16.2-60 mg	1	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***)	2	QL (0.36 grams per day.); SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***)	3/4	
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	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
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 hfa inhalation aerosol solution 17 mcg/act	1	QL (0.87 grams per day.); SM
ipratropium bromide inhalation solution 0.02 %	1	SM
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LOMOTIL ORAL TABLET 2.5-0.025 MG (***diphenoxylate-atropine***)	3/4	
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	1	
MOTOFEN ORAL TABLET 1-0.025 MG (***difenoxin-atropine***)	3/4	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
scopolamine transdermal patch 72 hour 1 mg/3days	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***tiotropium bromide***)	2	SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
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***)	3	
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (***revefenacin***)	3/4	PA; QL (3 ml per day.); SM
ANTIPARKINSONIAN AGENTS - Drugs for Parkinson		
benztropine mesylate oral tablet 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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		
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (***varenicline tartrate***)	1	H
CHANTIX ORAL TABLET 0.5 MG, 1 MG (***varenicline tartrate***)	1	H
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (***varenicline tartrate***)	1	H
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine mouth/throat gum 2 mg, 4 mg	1	H
ft nicotine mouth/throat lozenge 2 mg, 4 mg	1	H
ft nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	1	H
goodsense nicotine mouth/throat gum 2 mg, 4 mg	1	H
goodsense nicotine mouth/throat lozenge 4 mg	1	H
goodsense nicotine policrilex mouth/throat gum 4 mg	1	H
habitrol transdermal patch 24 hour 21 mg/24hr	1	H
NICORETTE MINI MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT GUM 2 MG (***nicotine polacrilex***)	1	H
NICORETTE MOUTH/THROAT LOZENGE 2 MG, 4 MG (***nicotine polacrilex***)	1	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
nicotine transdermal patch 24 hour 21 mg/24hr, 7 mg/24hr	1	H
NICOTROL NS NASAL SOLUTION 10 MG/ML (***nicotine***)	1	H
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	1	H
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	H
varenicline tartrate(continue) oral tablet 1 mg	1	H
CENTRALLY ACTING SKELETAL MUSCLE RELAXNT - Drugs for Relaxing Muscles		
ATMEKSI ORAL SUSPENSION 750 MG/5ML (***methocarbamol***)	3/4	PA
carisoprodol oral tablet 250 mg, 350 mg	1	
chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg	1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	
metaxalone oral tablet 400 mg, 800 mg	1	
methocarbamol oral tablet 1000 mg, 500 mg, 750 mg	1	
ONTRALFY ORAL SOLUTION 2 MG/5ML (***tizanidine hcl***)	3/4	PA
tanlor oral tablet 1000 mg	1	
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg	1	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (***cyclobenzaprine hcl (fibromy)***)	3/4	PA; QL (60 sublingual tablets per month.)
DIRECT-ACTING SKELETAL MUSCLE RELAXANTS - Drugs for Relaxing Muscles		
DANTRIUM ORAL CAPSULE 25 MG (***dantrolene sodium***)	3/4	
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	1	PA
baclofen oral solution 5 mg/5ml	1	
baclofen oral suspension 25 mg/5ml	1	PA
baclofen oral tablet 10 mg, 15 mg, 20 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
INDIRECT-ACTING SKELETAL MUSCLE RELAXANT - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
NON-SEL. BETA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate oral tablet 10 mg, 20 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
NON-SEL.ALPHA-1-ADRENERGIC BLOCKING AGTS - Drugs for the Heart		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
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	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
TEZRULY ORAL SOLUTION 1 MG/ML (***terazosin hcl***)	3/4	PA
NON-SEL.ALPHA-ADRENERGIC BLOCKING AGENTS - Drugs for the Heart		
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	3/4	
dihydroergotamine mesylate injection solution 1 mg/ml	1	
dihydroergotamine mesylate nasal solution 4 mg/ml	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***)	3/4	
ergotamine-caffeine oral tablet 1-100 mg	1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***)	3	
phenoxybenzamine hcl oral capsule 10 mg	1	
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, 23 mg, 5 mg	1	
donepezil hcl oral tablet dispersible 10 mg, 5 mg	1	
FIRDAPSE ORAL TABLET 10 MG (***amifampridine phosphate***)	2	PA; QL (300 tablets per month.)
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
galantamine hydrobromide oral solution 4 mg/ml	1	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	1	
memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg	1	
MESTINON ORAL SOLUTION 60 MG/5ML (***pyridostigmine bromide***)	3/4	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***)	3/4	
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	1	
pyridostigmine bromide er oral tablet extended release 180 mg	1	
PYRIDOSTIGMINE BROMIDE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG	3	
pyridostigmine bromide oral solution 60 mg/5ml	1	
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	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (***pilocarpine hcl***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
silodosin oral capsule 4 mg, 8 mg	1	
tamsulosin hcl oral capsule 0.4 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	2	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	1	SM
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	SM
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	1	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (***umeclidinium-vilanterol***)	3	SM
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day); SM
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***)	2	QL (0.36 grams per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.); SM
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 grams per day.); SM
DULERA INHALATION AEROSOL 50-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 mcg per day.); SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.); SM
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.); SM
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	1	SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	SM
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	3/4	QL (2 vials per day.); SM
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***salmeterol xinafoate***)	2	QL (1 diskus (60 blisters) per month.); SM
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***tiotropium bromide-olodaterol***)	2	SM
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	SM
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	SM
terbutaline sulfate oral tablet 2.5 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	SM
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	
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
LOPRESSOR ORAL TABLET 12.5 MG (***metoprolol tartrate***)	3/4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
METOPROLOL TARTRATE ORAL TABLET 12.5 MG	3/4	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
SKELETAL MUSCLE RELAXANTS, MISCELLANEOUS - Drugs for Relaxing Muscles		
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BLOOD FORMATION, COAGULATION, THROMBOSIS - Drugs for the Blood		
ANTIANEMIA DRUGS - Vitamins and Minerals		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (***darbepoetin alfa***)	2	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	QL (2 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (***darbepoetin alfa***)	2	QL (4 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (4 ml per 21 days.)
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	1	
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***)	2	PA; QL (1 vial per day and 58 vials per 120 days.); SP
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	3/4	QL (1 tablet per day.)
BLOOD FORM.,COAG,THROMBOSIS AGENTS MISC. - Drugs to Prevent Bleeding		
AQVESME ORAL TABLET 100 MG (***mitapivat sulfate***)	3/4	PA; QL (60 tablets per month.); SP; CM
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (***mitapivat sulfate***)	3	PA; QL (56 tablets per 28 days.); CM
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG (***mitapivat sulfate***)	3	PA; QL (7 tablets per 365 days.); 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***)	3	PA; QL (14 tablets per 365 days.); CM
TAVALISSE ORAL TABLET 100 MG, 150 MG (***fostamatinib disodium***)	3/4	PA; QL (2 tablets per day); SP
WAYRILZ ORAL TABLET 400 MG (***rilzabrutinib***)	3/4	PA; QL (60 tablets per month.)
COUMARIN DERIVATIVES - Drugs to Prevent Blood Clots		
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 (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG (***apixaban***)	2	QL (152 tablets per month.)
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG (***apixaban***)	2	QL (152 tablets per month.)
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (***apixaban***)	2	QL (2.5 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG (***apixaban***)	2	QL (76 sprinkle capsules per month.)
ELIQUIS ORAL TABLET 2.5 MG (***apixaban***)	2	QL (2 tablets per day.)
ELIQUIS ORAL TABLET 5 MG (***apixaban***)	2	QL (2.5 tablets per day.)
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG (***apixaban***)	2	QL (152 tablets per month.)
rivaroxaban oral suspension reconstituted 1 mg/ml	1	QL (20 ml per day.)
rivaroxaban oral tablet 2.5 mg	1	QL (2 tablets per day.)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (***edoxaban tosylate***)	3/4	QL (1 tablet per day.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (***rivaroxaban***)	2	QL (20 ml per day.)
XARELTO ORAL TABLET 10 MG (***rivaroxaban***)	2	QL (1 tablet per day.)
XARELTO ORAL TABLET 15 MG (***rivaroxaban***)	2	QL (52 tablets per month initial 1 tablet per day for maintenance.)
XARELTO ORAL TABLET 2.5 MG (***rivaroxaban***)	2	QL (2 tablets per day.)
XARELTO ORAL TABLET 20 MG (***rivaroxaban***)	2	QL (31 tablets per 31 days.)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (***rivaroxaban***)	2	QL (51 tablets per year.)
DIRECT THROMBIN INHIBITORS - Drugs to Prevent Blood Clots		
dabigatran etexilate mesylate oral capsule 110 mg	1	QL (2 capsules per day.)
dabigatran etexilate mesylate oral capsule 150 mg, 75 mg	1	QL (62 capsules per 31 days.)
PRADAXA ORAL PACKET 110 MG, 20 MG, 30 MG, 40 MG, 50 MG (***dabigatran etexilate mesylate***)	3/4	PA; QL (4 packets per day.)
PRADAXA ORAL PACKET 150 MG (***dabigatran etexilate mesylate***)	3/4	PA; QL (2 packets per day.)
HEMATOPOIETIC AGENTS - Drugs for Anemia		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (***eltrombopag choline***)	3/4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (***darbepoetin alfa***)	2	QL (4 syringes per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML (***darbepoetin alfa***)	2	QL (1.6 ml per month.)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML (***darbepoetin alfa***)	2	QL (1 prefill syringe per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML, 60 MCG/0.3ML (***darbepoetin alfa***)	2	QL (2 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML, 25 MCG/0.42ML, 40 MCG/0.4ML (***darbepoetin alfa***)	2	QL (4 vials per month)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML (***darbepoetin alfa***)	2	QL (2 vials per prescription)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (***darbepoetin alfa***)	2	QL (2 syringes per month)
DOPTELET ORAL TABLET 20 MG (***avatrombopag maleate***)	3/4	PA; QL (60 tablets per month.)
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (***avatrombopag maleate***)	3/4	PA; QL (60 capsules per month.)
eltrombopag olamine oral packet 12.5 mg, 25 mg	1	PA; QL (6 packets per day.)
eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg	1	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (***sargramostim***)	2	
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2ML (***plerixafor***)	3/4	
MULPLETA ORAL TABLET 3 MG (***lusutrombopag***)	3/4	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim***)	2	
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (***filgrastim-aafi***)	2	
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-aafi***)	2	
plerixafor subcutaneous solution 24 mg/1.2ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROMACTA ORAL PACKET 12.5 MG, 25 MG (***eltrombopag olamine***)	3/4	PA; QL (6 packets per day.)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (8 ml per 21 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (12 ml per 21 days.)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML (***epoetin alfa-epbx***)	2	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (***epoetin alfa-epbx***)	2	QL (4 ml per 21 days.)
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (***pegfilgrastim-cbqv***)	2	
VAFSEO ORAL TABLET 150 MG, 300 MG (***vadadustat***)	3/4	PA; QL (31 tablets per month.)
XOLREMDI ORAL CAPSULE 100 MG (***mavorixafor***)	2	PA; QL (120 capsules per month.); SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (***filgrastim-sndz***)	2	
HEMORRHEOLOGIC 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)***)	2	
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT, 750 UNIT	2	
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (***antihemophil fact single chain***)	2	
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor-vwf***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***coagulation factor ix***)	2	
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***coagulation factor ix (rfixfc)***)	3	
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact fc-vwf-xten-ehtl***)	2	
aminocaproic acid oral solution 0.25 gm/ml	1	
aminocaproic acid oral tablet 1000 mg, 500 mg	1	
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)***)	2	
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (***coagulation factor x (human)***)	2	
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (***factor xiii concentrate human***)	2	
CRENESSITY ORAL CAPSULE 100 MG, 50 MG (***crinecerfont***)	3/4	PA; QL (62 capsules per month.); SP
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	3/4	PA; QL (120 mL (4 bottles) per month.); SP
DESMODA ORAL SOLUTION 0.05 MG/ML (***desmopressin acetate***)	3/4	PA
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	
DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML	3	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate pf injection solution 4 mcg/ml	1	
desmopressin acetate spray nasal solution 0.01 %	1	
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (***antihem fact (bdd-rfviiifc)***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (***antiinhibitor coagulant cmplx***)	2	
GELFILM OPHTHALMIC FILM (***gelatin adsorbable***)	2	
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 12 MG/0.4ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML (***emicizumab-kxwh***)	2	PA; SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***)	2	
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (***antihemophilic factor-vwf***)	2	
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***marstacimab-hncq***)	2	PA; QL (4 mL (4 Auto-injectors) per month.)
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***marstacimab-hncq***)	2	PA; QL (4 ml (8 auto-injector/prefilled pens) per month.)
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (***coagulation factor ix (rix-fp)***)	3	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (***antihemophilic factor***)	2	
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (***antihemophilic factor***)	2	
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophil factor (rahf-pfm)***)	2	
MONSELS FERRIC SUBSULFATE EXTERNAL SOLUTION	3	
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihemophil fact bd truncated***)	2	
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (***coagulation factor viia recomb***)	2	
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,sim)***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,sim)***)	2	
OBIZUR INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	3	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (***factor ix complex***)	2	
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (***fitusiran sodium***)	3/4	PA; QL (0.2 mL (1 vial) per month.)
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***fitusiran sodium***)	3/4	PA; QL (0.5 mL (1 pen) per month.)
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (***antihem factor recomb (rfviii)***)	2	
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	2	
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG (***coagulation factor viia-jncw***)	3/4	
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	1	QL (1 tablet per day.)
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (***coagulation factor xiii a-sub***)	3	SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (***von willebrand factor (recomb)***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (***antihemophilic factor-vwf***)	2	
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	3/4	PA
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (***antihem fact (bdd-rfviii,mor)***)	3/4	PA
HEPARINS - Drugs to Prevent Blood Clots		
enoxaparin sodium injection solution 300 mg/3ml	1	
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml	1	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (***dalteparin sodium***)	3/4	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (***dalteparin sodium***)	3/4	
heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml	1	
heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml	1	
heparin sodium (porcine) +rfid injection solution 1000 unit/ml	1	
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml	1	
heparin sodium (porcine) injection solution prefilled syringe 5000 unit/0.5ml	1	
heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml, 5000 unit/ml	1	
INDIRECT FACTOR XA INHIBITORS - Drugs to Prevent Blood Clots		
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
IRON PREPARATIONS - Vitamins and Minerals		
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	3/4	
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	3/4	
NEONATAL COMPLETE ORAL TABLET 27-1 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	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
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	
PRENACORE ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe fumarate-fa***)	3	
prenatal 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***)	3/4	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***)	3/4	
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***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3/4	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3/4	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3/4	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	3/4	
TRINATE ORAL TABLET (***prenatal vit-fe fumarate-fa***)	3	
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	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
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	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
cyanocobalamin nasal solution 500 mcg/0.1ml	1	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (***cyanocobalamin***)	3	
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 adult 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	1	
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 adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 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	1	
ticagrelor oral tablet 60 mg, 90 mg	1	QL (2 tablets per day.)
ZONTIVITY ORAL TABLET 2.08 MG (***vorapaxar sulfate***)	3/4	QL (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 adult low dose oral tablet delayed release 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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 adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 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
VON WILLEBRAND FACTOR-RELATED ANTITHROMB - Drugs to Prevent Blood Clots		
CABLIVI INJECTION KIT 11 MG (***caplacizumab-yhdp***)	2	PA; QL (1 vial per day and 58 vials per 120 days.); SP
CARDIOVASCULAR DRUGS		
BRADYKININ RECEPTORS ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.)
CARBONIC ANHYDRASE INHIBITORS (24:36)		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
dichlorphenamide oral tablet 50 mg	1	PA; QL (4 tablets per day.)
methazolamide oral tablet 25 mg, 50 mg	1	
FACTOR XIIA INHIBITORS		
ANDEMBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.2ML (***garadacimab-gxii***)	2	PA; QL (1 auto-injector per month.)
KALLIKREIN INHIBITORS (24:48:08)		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LOOP DIURETICS (24:36)		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (***bumetanide***)	3	
ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (***bumetanide***)	3/4	PA
ethacrynic acid oral tablet 25 mg	1	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (***furosemide***)	3/4	PA
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***)	3/4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	3/4	QL (31 tablets per month.)
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OSMOTIC DIURETICS (24:36)		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
POTASSIUM-SPARING DIURETICS (24:36)		
amiloride hcl oral tablet 5 mg	1	
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene oral capsule 100 mg, 50 mg	1	
THIAZIDE DIURETICS (24:36)		
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
INZIRQO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***hydrochlorothiazide***)	3/4	PA
THIAZIDE-LIKE DIURETICS (24:36)		
chlorthalidone oral tablet 25 mg, 50 mg	1	
HEMICLOR ORAL TABLET 12.5 MG (***chlorthalidone***)	3/4	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	3/4	
CARDIOVASCULAR DRUGS - Drugs for the Heart		
ACL INHIBITORS - Drugs for Cholesterol		
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)
ALPHA-ADRENERGIC BLOCKING AGENTS (24:16) - Drugs for Varicose Veins		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
TEZRULY ORAL SOLUTION 1 MG/ML (***terazosin hcl***)	3/4	PA
ALPHA-ADRENERGIC BLOCKING AGT.(HYPOTEN) - Drugs for High Blood Pressure & Angina		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
ANGIOTENSIN II RECEP ANTAGONIST/NEPROLYS - Drugs for the Heart		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (2 tablets per day.)
ANGIOTENSIN II RECEPTOR ANTAGON.(HYPOTN) - Drugs for High Blood Pressure & Angina		
azilsartan medoxomil oral tablet 40 mg, 80 mg	1	
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
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	1	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
valsartan oral solution 4 mg/ml	1	PA
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	1	
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	1	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	1	
ARBLI ORAL SUSPENSION 10 MG/ML (***losartan potassium***)	3/4	PA
azilsartan medoxomil oral tablet 40 mg, 80 mg	1	
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***)	3/4	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
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	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (2 tablets per day.)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
valsartan oral solution 4 mg/ml	1	PA
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 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	
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	1	PA
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	3/4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
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	
ZESTRIL ORAL TABLET 10 MG, 20 MG, 5 MG (***lisinopril***)	3/4	
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS - Drugs for the Heart		
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	1	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	
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***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (***benazepril hcl***)	3/4	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
QBRELIS ORAL SOLUTION 1 MG/ML (***lisinopril***)	3/4	PA
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 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	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	1	
ZESTRIL ORAL TABLET 10 MG, 20 MG, 5 MG (***lisinopril***)	3/4	
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***)	3/4	
ANTILIPEMIC AGENTS, MISCELLANEOUS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (***lomitapide mesylate***)	3/4	PA; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 20 MG (***lomitapide mesylate***)	3/4	PA; QL (60 capsules per month.)
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	3/4	PA; QL (62 capsules per month.)
NEXLETOL ORAL TABLET 180 MG (***bempedoic acid***)	2	PA; QL (1 tablet per day.)
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
omega-3-acid ethyl esters oral capsule 1 gm	1	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 autoinjector (0.8 mL) per month.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP
BETA-ADRENERGIC BLOCKING AGENTS (24:20) - Drugs for High Blood Pressure		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (***doxazosin mesylate***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
LOPRESSOR ORAL TABLET 12.5 MG (***metoprolol tartrate***)	3/4	
metoprolol succinate er oral tablet extended release 24 hour 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
METOPROLOL TARTRATE ORAL TABLET 12.5 MG	3/4	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
colesevelam hcl oral packet 3.75 gm	1	
colesevelam hcl oral tablet 625 mg	1	
COLESTID ORAL GRANULES 5 GM (***colestipol hcl***)	3	
COLESTID ORAL TABLET 1 GM (***colestipol hcl***)	3/4	
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***)	3/4	
QUESTRAN ORAL PACKET 4 GM (***cholestyramine***)	3/4	
QUESTRAN ORAL POWDER 4 GM/DOSE (***cholestyramine***)	3/4	
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	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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	
CALCIUM-CHANNEL BLOCKING AGENTS - Drugs for High Blood Pressure & Angina		
CARDAMYST NASAL SOLUTION 2 X 70 MG/DOSE (***etripamil***)	3/4	PA
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	1	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
methazolamide oral tablet 25 mg, 50 mg	1	
CARDIAC DRUGS, MISCELLANEOUS - Drugs for Angina		
ATTRUBY ORAL TABLET THERAPY PACK 356 MG (***acoramidis hcl***)	2	PA; QL (124 tablets per month.)
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (***mavacamten***)	3/4	PA; QL (1 capsule per day.)
CORLANOR ORAL SOLUTION 5 MG/5ML (***ivabradine hcl***)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (***ivabradine hcl***)	3	PA; QL (2 tablets per day.)
ivabradine hcl oral tablet 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	1	
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
CARDIOTONIC AGENTS - Drugs for Angina		
CORLANOR ORAL SOLUTION 5 MG/5ML (***ivabradine hcl***)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (***ivabradine hcl***)	3	PA; QL (2 tablets per day.)
digoxin oral solution 0.05 mg/ml	1	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	1	
ivabradine hcl oral tablet 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
LANOXIN ORAL TABLET 125 MCG, 250 MCG (***digoxin***)	3	
LANOXIN ORAL TABLET 62.5 MCG (***digoxin***)	3/4	
CENTRAL ALPHA-AGONISTS - 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-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl oral tablet 10 mg, 20 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
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	1	
guanfacine hcl oral tablet 1 mg, 2 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
JAVADIN ORAL SOLUTION 0.02 MG/ML (***clonidine hcl***)	3/4	PA
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
LOPRESSOR ORAL TABLET 12.5 MG (***metoprolol tartrate***)	3/4	
methyldopa oral tablet 250 mg, 500 mg	1	PA
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 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	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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***)	3/4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
CGMP SYNTHESIS AGENT - Drugs for High Blood Pressure & Angina		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (***vericiguat***)	3/4	PA; QL (1 tablet per day.)
CHOLESTEROL ABSORPTION INHIBITORS - Drugs for Cholesterol		
ezetimibe oral tablet 10 mg	1	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	1	
NEXLIZET ORAL TABLET 180-10 MG (***bempedoic acid-ezetimibe***)	2	PA; QL (1 tablet per day.)
CLASS IA ANTIARRHYTHMICS - Drugs for Angina		
disopyramide phosphate oral capsule 100 mg, 150 mg	1	
NORPACE ORAL CAPSULE 100 MG, 150 MG (***disopyramide phosphate***)	3/4	
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-125 ORAL SUSPENSION 125 MG/5ML (***phenytoin***)	3	
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	1	
phenytek oral capsule 200 mg, 300 mg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	1	
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	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
betaxolol hcl ophthalmic solution 0.5 %	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
LOPRESSOR ORAL SOLUTION 10 MG/ML (***metoprolol tartrate***)	3/4	PA
LOPRESSOR ORAL TABLET 12.5 MG (***metoprolol tartrate***)	3/4	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
METOPROLOL TARTRATE ORAL TABLET 12.5 MG	3/4	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
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***)	3/4	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	1	
MULTAQ ORAL TABLET 400 MG (***dronedarone hcl***)	3/4	PA
PACERONE ORAL TABLET 100 MG (***amiodarone hcl***)	3	
PACERONE ORAL TABLET 200 MG (***amiodarone hcl***)	3/4	
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***)	3/4	PA
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (***dofetilide***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CLASS IV ANTIARRHYTHMICS - Drugs for Angina		
CARDAMYST NASAL SOLUTION 2 X 70 MG/DOSE (***etripamil***)	3/4	PA
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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	
DIHYDROPYRIDINES - Drugs for High Blood Pressure & Angina		
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	1	
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	1	
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg	1	QL (1 tablet per day)
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	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	
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	3/4	PA
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	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***)	3/4	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DIHYDROPYRIDINES (ANTIHYPERTENSIVE) - Drugs for High Blood Pressure & Angina		
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	
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	3/4	PA
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	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg	1	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (***nisoldipine***)	3/4	
DIRECT VASODILATORS - Drugs for High Blood Pressure & Angina		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	1	
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	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EDEX (2 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)
EDEX (6 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)
guanfacine hcl oral tablet 1 mg, 2 mg	1	
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	1	
methyldopa oral tablet 250 mg, 500 mg	1	PA
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	1	
fenofibrate oral capsule 134 mg, 150 mg, 200 mg, 50 mg, 67 mg	1	
fenofibrate oral tablet 120 mg, 145 mg, 160 mg, 40 mg, 48 mg, 54 mg	1	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	1	
fenofibric acid oral tablet 105 mg, 35 mg	1	
gemfibrozil oral tablet 600 mg	1	
LIPOFEN ORAL CAPSULE 150 MG, 50 MG (***fenofibrate***)	3/4	
LOPID ORAL TABLET 600 MG (***gemfibrozil***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HMG-COA REDUCTASE INHIBITORS - Drugs for Cholesterol		
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	1	
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg	1	QL (1 tablet per day)
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (***atorvastatin calcium***)	3/4	PA
atorvastatin calcium oral tablet 10 mg, 20 mg	1	H-N
atorvastatin calcium oral tablet 40 mg, 80 mg	1	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	1	
FLOLIPID ORAL SUSPENSION 20 MG/5ML, 40 MG/5ML	3/4	PA
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	1	
fluvastatin sodium oral capsule 20 mg, 40 mg	1	
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (***pitavastatin calcium***)	3/4	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	H
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	1	
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	1	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	H-N
simvastatin oral tablet 80 mg	1	
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (***pitavastatin magnesium***)	3/4	
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	1	
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***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SOAANZ ORAL TABLET 40 MG (***torsemide***)	3/4	QL (31 tablets per month.)
torsemide 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***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
KERENDIA ORAL TABLET 10 MG, 20 MG (***finerenone***)	3/4	PA; QL (1 tablet per day.)
KERENDIA ORAL TABLET 40 MG (***finerenone***)	3/4	PA; QL (30 tablets per month.)
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
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***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
MTP PROTEIN INHIBITORS - Drugs for Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (***lomitapide mesylate***)	3/4	PA; QL (1 capsule per day.)
JUXTAPID ORAL CAPSULE 2 MG (***lomitapide mesylate***)	3/4	PA; QL (30 capsules per month.)
JUXTAPID ORAL CAPSULE 20 MG (***lomitapide mesylate***)	3/4	PA; QL (60 capsules per month.)
JUXTAPID ORAL CAPSULE 30 MG (***lomitapide mesylate***)	3/4	PA; QL (62 capsules per month.)
NITRATES AND NITRITES - 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (***sotalol hcl af***)	3/4	
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	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	1	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	1	
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	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (***metoprolol succinate***)	3/4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
nitro-bid transdermal ointment 2 %	1	
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 rectal ointment 0.4 %	1	QL (30 grams per month.)
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	1	
nitroglycerin transdermal ointment 2 %	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
nitroglycerin translingual solution 0.4 mg/spray	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	3/4	
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (***nitroglycerin***)	3	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	3/4	QL (30 grams per month.)
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (***sotalol hcl***)	3/4	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
NITRATES AND NITRITES - Drugs for the Heart		
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	1	
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 %	1	
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 ointment 2 %	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
nitroglycerin translingual solution 0.4 mg/spray	1	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL 0.3 MG, 0.4 MG, 0.6 MG (***nitroglycerin***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (***nitroglycerin***)	3	
OMEGA-3-MEDIATED ANTILIPEMICS - Drugs for Cholesterol		
omega-3-acid ethyl esters oral capsule 1 gm	1	
PCSK9 INHIBITORS - Drugs for Cholesterol		
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (***evolocumab***)	2	QL (2 pens per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for High Blood Pressure & Angina		
alyq oral tablet 20 mg	1	PA; QL (6 tablets per month)
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (6 tablets per month)
cilostazol oral tablet 100 mg, 50 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	3/4	PA; QL (6 tablets per month)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (6 tablets per month)
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
vardenafil hcl oral tablet dispersible 10 mg	1	QL (6 tablets per month)
VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (***sildenafil citrate***)	3	QL (4 films per month.)
PHOSPHODIESTERASE TYPE 5 INHIBITORS - Drugs for the Heart		
alyq oral tablet 20 mg	1	PA; QL (6 tablets per month)
avanafil oral tablet 100 mg, 200 mg, 50 mg	1	PA; QL (6 tablets per month)
cilostazol oral tablet 100 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (***avanafil***)	3/4	PA; QL (6 tablets per month)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (6 tablets per month)
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
vardenafil hcl oral tablet dispersible 10 mg	1	QL (6 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***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
triamterene oral capsule 100 mg, 50 mg	1	
RENIN INHIBITORS - Drugs for the Heart		
aliskiren fumarate oral tablet 150 mg, 300 mg	1	
TEKTURNA ORAL TABLET 150 MG, 300 MG (***aliskiren fumarate***)	3	
RENIN-ANGIOTEN.-ALDOST. SYS. INHIB, MISC - Drugs for the Heart		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month.)
ENTRESTO ORAL CAPSULE SPRINKLE 6-6 MG (***sacubitril-valsartan***)	3/4	PA; QL (240 sprinkle capsules (pellets) per month)
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	PA; QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
STEROIDAL MINERALOCORTICOID RECEPTOR ANT - Drugs for the Heart		
CAROSPIR ORAL SUSPENSION 25 MG/5ML (***spironolactone***)	3/4	PA; SM
eplerenone oral tablet 25 mg, 50 mg	1	
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
THIAZIDE DIURETICS(HYPOTENSIVE AGENTS) - Drugs for High Blood Pressure & Angina		
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	
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	3/4	
VASODILATING AGENTS, MISC (24:08) - Drugs for High Blood Pressure & Angina		
phenoxybenzamine hcl oral capsule 10 mg	1	
VECAMYL ORAL TABLET 2.5 MG (***mecamylamine hcl***)	3/4	
VASODILATING AGENTS, MISCELLANEOUS - Drugs for the Heart		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.)
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.)
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.)
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)
CORLANOR ORAL SOLUTION 5 MG/5ML (***ivabradine hcl***)	3	PA; QL (20 ml per day.)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (***ivabradine hcl***)	3	PA; QL (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	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
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	1	
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 (2 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)
EDEX (6 CARTRIDGE) INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (***alprostadil (vasodilator)***)	3	QL (6 units per month)
ivabradine hcl oral tablet 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
KATERZIA ORAL SUSPENSION 1 MG/ML (***amlodipine benzoate***)	3/4	PA
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.)
matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
nimodipine oral capsule 30 mg	1	
NIMODIPINE ORAL SOLUTION 60 MG/20ML	2	
NORLIQVA ORAL SOLUTION 1 MG/ML (***amlodipine besylate***)	3/4	PA
NYMALIZE ORAL SOLUTION 6 MG/ML (***nimodipine***)	2	
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	3/4	PA; QL (744 tablets per month.)
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (***diltiazem hcl er beads***)	3/4	
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (***treprostinil***)	2	PA; QL (224 cartidges per month.)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (***treprostinil***)	2	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.)
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 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	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (***vericiguat***)	3/4	PA; QL (1 tablet per day.)
YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (***treprostinil sodium***)	2	PA; QL (140 capsules per month.)
CENTRAL NERVOUS SYSTEM AGENTS		
AMYOTROPHIC LATERAL SCLEROSIS(ALS) AGENT		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.)
riluzole oral tablet 50 mg	1	
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
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	
ADENOSINE A2A RECEPTOR ANTAGONISTS - Drugs for Parkinson		
NOURIANZ ORAL TABLET 20 MG, 40 MG (***istradefylline***)	3	PA; QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AMPHETAMINES - Drugs for the Nervous System		
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (***amphetamine***)	3/4	QL (1 tablet per day.)
amphetamine er oral tablet extended release dispersible 12.5 mg, 15.7 mg, 18.8 mg, 3.1 mg, 6.3 mg, 9.4 mg	1	QL (1 tablet per day.)
amphetamine sulfate oral tablet 10 mg, 5 mg	1	
amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	1	QL (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	
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg	1	QL (1 capsule per day)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	1	QL (5 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	1	QL (4 capsules per day.)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	1	QL (10 capsules per day.)
dextroamphetamine sulfate oral solution 5 mg/5ml	1	
dextroamphetamine sulfate oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	1	
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (***amphetamine***)	3/4	QL (15 mL per day.)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 10 MG, 15 MG, 5 MG (***amphetamine***)	3/4	QL (1 tablet per day.)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 20 MG (***amphetamine***)	3/4	QL (31 chewable tablets per month.)
EVEKEO ORAL TABLET 10 MG, 5 MG (***amphetamine sulfate***)	3/4	
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	1	QL (2 capsules per day.)
lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	1	QL (1 capsule per day)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	1	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	1	QL (1 tablet per day)
methamphetamine hcl oral tablet 5 mg	1	
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG, 50 MG (***amphetamine-dextroamphetamine***)	3/4	QL (1 capsule per day)
PROCENTRA ORAL SOLUTION 5 MG/5ML (***dextroamphetamine sulfate***)	3	
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (***dextroamphetamine***)	3	PA; QL (1 patch per day.)
ANALGESICS AND ANTIPYRETICS, MISC. - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	3/4	
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	1	
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
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 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
JOURNAVX ORAL TABLET 50 MG (***suzetrigine***)	3/4	QL (30 tablets per 90 days.)
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
ANOREXIGENIC AGENTS AND STIMULANTS, MISC - Drugs for the Nervous System		
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (***diazoxide choline***)	3	PA; QL (90 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (***diazoxide choline***)	3	PA; QL (120 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***diazoxide choline***)	3	PA; QL (210 tablets per month.)
ANOREXIGENIC AGENTS, MISCELLANEOUS - Drugs for the Nervous System		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (***setmelanotide acetate***)	3	PA; QL (9 mls per month.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (2 pens (6 mL) per month.)
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (3 pens (9 mL) per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG (***diazoxide choline***)	3	PA; QL (90 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG (***diazoxide choline***)	3	PA; QL (120 tablets per month.)
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***diazoxide choline***)	3	PA; QL (210 tablets per month.)
ANTICHOLINERGIC AGENTS (CNS) - Drugs for Parkinson		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
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	
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (***eslicarbazepine acetate***)	3/4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	3/4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	3/4	PA
brivaracetam oral solution 10 mg/ml	1	PA
brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	1	PA
BRIVIACT ORAL SOLUTION 10 MG/ML (***brivaracetam***)	3/4	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (***brivaracetam***)	3	PA
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
carbamazepine oral suspension 100 mg/5ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg, 200 mg	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine***)	3/4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***)	3	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***)	3	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (***cannabidiol***)	3	PA
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***)	3/4	
eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg	1	PA
felbamate oral suspension 600 mg/5ml	1	
felbamate oral tablet 400 mg, 600 mg	1	
FELBATOL ORAL TABLET 400 MG, 600 MG (***felbamate***)	3/4	
FINTEPLA ORAL SOLUTION 2.2 MG/ML (***fenfluramine hcl***)	3/4	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (***perampanel***)	3/4	PA
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (***perampanel***)	3	PA
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
gabapentin oral solution 250 mg/5ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	
KEPPRA ORAL SOLUTION 100 MG/ML (***levetiracetam***)	3/4	
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (***levetiracetam***)	3/4	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (***levetiracetam***)	3/4	
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	1	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***)	3/4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***)	3/4	
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***)	3/4	
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***)	3/4	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***)	3/4	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine odt oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	
lamotrigine starter kit-blue oral kit 35 x 25 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	1	
levetiracetam oral solution 100 mg/ml, 500 mg/5ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
LEVETIRACETAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG	3/4	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (***lacosamide***)	3	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	
oxcarbazepine oral suspension 300 mg/5ml	1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
perampanel oral suspension 0.5 mg/ml	1	PA
perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	1	PA
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
roweepra oral tablet 500 mg	1	
rufinamide oral suspension 40 mg/ml	1	
rufinamide oral tablet 200 mg, 400 mg	1	PA
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG (***levetiracetam***)	3/4	
SUBVENITE ORAL SUSPENSION 10 MG/ML (***lamotrigine***)	3/4	PA
subvenite oral tablet 100 mg, 150 mg, 200 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (***carbamazepine***)	3/4	
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	3/4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***)	3/4	
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (***topiramate***)	3/4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***)	3/4	PA
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***)	3/4	
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***)	3/4	
valproic acid oral capsule 250 mg	1	
valproic acid oral solution 250 mg/5ml	1	
vigabatrin oral packet 500 mg	1	PA; QL (6 packets per day.)
vigabatrin oral tablet 500 mg	1	PA; QL (6 tablets per day.)
VIGADRONE ORAL PACKET 500 MG (***vigabatrin***)	1	PA; QL (6 packets per day.); SP
VIGADRONE ORAL TABLET 500 MG (***vigabatrin***)	1	PA; QL (6 tablets per day.); SP
VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***)	3/4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***)	3/4	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (***cenobamate***)	3	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
XCOPRI ORAL TABLET THERAPY PACK 100 & 150 MG, 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG, 150 & 200 MG (***cenobamate***)	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (***zonisamide***)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (***zonisamide***)	3/4	PA
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
ZTALMY ORAL SUSPENSION 50 MG/ML (***ganaxolone***)	3/4	PA
ANTIDEPRESSANTS, MISCELLANEOUS - Drugs for Depression & Psychosis		
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (***dextromethorphan-bupropion***)	3/4	QL (2 tablets per day.)
AUVELITY TITRATION PACK ORAL TABLET EXTENDED RELEASE THERAPY PACK 30-105 MG & 45-105 MG (***dextromethorphan-bupropion***)	3/4	QL (1 titration pack every 365 days.)
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	
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	1	
BUPROPION HCL ER (XL) ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG	3/4	QL (1 tablet per day.)
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***)	3/4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	3/4	PA; QL (12 devices (4 kits) per month.)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (***zuranolone***)	2	PA; QL (28 capsules per year.)
ZURZUVAE ORAL CAPSULE 30 MG (***zuranolone***)	2	PA; QL (14 capsules per year.)
ANTIMANIC AGENTS - Drugs for Personality Disorder		
aripiprazole oral solution 1 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	
aripiprazole oral tablet dispersible 10 mg, 15 mg	1	QL (1 tablet per day.)
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	1	QL (2 tablets per day)
asenapine maleate sublingual tablet sublingual 2.5 mg	1	QL (2 tablets per day.)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	
carbamazepine oral suspension 100 mg/5ml	1	
carbamazepine oral tablet 200 mg	1	
carbamazepine oral tablet chewable 100 mg, 200 mg	1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine***)	3/4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (***carbamazepine (antipsychotic)***)	3/4	
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (***lamotrigine***)	3/4	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (***lamotrigine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (***lamotrigine***)	3/4	
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (***lamotrigine***)	3/4	
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (***lamotrigine***)	3/4	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (***lamotrigine***)	3/4	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	1	
lamotrigine odt oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	1	
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 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***)	3/4	
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	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-50 mg	1	QL (1 capsule per day)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	1	
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	
SUBVENITE ORAL SUSPENSION 10 MG/ML (***lamotrigine***)	3/4	PA
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	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (***carbamazepine***)	3/4	
TEGRETOL ORAL TABLET 200 MG (***carbamazepine***)	3/4	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (***carbamazepine***)	3/4	
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	1	
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 adult low dose oral tablet delayed release 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	1	
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	3/4	
caffeine citrate oral solution 60 mg/3ml	1	
CAMBIA ORAL PACKET 50 MG (***diclofenac potassium(migraine)***)	3/4	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (***divalproex sodium***)	3/4	
diclofenac potassium(migraine) oral packet 50 mg	1	
dihydroergotamine mesylate injection solution 1 mg/ml	1	
dihydroergotamine mesylate nasal solution 4 mg/ml	1	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral capsule delayed release sprinkle 125 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG (***ergotamine tartrate***)	3/4	
ergotamine-caffeine oral tablet 1-100 mg	1	
ft aspirin adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 81 mg	E	H
goodsense 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (***propranolol hcl***)	3	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (***topiramate***)	3/4	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (***topiramate***)	3/4	PA
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 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	
ANTIPSYCHOTICS, MISCELLANEOUS - Drugs for Depression & Psychosis		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (1 starter pack per year.)
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	1	
molindone hcl oral tablet 10 mg, 25 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
pimozide oral tablet 1 mg, 2 mg	1	
ANXIOLYTICS,SEDATIVES,AND HYPNOTICS,MISC - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***)	3/4	QL (1 tablet per day.)
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***zolpidem tartrate***)	3/4	QL (1 sublingual tablet per day)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (***tasimelteon***)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	3/4	PA; QL (1 capsule per day.)
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 12.5 mg/10ml, 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 (***promethazine hcl***)	3	
ramelteon oral tablet 8 mg	1	QL (1 tablet per day)
tasimelteon oral capsule 20 mg	1	PA; QL (1 capsule per day.)
zaleplon oral capsule 10 mg, 5 mg	1	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	
ZOLPIDEM TARTRATE ORAL CAPSULE 7.5 MG	3/4	QL (1 capsule per day.)
zolpidem tartrate oral tablet 10 mg, 5 mg	1	
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	1	QL (1 sublingual tablet per day)
ATYPICAL ANTIPSYCHOTICS - Drugs for Depression & Psychosis		
aripiprazole oral solution 1 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	
aripiprazole oral tablet dispersible 10 mg, 15 mg	1	QL (1 tablet per day.)
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	1	QL (2 tablets per day)
asenapine maleate sublingual tablet sublingual 2.5 mg	1	QL (2 tablets per day.)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (***lumateperone tosylate***)	3/4	PA; QL (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, 25 MG (***clozapine***)	3/4	
FANAPT ORAL TABLET 1 MG (***iloperidone***)	3/4	QL (86 tablets per year.)
FANAPT ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG (***iloperidone***)	3/4	QL (2 tablets per day)
FANAPT ORAL TABLET 2 MG (***iloperidone***)	3/4	QL (56 tablets per year.)
FANAPT TITRATION PACK A ORAL TABLET 1 & 2 & 4 & 6 MG (***iloperidone***)	3	QL (8 tablets (1 pack) per 365 days.)
FANAPT TITRATION PACK B ORAL TABLET 1 & 2 & 6 & 8 MG (***iloperidone***)	3/4	QL (1 pack (12 tablets) per 365 days.)
FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG (***iloperidone***)	3/4	QL (2 pack (8 tablets) per 365 days.)
lurasidone hcl oral tablet 120 mg, 20 mg, 60 mg	1	QL (1 tablet per day.)
lurasidone hcl oral tablet 40 mg	1	QL (1 tablet per day)
lurasidone hcl oral tablet 80 mg	1	QL (2 tablets per day.)
NUPLAZID ORAL CAPSULE 34 MG (***pimavanserin tartrate***)	3/4	PA; QL (31 capsules per month.)
NUPLAZID ORAL TABLET 10 MG (***pimavanserin tartrate***)	3/4	PA; QL (31 tablets per month.)
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	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	1	QL (1 capsule per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg	1	QL (1 tablet per day)
paliperidone er oral tablet extended release 24 hour 6 mg	1	QL (2 tablets per day)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	1	
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	1	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (***brexpiprazole***)	3/4	QL (1 tablet per day.)
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	
VERSACLOZ ORAL SUSPENSION 50 MG/ML (***clozapine***)	3/4	
VRAYLAR ORAL CAPSULE 0.5 MG (***cariprazine hcl***)	3/4	QL (60 capsules per month.)
VRAYLAR ORAL CAPSULE 0.75 MG (***cariprazine hcl***)	3/4	QL (30 capsules per month.)
VRAYLAR ORAL CAPSULE 1.5 MG, 4.5 MG, 6 MG (***cariprazine hcl***)	3/4	QL (1 capsule per day.)
VRAYLAR ORAL CAPSULE 3 MG (***cariprazine hcl***)	3/4	
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	
BARBITURATES (ANTICONVULSANTS) - Drugs for Seizures		
MYSOLINE ORAL TABLET 250 MG, 50 MG (***primidone***)	2	
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, 250 mg, 50 mg	1	
BARBITURATES (ANXIOLYTIC, SEDATIVE/HYP) - Drugs for Anxiety & Sleep Disorder		
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	3/4	
ascomp-codeine oral capsule 50-325-40-30 mg	1	
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	1	
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
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	
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
BENZODIAZEPINES (ANTICONVULSANTS) - Drugs for Seizures		
clobazam oral suspension 2.5 mg/ml	1	PA
clobazam oral tablet 10 mg, 20 mg	1	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	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG (***lorazepam***)	3/4	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***)	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***)	3/4	
ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***)	3/4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (***clobazam***)	3/4	PA
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (***diazepam***)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML (***diazepam***)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML (***diazepam***)	3	PA; QL (1 box (5 doses/box) per month.)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (***diazepam***)	3	PA; QL (1 box (5 doses/box) per month.)
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	
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	
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	1	
clobazam oral suspension 2.5 mg/ml	1	PA
clobazam oral tablet 10 mg, 20 mg	1	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
estazolam oral tablet 1 mg, 2 mg	1	
flurazepam hcl oral capsule 15 mg, 30 mg	1	
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	
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG, 3 MG (***lorazepam***)	3/4	
midazolam hcl oral syrup 2 mg/ml	1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (***midazolam (anticonvulsant)***)	3	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (***clobazam***)	3/4	
ONFI ORAL TABLET 10 MG, 20 MG (***clobazam***)	3/4	
oxazepam oral capsule 10 mg, 15 mg, 30 mg	1	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (***temazepam***)	3/4	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (***clobazam***)	3/4	PA
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, 70 MG/ML (***erenumab-aooe***)	2	PA; QL (1 pen per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (***galcanezumab-gnlm***)	2	PA; QL (0.04 ml per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***galcanezumab-gnlm***)	2	PA; QL (0.1 mL per day.)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***galcanezumab-gnlm***)	2	PA; QL (0.04 ml per day.)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (***rimegepant sulfate***)	2	PA; QL (0.27 tablets per day. 8 tablets per prescription.)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (***atogepant***)	2	PA; QL (1 tablet per day.)
UBRELVY ORAL TABLET 100 MG, 50 MG (***ubrogepant***)	2	PA; QL (0.27 tablets per day.)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (***zavegepant hcl***)	3/4	PA
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	
ONGENTYS ORAL CAPSULE 25 MG, 50 MG (***opicapone***)	3/4	QL (1 capsule per day.)
tolcapone oral tablet 100 mg	1	
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***)	3/4	PA; QL (1 tablet per day.)
atomoxetine hcl oral capsule 10 mg, 25 mg	1	QL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1	QL (1 capsule per day)
atomoxetine hcl oral capsule 18 mg	1	QL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	1	QL (2 capsules per day)
DAYBUE ORAL SOLUTION 200 MG/ML (***trofinetide***)	2	PA; QL (120 ml per day.)
DAYBUE STIX ORAL PACKET 5000 MG, 6000 MG, 8000 MG (***trofinetide***)	2	PA; QL (120 packets per month.)
dextromethorphan-quinidine oral capsule 20-10 mg	1	PA; QL (2 capsules per day.)
guanfacine hcl er oral tablet extended release 24 hour 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
guanfacine hcl oral tablet 1 mg, 2 mg	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
LYNKUET ORAL CAPSULE 60 MG (***elinzanetant***)	3/4	PA; QL (60 capsules per month.)
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	1	
memantine hcl oral solution 2 mg/ml	1	
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	1	
memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg	1	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (***memantine hcl-donepezil hcl***)	3/4	
NOURIANZ ORAL TABLET 20 MG, 40 MG (***istradefylline***)	3	PA; QL (1 tablet per day.)
NUEDEXTA ORAL CAPSULE 20-10 MG (***dextromethorphan-quinidine***)	2	PA; QL (2 capsules per day.)
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (50 ml per month.)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (***edaravone***)	3	PA; QL (1 starter kit per year.)
riluzole oral tablet 50 mg	1	
sodium oxybate oral solution 500 mg/ml	3/4	PA; QL (18 ml per day.); SP
TEGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML (***riluzole***)	3	PA
VEOZAH ORAL TABLET 45 MG (***fezolinetant***)	3/4	PA; QL (1 tablet per day.)
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	3/4	PA; QL (4 autoinjector pens (1.2mls) per month.)
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
XYWAV ORAL SOLUTION 500 MG/ML (***ca, mg, k, and na oxybates***)	3/4	PA; QL (18 mL per day.); SP
CYCLOOXYGENASE-2 (COX-2) INHIBITORS - Drugs for Pain		
celecoxib oral capsule 100 mg, 200 mg, 400 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VYSCOXA ORAL SUSPENSION 10 MG/ML (***celecoxib***)	3/4	PA
DIBENZOXAPINES - Drugs for Depression & Psychosis		
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	1	
DIHYDROINDOLONES - Drugs for Depression & Psychosis		
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	1	
DIPHENYLBUTYLPERIDINES - Drugs for Depression & Psychosis		
pimozide oral tablet 1 mg, 2 mg	1	
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	
CREXONT ORAL CAPSULE EXTENDED RELEASE 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG (***carbidopa-levodopa***)	3/4	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (***carbidopa-levodopa***)	3/4	PA
INBRIJA INHALATION CAPSULE 42 MG (***levodopa***)	3	PA; QL (10 tablets per day.)
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (***carbidopa-levodopa***)	3/4	
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	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FIBROMYALGIA AGENTS - Drugs for Nerve Pain		
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	
milnacipran hcl oral 12.5 & 25 & 50 mg	1	QL (1 pack per 365 days.)
milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	QL (2 tablets per day)
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
TONMYA SUBLINGUAL TABLET SUBLINGUAL 2.8 MG (***cyclobenzaprine hcl (fibromy)***)	3/4	PA; QL (60 sublingual tablets per month.)
GABA-MEDIATED ANTICONVULSANTS - Drugs for Seizures		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (***divalproex sodium***)	3/4	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (***divalproex sodium***)	3/4	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (***stiripentol***)	3	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (***stiripentol***)	3	PA
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
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	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	1	
valproic acid oral solution 250 mg/5ml	1	
vigabatrin oral packet 500 mg	1	PA; QL (6 packets per day.)
vigabatrin oral tablet 500 mg	1	PA; QL (6 tablets per day.)
VIGADRONE ORAL PACKET 500 MG (***vigabatrin***)	1	PA; QL (6 packets per day.); SP
VIGADRONE ORAL TABLET 500 MG (***vigabatrin***)	1	PA; QL (6 tablets per day.); SP
VIGAFYDE ORAL SOLUTION 100 MG/ML (***vigabatrin***)	1	PA; QL (900 mL per month.); SP
ZTALMY ORAL SUSPENSION 50 MG/ML (***ganaxolone***)	3/4	PA
GABAPENTINOIDS - Drugs for Seizures		
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	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (***pregabalin***)	3/4	
LYRICA ORAL SOLUTION 20 MG/ML (***pregabalin***)	3/4	
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (***gabapentin***)	3/4	
NEURONTIN ORAL SOLUTION 250 MG/5ML (***gabapentin***)	3/4	
NEURONTIN ORAL TABLET 600 MG, 800 MG (***gabapentin***)	3/4	
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
pregabalin oral solution 20 mg/ml	1	
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-125 ORAL SUSPENSION 125 MG/5ML (***phenytoin***)	3	
phenytek oral capsule 200 mg, 300 mg	1	
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	
ION CHANNEL INHIBITION AGENTS - Drugs for Seizures		
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (***eslicarbazepine acetate***)	3/4	PA
BANZEL ORAL SUSPENSION 40 MG/ML (***rufinamide***)	3/4	PA
BANZEL ORAL TABLET 200 MG, 400 MG (***rufinamide***)	3/4	PA
eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg	1	PA
lacosamide oral solution 10 mg/ml, 100 mg/10ml, 50 mg/5ml	1	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (***lacosamide***)	3	PA
oxcarbazepine oral suspension 300 mg/5ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	
rufinamide oral suspension 40 mg/ml	1	
rufinamide oral tablet 200 mg, 400 mg	1	PA
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (***oxcarbazepine***)	3/4	
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (***oxcarbazepine***)	3/4	
VIMPAT ORAL SOLUTION 10 MG/ML (***lacosamide***)	3/4	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (***lacosamide***)	3/4	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (***cenobamate***)	3	PA
XCOPRI ORAL TABLET THERAPY PACK 100 & 150 MG, 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG, 150 & 200 MG (***cenobamate***)	3	PA
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (***zonisamide***)	3/4	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML (***zonisamide***)	3/4	PA
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
MELATONIN RECEPTOR AGONISTS - Drugs for Anxiety & Sleep Disorder		
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (***tasimelteon***)	3/4	PA; QL (5.1 mL per day.)
HETLIOZ ORAL CAPSULE 20 MG (***tasimelteon***)	3/4	PA; QL (1 capsule per day.)
ramelteon oral tablet 8 mg	1	QL (1 tablet per day)
tasimelteon oral capsule 20 mg	1	PA; QL (1 capsule per day.)
MONOAMINE OXIDASE B INHIBITORS - Drugs for Parkinson		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (***selegiline***)	3	
rasagiline mesylate oral tablet 0.5 mg, 1 mg	1	
selegiline hcl oral capsule 5 mg	1	
selegiline hcl oral tablet 5 mg	1	
ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (***selegiline hcl***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MONOAMINE OXIDASE INHIBITORS - Drugs for Depression & Psychosis		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (***selegiline***)	3	
MARPLAN ORAL TABLET 10 MG (***isocarboxazid***)	3	
NARDIL ORAL TABLET 15 MG (***phenelzine sulfate***)	3/4	
PARNATE ORAL TABLET 10 MG (***tranylcypromine sulfate***)	3/4	
phenelzine sulfate oral tablet 15 mg	1	
rasagiline mesylate oral tablet 0.5 mg, 1 mg	1	
selegiline hcl oral capsule 5 mg	1	
selegiline hcl oral tablet 5 mg	1	
tranylcypromine sulfate oral tablet 10 mg	1	
ZELAPAR ORAL TABLET DISPERSIBLE 1.25 MG (***selegiline hcl***)	3	
NMDA ANTAGONISTS - Drugs for Depression & Psychosis		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	3/4	PA; QL (8 devices (4 kits) per month.)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (***esketamine hcl***)	3/4	PA; QL (12 devices (4 kits) per month.)
NON-BENZODIAZEPINE ANXIOLYTICS - Drugs for Anxiety & Sleep Disorder		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
meprobamate oral tablet 200 mg, 400 mg	1	
NON-BENZODIAZEPINE HYPNOTICS - Drugs for Anxiety & Sleep Disorder		
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (***zolpidem tartrate***)	3/4	QL (1 sublingual tablet per day)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	
zaleplon oral capsule 10 mg, 5 mg	1	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	1	
ZOLPIDEM TARTRATE ORAL CAPSULE 7.5 MG	3/4	QL (1 capsule per day.)
zolpidem tartrate 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	1	QL (1 sublingual tablet per day)
NONERGOT-DERIV.DOPAMINE RECEPTOR AGONIST - Drugs for Parkinson		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (***apomorphine hcl***)	3/4	PA; QL (3 ml per day.)
apomorphine hcl subcutaneous solution cartridge 30 mg/3ml	1	PA; QL (3 ml per day.)
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (***rotigotine***)	3	
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	
ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	1	
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	
NON-OPIOID ANALGESICS - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT
ALLZITAL ORAL TABLET 25-325 MG (***butalbital-acetaminophen***)	3/4	
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	
butalbital-acetaminophen oral tablet 50-325 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	1	
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
TENCON ORAL TABLET 50-325 MG (***butalbital-acetaminophen***)	3	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
NONSTEROIDAL ANTI-INFLAMM. AGENTS, MISC - Drugs for Pain		
CAMBIA ORAL PACKET 50 MG (***diclofenac potassium(migraine)***)	3/4	
diclofenac potassium oral capsule 25 mg	1	QL (4 capsules per day.)
diclofenac potassium oral tablet 50 mg	1	
diclofenac potassium(migraine) oral packet 50 mg	1	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	1	
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	1	
diflunisal oral tablet 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	PA
indomethacin rectal suppository 50 mg	1	PA
ketorolac tromethamine oral tablet 10 mg	1	
LURBIRO ORAL TABLET 100 MG (***flurbiprofen***)	3	
meclofenamate sodium oral capsule 100 mg, 50 mg	1	
mefenamic acid oral capsule 250 mg	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3/4	PA
meloxicam oral tablet 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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	
sulindac oral tablet 150 mg, 200 mg	1	
ZIPSOR ORAL CAPSULE 25 MG (***diclofenac potassium***)	3/4	QL (4 capsules per day.)
OPIOID AGONISTS (28:08) - Drugs for Pain		
acetaminophen-codeine oral solution 120-12 mg/5ml	1	NTT
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	NTT
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
ascomp-codeine oral capsule 50-325-40-30 mg	1	
belladonna alkaloids-opium rectal suppository 16.2-60 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
codeine sulfate oral tablet 15 mg, 30 mg, 60 mg	1	NTT
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (***tramadol hcl***)	3/4	QL (1 capsule per day)
diskets oral tablet soluble 40 mg	1	QL (1.5 tablets per day.)
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
fentanyl transdermal patch 72 hour 100 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr	1	PA; QL (0.34 patches per day)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr	1	PA; QL (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	1	PA; QL (2 capsules per day)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	1	PA; QL (0 tablet per 0 days)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	1	PA; QL (1 tablet per day)
hydrocodone-acetaminophen oral solution 10-300 mg/15ml, 7.5-325 mg/15ml	1	NTT
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	NTT
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT
hydromorphone hcl er oral tablet extended release 24 hour 12 mg	1	PA; QL (2 tablets per day)
hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 8 mg	1	PA; QL (1 tablet per day)
hydromorphone hcl er oral tablet extended release 24 hour 32 mg	1	PA; QL (0 tablet per 0 days)
hydromorphone hcl oral liquid 1 mg/ml	1	NTT
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	1	NTT
hydromorphone hcl rectal suppository 3 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
levorphanol tartrate oral tablet 2 mg, 3 mg	1	NTT
meperidine hcl oral solution 50 mg/5ml	1	NTT
meperidine hcl oral tablet 50 mg	1	NTT
methadone hcl intensol oral concentrate 10 mg/ml	1	QL (6 ml per day.)
methadone hcl oral concentrate 10 mg/ml	1	QL (6 ml per day.)
methadone hcl oral solution 10 mg/5ml	1	PA; QL (11.3 mL per day)
methadone hcl oral solution 5 mg/5ml	1	PA; QL (22.6 mL per day)
methadone hcl oral tablet 10 mg	1	PA; QL (2 tablets per day)
methadone hcl oral tablet 5 mg	1	PA; QL (4 tablets per day)
methadone hcl oral tablet soluble 40 mg	1	QL (1.5 tablets per day.)
METHADOSE ORAL CONCENTRATE 10 MG/ML (***methadone hcl***)	3	QL (6 ml per day.)
methadose oral tablet soluble 40 mg	1	QL (1.5 tablets per day.)
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (***methadone hcl***)	3	QL (6 ml per day.)
morphine sulfate (concentrate) oral solution 100 mg/5ml	1	NTT
morphine sulfate er beads oral capsule extended release 24 hour 120 mg	1	PA; QL (0 capsule per 100 days)
morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	1	PA; QL (1 capsule per day)
morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg	1	PA; QL (0 capsule per 100 days)
morphine sulfate er oral tablet extended release 15 mg, 30 mg	1	PA; QL (93 tablets per 31 days)
morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml	1	NTT
morphine sulfate oral tablet 15 mg, 30 mg	1	NTT
morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg	1	NTT
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (***tapentadol hcl***)	3	PA; QL (2 tablets per day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (***tapentadol hcl***)	3	PA; QL (0 capsule per 100 days)
opium oral tincture 10 mg/ml (1%)	1	
oxycodone hcl oral capsule 5 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
oxycodone hcl oral concentrate 100 mg/5ml	1	NTT
oxycodone hcl oral solution 5 mg/5ml	1	NTT
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	1	NTT
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	NTT
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg	1	PA; QL (2 tablets per day.)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg	1	PA; QL (0 tablet per 100 days.)
oxymorphone hcl er oral tablet extended release 12 hour 30 mg, 40 mg	1	PA; QL (0 capsule per 100 days)
oxymorphone hcl oral tablet 10 mg, 5 mg	1	QL (6 tablets per day.); NTT
TAPENTADOL HCL ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG	3/4	PA; QL (2 tablets per day.)
TAPENTADOL HCL ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG	3/4	PA; QL (0 capsule per 100 days.)
tapentadol hcl oral tablet 100 mg, 50 mg, 75 mg	1	NTT
TRAMADOL HCL (ER BIPHASIC) ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG	3/4	QL (1 capsule per day)
tramadol hcl (er biphasic) oral tablet extended release 24 hour 200 mg, 300 mg	1	QL (1 tablet per day)
tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	1	QL (1 tablet per day)
tramadol hcl oral tablet 100 mg, 50 mg	1	NTT
tramadol hcl oral tablet 25 mg	1	
tramadol-acetaminophen oral tablet 37.5-325 mg	1	NTT
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (***oxycodone***)	3/4	PA; QL (2 tablets per day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (***oxycodone***)	3/4	PA; QL (0 capsule per 100 days)
xyvona oral tablet 2 mg, 3 mg	1	NTT

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OPIOID ANTAGONISTS (28:10) - Drugs for Overdose or Poisoning		
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg	1	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	1	
ft naloxone hcl nasal liquid 4 mg/0.1ml	1	SM
KLOXXADO NASAL LIQUID 8 MG/0.1ML (***naloxone hcl***)	1	SM
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	1	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naloxone hcl nasal liquid 4 mg/0.1ml	1	SM
naltrexone hcl oral tablet 50 mg	1	
NARCAN NASAL LIQUID 4 MG/0.1ML (***naloxone hcl***)	1	SM
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (***nalmefene hcl***)	1	
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	NTT
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	3/4	QL (0.4 ml per day.)
REXTOVY NASAL LIQUID 4 MG/0.25ML (***naloxone hcl***)	1	SM
REZENOPY NASAL LIQUID 10 MG/0.11ML (***naloxone hcl***)	3	SM
RIVIVE NASAL LIQUID 3 MG/0.1ML (***naloxone hcl***)	1	SM
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (***nalmefene hcl***)	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OPIOID PARTIAL AGONISTS - Drugs for Pain		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG (***buprenorphine hcl***)	3	PA; QL (2 films per day)
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	1	
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg	1	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	1	
buprenorphine transdermal patch weekly 10 mcg/hr, 20 mcg/hr, 5 mcg/hr	1	PA; QL (4 patches per 28 days)
buprenorphine transdermal patch weekly 15 mcg/hr, 7.5 mcg/hr	1	PA; QL (4 patches per month)
butorphanol tartrate nasal solution 10 mg/ml	1	
pentazocine-naloxone hcl oral tablet 50-0.5 mg	1	NTT
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (***buprenorphine hcl-naloxone hcl***)	1	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (***buprenorphine hcl-naloxone hcl***)	1	
OREXIN RECEPTOR ANTAGONISTS - Drugs for Anxiety & Sleep Disorder		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (***suvorexant***)	3/4	QL (1 tablet per day.)
PHENOTHIAZINES - Drugs for Depression & Psychosis		
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml	1	PA
chlorpromazine hcl oral tablet 10 mg, 25 mg	1	QL (6 tablets per day.)
chlorpromazine hcl oral tablet 100 mg, 50 mg	1	QL (4 tablets per day.)
chlorpromazine hcl oral tablet 200 mg	1	QL (2 tablets per day.)
COMPRO RECTAL SUPPOSITORY 25 MG (***prochlorperazine***)	3	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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		
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	1	NTT
ascomp-codeine oral capsule 50-325-40-30 mg	1	
atomoxetine hcl oral capsule 10 mg, 25 mg	1	QL (3 capsules per day.)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg	1	QL (1 capsule per day)
atomoxetine hcl oral capsule 18 mg	1	QL (5 capsules per day.)
atomoxetine hcl oral capsule 40 mg	1	QL (2 capsules per day)
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (***serdexmethylphen-dexmethylphen***)	2	QL (1 capsule per day.)
bac (butalbital-acetamin-caff) oral tablet 50-325-40 mg	1	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	1	
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	1	
BUTALBITAL-APAP-CAFFEINE ORAL SOLUTION 50-325-40 MG/15ML	2	
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
CAFERGOT ORAL TABLET 1-100 MG (***ergotamine-caffeine***)	3/4	
caffeine citrate oral solution 60 mg/3ml	1	
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG (***methylphenidate***)	3/4	QL (1 tablet per day)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 5 mg	1	QL (2 capsules per day.)
dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg	1	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	1	
FIORICET ORAL CAPSULE 50-300-40 MG (***butalbital-apap-caffeine***)	3/4	
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (***dexmethylphenidate hcl***)	3/4	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (***methylphenidate hcl***)	2	QL (1 capsule per day.)
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (***methylphenidate hcl***)	3/4	
METHYLPHENIDATE ER ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG	3/4	QL (1 tablet per day)
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg	1	QL (2 capsules per day.)
methylphenidate hcl er (cd) oral capsule extended release 60 mg	1	QL (31 capsules per 31 days.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg	1	QL (5 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg	1	QL (5capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg	1	QL (3 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg	1	QL (2 capsules per day.)
methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg	1	QL (31 capsules per month.)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	1	QL (1 capsule per day.)
methylphenidate hcl er oral tablet extended release 10 mg	1	QL (10 tablets per day.)
methylphenidate hcl er oral tablet extended release 20 mg	1	QL (5 tablets per day.)
methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml	1	
methylphenidate hcl oral tablet 10 mg, 20 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg	1	
methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr	1	QL (1 patch per day)
methylphenidate transdermal patch 30 mg/9hr	1	QL (1 patch per day.)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (***ergotamine-caffeine***)	3	
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG, 40 MG (***methylphenidate hcl***)	3/4	QL (1 tablet per day.)
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML (***methylphenidate hcl***)	3/4	QL (360 mL per month.)
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	
TREZIX ORAL CAPSULE 320.5-30-16 MG (***apap-caff-dihydrocodeine***)	3	NTT
REVERSIBLE COX-1/COX-2 INHIBITORS - Drugs for Pain		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (***ketorolac tromethamine***)	3/4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***)	3/4	
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (***ketorolac tromethamine***)	3/4	
diclofenac sodium external gel 3 %	1	PA
diflunisal oral tablet 500 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
flurbiprofen oral tablet 100 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
flurbiprofen sodium ophthalmic solution 0.03 %	1	
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	NTT
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
indomethacin oral suspension 25 mg/5ml	1	PA
indomethacin rectal suppository 50 mg	1	PA
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
ketorolac tromethamine oral tablet 10 mg	1	
LURBIRO ORAL TABLET 100 MG (***flurbiprofen***)	3	
meclofenamate sodium oral capsule 100 mg, 50 mg	1	
mefenamic acid oral capsule 250 mg	1	
MELOXICAM ORAL SUSPENSION 7.5 MG/5ML	3/4	PA
meloxicam oral tablet 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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	
sulindac oral tablet 150 mg, 200 mg	1	
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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
aspirin childrens oral tablet chewable 81 mg	E	H
aspirin ec adult low dose oral tablet delayed release 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	1	
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	1	
ft aspirin adult low dose oral tablet delayed release 81 mg	E	H
ft aspirin low dose oral tablet delayed release 81 mg	E	H
ft aspirin oral tablet chewable 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	
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR - Drugs for Depression & Psychosis		
DESVENLAFAXINE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 50 MG	3/4	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG (***duloxetine hcl***)	3/4	QL (2 capsules per day.)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG (***duloxetine hcl***)	3/4	QL (1 capsule per day.)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (***levomilnacipran hcl***)	3/4	QL (1 capsule per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (***levomilnacipran hcl***)	3/4	QL (28 capsules per year.)
milnacipran hcl oral 12.5 & 25 & 50 mg	1	QL (1 pack per 365 days.)
milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	QL (2 tablets per day)
VENLAFAXINE BESYLATE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 112.5 MG	3/4	
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	1	
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 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	1	
eletriptan hydrobromide oral tablet 20 mg, 40 mg	1	
frovatriptan succinate oral tablet 2.5 mg	1	
naratriptan hcl oral tablet 1 mg, 2.5 mg	1	
ONZETRA XSAIL NASAL EXHALER POWDER 11 MG/NOSEPC (***sumatriptan succinate***)	3/4	
rizatriptan benzoate oral tablet 10 mg, 5 mg	1	
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	1	
sumatriptan nasal solution 20 mg/act, 5 mg/act	1	
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	1	
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	1	
TOSYMRA NASAL SOLUTION 10 MG/ACT (***sumatriptan***)	3/4	
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (***sumatriptan succinate***)	3/4	
zolmitriptan oral tablet 2.5 mg, 5 mg	1	
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	1	
ZOMIG NASAL SOLUTION 2.5 MG (***zolmitriptan***)	2	
ZOMIG NASAL SOLUTION 5 MG (***zolmitriptan***)	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS - Drugs for Depression & Psychosis		
citalopram hydrobromide oral capsule 30 mg	1	
citalopram hydrobromide oral solution 10 mg/5ml	1	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	1	
ESCITALOPRAM OXALATE ORAL CAPSULE 15 MG	3/4	
escitalopram oxalate oral solution 5 mg/5ml	1	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg	1	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral capsule delayed release 90 mg	1	QL (4 capsules per 28 days.)
fluoxetine hcl oral solution 20 mg/5ml	1	
fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg	1	
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	1	
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	1	QL (1 capsule per day)
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	1	
paroxetine hcl oral suspension 10 mg/5ml	1	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	1	
paroxetine mesylate oral capsule 7.5 mg	1	QL (1 capsule per day.)
sertraline hcl oral capsule 150 mg, 200 mg	1	
sertraline hcl oral concentrate 20 mg/ml	1	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	1	
SEROTONIN MODULATORS - Drugs for Depression & Psychosis		
EXXUA ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG, 36.3 MG, 54.5 MG, 72.6 MG (***gepirone hcl***)	3/4	QL (31 tablets per month.)
EXXUA TITRATION PACK ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG (***gepirone hcl***)	3/4	QL (31 tablets per month.)
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	1	
RALDESY ORAL SOLUTION 10 MG/ML (***trazodone hcl***)	3/4	PA
trazodone hcl oral tablet 100 mg, 150 mg, 25 mg, 300 mg, 50 mg, 75 mg	1	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (***vortioxetine hbr***)	3/4	QL (1 tablet per day.)
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	1	
SUCCINIMIDES - Drugs for Seizures		
CELONTIN ORAL CAPSULE 300 MG (***methsuximide***)	3/4	
ethosuximide oral capsule 250 mg	1	
ethosuximide oral solution 250 mg/5ml	1	
methsuximide oral capsule 300 mg	1	
ZARONTIN ORAL CAPSULE 250 MG (***ethosuximide***)	3/4	
ZARONTIN ORAL SOLUTION 250 MG/5ML (***ethosuximide***)	3/4	
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	1	
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	
doxepin hcl external cream 5 %	1	PA
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	
doxepin hcl oral tablet 3 mg, 6 mg	1	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	3/4	
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	
SILENOR ORAL TABLET 3 MG, 6 MG (***doxepin hcl***)	3/4	QL (1 tablet per day)
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	1	
VESICULAR MONOAMINE TRANSPORT2 INHIBITOR - Drugs for the Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (***deutetrabenazine***)	2	PA; QL (4 tablets per day)
AUSTEDO ORAL TABLET 6 MG (***deutetrabenazine***)	2	PA; QL (2 tablets per day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (***deutetrabenazine***)	2	PA; QL (30 tablets per month.)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (***deutetrabenazine***)	2	PA; QL (30 Tablets per month.)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (***deutetrabenazine***)	2	PA; QL (1 kit (28 tablets) per year.)
INGREZZA ORAL CAPSULE 40 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (1 capsule per day)
INGREZZA ORAL CAPSULE 60 MG (***valbenazine tosylate***)	2	PA; QL (1 capsule per day.)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (***valbenazine tosylate***)	2	PA; QL (30 capsules per month.)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (***valbenazine tosylate***)	2	PA; QL (1 kit (28 capsules) per year.)
tetrabenazine oral tablet 12.5 mg, 25 mg	1	PA
WAKEFULNESS-PROMOTING AGENTS - Drugs for the Nervous System		
armodafinil oral tablet 150 mg, 250 mg	1	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
armodafinil oral tablet 200 mg	1	QL (1 tablet per day.)
armodafinil oral tablet 50 mg	1	QL (2 tablets per day.)
diclofenac sodium oral tablet delayed release 75 mg	1	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	3/4	PA; QL (1 box (28 packets) per year.)
modafinil oral tablet 100 mg, 200 mg	1	QL (3 tablets per day.)
sodium oxybate oral solution 500 mg/ml	3/4	PA; QL (18 ml per day.); SP
SUNOSI ORAL TABLET 150 MG, 75 MG (***solriamfetol hcl***)	2	PA; QL (1 tablet per day.)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (***pitolisant hcl***)	3/4	PA; QL (2 tablets per day.)
DENTAL AGENTS		
NUTRITIONAL SUPPLEMENTS		
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (***stannous fluoride***)	3	
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	
multi-vitamin/fluoride oral suspension 0.25 mg/ml, 0.5 mg/ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	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 gel 1.1 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
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 (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
DENTAL AGENTS - Oral Care		
DENTAL AGENTS - Oral Care		
CLINPRO 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	3/4	
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (***stannous fluoride***)	3	
FLUORIDEX DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 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	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	
multi-vitamin/fluoride oral suspension 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride 5000 sensitive dental gel 1.1-5 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
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 (***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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
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***)	2	QL (1 meter or meter kit per year.)
ACCU-CHEK GUIDE ME KIT W/DEVICE (***blood glucose monitoring suppl***)	2	QL (1 meter or meter kit per year.)
ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID (***blood glucose calibration***)	1	
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT KIT (***lancets misc.***)	1	
ADVANTAGE SAFETY LANCETS 28G	3	
ADVOCATE SAFETY LANCETS 21G (***lancets***)	3	
ADVOCATE SAFETY LANCETS 23G (***lancets***)	3	
ADVOCATE SAFETY LANCETS 28G (***lancets***)	3	
AEROCHAMBER HOLDING CHAMBER DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (***spacer/aero-holding chambers***)	2	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (***spacer/aero-holding chambers***)	2	SM
AEROCHAMBER2GO ANTI-STATIC DEVICE (***spacer/aero-holding chambers***)	2	SM
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	QL (10 syringes per day.)
AQINJECT PEN NEEDLE 31G X 5 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
ASSURE CONTROL SOLUTION 2/3 IN VITRO LIQUID (***blood glucose calibration***)	2	
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
ASSURE ID PRO PEN NEEDLES 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM	2	QL (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	QL (10 pen needles per day.)
AUM PEN NEEDLE 32G X 5 MM , 33G X 4 MM , 33G X 5 MM , 33G X 6 MM	2	QL (10 pen needles per day.)
AUM READYGARD DUO PEN NEEDLE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUM SAFETY PEN NEEDLE 31G X 4 MM , 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUTOKEEPER SAFETY PEN NEEDLE 30G X 5 MM , 30G X 8 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
AUTOLET LANCING DEVICE (***lancet devices***)	3	
AUTOLET LITE LANCING DEVICE (***lancet devices***)	3	
BD AUTOSHIELD DUO PEN NEEDLES 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD BLUNT FILL NEEDLE 18G X 1" (***needle (disp)***)	2	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD SAFETYGLIDE NEEDLE 23G X 1-1/2" (***needle (disp)***)	2	
BD SHARPS COLLECTOR (***sharps container***)	3	
BD ULTRA-FINE INSULIN SYRINGES 29G X 1/2" 0.3 ML, 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 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
BD ULTRA-FINE INSULIN SYRINGES 31G X 6MM 0.5 ML (***insulin syringe/needle u-500***)	2	QL (10 syringes per day.)
BD ULTRA-FINE PEN NEEDLES 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
BIGFOOT UNITY PROGRAM KIT (***blood glucose monitoring suppl***)	3	QL (1 meter or meter kit per year.)
BREATHE COMFORT CHAMBER/ADULT DEVICE	2	SM
BREATHE COMFORT CHAMBER/CHILD DEVICE	2	SM
CAREPOINT POLY HUB NEEDLE 18G X 1" , 20G X 1" , 21G X 1" , 22G X 1" , 23G X 1" , 25G X 1" , 25G X 1-1/2" , 25G X 5/8"	2	
CAREPOINT POLY HUB NEEDLE 21G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 22G X 1-1/2"	2	
CAREPOINT POLY HUB NEEDLE 27G X 1/2"	2	
CAREPOINT PRECISION POLY HUB 23G X 1" (***needle (disp)***)	2	
CAREPOINT PRECISION POLY HUB 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
CARESENS S CONTROL SOLN A/B IN VITRO LIQUID (***blood glucose calibration***)	3	
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	
CEQUR SIMPLICITY 1U EXTND WEAR DEVICE (***injection device for insulin***)	3	
CEQUR SIMPLICITY 2U DEVICE (***injection device for insulin***)	3	
CEQUR SIMPLICITY 2U EXTND WEAR DEVICE (***injection device for insulin***)	3	
CHEMSTRIP BG LOG BOOK (***blood glucose monitoring suppl***)	1	
CHOSEN LANCETS 30G (***lancets***)	3	
CHOSEN LANCING DEVICE (***lancet devices***)	3	
CHOSEN SAFETY LANCETS 28G (***lancets***)	3	
CLEVER CHOICE COMFORT EZ (***lancets***)	3	
CLEVER CHOICE COMFORT EZ PLUS 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM , 31G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
COMFORT TOUCH TWIST LANCET 30G (***lancets***)	3	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CONTOUR NEXT EZ KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT GEN MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT MONITOR KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT ONE KIT (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR NEXT ONE KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.); SM
CONTOUR PLUS BLUE KIT W/DEVICE (***blood glucose monitoring suppl***)	1	QL (1 meter or meter kit per year.)
CONTOUR PLUS CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	2	
DEXCOM G6 RECEIVER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G6 SENSOR (***continuous glucose sensor***)	3	PA; QL (3 sensors per month.); SM
DEXCOM G6 TRANSMITTER (***continuous glucose transmitter***)	3	PA; QL (1 transmitter per 3 months for Dexcom G6 Transmitter.); SM
DEXCOM G7 15 DAY SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
DEXCOM G7 RECEIVER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 kit per 999 days.); SM
DEXCOM G7 SENSOR (***continuous glucose sensor***)	3	PA; QL (3 sensors per month.); SM
DIABETES MONITOR DIGIT ADD-ON KIT	3	QL (1 meter or meter kit per year.)
DIABETES MONITOR DIGIT SOLN KIT	3	QL (1 meter or meter kit per year.)
DROPLET MEDLANCE LANCET 30G (***lancets***)	3	
DROPLET MICRON 34G X 3.5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
DROPSAFE ACTI-LANCE 23G (***lancets***)	3	
DROPSAFE ACTI-LANCE LANCET 17G (***lancets***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DROPSAFE ACTI-LANCE LANCET 23G (***lancets***)	3	
DROPSAFE ACTI-LANCE LANCET 28G (***lancets***)	3	
DROPSAFE AUTOPROTECT DUO 31G X 4 MM , 31G X 5 MM , 31G X 8 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
DROPSAFE ERGOLANCE LANCET 21G (***lancets***)	3	
DROPSAFE ERGOLANCE LANCET 25G (***lancets***)	3	
DROPSAFE ERGOLANCE LANCET 30G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 1.5 (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 18G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 21G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 25G (***lancets***)	3	
DROPSAFE HAEMOLANCE LANCET 28G (***lancets***)	3	
DROPSAFE MEDISAFE LANCET 23G (***lancets***)	3	
DROPSAFE MEDISAFE LANCET 29G (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 0.8MM (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 21G (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 25G (***lancets***)	3	
DROPSAFE MEDLANCE LANCET 30G (***lancets***)	3	
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	QL (10 syringes per day.)
DROPSAFE SICURA 25G X 1" , 25G X 5/8" (***needle (disp)***)	2	
EASIVENT (***spacer/aero-holding chambers***)	2	SM
EASY COMFORT SHARPS CONTAINER	3	
EASY TOUCH HEALTHPRO HIGH/LOW IN VITRO LIQUID (***blood glucose calibration***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EMBECTA AUTOSHIELD DUO 30G X 5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYR ULTRAFINE 29G X 1/2" 0.5 ML, 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	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (***insulin syringe/needle u-500***)	2	QL (10 syringes per day.)
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE NANO 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
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	QL (10 pen needles per day.)
EMBRACE WAVE GLUCOSE CONTROL IN VITRO LIQUID HIGH (***blood glucose calibration***)	2	
ENLITE GLUCOSE SENSOR (***continuous glucose sensor***)	3	PA; SM
FLEXICHAMBER ADULT MASK/SMALL (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER CHILD MASK/LARGE (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER CHILD MASK/SMALL (***spacer/aero-hold chamber mask***)	2	SM
FLEXICHAMBER DEVICE (***spacer/aero-holding chambers***)	2	SM
FONDCIRCLE CONTROL SOLUTION IN VITRO LIQUID NORMAL	2	
FONDCIRCLE LANCING DEVICE	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FONDCIRCLE SINGLE USE LANCETS	3	
FORA TEST N' GO ADVANCE DEVICE (***blood glucose/ketone monitor***)	3	
FREESTYLE LIBRE 14 DAY READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 14 DAY SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 2 PLUS SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
FREESTYLE LIBRE 2 READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 receiver per 999 days.); SM
FREESTYLE LIBRE 2 SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per 21 days.); SM
FREESTYLE LIBRE 3 PLUS SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
FREESTYLE LIBRE 3 READER DEVICE (***continuous glucose receiver***)	3	PA; QL (1 reader per 999 days.); SM
FREESTYLE LIBRE 3 SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per 21 days.); SM
GUARDIAN 4 GLUCOSE SENSOR (***continuous glucose sensor***)	3	PA; QL (5 sensors per month.); SM
GUARDIAN 4 TRANSMITTER (***continuous glucose transmitter***)	3	PA; QL (1 transmitter kit per year.); SM
GUARDIAN REAL-TIME CHARGER (***continuous glucose monitor sup***)	3	SM
GUARDIAN REAL-TIME TEST PLUG (***continuous glucose monitor sup***)	3	SM
GUARDIAN SENSOR 3 (***continuous glucose sensor***)	3	PA; QL (5 sensors per 24 days.); SM
HAN-EASE (***injection device***)	3	
IHEALTH CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	3	
IHEALTH LANCING DEVICE (***lancet devices***)	3	
INPEN 100-BLUE-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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
INPEN 100-PINK-NOVOLOG-FIASP DEVICE (***injection device for insulin***)	3	
INSPIREASE RESERVOIR BAGS (***spacer/aero-hold chamber bags***)	2	SM
INSULIN PEN NEEDLES 29G X 10MM , 29G X 12.7MM , 29G X 12MM , 29G X 8MM , 31G X 4 MM , 31G X 6 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 , 34G X 3.5 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
INSULIN PEN NEEDLES 29G X 4MM , 29G X 5MM , 30G X 5 MM , 30G X 8 MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
INSULIN SYRINGES 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 29G X 5/16" 0.5 ML, 29G X 5/16" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 1/2" 0.3 ML	2	QL (10 syringes per day.)
INSULIN SYRINGES 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 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, 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, 32G X 5/16" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
INSUPEN32G EXTR3ME 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
KT TAPE CGM PATCH (***continuous glucose monitor sup***)	3	SM
LANCETS (***lancets***)	1	
LANCETS	3	
LANCETS 28G THIN	3	
LANCETS SUPER THIN (***lancets***)	3	
MICROLET NEXT LANCETS (***lancets***)	3	
MICROLET NEXT LANCING DEVICE (***lancet devices***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MINIMED INSTINCT GLUC SENSOR (***continuous glucose sensor***)	3	PA; QL (2 sensors per month.); SM
MOBI CONNECT LANCING DEVICE (***lancet devices***)	3	
MOBI CONNECT TWIST LANCETS (***lancets***)	3	
MOBILE LANCETS 30G	3	
NORDIPEN 5 INJECTION DEVICE (***injection device***)	3	
NOVOFINE PEN NEEDLE 32G X 6 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
NOVOPEN ECHO DEVICE (***injection device for insulin***)	3	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 180 days.)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (***insulin disposable pump***)	2	PA
OMNIPOD 5 LIBRE INTRO KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 2 years.)
OMNIPOD 5 LIBRE PODS (***insulin disposable pump***)	2	PA
ONETOUCH DELICA PLUS LANCING (***lancet devices***)	1	
ONETOUCH DELICA SAFETY LANCING (***lancets***)	1	
ONETOUCH ULTRA IN VITRO LIQUID (***blood glucose calibration***)	1	
ONETOUCH VERIO IN VITRO LIQUID HIGH (***blood glucose calibration***)	1	
PARI VORTEX ADULT MASK (***spacer/aero-hold chamber mask***)	2	SM
PARI VORTEX PEDIATRIC MASK (***spacer/aero-hold chamber mask***)	2	SM
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
PERFECT POINT SAFETY LANCETS (***lancets***)	3	
PERFECT POINT SAFETY NEEDLE 25G X 1" (***needle (disp)***)	2	
PIP GLUCOSE CONTROL SOLUTION IN VITRO LIQUID (***blood glucose calibration***)	3	
PIVOT SUPPLY KIT KIT	2	PA
PURE COMFORT SAFETY LANCET 30G	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM , 31G X 4 MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 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 , 33G X 8 MM (***insulin pen needle***)	2	QL (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	QL (10 pen needles per day.)
SAFETY PEN NEEDLES 30G X 5 MM , 30G X 8 MM	2	QL (10 pen needles per day.)
SENSILANCE SAFETY LANCETS 21G (***lancets***)	3	
SENSILANCE SAFETY LANCETS 26G (***lancets***)	3	
SENSILANCE SAFETY LANCETS 28G (***lancets***)	3	
SHARPS COLLECTOR	3	
SHARPS CONTAINER	3	
SIMPLERA SYNC SENSOR (***continuous glucose sensor***)	3	PA; SM
TECHLITE LANCETS 26G (***lancets***)	3	
TECHLITE PLUS PEN NEEDLES 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
TOPFINE INSULIN PEN NEEDLE 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
TRUE COMFORT SAFETY PEN NEEDLE 31G X 5 MM , 31G X 6 MM , 32G X 4 MM	2	QL (10 pen needles per day.)
TRUE METRIX LEVEL 1 IN VITRO SOLUTION LOW (***blood glucose calibration***)	2	
TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL (***blood glucose calibration***)	2	
TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (***blood glucose calibration***)	2	
TWIIST REFILL KIT KIT (***insulin disposable pump***)	2	PA
TWIIST REFILL KIT/INFUSION SET KIT (***insulin disposable pump***)	2	PA
TWIIST STARTER KIT KIT (***insulin disposable pump***)	2	PA; QL (1 kit per 730 days.)
ULTRA-CARE SAFETY LANCETS 30G	3	
UNIFINE OTC PEN NEEDLES 31G X 5 MM , 32G X 4 MM (***insulin pen needle***)	2	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM , 32G X 4 MM (***insulin pen needle***)	2	QL (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	QL (10 pen needles per day.)
VERIFINE INSULIN SYRINGE 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 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	QL (10 syringes per day.)
VERIFINE PLUS PEN NEEDLE 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (***insulin pen needle***)	2	QL (10 pen needles per day.)
VERIFINE SAFE LANCET MINI 21G (***lancets***)	3	
VERIFINE SAFE LANCET MINI 23G (***lancets***)	3	
VERIFINE SAFE LANCET MINI 28G (***lancets***)	3	
VERIFINE SAFE LANCET MINI 30G (***lancets***)	3	
VERIFINE SHARPS CONTAINER (***sharps container***)	3	
VERISAFE SAFETY INSULIN SYR 29G X 1/2" 1 ML (***insulin syringe-needle u-100***)	2	QL (10 syringes per day.)
VERISAFE SAFETY STERILE NEEDLE 23G X 1-1/2" , 25G X 1" (***needle (disp)***)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (***blood glucose calibration***)	2	
VIVAGUARD INO CONTROL SOLUTION LIQUID IN VITRO (***blood glucose calibration***)	3	
VIVAGUARD LANCETS 30G (***lancets***)	3	
VIVAGUARD LANCING DEVICE (***lancet devices***)	3	
VIVAGUARD SAFETY LANCETS 28G (***lancets***)	3	
VORTEX VALVE CHAMBER-PEDI MASK DEVICE (***spacer/aero-holding chambers***)	2	SM
VORTEX VALVED HOLDING CHAMBER DEVICE (***spacer/aero-holding chambers***)	2	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DIAGNOSTIC AGENTS		
ADRENOCORTICAL INSUFFICIENCY		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	3/4	PA; QL (10.5 mL (21 injectors) per treatment course.); SP
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (21 mL (21 injectors) per treatment course.); SP
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	3/4	PA; SP
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG (***cosyntropin***)	3/4	
cosyntropin injection solution reconstituted 0.25 mg	1	
CARDIAC FUNCTION		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
DIABETES MELLITUS		
ACCU-CHEK GUIDE TEST IN VITRO STRIP (***glucose blood***)	2	QL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR NEXT IN VITRO STRIP (***glucose blood***)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR NEXT TEST IN VITRO STRIP (***glucose blood***)	1	QL (51 strips per prescription without history 204 strips per prescription with history.)
CONTOUR PLUS TEST IN VITRO STRIP (***glucose blood***)	1	QL (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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RELION GLUCOSE TEST STRIPS IN VITRO STRIP (***glucose blood***)	3/4	QL (51 strips per prescription without history 204 strips per prescription with history.)
KETONES		
CHEMSTRIP K IN VITRO STRIP (***acetone (urine) test***)	2	
KETOSTIX IN VITRO STRIP (***acetone (urine) test***)	2	
PHEOCHROMOCYTOMA		
metyrosine oral capsule 250 mg	1	PA
PITUITARY FUNCTION		
METOPIRONE ORAL CAPSULE 250 MG (***metyrapone***)	3	
SUGAR		
DIASTIX REAGENT IN VITRO STRIP (***glucose urine test-glucose ox***)	3	
URINE AND FECES CONTENTS		
CHEMSTRIP UGK IN VITRO STRIP (***urine glucose-ketones test***)	3	
KETO-DIASTIX IN VITRO STRIP (***urine glucose-ketones test***)	3	
KETONE CARE IN VITRO STRIP (***urine glucose-ketones test***)	2	
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
DISINFECTANTS (FOR NON-DERMATOLOGIC USE) - Disinfectants		
formaldehyde external solution 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	3/4	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (***potassium citrate***)	3/4	
AMMONIA DETOXICANTS		
BUPHENYL ORAL POWDER 3 GM/TSP (***sodium phenylbutyrate***)	3/4	PA
carglumic acid oral tablet soluble 200 mg	1	PA; SP
constulose oral solution 10 gm/15ml	1	
enulose oral solution 10 gm/15ml	1	
generlac oral solution 10 gm/15ml	1	
glycerol phenylbutyrate oral liquid 1.1 gm/ml	1	PA; QL (17.5 ml per day.)
KRISTALOSE ORAL PACKET 10 GM, 20 GM (***lactulose***)	3	
lactulose encephalopathy oral solution 10 gm/15ml	1	
lactulose oral packet 20 gm	1	
lactulose oral solution 10 gm/15ml, 20 gm/30ml	1	
LITHOSTAT ORAL TABLET 250 MG (***acetohydroxamic acid***)	3	
sodium phenylbutyrate oral powder 3 gm/tsp	1	PA
sodium phenylbutyrate oral tablet 500 mg	1	PA
CALORIC AGENTS - Drugs for Nutrition		
DOJOLVI ORAL LIQUID 100 % (***triheptanoin***)	3/4	PA
CARBONIC ANHYDRASE INHIBITORS (40:28) - 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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 (40:28) - Drugs for Water Balance		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
BUMEX ORAL TABLET 0.5 MG (***bumetanide***)	3	
ENBUMYST NASAL SOLUTION 0.5 MG/0.1ML (***bumetanide***)	3/4	PA
ethacrynic acid oral tablet 25 mg	1	
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
LASIX ONYU SUBCUTANEOUS CARTRIDGE KIT 80 MG/2.67ML (***furosemide***)	3/4	PA
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (***furosemide***)	3/4	
SOAANZ ORAL TABLET 40 MG (***torsemide***)	3/4	QL (31 tablets per month.)
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
OSMOTIC DIURETICS (40:28) - Drugs for Water Balance		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
calcium acetate oral tablet 667 mg	1	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***)	3	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	1	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	PA
sevelamer carbonate oral tablet 800 mg	1	
VELPHORO ORAL TABLET CHEWABLE 500 MG (***sucroferric oxyhydroxide***)	3/4	
XPHOZAH ORAL TABLET 20 MG, 30 MG (***tenapanor hcl (ckd)***)	3/4	PA; QL (2 tablets per day.)
POTASSIUM-REMOVING AGENTS		
LOKELMA ORAL PACKET 10 GM (***sodium zirconium cyclosilicate***)	3	PA; QL (1 packet per day.)
LOKELMA ORAL PACKET 5 GM (***sodium zirconium cyclosilicate***)	3	PA; QL (3 packets per day.)
sodium polystyrene sulfonate combination suspension 15 gm/60ml	1	
sodium polystyrene sulfonate oral powder	1	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (***sodium polystyrene sulfonate***)	3	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (***sodium polystyrene sulfonate***)	3	
VELTASSA ORAL PACKET 1 GM (***patiromer sorbitex calcium***)	3	PA; QL (124 packets per month.)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (***patiromer sorbitex calcium***)	3	PA; QL (1 Packet per day.)
XPHOZAH ORAL TABLET 30 MG (***tenapanor hcl (ckd)***)	3/4	PA; QL (2 tablets per day.)
POTASSIUM-SPARING DIURETICS (40:28) - 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***)	3/4	PA; SM
eplerenone oral tablet 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
spironolactone oral suspension 25 mg/5ml	1	PA; SM
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	SM
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene oral capsule 100 mg, 50 mg	1	
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	
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	
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	
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (***insulin regular(human) in nacl***)	3	SM
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
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***)	3/4	
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***)	3/4	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3/4	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***)	3/4	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3/4	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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-dextose-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	
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	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
ZYCUBO SUBCUTANEOUS SOLUTION RECONSTITUTED 2.9 MG (***copper histidinate***)	3/4	PA; QL (30 single-dose vials per month.); SP
THIAZIDE DIURETICS (40:28) - Drugs for Water Balance		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	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	1	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	1	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (***azilsartan-chlorthalidone***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
INZIRQO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (***hydrochlorothiazide***)	3/4	PA
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	
LOPRESSOR ORAL TABLET 12.5 MG (***metoprolol tartrate***)	3/4	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (***benazepril-hydrochlorothiazide***)	3/4	
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	1	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	1	
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 (40:28) - Drugs for Water Balance		
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
chlorthalidone oral tablet 25 mg, 50 mg	1	
HEMICLOR ORAL TABLET 12.5 MG (***chlorthalidone***)	3/4	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
THALITONE ORAL TABLET 15 MG (***chlorthalidone***)	3/4	
URICOSURIC AGENTS		
colchicine-probenecid oral tablet 0.5-500 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	
probenecid oral tablet 500 mg	1	
VASOPRESSIN ANTAGONISTS - Drugs for Water Balance		
SAMSCA ORAL TABLET 15 MG (***tolvaptan (hyponatremia)***)	3/4	PA; QL (90 tablets per 365 days.); SP
SAMSCA ORAL TABLET 30 MG (***tolvaptan (hyponatremia)***)	3/4	PA; QL (60 tyablets per 365 days.); SP
tolvaptan (hyponatremia) oral tablet 15 mg	1	PA; QL (90 tablets per 365 days.)
tolvaptan (hyponatremia) oral tablet 30 mg	1	PA; QL (60 tablets per 365 days.)
tolvaptan oral tablet 15 mg, 30 mg	1	PA
tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg	1	PA; QL (2 tablets per day.)
tolvaptan oral tablet therapy pack 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	1	PA; QL (2 tablets per day)
ENZYMES		
ENZYME COFACTORS/CHAPERONES		
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	3/4	PA; QL (14 capsules per 21 days.)
JAVYGTOR ORAL PACKET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 packets per day.)
JAVYGTOR ORAL PACKET 500 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (4 packets per day.)
JAVYGTOR ORAL TABLET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 tablets per day)
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (***arimoclomol citrate***)	3/4	PA; QL (90 capsules per month.)
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.)
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.)
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SEPHIENCE ORAL PACKET 1000 MG (***sepiapterin***)	3/4	PA; QL (186 packets per month.)
SEPHIENCE ORAL PACKET 250 MG (***sepiapterin***)	3/4	PA; QL (682 packets per month.)
zelvysia oral packet 100 mg	1	PA; QL (589 packets per month.)
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.)
ENZYME INHIBITORS		
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA
HARLIKU ORAL TABLET 2 MG (***nitisinone (aku)***)	3/4	PA; QL (31 tablets per month.)
miglustat oral capsule 100 mg	1	
OPFOLDA ORAL CAPSULE 65 MG (***miglustat (gaa deficiency)***)	2	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.)
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	
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (***pegvaliase-pqpz***)	3	PA; QL (7 mL per year.); SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML (***pegvaliase-pqpz***)	3	PA; QL (6 syringes per 365 days.); SP
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (***pegvaliase-pqpz***)	3	PA; QL (1 ml per day.); SP
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (***pancrelipase (lip-prot-amyl)***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (***dornase alfa***)	2	PA; QL (5 ml per day.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML (***asfotase alfa***)	2	PA; QL (12 vials per month.); SP
SUCRAID ORAL SOLUTION 8500 UNIT/ML (***sacrosidase***)	2	PA; SP
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
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, 60000-189600 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
ALPHA-ADRENERGIC AGONISTS (52:40) - Drugs for the Eye		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (***brimonidine tartrate***)	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***)	3/4	
apraclonidine hcl ophthalmic solution 0.5 %	1	
brimonidine tartrate external gel 0.33 %	1	PA
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (***apraclonidine hcl***)	3	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (***brinzolamide-brimonidine***)	3/4	
ANTIALLERGIC AGENTS - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	
bepotastine besilate ophthalmic solution 1.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	SM
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
epinastine hcl ophthalmic solution 0.05 %	1	
olopatadine hcl nasal solution 0.6 %	1	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
ANTIBACTERIALS (52:04) - Drugs for Infections		
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	
AZASITE OPHTHALMIC SOLUTION 1 % (***azithromycin***)	3	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BESIFLOXACIN HCL OPHTHALMIC SUSPENSION 0.6 %	3	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (***besifloxacin hcl***)	3	
CETRAXAL OTIC SOLUTION 0.2 % (***ciprofloxacin hcl***)	3	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (***ciprofloxacin hcl***)	3	
CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***)	3/4	
ciprofloxacin hcl ophthalmic solution 0.3 %	1	
ciprofloxacin hcl otic solution 0.2 %	1	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	1	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (***neomycin-colist-hc-thonzonium***)	3	
ERY EXTERNAL PAD 2 %	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
erythromycin ophthalmic ointment 5 mg/gm	1	H-N

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
gatifloxacin ophthalmic solution 0.5 %	1	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
levofloxacin ophthalmic solution 0.5 %, 1.5 %	1	
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	3/4	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
MITOSOL OPHTHALMIC KIT 0.2 MG (***mitomycin***)	3	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	1	
neomycin sulfate oral tablet 500 mg	1	
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 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	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (***ofloxacin***)	3/4	
ofloxacin ophthalmic solution 0.3 %	1	
ofloxacin otic solution 0.3 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sulfacetamide sodium ophthalmic solution 10 %	1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TOBI NEBULIZER INHALATION NEBULIZATION SOLUTION 300 MG/5ML (***tobramycin***)	3/4	PA; QL (280 ml (1 carton) per 56 days.)
TOBI PODHALER INHALATION CAPSULE 28 MG (***tobramycin***)	3	PA; QL (224 capsules per 56 days.)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	3/4	
tobramycin inhalation nebulization solution 300 mg/4ml	1	PA; QL (224 ml per 56 days.)
tobramycin ophthalmic solution 0.3 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (***tobramycin***)	3	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (***loteprednol-tobramycin***)	3	
ANTIFUNGALS (EENT) - Drugs for Infections		
NATACYN OPHTHALMIC SUSPENSION 5 % (***natamycin***)	3	
ANTI-INFECTIVES, MISCELLANEOUS (52:04) - 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***)	3/4	
periogard mouth/throat solution 0.12 %	1	
PRAMOTIC OTIC LIQUID 1-0.1 % (***pramoxine-chloroxylenol***)	3	
silver nitrate external solution 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
XDEMVY OPHTHALMIC SOLUTION 0.25 % (***lotilaner***)	3/4	PA; QL (10 ml per 63 days.)
ANTI-INFLAMMATORY AGENTS (EENT) - Drugs for Inflammation		
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	
gengraf oral capsule 100 mg, 25 mg	1	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (***perfluorohexyloctane***)	3/4	PA; QL (1 bottle per month.)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	3/4	PA; QL (1 bottle per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3/4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	2	PA; QL (60 vials per month.)
ANTIVIRALS (EENT) - Drugs for Infections		
trifluridine ophthalmic solution 1 %	1	
ZIRGAN OPHTHALMIC GEL 0.15 % (***ganciclovir***)	3	
ASTRINGENTS (52:04) - Drugs for Infections		
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
BETA-ADRENERGIC BLOCKING AGENTS (52:40) - Drugs for the Eye		
betaxolol hcl ophthalmic solution 0.5 %	1	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***timolol hemihydrate***)	3/4	
carteolol hcl ophthalmic solution 1 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	1	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol hemihydrate ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	1	
timolol maleate ocudose ophthalmic solution 0.5 %	1	
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 %	1	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (***timolol maleate***)	3/4	
CARBONIC ANHYDRASE INHIBITORS (52:40) - 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 %	1	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (***dorzolamide hcl-timolol mal***)	3/4	
DORZOLAMIDE HCL SOLUTION 2 % OPHTHALMIC	3/4	
dorzolamide hcl solution 2 % ophthalmic	1	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	1	
methazolamide oral tablet 25 mg, 50 mg	1	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (***brinzolamide-brimonidine***)	3/4	
CORTICOSTEROIDS (EENT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	3/4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3/4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BYQLOVI OPHTHALMIC SUSPENSION 0.05 % (***clobetasol propionate***)	3/4	
CIPRO HC OTIC SUSPENSION 0.2-1 % (***ciprofloxacin-hydrocortisone***)	3/4	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	1	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (***neomycin-colist-hc-thonzonium***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	3/4	
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)	1	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
difluprednate ophthalmic emulsion 0.05 %	1	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (***loteprednol etabonate***)	2	
FLAREX OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone acetate***)	2	
flunisolide nasal solution 25 mcg/act (0.025%)	1	
fluocinolone acetonide body external oil 0.01 %	1	
fluocinolone acetonide external cream 0.01 %, 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluorometholone ophthalmic suspension 0.1 %	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	3/4	QL (1 inhaler per month.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); SM
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.); SM
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.); SM
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (***fluorometholone***)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (***fluorometholone***)	3/4	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	3/4	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
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 oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	
hydrocortisone valerate external ointment 0.2 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INVELTYS OPHTHALMIC SUSPENSION 1 % (***loteprednol etabonate***)	3	
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	PA
LOTEMAX OPHTHALMIC GEL 0.5 % (***loteprednol etabonate***)	3/4	
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (***loteprednol etabonate***)	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 % (***loteprednol etabonate***)	3	
loteprednol etabonate ophthalmic gel 0.5 %	1	
loteprednol etabonate ophthalmic suspension 0.2 %, 0.5 %	1	
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (***dexamethasone***)	2	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (***neomycin-polymyxin-dexameth***)	3/4	
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (***neomycin-polymyxin-dexameth***)	3/4	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	3/4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (***prednisolone acetate***)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
prednisolone sodium phosphate oral tablet dispersible 30 mg	1	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
procto-med hc external cream 2.5 %	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
SYNALAR EXTERNAL CREAM 0.025 % (***fluocinolone acetonide***)	3/4	
SYNALAR EXTERNAL OINTMENT 0.025 % (***fluocinolone acetonide***)	3/4	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21) (***dexamethasone***)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (***dexamethasone***)	3	
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (***tobramycin-dexamethasone***)	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (***tobramycin-dexamethasone***)	3/4	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (***loteprednol-tobramycin***)	3	
EENT ANTI-INFLAMMATORY AGENTS, MISC. - Drugs for Inflammation		
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	3/4	PA; QL (1 bottle per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3/4	PA; QL (4 vials per day.)
XIIDRA OPHTHALMIC SOLUTION 5 % (***lifitegrast***)	2	PA; QL (60 vials per month.)
EENT DRUGS, MISCELLANEOUS		
acetic acid otic solution 2 %	1	
apraclonidine hcl ophthalmic solution 0.5 %	1	
AQUORAL MOUTH/THROAT SOLUTION (***artificial saliva***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	SM
cromolyn sodium ophthalmic solution 4 %	1	
cromolyn sodium oral concentrate 100 mg/5ml	1	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (***cysteamine hcl***)	3/4	PA; QL (20 mL per 21 days); SP
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); 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	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (***perfluorohexyloctane***)	3/4	PA; QL (1 bottle per month.)
MUCOSITISRX MOUTH/THROAT PACKET (***artificial saliva***)	3	
OXERVATE OPHTHALMIC SOLUTION 0.002 % (***cenegermin-bkbj***)	3/4	PA; QL (1 ml per day and 56 ml per 365 days.); SP
TRYPTYR OPHTHALMIC SOLUTION 0.003 % (***acoltremon***)	3/4	PA; QL (60 vials per month.)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (***varenicline tartrate***)	3/4	PA; QL (0.28 ml per day.)
EENT NONSTEROIDAL ANTI-INFLAM. AGENTS - Drugs for Inflammation		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (***ketorolac tromethamine***)	3/4	
ACULAR OPHTHALMIC SOLUTION 0.5 % (***ketorolac tromethamine***)	3/4	
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (***ketorolac tromethamine***)	3/4	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	1	
bromfenac sodium ophthalmic solution 0.07 %, 0.075 %	1	
BROMSITE OPHTHALMIC SOLUTION 0.075 % (***bromfenac sodium***)	3/4	
diclofenac sodium ophthalmic solution 0.1 %	1	
flurbiprofen oral tablet 100 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (***nepafenac***)	3/4	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
ketorolac tromethamine oral tablet 10 mg	1	
LURBIRO ORAL TABLET 100 MG (***flurbiprofen***)	3	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (***nepafenac***)	3/4	
PROLENSA OPHTHALMIC SOLUTION 0.07 % (***bromfenac sodium***)	3/4	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (***ketorolac tromethamine***)	3/4	
LOCAL ANESTHETICS (EENT) - Drugs for Numbing		
AKTEN OPHTHALMIC GEL 3.5 % (***lidocaine hcl***)	3	
ALCAINE OPHTHALMIC SOLUTION 0.5 % (***proparacaine hcl***)	3	
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (***tetracaine hcl***)	3	
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	
MACULAR DEGENERATION AGENTS		
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (***cysteamine hcl***)	3/4	PA; QL (20 mL per 21 days); SP
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (***cysteamine hcl***)	2	PA; QL (60 ml (4 bottles) per month.); SP
MIOTICS - Drugs for the Eye		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (***echothiophate iodide***)	2	
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	1	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (***pilocarpine hcl***)	3/4	
MYDRIATICS - Drugs for the Eye		
atropine sulfate ophthalmic solution 1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 1 %, 2 % (***cyclopentolate hcl***)	3/4	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
cyclopentolate hcl ophthalmic solution 1 %	1	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
OSMOTIC AGENTS - Drugs for the Eye		
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	
urea external lotion 40 %	1	
PROSTAGLANDIN ANALOGS - Drugs for the Eye		
bimatoprost ophthalmic solution 0.01 %	1	
bimatoprost ophthalmic solution 0.03 %	1	
IYUZEH OPHTHALMIC SOLUTION 0.005 % (***latanoprost***)	3/4	
latanoprost ophthalmic solution 0.005 %	1	
OMLONTI OPHTHALMIC SOLUTION 0.002 % (***omidenepag isopropyl***)	3/4	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	
tafluprost (pf) ophthalmic solution 0.0015 %	1	
travoprost (bak free) ophthalmic solution 0.004 %	1	
VYZULTA OPHTHALMIC SOLUTION 0.024 % (***latanoprostene bunod***)	3/4	
XELPROS OPHTHALMIC EMULSION 0.005 % (***latanoprost***)	3	
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (***tafluprost***)	3	
RHO KINASE INHIBITORS - Drugs for the Eye		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (***netarsudil dimesylate***)	3	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (***netarsudil-latanoprost***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VASOCONSTRICTORS		
ADRENALIN NASAL SOLUTION 0.1 % (***epinephrine hcl (nasal)***)	2	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (***cyclopentolate-phenylephrine***)	3	
oxymetazoline hcl external cream 1 %	1	PA
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA
UPNEEQ OPHTHALMIC SOLUTION 0.1 % (***oxymetazoline hcl***)	3/4	PA
GASTROINTESTINAL DRUGS		
CHLORIDE CHANNEL ACTIVATORS		
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (***lubiprostone***)	3/4	PA; QL (2 capsules per day.)
lubiprostone oral capsule 24 mcg, 8 mcg	1	PA; QL (2 capsules per day.)
GUANYLATE CYCLASE C (GCC) RECEPT AGONIST		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (***linaclotide***)	2	PA; QL (1 capsule per day.)
TRULANCE ORAL TABLET 3 MG (***plecanatide***)	3/4	PA; QL (1 tablet per day)
IMMUNOMODULATORY AGENTS (56:44)		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; QL (0.05 ml per day.)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML & 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (3 ml (2 syringes/1 box) per month.)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML & 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (3 ml (2 syringes/1 box) per month.)
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (2 ml (1 auto-injector) per month.)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***mirikizumab-mrkz***)	2	PA; QL (2 ml (1 prefilled syringe) per month.)
OPIOID ANTAGONISTS (56:18)		
alvimopan oral capsule 12 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	3/4	QL (0.4 ml per day.)
SYMPROIC ORAL TABLET 0.2 MG (***naldemedine tosylate***)	2	PA; QL (1 tablet per day)
GASTROINTESTINAL DRUGS - Drugs for the Stomach		
5-HT3 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***)	3/4	
granisetron hcl oral tablet 1 mg	1	
GRANISOL ORAL SOLUTION 2 MG/10ML (***granisetron hcl***)	3	
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		
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
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***)	3/4	
MOTOFEN ORAL TABLET 1-0.025 MG (***difenoxin-atropine***)	3/4	
MYTESI ORAL TABLET DELAYED RELEASE 125 MG (***crofelemer***)	3/4	PA; QL (2 tablets per day.)
opium oral tincture 10 mg/ml (1%)	1	
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***)	3	PA; QL (2 tablets per day.)
XERMELO ORAL TABLET 250 MG (***telotristat etiprate***)	3	PA; QL (3 tablets per day)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANTIEMETICS, MISCELLANEOUS - Drugs for Vomiting and Nausea		
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	
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	1	
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	1	QL (1 capsule per day)
promethazine hcl oral solution 12.5 mg/10ml, 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 (***promethazine hcl***)	3	
scopolamine transdermal patch 72 hour 1 mg/3days	1	
SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***)	3/4	PA; QL (4 ml per day)
ANTIHISTAMINES (GI DRUGS) - Drugs for Vomiting and Nausea		
BONJESTA ORAL TABLET EXTENDED RELEASE 20-20 MG (***doxylamine-pyridoxine***)	2	
COMPRO RECTAL SUPPOSITORY 25 MG (***prochlorperazine***)	3	
doxylamine-pyridoxine oral tablet delayed release 10-10 mg	1	PA
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	1	
trimethobenzamide hcl oral capsule 300 mg	1	
ANTI-INFLAMMATORY AGENTS (GI DRUGS) - Drugs for Inflammation		
alosetron hcl oral tablet 0.5 mg, 1 mg	1	PA; QL (2 tablets per day)
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (***mesalamine***)	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
balsalazide disodium oral capsule 750 mg	1	
DIPENTUM ORAL CAPSULE 250 MG (***olsalazine sodium***)	3	
mesalamine oral capsule delayed release 400 mg	1	
mesalamine oral tablet delayed release 1.2 gm	1	
mesalamine rectal enema 4 gm	1	QL (28 bottles per month.)
mesalamine rectal suppository 1000 mg	1	QL (1 suppository per day.)
mesalamine-cleanser rectal kit 4 gm	1	QL (4 kits per month.)
ROWASA RECTAL KIT 4 GM (***mesalamine-cleanser***)	3/4	QL (4 kits per month.)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
ANTIULCER AGENTS AND ACID SUPPRESS.,MISC - Drugs for Ulcers and Stomach Acid		
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	1	QL (120 capsules per 180 days.)
PYLERA ORAL CAPSULE 140-125-125 MG (***bis subcit-metronid-tetracyc***)	3/4	QL (120 capsules per 180 days.)
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	
amoxicillin trihydrate oral suspension reconstituted 250 mg/5ml	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole oral capsule 375 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
metronidazole oral tablet 250 mg, 500 mg	1	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
CATHARTICS AND LAXATIVES - Drugs for Constipation		
bisacodyl ec oral tablet delayed release 5 mg	E	H
clearlax oral powder 17 gm/scoop	E	H
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	E	H
gavilyte-g oral solution reconstituted 236 gm	E	H
gavilyte-n with flavor pack oral solution reconstituted 420 gm	E	H
gentle laxative oral tablet delayed release 5 mg	E	H
glycolax oral powder 17 gm/scoop	E	H
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (***peg 3350-kcl-nabcb-nacl-nasulf***)	E	H
goodsense clearlax oral powder 17 gm/scoop	E	H
laxative osmotic oral powder 17 gm/scoop	E	H
magnesium citrate oral solution 1.745 gm/30ml	E	H
mm clearlax oral powder 17 gm/scoop	E	H
peg 3350 oral powder 17 gm/scoop	E	H
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	E	H
peg-3350/electrolytes oral solution reconstituted 236 gm	E	H
polyethylene glycol 3350 oral powder 17 gm/scoop	E	H
smooth lax oral powder 17 gm/scoop	E	H
CHOLELITHOLYTIC AGENTS - Drugs for the Stomach		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***)	2	PA; QL (4 capsules per day.)
CTEXLI ORAL TABLET 250 MG (***chenodiol (basds)***)	3/4	PA; QL (93 tablets per month.)
IQIRVO ORAL TABLET 80 MG (***elafibranor***)	3/4	PA; QL (31 tablets per month.)
LIVDELZI ORAL CAPSULE 10 MG (***seladelpar lysine***)	3/4	PA; QL (30 capsules per month.)
LIVMARLI ORAL SOLUTION 19 MG/ML (***maralixibat chloride***)	3/4	PA; QL (60 mL (1140 mg) per month.)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (***maralixibat chloride***)	3/4	PA; QL (4 mL per day.)
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG (***maralixibat chloride***)	3/4	PA; QL (60 tablets per month.)
LIVMARLI ORAL TABLET 30 MG (***maralixibat chloride***)	3/4	PA; QL (30 tablets per month.)
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet 250 mg, 500 mg	1	
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	
GATTEX SUBCUTANEOUS KIT 5 MG (***teduglutide (rdna)***)	2	PA; QL (1 vial per day.); SP
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT (***pancrelipase (lip-prot-amyl)***)	3	
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (***pancrelipase (lip-prot-amyl)***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (***pancrelipase (lip-prot-amyl)***)	2	
DOPAMINE RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
GI DRUGS, MISCELLANEOUS - Drugs for the Stomach		
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 auto-injectors) per month.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
alvimopan oral capsule 12 mg	1	
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (***lubiprostone***)	3/4	PA; QL (2 capsules per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (***odevixibat***)	3/4	PA; QL (1 capsule per day.)
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (***odevixibat***)	3/4	PA; QL (2 capsules per day.)
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (***cholic acid***)	2	PA; QL (4 capsules per day.)
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	1	
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; QL (0.05 ml per day.)
GATTEX SUBCUTANEOUS KIT 5 MG (***teduglutide (rdna)***)	2	PA; QL (1 vial per day.); SP
IQIRVO ORAL TABLET 80 MG (***elafibranor***)	3/4	PA; QL (31 tablets per month.)
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (***linaclotide***)	2	PA; QL (1 capsule per day.)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (***maralixibat chloride***)	3/4	PA; QL (4 mL per day.)
lubiprostone oral capsule 24 mcg, 8 mcg	1	PA; QL (2 capsules per day.)
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml	1	PA
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
prucalopride succinate oral tablet 1 mg, 2 mg	1	PA; QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	PA; QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML (***methylnaltrexone bromide***)	3/4	QL (0.6 ml per day.)
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.4ML (***methylnaltrexone bromide***)	3/4	QL (0.4 ml per day.)
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (***resmetirom***)	3/4	PA; QL (1 Tablet per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled cartridge (180 mg) every 8 weeks after induction.)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled cartridge (360 mg) every 8 weeks after induction.)
SYMPROIC ORAL TABLET 0.2 MG (***naldemedine tosylate***)	2	PA; QL (1 tablet per day)
SYNDROS ORAL SOLUTION 5 MG/ML (***dronabinol***)	3/4	PA; QL (4 ml per day)
TRULANCE ORAL TABLET 3 MG (***plecanatide***)	3/4	PA; QL (1 tablet per day)
VIBERZI ORAL TABLET 100 MG, 75 MG (***eluxadoline***)	3	PA; QL (2 tablets per day.)
VOWST ORAL CAPSULE (***fecal microb spores, live-brpk***)	3/4	PA; QL (12 capsules per 365 days.)
XPHOZAH ORAL TABLET 30 MG (***tenapanor hcl (ckd)***)	3/4	PA; QL (2 tablets per day.)
HISTAMINE H2-ANTAGONISTS - Drugs for Ulcers and Stomach Acid		
cimetidine hcl oral solution 300 mg/5ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
nizatidine oral capsule 150 mg, 300 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LIPOTROPIC AGENTS - Drugs for the Stomach		
scopolamine transdermal patch 72 hour 1 mg/3days	1	
NEUROKININ-1 RECEPTOR ANTAGONISTS - Drugs for Vomiting and Nausea		
AKYNZEO ORAL CAPSULE 300-0.5 MG (***netupitant-palonosetron***)	3/4	
aprepitant oral capsule 125 mg, 40 mg, 80 mg	1	
aprepitant oral capsule therapy pack 80 & 125 mg	1	
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (***aprepitant***)	2	
POTASSIUM-COMPETITIVE ACID BLOCKERS - Drugs for Ulcers and Stomach Acid		
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (***amoxicillin-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	3/4	PA; QL (60 tablets per month and 60 tablets per year.)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (***amoxicill-clarithro-vonoprazan***)	3/4	QL (112 tablets per 180 days.)
PROKINETIC AGENTS - Drugs for the Stomach		
metoclopramide hcl oral solution 5 mg/5ml	1	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	
REGLAN ORAL TABLET 10 MG, 5 MG (***metoclopramide hcl***)	3/4	
PROSTAGLANDINS - Drugs for Ulcers and Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (***misoprostol***)	3/4	SM
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	1	
misoprostol oral tablet 100 mcg, 200 mcg	1	SM
PROTECTANTS - Drugs for Ulcers and Stomach Acid		
sucralfate oral suspension 1 gm/10ml	1	
sucralfate oral tablet 1 gm	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROTON-PUMP INHIBITORS - Drugs for Ulcers and Stomach Acid		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	1	QL (112 capsules and tablets (1 Package) per 180 days.)
esomeprazole magnesium oral packet 10 mg, 2.5 mg, 20 mg, 5 mg	1	PA; QL (1 packet per day.)
esomeprazole magnesium oral packet 40 mg	1	PA; QL (1 packet per day)
FIRST-LANSOPRAZOLE ORAL SUSPENSION 3 MG/ML (***lansoprazole***)	3	PA
lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg	1	PA; QL (1 tablet per day.)
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	1	
pantoprazole sodium oral packet 40 mg	1	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (***omeprazole magnesium***)	3/4	
RABEPRAZOLE SODIUM ORAL CAPSULE SPRINKLE 10 MG	3/4	
rabeprazole sodium oral tablet delayed release 20 mg	1	QL (1 tablet per day)
VOQUEZNA ORAL TABLET 10 MG (***vonoprazan fumarate***)	3/4	PA; QL (1 tablet per day and 186 tablets per 365 days.)
VOQUEZNA ORAL TABLET 20 MG (***vonoprazan fumarate***)	3/4	PA; QL (60 tablets per month and 60 tablets per year.)
GOLD COMPOUNDS		
GOLD COMPOUNDS		
AURANOFIN ORAL CAPSULE 3 MG	3	
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
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	1	PA
deferasirox oral packet 180 mg, 360 mg, 90 mg	1	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	1	PA
deferiprone oral tablet 1000 mg, 500 mg	1	PA
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	
FERRIPROX ORAL SOLUTION 100 MG/ML (***deferiprone***)	2	PA
FERRIPROX ORAL TABLET 1000 MG (***deferiprone***)	3/4	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG (***deferiprone***)	3/4	PA
penicillamine oral tablet 250 mg	1	
trientine hcl oral capsule 250 mg, 500 mg	1	PA
HORMONES AND SYNTHETIC SUBSTITUTES		
MELANOCORTIN RECEPTOR AGONISTS		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (***setmelanotide acetate***)	3	PA; QL (9 mls per month.); SP
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (***bremelanotide acetate***)	3/4	PA; QL (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***)	2	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
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***)	3/4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3/4	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external foam 0.12 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
BREZTRI AEROSPHERE INHALATION AEROSOL 160-18-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (***budeson-glycopyrrol-formoterol***)	3	QL (0.36 grams per day.); SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
budesonide oral capsule delayed release particles 3 mg	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
CORTISONE ACETATE ORAL TABLET 25 MG	3/4	
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)	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	3/4	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 grams per day.); SM
DULERA INHALATION AEROSOL 50-5 MCG/ACT (***mometasone furo-formoterol fum***)	3/4	QL (0.44 mcg per day.); SM
EOHILIA ORAL SUSPENSION 2 MG/10ML (***budesonide***)	3/4	PA; QL (20 grams per day.)
fludrocortisone acetate oral tablet 0.1 mg	1	
flunisolide nasal solution 25 mcg/act (0.025%)	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	3/4	QL (1 inhaler per month.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); SM
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.); SM
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	3/4	
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
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 oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
INTRAROSA VAGINAL INSERT 6.5 MG (***prasterone***)	3/4	PA; QL (1 insert per day)
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	3/4	PA; QL (372 tablets per month.)
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (***methylprednisolone***)	3/4	
MEDROL ORAL TABLET 2 MG (***methylprednisolone***)	2	
MEDROL ORAL TABLET THERAPY PACK 4 MG (***methylprednisolone***)	3/4	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	3/4	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 30 MG (***prednisolone sodium phosphate***)	3/4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (***prednisolone acetate***)	3	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone oral tablet 5 mg	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
prednisolone sodium phosphate oral solution 15 mg/5ml	1	
prednisolone sodium phosphate oral tablet dispersible 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	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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 % (***hydrocortisone***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
SERNIVO EXTERNAL EMULSION 0.05 % (***betamethasone dipropionate***)	3/4	
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	QL (0.35 grams per day.); SM
SYMBICORT INHALATION AEROSOL 80-4.5 MCG/ACT (***budesonide-formoterol fumarate***)	1	SM
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (***dexamethasone***)	3	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (***dexamethasone***)	3/4	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21) (***dexamethasone***)	3	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (***dexamethasone***)	3	
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (***budesonide***)	3/4	PA; QL (4 capsules per day.)
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	
triderm external cream 0.5 %	1	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (***budesonide***)	1	
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
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	1	
ANDROGENS - Hormones		
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	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	3/4	SM
EEMT HS ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EEMT ORAL TABLET 1.25-2.5 MG (***est estrogens-methyltest***)	2	
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	
ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	
KYZATREX ORAL CAPSULE 150 MG, 200 MG (***testosterone undecanoate***)	3/4	QL (4 capsules per day.); SM
METHITEST ORAL TABLET 10 MG	2	SM
methyltestosterone oral capsule 10 mg	1	SM
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	SM
testosterone enanthate intramuscular solution 200 mg/ml	1	SM
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	1	PA; QL (150 grams (2 pumps) per month.); SM
ANTIDIABETIC AGENTS, MISCELLANEOUS - Drugs for Diabetes		
colesevelam hcl oral packet 3.75 gm	1	
colesevelam hcl oral tablet 625 mg	1	
CYCLOSET ORAL TABLET 0.8 MG (***bromocriptine mesylate***)	3	
mifepristone oral tablet 300 mg	1	PA; QL (4 tablets per day.); SP
ANTIESTROGENS - Drugs for Women		
anastrozole oral tablet 1 mg	1	H-N
exemestane oral tablet 25 mg	1	H-N
letrozole oral tablet 2.5 mg	1	H-N
ANTIGONADTROPINS - Hormones		
aftera 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (***cetrorelix acetate***)	3/4	PA; QL (14 cartons per 21 days.)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML (***testosterone cypionate***)	3	SM
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML (***testosterone cypionate***)	3/4	SM
econtra one-step oral tablet 1.5 mg	1	H
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (***degarelix acetate***)	3	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***degarelix acetate***)	3	
FYREMADEL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***ganirelix acetate***)	3	QL (7 ml per 21 days.)
ganirelix acetate subcutaneous solution prefilled syringe 250 mcg/0.5ml	1	QL (7 ml per 21 days.)
her style oral tablet 1.5 mg	1	H
KYZATREX ORAL CAPSULE 150 MG, 200 MG (***testosterone undecanoate***)	3/4	QL (4 capsules per day.); SM
levonorgestrel oral tablet 1.5 mg	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; QL (1 tablet day.)
new day oral tablet 1.5 mg	1	H
opcicon one-step oral tablet 1.5 mg	1	H
option 2 oral tablet 1.5 mg	1	H
ORGOVYX ORAL TABLET 120 MG (***relugolix***)	3	PA; QL (1 tablet per day); CM
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***)	2	PA; QL (2 capsules per day.)
ORILISSA ORAL TABLET 150 MG (***elagolix sodium***)	2	PA; QL (1 tablet per day.)
ORILISSA ORAL TABLET 200 MG (***elagolix sodium***)	2	PA; QL (2 tablets per day.)
PLAN B ONE-STEP ORAL TABLET 1.5 MG (***levonorgestrel***)	1	H
shewise 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SLYND ORAL TABLET 4 MG (***drospirenone***)	3/4	H
take action oral tablet 1.5 mg	1	H
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (***testosterone***)	1	PA; QL (100 mg Testosterone (2 X 5 grams tubes = 10 grams) per day); SM
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	SM
testosterone enanthate intramuscular solution 200 mg/ml	1	SM
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	1	PA; QL (150 grams (2 pumps) per month.); SM
your choice oral tablet 1.5 mg	1	H
ANTIHYPOGLYCEMIC AGENTS, MISCELLANEOUS - Hormones		
diazoxide oral suspension 50 mg/ml	1	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (***diazoxide***)	3/4	
ANTIPARATHYROID AGENTS - Drugs for Bones		
calcitonin (salmon) injection solution 200 unit/ml	1	
calcitonin (salmon) nasal solution 200 unit/act	1	
cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg	1	
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***)	3	
ANTITHYROID AGENTS - Drugs for the Thyroid		
iodine strong oral solution 5 %	1	
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	1	
BIGUANIDES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (***pioglitazone hcl-metformin hcl***)	3/4	QL (3 tablets per day)
ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG	2	QL (2 tablets per day.)
dapagliflozin-metformin hcl er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-1000 mg, 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	1	
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	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***linagliptin-metformin hcl***)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (***linagliptin-metformin hcl***)	2	QL (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	1	
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (3 tablets per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	1	QL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	1	QL (31 tablets per month.)
sitaglip phos-metformin hcl er oral tablet extended release 24 hour 100-1000 mg, 50-1000 mg, 50-500 mg	1	
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3/4	QL (31 Tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3/4	QL (62 Tablets per month.)
SITAGLIPTIN BASE-METFORMIN HCL ORAL TABLET 50-1000 MG, 50-500 MG	3/4	QL (62 tablets per month.)
sitagliptin phos-metformin hcl oral tablet 50-1000 mg, 50-500 mg	1	QL (2 tablets per day)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (***empagliflozin-metformin hcl***)	2	QL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (***empagliflozin-metformin hcl***)	2	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (***empagliflozin-metformin hcl***)	2	QL (2 tablets per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (2 tablets per day.)
ZITUVIMET ORAL TABLET 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (***sitagliptin base-metformin hcl***)	3/4	QL (31 Tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 Tablets per month.)
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	1	H
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (***segesterone-ethinyl estradiol***)	3	QL (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	1	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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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)	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	3/4	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	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	1	H
camrese oral tablet 0.15-0.03 &0.01 mg	1	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 oral tablet 0.3-30 mg-mcg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 (28) 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	1	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***)	3/4	QL (5 ml per year.); SM
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 mL per 365 days.); SM
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H; SM
dolishale oral tablet 90-20 mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	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	QL (1 tablet per 21 days.); H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
emzahh oral tablet 0.35 mg	1	H
enilloring vaginal ring 0.12-0.015 mg/24hr	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
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
falmina oral tablet 0.1-20 mg-mcg	1	H
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (***norethindrone acet-ethinyl est***)	3/4	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
galbriela oral tablet chewable 0.8-25 mg-mcg	1	H
gemmily oral capsule 1-20 mg-mcg(24)	1	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
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	1	H
incassia oral tablet 0.35 mg	1	H
introvale oral tablet 0.15-0.03 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 &0.01 mg	1	H
jasmiel oral tablet 3-0.02 mg	1	H
jencycla oral tablet 0.35 mg	1	H
jolessa oral tablet 0.15-0.03 mg	1	H
joyeaux oral tablet 0.1-20 mg-mcg(21)	1	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	1	H
kalliga oral tablet 0.15-30 mg-mcg	1	H
kariva oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
kelnor 1/35 oral tablet 1-35 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
lessina oral tablet 0.1-20 mg-mcg	1	H
levonest oral tablet 50-30/75-40/ 125-30 mcg	1	H
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	1	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	1	H
levonorgestrel oral tablet 1.5 mg	1	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg	1	H
levonorg-eth estrad triphasic 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (***norethin-eth estrad-fe biphas***)	1	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	1	H
loryna oral tablet 3-0.02 mg	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
luizza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
luizza 1/20 oral tablet 1-20 mg-mcg	1	H
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	QL (5 ml per year.); H; SM
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H; SM
meleya oral tablet 0.35 mg	1	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 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
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
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
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***)	3/4	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
nikki oral tablet 3-0.02 mg	1	H
nora-be oral tablet 0.35 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	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	H
norethindrone oral tablet 0.35 mg	1	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, 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
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
orquidea oral tablet 0.35 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)	1	H
PLAN B ONE-STEP ORAL TABLET 1.5 MG (***levonorgestrel***)	1	H
portia-28 oral tablet 0.15-30 mg-mcg	1	H
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
setlakin oral tablet 0.15-0.03 mg	1	H
sharobel oral tablet 0.35 mg	1	H
shewise oral tablet 1.5 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 &0.01 mg	1	H
SLYND ORAL TABLET 4 MG (***drospirenone***)	3/4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	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)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	1	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	1	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	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-mili 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
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	1	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***)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 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)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	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	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
xelria fe oral tablet chewable 0.4-35 mg-mcg	1	H
xulane transdermal patch weekly 150-35 mcg/24hr	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
your choice oral tablet 1.5 mg	1	H
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS - Drugs for Diabetes		
ALOGLIPTIN BENZOATE ORAL TABLET 12.5 MG, 25 MG, 6.25 MG	2	QL (1 tablet per day.)
ALOGLIPTIN-METFORMIN HCL ORAL TABLET 12.5-1000 MG, 12.5-500 MG	2	QL (2 tablets per day.)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)
BRYNOVIN ORAL SOLUTION 25 MG/ML (***sitagliptin hydrochloride***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (***empagliflozin-linagliptin***)	2	QL (1 tablet per day.)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (***linagliptin-metformin hcl***)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (***linagliptin-metformin hcl***)	2	QL (2 tablets per day.)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (***linagliptin-metformin hcl***)	2	QL (1 tablet per day.)
saxagliptin hcl oral tablet 2.5 mg, 5 mg	1	QL (1 tablet per day)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	1	QL (62 tablets per month.)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	1	QL (31 tablets per month.)
sitaglip phos-metformin hcl er oral tablet extended release 24 hour 100-1000 mg, 50-1000 mg, 50-500 mg	1	
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3/4	QL (31 Tablets per month.)
SITAGLIPT BASE-METFORM HCL ER ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3/4	QL (62 Tablets per month.)
SITAGLIPTIN BASE-METFORMIN HCL ORAL TABLET 50-1000 MG, 50-500 MG	3/4	QL (62 tablets per month.)
SITAGLIPTIN ORAL TABLET 100 MG, 25 MG, 50 MG	3/4	QL (1 tablet per day.)
sitagliptin phos-metformin hcl oral tablet 50-1000 mg, 50-500 mg	1	QL (2 tablets per day)
sitagliptin phosphate oral tablet 100 mg, 25 mg, 50 mg	1	QL (31 tablets per 31 days.)
TRADJENTA ORAL TABLET 5 MG (***linagliptin***)	2	QL (1 tablet per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (2 tablets per day.)
ZITUVIMET ORAL TABLET 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 tablets per month.)
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (***sitagliptin base-metformin hcl***)	3/4	QL (31 Tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (***sitagliptin base-metformin hcl***)	3/4	QL (62 Tablets per month.)
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG (***sitagliptin***)	3/4	QL (1 tablet per day.)
ESTROGEN AGONIST-ANTAGONISTS - Drugs for Women		
clomid oral tablet 50 mg	1	
clomiphene citrate oral tablet 50 mg	1	
DUAVEE ORAL TABLET 0.45-20 MG (***conj estrogens-bazedoxifene***)	3	QL (1 tablet per day)
milophene oral tablet 50 mg	1	
OSPHENA ORAL TABLET 60 MG (***ospemifene***)	2	PA; QL (1 tablet per day.)
raloxifene hcl oral tablet 60 mg	1	H-N
tamoxifen citrate oral tablet 10 mg	1	
tamoxifen citrate oral tablet 20 mg	1	H-N
toremifene citrate oral tablet 60 mg	1	CM
ESTROGENS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	1	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***)	3/4	
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	QL (8 patches (1 box) per 28 days.); SM
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	1	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	QL (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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ashlyna oral tablet 0.15-0.03 &0.01 mg	1	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)	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	3/4	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	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	1	H
camrese oral tablet 0.15-0.03 &0.01 mg	1	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***)	2	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (***estradiol-norethindrone acet***)	2	QL (8 patches per 28 days.)
COVARYX HS ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COVARYX ORAL TABLET 1.25-2.5 MG (***est estrogens-methyltest***)	2	
cryselle oral tablet 0.3-30 mg-mcg	1	H
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 (28) 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	1	H
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (***estradiol valerate***)	3/4	SM
delyla oral tablet 0.1-20 mg-mcg	1	H
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***)	3	SM
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	SM
dolishale oral tablet 90-20 mcg	1	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	1	QL (8 patches (1 box) per 28 days.); SM
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	H
DUAVEE ORAL TABLET 0.45-20 MG (***conj estrogens-bazedoxifene***)	3	QL (1 tablet per day)
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	SM
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
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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	
estarylla oral tablet 0.25-35 mg-mcg	1	H
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	SM
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	1	SM
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	1	QL (37.5 grams (1 box) per month.); SM
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.); SM
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	QL (4 patches (1 carton) per 28 days.); SM
estradiol vaginal cream 0.01 %	1	
estradiol vaginal tablet 10 mcg	1	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	SM
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	1	
ESTRATEST H.S. ORAL TABLET 0.625-1.25 MG (***est estrogens-methyltest***)	3	
ESTRING VAGINAL RING 7.5 MCG/24HR (***estradiol***)	2	QL (1 ring per 90 days.)
estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	1	
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (***estradiol***)	2	SM
falmina oral tablet 0.1-20 mg-mcg	1	H
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (***norethindrone acet-ethinyl est***)	3/4	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (***estradiol acetate***)	3	QL (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	1	
galbriela oral tablet chewable 0.8-25 mg-mcg	1	H
gemmily oral capsule 1-20 mg-mcg(24)	1	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
iclevia oral tablet 0.15-0.03 mg	1	H
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG (***estradiol***)	2	QL (0.29 vaginal insert per day.)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (***estradiol***)	2	QL (18 inserts per year.)
introvale oral tablet 0.15-0.03 mg	1	H
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 &0.01 mg	1	H
jasmiel oral tablet 3-0.02 mg	1	H
jinteli oral tablet 1-5 mg-mcg	1	
jolessa oral tablet 0.15-0.03 mg	1	H
joyeaux oral tablet 0.1-20 mg-mcg(21)	1	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	1	H
kalliga oral tablet 0.15-30 mg-mcg	1	H
kariva oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
kelnor 1/35 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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
lessina oral tablet 0.1-20 mg-mcg	1	H
levonest oral tablet 50-30/75-40/ 125-30 mcg	1	H
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	1	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	1	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg	1	H
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (***norethin-eth estrad-fe biphas***)	1	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	1	H
loryna oral tablet 3-0.02 mg	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
luizza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
luizza 1/20 oral tablet 1-20 mg-mcg	1	H
lutera oral tablet 0.1-20 mg-mcg	1	H
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	1	QL (8 patches (1 box) per 28 days.); SM
marlissa oral tablet 0.15-30 mg-mcg	1	H
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (***estradiol***)	3	QL (4 patches (1 carton) per 28 days.); SM
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 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
mili oral tablet 0.25-35 mg-mcg	1	H
mimvey oral tablet 1-0.5 mg	1	
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
mono-linyah oral tablet 0.25-35 mg-mcg	1	H
MYFEMBREE ORAL TABLET 40-1-0.5 MG (***relugolix-estradiol-norethind***)	2	PA; QL (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***)	3/4	H
nikki oral tablet 3-0.02 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	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	H
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
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, 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
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***)	2	PA; QL (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)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM (***estrogens, conjugated***)	3	
PREMPHASE ORAL TABLET 0.625-5 MG (***conj estrog-medroxyprogest ace***)	2	
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***)	2	
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 &0.01 mg	1	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
syeda oral tablet 3-0.03 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)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	1	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	1	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	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	1	H
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	1	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***)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 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)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	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	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
xelria fe oral tablet chewable 0.4-35 mg-mcg	1	H
xulane transdermal patch weekly 150-35 mcg/24hr	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
yuvafem vaginal tablet 10 mcg	1	
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GLYCOGENOLYTIC AGENTS - Hormones		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
GONADOTROPINS - Hormones		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	3	
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML (***follitropin beta***)	2	PA; QL (5.4 mL (15 cartridges)per 21 days.)
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 600 UNT/0.72ML (***follitropin beta***)	2	PA; QL (8.64 mL(12 cartridges)per 21 days.)
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 900 UNT/1.08ML (***follitropin beta***)	2	PA; QL (8.64 mL (8 cartridges)per 21 days.)
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (***follitropin alfa***)	3/4	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (***follitropin alfa***)	3/4	PA
leuprolide acetate injection kit 1 mg/0.2ml	1	PA; SM
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (***menotropins***)	3/4	PA; QL (6 vials per day.)
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (***chorionic gonadotropin***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (***choriogonadotropin alfa***)	3/4	
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (***chorionic gonadotropin***)	3	
SYNAREL NASAL SOLUTION 2 MG/ML (***nafarelin acetate***)	2	SM
INCRETIN MIMETICS - Drugs for Diabetes		
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (2 pens (6 mL) per month.)
liraglutide solution pen-injector 18 mg/3ml subcutaneous	1	PA; QL (3 pens (9 mL) per month.)
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-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***)	2	PA; QL (0.08 ml per day.)
OZEMPIC ORAL TABLET 1.5 MG, 9 MG (***semaglutide***)	2	PA; QL (30 tablets per month.)
OZEMPIC ORAL TABLET 4 MG (***semaglutide***)	2	PA; QL (30 Tablets per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (***semaglutide***)	2	PA; QL (1 Pen-injector per month.)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML, 8 MG/3ML (***semaglutide***)	2	PA; QL (3 ml per month.)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (***semaglutide***)	2	PA; QL (1 tablet per day.)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.); SM
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (***dulaglutide***)	2	PA; QL (2 ml per month.)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (***dulaglutide***)	2	PA; QL (2 mL per month.)
INTERMEDIATE-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	2	SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (***insulin nph human (isophane)***)	2	SM
HUMULIN N VIAL SUBCUTANEOUS SUSPENSION 100 UNIT/ML (***insulin nph human (isophane)***)	1	SM
LEPTINS - Hormones		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (***metreleptin***)	3	PA; QL (0.9 vial per day.); SP
LONG-ACTING INSULINS - Drugs for Diabetes		
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin glargine***)	1	SM
LANTUS U-100 VIAL SUBCUTANEOUS SOLUTION 100 UNIT/ML (***insulin glargine***)	1	SM
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (***insulin glargine-lixisenatide***)	2	QL (18 ml per month.); SM
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	SM
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (***insulin glargine***)	2	SM
MEGLITINIDES - Drugs for Diabetes		
nateglinide oral tablet 120 mg, 60 mg	1	
repaglinide oral tablet 0.5 mg, 1 mg	1	QL (4 tablets per day)
repaglinide oral tablet 2 mg	1	QL (8 tablets per day)
PARATHYROID AGENTS - Drugs for Bones		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (***teriparatide***)	3	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (1.12 mL) per 28 days.)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 294 MCG/0.98ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (1.96 mL) per 28 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 420 MCG/1.4ML (***palopegteriparatide***)	3/4	PA; QL (2 pens (2.8 mL) per 28 days.)
PITUITARY - Hormones		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML (***corticotropin***)	3/4	PA; QL (10.5 mL (21 injectors) per treatment course.); SP
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (21 mL (21 injectors) per treatment course.); SP
ACTHAR INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (***corticotropin***)	3/4	PA; SP
CORTROPHIN INJECTION GEL 80 UNIT/ML (***corticotropin***)	3/4	PA; QL (20 ml per 24 days.); SP
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (***crinecerfont***)	3/4	PA; QL (62 capsules per month.); SP
CRENESSITY ORAL SOLUTION 50 MG/ML (***crinecerfont***)	3/4	PA; QL (120 mL (4 bottles) per month.); SP
DESMODA ORAL SOLUTION 0.05 MG/ML (***desmopressin acetate***)	3/4	PA
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	1	
DESMOPRESSIN ACETATE NASAL SOLUTION 1.5 MG/ML	3	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate pf injection solution 4 mcg/ml	1	
desmopressin acetate spray nasal solution 0.01 %	1	
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML (***somatrogon-ghla***)	3/4	PA; QL (0.172 ml per day.)
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 60 MG/1.2ML (***somatrogon-ghla***)	3/4	PA; QL (4.8 mL (4 Prefilled Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL (9 Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; QL (9 mL (6 Pens) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL (18 Pens) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 ml (9 cartridges) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 ml (18 cartridges) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (***somatropin***)	2	PA; QL (16 vials per month.)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	3/4	PA; QL (1 vial per day.)
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 2.1 MG, 2.5 MG (***lonapegsomatropin-tcgd***)	3/4	PA; QL (4 single-dose prefilled cartridges per month.)
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***)	3/4	PA; QL (0.143 cartridge per day.)
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (***somapacitan-beco***)	3/4	PA; QL (0.215 ml per day.)
PROGESTINS - Drugs for Women		
abigale lo oral tablet 0.5-0.1 mg	1	
abigale oral tablet 1-0.5 mg	1	
ACTIVELLA ORAL TABLET 1-0.5 MG (***estradiol-norethindrone acet***)	3/4	
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
amethyst oral tablet 90-20 mcg	1	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	QL (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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ashlyna oral tablet 0.15-0.03 &0.01 mg	1	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)	1	H
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (***levonorgest-eth estrad-fe bisg***)	3/4	H
balziva oral tablet 0.4-35 mg-mcg	1	H
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	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	1	H
camrese oral tablet 0.15-0.03 &0.01 mg	1	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***)	2	QL (4 patches per month.)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (***estradiol-norethindrone acet***)	2	QL (8 patches per 28 days.)
CRINONE VAGINAL GEL 4 %, 8 % (***progesterone***)	3/4	
cryselle 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cyred eq oral tablet 0.15-30 mg-mcg	1	H
dasetta 1/35 (28) 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	1	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***)	3/4	QL (5 ml per year.); SM
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (***medroxyprogesterone acetate***)	3/4	QL (5 mL per 365 days.); SM
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (***medroxyprogesterone acetate***)	1	QL (3.25 ml per year.); H; SM
dolishale oral tablet 90-20 mcg	1	H
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	H
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	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	QL (1 tablet per 21 days.); H
eluryng vaginal ring 0.12-0.015 mg/24hr	1	H
emzahh oral tablet 0.35 mg	1	H
ENDOMETRIN VAGINAL INSERT 100 MG (***progesterone***)	2	
enilloring vaginal ring 0.12-0.015 mg/24hr	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
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	1	
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	1	H
falmina 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
feirza 1/20 oral tablet 1-20 mg-mcg	1	H
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (***norethindrone acet-ethinyl est***)	3/4	H
finzala oral tablet chewable 1-20 mg-mcg(24)	1	H
fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
galbriela oral tablet chewable 0.8-25 mg-mcg	1	H
gallifrey oral tablet 5 mg	1	
gemmily oral capsule 1-20 mg-mcg(24)	1	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
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	1	H
incassia oral tablet 0.35 mg	1	H
introvale oral tablet 0.15-0.03 mg	1	H
isibloom oral tablet 0.15-30 mg-mcg	1	H
jaimiess oral tablet 0.15-0.03 &0.01 mg	1	H
jasmiel oral tablet 3-0.02 mg	1	H
jencycla oral tablet 0.35 mg	1	H
jinteli oral tablet 1-5 mg-mcg	1	
jolessa oral tablet 0.15-0.03 mg	1	H
joyeaux oral tablet 0.1-20 mg-mcg(21)	1	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	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
kalliga oral tablet 0.15-30 mg-mcg	1	H
kariva oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
kelnor 1/35 oral tablet 1-35 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
lessina oral tablet 0.1-20 mg-mcg	1	H
levonest oral tablet 50-30/75-40/ 125-30 mcg	1	H
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	1	H
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	1	H
levonorgestrel oral tablet 1.5 mg	1	H
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg	1	H
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	H
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (***norethin-eth estrad-fe biphas***)	1	H
lojaimiess oral tablet 0.1-0.02 & 0.01 mg	1	H
loryna oral tablet 3-0.02 mg	1	H
low-ogestrel oral tablet 0.3-30 mg-mcg	1	H
lo-zumandimine oral tablet 3-0.02 mg	1	H
luizza 1.5/30 oral tablet 1.5-30 mg-mcg	1	H
luizza 1/20 oral tablet 1-20 mg-mcg	1	H
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	QL (5 ml per year.); H; SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	1	QL (5 mL per 365 days.); H; SM
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	SM
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml	1	
megestrol acetate oral tablet 20 mg, 40 mg	1	
meleya oral tablet 0.35 mg	1	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 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	1	
minzoya oral tablet 0.1-20 mg-mcg(21)	1	H
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; QL (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***)	3/4	H
nikki oral tablet 3-0.02 mg	1	H
nora-be oral tablet 0.35 mg	1	H
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	1	H
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	1	H
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
norethindrone acetate oral tablet 5 mg	1	
norethindrone acet-ethinyl est oral tablet 1-20 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	1	
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, 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
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
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (***elagolix-estradiol-norethind***)	2	PA; QL (2 capsules per day.)
orquidea oral tablet 0.35 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)	1	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 estrog-medroxyprogest ace***)	2	
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***)	2	
progesterone intramuscular oil 50 mg/ml	1	SM
progesterone oral capsule 100 mg, 200 mg	1	SM
progesterone vaginal insert 100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (***medroxyprogesterone acetate***)	3/4	SM
reclipsen oral tablet 0.15-30 mg-mcg	1	H
rivelsa oral tablet 42-21-21-7 days	1	H
rosyrah oral tablet 42-21-21-7 days	1	H
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
setlakin oral tablet 0.15-0.03 mg	1	H
sharobel oral tablet 0.35 mg	1	H
shewise oral tablet 1.5 mg	1	H
simliya oral tablet 0.15-0.02/0.01 mg (21/5)	1	H
simpesse oral tablet 0.15-0.03 &0.01 mg	1	H
SLYND ORAL TABLET 4 MG (***drospirenone***)	3/4	H
sprintec 28 oral tablet 0.25-35 mg-mcg	1	H
syeda oral tablet 3-0.03 mg	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)	1	H
TAYTULLA ORAL CAPSULE 1-20 MG-MCG(24) (***norethin ace-eth estrad-fe***)	E	H
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	1	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	1	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	1	H
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H
tri-mili 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
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	1	H

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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***)	3/4	H
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (***levonorgestrel-ethinyl estrad***)	1	H
tydemy oral tablet 3-0.03-0.451 mg	1	H
valtya 1/35 oral tablet 1-35 mg-mcg	1	H
valtya 1/50 oral tablet 1-50 mg-mcg	1	H
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	1	H
vestura oral tablet 3-0.02 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)	1	H
volnea oral tablet 0.15-0.02/0.01 mg (21/5)	1	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	1	H
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	1	H
xelria fe oral tablet chewable 0.4-35 mg-mcg	1	H
xulane transdermal patch weekly 150-35 mcg/24hr	1	H
YASMIN 28 ORAL TABLET 3-0.03 MG (***drospirenone-ethinyl estradiol***)	3	
YAZ ORAL TABLET 3-0.02 MG (***drospirenone-ethinyl estradiol***)	3	
your choice oral tablet 1.5 mg	1	H
zafemy transdermal patch weekly 150-35 mcg/24hr	1	H
zovia 1/35 (28) oral tablet 1-35 mg-mcg	1	H
zumandimine oral tablet 3-0.03 mg	1	H
RAPID-ACTING INSULINS - Drugs for Diabetes		
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60X4 &60X8 & 60X12 UNIT, 8 UNIT, 90 X 4 UNIT & 90X8 UNIT, 90 X 8 UNIT & 90X12 UNIT (***insulin regular human***)	3/4	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HUMALOG INJECTION SOLUTION 100 UNIT/ML (***insulin lispro***)	3/4	SM
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro***)	2	SM
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	SM
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	2	SM
HUMALOG MIX 75/25 VIAL SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (***insulin lispro prot & lispro***)	1	SM
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (***insulin lispro***)	2	SM
HUMALOG U-100 JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (***insulin lispro***)	2	SM
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	SM
INSULIN LISPRO INJECTION SOLUTION 100 UNIT/ML	1	SM
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	SM
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	SM
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (***insulin lispro-aabc***)	2	SM
LYUMJEV VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin lispro-aabc***)	1	SM
SHORT-ACTING INSULINS - Drugs for Diabetes		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	2	SM
HUMULIN 70/30 VIAL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (***insulin nph isophane & regular***)	1	SM
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (***insulin regular human***)	2	SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HUMULIN R VIAL INJECTION SOLUTION 100 UNIT/ML (***insulin regular human***)	1	SM
MYXREDLIN INTRAVENOUS SOLUTION 100-0.9 UT/100ML-% (***insulin regular(human) in nacl***)	3	SM
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB - Drugs for Diabetes		
BRENZAVVY ORAL TABLET 20 MG (***bexagliflozin***)	3	QL (1 tablet per day.)
dapagliflozin-metformin hcl er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-1000 mg, 5-500 mg	1	
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (***empagliflozin-linagliptin***)	2	QL (1 tablet per day.)
JARDIANCE ORAL TABLET 10 MG, 25 MG (***empagliflozin***)	2	QL (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	QL (2 tablets per day.)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG (***empagliflozin-metformin hcl***)	2	QL (1 tablet per day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG (***empagliflozin-metformin hcl***)	2	QL (2 tablets per day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (1 tablet per day.)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (***empagliflozin-linaglip-metform***)	2	QL (2 tablets per day.)
SOMATOSTATIN AGONISTS - Hormones		
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
octreotide acetate injection solution 1000 mcg/ml, 200 mcg/ml	1	PA
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	1	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (***pasireotide diaspartate***)	3/4	PA; QL (2 ampules per day.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SOMATOTROPIN AGONISTS - Hormones		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG (***tesamorelin acetate***)	3/4	PA; QL (1 vial per day.); SP
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG (***tesamorelin acetate***)	3/4	PA; QL (4 vials per month.); SP
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (***mecasermin***)	2	PA; QL (13 vials per month.); SP
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 mL (9 Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML (***somatropin***)	2	PA; QL (9 mL (6 Pens) per month.)
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 mL (18 Pens) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML (***somatropin***)	2	PA; QL (13.5 ml (9 cartridges) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***somatropin***)	2	PA; QL (27 ml (18 cartridges) per month.)
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (***somatropin***)	2	PA; QL (16 vials per month.)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***somatropin (non-refrigerated)***)	3/4	PA; QL (1 vial per day.)
SOMATOTROPIN ANTAGONISTS - Hormones		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (***pegvisomant***)	3/4	PA; QL (1 vial per day.); SP
SULFONYLUREAS - Drugs for Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (***pioglitazone hcl-glimepiride***)	3	
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, 2.5 mg, 5 mg	1	
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	1	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 5 MG (***glipizide***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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	
THIAZOLIDINEDIONES - Drugs for Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (***pioglitazone hcl-metformin hcl***)	3/4	QL (3 tablets per day)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	2	QL (1 tablet per day.)
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (***pioglitazone hcl-glimepiride***)	3	
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	1	
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	QL (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***)	2	
EVEXITHROID ORAL TABLET 120 MG, 15 MG, 180 MG, 30 MG, 60 MG, 90 MG (***thyroid***)	3	
LEVOTHYROXINE SODIUM ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	3/4	
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	1	
liomny oral tablet 25 mcg, 5 mcg, 50 mcg	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
RENTHYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (***thyroid***)	3	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (***resmetirom***)	3/4	PA; QL (1 Tablet per day.)
THYQUIDITY ORAL SOLUTION 100 MCG/5ML (***levothyroxine sodium***)	3/4	PA
thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	1	
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG (***levothyroxine sodium***)	3/4	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML (***levothyroxine sodium***)	2	PA
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	
IMMUNOMODULATORY AGENTS (90:00)		
AMINO ACID POLYMERS		
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
ANTIMETABOLITES		
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.)
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.)
ANTIMETABOLITES, IMMUNOSUPP THERAPY MISC		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
mycophenolate mofetil oral capsule 250 mg	1	
APRIL OR BAFF INHIBITOR AGENTS		
VOYXACT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 400 MG/2ML (***sibeprenlimab-szsi***)	3/4	PA; QL (1 prefilled syringe per month.); SP
CALCINEURIN INHIBITORS, MISC (90:28)		
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	
gengraf oral capsule 100 mg, 25 mg	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	PA
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	3/4	PA; QL (1 bottle per month.)
RESTASIS OPHTHALMIC EMULSION 0.05 % (***cyclosporine***)	1	PA; QL (60 vials per month.)
tacrolimus external ointment 0.03 %, 0.1 %	1	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
VERKAZIA OPHTHALMIC EMULSION 0.1 % (***cyclosporine***)	3/4	PA; QL (4 vials per day.)
COMPLEMENT INHIBITOR AGENTS (90:20)		
FABHALTA ORAL CAPSULE 200 MG (***iptacopan hcl***)	2	PA; QL (2 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP
COMPLEMENT INHIBITORS (90:08)		
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (***zilucoplan sodium***)	3/4	PA; QL (0.416 ml per day.); SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (***zilucoplan sodium***)	3/4	PA; QL (0.574 ml per day.); SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (***zilucoplan sodium***)	3/4	PA; QL (0.81 ml per day.); SP
DISEASE-MODIFYING ANTIRHEUMAT DRUGS MISC		
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (***vedolizumab***)	2	PA; QL (0.05 ml per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
DISEASE-MODIFYING ANTIRHEUMATIC DRUGS		
AURANOFIN ORAL CAPSULE 3 MG	3	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***)	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***)	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 auto-injector) per month.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (2 ml per 2 months)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (4 ml (2 pens/1 box) per month.)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
FUMARATES		
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.)
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; QL (56 capsules per year.)
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.)
IGG1 MONOCLONAL ANTIBODIES		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
IMMUNOMODULATORY AGENTS (90:00)		
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	CM
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
everolimus oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
everolimus oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
mercaptopurine oral suspension 2000 mg/100ml	1	CM
mercaptopurine oral tablet 50 mg	1	CM
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
torpenz oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
torpenz oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
yulithira oral tablet 10 mg, 7.5 mg	1	PA; QL (2 tablets per day.); CM
yulithira oral tablet 2.5 mg, 5 mg	1	PA; QL (1 tablet per day.); CM
INTERFERONS		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 pens (1 box) per month.)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 syringes (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BETASERON SUBCUTANEOUS KIT 0.3 MG (***interferon beta-1b***)	2	PA; QL (15 vials per month.)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
INTERLEUKIN INHIBITOR AGENTS, MISC		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***omalizumab***)	2	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***omalizumab***)	2	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
INTERLEUKIN-MEDIATED AGENTS, MISC		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 auto injector per month.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 prefilled syringes per month.)
AVTOZMA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab-anoh***)	3	PA; QL (4 autoinjectors per month.)
AVTOZMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab-anoh***)	3	PA; QL (4 syringes per month.)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 mL per month)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP
STARJEMZA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-hmny***)	2	PA; QL (1 single-dose vial every 3 months.)
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-hmny***)	2	PA; QL (1 prefilled syringe every 3 months.)
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-stba***)	2	
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-stba***)	2	PA; QL (1 syringe every 3 months.)
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-auub***)	2	PA; QL (1 single-dose vial every 3 months.)
WEZLANA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-auub***)	2	PA; QL (1 syringe per 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (***ustekinumab-kfce***)	2	PA; QL (1 single-dose vial every 3 months.)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (***ustekinumab-kfce***)	2	PA; QL (1 syringe every 3 months.)
JANUS KINASE INHIBITORS, MISCELLANEOUS		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (***baricitinib***)	3	PA; QL (1 tablet per day.)
RINVOQ LQ ORAL SOLUTION 1 MG/ML (***upadacitinib***)	2	PA; QL (360 mL (2 bottles) per month.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
tofacitinib citrate er oral tablet extended release 24 hour 11 mg, 22 mg	1	PA; QL (1 tablet per day.)
tofacitinib citrate oral solution 1 mg/ml	1	PA; QL (8 mL per day.)
tofacitinib citrate oral tablet 10 mg	1	PA; QL (2 tablets per day)
tofacitinib citrate oral tablet 5 mg	1	PA; QL (2 tablets per day.)
MONOCARBOXYLIC ACID AMIDE AGENTS		
leflunomide oral tablet 10 mg, 20 mg	1	
MONOCLONAL ANTIBODIES (90:04)		
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***ofatumumab***)	2	PA; QL (0.02 ml per day.)
MONOCLONAL ANTIBODIES (90:10)		
LEQEMBI IQLIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 360 MG/1.8ML (***lecanemab-irmb***)	3/4	PA; QL (7.2 mL (4 autoinjectors) per month.)
MONOCLONAL ANTIBODIES (90:12)		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	3/4	PA; QL (0.04 ml per day.); SP
MTOR INHIBITORS, MISCELLANEOUS		
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
NEONATAL FC RECEPTOR BLOCKERS		
VYVGART HYTRULO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML (***efgartigimod alfa-hyalur-qvfc***)	3/4	PA; QL (4 syringes every 50 days.)
PHOSPHODIESTERASE-4 INHIBITORS, MISC		
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.)
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (***apremilast***)	2	PA; QL (30 tablets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG (***apremilast***)	2	PA; QL (1 starter pack (41 tablets) per 365 days.)
SPHINGOSINE 1-PHOSPHATE (S1P) AGENTS		
fingolimod hcl oral capsule 0.5 mg	1	PA; QL (1 capsule per day.)
GILENYA ORAL CAPSULE 0.25 MG (***fingolimod hcl***)	3/4	PA; QL (1 capsule per day.)
MAYZENT ORAL TABLET 0.25 MG (***siponimod fumarate***)	3	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (7 tablets per 365 days.)
T-CELL BLOCKERS (90:24)		
LUPKYNIS ORAL CAPSULE 7.9 MG (***voclosporin***)	3/4	PA; QL (6 capsules per day.); SP
TUMOR NECROSIS FACTOR INHIBITORS, MISC		
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 auto-injectors) per month.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
LOCAL ANESTHETICS - Drugs for Numbing		
LOCAL ANESTHETICS - Drugs for Numbing		
ALTACAINE OPHTHALMIC SOLUTION 0.5 % (***tetracaine hcl***)	3	
tetracaine hcl ophthalmic solution 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ZTLIDO EXTERNAL PATCH 1.8 % (***lidocaine***)	3	PA; QL (3 patches per day.)
MISCELLANEOUS THERAPEUTIC AGENTS		
5-ALPHA-REDUCTASE INHIBITORS		
dutasteride oral capsule 0.5 mg	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	
finasteride oral tablet 5 mg	1	
5-ALPHA-REDUCTASE INHIBITORS (92:04) - Drugs for Alcohol Dependence		
disulfiram oral tablet 250 mg, 500 mg	1	
dutasteride oral capsule 0.5 mg	1	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	
finasteride oral tablet 5 mg	1	
naltrexone hcl oral tablet 50 mg	1	
ANTIDOTES (92:12) - Drugs for Overdose or Poisoning		
acetylcysteine inhalation solution 10 %, 20 %	1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (***glucagon***)	2	
CHEMET ORAL CAPSULE 100 MG (***succimer***)	2	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (***lanthanum carbonate***)	3	
glucagon emergency kit injection solution reconstituted 1 mg	1	
GLUCAGON EMERGENCY KIT INJECTION SOLUTION RECONSTITUTED 1 MG/ML	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (***glucagon***)	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (***glucagon***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (***glucagon***)	2	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	1	
lederle leucovorin oral tablet 5 mg	1	
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	SM
naloxone hcl injection solution cartridge 0.4 mg/ml	1	SM
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	1	SM
naltrexone hcl oral tablet 50 mg	1	
phytonadione oral tablet 5 mg	1	
RADIOGARDASE ORAL CAPSULE 0.5 GM (***prussian blue insoluble***)	3	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	1	PA
sevelamer carbonate oral tablet 800 mg	1	
sodium polystyrene sulfonate combination suspension 15 gm/60ml	1	
sodium polystyrene sulfonate oral powder	1	
SPS (SODIUM POLYSTYRENE SULF) COMBINATION SUSPENSION 15 GM/60ML (***sodium polystyrene sulfonate***)	3	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (***sodium polystyrene sulfonate***)	3	
VISTOGARD ORAL PACKET 10 GM (***uridine triacetate***)	2	PA
ANTIGOUT AGENTS - Drugs for Gout		
allopurinol oral tablet 100 mg, 200 mg, 300 mg	1	
colchicine oral capsule 0.6 mg	1	
colchicine oral tablet 0.6 mg	1	
colchicine-probenecid oral tablet 0.5-500 mg	1	
febuxostat oral tablet 40 mg, 80 mg	1	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (***colchicine***)	3/4	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
indomethacin oral suspension 25 mg/5ml	1	PA
indomethacin rectal suppository 50 mg	1	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 er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
ORLYNVAH ORAL TABLET 500-500 MG (***sulopenem etzadrox-probenecid***)	3/4	
probenecid oral tablet 500 mg	1	
ANTISENSE OLIGONUCLEOTIDES		
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (***sodium oxybate***)	3/4	PA; QL (1 packet per day.)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (***sodium oxybate***)	3/4	PA; QL (1 box (28 packets) per year.)
sodium oxybate oral solution 500 mg/ml	3/4	PA; QL (18 ml per day.); SP
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 autoinjector (0.8 mL) per month.); SP
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (***olezarsen sodium***)	3/4	PA; QL (1 Auto-injector (0.8 mL) per month.); SP
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (***eplontersen sodium***)	2	PA; QL (0.029 ml per day.)
BONE ANABOLIC AGENTS		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (***teriparatide***)	3	PA
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	3	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (***abaloparatide***)	3	PA
BONE RESORPTION INHIBITORS - Drugs for Bone Loss		
alendronate sodium oral solution 70 mg/75ml	1	
alendronate sodium oral tablet 10 mg, 35 mg, 70 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (***estradiol***)	3	QL (8 patches (1 box) per 28 days.); SM
BINOSTO ORAL TABLET EFFERVESCENT 70 MG (***alendronate sodium***)	3/4	
calcitonin (salmon) injection solution 200 unit/ml	1	
calcitonin (salmon) nasal solution 200 unit/act	1	
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML (***estradiol valerate***)	3/4	SM
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (***estradiol cypionate***)	3	SM
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	SM
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	1	QL (8 patches (1 box) per 28 days.); SM
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (***estradiol***)	3	SM
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	SM
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	1	SM
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	1	QL (37.5 grams (1 box) per month.); SM
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 patches (1 box) per 28 days.); SM
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	QL (4 patches (1 carton) per 28 days.); SM
estradiol vaginal cream 0.01 %	1	
estradiol vaginal tablet 10 mcg	1	
estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml	1	SM
ESTRING VAGINAL RING 7.5 MCG/24HR (***estradiol***)	2	QL (1 ring per 90 days.)
estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (***estradiol***)	2	SM
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (***estradiol acetate***)	3	QL (1 ring per 3 months.)
FOSAMAX ORAL TABLET 70 MG (***alendronate sodium***)	3/4	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (***alendronate-cholecalciferol***)	3	
ibandronate sodium oral tablet 150 mg	1	
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	1	QL (8 patches (1 box) per 28 days.); SM
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24HR (***estradiol***)	3	QL (4 patches (1 carton) per 28 days.); SM
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (***calcitonin (salmon)***)	3	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (***estrogens conjugated***)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM (***estrogens, conjugated***)	3	
raloxifene hcl oral tablet 60 mg	1	H-N
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	1	
risedronate sodium oral tablet delayed release 35 mg	1	
yuvafem vaginal tablet 10 mcg	1	
BRADYKININ RECEPTOR ANTAGONISTS		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.)
CARBONIC ANHYDRASE INHIBITORS (92:26)		
dichlorphenamide oral tablet 50 mg	1	PA; QL (4 tablets per day.)
CARIOSTATIC AGENTS - Vitamins and Fluoride		
CLINPRO 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
DENTA 5000 PLUS SENSITIVE DENTAL GEL 1.1-5 %	3	
DENTAGEL DENTAL GEL 1.1 %	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EASYGEL DENTAL GEL 0.4 % (***stannous fluoride***)	3	
FLORIVA ORAL LIQUID 0.25-400 MG-UNIT/ML (***sodium fluoride-vitamin d***)	3	
FLORIVA PLUS ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***pediatric multivitamins-fl***)	3	
FLUORIDEX DAILY RENEWAL MOUTH/THROAT CONCENTRATE 0.63 % (***stannous fluoride***)	3	
FLUORIDEX DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
FLUORIMAX 5000 SENSITIVE DENTAL GEL 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	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	
multi-vitamin/fluoride oral suspension 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT 5000 KIDS DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (***sodium fluoride***)	3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT 5000 SENSITIVE DENTAL GEL 1.1-5 % (***sod fluoride-potassium nitrate***)	3	
PREVIDENT DENTAL GEL 1.1 % (***sodium fluoride***)	3/4	
PREVIDENT MOUTH/THROAT SOLUTION 0.2 % (***sodium fluoride***)	3	
sf 5000 plus dental cream 1.1 %	1	
sf dental gel 1.1 %	1	
sod fluoride-potassium nitrate dental gel 1.1-5 %	1	
sodium fluoride 5000 enamel dental gel 1.1-5 %	1	
sodium fluoride 5000 plus dental cream 1.1 %	1	
sodium fluoride 5000 ppm dental gel 1.1 %	1	
sodium fluoride 5000 ppm dental paste 1.1 %	1	
sodium fluoride 5000 sensitive dental gel 1.1-5 %	1	
sodium fluoride dental cream 1.1 %	1	
sodium fluoride dental gel 1.1 %	1	
sodium fluoride mouth/throat solution 0.2 %	1	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	1	H
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	1	H
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 (***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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
COMPLEMENT INHIBITORS		
BERINERT INTRAVENOUS KIT 500 UNIT (***c1 esterase inhibitor (human)***)	3/4	PA; QL (0.4 boxes per day.); SP
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (***pegcetacoplan***)	2	PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP
FABHALTA ORAL CAPSULE 200 MG (***iptacopan hcl***)	2	PA; QL (2 capsules per day.)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (24 vials per month.); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (16 vials per month.); SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***)	3/4	PA; QL (0.27 vials per day.)
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP
VOYDEYA ORAL TABLET 100 MG (***danicopan***)	2	PA; QL (6 tablets per day.)
VOYDEYA ORAL TABLET THERAPY PACK 50 & 100 MG (***danicopan***)	2	PA; QL (180 tablets per month.)
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML (***zilucoplan sodium***)	3/4	PA; QL (0.416 ml per day.); SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 23 MG/0.574ML (***zilucoplan sodium***)	3/4	PA; QL (0.574 ml per day.); SP
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML (***zilucoplan sodium***)	3/4	PA; QL (0.81 ml per day.); SP
COMPLEMENT INHIBITORS (92:32)		
BERINERT INTRAVENOUS KIT 500 UNIT (***c1 esterase inhibitor (human)***)	3/4	PA; QL (0.4 boxes per day.); SP
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (***pegcetacoplan***)	2	PA; QL (5.8 ml per day. 2,100 ml per 360 days.); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (24 vials per month.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (***c1 esterase inhibitor (human)***)	2	PA; QL (16 vials per month.); SP
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	1	PA; QL (0.6 ml per day.)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (***c1 esterase inhibitor (recomb)***)	3/4	PA; QL (0.27 vials per day.)
TAVNEOS ORAL CAPSULE 10 MG (***avacopan***)	3/4	PA; QL (6 capsules per day.); SP
DISEASE-MODIFYING ANTIRHEUMATIC AGENTS - Drugs for Arthritis		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 auto injector per month.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 prefilled syringes per month.)
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 auto-injectors) per month.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
AURANOFIN ORAL CAPSULE 3 MG	3	
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
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	
DEPEN TITRATABS ORAL TABLET 250 MG (***penicillamine***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
gengraf oral capsule 100 mg, 25 mg	1	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 ml per month.)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***sarilumab***)	3/4	PA; QL (2.28 mL per month)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP
leflunomide oral tablet 10 mg, 20 mg	1	
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (***baricitinib***)	3	PA; QL (1 tablet per day.)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
penicillamine oral tablet 250 mg	1	
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML (***methotrexate (anti-rheumatic)***)	2	QL (0.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML (***methotrexate (anti-rheumatic)***)	2	QL (1 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 15 MG/0.3ML (***methotrexate (anti-rheumatic)***)	2	QL (1.2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML (***methotrexate (anti-rheumatic)***)	2	QL (1.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***methotrexate (anti-rheumatic)***)	2	QL (1.6 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML (***methotrexate (anti-rheumatic)***)	2	QL (1.8 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 25 MG/0.5ML (***methotrexate (anti-rheumatic)***)	2	QL (2 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/0.6ML (***methotrexate (anti-rheumatic)***)	2	QL (2.4 ml (4 auto-injectors) per month.)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML (***methotrexate (anti-rheumatic)***)	2	QL (0.6 ml (4 auto-injectors) per month.)
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (***upadacitinib***)	2	PA; QL (1 tablet per day.)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (***upadacitinib***)	2	PA; QL (84 tablets per 365 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
sulfasalazine oral tablet 500 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
sulfasalazine oral tablet delayed release 500 mg	1	
tofacitinib citrate er oral tablet extended release 24 hour 11 mg, 22 mg	1	PA; QL (1 tablet per day.)
tofacitinib citrate oral solution 1 mg/ml	1	PA; QL (8 mL per day.)
tofacitinib citrate oral tablet 10 mg	1	PA; QL (2 tablets per day)
tofacitinib citrate oral tablet 5 mg	1	PA; QL (2 tablets per day.)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (***methotrexate sodium***)	2	CM
XATMEP ORAL SOLUTION 2.5 MG/ML (***methotrexate***)	3/4	PA; CM
ENDOTHELIN RECEPTOR ANTAGONISTS (92:48)		
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	3/4	PA; QL (30 tablets per month.)
IMMUNOMODULATORY AGENTS - DRUGS FOR THE IMMUNE SYSTEM		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 auto injector per month.)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (***tocilizumab***)	3	PA; QL (4 prefilled syringes per month.)
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (***interferon gamma-1b***)	2	PA; QL (8.5 mls per month.); SP
ADALIMUMAB-AATY (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	2	
ADALIMUMAB-AATY (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	2	
ADALIMUMAB-AATY (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML	2	
ADALIMUMAB-AATY CD/UC/HS START SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	2	
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	2	PA; QL (1.6 mL (2 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1ML	2	PA; QL (0.01 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	2	PA; QL (0.02 ml per day.)
ADALIMUMAB-ADAZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	2	PA; QL (0.03 ml per day.)
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 auto-injectors (1 carton) per month.)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (***adalimumab-atto***)	2	PA; QL (2 syringes per month per month.)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML (***adalimumab-atto***)	2	PA
AURANOFIN ORAL CAPSULE 3 MG	3	
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 pens (1 box) per month.)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (***interferon beta-1a***)	2	PA; QL (4 syringes (1 box) per month.)
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (***sulfasalazine***)	3/4	
AZULFIDINE ORAL TABLET 500 MG (***sulfasalazine***)	3/4	
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (***monomethyl fumarate***)	2	PA; QL (4 capsules per day.)
BESREMI PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 MCG/0.5ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; SP; CM
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (***ropeginterferon alfa-2b-njft***)	3/4	PA; QL (0.08 ml per day.); SP; CM
BETASERON SUBCUTANEOUS KIT 0.3 MG (***interferon beta-1b***)	2	PA; QL (15 vials per month.)
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 syringe per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (2 syringes (1 carton) per month.)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (***certolizumab pegol***)	2	PA; QL (1 kit per 365 days.)
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
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	
dimethyl fumarate oral capsule delayed release 120 mg	1	PA; QL (56 capsules per year.)
dimethyl fumarate oral capsule delayed release 240 mg	1	PA; QL (2 capsules per day.)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	1	PA; QL (60 capsules (1 starter pack) per 365 days.)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (***etanercept***)	2	PA; QL (0.15 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (***satralizumab-mwge***)	3/4	PA; QL (0.04 ml per day.); SP
fingolimod hcl oral capsule 0.5 mg	1	PA; QL (1 capsule per day.)
gengraf oral capsule 100 mg, 25 mg	1	
GILENYA ORAL CAPSULE 0.25 MG (***fingolimod hcl***)	3/4	PA; QL (1 capsule per day.)
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
glatopa subcutaneous solution prefilled syringe 20 mg/ml	1	PA; QL (30 ml per month.)
glatopa subcutaneous solution prefilled syringe 40 mg/ml	1	PA; QL (12 ml per 21 days.)
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	1	
JOENJA ORAL TABLET 40 MG, 50 MG (***leniolisib phosphate***)	2	
JOENJA ORAL TABLET 70 MG (***leniolisib phosphate***)	2	PA; QL (2 tablets per day.)
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (***ofatumumab***)	2	PA; QL (0.02 ml per day.)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (***anakinra***)	3	PA; QL (0.67 ml (1 syringe) per day.); SP
leflunomide oral tablet 10 mg, 20 mg	1	
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	1	PA; QL (28 capsules per 21 days.); CM
lenalidomide oral capsule 20 mg, 25 mg	1	PA; QL (21 capsules per 21 days.); CM
MAYZENT ORAL TABLET 0.25 MG (***siponimod fumarate***)	3	PA; QL (4 tablets per day.)
MAYZENT ORAL TABLET 1 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT ORAL TABLET 2 MG (***siponimod fumarate***)	3	PA; QL (1 tablet per day.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (12 tablets per 365 days.)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (***siponimod fumarate***)	3	PA; QL (7 tablets per 365 days.)
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	CM
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (***abatacept***)	3	PA; QL (4 autoinjectors per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***abatacept***)	3	PA; QL (4 syringes per month.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML (***abatacept***)	3	PA; QL (0.06 ml per day.)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML (***abatacept***)	3	PA; QL (0.1 ml per day.)
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (***peginterferon alfa-2a***)	2	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (***peginterferon alfa-2a***)	2	
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (1 ml per month.); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (2 ml per year without additional quantity notification.); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (2 ml per year without additional quantity notification.); SP
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (1 ml per month.); SP
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (***peginterferon beta-1a***)	3	PA; QL (1 ml per month.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	1	PA; QL (21 capsules per 21 days.); CM
RHAPSIDO ORAL TABLET 25 MG (***remibrutinib***)	2	PA; QL (60 tablets per month.)
RIDAURA ORAL CAPSULE 3 MG (***auranofin***)	3	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 auto-injector per month.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***golimumab***)	2	PA; QL (1 syringe per 21 days.)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (***golimumab***)	2	PA; QL (1 syringe per month.)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
teriflunomide oral tablet 14 mg	1	PA; QL (1 tablet per day.)
teriflunomide oral tablet 7 mg	1	PA; QL (31 tablets per month.)
THALOMID ORAL CAPSULE 100 MG, 50 MG (***thalidomide***)	2	PA; 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***)	3/4	PA; CM
ZENBEXUS ORAL CAPSULE 0.75 MG, 1 MG (***iberdomide hydrochloride***)	3/4	PA; CM
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (***ozanimod hcl***)	3	PA; QL (7 capsules per year.)
ZEPOSIA ORAL CAPSULE 0.92 MG (***ozanimod hcl***)	3	PA; QL (1 capsule per day.)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (***ozanimod hcl***)	3	PA
IMMUNOSUPPRESSIVE AGENTS - Drugs for Transplant		
AZASAN ORAL TABLET 100 MG, 75 MG (***azathioprine***)	3/4	
azathioprine oral tablet 100 mg, 50 mg, 75 mg	1	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (***belimumab***)	2	PA; QL (4 ml per month.)
cladribine (10 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (4 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (5 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (6 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (7 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (8 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cladribine (9 tabs) oral tablet therapy pack 10 mg	1	PA; QL (40 tablets per 720 days.)
cyclophosphamide oral capsule 25 mg, 50 mg	1	CM
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	2	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	
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	1	
gengraf oral capsule 100 mg, 25 mg	1	
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
JYLAMVO ORAL SOLUTION 2 MG/ML (***methotrexate***)	3/4	PA; CM
leflunomide oral tablet 10 mg, 20 mg	1	
LUPKYNIS ORAL CAPSULE 7.9 MG (***voclosporin***)	3/4	PA; QL (6 capsules per day.); SP
mercaptopurine oral suspension 2000 mg/100ml	1	CM
mercaptopurine oral tablet 50 mg	1	CM
methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
methotrexate sodium injection solution reconstituted 1 gm	1	
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	1	
mycophenolic acid oral tablet delayed release 180 mg, 360 mg	1	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (***mycophenolate mofetil***)	1	
pimecrolimus external cream 1 %	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML (***mercaptopurine***)	3	CM
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
tacrolimus external ointment 0.03 %, 0.1 %	1	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 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***)	3/4	PA; CM
KALLIKREIN INHIBITORS		
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***lanadelumab-flyo***)	2	PA; QL (0.0375 ml per day.); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***lanadelumab-flyo***)	2	PA; QL (0.072 ml per day.); SP
OTHER MISCELLANEOUS THERAPEUTIC AGENTS		
AQNEURSA ORAL PACKET 1 GM (***levacetylleucine***)	3/4	PA; QL (112 packets per month.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; QL (4 vials per 21 days.); SP
betaine oral powder	1	
CARNITOR ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	3/4	
CARNITOR ORAL TABLET 330 MG (***levocarnitine***)	3/4	
CARNITOR SF ORAL SOLUTION 1 GM/10ML (***levocarnitine***)	3/4	
CERDELGA ORAL CAPSULE 84 MG (***eliglustat tartrate***)	2	PA
CYSTADANE ORAL POWDER (***betaine***)	3/4	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (***cysteamine bitartrate***)	2	
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA; QL (2 tablets per day)
DIABETES MONITOR DIGIT ADD-ON KIT	3	QL (1 meter or meter kit per year.)
DIABETES MONITOR DIGIT SOLN KIT	3	QL (1 meter or meter kit per year.)
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (***givinostat hcl***)	3/4	PA; QL (420 mL per month.)
EC-RX DHEA EXTERNAL CREAM 10 %, 4 % (***prasterone (dhea)***)	3	
ELMIRON ORAL CAPSULE 100 MG (***pentosan polysulfate sodium***)	3/4	
ENBRACE HR ORAL CAPSULE (***prenat vit-fe gly cys-fa-omega***)	3	
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	3/4	QL (6 packets per day)
EVOTAZ ORAL TABLET 300-150 MG (***atazanavir-cobicistat***)	2	
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (***risdiplam***)	2	PA; QL (6.7 ml per day, 1280 ml per 180 days.); SP
EVRYSDI ORAL TABLET 5 MG (***risdiplam***)	2	PA; QL (30 tablets per month.); SP
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)
FIRDAPSE ORAL TABLET 10 MG (***amifampridine phosphate***)	2	PA; QL (300 tablets per month.)
FORZINITY SUBCUTANEOUS SOLUTION 280 MG/3.5ML (***elamipretide hcl***)	3/4	PA; QL (4 vials (14 ml) per month.); SP

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
GALAFOLD ORAL CAPSULE 123 MG (***migalastat hcl***)	3/4	PA; QL (14 capsules per 21 days.)
ISTURISA ORAL TABLET 1 MG (***osilodrostat phosphate***)	3/4	PA; QL (8 tablets per day.)
ISTURISA ORAL TABLET 5 MG (***osilodrostat phosphate***)	3/4	PA; QL (372 tablets per month.)
JAVYGTOR ORAL PACKET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 packets per day.)
JAVYGTOR ORAL PACKET 500 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (4 packets per day.)
JAVYGTOR ORAL TABLET 100 MG (***sapropterin dihydrochloride***)	3/4	PA; QL (16 tablets per day)
KYGEVVI ORAL PACKET 2-2 GM (***doxecitine-doxribtimine***)	3/4	PA; QL (558 packets per month.); SP
levocarnitine oral solution 1 gm/10ml	1	
levocarnitine oral tablet 330 mg	1	
levocarnitine sf oral solution 1 gm/10ml	1	
l-glutamine oral packet 5 gm	1	QL (6 packets per day)
LODOCO ORAL TABLET 0.5 MG (***colchicine***)	3/4	QL (1 tablet per day.)
me/naphos/mb/hyo1 oral tablet 81.6 mg	1	
metyrosine oral capsule 250 mg	1	PA
miglustat oral capsule 100 mg	1	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (***prenat-fe-methylfol-dha w/o a***)	3	
OPFOLDA ORAL CAPSULE 65 MG (***miglustat (gaa deficiency)***)	2	PA; QL (8 capsules per 21 days.)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (***nitisinone***)	1	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (***nitisinone***)	2	PA
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***)	3/4	
PRENATE ENHANCE ORAL CAPSULE 28-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRENATE ESSENTIAL ORAL CAPSULE 18-0.6-0.4-300 MG (***prenat-feasp-meth-fa-dha w/o a***)	3/4	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3/4	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3/4	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3/4	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (***darunavir-cobicistat***)	2	
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (***cysteamine bitartrate***)	3/4	PA; SP
PROCYSBI ORAL PACKET 300 MG, 75 MG (***cysteamine bitartrate***)	3/4	SP
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
REZUROCK ORAL TABLET 200 MG (***belumosudil mesylate***)	3/4	PA; QL (1 tablet per day.); SP
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (***nedosiran sodium***)	3/4	PA; QL (0.04 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML (***nedosiran sodium***)	3/4	PA; QL (0.03 ml per day.)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***nedosiran sodium***)	3/4	PA; QL (0.04 ml per day.)
sapropterin dihydrochloride oral packet 100 mg	1	PA; QL (16 packets per day.)
sapropterin dihydrochloride oral packet 500 mg	1	PA; QL (4 packets per day.)
sapropterin dihydrochloride oral tablet 100 mg	1	PA; QL (16 tablets per day)
SKYCLARYS ORAL CAPSULE 50 MG (***omaveloxolone***)	2	PA; QL (3 capsules per day.)
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (***palovarotene***)	3/4	PA; QL (1 capsule per day.)
STRIBILD ORAL TABLET 150-150-200-300 MG (***elviteg-cobic-emtricit-tenofdf***)	3/4	QL (1 tablet per day.); SM
tiopronin oral tablet 100 mg	1	CM
tiopronin oral tablet delayed release 100 mg, 300 mg	1	CM
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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
URELLE ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	3	
uretron d/s oral tablet 81.6 mg	1	
UROGESIC-BLUE ORAL TABLET 81.6 MG (***methen-hyosc-meth blue-na phos***)	2	
VIJOICE ORAL PACKET 50 MG (***alpelisib***)	3/4	PA; QL (28 packets (1 carton) per month.)
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (***alpelisib***)	3/4	PA; QL (28 tablets (1 blister pack) per month.)
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (***alpelisib***)	3/4	PA; QL (56 tablets (2 blister packs) per month.)
VILEVEV MB ORAL TABLET 81 MG (***meth-hyo-m bl-na phos-ph sal***)	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	
VOWST ORAL CAPSULE (***fecal microb spores, live-brpk***)	3/4	PA; QL (12 capsules per 365 days.)
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (***vosoritide***)	3/4	PA; QL (1 vial per day.); SP
VYNDAMAX ORAL CAPSULE 61 MG (***tafamidis***)	2	PA; QL (1 capsule per day.)
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
YUVIWEL SUBCUTANEOUS SOLUTION RECONSTITUTED 1.3 MG, 2.8 MG, 5.5 MG (***navepegritide***)	3/4	PA; QL (4 vials per month.); SP
zelvysia oral packet 100 mg	1	PA; QL (589 packets per month.)
zelvysia oral packet 500 mg	1	PA; QL (4 packets per day.)
ZOKINVY ORAL CAPSULE 50 MG (***lonafarnib***)	2	PA; QL (5 capsules per day.)
ZOKINVY ORAL CAPSULE 75 MG (***lonafarnib***)	2	PA; QL (1 tablet per day.)
PROTECTIVE AGENTS		
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
dalfampridine er oral tablet extended release 12 hour 10 mg	1	PA; QL (2 tablets per day)
mesna oral tablet 400 mg	1	CM
MESNEX ORAL TABLET 400 MG (***mesna***)	3/4	CM
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
NONHORMONAL CONTRACEPTIVES - Drugs for Women		
CAYA VAGINAL DIAPHRAGM (***diaphragm arc-spring***)	3	H
CONDOMS	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN (***condoms latex lubricated***)	3	QL (12 condoms per month.); H
DUREX EXTRA SENSITIVE THIN DEVICE (***condoms latex lubricated***)	3	QL (12 condoms per month.); H
DUREX TROPICAL (***condoms latex lubricated***)	3	QL (12 condoms per month.); H
ENCARE VAGINAL SUPPOSITORY 100 MG (***nonoxynol-9***)	E	H
FC2 FEMALE CONDOM (***condoms - female***)	3	QL (12 condoms per month.); H
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (***cervical caps***)	3	H
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (***diaphragms***)	3	H
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (***nonoxynol-9***)	E	H
PHEXX VAGINAL GEL 1.8-1-0.4 % (***lactic ac-citric ac-pot bitart***)	3/4	H
TODAY SPONGE VAGINAL 1000 MG (***nonoxynol-9***)	E	H
TRUE COVER DEVICE	3	QL (12 condoms per month.); 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

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (***diaphragm wide seal***)	2	H
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 (***methylergonovine maleate***)	3/4	QL (28 tablets per year.)
methylergonovine maleate oral tablet 0.2 mg	1	QL (28 tablets per year.)
MIFEPREX ORAL TABLET 200 MG (***mifepristone***)	3	SM
mifepristone oral tablet 200 mg	1	SM
PREPIDIL VAGINAL GEL 0.5 MG/3GM (***dinoprostone***)	3	
PHARMACEUTICAL AIDS		
PHARMACEUTICAL AIDS		
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
VERSAPENN (AG) ANHYDROUS TRANSDERMAL GEL (***transdermal base***)	3	
VERSAPENN (AL) ANHYD LIPID TRANSDERMAL GEL (***transdermal base***)	3	
RESPIRATORY TRACT AGENTS		
DUAL PHOSPHODIESTERASE INHIBITOR (48:34)		
OHTUVAYRE INHALATION SUSPENSION 3 MG/2.5ML (***ensifentrine***)	3/4	PA; QL (150 mL per month.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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, 0.15 MG/0.15ML, 0.3 MG/0.3ML (***epinephrine***)	2	SM
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	1	SM
EPINEPHRINE INJECTION SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML	2	SM
ANTICHOLINERGIC AGENTS (RESPIR.TRACT) - Drugs for Asthma/COPD		
atropine sulfate ophthalmic solution 1 %	1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (***ipratropium-albuterol***)	2	QL (0.28 grams per day.); SM
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 hfa inhalation aerosol solution 17 mcg/act	1	QL (0.87 grams per day.); SM
ipratropium bromide inhalation solution 0.02 %	1	SM
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	SM
LEVBID ORAL TABLET EXTENDED RELEASE 12 HOUR 0.375 MG (***hyoscyamine sulfate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LEVSIN ORAL TABLET 0.125 MG (***hyoscyamine sulfate***)	3/4	
LEVSIN/SL SUBLINGUAL TABLET SUBLINGUAL 0.125 MG (***hyoscyamine sulfate***)	3/4	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (***hyoscyamine sulfate***)	3/4	
OSCIMIN ORAL TABLET 0.125 MG	3/4	
OSCIMIN SUBLINGUAL TABLET SUBLINGUAL 0.125 MG	3/4	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (***tiotropium bromide***)	1	QL (1 capsule per day); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT (***tiotropium bromide***)	2	QL (0.15 grams per day.); SM
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***tiotropium bromide***)	2	SM
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (***revefenacin***)	3/4	PA; QL (3 ml per day.); SM
ANTIFIBROTIC AGENTS - Drugs for the Lungs		
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	3/4	PA; QL (60 tablets per month.)
nintedanib esylate oral capsule 100 mg, 150 mg	1	PA; QL (2 capsules per day.)
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.)
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.)
pirfenidone oral tablet 534 mg, 801 mg	1	PA; QL (3 tablets per day.)
ANTI-INFLAMMATORY AGENTS (RESPIRATORY) - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (***brensocatib***)	3/4	PA; QL (31 tablets per month.)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***mepolizumab***)	3/4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***mepolizumab***)	3/4	PA; QL (0.04 mL per day.)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***mepolizumab***)	3/4	PA; QL (0.015 ml per day.)
ANTITUSSIVES - Drugs for Cough and Cold		
benzonatate oral capsule 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
codeine sulfate oral tablet 15 mg, 30 mg, 60 mg	1	NTT
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	1	PA
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	1	PA
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	1	PA
maxi-tuss ac oral solution 100-10 mg/5ml	1	
NEOTUSS PLUS ORAL LIQUID 7.5-4-30 MG/5ML (***phenylephrine-chlorphen-dm***)	3	
promethazine-codeine oral solution 6.25-10 mg/5ml	1	PA
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA
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	
CORTICOSTEROIDS (RESPIRATORY TRACT) - Drugs for Inflammation		
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (***fluticasone-salmeterol***)	2	QL (0.4 grams per day.); SM
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT (***fluticasone furoate-vilanterol***)	2	SM
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT (***fluticasone furoate-vilanterol***)	3	QL (2 blisters per day.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (***fluticasone furoate-vilanterol***)	3	SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
flunisolide nasal solution 25 mcg/act (0.025%)	1	
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT	3/4	SM
FLUTICASONE FUROATE-VILANTEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT	3/4	QL (2 blisters per day.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	3/4	QL (1 inhaler per month.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); SM
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.); SM
fluticasone propionate nasal suspension 50 mcg/act	1	
FLUTICASONE-SALMETEROL INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3/4	QL (0.4 grams per day.); SM
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
FLUTICASONE-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	2	QL (0.04 mcg per day.); SM
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mometasone furoate nasal suspension 50 mcg/act	1	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (***ciclesonide***)	3/4	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day); SM
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (***fluticasone-umeclidin-vilant***)	3	QL (2 blisters per day.); SM
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	1	QL (2 blisters per day.); SM
CYSTIC FIBROSIS (CFTR) CORRECTORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (84 tablets per month.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (***lumacaftor-ivacaftor***)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (***lumacaftor-ivacaftor***)	2	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (***tezacaftor-ivacaftor***)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.)
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day. 1092 tablets per 364 days.)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (2 packets per day. 728 packets per 356 days.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
CYSTIC FIBROSIS (CFTR) POTENTIATORS - Drugs for the Lungs		
ALYFTREK ORAL TABLET 10-50-125 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (56 tablets per month.)
ALYFTREK ORAL TABLET 4-20-50 MG (***vanzacaft-tezacaft-deutivacaft***)	3/4	PA; QL (84 tablets per month.)
KALYDECO ORAL PACKET 13.4 MG (***ivacaftor***)	2	PA; QL (2 packets per day. 728 packets per 356 days.)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (***ivacaftor***)	2	PA; QL (728 packets per 356 days.)
KALYDECO ORAL PACKET 5.8 MG (***ivacaftor***)	2	PA; QL (2 packets per day and 728 packets per 365 days.)
KALYDECO ORAL TABLET 150 MG (***ivacaftor***)	2	PA; QL (780 tablets per 356 days.)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (***lumacaftor-ivacaftor***)	2	PA; QL (728 packets per 356 days.)
ORKAMBI ORAL PACKET 75-94 MG (***lumacaftor-ivacaftor***)	2	PA; QL (2 packets per day and 56 packets per 21 days.)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (***lumacaftor-ivacaftor***)	2	PA; QL (1456 tablets per 356 days.)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (***tezacaftor-ivacaftor***)	2	PA; QL (56 tablets per month. 728 tablets per 365 days.)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day (1 pack per month) and 1092 tablets per year.)
TRIKAFTA ORAL TABLET THERAPY PACK 50-25-37.5 & 75 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (3 tablets per day. 1092 tablets per 364 days.)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (***elexacaftor-tezacaftor-ivacaft***)	2	PA; QL (2 packets per day. 728 packets per 356 days.)
ENDOTHELIN RECEPTOR ANTAGONISTS (48:48) - Drugs for the Lungs		
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.)
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.)
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
FILSPARI ORAL TABLET 200 MG, 400 MG (***sparsentan***)	3/4	PA; QL (60 tablets per month.)
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.)
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP
TRYVIO ORAL TABLET 12.5 MG (***aprocitentan***)	3/4	PA; QL (1 tablet per day.)
VANRAFIA ORAL TABLET 0.75 MG (***atrasentan hcl***)	3/4	PA; QL (30 tablets per month.)
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 (expectorant) 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 ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML	3/4	
carbinoxamine maleate oral solution 4 mg/5ml	1	
carbinoxamine maleate oral tablet 4 mg	1	
CARBZAH ORAL SOLUTION 4 MG/5ML	2	
clemastine fumarate oral tablet 2.68 mg	1	
CLEMSZA ORAL TABLET 2.68 MG (***clemastine fumarate***)	3	
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
diphenhydramine hcl oral elixir 12.5 mg/5ml	1	
KARBINAL ER ORAL SUSPENSION EXTENDED RELEASE 4 MG/5ML (***carbinoxamine maleate***)	3/4	
promethazine hcl oral solution 12.5 mg/10ml, 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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG (***promethazine hcl***)	3	
INTERLEUKIN ANTAGONISTS - Drugs for Inflammation		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (***rilonacept***)	2	PA; QL (4 vials per 21 days.); SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (***benralizumab***)	3/4	PA; QL (1 pen every 2 months.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	3/4	PA; QL (0.07 ml per day.)
LEUKOTRIENE MODIFIERS - Drugs for Inflammation		
montelukast sodium oral packet 4 mg	1	
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	
zileuton er oral tablet extended release 12 hour 600 mg	1	
MAST-CELL STABILIZERS - Drugs for Inflammation		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	SM
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***)	2	PA; QL (5 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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%)	1	
fluticasone propionate nasal suspension 50 mcg/act	1	
mometasone furoate nasal suspension 50 mcg/act	1	
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (***beclomethasone diprop (nasal)***)	3/4	
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (***olopatadine-mometasone***)	3/4	
NEUTROPHIL SERINE PROTEASE INHIBITORS - Drugs for Inflammation		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (***brensocatib***)	3/4	PA; QL (31 tablets per month.)
ORALLY INHALED PREPARATIONS (STEROIDS) - Drugs for Inflammation		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (***fluticasone furoate***)	1	SM
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***fluticasone furoate***)	1	QL (1 packet per day.); SM
budesonide inhalation suspension 0.25 mg/2ml	1	SM
budesonide inhalation suspension 0.5 mg/2ml	1	QL (120 ml (2 boxes) per 30 days.); SM
budesonide inhalation suspension 1 mg/2ml	1	QL (60 ml (1 box) per 30 days.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 110 MCG/ACT	3/4	QL (1 inhaler per month.); SM
FLUTICASONE PROPIONATE HFA INHALATION AEROSOL 220 MCG/ACT	3/4	QL (2 inhalers per month.); SM

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
fluticasone propionate hfa inhalation aerosol 44 mcg/act	1	QL (1 inhaler per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (10.6 grams per month.); SM
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (***beclomethasone diprop hfa***)	1	QL (42.4 grams per month.); SM
PHOSPHODIESTERASE TYPE 4 INHIBITORS - Drugs for the Lungs		
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	3/4	PA; QL (60 tablets per month.)
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.05 %, 0.15 % (***roflumilast***)	3/4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA
PHOSPHODIESTERASE-5 INHIBITORS (RESPIR) - Drugs for the Lungs		
alyq oral tablet 20 mg	1	PA; QL (6 tablets per month)
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (6 tablets per month)
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (***sildenafil citrate***)	3	QL (4 films per month.)
PROSTACYCLIN & PROSTACYCLIN DERIVATIVES - Drugs for the Lungs		
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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***)	3/4	PA; QL (252 tablets per year.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	3/4	PA; QL (744 tablets per month.)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (***treprostinil***)	2	PA; QL (224 cartidges per month.)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 48MCG & 112 X80MCG (***treprostinil***)	2	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.)
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.)
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (***treprostinil sodium***)	2	PA; QL (140 capsules per month.)
RESPIRATORY TRACT AGENTS, MISCELLANEOUS - Drugs for the Lungs		
BRONCHITOL INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; QL (20 capsules per day.); CM
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG (***mannitol (cystic fibrosis)***)	3	PA; QL (20 capsules per day.); CM
pirfenidone oral capsule 267 mg	1	PA; QL (9 capsules per day.)
pirfenidone oral tablet 267 mg	1	PA; QL (9 tablets per day.)
pirfenidone oral tablet 534 mg, 801 mg	1	PA; QL (3 tablets per day.)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (***tezepelumab-ekko***)	3/4	PA; QL (0.07 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (***sotatercept-csrk***)	3/4	PA; QL (1 kit every 3 weeks.); SP; SMCS
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***omalizumab***)	2	PA; QL (2 auto injectors per month.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***omalizumab***)	2	PA; QL (0.08 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***omalizumab***)	2	PA; QL (0.15 ml per day.)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***omalizumab***)	2	PA; QL (0.04 ml per day.)
SECOND GENERATION ANTIHIST(RESPIR TRACT) - Drugs for Allergy		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
azelastine hcl ophthalmic solution 0.05 %	1	
desloratadine oral tablet 5 mg	1	
desloratadine oral tablet dispersible 5 mg	1	
SELECT.BETA-2-ADRENERGIC AGONIST(RESPIR) - Drugs for Asthma/COPD		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (***albuterol-budesonide***)	3	SM
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	1	SM
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	SM
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	1	SM
ALBUTEROL SULFATE NEBULIZATION SOLUTION (5 MG/ML) 0.5% INHALATION	3	SM
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	1	QL (2 nebules per day); SM
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	1	QL (2 vials per day.); SM
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	1	SM
LEVALBUTEROL HFA INHALATION AEROSOL 45 MCG/ACT	3	SM
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (***formoterol fumarate***)	3/4	QL (2 vials per day.); SM
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***salmeterol xinafoate***)	2	QL (1 diskus (60 blisters) per month.); SM
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (***olodaterol hcl***)	2	SM
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (***levalbuterol tartrate***)	3	SM
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***)	2	PA; QL (3 tablets per day.)
alyq oral tablet 20 mg	1	PA; QL (6 tablets per month)
ambrisentan oral tablet 10 mg, 5 mg	1	PA; QL (1 tablet per day.)
bosentan oral tablet 125 mg, 62.5 mg	1	PA; QL (2 tablets per day.)
bosentan oral tablet soluble 32 mg	1	PA; QL (4 tablets per day.)
macitentan oral tablet 10 mg	1	PA; QL (1 tablet per day.)
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (168 tablets per year.)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (***treprostinil diolamine***)	3/4	PA; QL (336 tablets per year.)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (***treprostinil diolamine***)	3/4	PA; QL (252 tablets per year.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day.)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG (***treprostinil diolamine***)	3/4	PA; QL (6 tablets per day)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG (***treprostinil diolamine***)	3/4	PA; QL (744 tablets per month.)
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1	QL (6 tablets per month)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
tadalafil (pah) oral tablet 20 mg	1	PA; QL (6 tablets per month)
TADLIQ ORAL SUSPENSION 20 MG/5ML (***tadalafil (pah)***)	3	PA; QL (10 ml per day.)
TRACLEER ORAL TABLET SOLUBLE 32 MG (***bosentan***)	3/4	PA; QL (4 tablets per day.); SP
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (***treprostinil***)	2	PA; QL (112 cartridges per month.)
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (***treprostinil***)	2	PA; QL (252 cartridges per 365 days.)
TYVASO INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (***treprostinil***)	2	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	3/4	PA; QL (200 tablets per year.)
VASODILATING AGENTS, MISC (48:48) - Drugs for the Lungs		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (***riociguat***)	2	PA; QL (3 tablets per day.)
UPTRAVI ORAL TABLET 100 MCG, 150 MCG (***selexipag***)	3/4	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (140 tablets per 365 days.)
UPTRAVI TABLET 200 MCG ORAL (***selexipag***)	3/4	PA; QL (2 tablets per day.)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (***selexipag***)	3/4	PA; QL (200 tablets per year.)
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		
ANTIPROLIFERANTS		
AMELUZ EXTERNAL GEL 10 % (***aminolevulinic acid hcl***)	3	
bexarotene external gel 1 %	1	
bexarotene oral capsule 75 mg	1	CM
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
imiquimod external cream 5 %	1	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***)	3	
PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***)	3	
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	3/4	
VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***)	2	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
SKIN AND MUCOUS MEMBRANE AGENTS - Drugs for the Skin		
ADRENERGIC AGONISTS - Drugs for the Skin		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 % (***brimonidine tartrate***)	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.15 % (***brimonidine tartrate***)	3/4	
brimonidine tartrate external gel 0.33 %	1	PA
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (***brimonidine tartrate-timolol***)	1	
oxymetazoline hcl external cream 1 %	1	PA
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA
ALLYLAMINES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
naftifine hcl external cream 1 %, 2 %	1	
naftifine hcl external gel 2 %	1	
NAFTIN EXTERNAL GEL 2 % (***naftifine hcl***)	3/4	
ANTIBACTERIALS (84:04) - Drugs for the Skin		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	3/4	
AMZEEQ EXTERNAL FOAM 4 % (***minocycline hcl micronized***)	3/4	
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (***sulfacetamide sodium-sulfur***)	3/4	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (***sulfacetamide sodium-sulfur***)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (***sulfacetamide sodium-sulfur***)	3	
AVIDOXY ORAL TABLET 100 MG	3/4	
azelaic acid external gel 15 %	1	
AZELEX EXTERNAL CREAM 20 % (***azelaic acid***)	3	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (***benzoyl peroxide-erythromycin***)	2	
benzoyl peroxide-erythromycin external gel 5-3 %	1	
bp 10-1 external emulsion 10-1 %	1	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG (***clindamycin hcl***)	3/4	
CLEOCIN ORAL CAPSULE 75 MG (***clindamycin hcl***)	2	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (***clindamycin palmitate hcl***)	3/4	
CLEOCIN VAGINAL CREAM 2 % (***clindamycin phosphate***)	3/4	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (***clindamycin phosphate***)	2	
CLEOCIN-T EXTERNAL LOTION 1 % (***clindamycin phosphate***)	3/4	
clindacin etz external swab 1 %	1	
clindacin external foam 1 %	1	
clindacin-p external swab 1 %	1	
CLINDAGEL EXTERNAL GEL 1 % (***clindamycin phosphate***)	3/4	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	1	
clindamycin phos (once-daily) external gel 1 %	1	
clindamycin phos (twice-daily) external gel 1 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
clindamycin phosphate external foam 1 %	1	
clindamycin phosphate external lotion 1 %	1	
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
clindamycin phosphate vaginal cream 2 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CLINDESSE VAGINAL CREAM 2 % (***clindamycin phosphate (1 dose)***)	2	
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
doxycycline hyclate oral capsule 100 mg, 50 mg	1	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	1	
ERY EXTERNAL PAD 2 %	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
FINACEA EXTERNAL FOAM 15 % (***azelaic acid***)	2	
gentamicin sulfate external cream 0.1 %	1	
gentamicin sulfate external ointment 0.1 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
KLARON EXTERNAL LOTION 10 % (***sulfacetamide sodium (acne)***)	3/4	
levofloxacin oral solution 25 mg/ml	1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (***metronidazole***)	3/4	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %, 1 %	1	
metronidazole external lotion 0.75 %	1	
metronidazole oral capsule 375 mg	1	
metronidazole oral tablet 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
metronidazole vaginal gel 0.75 %	1	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	1	
moxifloxacin hcl oral tablet 400 mg	1	
mupirocin calcium external cream 2 %	1	
mupirocin external ointment 2 %	1	
neomycin sulfate oral tablet 500 mg	1	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (***neomycin-fluocinolone***)	3/4	
neuac external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
NUVESSA VAGINAL GEL 1.3 % (***metronidazole***)	3/4	
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	3/4	
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL CREAM 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL LOTION 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
sodium sulfacetamide external shampoo 10 %	1	
sodium sulfacetamide wash external liquid 10 %	1	
sss 10-5 external cream 10-5 %	1	
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 %, 9.8-4.8 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % (***sulfacetamide sodium-sulfur***)	3	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
SUMAXIN CP EXTERNAL KIT 10-4 % (***sulfacetamide-sulfur-cleanser***)	3/4	
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	3/4	
tetracycline hcl oral capsule 250 mg, 500 mg	1	
VANDAZOLE VAGINAL GEL 0.75 % (***metronidazole***)	3/4	
XACIATO VAGINAL GEL 2 % (***clindamycin phosphate***)	2	
XEPI EXTERNAL CREAM 1 % (***ozenoxacin***)	3	
ZILXI EXTERNAL FOAM 1.5 % (***minocycline hcl micronized***)	3/4	PA
ANTIFULGALS (SKIN, MUCOUS MEMBRANE),MISC - Drugs for the Skin		
EXODERM EXTERNAL LOTION 25-1 % (***sod thiosulfate-salicylic acd***)	3	
ANTI-INFLAMMATORY AGENTS, MISC (SKIN) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***)	3	
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	PA
ANTIPRURITICS AND LOCAL ANESTHETICS - Drugs for the Skin		
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANALPRAM HC EXTERNAL LOTION 2.5-1 % (***hydrocortisone ace-pramoxine***)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (***lidocaine-benzalkonium (pod)***)	3	
doxepin hcl external cream 5 %	1	PA
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	
doxepin hcl oral tablet 3 mg, 6 mg	1	QL (1 tablet per day)
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
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	
lidocaine external ointment 5 %	1	QL (1.19 grams per day.)
lidocaine external patch 5 %	1	PA
lidocaine hcl external solution 4 %	1	
lidocaine hcl urethral/mucosal external gel 2 %	1	
lidocaine hcl urethral/mucosal external prefilled syringe 2 %	1	
lidocaine-prilocaine external cream 2.5-2.5 %	1	
phenazopyridine hcl oral tablet 100 mg, 200 mg	1	
PRAMOSONE EXTERNAL CREAM 1-1 % (***pramoxine-hc***)	2	
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***)	3/4	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PYRIDIUM ORAL TABLET 100 MG, 200 MG (***phenazopyridine hcl***)	3	
SILENOR ORAL TABLET 3 MG, 6 MG (***doxepin hcl***)	3/4	QL (1 tablet per day)
ZTLIDO EXTERNAL PATCH 1.8 % (***lidocaine***)	3	PA; QL (3 patches per day.)
ANTIVIRALS (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
acyclovir external cream 5 %	1	
acyclovir external ointment 5 %	1	
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
DENAVIR EXTERNAL CREAM 1 % (***penciclovir***)	3/4	
penciclovir external cream 1 %	1	
ZELSUVMI EXTERNAL GEL 10.3 % (***berdazimer sodium***)	3/4	
ZOVIRAX EXTERNAL CREAM 5 % (***acyclovir***)	3/4	
ASTRINGENTS (84:12) - Drugs for the Skin		
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (***glycopyrrolate-formoterol***)	2	QL (0.36 grams per day.); SM
CUVPOSA ORAL SOLUTION 1 MG/5ML (***glycopyrrolate***)	3/4	
DRYSOL EXTERNAL SOLUTION 20 % (***aluminum chloride***)	2	
glycopyrrolate oral solution 1 mg/5ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3/4	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	3/4	
ASTRINGENTS, ANTI-INFECTIVE - Drugs for the Skin		
benzalkonium chloride external solution	2	
benzalkonium chloride external solution 50 %	1	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
iodine strong oral solution 5 %	1	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***)	3/4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
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 %	1	
ECONAZOLE NITRATE EXTERNAL FOAM 1 %	3/4	
ECOZA EXTERNAL FOAM 1 % (***econazole nitrate***)	3/4	
EXELDERM EXTERNAL CREAM 1 % (***sulconazole nitrate***)	3	
EXELDERM EXTERNAL SOLUTION 1 % (***sulconazole nitrate***)	3	
GYNAZOLE-1 VAGINAL CREAM 2 % (***butoconazole nitrate (1 dose)***)	3	
JUBLIA EXTERNAL SOLUTION 10 % (***efinaconazole***)	3/4	QL (4 ml per month.)
ketoconazole external cream 2 %	1	
ketoconazole external foam 2 %	1	
ketoconazole external shampoo 2 %	1	
ketodan external foam 2 %	1	
LULICONAZOLE EXTERNAL CREAM 1 %	3/4	
LUZU EXTERNAL CREAM 1 % (***luliconazole***)	3/4	
miconazole 3 vaginal suppository 200 mg	1	
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3/4	
ORAVIG BUCCAL TABLET 50 MG (***miconazole***)	3	
oxiconazole nitrate external cream 1 %	1	
OXISTAT EXTERNAL LOTION 1 % (***oxiconazole nitrate***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
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	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	3/4	
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	
XIRUN EXTERNAL GEL 40-10 %	3	
ZACARE EXTERNAL KIT 4 & 0.2 %, 8 & 0.2 % (***benzoyl peroxide-hyaluronate***)	3	
BASIC OINTMENTS AND PROTECTANTS - Drugs for the Skin		
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
attero external suspension 0.005-0.064 %	1	
calcipotriene external cream 0.005 %	1	
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
calcipotriene-betameth diprop external suspension 0.005-0.064 %	1	
CALCITRENE EXTERNAL OINTMENT 0.005 % (***calcipotriene***)	3	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams per month.)
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	3/4	QL (30 grams per month.)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	PA
BASIC POWDERS AND DEMULCENTS - Drugs for the Skin		
benzoin external tincture	1	
CELL STIMULANTS AND PROLIFERANTS - Drugs for the Skin		
ALTRENO EXTERNAL LOTION 0.05 % (***tretinoin***)	3/4	PA
clindamycin-tretinoin external gel 1.2-0.025 %	1	
ENTADFI ORAL CAPSULE 5-5 MG (***finasteride-tadalafil***)	3/4	
finasteride oral tablet 5 mg	1	
minoxidil oral tablet 10 mg, 2.5 mg	1	
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % (***tretinoin microsphere***)	3/4	PA
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	
tretinoin external gel 0.01 %, 0.025 %	1	
tretinoin external gel 0.05 %	1	PA
tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	1	PA
tretinoin oral capsule 10 mg	1	CM
TWYNEO EXTERNAL CREAM 0.1-3 % (***tretinoin-benzoyl peroxide***)	3/4	
CORTICOSTEROIDS (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
alclometasone dipropionate external cream 0.05 %	1	
alclometasone dipropionate external ointment 0.05 %	1	
amcinonide external cream 0.1 %	1	
amcinonide external ointment 0.1 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ANALPRAM HC EXTERNAL CREAM 1-1 %, 2.5-1 % (***hydrocortisone ace-pramoxine***)	3/4	
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***)	3/4	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3/4	
attero external suspension 0.005-0.064 %	1	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external foam 0.12 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
BRYHALI EXTERNAL LOTION 0.01 % (***halobetasol propionate***)	3/4	
budesonide rectal foam 2 mg, 2 mg/act	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
calcipotriene-betameth diprop external suspension 0.005-0.064 %	1	
clobetasol prop emollient base external cream 0.05 %	1	
clobetasol propionate e external cream 0.05 %	1	
clobetasol propionate emulsion external foam 0.05 %	1	
CLOBETASOL PROPIONATE EXTERNAL CREAM 0.025 %	3/4	
clobetasol propionate external cream 0.05 %	1	
clobetasol propionate external foam 0.05 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
clobetasol propionate external gel 0.05 %	1	
clobetasol propionate external liquid 0.05 %	1	
clobetasol propionate external lotion 0.05 %	1	
clobetasol propionate external ointment 0.05 %	1	
clobetasol propionate external shampoo 0.05 %	1	
clobetasol propionate external solution 0.05 %	1	
clocortolone pivalate external cream 0.1 %	1	
clodan external shampoo 0.05 %	1	
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (***flurandrenolide***)	3	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (***hydrocortisone***)	3/4	
CORTENEMA RECTAL ENEMA 100 MG/60ML (***hydrocortisone***)	3/4	
CORTIFOAM EXTERNAL FOAM 10 % (***hydrocortisone acetate***)	2	
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (***fluocinolone acetonide***)	3/4	
DERMOTIC OTIC OIL 0.01 % (***fluocinolone acetonide***)	3/4	
desonide external cream 0.05 %	1	
desonide external gel 0.05 %	1	
desonide external lotion 0.05 %	1	
desonide external ointment 0.05 %	1	
desoximetasone external cream 0.05 %, 0.25 %	1	
desoximetasone external gel 0.05 %	1	
desoximetasone external liquid 0.25 %	1	
desoximetasone external ointment 0.05 %, 0.25 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
diflorasone diacetate external cream 0.05 %	1	
diflorasone diacetate external ointment 0.05 %	1	
DIPROLENE EXTERNAL OINTMENT 0.05 % (***betamethasone dipropionate aug***)	3/4	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	
EPIFOAM EXTERNAL FOAM 1-1 % (***pramoxine-hc***)	2	
fluocinolone acetonide body external oil 0.01 %	1	
fluocinolone acetonide external cream 0.01 %, 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide otic oil 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluocinonide emulsified base external cream 0.05 %	1	
fluocinonide external cream 0.05 %, 0.1 %	1	
fluocinonide external gel 0.05 %	1	
fluocinonide external ointment 0.05 %	1	
fluocinonide external solution 0.05 %	1	
flurandrenolide external lotion 0.05 %	1	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
halcinonide external cream 0.1 %	1	
halobetasol propionate external cream 0.05 %	1	
halobetasol propionate external ointment 0.05 %	1	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	3	
HEMMOREX-HC RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
hydrocortisone (perianal) external cream 2.5 %	1	
hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %	1	
HYDROCORTISONE ACETATE EXTERNAL CREAM 2.5 %	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
hydrocortisone acetate rectal suppository 25 mg, 30 mg	1	
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 oral tablet 10 mg, 20 mg, 5 mg	1	
hydrocortisone rectal enema 100 mg/60ml	1	
hydrocortisone valerate external cream 0.2 %	1	
hydrocortisone valerate external ointment 0.2 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
hydrocort-pramoxine (perianal) external cream 2.5-1 %	1	
IMPOYZ EXTERNAL CREAM 0.025 % (***clobetasol propionate***)	3/4	
KHINDIVI ORAL SOLUTION 1 MG/ML (***hydrocortisone***)	3/4	PA
KOURZEQ MOUTH/THROAT PASTE 0.1 % (***triamcinolone acetonide***)	2	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (***neomycin-fluocinolone***)	3/4	
NUCORT EXTERNAL LOTION 2 % (***hydrocortisone acetate***)	3	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
ORALONE MOUTH/THROAT PASTE 0.1 % (***triamcinolone acetonide***)	2	
PRAMOSONE EXTERNAL CREAM 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (***pramoxine-hc***)	2	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRAMOSONE EXTERNAL OINTMENT 1-1 % (***pramoxine-hc***)	2	
PRAMOSONE EXTERNAL OINTMENT 1-2.5 % (***pramoxine-hc***)	3/4	
PROCORT EXTERNAL CREAM 1.85-1.15 % (***hydrocortisone ace-pramoxine***)	3/4	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (***hydrocortisone acetate***)	3/4	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (***hydrocortisone ace-pramoxine***)	2	
procto-med hc external cream 2.5 %	1	
PROCTOSOL HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 % (***hydrocortisone***)	3/4	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***)	3	
SERNIVO EXTERNAL EMULSION 0.05 % (***betamethasone dipropionate***)	3/4	
SYNALAR EXTERNAL CREAM 0.025 % (***fluocinolone acetonide***)	3/4	
SYNALAR EXTERNAL OINTMENT 0.025 % (***fluocinolone acetonide***)	3/4	
TEXACORT EXTERNAL SOLUTION 2.5 % (***hydrocortisone***)	2	
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (***desoximetasone***)	3/4	
tovet external foam 0.05 %	1	
triamcinolone acetonide external aerosol solution 0.147 mg/gm	1	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	
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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
EMOLLIENTS, DEMULCENTS, AND PROTECTANTS - Drugs for the Skin		
MICONAZOLE-ZINC OXIDE-PETROLAT EXTERNAL OINTMENT 0.25-15-81.35 %	3/4	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (***miconazole-zinc oxide-petrolat***)	3/4	
HYDROXYPYRIDONES (SKIN, MUCOUS MEMBRANE) - Drugs for the Skin		
ciclodan external solution 8 %	1	
ciclopirox external gel 0.77 %	1	
ciclopirox external shampoo 1 %	1	
ciclopirox external solution 8 %	1	
ciclopirox olamine external cream 0.77 %	1	
ciclopirox olamine external suspension 0.77 %	1	
CICLOPIROX TREATMENT EXTERNAL KIT 8 %	3/4	
IMMUNOMODULATORY AGENTS (84:06) - Drugs for the Skin		
ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***tralokinumab-ldrm***)	2	PA; QL (2 auto-injectors per month.)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; QL (0.15 ml per day.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; QL (2 ml (1 syringe) per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 syringe per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (***bimekizumab-bkzx***)	3	PA; QL (2 ml (1 syringe) per month.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; QL (1 pen (2 ml) per month.)
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (***lebrikizumab-lbkz***)	2	PA; QL (1 pen (2 ml) per month.)
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
ICOTYDE ORAL TABLET 200 MG (***icotrokinra hcl***)	2	PA; QL (30 tablets per month.)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (***nemolizumab-ilto***)	2	PA; QL (2 pens every 4 weeks.)
pimecrolimus external cream 1 %	1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (***tacrolimus***)	3/4	
PROGRAF ORAL PACKET 0.2 MG, 1 MG (***tacrolimus***)	3/4	PA
RHAPSIDO ORAL TABLET 25 MG (***remibrutinib***)	2	PA; QL (60 tablets per month.)
sirolimus oral solution 1 mg/ml	1	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	1	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 55 MG/0.37ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (55 mg/0.37ml) every 12 weeks.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***spesolimab-sbzo***)	3/4	PA; QL (2 Prefilled syringes per month.)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***spesolimab-sbzo***)	3/4	PA; QL (1 prefilled syringe per month.)
tacrolimus external ointment 0.03 %, 0.1 %	1	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 auto-injector) per month.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (2 ml per 2 months)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (***guselkumab***)	2	PA; QL (2 ml (1 syringe) per month.)
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (***guselkumab***)	2	PA; QL (4 ml (2 pens/1 box) per month.)
JANUS KINASE INHIBITORS (84:06) - Drugs for the Skin		
ANZUPGO EXTERNAL CREAM 20 MG/GM (***delgocitinib***)	3/4	PA
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (***ruxolitinib phosphate***)	2	PA; QL (2 tablets per day.); CM
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (***ruxolitinib phosphate***)	2	PA; CM
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.)
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.15 % (***roflumilast***)	3/4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA
KERATOLYTIC AGENTS - Drugs for the Skin		
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	3/4	PA
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
AVAR CLEANSER EXTERNAL LIQUID 10-5 % (***sulfacetamide sodium-sulfur***)	3/4	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (***sulfacetamide sodium-sulfur***)	3	
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (***sulfacetamide sodium-sulfur***)	3	
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
bp 10-1 external emulsion 10-1 %	1	
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***)	3/4	
DERMACINRX UREA EXTERNAL CREAM 41 % (***urea***)	3/4	
DERMACURE EXTERNAL CREAM 41 % (***urea***)	3/4	
EXODERM EXTERNAL LOTION 25-1 % (***sod thiosulfate-salicylic acd***)	3	
GORDOFILM EXTERNAL SOLUTION 16.7-16.7 % (***salicylic acid-lactic acid***)	2	
HYDRO 40 EXTERNAL FOAM 40 % (***urea***)	3	
isotretinoin capsule 10 mg oral	1	
isotretinoin capsule 20 mg oral	1	
isotretinoin capsule 30 mg oral	1	
isotretinoin capsule 40 mg oral	1	
PLEXION CLEANSER EXTERNAL LIQUID 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION CLEANSING CLOTH EXTERNAL PAD 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL CREAM 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PLEXION EXTERNAL LOTION 9.8-4.8 % (***sulfacetamide sodium-sulfur***)	3/4	
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
PRONAL EXTERNAL GEL 40-10 % (***urea-lactic acid***)	3	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
SALICATE EXTERNAL LIQUID 10 % (***salicylic acid***)	3	
salicylic acid external solution 26 %	1	
SALVAX DUO PLUS EXTERNAL KIT 6 & 35 % (***salicylic acid-urea in lactac***)	3	
SCALACORT DK EXTERNAL KIT 2 & 2-2 % (***hc & sal acid-sulfur & shampoo***)	3	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external emulsion 10-1 %	1	
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %, 9.8-4.8 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	1	
sulfacetamide sod-sulfur wash external liquid 9-4 %	1	
sulfacetamide-sulfur in urea external emulsion 10-5 %	1	
SULFACLEANSE 8/4 EXTERNAL SUSPENSION 8-4 % (***sulfacetamide sodium-sulfur***)	3	
SUMAXIN CP EXTERNAL KIT 10-4 % (***sulfacetamide-sulfur-cleanser***)	3/4	
SUMAXIN EXTERNAL PAD 10-4 % (***sulfacetamide sodium-sulfur***)	3/4	
tazarotene external cream 0.05 %, 0.1 %	1	PA
TAZAROTENE EXTERNAL FOAM 0.1 %	3/4	PA; QL (50 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	1	PA
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
URAMAXIN EXTERNAL GEL 45 % (***urea***)	3/4	
urea external cream 20 %, 40 %, 41 %	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
urea external lotion 40 %	1	
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	
XIRUN EXTERNAL GEL 40-10 %	3	
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
KERATOPLASTIC AGENTS - Drugs for the Skin		
coal tar external solution 20 %	1	
LOCAL ANTI-INFECTIVES, MISCELLANEOUS - Drugs for the Skin		
ACANYA EXTERNAL GEL 1.2-2.5 % (***clindamycin phos-benzoyl perox***)	3/4	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
benzalkonium chloride external solution	2	
benzalkonium chloride external solution 50 %	1	
BENZAMYCIN EXTERNAL GEL 5-3 % (***benzoyl peroxide-erythromycin***)	2	
benzoyl peroxide-erythromycin external gel 5-3 %	1	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
clindamycin phos-benzoyl perox external gel 1.2-5 %	1	QL (1 bottle (45 grams) per month.)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (***hc-pramoxine-chloroxylenol***)	3/4	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (***sulfuric acid-sulf phenolics***)	2	
DIABECIN HR EXTERNAL CREAM 4.12-0.13 % (***lidocaine-benzalkonium (pod)***)	3	
FEM PH VAGINAL GEL 0.9-0.025 % (***acetic acid-oxyquinoline***)	3/4	
iodine tincture external tincture 2 %	1	
LUGOLS STRONG IODINE EXTERNAL SOLUTION 5-10 %	3	
neuac external gel 1.2-5 %	1	QL (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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ONEXTON EXTERNAL GEL 1.2-3.75 % (***clindamycin phos-benzoyl perox***)	3/4	
PERIDEX MOUTH/THROAT SOLUTION 0.12 % (***chlorhexidine gluconate***)	3/4	
periogard mouth/throat solution 0.12 %	1	
selenium sulfide external lotion 2.5 %	1	
SILVADENE EXTERNAL CREAM 1 % (***silver sulfadiazine***)	3/4	
silver sulfadiazine external cream 1 %	1	
ssd external cream 1 %	1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (***mafenide acetate***)	3	
TWYNEO EXTERNAL CREAM 0.1-3 % (***tretinoin-benzoyl peroxide***)	3/4	
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 %	1	PA
OXABOROLES - Drugs for the Skin		
tavaborole external solution 5 %	1	QL (10 mL per month.)
PHOSPHODIESTERASE-4 INHIBITORS (84:06) - Drugs for the Skin		
EUCRISA EXTERNAL OINTMENT 2 % (***crisaborole***)	3	
JASCAYD ORAL TABLET 18 MG, 9 MG (***nerandomilast***)	3/4	PA; QL (60 tablets per month.)
roflumilast oral tablet 250 mcg	1	QL (31 tablets per year.)
roflumilast oral tablet 500 mcg	1	QL (1 tablet per day)
ZORYVE EXTERNAL CREAM 0.05 %, 0.15 % (***roflumilast***)	3/4	PA
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
PIGMENTING AGENTS - Drugs for the Skin		
methoxsalen rapid oral capsule 10 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
POLYENES (SKIN AND MUCOUS MEMBRANE) - Drugs for the Skin		
klayesta external powder 100000 unit/gm	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	
nystatin mouth/throat suspension 100000 unit/ml	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
nystop external powder 100000 unit/gm	1	
SCABICIDES AND PEDICULICIDES - Drugs for the Skin		
CROTAN EXTERNAL LOTION 10 % (***crotamiton***)	3	
EURAX EXTERNAL CREAM 10 % (***crotamiton***)	2	
malathion external lotion 0.5 %	1	
OVIDE EXTERNAL LOTION 0.5 % (***malathion***)	3/4	
permethrin external cream 5 %	1	
PRURADIK EXTERNAL LOTION 10 % (***crotamiton***)	3	
SOOLANTRA EXTERNAL CREAM 1 % (***ivermectin***)	1	
spinosad external suspension 0.9 %	1	
sulfurated lime external solution	1	
SKIN AND MUCOUS MEMBRANE AGENTS, MISC. - Drugs for the Skin		
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	1	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	1	
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***tralokinumab-ldrm***)	2	PA; QL (0.15 ml per day.)
AKLIEF EXTERNAL CREAM 0.005 % (***trifarotene***)	3/4	PA
AMELUZ EXTERNAL GEL 10 % (***aminolevulinic acid hcl***)	3	
amnesteem oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
ARTISS EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
attero external suspension 0.005-0.064 %	1	
azelaic acid external gel 15 %	1	
AZELEX EXTERNAL CREAM 20 % (***azelaic acid***)	3	
B & C EXTERNAL OINTMENT	3	
balsam peru-castor oil external ointment	1	
bexarotene external gel 1 %	1	
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 auto-injector per month.)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (***bimekizumab-bkzx***)	3	PA; QL (1 syringe per month.)
brimonidine tartrate external gel 0.33 %	1	PA
calcipotriene external cream 0.005 %	1	
calcipotriene external ointment 0.005 %	1	
calcipotriene external solution 0.005 %	1	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	1	
calcipotriene-betameth diprop external suspension 0.005-0.064 %	1	
CALCITRENE EXTERNAL OINTMENT 0.005 % (***calcipotriene***)	3	
calcitriol external ointment 3 mcg/gm	1	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (***abrocitinib***)	2	PA; QL (1 tablet per day.); CM
claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
clindamycin-tretinoin external gel 1.2-0.025 %	1	
CONDYLOX EXTERNAL GEL 0.5 % (***podofilox***)	3/4	
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX 150 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (***secukinumab***)	2	PA; QL (0.018 ml per day.)

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***secukinumab***)	2	PA; QL (0.036 ml per day.)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***secukinumab***)	2	PA; QL (0.072 ml per day.)
dapsone external gel 5 %, 7.5 %	1	
dapsone oral tablet 100 mg, 25 mg	1	
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (***dupilumab***)	2	PA; QL (0.09 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (***dupilumab***)	2	PA; QL (0.15 ml per day.)
ENDARI ORAL PACKET 5 GM (***glutamine (sickle cell)***)	3/4	QL (6 packets per day)
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (***calcipotriene-betameth diprop***)	3/4	
FEM PH VAGINAL GEL 0.9-0.025 % (***acetic acid-oxyquinoline***)	3/4	
FILSUVEZ EXTERNAL GEL 10 % (***birch triterpenes***)	3/4	PA; QL (14.4 grams per day.)
FINACEA EXTERNAL FOAM 15 % (***azelaic acid***)	2	
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %, 5 %	1	
HALUCORT EXTERNAL GEL (***dermatological products, misc.***)	3	
HYFTOR EXTERNAL GEL 0.2 % (***sirolimus***)	3/4	PA; QL (10 g per 23 days.)
imiquimod external cream 5 %	1	
isotretinoin capsule 10 mg oral	1	
isotretinoin capsule 20 mg oral	1	
isotretinoin capsule 30 mg oral	1	
isotretinoin capsule 40 mg oral	1	
KLISYRI (250 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	
KLISYRI (350 MG) EXTERNAL OINTMENT 1 % (***tirbanibulin***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (***aminolevulinic acid hcl***)	3	
l-glutamine oral packet 5 gm	1	QL (6 packets per day)
LITFULO ORAL CAPSULE 50 MG (***ritlecitinib tosylate***)	3	PA; QL (1 capsule per day.)
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	1	
nitroglycerin rectal ointment 0.4 %	1	QL (30 grams per month.)
OPZELURA EXTERNAL CREAM 1.5 % (***ruxolitinib phosphate***)	3/4	PA; QL (240 grams per prescription and 1200 grams per 365 days.)
OTEZLA ORAL TABLET 20 MG (***apremilast***)	2	PA; QL (60 tablets per month.)
OTEZLA ORAL TABLET 30 MG (***apremilast***)	2	PA; QL (2 tablets per day.)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***apremilast***)	2	PA; QL (55 tablets (one starter pack) per year.)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (***apremilast***)	2	PA; QL (1 starter pack per year.)
oxymetazoline hcl external cream 1 %	1	PA
PANRETIN EXTERNAL GEL 0.1 % (***alitretinoin***)	3	
pimecrolimus external cream 1 %	1	
PODOCON-25 EXTERNAL SOLUTION 25 % (***podophyllum resin***)	3	
podofilox external gel 0.5 %	1	
podofilox external solution 0.5 %	1	
PYROGALLIC ACID EXTERNAL OINTMENT 25-2 %	2	
RECTIV RECTAL OINTMENT 0.4 % (***nitroglycerin***)	3/4	QL (30 grams per month.)
RHOFADE EXTERNAL CREAM 1 % (***oxymetazoline hcl***)	3/4	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (***collagenase***)	3	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (***risankizumab-rzaa***)	2	PA; QL (1 prefilled syringe (150 mg) every 12 weeks.)
tacrolimus external ointment 0.03 %, 0.1 %	1	
tazarotene external cream 0.05 %, 0.1 %	1	PA

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TAZAROTENE EXTERNAL FOAM 0.1 %	3/4	PA; QL (50 grams per prescription.)
tazarotene external gel 0.05 %, 0.1 %	1	PA
TAZORAC EXTERNAL CREAM 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 % (***tazarotene***)	3/4	PA
TISSEEL EXTERNAL KIT 10 ML, 2 ML, 4 ML (***fibrin sealant component***)	3	
TOLAK EXTERNAL CREAM 4 % (***fluorouracil***)	3/4	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (***guselkumab***)	2	PA; QL (1 mL (1 device) every 8 weeks.)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (***guselkumab***)	2	PA; QL (2 ml per 2 months)
VALCHLOR EXTERNAL GEL 0.016 % (***mechlorethamine hcl (topical)***)	2	PA
VENELEX EXTERNAL OINTMENT (***balsam peru-castor oil***)	3	
VEREGEN EXTERNAL OINTMENT 15 % (***sinecatechins***)	3	
VTAMA EXTERNAL CREAM 1 % (***tapinarof***)	3/4	PA
ZELSUVMI EXTERNAL GEL 10.3 % (***berdazimer sodium***)	3/4	
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
ZORYVE EXTERNAL CREAM 0.3 % (***roflumilast***)	3/4	PA; QL (60 grams per 30 days.)
ZORYVE EXTERNAL FOAM 0.3 % (***roflumilast***)	3/4	PA
SUNSCREEN AGENTS - Drugs for the Skin		
AVIDOXY DK COMBINATION KIT 100 MG (***doxycycline-suncreen-sal acid***)	3	
SMOOTH MUSCLE RELAXANTS - Drugs to Relax Muscles		
ANTIMUSCARINICS - Drugs for the Urinary System		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (62 capsules per month.)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG (***xanomeline-trospium chloride***)	3/4	PA; QL (1 starter pack per year.)
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	1	
flavoxate hcl oral tablet 100 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	1	
oxybutynin chloride oral solution 5 mg/5ml	1	
oxybutynin chloride oral tablet 2.5 mg, 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	1	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	1	
tolterodine tartrate oral tablet 1 mg, 2 mg	1	
trospium chloride er oral capsule extended release 24 hour 60 mg	1	
trospium chloride oral tablet 20 mg	1	
RESPIRATORY SMOOTH MUSCLE RELAXANTS - Drugs for Lungs		
elixophyllin oral elixir 80 mg/15ml	3	
sildenafil citrate oral suspension reconstituted 10 mg/ml	1	PA; QL (186 ml per month.)
sildenafil citrate oral tablet 20 mg	1	QL (0.5 tablet per day.)
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	
SELECTIVE BETA-3-ADRENERGIC AGONISTS - Drugs for the Urinary System		
GEMTESA ORAL TABLET 75 MG (***vibegron***)	3/4	
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	1	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG (***mirabegron***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VITAMINS		
MULTIVITAMIN PREPARATIONS		
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE 0.75 MG (***pediatric multivitamins-fl***)	3/4	
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 SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG (***pediatric multivitamins-fl***)	3/4	
FLOTREX ORAL TABLET CHEWABLE 1 MG (***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	
multivitamin/fluoride oral suspension 0.25 mg/ml	1	
multi-vitamin/fluoride oral suspension 0.25 mg/ml, 0.5 mg/ml	1	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	1	
NATAL PNV ORAL TABLET 6-0.5 MG	3/4	
NEONATAL COMPLETE ORAL TABLET 27-1 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	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3/4	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (***pediatric multivitamins-fl***)	3/4	
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	
PRENACORE ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe fumarate-fa***)	3	
prenatal 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***)	3/4	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***)	3/4	
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***)	3/4	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3/4	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***)	3/4	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3/4	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3/4	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	3/4	
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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-fl***)	3	
TRI-VI-FLORO ORAL SUSPENSION 0.25 MG/ML, 0.5 MG/ML	3	
TRI-VITAMIN WITH FLUORIDE ORAL SUSPENSION 0.25 MG/ML	3/4	
tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	1	
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	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL DHA ORAL CAPSULE 31-0.6-0.4-200 MG	3	
VITAMIN A		
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-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 B COMPLEX		
BEYAZ ORAL TABLET 3-0.02-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
CALCIFOL ORAL WAFER 1342-1.6 MG (***ca carb-fa-d-b6-b12-boron-mg***)	3	
cyanocobalamin injection solution 1000 mcg/ml	1	
CYANOCOBALAMIN INJECTION SOLUTION 2000 MCG/ML	3	
cyanocobalamin nasal solution 500 mcg/0.1ml	1	
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	1	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	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
folic acid oral tablet 400 mcg, 800 mcg	E	H
folic acid tablet 1 mg oral (rx)	1	
ft folic acid oral tablet 400 mcg, 800 mcg	E	H
HEMATINIC/FOLIC ACID ORAL TABLET 324-1 MG	3/4	
lederle leucovorin oral tablet 5 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 oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	1	
NASCOBAL NASAL SOLUTION 500 MCG/0.1ML (***cyanocobalamin***)	3	
NATAL PNV ORAL TABLET 6-0.5 MG	3/4	
NEONATAL COMPLETE ORAL TABLET 27-1 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	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
ONE VITE WOMENS PLUS ORAL TABLET 27-1 MG	3	
ONENATAL RX ORAL TABLET 1 MG (***prenatal multivit-min-fe-fa***)	3	
pnv 27-ca/fe/fa oral tablet 60-1 mg	1	
PREMESISRX ORAL TABLET 1 MG (***prenatal ca-b6-b12-fa-ginger***)	3	
PRENACORE ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe fumarate-fa***)	3	
prenatal 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***)	3/4	
PRENATE ELITE ORAL TABLET 20-0.6-0.4 MG (***prenatal-feaspgly-methylfol-fa***)	3/4	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

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***)	3/4	
PRENATE MINI ORAL CAPSULE 18-0.6-0.4-350 MG (***prenat-fecbn-feasp-meth-fa-dha***)	3/4	
PRENATE ORAL TABLET CHEWABLE 0.6-0.4 MG (***prenat mv-min-methylfolate-fa***)	3/4	
PRENATE PIXIE ORAL CAPSULE 10-0.6-0.4-200 MG (***prenat-feasp-meth-fa-dha w/o a***)	3/4	
PRENATE RESTORE ORAL CAPSULE 27-0.6-0.4-400 MG (***prenat w/o a-fe-methfol-fa-dha***)	3/4	
RELNATE DHA ORAL CAPSULE 28-1-200 MG	3	
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (***drospiren-eth estrad-levomefol***)	E	H
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (***prenatal vit-fe psac cmplx-fa***)	3/4	
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 (***pediatric multivitamins-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	1	H
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	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (***prenatal vit-fe fumarate-fa***)	3	
WESCAP-PN DHA ORAL CAPSULE 27-0.6-0.4-300 MG	3/4	
WESNATE DHA ORAL CAPSULE 28-1-200 MG	3	
WESTGEL 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 to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

Prescription drug name	Drug tier	Coverage requirements & limits
VITAMIN C		
TRI-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (***pediatric multivitamins-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		
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	
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 (***pediatric multivitamins-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)	1	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (***paricalcitol***)	3/4	
VITAMIN E		
wheat germ oil oral oil	1	
VITAMIN K ACTIVITY		
phytonadione oral tablet 5 mg	1	

Drug Tier 1: Your lowest cost medications; Drug Tier 2: Your mid-range cost medications; Drug Tier 3: Your mid-range to high-cost medications; Drug Tier 3/4: Your highest cost medications; PA: Prior authorization required; QL: Quantity Limit; H: Part of Health Care Reform; H-N: Part of Health Care Reform with confirmation of age and/or condition appropriate preventive use.; SP: Specialty medication; CM: Orally administered anticancer medication; SMCS: Specialty medication cost share may apply; E: Excluded from coverage unless covered as part of health care reform preventive; SM: State Mandated Benefit Program, Cost-share cap by state mandate applies when condition appropriate.; NTT: If you are new to opioid therapy, you will be limited to a 7-day supply (or 3-day supply if 19 years or younger) and less than 50 morphine milligram equivalents.

abacavir sulfate 33
abacavir sulfate-lamivudine ... 33
abigale 237, 250
abigale lo 237, 250
abiraterone acetate 44
abirtega 44
ABRYSVO 59
acamprosate calcium 15, 139
ACANYA 36, 314, 334
acarbose 223
ACCU-CHEK AVIVA 168
ACCU-CHEK FASTCLIX LANCET KIT 168
ACCU-CHEK GUIDE 168
ACCU-CHEK GUIDE CONTROL 168
ACCU-CHEK GUIDE ME 168
ACCU-CHEK GUIDE TEST 180
ACCU-CHEK SMARTVIEW CONTROL 168
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT 168
accutane 331, 336
ACD-A NOCLOT-50 76
acebutolol hcl 75, 95, 100, 103, 110
acetaminophen-codeine 120, 147, 149
acetazolamide 88, 100, 122, 182, 196
acetazolamide er 88, 100, 122, 182, 196
acetic acid 202
acetylcysteine 15, 273, 306
acitretin 331, 336
ACTEMRA 268, 281, 285
ACTEMRA ACTPEN 268, 281, 285
ACTHAR 180, 249
ACTHAR GEL 180, 249
ACTHIB 60
ACTIMMUNE 285
ACTIVELLA 237, 250
ACTOPLUS MET 226, 262
ACULAR 157, 203
ACULAR LS 157, 203
ACUVAIL 157, 203
acyclovir 38, 320
ADACEL 59, 60
ADALIMUMAB-AATY (1 PEN) 212, 271, 281, 285
ADALIMUMAB-AATY (2 PEN) 212, 271, 281, 285
ADALIMUMAB-AATY (2 SYRINGE) 212, 271, 281, 285
ADALIMUMAB-AATY CD/UC/HS START 212, 271, 281, 285
ADALIMUMAB-ADAZ 212, 271, 281, 285, 286
adapalene-benzoyl peroxide 296, 331, 334, 336
ADBRY 329, 336
ADDYI 139
adefovir dipivoxil 38
ADEMPAS 311, 312
ADRENALIN 64, 206, 299
ADVAIR HFA 73, 196, 217, 301
ADVANTAGE SAFETY LANCETS 28G 168
ADVATE 80
ADVOCATE SAFETY LANCETS 21G 168
ADVOCATE SAFETY LANCETS 23G 168
ADVOCATE SAFETY LANCETS 28G 168
ADYNOVATE 80
ADZENYS XR-ODT 119
AEROCHAMBER HOLDING CHAMBER 168
AEROCHAMBER PLS FLOVU MTHPIECE 168
AEROCHAMBER PLUS FLO-VU INTERM 168
AEROCHAMBER PLUS FLO-VU LARGE 168
AEROCHAMBER PLUS FLO-VU MEDIUM 168
AEROCHAMBER PLUS FLO-VU SMALL 169
AEROCHAMBER2GO ANTI-STATIC 169
afirmelle 228, 237, 250
AFREZZA 258
AFSTYLA 80
aftera 224, 228, 250
AIMOVIG 138
AIRSUPRA 73, 196, 217, 301, 307, 310
AKEEGA 44
AKLIEF 331, 336
AKTEN 204
AKYNZEO 207, 215
albendazole 23
albuterol sulfate 73, 310
ALBUTEROL SULFATE ... 73, 310
albuterol sulfate hfa 73, 310
ALCAINE 204
alclometasone dipropionate 323
ALCOHOL PREP PADS 169
ALECENSA 44
alendronate sodium 275
alfuzosin hcl er 72
aliskiren fumarate 114
allopurinol 274
ALLZITAL 120, 135, 147
almotriptan malate 160
ALOGLIPTIN BENZOATE 235
ALOGLIPTIN-METFORMIN HCL 226, 235
ALOGLIPTIN-PIOGLITAZONE 235, 262
ALORA 237, 276
alosetron hcl 208
ALPHAGAN P 191, 314
ALPHANATE 80
ALPHANINE SD 81
alprazolam 137
alprazolam er 137
alprazolam intensol 137
alprazolam xr 137
ALPROLIX 81
ALTACAINE 204, 272
altavera 228, 237, 250
ALTRENO 45, 323
ALTUVIIIO 81
ALUNBRIG 45
ALVAIZ 78
alvimopan 206, 212
alyacen 1/35 ..... 228, 237, 250
alyacen 7/7/7 ..... 228, 237, 250
ALYFTREK 303, 304
alyq 113, 308, 311
amantadine hcl 21, 118
ambrisentan 115, 304, 311
amcinonide 323
AMELUZ 313, 336
amethyst 228, 237, 250
amiloride hcl 89, 114, 184
amiloride-hydrochlorothiazide 184, 187
aminocaproic acid 81
amiodarone hcl 104
AMITIZA 206, 212

amitriptyline hcl 162
AMJEVITA
..... 212, 213, 272, 281, 282, 286
AMJEVITA-PED 15KG TO
<30KG 213, 272, 282, 286
amlodipine besylate
..... 105, 107, 115
amlodipine besylate-
benazepril hcl 93, 105
amlodipine besylate-
valsartan 91, 106
amlodipine-atorvastatin 106, 109
amlodipine-olmesartan ...91, 106
amlodipine-valsartan-hctz
..... 91, 106, 187
amnesteem 331, 336
amoxapine 162
amoxicill-clarithro-lansopraz
..... 22, 39, 40, 216
amoxicillin 22, 23, 209
amoxicillin trihydrate 23, 209
amoxicillin-potassium
clavulanate 23
amoxicillin-potassium
clavulanate er 23
amphetamine er 119
amphetamine sulfate 119
amphetamine-
dextroamphetamine 119
amphetamine-
dextroamphetamine er 119
amphet-dextroamphet 3-
bead er 119
ampicillin 23
AMZEEQ 24, 42, 192, 314
anagrelide hcl 87
ANALPRAM HC
..... 196, 197, 217, 318, 319, 324
anastrozole 45, 224
ANCOBON 41
ANDEMBRY 88
ANGELIQ 237, 250
ANNOVERA 228, 237, 250
ANORO ELLIPTA 65, 73
ANTICOAGULANT SODIUM
CITRATE 76
ANUCORT-HC 197, 217, 324
ANUSOL-HC 197, 217, 324
ANZUPGO 331
apap-caff-dihydrocodeine
..... 120, 147, 149, 155
APOKYN 147
apomorphine hcl 147
apraclonidine hcl 191, 202
aprepitant 215
apri 228, 237, 250
APRISO 208
APTIOM 122, 144
APTIVUS 35
AQ INSULIN SYRINGE 169
AQINJECT PEN NEEDLE 169
AQNEURSA 292
AQUORAL 202
AQVESME 77
ARAKODA 24
aranelle 228, 237, 250
ARANESP (ALBUMIN FREE)
..... 76, 78, 79
ARBLI 91
ARCALYST 293, 306
AREXVY 60
arformoterol tartrate 73, 311
ARIKAYCE 22
aripiprazole 127, 128, 133, 134
armodafinil 163, 164
ARMOUR THYROID 262
ARNUITY ELLIPTA
..... 197, 217, 301, 307
ARTISS 322, 337
ARZOL SILVER NIT
APPLICATORS 194
ascomp-codeine
..... 135, 149, 155, 158
asenapine maleate 128, 134
ashlyna 228, 238, 251
aspirin 87, 88, 131, 159
aspirin 81 ..... 86, 87, 130, 158
aspirin adult low dose
..... 86, 87, 130, 158
aspirin adult low strength
..... 86, 87, 130, 158
aspirin childrens 86, 87, 130, 159
aspirin ec adult low dose
..... 86, 87, 130, 159
aspirin ec low dose . 87, 130, 159
aspirin ec low strength
..... 87, 130, 159
aspirin low dose 87, 88, 131, 159
aspirin regimen . 87, 88, 131, 159
aspirin-dipyridamole er
..... 87, 113, 159, 180
ASSURE CONTROL
SOLUTION 2/3 169
ASSURE ID DUO PRO PEN
NEEDLES 169
ASSURE ID PRO PEN
NEEDLES 169
ASTRINGYN 81
atazanavir sulfate 35
atenolol 75, 95, 100, 103, 110
atenolol-chlorthalidone
..... 95, 100, 188
ATMEKSI 69
atomoxetine hcl 139, 155
ATORVALIQ 109
atorvastatin calcium 109
atovaquone 25
atovaquone-proguanil hcl 24
atropine sulfate . 15, 65, 204, 299
attero 322, 324, 337
ATTRUBY 100
aubra eq 228, 238, 251
AUGMENTIN 23
AUGTYRO 45
AUM INSULIN SAFETY PEN
NEEDLE 169
AUM MINI INSULIN PEN
NEEDLE 169
AUM PEN NEEDLE 169
AUM READYGARD DUO PEN
NEEDLE 169
AUM SAFETY PEN NEEDLE . 169
AURANOFIN ... 216, 265, 282, 286
aurovela 1.5/30 ..... 228, 238, 251
aurovela 1/20 ..... 228, 238, 251
aurovela 24 fe 228, 238, 251
aurovela fe 1.5/30 .. 228, 238, 251
aurovela fe 1/20 ..... 228, 238, 251
AUSTEDO 163
AUSTEDO XR 163
AUSTEDO XR PATIENT
TITRATION 163
AUTOKEEPER SAFETY PEN
NEEDLE 169
AUTOLET LANCING DEVICE 169
AUTOLET LITE LANCING
DEVICE 169
AUVELITY 127
AUVELITY TITRATION PACK 127
AUVI-Q 64, 299
avanafil 113
AVAR CLEANSER 314, 332
AVAR LS CLEANSER 314, 332
AVAR-E EMOLLIENT 314, 332
aviane 229, 238, 251
AVIDOXY 24, 43, 314
AVIDOXY DK 43, 332, 340

AVMAPKI FAKZYNJA CO-PACK 45
AVONEX PEN 267, 286
AVONEX PREFILLED 267, 286
AVTOZMA 268
ayuna 229, 238, 251
AYVAKIT 45
AZASAN 264, 282, 286, 290
AZASITE 192
azathioprine ... 264, 282, 286, 290
azelaic acid 314, 337
azelastine hcl 191, 310
AZELEX 314, 337
azilsartan medoxomil 91
azithromycin 39, 40
AZSTARYS 155
AZULFIDINE 42, 208, 265, 282, 286
AZULFIDINE EN-TABS 42, 208, 265, 282, 286
azurette 229, 238, 251
B & C 337
bac (butalbital-acetamin-caff) 120, 135, 147, 155
bacitracin-polymyxin b 29, 192, 314
bacitra-neomycin-polymyxin-hc ... 29, 192, 197, 315
baclofen 69
BACTRIM 25, 42, 43
BACTRIM DS 25, 42, 43
BAFIERTAM 266, 286
BALCOLTRA 229, 238, 251
balsalazide disodium 209
balsam peru-castor oil 337
BALVERSA 45
balziva 229, 238, 251
BANZEL 122, 144
BAQSIMI ONE PACK 15, 246, 273
BAQSIMI TWO PACK 15, 246, 273
BARACLUDE 38
BAXDELA 41
BD AUTOSHIELD DUO PEN NEEDLES 169
BD BLUNT FILL NEEDLE 169
BD ECLIPSE LUER-LOK NEEDLE 169
BD ECLIPSE NEEDLE 169
BD PEN NEEDLE MICRO ULTRAFINE 170
BD PEN NEEDLE MINI ULTRAFINE 170
BD PEN NEEDLE NANO ULTRAFINE 170
BD PEN NEEDLE ORIG ULTRAFINE 170
BD PEN NEEDLE SHORT ULTRAFINE 170
BD SAFETYGLIDE NEEDLE .. 170
BD SHARPS COLLECTOR 170
BD ULTRA-FINE INSULIN SYRINGES 170
BD ULTRA-FINE PEN NEEDLES 170
BD VEO INSULIN SYR ULTRAFINE 170
BELBUCA 154
belladonna alkaloids-opium 65, 149
BELSOMRA 133, 154
benazepril hcl 92, 93
benazepril-hydrochlorothiazide 93, 187
BENEFIX 81
BENLYSTA 267, 290, 291
benzalkonium chloride . 320, 334
BENZAMYCIN 315, 334
BENZNIDAZOLE 25, 26, 37, 38
benzoin 323
benzonatate 300
benzoyl peroxide-erythromycin 315, 334
benztropine mesylate 67, 122
bepotastine besilate 19, 191
BEQALZI 45
BEQALZI STARTER PACK 45
BERINERT 280
BESIFLOXACIN HCL 192
BESIVANCE 192
BESREMI 35, 45, 286
BESREMI PEN 35, 45, 286
BETADINE OPHTHALMIC PREP 194
betaine 293
betamethasone dipropionate 218, 324
betamethasone dipropionate aug 218, 324
betamethasone valerate 218, 324
BETAPACE AF 70, 95, 100, 103, 104, 111
BETASERON 268, 286
betaxolol hcl 75, 95, 100, 103, 111, 195
bethanechol chloride 71
BETIMOL 70, 95, 103, 195
BEVESPI AEROSPHERE 65, 73, 320
bexarotene 45, 313, 337
BEXSERO 60
BEYAZ 229, 238, 251, 344
BEYFORTUS 37
bicalutamide 45
BIGFOOT UNITY PROGRAM 170
BIJUVA 238, 251
BIKTARVY 31, 32, 33
BILTRICIDE 23
bimatoprost 205
BIMZELX 329, 337
BINOSTO 276
bis subcit-metronid-tetracyc 24, 26, 43, 207, 209
bisacodyl ec 210
bismuth/metronidaz/tetracyc lin 24, 26, 43, 207, 209
bisoprolol fumarate 75, 95, 101, 103, 111
bisoprolol-hydrochlorothiazide 95, 101, 187
BIXLENVO 31
blisovi 24 fe 229, 238, 251
blisovi fe 1.5/30 ..... 229, 238, 251
blisovi fe 1/20 ..... 229, 238, 251
BLUJEPA 43
BONJESTA 208
BONSITY 248, 275
BOOSTRIX 59, 60
bosentan 115, 304, 311
BOSULIF 45, 46
bosutinib 46
bp 10-1 ..... 315, 332
BRAFTOVI 46
BREATHE COMFORT CHAMBER/ADULT 170
BREATHE COMFORT CHAMBER/CHILD 170
BRENZAVVY 260
BREO ELLIPTA 73, 197, 218, 301, 302
BREZTRI AEROSPHERE 65, 73, 218
briellyn 229, 238, 251
brimonidine tartrate 191, 314, 337
BRINSUPRI 300, 307

brinzolamide 196
brivaracetam 122
BRIVIACT 122
bromfenac sodium 203
bromfenac sodium (once-daily) 203
bromocriptine mesylate 141
BROMSITE 203
BRONCHITOL 309
BRONCHITOL TOLERANCE TEST 309
BRUKINSA 46
BRYHALI 324
BRYNOVIN 235
budesonide 218, 302, 307, 324
bumetanide 89, 109, 183
BUMEX 89, 109, 183
BUPHENYL 182
buprenorphine 154
buprenorphine hcl 154
buprenorphine hcl-naloxone hcl 153, 154
bupropion hcl 127
bupropion hcl er (smoking det) 63, 127
bupropion hcl er (sr) 127
bupropion hcl er (xl) 127
BUPROPION HCL ER (XL) 127
buspirone hcl 133, 146
butalbital-acetaminophen 120, 136, 147
butalbital-apap-caff-cod 120, 136, 147, 150, 155
butalbital-apap-caffeine 120, 136, 147, 155
BUTALBITAL-APAP-CAFFEINE 120, 136, 147, 155
butalbital-asa-caff-codeine 136, 150, 155, 159
butalbital-aspirin-caffeine 136, 155, 159
butorphanol tartrate 131, 154
BYLVAY 210, 213
BYLVAY (PELLETS) 210, 213
BYQLOVI 197
cabergoline 141
CABLIVI 77, 88
CABOMETYX 46
CAFERGOT 71, 131, 155
caffeine citrate 131, 155
CALCIFOL 185, 344, 347
calcipotriene 322, 337
calcipotriene-betameth diprop 322, 324, 337
calcitonin (salmon) 226, 276
CALCITRENE 322, 337
calcitriol 337, 347
calcium acetate 184, 185
calcium acetate (phos binder) 183, 185
CALQUENCE 46
CAMBIA 131, 148
camila 229, 251
camrese 229, 238, 251
camrese lo 229, 238, 251
CAMZYOS 100
candesartan cilexetil 91
candesartan cilexetil-hctz 91, 187
capecitabine 46
CAPLYTA 134
CAPRELSA 46
captopril 92, 93
captopril-hydrochlorothiazide 93, 187
CAPVAXIVE 60
carbamazepine 123, 128
carbamazepine er .. 122, 123, 128
CARBATROL 123, 128
carbidopa 141
carbidopa-levodopa 141
carbidopa-levodopa er 141
carbidopa-levodopa-entacapone 139, 141
carbinoxamine maleate 17, 18, 305
CARBINOXAMINE MALEATE ER 17, 18, 305
CARBZAH 17, 18, 305
CARDAMYST 98, 105
CARDURA 71, 90, 95
CARDURA XL 71, 90, 95
CAREPOINT POLY HUB NEEDLE 170
CAREPOINT PRECISION POLY HUB 170
CAREPOINT SAFETY 1ST NEEDLE 171
CARESENS CONTROL SOLUTION A/B 171
CARESENS LANCETS 30G ... 171
CARESENS S CONTROL SOLN A/B 171
CARETOUCH CONTROL SOL LEVEL 2 171
CARETOUCH HYPODERMIC NEEDLE 171
CARETOUCH LANCING/EJECTOR 171
carglumic acid 182
carisoprodol 69
CARNITOR 293
CARNITOR SF 293
CAROSPIR 89, 110, 114, 115, 184
carteolol hcl 195
cartia xt 97, 98, 99, 105, 115
carvedilol 70, 72, 90, 95, 101, 103, 111
carvedilol phosphate er 70, 72, 90, 95, 101, 103, 111
CAVERJECT 107, 116
CAVERJECT IMPULSE .. 107, 115
CAYA 297
CAYSTON 37
cefaclor 20
cefaclor er 20
cefadroxil 20
cefdinir 21
cefixime 21
CEFIXIME 21
cefpodoxime proxetil 21
cefprozil 20, 21
cefuroxime axetil 21
celecoxib 140
CELONTIN 162
cephalexin 20
CEQUR SIMPLICITY 1U EXTND WEAR 171
CEQUR SIMPLICITY 2U 171
CEQUR SIMPLICITY 2U EXTND WEAR 171
CERDELGA 190, 293
CERVIDIL 298
CETRAXAL 192
CETROTIDE 225
cevimeline hcl 71
CHANTIX 63, 68
CHANTIX CONTINUING MONTH PAK 63, 68
CHANTIX STARTING MONTH PAK 63, 68
charlotte 24 fe 229, 238, 251
chateal eq 229, 238, 251
CHEMET 15, 216, 273
CHEMSTRIP BG LOG BOOK . 171
CHEMSTRIP K 181
CHEMSTRIP UGK 181
chlordiazepoxide hcl 137

chlordiazepoxide-amitriptyline.....137, 162
chlordiazepoxide-clidinium
..... 65, 137
chlorhexidine gluconate
..... 21, 194, 195, 320, 334
chloroquine phosphate..... 24
chlorpromazine hcl..... 154
chlorthalidone..... 90, 115, 188
chlorzoxazone..... 69
CHOLBAM..... 211, 213
cholestyramine.....96
cholestyramine light..... 96
CHORIONIC GONADOTROPIN..... 246
CHOSEN LANCETS 30G..... 171
CHOSEN LANCING DEVICE. 171
CHOSEN SAFETY LANCETS 28G..... 171
CIBINQO.....269, 282, 331, 337
ciclodan..... 329
ciclopirox.....329
ciclopirox olamine..... 329
CICLOPIROX TREATMENT...329
cilostazol.....87, 113
CILOXAN..... 192
CIMDUO..... 33
cimetidine..... 19, 214
cimetidine hcl.....19, 214
CIMZIA (1 SYRINGE)
..... 213, 265, 272, 282, 286
CIMZIA (2 SYRINGE)
..... 213, 265, 272, 282, 287
CIMZIA-STARTER
..... 213, 265, 272, 282, 287
cinacalcet hcl..... 226
CIPRO.....27, 41
CIPRO HC..... 192, 197
ciprofloxacin hcl..... 27, 41, 192
ciprofloxacin-dexamethasone.....192, 197
ciprofloxacin-hydrocortisone
..... 192, 197
citalopram hydrobromide.....161
cladribine (10 tabs)
..... 46, 263, 287, 291
cladribine (4 tabs)
..... 46, 263, 287, 291
cladribine (5 tabs)
..... 46, 263, 287, 291
cladribine (6 tabs)
..... 46, 263, 287, 291
cladribine (7 tabs)
..... 46, 264, 287, 291
cladribine (8 tabs)
..... 46, 264, 287, 291
cladribine (9 tabs)
..... 46, 264, 287, 291
claravis.....332, 337
CLARINEX-D 12 HOUR.....20, 64
clarithromycin..... 27, 39, 40, 209
clarithromycin er. 27, 39, 40, 209
clearlax.....210
clemastine fumarate. 17, 18, 305
CLEMSZA.....17, 18, 305
CLEOCIN.....36, 315
CLEOCIN-T.....36, 315
CLEVER CHOICE COMFORT EZ..... 171
CLEVER CHOICE COMFORT EZ PLUS.....171
CLIMARA PRO..... 238, 251
clindacin..... 36, 315
clindacin etz..... 36, 315
clindacin-p.....36, 315
CLINDAGEL.....36, 315
clindamycin hcl.....36, 315
clindamycin palmitate hcl
..... 36, 315
clindamycin phos (once-daily).....36, 315
clindamycin phos (twice-daily).....36, 315
clindamycin phos-benzoyl perox..... 36, 315, 334
clindamycin phosphate.. 36, 315
clindamycin-tretinoin
..... 36, 316, 323, 337
CLINDESSE.....37, 316
CLINPRO 5000.....165, 277
clobazam.....136, 137
clobetasol prop emollient base.....324
CLOBETASOL PROPIONATE324
clobetasol propionate...324, 325
clobetasol propionate e.....324
clobetasol propionate emulsion..... 324
clocortolone pivalate..... 325
clodan..... 325
clomid..... 237
clomiphene citrate..... 237
clomipramine hcl..... 162
clonazepam..... 136, 137
clonidine..... 65, 101, 107
clonidine hcl..... 65, 101, 107
clonidine hcl er.....65, 107
clopidogrel bisulfate.....87
clorazepate dipotassium
..... 136, 138
clotrimazole.....321
clotrimazole-betamethasone
..... 321, 325
clozapine.....134
CLOZARIL..... 134
COAGADEX.....81
coal tar..... 334
COARTEM.....24
COBENFY.....132, 340
COBENFY STARTER PACK
..... 132, 340
codeine sulfate.....150, 301
colchicine..... 274
colchicine-probenecid..189, 274
colesevelam hcl..... 97, 224
COLESTID.....97
colestipol hcl.....97
colistimethate sodium (cba).. 41
COLY-MYCIN M..... 41
COMBIGAN..... 191, 195, 314
COMBIPATCH.....238, 251
COMBIVENT RESPIMAT
..... 66, 74, 299
COMETRIQ.....47
COMFORT EZ PRO PEN NEEDLES..... 171
COMFORT TOUCH TWIST LANCET 30G.....171
COMIRNATY..... 60
COMIRNATY 5-11 YEARS..... 60
COMPLERA.....32, 33, 38
COMPRO.....154, 208
CONDOMS..... 297
CONDYLOX.....332, 337
constulose.....182
CONTOUR CONTROL..... 171
CONTOUR NEXT..... 180
CONTOUR NEXT CONTROL.171
CONTOUR NEXT EZ.....172
CONTOUR NEXT GEN MONITOR.....172
CONTOUR NEXT MONITOR. 172
CONTOUR NEXT ONE..... 172
CONTOUR NEXT TEST..... 180
CONTOUR PLUS BLUE..... 172
CONTOUR PLUS CONTROL SOLUTION.....172
CONTOUR PLUS TEST..... 180

CONZIP 150
COPIKTRA 47
CORDRAN 325
CORIFACT 81
CORLANOR 100, 116
CORPHENA 18, 19
CORTANE-B
..... 197, 218, 319, 325, 334
CORTEF 197, 218, 325
CORTENEMA 197, 219, 325
CORTIFOAM 197, 219, 325
CORTISONE ACETATE 219
CORTISPORIN-TC 192, 197
CORTROPHIN 180, 249
CORTROPHIN GEL 180, 249
CORTROSYN 180
COSENTYX (300 MG DOSE)
..... 268, 282, 337
COSENTYX 150 MG/ML
..... 268, 282, 337
COSENTYX SENSOREADY
(300 MG) 268, 282, 338
COSENTYX SENSOREADY
PEN 269, 282, 338
COSENTYX UNOREADY
..... 269, 282, 338
COSOPT 195, 196
cosyntropin 180
COTELLIC 47
COTEMPLA XR-ODT 155
COVARYX 223, 239
COVARYX HS 223, 238
CRENESSITY 81, 249
CREON 190, 211
CRESEMBA 28
CREXONT 141
CRINONE 251
cromolyn sodium .. 192, 203, 306
CROTAN 336
cryselle 229, 239, 251
CTEXLI 211
CUVPOSA 66, 320
cyanocobalamin 86, 344
CYANOCOBALAMIN 86, 344
cyclobenzaprine hcl 69
CYCLOGYL 205
CYCLOMYDRIL 205, 206
cyclopentolate hcl 205
cyclophosphamide . 47, 267, 291
CYCLOPHOSPHAMIDE
..... 47, 267, 291
cycloserine 27
CYCLOSET 224
cyclosporine
..... 195, 264, 282, 287, 291
cyclosporine modified
..... 195, 264, 282, 287, 291
cyproheptadine hcl 18, 305
cyred eq 229, 239, 252
CYSTADANE 293
CYSTADROPS 203, 204
CYSTAGON 293
CYSTARAN 203, 204
CYTOTEC 215
cytra k crystals 181
dabigatran etexilate
mesylate 78
dalfampridine er 293, 297
danazol 223
DANTRIUM 69
dantrolene sodium 69
dapagliflozin-metformin hcl
er 226, 260
dapsone 24, 25, 26, 316, 338
DAPTACEL 59, 60
DARAPRIM 24
darifenacin hydrobromide er 340
darunavir 35
dasatinib 47
dasetta 1/35 (28) 229, 239, 252
dasetta 7/7/7 ..... 229, 239, 252
DAURISMO 47
DAVIMET-FLUORIDE
..... 164, 166, 277, 342
DAYBUE 139
DAYBUE STIX 139
daysee 229, 239, 252
DEBACTEROL 203, 334
deblitane 229, 252
deferasirox 216, 217
deferasirox granules 216
deferiprone 217
DELESTROGEN 239, 276
DELSTRIGO 32, 33
delyla 229, 239, 252
demeclocycline hcl 43
DENAVIR 320
DENGVAXIA 60
DENTA 5000 PLUS 164, 166, 277
DENTA 5000 PLUS
SENSITIVE 166, 277
DENTAGEL 164, 166, 277
DEPAKOTE 123, 128, 131, 142
DEPAKOTE ER
..... 123, 128, 131, 142
DEPAKOTE SPRINKLES
..... 123, 128, 131
DEPEN TITRATABS . 15, 217, 282
DEPO-ESTRADIOL 239, 276
DEPO-PROVERA 229, 252
DEPO-SUBQ PROVERA 104
..... 229, 252
DEPO-TESTOSTERONE 223, 225
DERMACINRX UREA
..... 89, 183, 205, 332
DERMACURE ... 89, 183, 205, 332
DERMA-SMOOTHE/FS BODY
..... 198, 325
DERMA-SMOOTHE/FS
SCALP 198, 325
DERMOTIC 198, 325
DESCOVY 33, 38
desipramine hcl 162
desloratadine 20, 310
DESMODA 81, 249
desmopressin ace spray
refrig 81, 249
desmopressin acetate 81, 249
DESMOPRESSIN ACETATE
..... 81, 249
desmopressin acetate pf 81, 249
desmopressin acetate spray
..... 81, 249
desonide 325
desoximetasone 325
DESVENLAFAXINE ER 159
desvenlafaxine succinate er 159
dexamethasone 198, 219
dexamethasone intensol
..... 198, 219
dexamethasone sodium
phosphate 198
DEXCOM G6 RECEIVER 172
DEXCOM G6 SENSOR 172
DEXCOM G6 TRANSMITTER 172
DEXCOM G7 15 DAY
SENSOR 172
DEXCOM G7 RECEIVER 172
DEXCOM G7 SENSOR 172
dexmethylphenidate hcl 156
dexmethylphenidate hcl er ... 155
dextroamphetamine sulfate . 119
dextroamphetamine sulfate
er 119
dextromethorphan-quinidine
..... 139
DIABECIN HR 319, 334

DIABETES MONITOR DIGIT ADD-ON 172, 293
DIABETES MONITOR DIGIT SOLN 172, 293
DIACOMIT 123, 142
DIASTIX REAGENT 181
diazepam 136, 138
diazepam intensol 136, 138
diazoxide 226
dichlorphenamide 88, 277
diclofenac potassium 148
diclofenac potassium(migraine) 131, 148
diclofenac sodium 148, 157, 164, 203, 335
diclofenac sodium er 148
diclofenac-misoprostol 148, 215
dicloxacillin sodium 40
dicyclomine hcl 66
DIFICID 39, 40
diflorasone diacetate 326
diflunisal 148, 157
difluprednate 198
digoxin 94, 100
dihydroergotamine mesylate 71, 131
DILANTIN 102, 144
DILANTIN INFATABS 102, 144
DILANTIN-125 ..... 102, 144
diltiazem hcl 97, 98, 99, 105, 116
diltiazem hcl er 97, 98, 99, 105, 116
diltiazem hcl er beads 97, 98, 99, 105, 116
diltiazem hcl er coated beads 97, 98, 99, 105, 116
dilt-xr 97, 98, 99, 105, 116
dimethyl fumarate 266, 287
dimethyl fumarate starter pack 267, 287
DIPENTUM 209
diphenhydramine hcl 17, 18, 68, 122, 133, 301, 305
diphenoxylate-atropine .. 66, 207
DIPROLENE 219, 326
dipyridamole 87, 113, 116, 180
diskets 150
disopyramide phosphate 102
disulfiram 15, 273
divalproex sodium 123, 128, 131, 142
divalproex sodium er 123, 128, 131, 142
DIVIGEL 239, 276
dofetilide 104
DOJOLVI 182
dolishale 229, 239, 252
donepezil hcl 71
DOPTELET 79
DOPTELET SPRINKLE 79
DORZOLAMIDE HCL 196
dorzolamide hcl 196
dorzolamide hcl-timolol mal 196
dorzolamide hcl-timolol mal pf 196
dotti 239, 276
DOVATO 31, 33
doxazosin mesylate 71, 90, 95
doxepin hcl 162, 319
doxercalciferol 347
doxycycline hyclate .. 24, 43, 316
doxycycline monohydrate 24, 25, 43, 316
doxylamine-pyridoxine 208
DRIZALMA SPRINKLE 159
dronabinol 208, 213
DROPLET MEDLANCE LANCET 30G 172
DROPLET MICRON 172
DROPSAFE ACTI-LANCE 23G 172
DROPSAFE ACTI-LANCE LANCET 17G 172
DROPSAFE ACTI-LANCE LANCET 23G 173
DROPSAFE ACTI-LANCE LANCET 28G 173
DROPSAFE AUTOPROTECT DUO 173
DROPSAFE ERGOLANCE LANCET 21G 173
DROPSAFE ERGOLANCE LANCET 25G 173
DROPSAFE ERGOLANCE LANCET 30G 173
DROPSAFE HAEMOLANCE LANCET 1.5 173
DROPSAFE HAEMOLANCE LANCET 18G 173
DROPSAFE HAEMOLANCE LANCET 21G 173
DROPSAFE HAEMOLANCE LANCET 25G 173
DROPSAFE HAEMOLANCE LANCET 28G 173
DROPSAFE MEDISAFE LANCET 23G 173
DROPSAFE MEDISAFE LANCET 29G 173
DROPSAFE MEDLANCE LANCET 0.8MM 173
DROPSAFE MEDLANCE LANCET 21G 173
DROPSAFE MEDLANCE LANCET 25G 173
DROPSAFE MEDLANCE LANCET 30G 173
DROPSAFE SAFETY SYRINGE/NEEDLE 173
DROPSAFE SICURA 173
drospiren-eth estrad-levomefol 230, 239, 252, 344
drospirenone-ethinyl estradiol 230, 239, 252
DROXIA 47
droxidopa 64
DRYSOL 320
DUAVEE 237, 239
DUETACT 261, 262
DULERA 74, 219
duloxetine hcl 142, 159
DUOPA 141
DUPIXENT 306, 329, 330, 338
DUREX EXTRA SENSITIVE THIN 297
DUREX TROPICAL 297
dutasteride 273
dutasteride-tamsulosin hcl 72, 273
DUVYZAT 293
DYANAVEL XR 119
E.E.S. GRANULES 29
EASIVENT 173
EASY COMFORT SHARPS CONTAINER 173
EASY TOUCH HEALTHPRO HIGH/LOW 173
EASYGEL 164, 166, 278
EASYMAX 15 LEVEL 2-3 CONTROL 173
EASYMAX CONTROL 173
EASYMAX CONTROL NORMAL/HIGH 173
EBGLYSS 330
econazole nitrate 321
ECONAZOLE NITRATE 321

econtra one-step ... 225, 230, 252
ECOZA 321
EC-RX DHEA 293
EDARBYCLOR 92, 187
EDEX (2 CARTRIDGE) ... 108, 116
EDEX (6 CARTRIDGE) ... 108, 116
EDLUAR 133, 146
EDURANT PED 32
EEMT 224, 239
EEMT HS 223, 239
efavirenz 32
efavirenz-emtricitab-tenofo df 32, 33
efavirenz-lamivudine-tenofovir 32, 34
EFFER-K 185
effer-k 185
EGATEN 23
EGRIFTA SV 261
EGRIFTA WR 261
ELESTRIN 239, 276
eletriptan hydrobromide 160
elinest 230, 239, 252
ELIQUIS 78
ELIQUIS (1.5 MG PACK) 77
ELIQUIS (2 MG PACK) 77
ELIQUIS DVT/PE STARTER PACK 77
ELITE-OB 85, 342, 344
elixophyllin 108, 156, 182, 313, 341
ELLA 230, 252
ELMIRON 293
ELOCTATE 81
eltrombopag olamine 79
eluryng 230, 239, 252
EMBECTA AUTOSHIELD DUO 174
EMBECTA INS SYR U/F 1/2 UNIT 174
EMBECTA INSULIN SYR ULTRAFINE 174
EMBECTA INSULIN SYRINGE 174
EMBECTA INSULIN SYRINGE U-100 174
EMBECTA INSULIN SYRINGE U-500 174
EMBECTA PEN NEEDLE NANO 174
EMBECTA PEN NEEDLE NANO 2 GEN 174
EMBECTA PEN NEEDLE ULTRAFINE 174
EMBRACE PEN NEEDLES 174
EMBRACE WAVE GLUCOSE CONTROL 174
EMEND 215
EMGALITY 139
EMPAVELI 280
EMSAM 145, 146
emtricitabine 34
emtricitabine-tenofovir df 34, 38
emtricitab-rilpivir-tenofov df 32, 34, 38
EMTRIVA 34
EMVERM 23
emzahh 230, 252
enalapril maleate 92, 93
enalapril-hydrochlorothiazide 93, 187
ENBRACE HR .. 85, 293, 342, 344
ENBREL 272, 283, 287
ENBREL MINI 272, 283, 287
ENBREL SURECLICK 272, 283, 287
ENBUMYST 89, 183
ENCARE 297
ENDARI 293, 338
endocet 120, 147, 150
ENDOMETRIN 252
ENFLONSIA 37
ENGERIX-B 60
enilloring 230, 239, 252
ENLITE GLUCOSE SENSOR 174
enoxaparin sodium 84
ENSACOVE 47
enskyce 230, 239, 252
ENSPRYNG 270, 288
ENSTILAR 322, 326, 338
entacapone 139
ENTADFI 113, 114, 273, 323
entecavir 38
ENTRESTO 91, 92, 114
ENTYVIO PEN 206, 213, 265
enulose 182
EOHILIA 219
EPIDIOLEX 123
EPIFOAM 319, 326
epinastine hcl 20, 192
epinephrine 64, 299
EPINEPHRINE 65, 299
EPIVIR 34
eplerenone 89, 110, 114, 115, 184
EQUETRO 123, 128
ergocalciferol 347
ERGOMAR 71, 131
ergotamine-caffeine 71, 131, 156
ERIVEDGE 47
ERLEADA 47
erlotinib hcl 47
errin 230, 252
ERY 29, 192, 316
ERYPED 400 29
erythromycin 30, 192, 316
erythromycin base 29
erythromycin ethylsuccinate 29
ESCITALOPRAM OXALATE .. 161
escitalopram oxalate 161
eslicarbazepine acetate 123, 144
esomeprazole magnesium ... 216
est estrogens-methyltest 224, 240
est estrogens-methyltest ds 224, 240
est estrogens-methyltest hs 224, 240
estarylla 230, 240, 252
estazolam 138
estradiol 240, 276
estradiol valerate 240, 276
estradiol-norethindrone acet 240, 252
ESTRATEST H.S. 224, 240
ESTRING 240, 276
estrogens conjugated ... 240, 276
eszopiclone 133, 146
ETCAMAH 47
ethacrynic acid 89, 109, 183
ethambutol hcl 27
ethosuximide 162
etodolac 148, 157
etodolac er 148, 157
etonogestrel-ethinyl estradiol 230, 240, 252
etoposide 47
etravirine 32
EUCRISA 318, 335
EURAX 336
EVAMIST 240, 277
EVEKEO 119
everolimus 47, 48, 267, 291
EVEXITHROID 262
EVOTAZ 35, 293
EVRYSDI 293

EXELDERM 321
exemestane 48, 224
EXODERM 17, 318, 332
EXXUA 161
EXXUA TITRATION PACK 161
EYSUVIS 198
ezetimibe 102
ezetimibe-simvastatin ... 102, 109
FABHALTA 264, 280
falmina 230, 240, 252
famciclovir 39
famotidine 19, 214
FANAPT 134
FANAPT TITRATION PACK A 134
FANAPT TITRATION PACK B 134
FANAPT TITRATION PACK C 134
FASENRA PEN 306
FC2 FEMALE CONDOM 297
febuxostat 274
FEIBA 82
feirza 1.5/30 ..... 230, 240, 253
feirza 1/20 ..... 230, 240, 253
felbamate 123
FELBATOL 123
felodipine er 106, 107
FEM PH 334, 338
FEMCAP 297
FEMLYV 230, 240, 253
FEMRING 241, 277
fenofibrate 108
fenofibrate micronized 108
fenofibric acid 108
fentanyl 150
FERRIPROX 217
FERRIPROX TWICE-A-DAY 217
FETZIMA 159
FETZIMA TITRATION 160
fidaxomicin 39, 40
FILSPARI 114, 285, 293, 305
FILSUVEZ 338
FINACEA 316, 338
finasteride 273, 323
fingolimod hcl 271, 288
FINTEPLA 123
finzala 230, 241, 253
FIORICET 120, 136, 148, 156
FIRDAPSE 71, 293
FIRMAGON 48, 225
FIRMAGON (240 MG DOSE) 48, 225
FIRST-LANSOPRAZOLE 216
FIRVANQ 30
FLAREX 198
flavoxate hcl 340
flecainide acetate 103
FLEXICHAMBER 174
FLEXICHAMBER ADULT MASK/SMALL 174
FLEXICHAMBER CHILD MASK/LARGE 174
FLEXICHAMBER CHILD MASK/SMALL 174
FLOLIPID 109
FLORIVA 164, 166, 278, 347
FLORIVA PLUS 164, 166, 278, 342
FLOTREX 164, 166, 278, 342
FLUAD 60
FLUARIX 60
FLUCELVAX 60
fluconazole 28
flucytosine 41
fludrocortisone acetate 219
FLULAVAL 61
FLUMIST 61
flunisolide 198, 219, 302, 307
fluocinolone acetonide 198, 326
fluocinolone acetonide body 198, 326
fluocinolone acetonide scalp 198, 326
fluocinonide 326
fluocinonide emulsified base 326
FLUORIDEX 166, 278
FLUORIDEX DAILY RENEWAL 164, 166, 278
FLUORIDEX ENHANCED WHITENING 166, 278
FLUORIMAX 5000 ..... 166, 278
FLUORIMAX 5000 SENSITIVE 166, 278
fluorometholone 198
fluorouracil 48, 313, 338
fluoxetine hcl 161
fluoxetine hcl (pmdd) 161
fluphenazine hcl 154
flurandrenolide 326
flurazepam hcl 138
flurbiprofen 148, 157, 203
flurbiprofen sodium 158, 204
FLUTICASONE FUROATE-VILANTEROL 74, 198, 219, 302
fluticasone propionate 199, 219, 220, 302, 307, 326
FLUTICASONE PROPIONATE HFA 198, 199, 219, 302, 307
fluticasone propionate hfa 199, 219, 302, 308
FLUTICASONE-SALMETEROL 74, 199, 220, 302
fluticasone-salmeterol 74, 199, 220, 302
fluvastatin sodium 109
fluvastatin sodium er 109
fluvoxamine maleate 161
fluvoxamine maleate er 161
FLUZONE 61
FLUZONE HIGH-DOSE 61
FML FORTE 199
FML LIQUIFILM 199
FOCALIN 156
folic acid 345
FOLLISTIM AQ 246
fondaparinux sodium 77, 84
FONDCIRCLE CONTROL SOLUTION 174
FONDCIRCLE LANCING DEVICE 174
FONDCIRCLE SINGLE USE LANCETS 175
FORA TEST N' GO ADVANCE 175
FORA TEST N'GO ADV-VOICE-6 CON 180
FORANE 144
formaldehyde 181
formoterol fumarate 74, 311
FORZINITY 293
FOSAMAX 277
FOSAMAX PLUS D 277, 347
fosamprenavir calcium 35
fosfomycin tromethamine 44
fosinopril sodium 93
fosinopril sodium-hctz 93, 187
FOSRENOL 184, 273
FOTIVDA 48
FRAGMIN 84
FREESTYLE LIBRE 14 DAY READER 175
FREESTYLE LIBRE 14 DAY SENSOR 175
FREESTYLE LIBRE 2 PLUS SENSOR 175
FREESTYLE LIBRE 2 READER 175
FREESTYLE LIBRE 2 SENSOR 175

FREESTYLE LIBRE 3 PLUS SENSOR 175
FREESTYLE LIBRE 3 READER 175
FREESTYLE LIBRE 3 SENSOR 175
frovatriptan succinate 160
FRUZAQLA 48
ft aspirin 87, 88, 131, 159
ft aspirin adult low dose 87, 88, 131, 159
ft aspirin low dose 87, 88, 131, 159
ft clearlax 210
ft folic acid 345
ft laxative 210
ft magnesium citrate 210
ft naloxone hcl 15, 153
ft nicotine 63, 68
ft nicotine mini 63, 68
furosemide 89, 109, 183
fyavolv 241, 253
FYCOMPA 123
FYREMADEL 225
gabapentin 120, 123, 124, 142, 143
GALAFOLD 189, 294
galantamine hydrobromide 72
galantamine hydrobromide er 71
galbriela 230, 241, 253
gallifrey 253
GALZIN 185
ganirelix acetate 225
GARDASIL 9 61
gatifloxacin 193
GATTEX 211, 213
gavilax 210
gavilyte-c 210
gavilyte-g 210
gavilyte-n with flavor pack 210
GAVRETO 48
gefitinib 48
GELFILM 82
gemfibrozil 108
gemmily 230, 241, 253
GEMTESA 341
generlac 182
gengraf 195, 264, 283, 288, 291
gentamicin sulfate 22, 193, 316
gentle laxative 210
GENVOYA 32, 34
GILENYA 271, 288
GILOTRIF 48
glatiramer acetate 263, 288
glatopa 263, 288
GLEOSTINE 48
glimepiride 261
glipizide 261
glipizide er 261
glipizide-metformin hcl 227, 261
GLOPERBA 274
glucagon emergency kit 15, 246, 273
GLUCAGON EMERGENCY KIT 15, 246, 273
GLUCOTROL XL 261
glutaraldehyde 181
glyburide 262
glyburide-metformin 227, 262
glycerol phenylbutyrate 182
glycolax 210
glycopyrrolate 66, 320
glydo 319
GLYXAMBI 236, 260
GOLYTELY 210
GOMEKLI 48
GONAL-F 246
GONAL-F RFF REDIJECT 246
goodsense aspirin low dose 87, 88, 131, 159
goodsense clearlax 210
goodsense nicotine 63, 68
goodsense nicotine policrilex 63, 68
GORDOFILM 322, 332
granisetron hcl 207
GRANISOL 207
GRASTEK 58
griseofulvin microsize 23, 24
griseofulvin ultramicrosize 24
guaifenesin-codeine 301, 305
guanfacine hcl 101, 108, 140
guanfacine hcl er 139
GUARDIAN 4 GLUCOSE SENSOR 175
GUARDIAN 4 TRANSMITTER 175
GUARDIAN REAL-TIME CHARGER 175
GUARDIAN REAL-TIME TEST PLUG 175
GUARDIAN SENSOR 3 175
GVOKE HYPOPEN 1-PACK 15, 246, 273
GVOKE HYPOPEN 2-PACK 15, 246, 273
GVOKE KIT 15, 246, 273
GVOKE PFS 15, 246, 274
GYNAZOLE-1 321
habitrol 63, 68
HAEGARDA 280, 281
hailey 1.5/30 ..... 230, 241, 253
hailey 24 fe 230, 241, 253
hailey fe 1.5/30 ..... 230, 241, 253
hailey fe 1/20 ..... 230, 241, 253
halcinonide 326
halobetasol propionate 326
haloperidol 138
haloperidol lactate 138
HALUCORT 338
HAN-EASE 175
HARLIKU 190
HAVRIX 61
heather 230, 253
HEMANGEOL 70, 95, 101, 103, 111, 132
HEMATINIC/FOLIC ACID 85, 345
HEMICLOR 90, 188
HEMLIBRA 82
HEMMOREX-HC 199, 220, 326
HEMOFIL M 82
heparin na (pork) lock flsh pf 84
heparin sod (pork) lock flush 84
heparin sodium (porcine) 84
heparin sodium (porcine) +rfid 84
heparin sodium (porcine) pf 84
HEPCLUDEX 29
HEPLISAV-B 61
HEPZATO W/50MM CATHETER 48
HEPZATO W/62MM CATHETER 49
her style 225, 230, 253
HERNEXEOS 49
HETLIOZ 133, 145
HETLIOZ LQ 133, 145
HIBERIX 61
HUMALOG 259
HUMALOG KWIKPEN 259
HUMALOG MIX 50/50 KWIKPEN 259
HUMALOG MIX 75/25 KWIKPEN 259
HUMALOG MIX 75/25 VIAL 259
HUMALOG U-100 JUNIOR KWIKPEN 259

HUMATE-P 82
HUMATIN 21, 22
HUMULIN 70/30 KWIKPEN 247, 259
HUMULIN 70/30 VIAL 247, 259
HUMULIN N KWIKPEN 248
HUMULIN N VIAL 248
HUMULIN R U-500 KWIKPEN 259
HUMULIN R VIAL 260
HYCAMTIN 49
hydralazine hcl 108
HYDRO 40 ..... 89, 183, 205, 332
hydrochlorothiazide 89, 115, 187, 188
hydrocod poli-chlorphe poli er 18, 19, 301
hydrocodone bitartrate er 150
hydrocodone bit-homatrop mbr 66, 301
hydrocodone-acetaminophen 120, 121, 148, 150
hydrocodone-ibuprofen 148, 150, 158
hydrocortisone 199, 220, 327
hydrocortisone (perianal) 199, 220, 326
hydrocortisone ace-pramoxine 199, 220, 319, 326
HYDROCORTISONE ACETATE 199, 220, 326
hydrocortisone acetate 199, 220, 327
hydrocortisone butyrate 199, 220, 327
hydrocortisone valerate 199, 220, 327
hydrocortisone-acetic acid 200, 203, 220, 327
hydrocort-pramoxine (perianal) 200, 220, 319, 327
hydromorphone hcl 150
hydromorphone hcl er 150
hydroxychloroquine sulfate 25, 265, 283, 288
hydroxyurea 49
hydroxyzine hcl 18, 19, 133
hydroxyzine pamoate 18, 19, 133
HYFTOR 270, 291, 330, 338
HYMPAVZI 82
hyoscyamine sulfate 15, 16, 66, 299
hyoscyamine sulfate er 15, 66, 299
hyoscyamine sulfate sl 16, 66, 299
hyosyne 16, 66, 299
HYPERSAL 306
HYRNUO 49
ibandronate sodium 277
IBRANCE 49
IBTROZI 49
ibuprofen 132, 149, 158
icatibant acetate 88, 277, 281
iclevia 230, 241, 253
ICLUSIG 49
ICOTYDE 330
IDELVION 82
IDHIFA 49
IDVYNSO 33, 34
IHEALTH CONTROL SOLUTION 175
IHEALTH LANCING DEVICE . 175
ILEVRO 204
imatinib mesylate 49
IMBRUVICA 49
IMCIVREE 121, 217
imipramine hcl 163
imipramine pamoate 163
imiquimod 313, 338
IMKELDI 49
IMPAVIDO 26, 37
IMPOYZ 327
IMVEXXY MAINTENANCE PACK 241
IMVEXXY STARTER PACK ... 241
INBRIJA 141
incassia 230, 253
INCRELEX 261
indapamide 90, 115, 188
indomethacin .149, 158, 274, 275
indomethacin er 149, 158, 274
INFANRIX 59, 61
INGREZZA 163
INLURIYO 49
INLYTA 50
INPEN 100-BLUE-LILLY-HUMALOG 175
INPEN 100-BLUE-NOVOLOG-FIASP 176
INPEN 100-GREY-LILLY-HUMALOG 176
INPEN 100-GREY-NOVOLOG-FIASP 176
INPEN 100-PINK-LILLY-HUMALOG 176
INPEN 100-PINK-NOVOLOG-FIASP 176
INQOVI 50
INSPIREASE RESERVOIR BAGS 176
INSULIN LISPRO 259
INSULIN LISPRO (1 UNIT DIAL) 259
INSULIN LISPRO JUNIOR KWIKPEN 259
INSULIN LISPRO PROT & LISPRO 259
INSULIN PEN NEEDLES 176
INSULIN SYRINGES 176
INSUPEN32G EXTR3ME 176
INTELENCE 33
INTRAROSA 220
introvale 230, 241, 253
INVELTYS 200
INZIRQO 90, 188
iodine strong 16, 24, 226, 305, 320
iodine tincture 320, 334
IOPIDINE 191, 203
IPOL 61
ipratropium bromide 66, 299
ipratropium bromide hfa 66, 299
ipratropium-albuterol 66, 74, 299
IQIRVO 211, 213
irbesartan 91, 92
irbesartan-hydrochlorothiazide 92, 188
IRESSA 50
ISENTRESS 32
ISENTRESS HD 32
isibloom 231, 241, 253
isoflurane 144
isoniazid 27
isosorb dinitrate-hydralazine 108, 111, 112
isosorbide dinitrate 111, 112
isosorbide mononitrate 111, 112
isosorbide mononitrate er 111, 112
isotretinoin 332, 338
isradipine 106, 107
ISTURISA 220, 294
ITOVEBI 50
itraconazole 28
ivabradine hcl 100, 116
ivermectin 23

IWILFIN.....50
IYUZEH.....205
jaimiess.....231, 241, 253
JAKAFI.....50, 331
JAKAFI XR.....50, 331
JARDIANCE.....260
JASCAYD..... 300, 308, 335
jasmiel.....231, 241, 253
JAVADIN.....65, 101
JAVYGTOR.....189, 294
JAYPIRCA..... 50
jencycla.....231, 253
JENTADUETO.....227, 236
JENTADUETO XR..... 227, 236
jinteli.....241, 253
JOENJA..... 288
jolessa.....231, 241, 253
JORNAY PM.....156
JOURNAVX..... 121
joyeaux.....231, 241, 253
JUBLIA.....321
juleber..... 231, 241, 253
JULUCA.....32, 33
junel 1.5/30.....231, 241, 253
junel 1/20.....231, 241, 253
junel fe 1.5/30..... 231, 241, 253
junel fe 1/20..... 231, 241, 253
junel fe 24..... 231, 241, 253
JUST RIGHT 5000.....166, 278
JUXTAPID.....94, 110
JYLAMVO. 50, 265, 283, 288, 291
kaitlib fe..... 231, 241, 253
KALETRA.....35
kalliga.....231, 241, 254
KALYDECO..... 304
KAPSPARGO SPRINKLE
..... 75, 95, 101, 103, 111
KARBINAL ER..... 17, 18, 305
kariva.....231, 241, 254
KATERZIA..... 106, 107, 116
kelnor 1/35..... 231, 241, 254
KEPPRA..... 124
KEPPRA XR..... 124
KERENDIA.....110
KESIMPTA.....270, 288
ketoconazole..... 28, 321
ketodan..... 28, 321
KETO-DIASTIX.....181
KETONE CARE..... 181
ketorolac tromethamine
..... 149, 158, 204
KETOSTIX..... 181
KEVZARA..... 269, 283
KHINDIVI..... 200, 220, 327
KINERET..... 269, 283, 288
KISQALI (200 MG DOSE).....50
KISQALI (400 MG DOSE).....50
KISQALI (600 MG DOSE).....50
KLARON..... 316
klayesta.....41, 336
KLISYRI (250 MG)..... 313, 338
KLISYRI (350 MG)..... 313, 338
klor-con.....185
klor-con 10.....185
klor-con m10.....185
klor-con m15.....185
klor-con m20.....185
KLOXXADO..... 16, 153
KOATE.....82
KOATE-DVI.....82
KOMZIFTI..... 50
KOSELUGO.....51
KOURZEQ..... 327
KOVALTRY.....82
K-PHOS..... 185
K-PHOS NO 2.....181
K-PHOS-NEUTRAL..... 185
KRAZATI.....51
KRINTAFEL..... 25
KRISTALOSE..... 182
KT TAPE CGM PATCH..... 176
kurvelo..... 231, 242, 254
KYGEVVI..... 294
KYZATREX.....224, 225
labetalol hcl
..... 70, 72, 90, 95, 101, 103, 111
lacosamide..... 124, 144
lactulose..... 182
lactulose encephalopathy.... 182
LAGEVRIO.....39
LAMICTAL..... 124, 128, 129
LAMICTAL ODT.....124, 128
LAMICTAL STARTER.....124, 129
LAMICTAL XR..... 124, 129
lamivudine..... 34
lamivudine-zidovudine..... 34
lamotrigine.....124, 129
lamotrigine er..... 124, 129
lamotrigine odt.....124, 129
lamotrigine starter kit-blue
..... 124, 129
lamotrigine starter kit-green
..... 125, 129
lamotrigine starter kit-orange.....125, 129
LAMPIT.....26
LANCETS..... 176
LANCETS 28G THIN..... 176
LANCETS SUPER THIN.....176
LANOXIN..... 94, 100
lansoprazole.....216
lanthanum carbonate....184, 274
LANTUS SOLOSTAR..... 248
LANTUS U-100 VIAL..... 248
lapatinib ditosylate..... 51
larin 1.5/30..... 231, 242, 254
larin 1/20..... 231, 242, 254
larin 24 fe..... 231, 242, 254
larin fe 1.5/30..... 231, 242, 254
larin fe 1/20..... 231, 242, 254
LASIX.....89, 109, 183
LASIX ONYU..... 89, 183
latanoprost..... 205
laxative osmotic.....210
LAZCLUZE.....51
lederle leucovorin... 17, 274, 345
LEDIPASVIR-SOFOSBUVIR
..... 30, 31
leflunomide....270, 283, 288, 291
lenalidomide.....51, 288
LENVIMA.....51
LEQEMBI IQLIK.....270
lessina.....231, 242, 254
letrozole.....51, 224
leucovorin calcium. 17, 274, 345
LEUKERAN.....51
LEUKINE.....79
leuprolide acetate..... 51, 246
levalbuterol hcl.....74, 311
LEVALBUTEROL HFA.....74, 311
LEVBID..... 16, 66, 299
levetiracetam.....125
LEVETIRACETAM.....125
levetiracetam er.....125
levobunolol hcl.....196
levocarnitine.....294
levocarnitine sf.....294
levocetirizine dihydrochloride.....20
levofloxacin..... 27, 41, 193, 316
levonest..... 231, 242, 254
levonorgest-eth estrad 91-day.....231, 242, 254
levonorgest-eth estradiol-iron..... 231, 242, 254
levonorgestrel..... 225, 231, 254
levonorgestrel-ethinyl estrad
..... 231, 242, 254

levonorg-eth estrad triphasic 231, 242, 254
levorphanol tartrate 151
LEVOTHYROXINE SODIUM .. 262
levothyroxine sodium 262
levoxyl 262
LEVSIN 16, 66, 300
LEVSIN/SL 16, 66, 300
LEVULAN KERASTICK .. 313, 339
l-glutamine 294, 339
lidocaine 319
lidocaine hcl 204, 319
lidocaine hcl urethral/mucosal 319
lidocaine viscous hcl 204
lidocaine-prilocaine 319
LIFYORLI (125 MG DOSE) 51
LIFYORLI (150 MG DOSE) . 51, 52
LIKMEZ 21, 26, 38, 209, 316
linezolid 40
LINZESS 206, 213
liomny 262
liothyronine sodium 262
LIPOFEN 108
liraglutide 122, 247
lisdexamfetamine dimesylate 119, 120
lisinopril 93
lisinopril-hydrochlorothiazide 93, 188
LITFULO 331, 339
lithium 129
lithium carbonate 129
lithium carbonate er 129
LITHOBID 129
LITHOSTAT 182
LIVALO 109
LIVDELZI 211
LIVMARLI 211, 213
LIVTENCITY 27
LO LOESTRIN FE ... 232, 242, 254
LODOCO 77, 294
lofexidine hcl 65
lojaimiess 232, 242, 254
LOKELMA 184
LOMOTIL 67, 207
lomustine 52
LONSURF 52
LOPID 108
lopinavir-ritonavir 35
LOPRESSOR 75, 95, 101, 103, 188
lorazepam 136, 138
lorazepam intensol 136, 138
LORBRENA 52
LOREEV XR 137, 138
loryna 232, 242, 254
losartan potassium 91, 92
losartan potassium-hctz . 92, 188
LOTEMAX 200
LOTEMAX SM 200
LOTENSIN 93, 94
LOTENSIN HCT 93, 188
loteprednol etabonate 200
loteprednol-tobramycin 193, 200
lovastatin 109
low-ogestrel 232, 242, 254
loxapine succinate 132, 141
lo-zumandimine 232, 242, 254
lubiprostone 206, 213
LUGOLS STRONG IODINE 320, 334
luizza 1.5/30 ..... 232, 242, 254
luizza 1/20 ..... 232, 242, 254
LULICONAZOLE 321
LUMAKRAS 52
LUMRYZ 140, 164, 275
LUMRYZ STARTER PACK 164, 275
LUPKYNIS 271, 291
lurasidone hcl 134
LURBIRO 149, 158, 204
lutera 232, 242, 254
LUZU 321
lyleq 232, 254
lyllana 242, 277
LYNKUET 140
LYNPARZA 52
LYRICA 125, 142, 143
LYSODREN 52
LYTGOBI (12 MG DAILY DOSE) 52
LYTGOBI (16 MG DAILY DOSE) 52
LYTGOBI (20 MG DAILY DOSE) 52
LYUMJEV KWIKPEN 259
LYUMJEV VIAL 259
lyza 232, 254
macitentan 116, 305, 311
MACROBID 44
magnesium citrate 210
MALARONE 25
malathion 336
maraviroc 31
marlissa 232, 242, 254
MARPLAN 146
MATULANE 52
matzim la 97, 98, 99, 105, 116
MAVYRET 30, 31
MAXIDEX 200
MAXITROL 193, 200
maxi-tuss ac 301, 305
MAYZENT 271, 288
MAYZENT STARTER PACK 271, 288
me/naphos/mb/hyo1 . 44, 67, 294
meclofenamate sodium 149, 158
MEDROL 221
medroxyprogesterone acetate 232, 254, 255
mefenamic acid 149, 158
mefloquine hcl 25
megestrol acetate 52, 255
MEKINIST 52, 53
MEKTOVI 53
meleya 232, 255
MELOXICAM 149, 158
meloxicam 149, 158
memantine hcl 140
memantine hcl er 140
memantine hcl-donepezil hcl er 72, 140
MENOPUR 246
MENOSTAR 242, 277
MENQUADFI 61
MENVEO 61
meperidine hcl 151
meprobamate 133, 146
mercaptopurine 53, 267, 291
mesalamine 209
mesalamine-cleanser 209
mesna 297
MESNEX 297
MESTINON 72
metaxalone 69
metformin hcl 227
metformin hcl er 227
methadone hcl 151
methadone hcl intensol 151
METHADOSE 151
methadose 151
METHADOSE SUGAR-FREE . 151
methamphetamine hcl 120
methazolamide 88, 100, 196
methenamine hippurate 44
methenamine mandelate 44
METHERGINE 298
methimazole 226

METHITEST 224
methocarbamol 33, 69
methotrexate sodium 53, 266, 283, 289, 291, 292
methotrexate sodium (pf) 53, 266, 283, 288, 291
methoxsalen rapid 335
methscopolamine bromide 67
methsuximide 162
methyl salicylate 322
methyldopa 65, 101, 108
methylergonovine maleate ... 298
METHYLIN 156
methylphenidate 157
METHYLPHENIDATE ER 156
methylphenidate hcl 156, 157
methylphenidate hcl er 156
methylphenidate hcl er (cd) . 156
methylphenidate hcl er (la) .. 156
methylphenidate hcl er (xr) .. 156
methylprednisolone 221
methyltestosterone 224
metoclopramide hcl 215
metolazone 90, 115, 188
METOPIRONE 181
metoprolol succinate er 75, 95, 101, 103, 111
metoprolol tartrate 75, 96, 101, 103, 111
METOPROLOL TARTRATE 75, 96, 103
metoprolol-hydrochlorothiazide 96, 101, 188
metronidazole 21, 26, 38, 209, 210, 316, 317
metyrosine 181, 294
mexiletine hcl 102
MIACALCIN 226, 277
mibelas 24 fe 232, 242, 255
miconazole 3 321
MICONAZOLE-ZINC OXIDE-PETROLAT 320, 321, 329
microgestin 1.5/30 . 232, 242, 255
microgestin 1/20 .... 232, 242, 255
microgestin fe 1.5/30 ..... 232, 242, 255
microgestin fe 1/20 232, 242, 255
MICROLET NEXT LANCETS . 176
MICROLET NEXT LANCING DEVICE 176
midazolam hcl 138
midodrine hcl 65
MIEBO 195, 203
MIFEPREX 298
mifepristone 224, 298
MIGERGOT 71, 132, 157
miglitol 223
miglustat 190, 294
mili 232, 243, 255
milnacipran hcl 142, 160
milophene 237
mimvey 243, 255
MINIMED INSTINCT GLUC SENSOR 177
minocycline hcl . 25, 43, 193, 317
minocycline hcl er 25, 43, 193, 317, 339
minoxidil 108, 323
minzoya 232, 243, 255
MIPLYFFA 189
mirabegron er 341
mirtazapine 127, 161, 162
misoprostol 215
MITIGARE 275
MITOSOL 193
mm aspirin 87, 88, 132, 159
mm clearlax 210
M-M-R II 61
M-NATAL PLUS 85, 342, 345
MNEXSPIKE 61
MOBI CONNECT LANCING DEVICE 177
MOBI CONNECT TWIST LANCETS 177
MOBILE LANCETS 30G 177
modafinil 164
MODEYSO 53
moexipril hcl 93, 94
molindone hcl 132, 141
mometasone furoate 200, 221, 302, 307, 327
mono-linyah 232, 243, 255
MONSELS FERRIC SUBSULFATE 82
montelukast sodium 306
morphine sulfate 151
morphine sulfate (concentrate) 151
morphine sulfate er 151
morphine sulfate er beads ... 151
MOTOFEN 67, 207
MOTPOLY XR 125, 144
MOUNJARO 247
moxifloxacin hcl 27, 42, 193, 317
moxifloxacin hcl (2x day) 41, 193
MOZOBIL 79
MUCOSITISRX 203
MULPLETA 79
MULTAQ 104
multivitamin w/fluoride 164, 166, 278, 342
multivitamin/fluoride 164, 165, 166, 278, 342, 345
multi-vitamin/fluoride 164, 166, 278, 342
multi-vitamin/fluoride/iron 85, 278, 342
mupirocin 317
mupirocin calcium 317
my choice 225, 232, 255
my way 225, 232, 255
MYALEPT 248
mycophenolate mofetil . 264, 292
mycophenolate sodium 292
mycophenolic acid 292
MYDAYIS 120
MYFEMBREE 225, 243, 255
MYHIBBIN 292
MYLERAN 53
MYRBETRIQ 341
MYSOLINE 135
MYTESI 207
MYXREDLIN 185, 260
nabumetone 149, 158
nadolol 70, 75, 90, 96, 101, 103, 111
naftifine hcl 314
NAFTIN 314
naloxone hcl 16, 153, 274
naltrexone hcl 15, 16, 63, 153, 273, 274
NAMZARIC 72, 140
naproxen 132, 149, 158, 275
naproxen dr ... 132, 149, 158, 275
naproxen sodium 132, 149, 158, 275
naproxen sodium er 132, 149, 158, 275
naratriptan hcl 160
NARCAN 16, 153
NARDIL 146
NASCOBAL 86, 345
NATACYN 194
NATAL PNV 85, 342, 345
NATAZIA 232, 243, 255
nateglinide 248
NAYZILAM 137, 138
nebivolol hcl 70, 96, 101, 103
NEBUPENT 26

NEBUSAL 306
necon 0.5/35 (28) ... 232, 243, 255
nefazodone hcl 162
NEFFY 65
NEMLUVIO 330
neomycin sulfate 22, 193, 317
neomycin-bacitracin zn-polymyx 193
neomycin-polymyxin-dexameth 193, 200
neomycin-polymyxin-gramicidin 193
neomycin-polymyxin-hc 193, 200
NEONATAL COMPLETE 85, 342, 345
NEONATAL PLUS 85, 342, 345
NEO-SYNALAR 317, 327
NEOTUSS PLUS .. 18, 20, 65, 301
NERLYNX 53
NESTABS 85, 342, 345
NESTABS ONE 85, 294, 342, 345
neuac 37, 317, 334
NEULASTA 79
NEUPRO 147
NEURONTIN 121, 125, 143
NEVANAC 204
nevirapine 33
nevirapine er 33
new day 225, 232, 255
NEXLETOL 90, 94
NEXLIZET 90, 94, 102
NEXTSTELLIS 232, 243, 255
NGENLA 249
niacin er (antihyperlipidemic) 94, 345
nicardipine hcl 106, 107, 116
NICORETTE 63, 64, 68
NICORETTE MINI 63, 68
nicotine 64, 68, 69
nicotine mini 64, 68
nicotine polacrilex 64, 68
nicotine polacrilex mini 64, 68
nicotine step 1 ..... 64, 68
nicotine step 2 ..... 64, 68
nicotine step 3 ..... 64, 68
NICOTROL NS 64, 69
nifedipine 106, 107, 116
nifedipine er 106, 107, 116
nifedipine er osmotic release 106, 107, 116
nikki 233, 243, 255
nilotinib hcl 53
nimodipine 106, 107, 117
NIMODIPINE 106, 107, 117
NINLARO 53
nintedanib esylate 300
nisoldipine er 106, 107
nitazoxanide 25, 26
nitro-bid 111, 112
NITRO-DUR 111, 112
nitrofurantoin 44
nitrofurantoin macrocrystal ... 44
nitrofurantoin monohydrate macrocrystals 44
nitroglycerin .. 111, 112, 323, 339
NITROSTAT 112
NITRO-TIME 112, 113
NIVA THYROID 262
NIVESTYM 79
nizatidine 19, 214
nora-be 233, 255
NORDIPEN 5 INJECTION DEVICE 177
NORDITROPIN FLEXPRO 249, 250, 261
norelgestromin-eth estradiol 233, 243, 255
norethin ace-eth estrad-fe 233, 243, 255
norethindrone 233, 256
norethindrone acetate 256
norethindrone acet-ethinyl est 233, 243, 256
norethindrone-eth estradiol 243, 256
norgestimate-eth estradiol 233, 243, 256
norgestimate-ethinyl estradiol triphasic . 233, 243, 256
NORLIQVA 106, 107, 117
norlyroc 233, 256
NORPACE 102
NORPRAMIN 163
nortrel 0.5/35 (28) .. 233, 243, 256
nortrel 1/35 (21) 233, 243, 256
nortrel 1/35 (28) 233, 243, 256
nortrel 7/7/7 ..... 233, 243, 256
nortriptyline hcl 163
NORVIR 35
NOURIANZ 118, 140
NOVAREL 246
NOVOEIGHT 82
NOVOFINE PEN NEEDLE 177
NOVOFINE PLUS PEN NEEDLE 177
NOVOPEN ECHO 177
NOVOSEVEN RT 82
NOXAFIL 28
np thyroid 262
NUBEQA 53
NUCALA 300
NUCORT 200, 221, 327
NUCYNTA ER 151
NUEDEXTA 140
NULEV 16, 67, 300
NUPLAZID 134
NURTEC 139
NUVESSA 21, 38, 317
NUWIQ 82, 83
NUZYRA 22
nylia 1/35 ..... 233, 243, 256
nylia 7/7/7 ..... 233, 243, 256
NYMALIZE 106, 107, 117
nystatin 41, 336
nystatin-triamcinolone 41, 327, 336
nystop 41, 336
OBIZUR 83
octreotide acetate 213, 260
OCUFLOX 42, 193
ODACTRA 58
ODEFSEY 33, 34, 39
ODOMZO 53
ofloxacin 42, 193
OGSIVEO 53
OHTUVAYRE 298
OJEMDA 53
OJJAARA 53
olanzapine 129, 134, 208
olanzapine-fluoxetine hcl 130, 134, 161, 208
olmesartan medoxomil 91, 92
olmesartan medoxomil-hctz 92, 188
olmesartan-amlodipine-hctz 92, 106, 188
olopatadine hcl 19, 192
OLUMIANT 269, 283
omega-3-acid ethyl esters 94, 113
omeprazole 216
OMLONTI 205
OMNARIS 200, 221, 302
OMNIFLEX DIAPHRAGM 297
OMNIPOD 5 DEXG7G6 INTRO GEN 5 177
OMNIPOD 5 DEXG7G6 PODS GEN 5 177

OMNIPOD 5 LIBRE INTRO 177
OMNIPOD 5 LIBRE PODS 177
OMNITROPE 250, 261
OMVOH 206
OMVOH (300 MG DOSE) 206
ondansetron hcl 207
ondansetron odt 207
ONE VITE WOMENS PLUS 85, 342, 345
ONENATAL RX .85, 185, 342, 345
ONETOUCH DELICA PLUS LANCING 177
ONETOUCH DELICA SAFETY LANCING 177
ONETOUCH ULTRA 177
ONETOUCH VERIO 177
ONEXTON 37, 317, 335
ONFI 137, 138
ONGENTYS 139
ONTRALFY 69
ONUREG 53
ONYDA XR 65
ONZETRA XSAIL 160
opcicon one-step .. 225, 233, 256
OPFOLDA 190, 294
OPILL 233, 256
opium 151, 207
option 2 ..... 225, 233, 256
OPTIONS GYNOL II CONTRACEPTIVE 297
OPVEE 153
OPZELURA 54, 331, 339
ORACIT 181
ORALAIR 59
ORALAIR ADULT STARTER PACK 58
ORALAIR CHILDRENS STARTER PACK 59
ORALONE 327
ORAPRED ODT 201, 221
ORAVIG 321
ORENCIA 265, 283, 289
ORENCIA CLICKJECT 265, 283, 289
ORENITRAM 117, 309, 312
ORENITRAM MONTH 1 ..... 117, 308, 311
ORENITRAM MONTH 2 ..... 117, 308, 311
ORENITRAM MONTH 3 ..... 117, 309, 311
ORFADIN 190, 294
ORGOVYX 54, 225
ORIAHNN 225, 243, 256
ORILISSA 225
ORKAMBI 303, 304
ORLYNVAH 44, 189, 275
orphenadrine citrate er 70, 75, 122
orquidea 233, 256
ORSERDU 54
OSCIMIN 16, 67, 300
oseltamivir phosphate 37
OSPHENA 237
OTEZLA .. 270, 283, 284, 289, 339
OTEZLA XR 270
OTEZLA/OTEZLA XR INITIATION PK 271
OVIDE 336
OVIDREL 247
oxaprozin 149, 158
oxazepam 138
oxcarbazepine 125, 144, 145
OXERVATE 195, 203
oxiconazole nitrate 321
OXISTAT 321
oxybutynin chloride 341
oxybutynin chloride er 341
oxycodone hcl 151, 152
oxycodone-acetaminophen 121, 148, 152
oxymetazoline hcl . 206, 314, 339
oxymorphone hcl 152
oxymorphone hcl er 152
OZEMPIC 247
PACERONE 104
paliperidone er 135
PALYNZIQ 190
PANCREAZE 190, 211
PANRETIN 313, 339
pantoprazole sodium 216
PARI VORTEX ADULT MASK 177
PARI VORTEX PEDIATRIC MASK 177
paricalcitol 347
PARNATE 146
paroxetine hcl 161
paroxetine hcl er 161
paroxetine mesylate 161
PAXLOVID (150/100) 27, 29
PAXLOVID (300/100 & 150/100) 28, 29
PAXLOVID (300/100) 28, 29
pazopanib hcl 54
PEDIARIX 59, 61
PEDVAXHIB 62
peg 3350 210
peg 3350-kcl-na bicarb-nacl . 210
peg-3350/electrolytes 210
PEGASYS 35, 36, 54, 268, 289
PEMAZYRE 54
PEN NEEDLE/5-BEVEL TIP ... 177
PENBRAYA 62
penciclovir 320
penicillamine 16, 217, 284
penicillin v potassium 37
PENMENVY 62
PENTACEL 59, 62
pentamidine isethionate 26
pentazocine-naloxone hcl 153, 154
pentoxifylline er 80
perampanel 125
PERFECT POINT SAFETY LANCETS 177
PERFECT POINT SAFETY NEEDLE 177
PERFOROMIST 74, 311
PERIDEX .. 22, 194, 195, 321, 335
perindopril erbumine 93, 94
periogard . 22, 194, 195, 321, 335
permethrin 336
perphenazine 154
perphenazine-amitriptyline 155, 163
PERTZYE 191, 211
phenazopyridine hcl 319
phenelzine sulfate 146
phenobarbital 135, 136
phenoxybenzamine hcl .. 71, 115
phenylephrine hcl 205, 206
phenytek 102, 144
phenytoin 102, 144
phenytoin infatabs 102, 144
phenytoin sodium extended 102, 144
PHEXX 297
philith 233, 243, 256
PHOSPHA 250 NEUTRAL 185
PHOSPHOLINE IODIDE 204
phosphorous 185
phospho-trin 250 neutral 186
PHOXILLUM B22K4/0 186
PHOXILLUM BK4/2.5 186
phytonadione 16, 274, 347
PIFELTRO 33
pilocarpine hcl 72, 204
pimecrolimus 292, 330, 339
pimozide 133, 141

pimtrea 233, 243, 256
pindolol 70, 96, 101, 104, 112
pioglitazone hcl 262
pioglitazone hcl-glimepiride 262
pioglitazone hcl-metformin hcl 227, 262
PIP GLUCOSE CONTROL SOLUTION 177
PIQRAY 54
pirfenidone 300, 309
piroxicam 149, 158
pitavastatin calcium 109
PIVOT SUPPLY KIT 177
PIVYA 23
PLAN B ONE-STEP 225, 233, 256
PLEGRIDY 289
PLEGRIDY STARTER PACK . 289
plerixafor 79
PLEXION 317, 332
PLEXION CLEANSER 317, 332
PLEXION CLEANSING CLOTH 317, 332
PNEUMOVAX 23 62
pnv 27-ca/fe/fa 85, 342, 345
PODOCON-25 ..... 332, 339
podofilox 332, 339
polyethylene glycol 3350 210
polymyxin b-trimethoprim 41, 194, 317
POLY-VI-FLOR 165, 166, 278, 343
POLY-VI-FLOR/IRON 85, 278, 343
pomalidomide 54, 290
portia-28 ..... 233, 244, 256
posaconazole 28
potassium chloride 186
potassium chloride crys er .. 186
potassium chloride er 186
potassium citrate er 182
potassium citrate-citric acid 182
potassium iodide (expectorant) 305
PRADAXA 78
pramipexole dihydrochloride 147
PRAMOSONE 319, 327, 328
PRAMOTIC 194, 204
prasugrel hcl 87
pravastatin sodium 109
praziquantel 23
prazosin hcl 71, 90, 91, 96
PRED MILD 201, 221
prednisolone 201, 221
prednisolone acetate 201, 221
prednisolone sodium phosphate 201, 221
prednisone 221
prednisone intensol 221
pregabalin 125, 142, 143, 144
pregabalin er 121, 142, 143
PREGNYL 247
PREMARIN 244, 277
PREMESISRX 186, 294, 343, 345
PREMPHASE 244, 256
PREMPRO 244, 256
PRENACORE 85, 343, 345
prenatal 85, 343, 345
PRENATE 186, 343, 346
PRENATE DHA 85, 186, 294, 343, 345
PRENATE ELITE 85, 343, 345
PRENATE ENHANCE 85, 186, 294, 343, 346
PRENATE ESSENTIAL 85, 186, 295, 343, 346
PRENATE MINI 86, 186, 295, 343, 346
PRENATE PIXIE 86, 186, 295, 343, 346
PRENATE RESTORE 86, 186, 295, 343, 346
PREPIDIL 298
PRETOMANID 27
prevalite 97
PREVIDENT 165, 167, 279
PREVIDENT 5000 BOOSTER PLUS 167, 279
PREVIDENT 5000 DRY MOUTH 165, 167, 279
PREVIDENT 5000 ENAMEL PROTECT 167, 279
PREVIDENT 5000 KIDS . 167, 279
PREVIDENT 5000 ORTHO DEFENSE 167, 279
PREVIDENT 5000 PLUS 165, 167, 279
PREVIDENT 5000 SENSITIVE 167, 279
PREVNAR 20 62
PREVYMIS 28
PREZCOBIX 35, 295
PREZISTA 35
PRIFTIN 27, 42
PRILOSEC 216
primaquine phosphate 25
primidone 135
PRIORIX 62
PRISMASOL B22GK 4/0 186
PRISMASOL BGK 0/2.5 186
PRISMASOL BGK 2/0 186
PRISMASOL BGK 2/3.5 187
PRISMASOL BGK 4/0/1.2 187
PRISMASOL BGK 4/2.5 187
PRISMASOL BK 0/0/1.2 187
probenecid 189, 275
PROCENTRA 120
prochlorperazine 155, 208
prochlorperazine maleate 155, 208
PROCORT 201, 221, 319, 328
PROCTOCORT 201, 221, 328
PROCTOFOAM HC 201, 222, 319, 328
procto-med hc 201, 222, 328
PROCTOSOL HC ... 201, 222, 328
PROCTOZONE-HC 201, 222, 328
PROCYSBI 295
PROFILNINE 83
progesterone 256
PROGLYCEM 226
PROGRAF 264, 292, 330
PROLENSA 204
PROMACTA 80
promethazine hcl 17, 18, 19, 133, 208, 212, 305
promethazine-codeine 18, 19, 301
promethazine-dm 18, 19, 301
promethazine-phenylephrine 18, 19, 65
PROMETHEGAN 19, 133, 208, 212, 306
PRONAL 322, 333
propafenone hcl 103
propafenone hcl er 103
proparacaine hcl 204
propranolol hcl 70, 96, 101, 104, 112, 132
propranolol hcl er 70, 96, 101, 104, 112, 132
propylthiouracil 226
PROQUAD 62
protriptyline hcl 163
PROVERA 257
prucalopride succinate 213
PRURADIK 336
pseudoephedrine-bromphen-dm 19, 20, 65, 301

PULMOSAL 306
PULMOZYME 191, 306
PURE COMFORT SAFETY LANCET 30G 177
PURE COMFORT SAFETY PEN NEEDLE 178
PURIXAN 54, 267, 292
PYLERA 24, 26, 43, 207, 209
pyrazinamide 27
PYRIDIUM 320
pyridostigmine bromide 72
pyridostigmine bromide er 72
PYRIDOSTIGMINE BROMIDE ER 72
pyrimethamine 25
PYROGALLIC ACID 298, 333, 339
PYRUKYND 77
PYRUKYND TAPER PACK 77
QBRELIS 94
QFITLIA 83
QINLOCK 54
QNASL 201, 222, 302, 307
QNASL CHILDRENS 201, 222, 302, 307
QUADRACEL 59, 62
QUESTRAN 97
QUESTRAN LIGHT 97
quetiapine fumarate 130, 135
quetiapine fumarate er . 130, 135
QUICK TOUCH INSULIN PEN NEEDLE 178
QUILLICHEW ER 157
QUILLIVANT XR 157
quinapril hcl 93, 94
quinapril-hydrochlorothiazide 94, 188
quinidine gluconate er 25, 102
quinidine sulfate 25, 102
quinine sulfate 25
QULIPTA 139
QVAR REDIHALER 222, 303, 308
RABEPRAZOLE SODIUM 216
rabeprazole sodium 216
RADICAVA ORS 118, 140
RADICAVA ORS STARTER KIT 118, 140
RADIOGARDASE 17, 183, 274
RAGWITEK 59
RALDESY 162
raloxifene hcl 237, 277
ramelteon 133, 145
ramipril 93, 94
ranolazine er 100
rasagiline mesylate 145, 146
RASONQUE 54
RASUVO 266, 284
RAYA SURE PEN NEEDLE ... 178
reclipsen 233, 244, 257
RECOMBINATE 83
RECOMBIVAX HB 62
RECOTHROM 83
RECOTHROM SPRAY KIT 83
RECTIV 112, 323, 339
REGLAN 215
RELENZA DISKHALER 37
RELION GLUCOSE TEST STRIPS 181
RELISTOR 153, 207, 214
RELNATE DHA . 86, 295, 343, 346
RENTHYROID 263
repaglinide 248
REPATHA SURECLICK 113
RESTASIS 195, 202, 264
RESTASIS MULTIDOSE 195, 202, 264
RESTORIL 138
RETACRIT 76, 80
RETEVMO 54
RETIN-A MICRO PUMP ... 54, 323
RETROVIR 34
REVUFORJ 55
REXTOVY 16, 153
REXULTI 135
REYATAZ 35
REZDIFFRA 214, 263
REZENOPY 16, 153
REZLIDHIA 55
REZUROCK 295
RHAPSIDO 290, 330
RHOFADE 206, 314, 339
RHOPRESSA 205
ribavirin 39
RIDAURA 216, 266, 284, 290
rifabutin 27, 42
rifampin 27, 42
rifapentine 27, 42
rilpivirine hcl 33
riluzole 118, 140
rimantadine hcl 21
RINVOQ 269, 284
RINVOQ LQ 269
risedronate sodium 277
risperidone 130, 135
ritonavir 35
rivaroxaban 78
rivastigmine 72
rivastigmine tartrate 72
rivelsa 233, 244, 257
RIVFLOZA 295
RIVIVE 16, 153
RIXUBIS 83
rizatriptan benzoate 160
ROCKLATAN 205
roflumilast 308, 331, 335
ROMVIMZA 55
ropinirole hcl 147
ropinirole hcl er 147
rosuvastatin calcium 109
rosyrah 233, 244, 257
ROTARIX 62
ROTATEQ 62
ROWASA 209
roweepra 125
ROZLYTREK 55
RUBRACA 55
RUCONEST 280, 281
rufinamide 125, 145
RUKOBIA 31
RYALTRIS 19, 192, 201, 222, 303, 307
RYBELSUS 247
RYCLORA 19, 20
RYDAPT 55
sacubitril-valsartan ... 91, 92, 114
SAFETY PEN NEEDLES 178
SAFYRAL 233, 244, 257, 346
SALAGEN 72, 204
SALICATE 333
salicylic acid 333
salsalate 159
SALVAX DUO PLUS 322, 333
SAMSCA 189
SANTYL 191, 323, 339
sapropterin dihydrochloride 189, 295
SAVAYSA 78
saxagliptin hcl 236
saxagliptin-metformin er 227, 236
SCALACORT DK 328, 333
SCEMBLIX 55
scopolamine 67, 208, 215
SELECT-OB 86, 343, 346
selegiline hcl 145, 146
selenium sulfide 321, 335
SELZENTRY 31
SENSILANCE SAFETY LANCETS 21G 178

SENSILANCE SAFETY LANCETS 26G 178
SENSILANCE SAFETY LANCETS 28G 178
SEPHIENCE 190
SEREVENT DISKUS 74, 311
SERNIVO 222, 328
SEROSTIM 250, 261
sertraline hcl 161
setlakin 234, 244, 257
sevelamer carbonate 17, 184, 274
SEVENFACT 83
sevoflurane 144
sf 165, 167, 279
sf 5000 plus 165, 167, 279
sharobel 234, 257
SHARPS COLLECTOR 178
SHARPS CONTAINER 178
shewise 225, 234, 257
SIGNIFOR 260
sildenafil citrate 113, 114, 308, 312, 341
SILENOR 163, 320
silodosin 72
SILVADENE 321, 335
silver nitrate 194
silver sulfadiazine 321, 335
SIMBRINZA 191, 196
simliya 234, 244, 257
simpesse 234, 244, 257
SIMPLERA SYNC SENSOR ... 178
SIMPONI 214, 272, 284, 290
simvastatin 109
SINEMET 141
SINGULAIR 306
sirolimus 270, 292, 330
SIRTURO 27
sitaglip phos-metformin hcl er 227, 236
SITAGLIPT BASE-METFORM HCL ER 227, 236
SITAGLIPTIN 236
SITAGLIPTIN BASE-METFORMIN HCL 227, 236
sitagliptin phos-metformin hcl 227, 236
sitagliptin phosphate 236
SIVEXTRO 40
SKYCLARYS 295
SKYRIZI 214, 330, 339
SKYRIZI PEN 330, 339
SKYTROFA 250
SLYND 226, 234, 257
smooth lax 210
SOAANZ 89, 110, 183
sod citrate-citric acid 182
sod fluoride-potassium nitrate 167, 279
sodium chloride 307
sodium fluoride 165, 167, 279
sodium fluoride 5000 enamel 167, 279
sodium fluoride 5000 plus 165, 167, 279
sodium fluoride 5000 ppm 165, 167, 279
sodium fluoride 5000 sensitive 167, 279
sodium oxybate 140, 164, 275
sodium phenylbutyrate 182
sodium polystyrene sulfonate 17, 184, 274
sodium sulfacetamide 317
sodium sulfacetamide wash 317
SOFOSBUVIR-VELPATASVIR 30, 31
SOGROYA 250
SOHONOS 295
solifenacin succinate 341
SOLIQUA 247, 248
SOLOSEC 26
SOMAVERT 261
SOOLANTRA 336
sorafenib tosylate 55
sotalol hcl .. 70, 96, 102, 104, 112
sotalol hcl (af) 70, 96, 101, 104, 112
SOTYLIZE ... 70, 96, 102, 104, 112
SOVALDI 30
SPEVIGO 330
SPIKEVAX 62
SPIKEVAX 6M-11Y 62
spinosad 336
SPIRIVA HANDIHALER 67, 300
SPIRIVA RESPIMAT 67, 300
spironolactone 89, 110, 114, 115, 185
spironolactone-hctz 89, 110, 115, 185, 188
SPORANOX 28
SPRAVATO (56 MG DOSE) 127, 146
SPRAVATO (84 MG DOSE) 127, 146
sprintec 28 ..... 234, 244, 257
SPRITAM 125
SPRIX 149, 158, 204
SPS (SODIUM POLYSTYRENE SULF) 17, 184, 274
ssd 321, 335
SSKI 305
sss 10-5 ..... 317, 333
STARJEMZA 269
STENDRA 113, 114
STEQEYMA 269
STIOLTO RESPIMAT 67, 74
STIVARGA 55
STRENSIQ 191
STRIBILD 32, 34, 295
STRIVERDI RESPIMAT ... 74, 311
STROMECTOL 23
SUBOXONE 153, 154
SUBVENITE 125, 130
subvenite 125, 130
subvenite starter kit-blue 126, 130
subvenite starter kit-green 126, 130
subvenite starter kit-orange 126, 130
SUCRAID 191
sucralfate 215
SULAR 106, 107
SULCONAZOLE NITRATE 322
sulfacetamide sodium .. 194, 317
sulfacetamide sodium (acne) 317
sulfacetamide sodium (cleans) 317
sulfacetamide sodium-sulfur 317, 318, 333
sulfacetamide sod-sulfur wash 318, 333
sulfacetamide-prednisolone 194, 201
sulfacetamide-sulfur in urea 318, 333
SULFACLEANSE 8/4 ..... 318, 333
sulfadiazine 42
sulfamethoxazole-trimethoprim 26, 42, 44
SULFAMYLON 318, 335
sulfasalazine 42, 209, 266, 284, 285, 290
sulfatrim pediatric 26, 42, 44
sulfurated lime 336
sulindac 149, 158

sumatriptan 160
sumatriptan succinate 160
SUMAXIN 318, 333
SUMAXIN CP 318, 333
sunitinib malate 55
SUNLENCA 27, 31
SUNOSI 164
syeda 234, 244, 257
SYMBICORT 74, 222
SYMDEKO 303, 304
SYMFI 33, 34
SYMPAZAN 137, 138
SYMPROIC 207, 214
SYNALAR 201, 328
SYNAREL 247
SYNDROS 208, 214
SYNJARDY 227, 260
SYNJARDY XR 227, 228, 260
TABLOID 55
TABRECTA 55
tacrolimus 264, 292, 330, 339
tadalafil 113, 114, 308
tadalafil (pah) 113, 114, 308, 312
TADLIQ 113, 114, 308, 312
TAFINLAR 55
tafluprost (pf) 205
TAGRISSO 56
take action 226, 234, 257
TAKHZYRO 88, 292
TALZENNA 56
tamoxifen citrate 56, 237
tamsulosin hcl 72
tanlor 69
tapentadol hcl 152
TAPENTADOL HCL ER 152
TAPERDEX 12-DAY 201, 222
TAPERDEX 6-DAY 202, 222
TAPERDEX 7-DAY 202, 222
tarina 24 fe 234, 244, 257
tarina fe 1/20 eq 234, 244, 257
TARPEYO 222
tasimelteon 133, 145
tavaborole 335
TAVALISSE 77
TAVNEOS 265, 280, 281
taysofy 234, 244, 257
TAYTULLA 234, 244, 257
tazarotene 333, 339, 340
TAZAROTENE 333, 340
TAZORAC 333, 340
TECHLITE LANCETS 26G 178
TECHLITE PLUS PEN NEEDLES 178
TEGLUTIK 118, 140
TEGRETOL 126, 130
TEGRETOL-XR 126, 130
TEKTURNA 114
telmisartan 91, 92
telmisartan-amlodipine 92, 106
telmisartan-hctz 92, 188
temazepam 138
TEMBEXA 39
temozolomide 56
TENCON 121, 136, 148
TENIVAC 59
tenofovir disoproxil fumarate 34
TEPMETKO 56
terazosin hcl 71, 90, 91, 96
terbinafine hcl 21
terbutaline sulfate 74, 311
terconazole 322
teriflunomide 264, 290
TERIPARATIDE 248, 275
terrell 144
TESTIM 224, 226
testosterone 224, 226
testosterone cypionate 224, 226
testosterone enanthate 224, 226
tetrabenazine 163
tetracaine hcl 204, 272
tetracycline hcl 25, 43, 210, 318
TEXACORT 202, 222, 328
TEZRULY 71, 90
TEZSPIRE 306, 309
THALITONE 90, 115, 189
THALOMID 56, 290
THEO-24 ..... 108, 157, 183, 313, 341
theophylline 108, 157, 183, 313, 341
theophylline er 108, 157, 183, 313, 341
thioridazine hcl 155
thiothixene 162
THROMBIN-JMI 83
THROMBIN-JMI EPISTAXIS 83
THROMBOGEN 83
THYQUIDITY 263
thyroid 263
tiadylt er 97, 98, 99, 105, 117
tiagabine hcl 126, 143
TIAZAC 98, 99, 105, 117
TIBSOVO 56
ticagrelor 87
TIGLUTIK 118, 140
TIKOSYN 104
tilia fe 234, 244, 257
timolol hemihydrate 70, 96, 104, 196
timolol maleate 70, 96, 102, 104, 112, 132, 196
timolol maleate (once-daily) 70, 96, 104, 196
timolol maleate ocudose 70, 96, 104, 196
timolol maleate pf 71, 96, 104, 196
TIMOPTIC OCUDOSE 71, 96, 104, 196
tinidazole 26
tiopronin 295
TIROSINT 263
TIROSINT-SOL 263
TISSEEL 323, 340
TIVICAY 32
TIVICAY PD 32
tizanidine hcl 69
TOBI NEBULIZER 22, 194
TOBI PODHALER 22, 194
TOBRADEX 22, 194, 202
TOBRADEX ST 22, 194, 202
tobramycin 22, 194
tobramycin-dexamethasone 22, 194, 202
TOBREX 22, 194
TODAY SPONGE 297
tofacitinib citrate 270, 285
tofacitinib citrate er 270, 285
TOLAK 56, 313, 340
tolcapone 139
tolterodine tartrate 341
tolterodine tartrate er 341
tolvaptan 189
tolvaptan (hyponatremia) 189
TONMYA 69, 142
TOPAMAX 126, 132
TOPAMAX SPRINKLE 126, 132
TOPFINE INSULIN PEN NEEDLE 178
TOPICORT 328
topiramate 126, 132
toremifene citrate 56, 237
torpenz 56, 267
torsemide 89, 110, 183
TOSYMRA 160
TOUJEO MAX SOLOSTAR 248
TOUJEO SOLOSTAR 248
tovet 328
TPOXX 28
TRACLEER 117, 305, 312

TRADJENTA 236
tramadol hcl 152
TRAMADOL HCL (ER BIPHASIC) 152
tramadol hcl (er biphasic) 152
tramadol hcl er 152
tramadol-acetaminophen 121, 148, 152
trandolapril 93, 94
trandolapril-verapamil hcl er 94, 99
tranexamic acid 83
tranylcypromine sulfate 146
travoprost (bak free) 205
trazodone hcl 162
TRELEGY ELLIPTA 67, 75, 202, 223, 303
TREMFYA 266, 331, 340
TREMFYA ONE-PRESS 266, 330, 340
TREMFYA PEN 266, 331
TREMFYA-CD/UC INDUCTION 266, 331
tretinoin 56, 323
tretinoin microsphere 56, 323
tretinoin microsphere pump 56, 323
TRETTEN 83
TREXALL .. 56, 266, 285, 290, 292
TREZIX 121, 148, 152, 157
triamcinolone acetonide 223, 328
triamterene 89, 114, 185
triamterene-hctz 185, 188
triazolam 138
TRICITRASOL 77
tricitrates 182
triderm 223, 328
trientine hcl 217
tri-estarylla 234, 244, 257
trifluoperazine hcl 155
trifluridine 195
trihexyphenidyl hcl 68, 122
TRIJARDY XR 228, 236, 260
TRIKAFTA 303, 304
tri-legest fe 234, 244, 257
TRILEPTAL 126, 145
tri-linyah 234, 244, 257
tri-lo-estarylla 234, 244, 257
tri-lo-marzia 234, 244, 257
tri-lo-mili 234, 244, 257
tri-lo-sprintec 234, 244, 257
trimethobenzamide hcl 208
trimethoprim 44
tri-mili 234, 244, 257
trimipramine maleate 163
TRINATE 86, 343, 346
TRINTELLIX 162
tri-sprintec 234, 245, 257
TRISTART DHA 86, 187, 295, 343, 346
TRIUMEQ 32, 34
TRIUMEQ PD 32, 34
TRI-VI-FLOR 165, 167, 279, 344, 346, 347
TRI-VI-FLORO 165, 168, 280, 344, 346, 347
TRI-VITAMIN WITH FLUORIDE 165, 168, 280, 344
tri-vite/fluoride 165, 168, 280, 344, 347
tri-vylibra 234, 245, 258
tri-vylibra lo 234, 245, 257
trospium chloride 341
trospium chloride er 341
TRUE COMFORT SAFETY PEN NEEDLE 178
TRUE COVER 297
TRUE FOLIC ACID 346
TRUE METRIX LEVEL 1 178
TRUE METRIX LEVEL 2 178
TRUE METRIX LEVEL 3 178
TRULANCE 206, 214
TRULICITY 247
TRUMENBA 62
TRUQAP 56
TRUVADA 34, 39
TRYNGOLZA 94, 95, 223, 275
TRYPTYR 203
TRYVIO 305
TUKYSA 56, 57
TURALIO 57
turpentine 322
turqoz 234, 245, 258
TUXARIN ER 19, 20, 301
TWIIST REFILL KIT 178
TWIIST REFILL KIT/INFUSION SET 178
TWIIST STARTER KIT 178
TWINRIX 62
TWIRLA 234, 245, 258
TWYNEO 323, 335
TYBLUME 234, 245, 258
tydemy 234, 245, 258, 346
TYMLOS 248, 275
TYRVAYA 64, 203
TYVASO 118, 309, 312
TYVASO DPI MAINTENANCE KIT 117, 309, 312
TYVASO DPI TITRATION KIT 117, 309, 312
TYVASO REFILL KIT 118, 309, 312
TYVASO STARTER KIT 118, 309, 312
UBRELVY 139
UCERIS 223
UDENYCA 80
ULTANE 144
ULTRA-CARE SAFETY LANCETS 30G 178
UNIFINE OTC PEN NEEDLES 178
UNIFINE PROTECT PEN NEEDLE 179
UNISTRIP CONTROL 179
unithroid 263
UPNEEQ 206
UPTRAVI 312, 313
UPTRAVI TITRATION 312, 313
URAMAXIN 89, 183, 205, 333
urea 89, 183, 205, 333, 334
URELLE 44, 67, 121, 296
uretron d/s 44, 67, 121, 296
UROCIT-K 10 182
UROCIT-K 15 182
UROGESIC-BLUE 44, 67, 296
ursodiol 211
VAFSEO 80
valacyclovir hcl 39
VALCHLOR 313, 340
valganciclovir hcl 39
valproic acid .. 126, 130, 132, 143
valsartan 91, 92
valsartan-hydrochlorothiazide 92, 188
VALTOCO 10 MG DOSE 137
VALTOCO 15 MG DOSE 137
VALTOCO 20 MG DOSE 137
VALTOCO 5 MG DOSE 137
valtya 1/35 ..... 235, 245, 258
valtya 1/50 ..... 235, 245, 258
VANCOCIN 30
vancomycin hcl 30
VANDAZOLE 22, 38, 318
VANFLYTA 57
VANRAFIA 285, 305
VAQTA 63
vardenafil hcl 113, 114

varenicline tartrate 64, 69
varenicline tartrate (starter) 64, 69
varenicline tartrate(continue) 64, 69
VARIVAX 63
VAXELIS 59, 63
VAXNEUVANCE 63
VCF VAGINAL CONTRACEPTIVE 297
VECAMYL 115
velivet 235, 245, 258
VELPHORO 184
VELTASSA 184
VENCLEXTA 57
VENCLEXTA STARTING PACK 57
VENELEX 340
VENLAFAXINE BESYLATE ER 160
venlafaxine hcl 160
venlafaxine hcl er 160
VEOZAH 140
verapamil hcl 98, 99, 105, 118
verapamil hcl er .98, 99, 105, 118
VEREGEN 334, 340
VERIFINE INSULIN PEN NEEDLE 179
VERIFINE INSULIN SYRINGE 179
VERIFINE PLUS PEN NEEDLE 179
VERIFINE SAFE LANCET MINI 21G 179
VERIFINE SAFE LANCET MINI 23G 179
VERIFINE SAFE LANCET MINI 28G 179
VERIFINE SAFE LANCET MINI 30G 179
VERIFINE SHARPS CONTAINER 179
VERISAFE SAFETY INSULIN SYR 179
VERISAFE SAFETY STERILE NEEDLE 179
VERKAZIA 195, 202, 264
VERQUVO 102, 118
VERSACLOZ 135
VERSAPENN (AG) ANHYDROUS 298
VERSAPENN (AL) ANHYD LIPID 298
VERZENIO 57
vestura 235, 245, 258
VFEND 28
VIBERZI 207, 214
vienva 235, 245, 258
vigabatrin 126, 143
VIGADRONE 126, 143
VIGAFYDE 143
VIJOICE 296
vilazodone hcl 162
VILEVEV MB 44, 67, 121, 296
VIMPAT 126, 145
VIOKACE 191, 211
viorele 235, 245, 258
VIRACEPT 35
VIREAD 34, 35
VISTOGARD 17, 274
VITAFOL FE+ 86, 187, 296, 344, 346
VITAFOL-OB+DHA 86, 187, 296, 344, 346
VITAMIN C BRIGHTENING SERUM 322
vitamin d (ergocalciferol) 347
VITATHELY WITH GINGER 86, 344, 346
VITRAKVI 57
VIVAGUARD INO CONTROL SOLUTION 179
VIVAGUARD LANCETS 30G . 179
VIVAGUARD LANCING DEVICE 179
VIVAGUARD SAFETY LANCETS 28G 179
VIVJOA 28
VOCABRIA 32
volnea 235, 245, 258
VONVENDI 83
VOQUEZNA 215, 216
VOQUEZNA DUAL PAK ... 23, 215
VOQUEZNA TRIPLE PAK 23, 39, 40, 215
VORANIGO 57
voriconazole 29
VORTEX VALVE CHAMBER-PEDI MASK 179
VORTEX VALVED HOLDING CHAMBER 179
VOSEVI 30, 31
VOWST 214, 296
VOXZOGO 296
VOYDEYA 280
VOYXACT 264
VRAYLAR 135
VTAMA 318, 323, 340
VUSION 320, 322, 329
VYBRIQUE 113, 308
vyfemla 235, 245, 258
VYKAT XR 121, 122
VYLEESI 140, 217
vylibra 235, 245, 258
VYNDAMAX 100, 140, 296
VYSCOXA 141
VYVGART HYTRULO 270
VYZULTA 205
WAINUA 275
WAKIX 164
warfarin sodium 77
WAYRILZ 77
WELIREG 57
wera 235, 245, 258
WESCAP-PN DHA 86, 187, 296, 344, 346
WESNATE DHA 86, 296, 344, 346
WESTGEL DHA 86, 187, 296, 344, 346
WEZLANA 269
wheat germ oil 347
WIDE-SEAL DIAPHRAGM 60 297
WIDE-SEAL DIAPHRAGM 65 298
WIDE-SEAL DIAPHRAGM 70 298
WIDE-SEAL DIAPHRAGM 75 298
WIDE-SEAL DIAPHRAGM 80 298
WIDE-SEAL DIAPHRAGM 85 298
WIDE-SEAL DIAPHRAGM 90 298
WIDE-SEAL DIAPHRAGM 95 298
WILATE 84
WINREVAIR 310
wixela inhub 75, 202, 223, 303
wymzya fe 235, 245, 258
XACIATO 37, 318
xarah fe 235, 245, 258
XARELTO 78
XARELTO STARTER PACK 78
XATMEP ... 57, 266, 285, 290, 292
XCOPRI 126, 127, 145
XDEMVY 195
XELPROS 205
xelria fe 235, 245, 258
XELSTRYM 120
XEPI 318
XERMELO 207
XIFAXAN 42
XIIDRA 195, 202
XIRUN 322, 334
XOFLUZA (40 MG DOSE) .. 28, 29

XOFLUZA (80 MG DOSE).. 28, 29
XOLAIR.....268, 310
XOLREMDI..... 80
XOPENEX HFA..... 75, 311
XOSPATA.....57
XPHOZAH.....184, 214
XPOVIO (100 MG ONCE WEEKLY).....57
XPOVIO (40 MG ONCE WEEKLY).....57
XPOVIO (40 MG TWICE WEEKLY).....57
XPOVIO (60 MG ONCE WEEKLY).....58
XPOVIO (60 MG TWICE WEEKLY).....58
XPOVIO (80 MG ONCE WEEKLY).....58
XPOVIO (80 MG TWICE WEEKLY).....58
XROMI..... 58
XTAMPZA ER.....152
XTANDI.....58
xulane.....235, 245, 258
XYNTHA..... 84
XYNTHA SOLOFUSE.....84
xyvona.....152
XYWAV.....140
YASMIN 28..... 235, 245, 258
YAZ.....235, 245, 258
YESINTEK..... 269
YEZTUGO.....31
YORVIPATH..... 248, 249
your choice.....226, 235, 258
yulithira.....58, 267
YUPELRI.....67, 300
YUTREPIA.....118, 309
yuvafem..... 245, 277
YUVIWEL.....296
ZACARE..... 322, 335
ZACLIR CLEANSING..... 335
zafemy.....235, 245, 258
zafirlukast..... 306
zaleplon.....133, 146
ZARONTIN.....162
ZARXIO.....80
ZAVZPRET..... 139
ZELAPAR.....145, 146
ZELBORAF.....58
ZELSUVMI.....320, 340
zelvysia..... 190, 296
ZEMBRACE SYMTOUCH..... 160
ZEMPLAR.....347
zenatane.....334, 340
ZENBEXUS.....58, 290
ZENPEP.....191, 212
ZEPOSIA..... 290
ZEPOSIA 7-DAY STARTER PACK..... 290
ZEPOSIA STARTER KIT..... 290
ZESTRIL..... 93, 94
ZIAGEN.....35
zidovudine..... 35
ZILBRYSQ..... 265, 280
zileuton er.....306
ZILXI..... 25, 43, 194, 318
ZIOPTAN..... 205
ziprasidone hcl.....130, 135
ZIPSOR.....149
ZIRGAN..... 39, 195
ZITHROMAX.....40
ZITHROMAX TRI-PAK.....40
ZITHROMAX Z-PAK..... 40
ZITUVIMET.....228, 236
ZITUVIMET XR..... 228, 236, 237
ZITUVIO.....237
ZOKINVY..... 190, 296
ZOLINZA.....58
zolmitriptan.....160
ZOLPIDEM TARTRATE..133, 146
zolpidem tartrate... 133, 146, 147
zolpidem tartrate er.....133, 146
ZOMIG..... 160
ZONEGRAN.....127, 145
ZONISADE.....127, 145
zonisamide..... 127, 145
ZONTIVITY..... 87
ZORYVE..... 308, 331, 335, 340
zovia 1/35 (28).....235, 245, 258
ZOVIRAX..... 39, 320
ZTALMY.....127, 143
ZTLIDO..... 273, 320
ZUBSOLV..... 153, 154
zumandimine..... 235, 245, 258
ZURNAI.....153
ZURZUVAE.....127
ZYCUBO.....187
ZYDELIG.....58
ZYLET.....194, 202
ZYPITAMAG..... 109