# Jefferson Health Plans
# 2024 Formulary
# (List of Covered Drugs)
## Special (HMO SNP)
## Dual Pearl (HMO SNP)

Jefferson
Health Plans

# Jefferson Health Plans

# 2024 Formulary

# (List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN**

Formulary ID 24482, Version 14

This formulary was updated on 06/01/2024. For more recent information or other questions, please contact Jefferson Health Plans Member Relations at 1-866-901-8000 (TTY users should call 1-877-454-8477) or visit JeffersonHealthPlans.com/medicare. From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday.

**Note to existing members**: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us", or "our," it means Jefferson Health Plans. When it refers to "plan" or "our plan," it means Jefferson Health Plans Special (SNP HMO) and Dual Pearl (SNP HMO).

This document includes list of the drugs (formulary) for our plan which is current as of 06/01/2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025, and from time to time during the year.

## What is the Jefferson Health Plans Formulary?

A formulary is a list of covered drugs selected by Jefferson Health Plans in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Jefferson Health Plans will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Jefferson Health Plans network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

For a complete listing of all prescription drugs covered by Jefferson Health Plans, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

## Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but Jefferson Health Plans may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

**Changes that can affect you this year:** In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled "How do I request an exception to the Jefferson Health Plans' Formulary?"

  **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Jefferson Health Plans' Formulary?"

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 06/01/2024. To get updated information about the drugs covered by Jefferson Health Plans please contact us. Our contact information appears on the front and back cover pages.

Our print formulary will be updated by reprinting in the event of mid-year non-maintenance formulary changes.

## How do I use the Formulary?

There are two ways to find your drug within the formulary:

**Medical Condition**

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, Cardiovascular Agents. If you know what your drug is used for, look for the category name in the list that begins on A-7. Then look under the category name for your drug.

**Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 104. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

Jefferson Health Plans covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

## Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Jefferson Health Plans requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Jefferson Health Plans before you fill your prescriptions. If you don't get approval, Jefferson Health Plans may not cover the drug.

- **Quantity Limits:** For certain drugs, Jefferson Health Plans limits the amount of the drug that Jefferson Health Plans will cover. For example, Jefferson Health Plans provides 60 tablets per prescription for atorvastatin 10 mg. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Jefferson Health Plans requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Jefferson Health Plans may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Jefferson Health Plans will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Jefferson Health Plans to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Jefferson Health Plans' formulary?" below for information about how to request an exception.

## What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Relations at 1-866-901-8000 (TTY 1-877-454-8477) and ask if your drug is covered.

If you learn that Jefferson Health Plans does not cover your drug, you have two options:

- You can ask Member Relations for a list of similar drugs that are covered by Jefferson Health Plans. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Jefferson Health Plans.

- You can ask Jefferson Health Plans to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the Jefferson Health Plans' Formulary?

You can ask Jefferson Health Plans to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Jefferson Health Plans limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Jefferson Health Plans will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72

hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

## What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you are a current member and have a change in treatment setting due to a change in the level of care you require, you can ask us to make a formulary exception. Examples of level of care changes might include:

- Discharge from a hospital to home
- Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and you now need to use your Part D plan Changing from hospice status and reverting back to standard Medicare Part A and B coverage
- Ending a long-term care stay and returning to the community
- Discharges from chronic psychiatric hospitals with highly individualized drug regimens

For these unplanned transitions, you can ask us to make a formulary exception or appeal for continued coverage of your drug. In addition, we will review requests for continuation of therapy on a case-by-case basis for members that have had a change in their level of care and are stabilized on drug regimens that if altered are known to have risks.

## For more information

For more detailed information about your Jefferson Health Plans prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Jefferson Health Plans, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

## Jefferson Health Plans Formulary

The formulary that begins on the page 2 provides coverage information about the drugs covered by Jefferson Health Plans. If you have trouble finding your drug in the list, turn to the Index that begins on page 104.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., ENTRESTO) and generic drugs are listed in lower-case italics (e.g., *valsartan*).

The information in the Requirements/Limits column tells you if Jefferson Health Plans has any special requirements for coverage of your drug.

# Category Listing

# LEGEND

| TIER | NAME |
|---|---|
| 1 | Covered |

| SYMBOL | NAME | DESCRIPTION |
|---|---|---|
| QL | Quantity Limit | There is a limit on the amount of this drug that is covered per prescription, or within a specific time frame. |
| PA3 | Prior Authorization (Part B vs. Part D) | This prescription may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination. |
| PA2 | Prior Authorization (New Starts Only) | Prior authorization applies to new starts only. You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug. |
| PA | Prior Authorization | You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug. |
| ST | Step Therapy | In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition. |
| $0 CS | $0 Cost Share | This prescription drug is available at a $0 Cost Share. |
| NDS | Non-Extended Day Supply | You cannot obtain an extended day supply for this type of drug. We will cover up to a 30-day supply per prescription only. |

# JEFFERSON HEALTH PLANS 1 TIER FORMULARY (List of Covered Drugs)

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **ANALGESICS** | | |
| **NONSTEROIDAL ANTI-INFLAMMATORY DRUGS** | | |
| *butalbital-aspirin-caffeine 50-325-40 mg cap* | 1-Covered | PA, QL (180 PER 30 DAYS) |
| *cataflam* | 1-Covered | |
| *celecoxib* | 1-Covered | QL (60 PER 30 DAYS) |
| *diclofenac potassium 50 mg tab* | 1-Covered | |
| *diclofenac sodium (25 mg tab dr, 50 mg tab dr, 75 mg tab dr)* | 1-Covered | |
| *diclofenac sodium 1 % gel* | 1-Covered | QL (1000 PER 30 DAYS) |
| *diclofenac sodium 1.5 % solution* | 1-Covered | QL (300 PER 28 DAYS) |
| *diclofenac sodium er* | 1-Covered | |
| *diclofenac-misoprostol* | 1-Covered | |
| *diflunisal* | 1-Covered | |
| *ec-naproxen* | 1-Covered | |
| *etodolac* | 1-Covered | |
| *etodolac er* | 1-Covered | |
| *flurbiprofen* | 1-Covered | |
| *ibu* | 1-Covered | |
| *ibuprofen (100 mg/5ml suspension, 400 mg tab, 600 mg tab, 800 mg tab)* | 1-Covered | |
| *indomethacin (25 mg cap, 50 mg cap)* | 1-Covered | PA |
| *indomethacin er* | 1-Covered | PA |
| *meloxicam (7.5 mg tab, 15 mg tab)* | 1-Covered | |
| *nabumetone* | 1-Covered | |
| *naproxen (250 mg tab, 375 mg tab, 375 mg tab dr, 500 mg tab, 500 mg tab dr)* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *naproxen dr* | 1-Covered | |
| *naproxen sodium* | 1-Covered | |
| *oxaprozin* | 1-Covered | |
| *piroxicam (10 mg cap, 20 mg cap)* | 1-Covered | |
| *relafen* | 1-Covered | |
| *sulindac* | 1-Covered | |
| **OPIOID ANALGESICS, LONG-ACTING** | | |
| *buprenorphine* | 1-Covered | QL (4 PER 28 DAYS) |
| *fentanyl* | 1-Covered | QL (10 PER 30 DAYS) |
| *methadone hcl 10 mg tab* | 1-Covered | QL (240 PER 30 DAYS) |
| *methadone hcl 10 mg/5ml solution* | 1-Covered | QL (1800 PER 30 DAYS) |
| *methadone hcl 5 mg tab* | 1-Covered | QL (480 PER 30 DAYS) |
| *methadone hcl 5 mg/5ml solution* | 1-Covered | QL (3600 PER 30 DAYS) |
| *morphine sulfate er (15 mg tab er, 30 mg tab er, 60 mg tab er, 100 mg tab er, 200 mg tab er)* | 1-Covered | QL (90 PER 30 DAYS) |
| *tramadol hcl (er biphasic)* | 1-Covered | QL (30 PER 30 DAYS) |
| *tramadol hcl er (100 mg tab er 24h, 200 mg tab er 24h, 300 mg tab er 24h)* | 1-Covered | QL (30 PER 30 DAYS) |
| XTAMPZA ER | 1-Covered | QL (60 PER 30 DAYS) |
| **OPIOID ANALGESICS, SHORT-ACTING** | | |
| *acetaminophen-codeine 120-12 mg/5ml solution* | 1-Covered | QL (2700 PER 30 DAYS) |
| *acetaminophen-codeine 300-15 mg tab* | 1-Covered | QL (390 PER 30 DAYS) |
| *acetaminophen-codeine 300-30 mg tab* | 1-Covered | QL (360 PER 30 DAYS) |
| *acetaminophen-codeine 300-60 mg tab* | 1-Covered | QL (180 PER 30 DAYS) |
| *butalbital-apap-caff-cod 50-325-40-30 mg cap* | 1-Covered | PA, QL (180 PER 30 DAYS) |
| *butorphanol tartrate 10 mg/ml solution* | 1-Covered | QL (5 PER 30 DAYS) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *endocet (2.5-325 mg tab, 5-325 mg tab)* | 1-Covered | QL (360 PER 30 DAYS) |
| *endocet 10-325 mg tab* | 1-Covered | QL (180 PER 30 DAYS) |
| *endocet 7.5-325 mg tab* | 1-Covered | QL (240 PER 30 DAYS) |
| *fentanyl citrate (400 mcg loz handle, 600 mcg loz handle, 800 mcg loz handle, 1200 mcg loz handle, 1600 mcg loz handle)* | 1-Covered | PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *fentanyl citrate 200 mcg loz handle* | 1-Covered | PA, QL (120 PER 30 DAYS) |
| *hydrocodone-acetaminophen (2.5-108 mg/5ml solution, 5-217 mg/10ml solution, 7.5-325 mg/15ml solution)* | 1-Covered | QL (2700 PER 30 DAYS) |
| *hydrocodone-acetaminophen 10-325 mg tab* | 1-Covered | QL (180 PER 30 DAYS) |
| *hydrocodone-acetaminophen 5-325 mg tab* | 1-Covered | QL (360 PER 30 DAYS) |
| *hydrocodone-acetaminophen 7.5-325 mg tab* | 1-Covered | QL (240 PER 30 DAYS) |
| *hydrocodone-ibuprofen* | 1-Covered | QL (150 PER 30 DAYS) |
| *hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)* | 1-Covered | QL (180 PER 30 DAYS) |
| MORPHINE SULFATE (10 MG/5ML SOLUTION, 20 MG/5ML SOLUTION) | 1-Covered | QL (900 PER 30 DAYS) |
| *morphine sulfate (15 mg tab, 30 mg tab)* | 1-Covered | QL (180 PER 30 DAYS) |
| MORPHINE SULFATE (CONCENTRATE) (, 100 MG/5ML SOLUTION) | 1-Covered | QL (180 PER 30 DAYS) |
| *oxycodone hcl (5 mg cap, 5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab, 100 mg/5ml conc)* | 1-Covered | QL (180 PER 30 DAYS) |
| *oxycodone hcl 5 mg/5ml solution* | 1-Covered | QL (900 PER 30 DAYS) |
| *oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab)* | 1-Covered | QL (360 PER 30 DAYS) |
| *oxycodone-acetaminophen 10-325 mg tab* | 1-Covered | QL (180 PER 30 DAYS) |
| *oxycodone-acetaminophen 7.5-325 mg tab* | 1-Covered | QL (240 PER 30 DAYS) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *oxymorphone hcl* | 1-Covered | QL (180 PER 30 DAYS) |
| *tramadol hcl 50 mg tab* | 1-Covered | QL (240 PER 30 DAYS) |
| *tramadol-acetaminophen* | 1-Covered | QL (240 PER 30 DAYS) |
| **ANESTHETICS** | | |
| **LOCAL ANESTHETICS** | | |
| *lidocaine 5 % ointment* | 1-Covered | QL (50 PER 30 DAYS) |
| *lidocaine 5 % patch* | 1-Covered | PA, QL (90 PER 30 DAYS) |
| *lidocaine viscous hcl* | 1-Covered | |
| *lidocaine-prilocaine* | 1-Covered | QL (30 PER 30 DAYS) |
| *lidocan* | 1-Covered | PA, QL (90 PER 30 DAYS) |
| **ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS** | | |
| **ALCOHOL DETERRENTS/ANTI-CRAVING** | | |
| *acamprosate calcium* | 1-Covered | |
| DISULFIRAM (, 500 MG TAB) | 1-Covered | |
| *naltrexone hcl 50 mg tab* | 1-Covered | |
| VIVITROL | 1-Covered | NDS (Non-Extended Day Supply) |
| **OPIOID DEPENDENCE** | | |
| *buprenorphine hcl 2 mg sl tab* | 1-Covered | QL (90 PER 30 DAYS) |
| *buprenorphine hcl 8 mg sl tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *buprenorphine hcl-naloxone hcl (2-0.5 mg film, 4-1 mg film, 8-2 mg film, 8-2 mg sl tab)* | 1-Covered | QL (90 PER 30 DAYS) |
| *buprenorphine hcl-naloxone hcl 12-3 mg film* | 1-Covered | QL (60 PER 30 DAYS) |
| *buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab* | 1-Covered | QL (120 PER 30 DAYS) |
| LUCEMYRA | 1-Covered | PA, QL (16 PER 1 DAYS), NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **OPIOID REVERSAL AGENTS** | | |
| *naloxone hcl (0.4 mg/ml soln cart, 0.4 mg/ml solution, 2 mg/2ml soln prsyr, 4 mg/0.1ml liquid, 4 mg/10ml solution)* | 1-Covered | |
| **SMOKING CESSATION AGENTS** | | |
| *bupropion hcl er (smoking det)* | 1-Covered | QL (60 PER 30 DAYS) |
| NICOTROL | 1-Covered | |
| NICOTROL NS | 1-Covered | |
| *varenicline tartrate* | 1-Covered | |
| *varenicline tartrate (starter)* | 1-Covered | |
| **ANTIBACTERIALS** | | |
| **AMINOGLYCOSIDES** | | |
| *amikacin sulfate* | 1-Covered | |
| *gentamicin in saline* | 1-Covered | |
| *gentamicin sulfate (0.1 % cream, 0.1 % ointment)* | 1-Covered | QL (60 PER 30 DAYS) |
| *gentamicin sulfate (10 mg/ml solution, 40 mg/ml solution)* | 1-Covered | |
| *neomycin sulfate* | 1-Covered | |
| *paromomycin sulfate* | 1-Covered | |
| *streptomycin sulfate* | 1-Covered | NDS (Non-Extended Day Supply) |
| *tobramycin sulfate (1.2 gm recon soln, 1.2 gm/30ml solution, 2 gm/50ml solution, 10 mg/ml solution, 80 mg/2ml solution)* | 1-Covered | |
| **ANTIBACTERIALS, OTHER** | | |
| *acetic acid 2 % solution* | 1-Covered | |
| *aztreonam* | 1-Covered | |
| *clindamycin hcl* | 1-Covered | |
| *clindamycin palmitate hcl* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *clindamycin phosphate (1 % swab, 2 % cream, 300 mg/2ml solution, 600 mg/4ml solution, 900 mg/6ml solution, 9000 mg/60ml solution)* | 1-Covered | |
| *clindamycin phosphate in d5w* | 1-Covered | |
| *colistimethate sodium (cba)* | 1-Covered | NDS (Non-Extended Day Supply) |
| DAPTOMYCIN (, 350 MG RECON SOLN) | 1-Covered | NDS (Non-Extended Day Supply) |
| *fosfomycin tromethamine* | 1-Covered | |
| *linezolid 100 mg/5ml recon susp* | 1-Covered | QL (1800 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *linezolid 600 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *linezolid 600 mg/300ml solution* | 1-Covered | |
| *methenamine hippurate* | 1-Covered | |
| *metronidazole (0.75 % cream, 0.75 % gel, 0.75 % lotion, 1 % gel, 250 mg tab, 500 mg tab, 500 mg/100ml solution)* | 1-Covered | |
| *nitrofurantoin macrocrystal (50 mg cap, 100 mg cap)* | 1-Covered | |
| *nitrofurantoin monohyd macro* | 1-Covered | |
| *polymyxin b sulfate* | 1-Covered | |
| TIGECYCLINE | 1-Covered | NDS (Non-Extended Day Supply) |
| *trimethoprim* | 1-Covered | |
| *vancomycin hcl (1 gm recon soln, 5 gm recon soln, 10 gm recon soln, 100 gm recon soln, 500 mg recon soln, 750 mg recon soln)* | 1-Covered | |
| *vancomycin hcl 125 mg cap* | 1-Covered | QL (120 PER 30 DAYS) |
| *vancomycin hcl 250 mg cap* | 1-Covered | QL (240 PER 30 DAYS) |
| XIFAXAN 200 MG TAB | 1-Covered | PA |
| XIFAXAN 550 MG TAB | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| **BETA-LACTAM, CEPHALOSPORINS** | | |
| *cefaclor (250 mg cap, 500 mg cap)* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| CEFACLOR ER | 1-Covered | |
| *cefadroxil (250 mg/5ml recon susp, 500 mg cap, 500 mg/5ml recon susp)* | 1-Covered | |
| *cefazolin sodium (1 gm recon soln, 10 gm recon soln, 100 gm recon soln, 300 gm recon soln, 500 mg recon soln)* | 1-Covered | |
| *cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)* | 1-Covered | |
| *cefepime hcl (1 gm recon soln, 2 gm recon soln)* | 1-Covered | |
| *cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)* | 1-Covered | |
| *cefotetan disodium* | 1-Covered | |
| *cefoxitin sodium* | 1-Covered | |
| *cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg tab, 100 mg/5ml recon susp, 200 mg tab)* | 1-Covered | |
| *cefprozil (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)* | 1-Covered | |
| *ceftazidime* | 1-Covered | |
| *ceftriaxone sodium (1 gm recon soln, 2 gm recon soln, 10 gm recon soln, 100 gm recon soln, 250 mg recon soln, 500 mg recon soln)* | 1-Covered | |
| *ceftriaxone sodium in dextrose* | 1-Covered | |
| *cefuroxime axetil* | 1-Covered | |
| *cefuroxime sodium* | 1-Covered | |
| *cephalexin (125 mg/5ml recon susp, 250 mg cap, 250 mg/5ml recon susp, 500 mg cap)* | 1-Covered | |
| *tazicef* | 1-Covered | |
| TEFLARO | 1-Covered | NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **BETA-LACTAM, PENICILLINS** | | |
| *amoxicillin (125 mg chew tab, 125 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg cap, 250 mg chew tab, 250 mg/5ml recon susp, 400 mg/5ml recon susp, 500 mg cap, 500 mg tab, 875 mg tab)* | 1-Covered | |
| *amoxicillin-pot clavulanate (200-28.5 mg chew tab, 200-28.5 mg/5ml recon susp, 250-125 mg tab, 250-62.5 mg/5ml recon susp, 400-57 mg chew tab, 400-57 mg/5ml recon susp, 500-125 mg tab, 600-42.9 mg/5ml recon susp, 875-125 mg tab)* | 1-Covered | |
| *amoxicillin-pot clavulanate er* | 1-Covered | |
| *ampicillin* | 1-Covered | |
| *ampicillin sodium* | 1-Covered | |
| *ampicillin-sulbactam sodium* | 1-Covered | |
| BICILLIN L-A | 1-Covered | |
| *dicloxacillin sodium* | 1-Covered | |
| *nafcillin sodium* | 1-Covered | |
| *oxacillin sodium* | 1-Covered | |
| OXACILLIN SODIUM IN DEXTROSE | 1-Covered | |
| PENICILLIN G POT IN DEXTROSE | 1-Covered | |
| *penicillin g potassium* | 1-Covered | |
| *penicillin g sodium* | 1-Covered | |
| *penicillin v potassium (125 mg/5ml recon soln, 250 mg tab, 250 mg/5ml recon soln, 500 mg tab)* | 1-Covered | |
| *pfizerpen* | 1-Covered | |
| *piperacillin sod-tazobactam so* | 1-Covered | |
| **CARBAPENEMS** | | |
| *ertapenem sodium* | 1-Covered | |
| *imipenem-cilastatin* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *meropenem* | 1-Covered | |
| **MACROLIDES** | | |
| *azithromycin (1 gm packet, 100 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg tab, 500 mg recon soln, 500 mg tab, 600 mg tab)* | 1-Covered | |
| *clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)* | 1-Covered | |
| *clarithromycin er* | 1-Covered | |
| DIFICID (40 MG/ML RECON SUSP, 200 MG TAB) | 1-Covered | NDS (Non-Extended Day Supply) |
| ERYTHROCIN LACTOBIONATE | 1-Covered | |
| *erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)* | 1-Covered | |
| *erythromycin base* | 1-Covered | |
| *erythromycin ethylsuccinate 400 mg tab* | 1-Covered | |
| **QUINOLONES** | | |
| *ciprofloxacin hcl (0.3 % solution, 250 mg tab, 500 mg tab, 750 mg tab)* | 1-Covered | |
| *ciprofloxacin in d5w* | 1-Covered | |
| *levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)* | 1-Covered | |
| *levofloxacin in d5w* | 1-Covered | |
| *levofloxacin oral soln 25 mg/ml* | 1-Covered | |
| *moxifloxacin hcl 400 mg tab* | 1-Covered | |
| *moxifloxacin hcl in nacl* | 1-Covered | |
| *ofloxacin (300 mg tab, 400 mg tab)* | 1-Covered | |
| **SULFONAMIDES** | | |
| *sulfacetamide sodium (acne)* | 1-Covered | QL (118 PER 30 DAYS) |
| *sulfadiazine* | 1-Covered | |
| *sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab)* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **TETRACYCLINES** | | |
| *demeclocycline hcl* | 1-Covered | |
| *doxy 100* | 1-Covered | |
| *doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg cap, 100 mg recon soln, 100 mg tab)* | 1-Covered | |
| *doxycycline monohydrate (25 mg/5ml recon susp, 50 mg cap, 50 mg tab, 75 mg tab, 100 mg cap, 100 mg tab, 150 mg tab)* | 1-Covered | |
| *minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)* | 1-Covered | |
| *mondoxyne nl* | 1-Covered | |
| *tetracycline hcl (250 mg cap, 500 mg cap)* | 1-Covered | |
| **ANTICONVULSANTS** | | |
| **ANTICONVULSANTS, OTHER** | | |
| BRIVIACT (10 MG TAB, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB) | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| BRIVIACT 10 MG/ML SOLUTION | 1-Covered | QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| BRIVIACT 50 MG/5ML SOLUTION | 1-Covered | NDS (Non-Extended Day Supply) |
| DIACOMIT (250 MG CAP, 250 MG PACKET) | 1-Covered | PA2, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| DIACOMIT (500 MG CAP, 500 MG PACKET) | 1-Covered | PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *divalproex sodium* | 1-Covered | |
| *divalproex sodium er* | 1-Covered | |
| EPIDIOLEX | 1-Covered | PA2, QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| EPRONTIA | 1-Covered | |
| *felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)* | 1-Covered | |
| FINTEPLA | 1-Covered | PA2, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| FYCOMPA (4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB) | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| FYCOMPA 0.5 MG/ML SUSPENSION | 1-Covered | QL (720 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| FYCOMPA 2 MG TAB | 1-Covered | QL (30 PER 30 DAYS) |
| *lamotrigine (25 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)* | 1-Covered | |
| *levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)* | 1-Covered | |
| *levetiracetam er* | 1-Covered | |
| LEVETIRACETAM IN NACL | 1-Covered | |
| *roweepra* | 1-Covered | |
| *roweepra xr* | 1-Covered | |
| SPRITAM | 1-Covered | |
| *subvenite* | 1-Covered | |
| *topiramate (15 mg cap sprink, 25 mg cap sprink, 25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)* | 1-Covered | |
| *valproate sodium* | 1-Covered | |
| *valproic acid (250 mg cap, 250 mg/5ml solution)* | 1-Covered | |
| XCOPRI (14 X 150 MG & 14 X200 MG TAB THPK, 14 X 50 MG & 14 X100 MG TAB THPK) | 1-Covered | QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| XCOPRI (150 MG TAB, 200 MG TAB) | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| XCOPRI (25 MG TAB, 50 MG TAB, 100 MG TAB) | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| XCOPRI (250 MG DAILY DOSE) | 1-Covered | QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| XCOPRI (350 MG DAILY DOSE) | 1-Covered | QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK | 1-Covered | QL (28 PER 28 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| ZTALMY | 1-Covered | PA2, QL (1100 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **CALCIUM CHANNEL MODIFYING AGENTS** | | |
| *ethosuximide (250 mg cap, 250 mg/5ml solution)* | 1-Covered | |
| *methsuximide* | 1-Covered | |
| **GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS** | | |
| *clobazam (10 mg tab, 20 mg tab)* | 1-Covered | QL (60 PER 30 DAYS) |
| *clobazam 2.5 mg/ml suspension* | 1-Covered | QL (480 PER 30 DAYS) |
| *diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)* | 1-Covered | |
| *gabapentin (100 mg cap, 250 mg/5ml solution, 300 mg cap, 300 mg/6ml solution, 400 mg cap, 600 mg tab, 800 mg tab)* | 1-Covered | |
| NAYZILAM | 1-Covered | PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *phenobarbital (15 mg tab, 16.2 mg tab, 20 mg/5ml elixir, 20 mg/5ml solution, 30 mg tab, 32.4 mg tab, 60 mg tab, 64.8 mg tab, 97.2 mg tab, 100 mg tab)* | 1-Covered | |
| *primidone* | 1-Covered | |
| SYMPAZAN (10 MG FILM, 20 MG FILM) | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| SYMPAZAN 5 MG FILM | 1-Covered | PA2, QL (60 PER 30 DAYS) |
| *tiagabine hcl* | 1-Covered | |
| VALTOCO 10 MG DOSE | 1-Covered | PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VALTOCO 15 MG DOSE | 1-Covered | PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VALTOCO 20 MG DOSE | 1-Covered | PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VALTOCO 5 MG DOSE | 1-Covered | PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *vigabatrin* | 1-Covered | QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *vigadrone* | 1-Covered | QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *vigpoder* | 1-Covered | QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **SODIUM CHANNEL AGENTS** | | |
| APTIOM (200 MG TAB, 400 MG TAB) | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| APTIOM (600 MG TAB, 800 MG TAB) | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *carbamazepine (100 mg chew tab, 100 mg/5ml suspension, 200 mg tab)* | 1-Covered | |
| *carbamazepine er* | 1-Covered | |
| DILANTIN 30 MG CAP | 1-Covered | |
| *epitol* | 1-Covered | |
| *fosphenytoin sodium* | 1-Covered | |
| *lacosamide (10 mg/ml solution, 50 mg/5ml solution, 100 mg/10ml solution)* | 1-Covered | QL (1200 PER 30 DAYS) |
| *lacosamide (100 mg tab, 150 mg tab, 200 mg tab)* | 1-Covered | QL (60 PER 30 DAYS) |
| *lacosamide 200 mg/20ml solution* | 1-Covered | |
| *lacosamide 50 mg tab* | 1-Covered | QL (120 PER 30 DAYS) |
| *oxcarbazepine (150 mg tab, 300 mg tab, 300 mg/5ml suspension, 600 mg tab)* | 1-Covered | |
| *phenytek* | 1-Covered | |
| *phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)* | 1-Covered | |
| *phenytoin infatabs* | 1-Covered | |
| *phenytoin sodium 50 mg/ml solution* | 1-Covered | |
| *phenytoin sodium extended* | 1-Covered | |
| *rufinamide 200 mg tab* | 1-Covered | PA2, QL (480 PER 30 DAYS) |
| *rufinamide 40 mg/ml suspension* | 1-Covered | PA2, QL (2760 PER 30 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *rufinamide 400 mg tab* | 1-Covered | PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ZONISADE | 1-Covered | |
| *zonisamide (25 mg cap, 50 mg cap, 100 mg cap)* | 1-Covered | |
| **ANTIDEMENTIA AGENTS** | | |
| **ANTIDEMENTIA AGENTS, OTHER** | | |
| *ergoloid mesylates* | 1-Covered | PA |
| NAMZARIC | 1-Covered | |
| **CHOLINESTERASE INHIBITORS** | | |
| *donepezil hcl (5 mg tab, 5 mg tab disp, 10 mg tab, 10 mg tab disp)* | 1-Covered | QL (60 PER 30 DAYS) |
| *galantamine hydrobromide (4 mg tab, 8 mg tab, 12 mg tab)* | 1-Covered | QL (60 PER 30 DAYS) |
| *galantamine hydrobromide 4 mg/ml solution* | 1-Covered | QL (360 PER 30 DAYS) |
| *galantamine hydrobromide er* | 1-Covered | QL (30 PER 30 DAYS) |
| *rivastigmine* | 1-Covered | QL (30 PER 30 DAYS) |
| *rivastigmine tartrate* | 1-Covered | QL (60 PER 30 DAYS) |
| **N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST** | | |
| *memantine hcl (2 mg/ml solution, 28 x 5 mg & 21 x 10 mg tab)* | 1-Covered | |
| *memantine hcl (5 mg tab, 10 mg tab)* | 1-Covered | QL (60 PER 30 DAYS) |
| *memantine hcl er* | 1-Covered | QL (30 PER 30 DAYS) |
| **ANTIDEPRESSANTS** | | |
| **ANTIDEPRESSANTS, OTHER** | | |
| AUVELITY | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *bupropion hcl* | 1-Covered | QL (120 PER 30 DAYS) |
| *bupropion hcl er (sr)* | 1-Covered | QL (60 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *bupropion hcl er (xl) 150 mg tab er 24h* | 1-Covered | QL (90 PER 30 DAYS) |
| *bupropion hcl er (xl) 300 mg tab er 24h* | 1-Covered | QL (30 PER 30 DAYS) |
| *chlordiazepoxide-amitriptyline* | 1-Covered | |
| LYBALVI | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *mirtazapine (15 mg tab, 15 mg tab disp)* | 1-Covered | QL (90 PER 30 DAYS) |
| *mirtazapine (30 mg tab, 30 mg tab disp)* | 1-Covered | QL (60 PER 30 DAYS) |
| *mirtazapine (7.5 mg tab, 45 mg tab, 45 mg tab disp)* | 1-Covered | QL (30 PER 30 DAYS) |
| *olanzapine-fluoxetine hcl* | 1-Covered | |
| *perphenazine-amitriptyline* | 1-Covered | |
| ZURZUVAE (20 MG CAP, 25 MG CAP) | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ZURZUVAE 30 MG CAP | 1-Covered | PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **MONOAMINE OXIDASE INHIBITORS** | | |
| EMSAM | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| MARPLAN | 1-Covered | |
| *phenelzine sulfate* | 1-Covered | |
| *tranylcypromine sulfate* | 1-Covered | |
| **SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)** | | |
| *citalopram hydrobromide (20 mg tab, 40 mg tab)* | 1-Covered | QL (45 PER 30 DAYS) |
| *citalopram hydrobromide 10 mg tab* | 1-Covered | QL (90 PER 30 DAYS) |
| *citalopram hydrobromide 10 mg/5ml solution* | 1-Covered | QL (600 PER 30 DAYS) |
| *desvenlafaxine succinate er* | 1-Covered | QL (30 PER 30 DAYS) |
| *escitalopram oxalate 10 mg tab* | 1-Covered | QL (45 PER 30 DAYS) |
| *escitalopram oxalate 20 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *escitalopram oxalate 5 mg tab* | 1-Covered | QL (90 PER 30 DAYS) |
| *escitalopram oxalate 5 mg/5ml solution* | 1-Covered | QL (600 PER 30 DAYS) |
| FETZIMA | 1-Covered | QL (30 PER 30 DAYS) |
| FETZIMA TITRATION | 1-Covered | |
| *fluoxetine hcl (10 mg cap, 10 mg tab)* | 1-Covered | QL (90 PER 30 DAYS) |
| *fluoxetine hcl (20 mg cap, 20 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| *fluoxetine hcl 20 mg/5ml solution* | 1-Covered | |
| *fluoxetine hcl 40 mg cap* | 1-Covered | QL (60 PER 30 DAYS) |
| *fluoxetine hcl 90 mg cap dr* | 1-Covered | QL (4 PER 28 DAYS) |
| *fluvoxamine maleate* | 1-Covered | QL (90 PER 30 DAYS) |
| *fluvoxamine maleate er* | 1-Covered | QL (60 PER 30 DAYS) |
| *nefazodone hcl* | 1-Covered | |
| *paroxetine hcl (10 mg tab, 10 mg/5ml suspension, 20 mg tab, 30 mg tab, 40 mg tab)* | 1-Covered | |
| *paroxetine hcl er* | 1-Covered | |
| *sertraline hcl (25 mg tab, 50 mg tab)* | 1-Covered | QL (90 PER 30 DAYS) |
| *sertraline hcl 100 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *sertraline hcl 20 mg/ml conc* | 1-Covered | QL (300 PER 30 DAYS) |
| *trazodone hcl* | 1-Covered | |
| TRINTELLIX | 1-Covered | QL (30 PER 30 DAYS) |
| VENLAFAXINE BESYLATE ER | 1-Covered | QL (60 PER 30 DAYS) |
| *venlafaxine hcl* | 1-Covered | |
| *venlafaxine hcl er (37.5 mg cap er 24h, 75 mg cap er 24h)* | 1-Covered | QL (90 PER 30 DAYS) |
| *venlafaxine hcl er 150 mg cap er 24h* | 1-Covered | QL (60 PER 30 DAYS) |
| *vilazodone hcl* | 1-Covered | QL (30 PER 30 DAYS) |

## TRICYCLICS

| | | |
|---|---|---|
| *amitriptyline hcl* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *amoxapine* | 1-Covered | |
| *clomipramine hcl* | 1-Covered | |
| *desipramine hcl* | 1-Covered | |
| *doxepin hcl (10 mg cap, 10 mg/ml conc, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)* | 1-Covered | |
| *imipramine hcl* | 1-Covered | |
| *imipramine pamoate* | 1-Covered | |
| *nortriptyline hcl (10 mg cap, 10 mg/5ml solution, 25 mg cap, 50 mg cap, 75 mg cap)* | 1-Covered | |
| *protriptyline hcl* | 1-Covered | |
| *trimipramine maleate* | 1-Covered | |
| **ANTIEMETICS** | | |
| **ANTIEMETICS, OTHER** | | |
| *compro* | 1-Covered | |
| *meclizine hcl (12.5 mg tab, 25 mg tab)* | 1-Covered | |
| *metoclopramide hcl (5 mg tab, 5 mg/5ml solution, 10 mg tab, 10 mg/10ml solution)* | 1-Covered | |
| *perphenazine* | 1-Covered | |
| *prochlorperazine* | 1-Covered | |
| *prochlorperazine edisylate* | 1-Covered | |
| *prochlorperazine maleate* | 1-Covered | |
| *promethazine hcl (12.5 mg suppos, 25 mg suppos)* | 1-Covered | |
| *promethazine hcl (12.5 mg tab, 25 mg tab, 50 mg tab)* | 1-Covered | PA |
| *promethegan* | 1-Covered | |
| *scopolamine* | 1-Covered | QL (10 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **EMETOGENIC THERAPY ADJUNCTS** | | |
| *aprepitant* | 1-Covered | PA3 |
| *dronabinol* | 1-Covered | PA, QL (60 PER 30 DAYS) |
| EMEND 125 MG/5ML RECON SUSP | 1-Covered | PA3 |
| *granisetron hcl 1 mg tab* | 1-Covered | PA3, QL (60 PER 30 DAYS) |
| *ondansetron 4 mg tab disp* | 1-Covered | PA3, QL (180 PER 30 DAYS) |
| *ondansetron 8 mg tab disp* | 1-Covered | PA3, QL (90 PER 30 DAYS) |
| *ondansetron hcl (4 mg/2ml soln prsyr, 4 mg/2ml solution, 40 mg/20ml solution)* | 1-Covered | |
| *ondansetron hcl 4 mg tab* | 1-Covered | PA3, QL (180 PER 30 DAYS) |
| *ondansetron hcl 8 mg tab* | 1-Covered | PA3, QL (90 PER 30 DAYS) |
| *ondansetron hcl oral soln 4 mg/5ml* | 1-Covered | PA3 |
| SANCUSO | 1-Covered | ST, QL (4 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| **ANTIFUNGALS** | | |
| ABELCET | 1-Covered | PA3 |
| *amphotericin b* | 1-Covered | PA3 |
| *amphotericin b liposome* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *caspofungin acetate 50 mg recon soln* | 1-Covered | NDS (Non-Extended Day Supply) |
| *caspofungin acetate 70 mg recon soln* | 1-Covered | |
| *ciclopirox olamine 0.77 % cream* | 1-Covered | QL (90 PER 30 DAYS) |
| *ciclopirox olamine 0.77 % suspension* | 1-Covered | QL (60 PER 30 DAYS) |
| *clotrimazole 1 % cream* | 1-Covered | QL (90 PER 30 DAYS) |
| *clotrimazole 1 % solution* | 1-Covered | QL (30 PER 30 DAYS) |
| *clotrimazole 10 mg troche* | 1-Covered | |
| *econazole nitrate* | 1-Covered | QL (85 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *fluconazole (10 mg/ml recon susp, 40 mg/ml recon susp, 50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)* | 1-Covered | |
| *fluconazole in sodium chloride (200-0.9 mg/100ml-% solution, 400-0.9 mg/200ml-% solution)* | 1-Covered | |
| *flucytosine* | 1-Covered | NDS (Non-Extended Day Supply) |
| *griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)* | 1-Covered | |
| *griseofulvin ultramicrosize* | 1-Covered | |
| *itraconazole (10 mg/ml solution, 100 mg cap)* | 1-Covered | |
| *ketoconazole 2 % cream* | 1-Covered | QL (60 PER 30 DAYS) |
| *ketoconazole 2 % shampoo* | 1-Covered | QL (120 PER 30 DAYS) |
| *ketoconazole 200 mg tab* | 1-Covered | |
| *klayesta* | 1-Covered | QL (60 PER 30 DAYS) |
| *micafungin sodium* | 1-Covered | NDS (Non-Extended Day Supply) |
| *naftifine hcl 1 % cream* | 1-Covered | QL (90 PER 30 DAYS) |
| *naftifine hcl 2 % cream* | 1-Covered | QL (60 PER 30 DAYS) |
| *nyamyc* | 1-Covered | QL (60 PER 30 DAYS) |
| *nystatin (100000 unit/gm cream, 100000 unit/gm ointment, 100000 unit/gm powder)* | 1-Covered | QL (60 PER 30 DAYS) |
| *nystatin (100000 unit/ml suspension, 500000 unit tab)* | 1-Covered | |
| *nystop* | 1-Covered | QL (60 PER 30 DAYS) |
| *posaconazole 100 mg tab dr* | 1-Covered | PA, QL (93 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *posaconazole 40 mg/ml suspension* | 1-Covered | PA, QL (630 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *terbinafine hcl 250 mg tab* | 1-Covered | |
| *terconazole (0.4 % cream, 0.8 % cream, 80 mg suppos)* | 1-Covered | |
| *voriconazole (50 mg tab, 200 mg tab)* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *voriconazole 200 mg recon soln* | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *voriconazole 40 mg/ml recon susp* | 1-Covered | NDS (Non-Extended Day Supply) |
| **ANTIGOUT AGENTS** | | |
| *allopurinol (100 mg tab, 300 mg tab)* | 1-Covered | |
| *colchicine 0.6 mg tab* | 1-Covered | |
| *colchicine-probenecid* | 1-Covered | |
| *febuxostat* | 1-Covered | ST |
| MITIGARE | 1-Covered | |
| *probenecid* | 1-Covered | |
| **ANTIMIGRAINE AGENTS** | | |
| **ANTIMIGRAINE AGENTS, OTHER** | | |
| AIMOVIG | 1-Covered | PA, QL (1 PER 28 DAYS) |
| AJOVY | 1-Covered | PA, QL (1.5 PER 28 DAYS) |
| EMGALITY | 1-Covered | PA, QL (2 PER 28 DAYS) |
| EMGALITY (300 MG DOSE) | 1-Covered | PA, QL (3 PER 28 DAYS) |
| NURTEC | 1-Covered | ST, QL (16 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **CALCITONIN GENE-RELATED PEPTIDE (CRGP) RECEPTOR** | | |
| UBRELVY | 1-Covered | ST, QL (16 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **ERGOT ALKALOIDS** | | |
| *dihydroergotamine mesylate 4 mg/ml solution* | 1-Covered | PA, QL (8 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ERGOTAMINE-CAFFEINE | 1-Covered | |
| **SEROTONIN (5-HT) RECEPTOR AGONIST** | | |
| *naratriptan hcl* | 1-Covered | QL (9 PER 30 DAYS) |
| *rizatriptan benzoate* | 1-Covered | QL (12 PER 30 DAYS) |
| *sumatriptan (5 mg/act solution, 20 mg/act solution)* | 1-Covered | QL (12 PER 28 DAYS) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)* | 1-Covered | QL (9 PER 30 DAYS) |
| *sumatriptan succinate (4 mg/0.5ml soln a-inj, 6 mg/0.5ml soln a-inj, 6 mg/0.5ml solution)* | 1-Covered | QL (6 PER 30 DAYS) |
| *sumatriptan succinate refill* | 1-Covered | QL (6 PER 30 DAYS) |
| *zolmitriptan (2.5 mg tab, 2.5 mg tab disp, 5 mg tab, 5 mg tab disp)* | 1-Covered | QL (9 PER 30 DAYS) |
| **ANTIMYASTHENIC AGENTS** | | |
| **PARASYMPATHOMIMETICS** | | |
| *pyridostigmine bromide 60 mg tab* | 1-Covered | |
| *pyridostigmine bromide er* | 1-Covered | |
| **ANTIMYCOBACTERIALS** | | |
| **ANTIMYCOBACTERIALS, OTHER** | | |
| *dapsone (25 mg tab, 100 mg tab)* | 1-Covered | |
| *rifabutin* | 1-Covered | |
| **ANTITUBERCULARS** | | |
| *ethambutol hcl* | 1-Covered | |
| *isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)* | 1-Covered | |
| PRETOMANID | 1-Covered | QL (30 PER 30 DAYS) |
| PRIFTIN | 1-Covered | |
| *pyrazinamide* | 1-Covered | |
| *rifampin* | 1-Covered | |
| SIRTURO | 1-Covered | NDS (Non-Extended Day Supply) |
| TRECATOR | 1-Covered | |
| **ANTINEOPLASTICS** | | |
| **ALKYLATING AGENTS** | | |
| *bendamustine hcl (25 mg recon soln, 100 mg recon soln)* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *busulfan* | 1-Covered | NDS (Non-Extended Day Supply) |
| *carboplatin* | 1-Covered | PA3 |
| *cisplatin* | 1-Covered | PA3 |
| CYCLOPHOSPHAMIDE (25 MG CAP, 25 MG TAB, 50 MG CAP, 50 MG TAB) | 1-Covered | PA3 |
| GLEOSTINE (10 MG CAP, 40 MG CAP) | 1-Covered | |
| GLEOSTINE 100 MG CAP | 1-Covered | NDS (Non-Extended Day Supply) |
| *ifosfamide (1 gm recon soln, 1 gm/20ml solution, 3 gm/60ml solution)* | 1-Covered | |
| LEUKERAN | 1-Covered | |
| MATULANE | 1-Covered | NDS (Non-Extended Day Supply) |
| *melphalan* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *melphalan hcl* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *oxaliplatin (50 mg recon soln, 50 mg/10ml solution, 100 mg recon soln, 100 mg/20ml solution)* | 1-Covered | PA3 |
| *paraplatin* | 1-Covered | PA3 |
| VALCHLOR | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| YONDELIS | 1-Covered | NDS (Non-Extended Day Supply) |
| ZANOSAR | 1-Covered | PA3 |
| **ANTIANDROGENS** | | |
| *abiraterone acetate 250 mg tab* | 1-Covered | PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *abiraterone acetate 500 mg tab* | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *bicalutamide* | 1-Covered | |
| ERLEADA 240 MG TAB | 1-Covered | PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ERLEADA 60 MG TAB | 1-Covered | PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *flutamide* | 1-Covered | |
| *nilutamide* | 1-Covered | NDS (Non-Extended Day Supply) |
| NUBEQA | 1-Covered | PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ORSERDU 345 MG TAB | 1-Covered | PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ORSERDU 86 MG TAB | 1-Covered | PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| XTANDI (40 MG CAP, 40 MG TAB) | 1-Covered | PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| XTANDI 80 MG TAB | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| YONSA | 1-Covered | PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **ANTIANGIOGENIC AGENTS** | | |
| *lenalidomide* | 1-Covered | PA2, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| POMALYST | 1-Covered | PA2, QL (21 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| REVLIMID | 1-Covered | PA2, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| THALOMID (150 MG CAP, 200 MG CAP) | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| THALOMID (50 MG CAP, 100 MG CAP) | 1-Covered | PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **ANTIESTROGENS/MODIFIERS** | | |
| EMCYT | 1-Covered | NDS (Non-Extended Day Supply) |
| *fulvestrant* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| SOLTAMOX | 1-Covered | NDS (Non-Extended Day Supply) |
| *tamoxifen citrate* | 1-Covered | |
| *toremifene citrate* | 1-Covered | NDS (Non-Extended Day Supply) |
| **ANTIMETABOLITES** | | |
| *adrucil* | 1-Covered | PA3 |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *azacitidine* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *cladribine* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *clofarabine* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *cytarabine* | 1-Covered | PA3 |
| *cytarabine (pf)* | 1-Covered | PA3 |
| *decitabine* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| DROXIA | 1-Covered | |
| *fluorouracil (1 gm/20ml solution, 2.5 gm/50ml solution, 5 gm/100ml solution, 500 mg/10ml solution)* | 1-Covered | PA3 |
| *gemcitabine hcl 1 gm recon soln* | 1-Covered | PA3 |
| *hydroxyurea* | 1-Covered | |
| INQOVI | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *mercaptopurine* | 1-Covered | |
| NIPENT | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *pemetrexed disodium (100 mg recon soln, 500 mg recon soln, 750 mg recon soln, 1000 mg recon soln)* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| PURIXAN | 1-Covered | NDS (Non-Extended Day Supply) |
| TABLOID | 1-Covered | |
| VYXEOS | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| **ANTINEOPLASTICS, OTHER** | | |
| AKEEGA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *arsenic trioxide 10 mg/10ml solution* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| AUGTYRO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| AYVAKIT | 1-Covered | PA2, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| BESREMI | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *bleomycin sulfate* | 1-Covered | PA3 |
| BRUKINSA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *dacarbazine 200 mg recon soln* | 1-Covered | |
| *dactinomycin* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| DOCETAXEL | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| EXKIVITY | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *fludarabine phosphate 50 mg recon soln* | 1-Covered | |
| FOTIVDA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| HALAVEN | 1-Covered | NDS (Non-Extended Day Supply) |
| IDHIFA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| IWILFIN | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| JAYPIRCA 100 MG TAB | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| JAYPIRCA 50 MG TAB | 1-Covered | PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| KISQALI FEMARA (400 MG DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| KISQALI FEMARA (600 MG DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| KISQALI FEMARA(200 MG DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| KRAZATI | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *leucovorin calcium (50 mg recon soln, 100 mg recon soln, 200 mg recon soln, 350 mg recon soln, 500 mg recon soln)* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *levoleucovorin calcium* | 1-Covered | NDS (Non-Extended Day Supply) |
| LEVOLEUCOVORIN CALCIUM PF (, 250 MG/25ML SOLUTION) | 1-Covered | NDS (Non-Extended Day Supply) |
| LONSURF | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LUMAKRAS 120 MG TAB | 1-Covered | PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| LUMAKRAS 320 MG TAB | 1-Covered | PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *mitomycin (5 mg recon soln, 20 mg recon soln, 40 mg recon soln)* | 1-Covered | |
| *mitoxantrone hcl* | 1-Covered | |
| *mutamycin* | 1-Covered | |
| NINLARO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ONUREG | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| QINLOCK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| RETEVMO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| TABRECTA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| TAZVERIK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| VANFLYTA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *vinblastine sulfate* | 1-Covered | PA3 |
| *vincristine sulfate* | 1-Covered | PA3 |
| *vinorelbine tartrate 50 mg/5ml solution* | 1-Covered | |
| WELIREG | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| XPOVIO (60 MG TWICE WEEKLY) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| XPOVIO (80 MG TWICE WEEKLY) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ZALTRAP 100 MG/4ML SOLUTION | 1-Covered | NDS (Non-Extended Day Supply) |
| ZOLINZA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| **AROMATASE INHIBITORS, 3RD GENERATION** | | |
| *anastrozole* | 1-Covered | |
| *exemestane* | 1-Covered | |
| *letrozole* | 1-Covered | |
| **ENZYME INHIBITORS** | | |
| *adriamycin 2 mg/ml solution* | 1-Covered | PA3 |
| *daunorubicin hcl (, 20 mg/4ml solution)* | 1-Covered | PA3 |
| *doxorubicin hcl 2 mg/ml solution* | 1-Covered | PA3 |
| *doxorubicin hcl liposomal* | 1-Covered | PA3 |
| *epirubicin hcl* | 1-Covered | PA3 |
| *etoposide* | 1-Covered | |
| *idarubicin hcl* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *irinotecan hcl* | 1-Covered | PA3 |
| OJJAARA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *romidepsin 10 mg recon soln* | 1-Covered | NDS (Non-Extended Day Supply) |
| *topotecan hcl 4 mg recon soln* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| TRUQAP | 1-Covered | PA2, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **MOLECULAR TARGET INHIBITORS** | | |
| ALECENSA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ALIQOPA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| ALUNBRIG | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| BALVERSA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| BORTEZOMIB 3.5 MG RECON SOLN | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| BOSULIF | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| BRAFTOVI | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| CABOMETYX | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| CALQUENCE | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| CAPRELSA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| COMETRIQ (100 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| COMETRIQ (140 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| COMETRIQ (60 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| COPIKTRA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| COTELLIC | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| DAURISMO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ERIVEDGE | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *erlotinib hcl* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *everolimus (2 mg tab sol, 2.5 mg tab, 3 mg tab sol, 5 mg tab, 5 mg tab sol, 7.5 mg tab, 10 mg tab)* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| FRUZAQLA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| GAVRETO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *gefitinib* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| GILOTRIF | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| IBRANCE | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ICLUSIG | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *imatinib mesylate* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| IMBRUVICA (70 MG CAP, 70 MG/ML SUSPENSION, 140 MG CAP, 140 MG TAB, 280 MG TAB, 420 MG TAB) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| INLYTA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| INREBIC | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| JAKAFI | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| JEVTANA | 1-Covered | NDS (Non-Extended Day Supply) |
| KISQALI (200 MG DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| KISQALI (400 MG DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| KISQALI (600 MG DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| KOSELUGO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| KYPROLIS | 1-Covered | PA3, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *lapatinib ditosylate* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (10 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (12 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (14 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (18 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (20 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (24 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (4 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LENVIMA (8 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LORBRENA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LYNPARZA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LYTGOBI (12 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LYTGOBI (16 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| LYTGOBI (20 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| MEKINIST (0.05 MG/ML RECON SOLN, 0.5 MG TAB, 2 MG TAB) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| MEKTOVI | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| NERLYNX | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ODOMZO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| OGSIVEO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *paclitaxel* | 1-Covered | PA3 |
| *paclitaxel protein-bound part* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *pazopanib hcl* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| PEMAZYRE | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| PIQRAY (200 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| PIQRAY (250 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| PIQRAY (300 MG DAILY DOSE) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| REZLIDHIA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ROZLYTREK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| RUBRACA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| RYDAPT | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| SCEMBLIX 20 MG TAB | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| SCEMBLIX 40 MG TAB | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *sorafenib tosylate* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| SPRYCEL | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| STIVARGA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *sunitinib malate* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| SYNRIBO | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| TAFINLAR | 1-Covered | PA2, NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| TAGRISSO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| TALZENNA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| TASIGNA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| *temsirolimus* | 1-Covered | NDS (Non-Extended Day Supply) |
| TEPMETKO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| TIBSOVO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| TRUSELTIQ (100MG DAILY DOSE) | 1-Covered | |
| TRUSELTIQ (125MG DAILY DOSE) | 1-Covered | |
| TRUSELTIQ (50MG DAILY DOSE) | 1-Covered | |
| TRUSELTIQ (75MG DAILY DOSE) | 1-Covered | |
| TUKYSA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| TURALIO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| VENCLEXTA (50 MG TAB, 100 MG TAB) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| VENCLEXTA 10 MG TAB | 1-Covered | PA2 |
| VENCLEXTA STARTING PACK | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| VERZENIO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| VITRAKVI (20 MG/ML SOLUTION, 25 MG CAP, 100 MG CAP) | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| VIZIMPRO | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| VONJO | 1-Covered | PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VOTRIENT | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| XALKORI | 1-Covered | PA2, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| XOSPATA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ZEJULA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ZELBORAF | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ZYDELIG | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| ZYKADIA | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| **MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE** | | |
| ALYMSYS | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| AVASTIN | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| BAVENCIO | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| CYRAMZA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| DARZALEX | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| EMPLICITI | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| ERBITUX 100 MG/50ML SOLUTION | 1-Covered | NDS (Non-Extended Day Supply) |
| HERCEPTIN HYLECTA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| HERZUMA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| IMFINZI | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| KADCYLA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| KANJINTI | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| KEYTRUDA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| MVASI | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| MYLOTARG | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| OGIVRI | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| ONTRUZANT | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| OPDIVO | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| PERJETA | 1-Covered | NDS (Non-Extended Day Supply) |
| RIABNI | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| RITUXAN HYCELA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| RUXIENCE | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| TECENTRIQ | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| TRAZIMERA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| TRUXIMA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| VECTIBIX 100 MG/5ML SOLUTION | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| YERVOY 50 MG/10ML SOLUTION | 1-Covered | NDS (Non-Extended Day Supply) |
| ZIRABEV | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| **RETINOIDS** | | |
| *bexarotene 1 % gel* | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *bexarotene 75 mg cap* | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| PANRETIN | 1-Covered | PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *tretinoin 10 mg cap* | 1-Covered | NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **TREATMENT ADJUNCTS** | | |
| *leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab)* | 1-Covered | |
| *mesna* | 1-Covered | |
| MESNEX 400 MG TAB | 1-Covered | NDS (Non-Extended Day Supply) |
| **ANTIPARASITICS** | | |
| **ANTHELMINTHICS** | | |
| *albendazole* | 1-Covered | NDS (Non-Extended Day Supply) |
| *ivermectin 3 mg tab* | 1-Covered | |
| *praziquantel* | 1-Covered | |
| **ANTIPROTOZOALS** | | |
| *atovaquone* | 1-Covered | |
| *atovaquone-proguanil hcl* | 1-Covered | |
| BENZNIDAZOLE | 1-Covered | |
| *chloroquine phosphate* | 1-Covered | |
| COARTEM | 1-Covered | |
| *hydroxychloroquine sulfate 200 mg tab* | 1-Covered | |
| *mefloquine hcl* | 1-Covered | |
| *nitazoxanide* | 1-Covered | QL (6 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *pentamidine isethionate for nebulization soln 300 mg* | 1-Covered | PA3 |
| *pentamidine isethionate for soln 300 mg* | 1-Covered | |
| *primaquine phosphate* | 1-Covered | |
| *pyrimethamine* | 1-Covered | NDS (Non-Extended Day Supply) |
| *quinine sulfate* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **ANTIPARKINSON AGENTS** | | |
| **ANTICHOLINERGICS** | | |
| *benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)* | 1-Covered | |
| *trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)* | 1-Covered | |
| **ANTIPARKINSON AGENTS, OTHER** | | |
| *amantadine hcl (50 mg/5ml solution, 100 mg cap, 100 mg tab)* | 1-Covered | |
| *carbidopa-levodopa-entacapone* | 1-Covered | |
| *entacapone* | 1-Covered | |
| *tolcapone* | 1-Covered | NDS (Non-Extended Day Supply) |
| **DOPAMINE AGONISTS** | | |
| *apomorphine hcl* | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *bromocriptine mesylate* | 1-Covered | |
| NEUPRO | 1-Covered | |
| *pramipexole dihydrochloride* | 1-Covered | |
| *pramipexole dihydrochloride er* | 1-Covered | |
| *ropinirole hcl* | 1-Covered | |
| *ropinirole hcl er* | 1-Covered | |
| **DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS** | | |
| *carbidopa* | 1-Covered | |
| *carbidopa-levodopa* | 1-Covered | |
| *carbidopa-levodopa er* | 1-Covered | |
| **MONOAMINE OXIDASE B (MAO-B) INHIBITORS** | | |
| *rasagiline mesylate* | 1-Covered | |
| *selegiline hcl* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **ANTIPSYCHOTICS** | | |
| **1ST GENERATION/TYPICAL** | | |
| *chlorpromazine hcl (10 mg tab, 25 mg tab, 25 mg/ml solution, 30 mg/ml conc, 50 mg tab, 50 mg/2ml solution, 100 mg tab, 100 mg/ml conc, 200 mg tab)* | 1-Covered | |
| *fluphenazine decanoate* | 1-Covered | |
| *fluphenazine hcl (1 mg tab, 2.5 mg tab, 2.5 mg/5ml elixir, 2.5 mg/ml solution, 5 mg tab, 5 mg/ml conc, 10 mg tab)* | 1-Covered | |
| *haloperidol (0.5 mg tab, 1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)* | 1-Covered | |
| *haloperidol decanoate* | 1-Covered | |
| *haloperidol lactate* | 1-Covered | |
| *loxapine succinate* | 1-Covered | |
| *molindone hcl* | 1-Covered | |
| *pimozide* | 1-Covered | |
| *thioridazine hcl* | 1-Covered | |
| *thiothixene* | 1-Covered | |
| *trifluoperazine hcl* | 1-Covered | |
| **2ND GENERATION/ATYPICAL** | | |
| ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR | 1-Covered | QL (2.4 PER 56 DAYS), NDS (Non-Extended Day Supply) |
| ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR | 1-Covered | QL (3.2 PER 56 DAYS), NDS (Non-Extended Day Supply) |
| ABILIFY MAINTENA | 1-Covered | QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *aripiprazole (1 mg/ml solution, 2 mg tab, 5 mg tab, 10 mg tab, 10 mg tab disp, 15 mg tab, 15 mg tab disp, 20 mg tab, 30 mg tab)* | 1-Covered | |
| ARISTADA 1064 MG/3.9ML PRSYR | 1-Covered | QL (3.9 PER 56 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| ARISTADA 441 MG/1.6ML PRSYR | 1-Covered | QL (1.6 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| ARISTADA 662 MG/2.4ML PRSYR | 1-Covered | QL (2.4 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| ARISTADA 882 MG/3.2ML PRSYR | 1-Covered | QL (3.2 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| ARISTADA INITIO | 1-Covered | NDS (Non-Extended Day Supply) |
| *asenapine maleate* | 1-Covered | |
| CAPLYTA | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB) | 1-Covered | QL (60 PER 30 DAYS) |
| FANAPT (6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB) | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| FANAPT TITRATION PACK | 1-Covered | |
| INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR | 1-Covered | QL (3.5 PER 180 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR | 1-Covered | QL (5 PER 180 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR | 1-Covered | QL (0.75 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA SUSTENNA 156 MG/ML SUSP PRSYR | 1-Covered | QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR | 1-Covered | QL (1.5 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR | 1-Covered | QL (0.25 PER 28 DAYS) |
| INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR | 1-Covered | QL (0.5 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR | 1-Covered | QL (0.88 PER 84 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR | 1-Covered | QL (1.32 PER 84 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR | 1-Covered | QL (1.75 PER 84 DAYS), NDS (Non-Extended Day Supply) |
| INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR | 1-Covered | QL (2.63 PER 84 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| LATUDA (20 MG TAB, 40 MG TAB, 60 MG TAB, 120 MG TAB) | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| LATUDA 80 MG TAB | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *lurasidone hcl (20 mg tab, 40 mg tab, 60 mg tab, 120 mg tab)* | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *lurasidone hcl 80 mg tab* | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| NUPLAZID | 1-Covered | PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *olanzapine* | 1-Covered | |
| *paliperidone er 1.5 mg tab er 24h* | 1-Covered | QL (240 PER 30 DAYS) |
| *paliperidone er 3 mg tab er 24h* | 1-Covered | QL (120 PER 30 DAYS) |
| *paliperidone er 6 mg tab er 24h* | 1-Covered | QL (60 PER 30 DAYS) |
| *paliperidone er 9 mg tab er 24h* | 1-Covered | QL (30 PER 30 DAYS) |
| PERSERIS | 1-Covered | QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *quetiapine fumarate* | 1-Covered | |
| *quetiapine fumarate er* | 1-Covered | |
| REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB) | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| REXULTI (2 MG TAB, 3 MG TAB, 4 MG TAB) | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| RISPERDAL CONSTA (12.5 MG, 25 MG) | 1-Covered | QL (2 PER 28 DAYS) |
| RISPERDAL CONSTA (37.5 MG, 50 MG) | 1-Covered | QL (2 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *risperidone (0.25 mg tab, 0.25 mg tab disp, 0.5 mg tab, 0.5 mg tab disp, 1 mg tab, 1 mg tab disp, 2 mg tab, 2 mg tab disp, 3 mg tab, 3 mg tab disp, 4 mg tab, 4 mg tab disp)* | 1-Covered | QL (60 PER 30 DAYS) |
| *risperidone 1 mg/ml solution* | 1-Covered | |
| SECUADO | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| UZEDY 100 MG/0.28ML SUSP PRSYR | 1-Covered | QL (0.28 PER 28 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| UZEDY 125 MG/0.35ML SUSP PRSYR | 1-Covered | QL (0.35 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| UZEDY 150 MG/0.42ML SUSP PRSYR | 1-Covered | QL (0.42 PER 56 DAYS), NDS (Non-Extended Day Supply) |
| UZEDY 200 MG/0.56ML SUSP PRSYR | 1-Covered | QL (0.56 PER 56 DAYS), NDS (Non-Extended Day Supply) |
| UZEDY 250 MG/0.7ML SUSP PRSYR | 1-Covered | QL (0.7 PER 56 DAYS), NDS (Non-Extended Day Supply) |
| UZEDY 50 MG/0.14ML SUSP PRSYR | 1-Covered | QL (0.14 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| UZEDY 75 MG/0.21ML SUSP PRSYR | 1-Covered | QL (0.21 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP) | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VRAYLAR 1.5 & 3 MG CAP THPK | 1-Covered | |
| *ziprasidone hcl* | 1-Covered | QL (60 PER 30 DAYS) |
| *ziprasidone mesylate* | 1-Covered | |
| ZYPREXA RELPREVV | 1-Covered | |
| **TREATMENT-RESISTANT** | | |
| *clozapine* | 1-Covered | |
| VERSACLOZ | 1-Covered | NDS (Non-Extended Day Supply) |
| **ANTISPASTICITY AGENTS** | | |
| *baclofen (5 mg tab, 10 mg tab, 20 mg tab)* | 1-Covered | |
| *dantrolene sodium* | 1-Covered | |
| *tizanidine hcl (2 mg tab, 4 mg tab)* | 1-Covered | |
| **ANTIVIRALS** | | |
| **ANTI-CYTOMEGALOVIRUS (CMV) AGENTS** | | |
| PREVYMIS (240 MG TAB, 480 MG TAB) | 1-Covered | QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *valganciclovir hcl 450 mg tab* | 1-Covered | |
| *valganciclovir hcl 50 mg/ml recon soln* | 1-Covered | NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **ANTI-HEPATITIS B (HBV) AGENTS** | | |
| *adefovir dipivoxil* | 1-Covered | |
| BARACLUDE 0.05 MG/ML SOLUTION | 1-Covered | NDS (Non-Extended Day Supply) |
| *entecavir* | 1-Covered | |
| EPIVIR HBV 5 MG/ML SOLUTION | 1-Covered | |
| *lamivudine 100 mg tab* | 1-Covered | |
| VEMLIDY | 1-Covered | NDS (Non-Extended Day Supply) |
| **ANTI-HEPATITIS C (HCV) AGENTS** | | |
| EPCLUSA (150-37.5 MG PACKET, 400-100 MG TAB) | 1-Covered | PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| EPCLUSA (200-50 MG PACKET, 200-50 MG TAB) | 1-Covered | PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| HARVONI (33.75-150 MG PACKET, 90-400 MG TAB) | 1-Covered | PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| HARVONI (45-200 MG PACKET, 45-200 MG TAB) | 1-Covered | PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| MAVYRET 100-40 MG TAB | 1-Covered | PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| MAVYRET 50-20 MG PACKET | 1-Covered | PA, QL (140 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *ribavirin* | 1-Covered | |
| SOFOSBUVIR-VELPATASVIR | 1-Covered | PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| **ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)** | | |
| APRETUDE | 1-Covered | NDS (Non-Extended Day Supply) |
| BIKTARVY | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| DOVATO | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| GENVOYA | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ISENTRESS (100 MG CHEW TAB, 100 MG PACKET) | 1-Covered | QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| ISENTRESS 25 MG CHEW TAB | 1-Covered | QL (180 PER 30 DAYS) |
| ISENTRESS 400 MG TAB | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ISENTRESS HD | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| JULUCA | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| STRIBILD | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| TIVICAY (25 MG TAB, 50 MG TAB) | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| TIVICAY 10 MG TAB | 1-Covered | QL (60 PER 30 DAYS) |
| TIVICAY PD | 1-Covered | QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)** | | |
| COMPLERA | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| DELSTRIGO | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| EDURANT | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *efavirenz 200 mg cap* | 1-Covered | QL (90 PER 30 DAYS) |
| *efavirenz 50 mg cap* | 1-Covered | QL (240 PER 30 DAYS) |
| *efavirenz 600 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| *efavirenz-emtricitab-tenofo df* | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *efavirenz-lamivudine-tenofovir* | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *etravirine* | 1-Covered | NDS (Non-Extended Day Supply) |
| INTELENCE 25 MG TAB | 1-Covered | QL (120 PER 30 DAYS) |
| *nevirapine 200 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *nevirapine 50 mg/5ml suspension* | 1-Covered | |
| *nevirapine er* | 1-Covered | QL (30 PER 30 DAYS) |
| ODEFSEY | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| PIFELTRO | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)** | | |
| *abacavir sulfate 20 mg/ml solution* | 1-Covered | |
| *abacavir sulfate 300 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *abacavir sulfate-lamivudine* | 1-Covered | QL (30 PER 30 DAYS) |
| CIMDUO | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| DESCOVY | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *emtricitabine* | 1-Covered | QL (30 PER 30 DAYS) |
| *emtricitabine-tenofovir df (100-150 mg tab, 133-200 mg tab, 167-250 mg tab)* | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *emtricitabine-tenofovir df 200-300 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| EMTRIVA 10 MG/ML SOLUTION | 1-Covered | |
| *lamivudine 10 mg/ml solution* | 1-Covered | |
| *lamivudine 150 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *lamivudine 300 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| *lamivudine-zidovudine* | 1-Covered | QL (60 PER 30 DAYS) |
| *tenofovir disoproxil fumarate* | 1-Covered | QL (30 PER 30 DAYS) |
| TRIUMEQ | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| TRIUMEQ PD | 1-Covered | QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| TRIZIVIR | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB) | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VIREAD 40 MG/GM POWDER | 1-Covered | NDS (Non-Extended Day Supply) |
| *zidovudine 100 mg cap* | 1-Covered | QL (180 PER 30 DAYS) |
| *zidovudine 300 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *zidovudine 50 mg/5ml syrup* | 1-Covered | |
| **ANTI-HIV AGENTS, OTHER** | | |
| CABENUVA | 1-Covered | NDS (Non-Extended Day Supply) |
| FUZEON | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *maraviroc* | 1-Covered | NDS (Non-Extended Day Supply) |
| RUKOBIA | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| SELZENTRY (20 MG/ML SOLUTION, 75 MG TAB) | 1-Covered | NDS (Non-Extended Day Supply) |
| SELZENTRY 25 MG TAB | 1-Covered | |
| SUNLENCA (4 X 300 MG TAB THPK, 5 X 300 MG TAB THPK, 463.5 MG/1.5ML SOLUTION) | 1-Covered | NDS (Non-Extended Day Supply) |
| TROGARZO | 1-Covered | NDS (Non-Extended Day Supply) |
| TYBOST | 1-Covered | QL (30 PER 30 DAYS) |
| **ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)** | | |
| APTIVUS | 1-Covered | QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *atazanavir sulfate (150 mg cap, 200 mg cap)* | 1-Covered | QL (60 PER 30 DAYS) |
| *atazanavir sulfate 300 mg cap* | 1-Covered | QL (30 PER 30 DAYS) |
| *darunavir* | 1-Covered | NDS (Non-Extended Day Supply) |
| EVOTAZ | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *fosamprenavir calcium* | 1-Covered | NDS (Non-Extended Day Supply) |
| LEXIVA 50 MG/ML SUSPENSION | 1-Covered | |
| *lopinavir-ritonavir (100-25 mg tab, 200-50 mg tab, 400-100 mg/5ml solution)* | 1-Covered | |
| NORVIR 100 MG PACKET | 1-Covered | |
| PREZCOBIX | 1-Covered | NDS (Non-Extended Day Supply) |
| PREZISTA (75 MG TAB, 150 MG TAB) | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| PREZISTA 100 MG/ML SUSPENSION | 1-Covered | NDS (Non-Extended Day Supply) |
| REYATAZ 50 MG PACKET | 1-Covered | |
| *ritonavir* | 1-Covered | |
| SYMTUZA | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VIRACEPT 250 MG TAB | 1-Covered | QL (270 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| VIRACEPT 625 MG TAB | 1-Covered | QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **ANTI-INFLUENZA AGENTS** | | |
| *oseltamivir phosphate (6 mg/ml recon susp, 30 mg cap, 45 mg cap, 75 mg cap)* | 1-Covered | |
| RELENZA DISKHALER | 1-Covered | |
| *rimantadine hcl* | 1-Covered | |
| **ANTIHERPETIC AGENTS** | | |
| *acyclovir (200 mg cap, 200 mg/5ml suspension, 400 mg tab, 800 mg tab)* | 1-Covered | |
| *acyclovir sodium* | 1-Covered | PA3 |
| *famciclovir* | 1-Covered | QL (90 PER 30 DAYS) |
| *trifluridine* | 1-Covered | |
| *valacyclovir hcl (1 gm tab, 500 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| **ANTIVIRAL, CORONAVIRUS AGENTS** | | |
| PAXLOVID (150/100) | 1-Covered | QL (40 PER 30 DAYS), $0 CS ($0 Cost Share) |
| PAXLOVID (300/100) | 1-Covered | QL (60 PER 30 DAYS), $0 CS ($0 Cost Share) |
| **ANXIOLYTICS** | | |
| **ANXIOLYTICS, OTHER** | | |
| *buspirone hcl* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *hydroxyzine pamoate* | 1-Covered | |
| **BENZODIAZEPINES** | | |
| *alprazolam (0.25 mg tab, 0.5 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| *alprazolam (1 mg tab, 2 mg tab)* | 1-Covered | QL (150 PER 30 DAYS) |
| *chlordiazepoxide hcl 10 mg cap* | 1-Covered | QL (300 PER 30 DAYS) |
| *chlordiazepoxide hcl 25 mg cap* | 1-Covered | QL (360 PER 30 DAYS) |
| *chlordiazepoxide hcl 5 mg cap* | 1-Covered | QL (240 PER 30 DAYS) |
| *clonazepam (0.125 mg tab disp, 0.25 mg tab disp, 0.5 mg tab, 0.5 mg tab disp, 1 mg tab, 1 mg tab disp)* | 1-Covered | QL (120 PER 30 DAYS) |
| *clonazepam (2 mg tab, 2 mg tab disp)* | 1-Covered | QL (300 PER 30 DAYS) |
| *clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)* | 1-Covered | QL (90 PER 30 DAYS) |
| *clorazepate dipotassium 15 mg tab* | 1-Covered | QL (180 PER 30 DAYS) |
| *diazepam (2 mg tab, 5 mg tab, 10 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| *diazepam 5 mg/5ml solution* | 1-Covered | QL (1200 PER 30 DAYS) |
| *diazepam 5 mg/ml conc* | 1-Covered | QL (240 PER 30 DAYS) |
| *diazepam intensol* | 1-Covered | QL (240 PER 30 DAYS) |
| *lorazepam (2 mg tab, 2 mg/ml conc)* | 1-Covered | QL (150 PER 30 DAYS) |
| *lorazepam 0.5 mg tab* | 1-Covered | QL (600 PER 30 DAYS) |
| *lorazepam 1 mg tab* | 1-Covered | QL (300 PER 30 DAYS) |
| *lorazepam intensol* | 1-Covered | QL (150 PER 30 DAYS) |
| *oxazepam* | 1-Covered | QL (120 PER 30 DAYS) |
| **BIPOLAR AGENTS** | | |
| **MOOD STABILIZERS** | | |
| *lamotrigine (5 mg chew tab, 25 mg chew tab, 25 mg tab disp, 50 mg tab disp, 100 mg tab disp, 200 mg tab disp)* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *lamotrigine er* | 1-Covered | |
| *lithium* | 1-Covered | |
| *lithium carbonate* | 1-Covered | |
| *lithium carbonate er* | 1-Covered | |
| **BLOOD GLUCOSE REGULATORS** | | |
| **ANTIDIABETIC AGENTS** | | |
| *acarbose* | 1-Covered | QL (90 PER 30 DAYS) |
| *alogliptin benzoate* | 1-Covered | QL (30 PER 30 DAYS) |
| *alogliptin-metformin hcl* | 1-Covered | QL (60 PER 30 DAYS) |
| *alogliptin-pioglitazone (12.5-30 mg tab, 25-15 mg tab, 25-30 mg tab, 25-45 mg tab)* | 1-Covered | QL (30 PER 30 DAYS) |
| *alogliptin-pioglitazone 12.5-45 mg tab* | 1-Covered | |
| BYDUREON BCISE | 1-Covered | QL (3.4 PER 28 DAYS) |
| BYETTA 10 MCG PEN | 1-Covered | QL (2.4 PER 30 DAYS) |
| BYETTA 5 MCG PEN | 1-Covered | QL (1.2 PER 30 DAYS) |
| CYCLOSET | 1-Covered | |
| FARXIGA | 1-Covered | QL (30 PER 30 DAYS) |
| *glimepiride (1 mg tab, 2 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| *glimepiride 4 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *glipizide (5 mg tab, 10 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| *glipizide er 10 mg tab er 24h* | 1-Covered | QL (60 PER 30 DAYS) |
| *glipizide er 2.5 mg tab er 24h* | 1-Covered | QL (120 PER 30 DAYS) |
| *glipizide er 5 mg tab er 24h* | 1-Covered | QL (90 PER 30 DAYS) |
| *glipizide xl 10 mg tab er 24h* | 1-Covered | QL (60 PER 30 DAYS) |
| *glipizide xl 2.5 mg tab er 24h* | 1-Covered | QL (120 PER 30 DAYS) |
| *glipizide xl 5 mg tab er 24h* | 1-Covered | QL (90 PER 30 DAYS) |
| *glipizide-metformin hcl* | 1-Covered | QL (120 PER 30 DAYS) |
| *glyburide* | 1-Covered | QL (120 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| GLYBURIDE MICRONIZED | 1-Covered | QL (60 PER 30 DAYS) |
| *glyburide-metformin* | 1-Covered | QL (120 PER 30 DAYS) |
| GLYXAMBI | 1-Covered | QL (30 PER 30 DAYS) |
| JANUMET | 1-Covered | QL (60 PER 30 DAYS) |
| JANUMET XR (50-1000 MG TAB ER 24H, 50-500 MG TAB ER 24H) | 1-Covered | QL (60 PER 30 DAYS) |
| JANUMET XR 100-1000 MG TAB ER 24H | 1-Covered | QL (30 PER 30 DAYS) |
| JANUVIA | 1-Covered | QL (30 PER 30 DAYS) |
| JARDIANCE | 1-Covered | QL (30 PER 30 DAYS) |
| JENTADUETO (2.5-1000 MG TAB, 2.5-500 MG TAB) | 1-Covered | QL (60 PER 30 DAYS) |
| JENTADUETO XR 2.5-1000 MG TAB ER 24H | 1-Covered | QL (60 PER 30 DAYS) |
| JENTADUETO XR 5-1000 MG TAB ER 24H | 1-Covered | QL (30 PER 30 DAYS) |
| KERENDIA | 1-Covered | PA, QL (30 PER 30 DAYS) |
| *metformin hcl 1000 mg tab* | 1-Covered | QL (75 PER 30 DAYS) |
| *metformin hcl 500 mg tab* | 1-Covered | QL (150 PER 30 DAYS) |
| *metformin hcl 850 mg tab* | 1-Covered | QL (90 PER 30 DAYS) |
| *metformin hcl er 500 mg tab er 24h* | 1-Covered | QL (120 PER 30 DAYS) |
| *metformin hcl er 750 mg tab er 24h* | 1-Covered | QL (60 PER 30 DAYS) |
| *miglitol* | 1-Covered | QL (90 PER 30 DAYS) |
| MOUNJARO | 1-Covered | QL (2 PER 28 DAYS) |
| *nateglinide 120 mg tab* | 1-Covered | QL (90 PER 30 DAYS) |
| *nateglinide 60 mg tab* | 1-Covered | QL (180 PER 30 DAYS) |
| OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/1.5ML SOLN PEN | 1-Covered | QL (1.5 PER 28 DAYS) |
| OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN | 1-Covered | QL (3 PER 28 DAYS) |
| OZEMPIC (1 MG/DOSE) | 1-Covered | QL (3 PER 28 DAYS) |
| OZEMPIC (2 MG/DOSE) | 1-Covered | QL (3 PER 28 DAYS) |
| *pioglitazone hcl* | 1-Covered | QL (30 PER 30 DAYS) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *pioglitazone hcl-glimepiride* | 1-Covered | QL (30 PER 30 DAYS) |
| *pioglitazone hcl-metformin hcl* | 1-Covered | QL (90 PER 30 DAYS) |
| *repaglinide (0.5 mg tab, 1 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| *repaglinide 2 mg tab* | 1-Covered | QL (240 PER 30 DAYS) |
| RYBELSUS | 1-Covered | QL (30 PER 30 DAYS) |
| SOLIQUA | 1-Covered | QL (18 PER 30 DAYS) |
| SYMLINPEN 120 | 1-Covered | QL (10.8 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| SYMLINPEN 60 | 1-Covered | QL (6 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| SYNJARDY (5-1000 MG TAB, 12.5-1000 MG TAB, 12.5-500 MG TAB) | 1-Covered | QL (60 PER 30 DAYS) |
| SYNJARDY 5-500 MG TAB | 1-Covered | QL (120 PER 30 DAYS) |
| SYNJARDY XR (5-1000 MG TAB ER 24H, 10-1000 MG TAB ER 24H, 12.5-1000 MG TAB ER 24H) | 1-Covered | QL (60 PER 30 DAYS) |
| SYNJARDY XR 25-1000 MG TAB ER 24H | 1-Covered | QL (30 PER 30 DAYS) |
| TRADJENTA | 1-Covered | QL (30 PER 30 DAYS) |
| TRIJARDY XR (10-5-1000 MG TAB ER 24H, 25-5-1000 MG TAB ER 24H) | 1-Covered | QL (30 PER 30 DAYS) |
| TRIJARDY XR (5-2.5-1000 MG TAB ER 24H, 12.5-2.5-1000 MG TAB ER 24H) | 1-Covered | QL (60 PER 30 DAYS) |
| TRULICITY | 1-Covered | QL (2 PER 28 DAYS) |
| XIGDUO XR (10-1000 MG TAB ER 24H, 10-500 MG TAB ER 24H) | 1-Covered | QL (30 PER 30 DAYS) |
| XIGDUO XR (2.5-1000 MG TAB ER 24H, 5-1000 MG TAB ER 24H, 5-500 MG TAB ER 24H) | 1-Covered | QL (60 PER 30 DAYS) |
| **GLYCEMIC AGENTS** | | |
| BAQSIMI ONE PACK | 1-Covered | |
| BAQSIMI TWO PACK | 1-Covered | |
| *diazoxide* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| GLUCAGEN HYPOKIT | 1-Covered | |
| GLUCAGON EMERGENCY 1 MG KIT (GENERIC) | 1-Covered | |
| GLUCAGON EMERGENCY 1 MG/ML RECON SOLN | 1-Covered | |
| GVOKE HYPOPEN 1-PACK | 1-Covered | |
| GVOKE HYPOPEN 2-PACK | 1-Covered | |
| GVOKE KIT | 1-Covered | |
| GVOKE PFS | 1-Covered | |
| **INSULINS** | | |
| ADMELOG | 1-Covered | |
| ADMELOG SOLOSTAR | 1-Covered | |
| BASAGLAR KWIKPEN | 1-Covered | |
| HUMALOG | 1-Covered | |
| HUMALOG JUNIOR KWIKPEN | 1-Covered | |
| HUMALOG KWIKPEN | 1-Covered | |
| HUMALOG MIX 50/50 KWIKPEN | 1-Covered | |
| HUMALOG MIX 75/25 | 1-Covered | |
| HUMALOG MIX 75/25 KWIKPEN | 1-Covered | |
| HUMULIN 70/30 | 1-Covered | |
| HUMULIN 70/30 KWIKPEN | 1-Covered | |
| HUMULIN N | 1-Covered | |
| HUMULIN N KWIKPEN | 1-Covered | |
| HUMULIN R | 1-Covered | |
| HUMULIN R U-500 (CONCENTRATED) | 1-Covered | |
| HUMULIN R U-500 KWIKPEN | 1-Covered | |
| INSULIN LISPRO | 1-Covered | |
| INSULIN LISPRO (1 UNIT DIAL) | 1-Covered | |
| INSULIN LISPRO JUNIOR KWIKPEN | 1-Covered | |
| INSULIN LISPRO PROT & LISPRO | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| LANTUS | 1-Covered | |
| LANTUS SOLOSTAR | 1-Covered | |
| LEVEMIR | 1-Covered | |
| LEVEMIR FLEXPEN | 1-Covered | |
| LEVEMIR FLEXTOUCH | 1-Covered | |
| LYUMJEV | 1-Covered | |
| LYUMJEV KWIKPEN | 1-Covered | |
| TOUJEO MAX SOLOSTAR | 1-Covered | |
| TOUJEO SOLOSTAR | 1-Covered | |
| TRESIBA | 1-Covered | |
| TRESIBA FLEXTOUCH | 1-Covered | |

## BLOOD PRODUCTS AND MODIFIERS

### ANTICOAGULANTS

| | | |
|---|---|---|
| ELIQUIS | 1-Covered | |
| ELIQUIS DVT/PE STARTER PACK | 1-Covered | |
| *enoxaparin sodium (30 mg/0.3ml soln prsyr, 40 mg/0.4ml soln prsyr, 60 mg/0.6ml soln prsyr, 80 mg/0.8ml soln prsyr, 100 mg/ml soln prsyr, 120 mg/0.8ml soln prsyr, 150 mg/ml soln prsyr)* | 1-Covered | |
| *fondaparinux sodium (5 mg/0.4ml solution, 7.5 mg/0.6ml solution, 10 mg/0.8ml solution)* | 1-Covered | NDS (Non-Extended Day Supply) |
| *fondaparinux sodium 2.5 mg/0.5ml solution* | 1-Covered | |
| *heparin sodium (porcine) (1000 unit/ml solution, 5000 unit/ml solution, 10000 unit/ml solution, 20000 unit/ml solution)* | 1-Covered | |
| *heparin sodium (porcine) pf 1000 unit/ml solution* | 1-Covered | |
| *jantoven* | 1-Covered | |
| *warfarin sodium* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| XARELTO (1 MG/ML RECON SUSP, 2.5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB) | 1-Covered | |
| XARELTO STARTER PACK | 1-Covered | |
| ZONTIVITY | 1-Covered | |
| **BLOOD PRODUCTS AND MODIFIERS, OTHER** | | |
| *anagrelide hcl* | 1-Covered | |
| LEUKINE | 1-Covered | NDS (Non-Extended Day Supply) |
| NYVEPRIA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| PROCRIT (2000 UNIT/ML SOLUTION, 3000 UNIT/ML SOLUTION, 4000 UNIT/ML SOLUTION, 10000 UNIT/ML SOLUTION) | 1-Covered | PA3 |
| PROCRIT (20000 UNIT/ML SOLUTION, 40000 UNIT/ML SOLUTION) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| PROMACTA (12.5 MG TAB, 25 MG TAB) | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| PROMACTA (50 MG TAB, 75 MG TAB) | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| PROMACTA 12.5 MG PACKET | 1-Covered | PA, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| PROMACTA 25 MG PACKET | 1-Covered | PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| RETACRIT | 1-Covered | PA3 |
| ZARXIO | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| ZIEXTENZO | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| **HEMOSTASIS AGENTS** | | |
| *tranexamic acid 650 mg tab* | 1-Covered | |
| **PLATELET MODIFYING AGENTS** | | |
| *aspirin-dipyridamole er* | 1-Covered | |
| BRILINTA | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *cilostazol* | 1-Covered | |
| *clopidogrel bisulfate* | 1-Covered | |
| *dipyridamole* | 1-Covered | PA |
| *prasugrel hcl* | 1-Covered | |

## CARDIOVASCULAR AGENTS

### ALPHA-ADRENERGIC AGONISTS

| | | |
|---|---|---|
| *clonidine* | 1-Covered | QL (4 PER 28 DAYS) |
| *clonidine hcl* | 1-Covered | |
| *droxidopa (200 mg cap, 300 mg cap)* | 1-Covered | QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *droxidopa 100 mg cap* | 1-Covered | QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *guanfacine hcl* | 1-Covered | PA |
| *midodrine hcl* | 1-Covered | |

### ALPHA-ADRENERGIC BLOCKING AGENTS

| | | |
|---|---|---|
| *doxazosin mesylate* | 1-Covered | |
| *phenoxybenzamine hcl* | 1-Covered | NDS (Non-Extended Day Supply) |
| *prazosin hcl* | 1-Covered | |
| *terazosin hcl* | 1-Covered | |

### ANGIOTENSIN II RECEPTOR ANTAGONISTS

| | | |
|---|---|---|
| *candesartan cilexetil* | 1-Covered | |
| *irbesartan* | 1-Covered | |
| *losartan potassium* | 1-Covered | |
| *olmesartan medoxomil* | 1-Covered | |
| *telmisartan* | 1-Covered | |
| *valsartan (40 mg tab, 80 mg tab, 160 mg tab, 320 mg tab)* | 1-Covered | |

### ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

| | | |
|---|---|---|
| *benazepril hcl* | 1-Covered | |
| *captopril* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)* | 1-Covered | |
| *fosinopril sodium* | 1-Covered | |
| *lisinopril* | 1-Covered | |
| *moexipril hcl* | 1-Covered | |
| *perindopril erbumine (2 mg tab, 4 mg tab, 8 mg tab)* | 1-Covered | |
| *quinapril hcl* | 1-Covered | |
| *ramipril* | 1-Covered | |
| *trandolapril* | 1-Covered | |
| **ANTIARRHYTHMICS** | | |
| *amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)* | 1-Covered | |
| *disopyramide phosphate* | 1-Covered | PA |
| *dofetilide* | 1-Covered | |
| *flecainide acetate* | 1-Covered | |
| *mexiletine hcl (150 mg cap, 200 mg cap, 250 mg cap)* | 1-Covered | |
| MULTAQ | 1-Covered | |
| *pacerone* | 1-Covered | |
| *propafenone hcl* | 1-Covered | |
| *propafenone hcl er* | 1-Covered | |
| *quinidine sulfate* | 1-Covered | |
| *sorine* | 1-Covered | |
| *sotalol hcl* | 1-Covered | |
| *sotalol hcl (af)* | 1-Covered | |
| **BETA-ADRENERGIC BLOCKING AGENTS** | | |
| *acebutolol hcl* | 1-Covered | |
| *atenolol* | 1-Covered | |
| *betaxolol hcl (10 mg tab, 20 mg tab)* | 1-Covered | |
| *bisoprolol fumarate* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *carvedilol* | 1-Covered | |
| *labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)* | 1-Covered | |
| *metoprolol succinate er* | 1-Covered | |
| *metoprolol tartrate (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)* | 1-Covered | |
| *nadolol* | 1-Covered | |
| *nebivolol hcl (2.5 mg tab, 5 mg tab, 10 mg tab)* | 1-Covered | QL (30 PER 30 DAYS) |
| *nebivolol hcl 20 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *pindolol* | 1-Covered | |
| *propranolol hcl (10 mg tab, 20 mg tab, 20 mg/5ml solution, 40 mg tab, 40 mg/5ml solution, 60 mg tab, 80 mg tab)* | 1-Covered | |
| *propranolol hcl er* | 1-Covered | |
| *timolol maleate (5 mg tab, 10 mg tab, 20 mg tab)* | 1-Covered | |
| **CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES** | | |
| *amlodipine besylate* | 1-Covered | |
| *felodipine er* | 1-Covered | |
| *isradipine* | 1-Covered | |
| *nicardipine hcl (20 mg cap, 30 mg cap)* | 1-Covered | |
| *nifedipine er* | 1-Covered | |
| *nifedipine er osmotic release* | 1-Covered | |
| *nimodipine* | 1-Covered | |
| **CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES** | | |
| *cartia xt* | 1-Covered | |
| *dilt-xr* | 1-Covered | |
| *diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)* | 1-Covered | |
| *diltiazem hcl er* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *diltiazem hcl er beads* | 1-Covered | |
| *diltiazem hcl er coated beads* | 1-Covered | |
| *matzim la* | 1-Covered | |
| *taztia xt* | 1-Covered | |
| *tiadylt er* | 1-Covered | |
| *verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)* | 1-Covered | |
| *verapamil hcl er* | 1-Covered | |
| **CARDIOVASCULAR AGENTS, OTHER** | | |
| *acetazolamide* | 1-Covered | |
| *aliskiren fumarate* | 1-Covered | QL (30 PER 30 DAYS) |
| *amiloride-hydrochlorothiazide* | 1-Covered | |
| *amlodipine besy-benazepril hcl* | 1-Covered | |
| *amlodipine besylate-valsartan* | 1-Covered | |
| *amlodipine-atorvastatin* | 1-Covered | |
| *amlodipine-olmesartan* | 1-Covered | |
| *amlodipine-valsartan-hctz* | 1-Covered | |
| *atenolol-chlorthalidone* | 1-Covered | |
| *benazepril-hydrochlorothiazide* | 1-Covered | |
| *bisoprolol-hydrochlorothiazide* | 1-Covered | |
| *candesartan cilexetil-hctz* | 1-Covered | |
| CORLANOR (5 MG TAB, 7.5 MG TAB) | 1-Covered | QL (60 PER 30 DAYS) |
| CORLANOR 5 MG/5ML SOLUTION | 1-Covered | QL (450 PER 30 DAYS) |
| *digoxin (125 mcg tab, 250 mcg tab)* | 1-Covered | QL (30 PER 30 DAYS) |
| *digoxin 0.05 mg/ml solution* | 1-Covered | |
| *enalapril-hydrochlorothiazide* | 1-Covered | |
| ENTRESTO | 1-Covered | QL (60 PER 30 DAYS) |
| *fosinopril sodium-hctz* | 1-Covered | |
| *irbesartan-hydrochlorothiazide* | 1-Covered | |
| *lisinopril-hydrochlorothiazide* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *losartan potassium-hctz* | 1-Covered | |
| *metoprolol-hydrochlorothiazide* | 1-Covered | |
| *metyrosine* | 1-Covered | NDS (Non-Extended Day Supply) |
| NEXLETOL | 1-Covered | PA, QL (30 PER 30 DAYS) |
| *olmesartan medoxomil-hctz* | 1-Covered | |
| *olmesartan-amlodipine-hctz* | 1-Covered | |
| *pentoxifylline er* | 1-Covered | |
| *ranolazine er* | 1-Covered | |
| *spironolactone-hctz* | 1-Covered | |
| *telmisartan-amlodipine* | 1-Covered | |
| *telmisartan-hctz* | 1-Covered | |
| *trandolapril-verapamil hcl er* | 1-Covered | |
| *triamterene-hctz* | 1-Covered | |
| *valsartan-hydrochlorothiazide* | 1-Covered | |
| VERQUVO | 1-Covered | QL (30 PER 30 DAYS) |
| **DIURETICS, LOOP** | | |
| *bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)* | 1-Covered | |
| *furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)* | 1-Covered | |
| *torsemide* | 1-Covered | |
| **DIURETICS, POTASSIUM-SPARING** | | |
| *amiloride hcl* | 1-Covered | |
| *eplerenone* | 1-Covered | |
| *spironolactone (25 mg tab, 50 mg tab, 100 mg tab)* | 1-Covered | |
| **DIURETICS, THIAZIDE** | | |
| *chlorthalidone* | 1-Covered | |
| *hydrochlorothiazide* | 1-Covered | |
| *indapamide* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *metolazone* | 1-Covered | |
| **DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES** | | |
| *fenofibrate (48 mg tab, 54 mg tab, 67 mg cap, 134 mg cap, 145 mg tab, 160 mg tab, 200 mg cap)* | 1-Covered | |
| *fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)* | 1-Covered | |
| *fenofibric acid (45 mg cap dr, 135 mg cap dr)* | 1-Covered | |
| *gemfibrozil* | 1-Covered | |
| **DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS** | | |
| *atorvastatin calcium (10 mg tab, 40 mg tab)* | 1-Covered | QL (60 PER 30 DAYS) |
| *atorvastatin calcium 20 mg tab* | 1-Covered | QL (90 PER 30 DAYS) |
| *atorvastatin calcium 80 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| LIVALO | 1-Covered | ST, QL (30 PER 30 DAYS) |
| *lovastatin (10 mg tab, 20 mg tab)* | 1-Covered | QL (30 PER 30 DAYS) |
| *lovastatin 40 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *pitavastatin calcium* | 1-Covered | QL (30 PER 30 DAYS) |
| *pravastatin sodium* | 1-Covered | QL (30 PER 30 DAYS) |
| *rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab)* | 1-Covered | QL (60 PER 30 DAYS) |
| *rosuvastatin calcium 40 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| *simvastatin* | 1-Covered | QL (30 PER 30 DAYS) |
| **DYSLIPIDEMICS, OTHER** | | |
| *cholestyramine (4 gm packet, 4 gm/dose powder)* | 1-Covered | |
| *cholestyramine light (4 gm packet, 4 gm/dose powder)* | 1-Covered | |
| *colesevelam hcl* | 1-Covered | |
| *colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)* | 1-Covered | |
| *ezetimibe* | 1-Covered | QL (30 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *ezetimibe-simvastatin* | 1-Covered | QL (30 PER 30 DAYS) |
| NEXLIZET | 1-Covered | PA, QL (30 PER 30 DAYS) |
| *niacin er (antihyperlipidemic)* | 1-Covered | |
| *omega-3-acid ethyl esters* | 1-Covered | |
| *prevalite (4 gm packet, 4 gm/dose powder)* | 1-Covered | |
| REPATHA | 1-Covered | PA, QL (3 PER 28 DAYS) |
| REPATHA PUSHTRONEX SYSTEM | 1-Covered | PA, QL (3.5 PER 28 DAYS) |
| REPATHA SURECLICK | 1-Covered | PA, QL (3 PER 28 DAYS) |
| VASCEPA | 1-Covered | |
| **VASODILATORS, DIRECT-ACTING ARTERIAL** | | |
| *hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)* | 1-Covered | |
| *minoxidil (2.5 mg tab, 10 mg tab)* | 1-Covered | |
| **VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS** | | |
| *isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)* | 1-Covered | |
| *isosorbide mononitrate* | 1-Covered | |
| *isosorbide mononitrate er* | 1-Covered | |
| NITRO-BID | 1-Covered | |
| *nitroglycerin (0.1 mg/hr patch 24hr, 0.2 mg/hr patch 24hr, 0.3 mg sl tab, 0.4 mg sl tab, 0.4 mg/hr patch 24hr, 0.4 mg/spray solution, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)* | 1-Covered | |
| *nitroglycerin 0.4 % ointment* | 1-Covered | QL (30 PER 30 DAYS) |
| RECTIV | 1-Covered | QL (30 PER 30 DAYS) |
| **CENTRAL NERVOUS SYSTEM AGENTS** | | |
| **ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES** | | |
| *amphetamine-dextroamphet er* | 1-Covered | QL (30 PER 30 DAYS) |
| *amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)* | 1-Covered | QL (90 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab)* | 1-Covered | QL (120 PER 30 DAYS) |
| *amphetamine-dextroamphetamine 30 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| *dextroamphetamine sulfate (5 mg tab, 10 mg tab)* | 1-Covered | QL (180 PER 30 DAYS) |
| *dextroamphetamine sulfate er* | 1-Covered | QL (120 PER 30 DAYS) |
| **ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES** | | |
| *atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)* | 1-Covered | QL (60 PER 30 DAYS) |
| *atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)* | 1-Covered | QL (30 PER 30 DAYS) |
| *atomoxetine hcl 18 mg cap* | 1-Covered | QL (120 PER 30 DAYS) |
| *dexmethylphenidate hcl* | 1-Covered | QL (60 PER 30 DAYS) |
| *guanfacine hcl er* | 1-Covered | QL (30 PER 30 DAYS) |
| *methylphenidate hcl (2.5 mg chew tab, 5 mg chew tab, 10 mg chew tab)* | 1-Covered | QL (180 PER 30 DAYS) |
| *methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)* | 1-Covered | QL (90 PER 30 DAYS) |
| *methylphenidate hcl 10 mg/5ml solution* | 1-Covered | QL (900 PER 30 DAYS) |
| *methylphenidate hcl 5 mg/5ml solution* | 1-Covered | QL (1800 PER 30 DAYS) |
| *methylphenidate hcl er (10 mg tab er, 20 mg tab er)* | 1-Covered | QL (90 PER 30 DAYS) |
| **CENTRAL NERVOUS SYSTEM, OTHER** | | |
| AUSTEDO (9 MG TAB, 12 MG TAB) | 1-Covered | PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| AUSTEDO 6 MG TAB | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| AUSTEDO XR | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| AUSTEDO XR PATIENT TITRATION | 1-Covered | PA, QL (42 PER 28 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *bac* | 1-Covered | PA, QL (180 PER 30 DAYS) |
| *butalbital-apap-caffeine 50-325-40 mg tab* | 1-Covered | PA, QL (180 PER 30 DAYS) |
| INGREZZA (40 MG CAP, 60 MG CAP, 80 MG CAP) | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| INGREZZA 40 & 80 MG CAP THPK | 1-Covered | PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| NUEDEXTA | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *riluzole* | 1-Covered | |
| *tetrabenazine 12.5 mg tab* | 1-Covered | PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *tetrabenazine 25 mg tab* | 1-Covered | PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **FIBROMYALGIA AGENTS** | | |
| DRIZALMA SPRINKLE | 1-Covered | |
| *duloxetine hcl (20 mg cp dr part, 30 mg cp dr part, 60 mg cp dr part)* | 1-Covered | QL (60 PER 30 DAYS) |
| *pregabalin (225 mg cap, 300 mg cap)* | 1-Covered | QL (60 PER 30 DAYS) |
| *pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)* | 1-Covered | QL (90 PER 30 DAYS) |
| *pregabalin 20 mg/ml solution* | 1-Covered | QL (900 PER 30 DAYS) |
| *pregabalin er (82.5 mg tab er 24h, 165 mg tab er 24h)* | 1-Covered | PA, QL (90 PER 30 DAYS) |
| *pregabalin er 330 mg tab er 24h* | 1-Covered | PA, QL (60 PER 30 DAYS) |
| SAVELLA | 1-Covered | |
| SAVELLA TITRATION PACK | 1-Covered | |
| **MULTIPLE SCLEROSIS AGENTS** | | |
| AUBAGIO | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| AVONEX PEN | 1-Covered | QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| AVONEX PREFILLED | 1-Covered | QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| BETASERON | 1-Covered | QL (14 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| COPAXONE 20 MG/ML SOLN PRSYR | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| COPAXONE 40 MG/ML SOLN PRSYR | 1-Covered | QL (12 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *dalfampridine er* | 1-Covered | QL (60 PER 30 DAYS) |
| *fingolimod hcl* | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| KESIMPTA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| PLEGRIDY | 1-Covered | QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| PLEGRIDY STARTER PACK | 1-Covered | NDS (Non-Extended Day Supply) |
| TECFIDERA (120 MG CAP DR, 240 MG CAP DR) | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| TECFIDERA 120 & 240 MG CPDR THPK | 1-Covered | NDS (Non-Extended Day Supply) |
| VUMERITY | 1-Covered | QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |

## DENTAL AND ORAL AGENTS

| | | |
|---|---|---|
| *cevimeline hcl* | 1-Covered | |
| *chlorhexidine gluconate* | 1-Covered | |
| *kourzeq* | 1-Covered | |
| *oralone* | 1-Covered | |
| *paroex* | 1-Covered | |
| *periogard* | 1-Covered | |
| *pilocarpine hcl (5 mg tab, 7.5 mg tab)* | 1-Covered | |
| *triamcinolone acetonide 0.1 % paste* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **DERMATOLOGICAL AGENTS** | | |
| **ACNE AND ROSACEA AGENTS** | | |
| *accutane* | 1-Covered | |
| *acitretin* | 1-Covered | PA2 |
| *amnesteem* | 1-Covered | |
| *benzoyl peroxide-erythromycin* | 1-Covered | QL (46.6 PER 30 DAYS) |
| *claravis* | 1-Covered | |
| *clindamycin phos-benzoyl perox 1-5 % gel* | 1-Covered | QL (50 PER 30 DAYS) |
| *clindamycin phos-benzoyl perox 1.2-5 % gel* | 1-Covered | QL (45 PER 30 DAYS) |
| *isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)* | 1-Covered | |
| *myorisan* | 1-Covered | |
| *tazarotene 0.1 % cream* | 1-Covered | QL (60 PER 30 DAYS) |
| TAZORAC 0.05 % CREAM | 1-Covered | QL (60 PER 30 DAYS) |
| *tretinoin (0.01 % gel, 0.025 % cream, 0.025 % gel, 0.05 % cream, 0.1 % cream)* | 1-Covered | PA, QL (45 PER 30 DAYS) |
| *zenatane* | 1-Covered | |
| **DERMATITIS AND PRURITUS AGENTS** | | |
| *ala-cort* | 1-Covered | |
| *alclometasone dipropionate* | 1-Covered | |
| *ammonium lactate* | 1-Covered | |
| *betamethasone dipropionate (0.05 % cream, 0.05 % lotion, 0.05 % ointment)* | 1-Covered | |
| *betamethasone dipropionate aug (0.05 % cream, 0.05 % gel, 0.05 % ointment)* | 1-Covered | |
| *betamethasone valerate (0.1 % cream, 0.1 % lotion, 0.1 % ointment)* | 1-Covered | |
| *clobetasol prop emollient base* | 1-Covered | QL (120 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *clobetasol propionate (0.05 % cream, 0.05 % gel, 0.05 % ointment)* | 1-Covered | QL (120 PER 30 DAYS) |
| *clobetasol propionate (0.05 % foam, 0.05 % solution)* | 1-Covered | QL (100 PER 30 DAYS) |
| *clobetasol propionate (0.05 % lotion, 0.05 % shampoo)* | 1-Covered | QL (118 PER 30 DAYS) |
| *clobetasol propionate 0.05 % liquid* | 1-Covered | QL (125 PER 30 DAYS) |
| *clobetasol propionate e* | 1-Covered | QL (120 PER 30 DAYS) |
| *clobetasol propionate emulsion* | 1-Covered | QL (100 PER 30 DAYS) |
| *clodan* | 1-Covered | QL (118 PER 30 DAYS) |
| *desonide (0.05 % cream, 0.05 % lotion, 0.05 % ointment)* | 1-Covered | |
| *desoximetasone (0.05 % cream, 0.05 % gel, 0.05 % ointment, 0.25 % cream, 0.25 % ointment)* | 1-Covered | |
| *fluocinolone acetonide (0.01 % cream, 0.01 % solution, 0.025 % cream, 0.025 % ointment)* | 1-Covered | |
| *fluocinolone acetonide body* | 1-Covered | |
| *fluocinolone acetonide scalp* | 1-Covered | |
| *fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment)* | 1-Covered | QL (120 PER 30 DAYS) |
| *fluocinonide 0.05 % solution* | 1-Covered | QL (60 PER 30 DAYS) |
| *fluocinonide emulsified base* | 1-Covered | QL (120 PER 30 DAYS) |
| *fluticasone propionate (0.005 % ointment, 0.05 % cream)* | 1-Covered | |
| *halobetasol propionate (0.05 % cream, 0.05 % ointment)* | 1-Covered | QL (50 PER 30 DAYS) |
| *hydrocortisone (1 % cream, 1 % ointment, 2.5 % cream, 2.5 % lotion, 2.5 % ointment)* | 1-Covered | |
| *hydrocortisone (perianal)* | 1-Covered | |
| *hydrocortisone butyrate 0.1 % ointment* | 1-Covered | QL (45 PER 30 DAYS) |
| *hydrocortisone butyrate 0.1 % solution* | 1-Covered | QL (60 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *hydrocortisone valerate* | 1-Covered | |
| *mometasone furoate (0.1 % cream, 0.1 % ointment, 0.1 % solution)* | 1-Covered | |
| *procto-med hc* | 1-Covered | |
| *proctosol hc* | 1-Covered | |
| *proctozone-hc* | 1-Covered | |
| *selenium sulfide 2.5 % lotion* | 1-Covered | |
| *tacrolimus (0.03 % ointment, 0.1 % ointment)* | 1-Covered | QL (100 PER 30 DAYS) |
| *tovet* | 1-Covered | QL (100 PER 30 DAYS) |
| *triamcinolone acetonide (0.025 % cream, 0.025 % lotion, 0.025 % ointment, 0.1 % cream, 0.1 % lotion, 0.1 % ointment, 0.5 % cream, 0.5 % ointment)* | 1-Covered | |
| *triderm* | 1-Covered | |
| **DERMATOLOGICAL AGENTS, OTHER** | | |
| *calcipotriene (0.005 % cream, 0.005 % ointment)* | 1-Covered | QL (120 PER 30 DAYS) |
| *calcipotriene 0.005 % solution* | 1-Covered | QL (60 PER 30 DAYS) |
| *calcitrene* | 1-Covered | QL (120 PER 30 DAYS) |
| *clotrimazole-betamethasone 1-0.05 % cream* | 1-Covered | QL (45 PER 30 DAYS) |
| *clotrimazole-betamethasone 1-0.05 % lotion* | 1-Covered | QL (60 PER 30 DAYS) |
| *fluorouracil (2 % solution, 5 % solution)* | 1-Covered | QL (20 PER 30 DAYS) |
| *fluorouracil 0.5 % cream* | 1-Covered | QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *fluorouracil 5 % cream* | 1-Covered | QL (80 PER 30 DAYS) |
| *imiquimod 5 % cream* | 1-Covered | QL (24 PER 30 DAYS) |
| *methoxsalen rapid* | 1-Covered | NDS (Non-Extended Day Supply) |
| *nystatin-triamcinolone* | 1-Covered | QL (60 PER 30 DAYS) |
| *podofilox 0.5 % solution* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| REGRANEX | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| SANTYL | 1-Covered | QL (90 PER 30 DAYS) |
| *silver sulfadiazine* | 1-Covered | |
| *ssd* | 1-Covered | |
| **PEDICULICIDES/SCABICIDES** | | |
| *lindane* | 1-Covered | |
| *malathion* | 1-Covered | |
| *permethrin* | 1-Covered | |
| **TOPICAL ANTI-INFECTIVES** | | |
| *acyclovir 5 % ointment* | 1-Covered | QL (30 PER 30 DAYS) |
| *ciclodan* | 1-Covered | QL (13.2 PER 30 DAYS) |
| *ciclopirox 0.77 % gel* | 1-Covered | QL (100 PER 30 DAYS) |
| *ciclopirox 1 % shampoo* | 1-Covered | QL (120 PER 30 DAYS) |
| *ciclopirox 8 % solution* | 1-Covered | QL (13.2 PER 30 DAYS) |
| *clindamycin phosphate (1 % lotion, 1 % solution)* | 1-Covered | QL (60 PER 30 DAYS) |
| *clindamycin phosphate 1 % gel* | 1-Covered | QL (75 PER 30 DAYS) |
| *ery* | 1-Covered | QL (60 PER 30 DAYS) |
| *erythromycin 2 % gel* | 1-Covered | QL (60 PER 30 DAYS) |
| *erythromycin 2 % solution* | 1-Covered | QL (120 PER 30 DAYS) |
| *mupirocin 2 % ointment* | 1-Covered | QL (66 PER 30 DAYS) |
| **ELECTROLYTES/MINERALS/METALS/VITAMINS** | | |
| **ELECTROLYTE/MINERAL REPLACEMENT** | | |
| *carglumic acid* | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| CLINIMIX E/DEXTROSE (2.75/5) | 1-Covered | PA3 |
| CLINIMIX E/DEXTROSE (4.25/10) | 1-Covered | PA3 |
| CLINIMIX E/DEXTROSE (4.25/5) | 1-Covered | PA3 |
| CLINIMIX E/DEXTROSE (5/15) | 1-Covered | PA3 |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| CLINIMIX E/DEXTROSE (5/20) | 1-Covered | PA3 |
| CLINIMIX/DEXTROSE (4.25/10) | 1-Covered | PA3 |
| CLINIMIX/DEXTROSE (4.25/5) | 1-Covered | PA3 |
| CLINIMIX/DEXTROSE (5/15) | 1-Covered | PA3 |
| CLINIMIX/DEXTROSE (5/20) | 1-Covered | PA3 |
| *clinisol sf* | 1-Covered | PA3 |
| *dextrose* | 1-Covered | |
| *dextrose-sodium chloride (2.5-0.45 % solution, 5-0.2 % solution, 5-0.225 % solution, 5-0.33 % solution, 5-0.45 % solution, 5-0.9 % solution, 10-0.2 % solution, 10-0.45 % solution)* | 1-Covered | |
| FREAMINE III | 1-Covered | PA3 |
| INTRALIPID | 1-Covered | PA3 |
| ISOLYTE-P IN D5W | 1-Covered | |
| ISOLYTE-S | 1-Covered | |
| ISOLYTE-S PH 7.4 | 1-Covered | |
| KCL (0.149%) IN NACL | 1-Covered | |
| *kcl in dextrose-nacl (10-5-0.45 meq/l-%-% solution, 20-5-0.2 meq/l-%-% solution, 20-5-0.45 meq/l-%-% solution, 20-5-0.9 meq/l-%-% solution, 30-5-0.45 meq/l-%-% solution, 40-5-0.45 meq/l-%-% solution, 40-5-0.9 meq/l-%-% solution)* | 1-Covered | |
| KCL-LACTATED RINGERS-D5W | 1-Covered | |
| *klor-con* | 1-Covered | |
| *klor-con 10* | 1-Covered | |
| *klor-con m10* | 1-Covered | |
| *klor-con m15* | 1-Covered | |
| *klor-con m20* | 1-Covered | |
| *klor-con sprinkle* | 1-Covered | |
| *levocarnitine (1 gm/10ml solution, 330 mg tab)* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *levocarnitine sf* | 1-Covered | |
| *magnesium sulfate 50 % solution* | 1-Covered | |
| *multiple electro type 1 ph 5.5* | 1-Covered | |
| *multiple electro type 1 ph 7.4* | 1-Covered | |
| NUTRILIPID | 1-Covered | PA3 |
| PLASMA-LYTE A | 1-Covered | |
| *plenamine* | 1-Covered | PA3 |
| POTASSIUM CHLORIDE (2 MEQ/ML SOLUTION, 10 % SOLUTION, 10 MEQ/100ML SOLUTION, 10 MEQ/50ML SOLUTION, 20 MEQ PACKET, 20 MEQ/100ML SOLUTION, 20 MEQ/15ML (10%) SOLUTION, 20 MEQ/50ML SOLUTION, 40 MEQ/100ML SOLUTION, 40 MEQ/15ML (20%) SOLUTION) | 1-Covered | |
| *potassium chloride crys er* | 1-Covered | |
| *potassium chloride er* | 1-Covered | |
| *potassium chloride in dextrose 20-5 meq/l-% solution* | 1-Covered | |
| POTASSIUM CHLORIDE IN NACL (, 20-0.45 MEQ/L-% SOLUTION, 40-0.9 MEQ/L-% SOLUTION) | 1-Covered | |
| *potassium citrate er* | 1-Covered | |
| PREMASOL | 1-Covered | PA3 |
| PROSOL | 1-Covered | PA3 |
| *sodium chloride (0.45 % solution, 0.9 % solution, 3 % solution, 5 % solution)* | 1-Covered | |
| *sodium chloride (pf)* | 1-Covered | |
| *sodium fluoride (0.55 (0.25 f) mg chew tab, 1.1 (0.5 f) mg chew tab, 1.1 (0.5 f) mg/ml solution, 2.2 (1 f) mg chew tab)* | 1-Covered | |
| TPN ELECTROLYTES | 1-Covered | PA3 |
| TRAVASOL | 1-Covered | PA3 |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| TROPHAMINE | 1-Covered | PA3 |
| **ELECTROLYTE/MINERAL/METAL MODIFIERS** | | |
| CHEMET | 1-Covered | |
| *deferasirox (90 mg packet, 180 mg packet, 180 mg tab, 250 mg tab sol, 360 mg packet, 360 mg tab, 500 mg tab sol)* | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *deferasirox (90 mg tab, 125 mg tab sol)* | 1-Covered | PA |
| *deferasirox granules* | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *deferiprone* | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| FERRIPROX 100 MG/ML SOLUTION | 1-Covered | NDS (Non-Extended Day Supply) |
| *trientine hcl 250 mg cap* | 1-Covered | QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *trientine hcl 500 mg cap* | 1-Covered | QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **PHOSPHATE BINDERS** | | |
| *calcium acetate* | 1-Covered | |
| *calcium acetate (phos binder)* | 1-Covered | |
| *sevelamer carbonate* | 1-Covered | |
| **POTASSIUM BINDERS** | | |
| LOKELMA | 1-Covered | |
| *sodium polystyrene sulfonate* | 1-Covered | |
| *sps* | 1-Covered | |
| VELTASSA | 1-Covered | |
| **VITAMINS** | | |
| PRENATAL VITAMIN ORAL TABLET | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **GASTROINTESTINAL AGENTS** | | |
| **ANTI-CONSTIPATION AGENTS** | | |
| CLENPIQ | 1-Covered | |
| *constulose* | 1-Covered | |
| *enulose* | 1-Covered | |
| *gavilyte-n with flavor pack* | 1-Covered | |
| *generlac* | 1-Covered | |
| *lactulose (10 gm/15ml solution, 20 gm/30ml solution)* | 1-Covered | |
| *lactulose encephalopathy* | 1-Covered | |
| LINZESS | 1-Covered | QL (30 PER 30 DAYS) |
| *lubiprostone* | 1-Covered | QL (60 PER 30 DAYS) |
| MOVANTIK | 1-Covered | QL (30 PER 30 DAYS) |
| RELISTOR (8 MG/0.4ML SOLUTION, 12 MG/0.6ML SOLUTION, 150 MG TAB) | 1-Covered | NDS (Non-Extended Day Supply) |
| **ANTI-DIARRHEAL AGENTS** | | |
| *alosetron hcl* | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)* | 1-Covered | |
| *loperamide hcl 2 mg cap* | 1-Covered | |
| VIBERZI | 1-Covered | QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| XERMELO | 1-Covered | PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| **ANTISPASMODICS, GASTROINTESTINAL** | | |
| *dicyclomine hcl (10 mg cap, 10 mg/5ml solution, 20 mg tab)* | 1-Covered | |
| *glycopyrrolate (1 mg tab, 2 mg tab)* | 1-Covered | |
| *methscopolamine bromide* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **GASTROINTESTINAL AGENTS, OTHER** | | |
| GATTEX | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *gavilyte-c* | 1-Covered | |
| *gavilyte-g* | 1-Covered | |
| MYALEPT | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *na sulfate-k sulfate-mg sulf* | 1-Covered | |
| OCALIVA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *peg 3350-kcl-na bicarb-nacl* | 1-Covered | |
| *peg-3350/electrolytes* | 1-Covered | |
| *peg-3350/electrolytes/ascorbat* | 1-Covered | |
| *peg-kcl-nacl-nasulf-na asc-c* | 1-Covered | |
| SKYRIZI 180 MG/1.2ML SOLN CART | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *ursodiol (250 mg tab, 300 mg cap, 500 mg tab)* | 1-Covered | |
| **HISTAMINE2 (H2) RECEPTOR ANTAGONISTS** | | |
| *cimetidine* | 1-Covered | |
| CIMETIDINE HCL 300 MG/5ML SOLUTION | 1-Covered | |
| *famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)* | 1-Covered | |
| *nizatidine (150 mg cap, 300 mg cap)* | 1-Covered | |
| **PROTECTANTS** | | |
| *misoprostol* | 1-Covered | |
| *sucralfate (1 gm tab, 1 gm/10ml suspension)* | 1-Covered | |
| **PROTON PUMP INHIBITORS** | | |
| *esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)* | 1-Covered | QL (60 PER 30 DAYS) |
| *lansoprazole (15 mg cap dr, 30 mg cap dr)* | 1-Covered | QL (60 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *omeprazole (10 mg cap dr, 20 mg cap dr, 40 mg cap dr)* | 1-Covered | QL (60 PER 30 DAYS) |
| *pantoprazole sodium (20 mg tab dr, 40 mg tab dr)* | 1-Covered | QL (60 PER 30 DAYS) |
| *rabeprazole sodium* | 1-Covered | QL (30 PER 30 DAYS) |
| **GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT** | | |
| ARALAST NP | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *betaine* | 1-Covered | NDS (Non-Extended Day Supply) |
| CREON | 1-Covered | |
| *cromolyn sodium 100 mg/5ml conc* | 1-Covered | |
| CYSTAGON | 1-Covered | |
| CYSTARAN | 1-Covered | PA, QL (60 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| ENDARI | 1-Covered | PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| GLASSIA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *javygtor* | 1-Covered | NDS (Non-Extended Day Supply) |
| *miglustat* | 1-Covered | QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *nitisinone* | 1-Covered | NDS (Non-Extended Day Supply) |
| NITYR | 1-Covered | NDS (Non-Extended Day Supply) |
| PROLASTIN-C | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| RAVICTI | 1-Covered | PA, QL (525 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *sapropterin dihydrochloride* | 1-Covered | NDS (Non-Extended Day Supply) |
| *sodium phenylbutyrate (3 gm/tsp powder, 500 mg tab)* | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *yargesa* | 1-Covered | QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| ZEMAIRA | 1-Covered | PA, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| ZENPEP | 1-Covered | |

## GENITOURINARY AGENTS

### ANTISPASMODICS, URINARY

| | | |
|---|---|---|
| *darifenacin hydrobromide er* | 1-Covered | QL (30 PER 30 DAYS) |
| *fesoterodine fumarate er* | 1-Covered | QL (30 PER 30 DAYS) |
| *flavoxate hcl* | 1-Covered | |
| GEMTESA | 1-Covered | QL (30 PER 30 DAYS) |
| MYRBETRIQ (25 MG TAB ER 24H, 50 MG TAB ER 24H) | 1-Covered | QL (30 PER 30 DAYS) |
| MYRBETRIQ 8 MG/ML SRER | 1-Covered | QL (300 PER 30 DAYS) |
| *oxybutynin chloride (5 mg tab, 5 mg/5ml solution)* | 1-Covered | |
| *oxybutynin chloride er* | 1-Covered | QL (60 PER 30 DAYS) |
| *solifenacin succinate* | 1-Covered | QL (30 PER 30 DAYS) |
| *tolterodine tartrate* | 1-Covered | QL (60 PER 30 DAYS) |
| *tolterodine tartrate er* | 1-Covered | QL (30 PER 30 DAYS) |
| *trospium chloride* | 1-Covered | QL (60 PER 30 DAYS) |
| *trospium chloride er* | 1-Covered | QL (30 PER 30 DAYS) |

### BENIGN PROSTATIC HYPERTROPHY AGENTS

| | | |
|---|---|---|
| *alfuzosin hcl er* | 1-Covered | QL (30 PER 30 DAYS) |
| *dutasteride* | 1-Covered | QL (30 PER 30 DAYS) |
| *dutasteride-tamsulosin hcl* | 1-Covered | QL (30 PER 30 DAYS) |
| *finasteride* | 1-Covered | QL (30 PER 30 DAYS) |
| *silodosin* | 1-Covered | QL (30 PER 30 DAYS) |
| *tamsulosin hcl* | 1-Covered | QL (60 PER 30 DAYS) |

### GENITOURINARY AGENTS, OTHER

| | | |
|---|---|---|
| *bethanechol chloride* | 1-Covered | |
| ELMIRON | 1-Covered | |
| *penicillamine 250 mg tab* | 1-Covered | NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)** | | |
| ACTHAR | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *betamethasone dipropionate aug 0.05 % lotion* | 1-Covered | |
| CORTROPHIN | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *dexamethasone (0.5 mg tab, 0.5 mg/5ml elixir, 0.5 mg/5ml solution, 0.75 mg tab, 1 mg tab, 1.5 mg tab, 2 mg tab, 4 mg tab, 6 mg tab)* | 1-Covered | |
| *dexamethasone sod phosphate pf 10 mg/ml solution* | 1-Covered | |
| *dexamethasone sodium phosphate (4 mg/ml soln prsyr, 4 mg/ml solution, 10 mg/ml solution, 20 mg/5ml solution, 100 mg/10ml solution, 120 mg/30ml solution)* | 1-Covered | |
| *fludrocortisone acetate* | 1-Covered | |
| KORLYM | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *methylprednisolone* | 1-Covered | |
| *methylprednisolone acetate* | 1-Covered | |
| *methylprednisolone sodium succ* | 1-Covered | |
| *prednisolone 15 mg/5ml solution* | 1-Covered | |
| *prednisolone sodium phosphate (6.7 (5 base) mg/5ml solution, 15 mg/5ml solution, 25 mg/5ml solution)* | 1-Covered | |
| *prednisone (1 mg tab, 2.5 mg tab, 5 mg (21) tab thpk, 5 mg (48) tab thpk, 5 mg tab, 5 mg/5ml solution, 10 mg (21) tab thpk, 10 mg (48) tab thpk, 10 mg tab, 20 mg tab, 50 mg tab)* | 1-Covered | |
| PREDNISONE INTENSOL | 1-Covered | |
| SOLU-MEDROL 2 GM RECON SOLN | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)** | | |
| *desmopressin ace spray refrig* | 1-Covered | |
| *desmopressin acetate (0.1 mg tab, 0.2 mg tab, 4 mcg/ml solution)* | 1-Covered | |
| *desmopressin acetate pf* | 1-Covered | |
| *desmopressin acetate spray* | 1-Covered | |
| INCRELEX | 1-Covered | NDS (Non-Extended Day Supply) |
| NORDITROPIN FLEXPRO | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| **HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)** | | |
| **ANDROGENS** | | |
| *danazol* | 1-Covered | |
| *depo-testosterone* | 1-Covered | PA2 |
| *testosterone (12.5 mg/act (1%) gel, 25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)* | 1-Covered | PA, QL (300 PER 30 DAYS) |
| *testosterone cypionate* | 1-Covered | PA2 |
| *testosterone enanthate* | 1-Covered | PA2 |
| *testosterone td gel pump 20.25 mg/act (1.62%)* | 1-Covered | PA, QL (150 PER 30 DAYS) |
| **ESTROGENS** | | |
| *afirmelle* | 1-Covered | |
| *altavera* | 1-Covered | |
| *alyacen 1/35* | 1-Covered | |
| *alyacen 7/7/7* | 1-Covered | |
| *amabelz* | 1-Covered | |
| *amethyst* | 1-Covered | |
| *apri* | 1-Covered | |
| *aranelle* | 1-Covered | |
| *aubra eq* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *aurovela 1.5/30* | 1-Covered | |
| *aurovela 1/20* | 1-Covered | |
| *aurovela 24 fe* | 1-Covered | |
| *aurovela fe 1.5/30* | 1-Covered | |
| *aurovela fe 1/20* | 1-Covered | |
| *aviane* | 1-Covered | |
| *ayuna* | 1-Covered | |
| *azurette* | 1-Covered | |
| *balziva* | 1-Covered | |
| *bekyree* | 1-Covered | |
| *blisovi 24 fe* | 1-Covered | |
| *blisovi fe 1.5/30* | 1-Covered | |
| *blisovi fe 1/20* | 1-Covered | |
| *briellyn* | 1-Covered | |
| *camrese lo* | 1-Covered | |
| *chateal eq* | 1-Covered | |
| *cryselle-28* | 1-Covered | |
| *cyred eq* | 1-Covered | |
| *dasetta 1/35* | 1-Covered | |
| *dasetta 7/7/7* | 1-Covered | |
| *delyla* | 1-Covered | |
| *desogestrel-ethinyl estradiol* | 1-Covered | |
| *dolishale* | 1-Covered | |
| *dotti* | 1-Covered | |
| *drospirenone-ethinyl estradiol* | 1-Covered | |
| *elinest* | 1-Covered | |
| *eluryng* | 1-Covered | |
| *emoquette* | 1-Covered | |
| *enilloring* | 1-Covered | |
| *enpresse-28* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *enskyce* | 1-Covered | |
| *estarylla* | 1-Covered | |
| *estradiol (0.025 mg/24hr patch tw, 0.025 mg/24hr patch wk, 0.0375 mg/24hr patch tw, 0.0375 mg/24hr patch wk, 0.05 mg/24hr patch tw, 0.05 mg/24hr patch wk, 0.06 mg/24hr patch wk, 0.075 mg/24hr patch tw, 0.075 mg/24hr patch wk, 0.1 mg/24hr patch tw, 0.1 mg/24hr patch wk, 0.1 mg/gm cream, 0.5 mg tab, 1 mg tab, 2 mg tab, 10 mcg tab)* | 1-Covered | |
| *estradiol valerate* | 1-Covered | |
| *estradiol-norethindrone acet* | 1-Covered | |
| ESTRING | 1-Covered | |
| *ethynodiol diac-eth estradiol* | 1-Covered | |
| *etonogestrel-ethinyl estradiol* | 1-Covered | |
| *falmina* | 1-Covered | |
| *femynor* | 1-Covered | |
| *hailey 1.5/30* | 1-Covered | |
| *hailey 24 fe* | 1-Covered | |
| *hailey fe 1.5/30* | 1-Covered | |
| *hailey fe 1/20* | 1-Covered | |
| *haloette* | 1-Covered | |
| *iclevia* | 1-Covered | |
| *introvale* | 1-Covered | |
| *isibloom* | 1-Covered | |
| *jasmiel* | 1-Covered | |
| *jolessa* | 1-Covered | |
| *juleber* | 1-Covered | |
| *junel 1.5/30* | 1-Covered | |
| *junel 1/20* | 1-Covered | |
| *junel fe 1.5/30* | 1-Covered | |
| *junel fe 1/20* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *junel fe 24* | 1-Covered | |
| *kalliga* | 1-Covered | |
| *kariva* | 1-Covered | |
| *kelnor 1/35* | 1-Covered | |
| *kelnor 1/50* | 1-Covered | |
| *kurvelo* | 1-Covered | |
| *larin 1.5/30* | 1-Covered | |
| *larin 1/20* | 1-Covered | |
| *larin 24 fe* | 1-Covered | |
| *larin fe 1.5/30* | 1-Covered | |
| *larin fe 1/20* | 1-Covered | |
| *leena* | 1-Covered | |
| *lessina* | 1-Covered | |
| *levonest* | 1-Covered | |
| *levonorg-eth estrad triphasic* | 1-Covered | |
| *levonorgest-eth estrad 91-day (0.1-0.02 & 0.01 mg tab, 0.15-0.03 mg tab)* | 1-Covered | |
| *levonorgestrel-ethinyl estrad* | 1-Covered | |
| *levora 0.15/30 (28)* | 1-Covered | |
| *lo-zumandimine* | 1-Covered | |
| *loestrin 1.5/30 (21)* | 1-Covered | |
| *loestrin 1/20 (21)* | 1-Covered | |
| *loestrin fe 1.5/30* | 1-Covered | |
| *loestrin fe 1/20* | 1-Covered | |
| *lojaimiess* | 1-Covered | |
| *loryna* | 1-Covered | |
| *low-ogestrel* | 1-Covered | |
| *lutera* | 1-Covered | |
| *lyllana* | 1-Covered | |
| *marlissa* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *microgestin 1.5/30* | 1-Covered | |
| *microgestin 1/20* | 1-Covered | |
| *microgestin 24 fe* | 1-Covered | |
| *microgestin fe 1.5/30* | 1-Covered | |
| *microgestin fe 1/20* | 1-Covered | |
| *mili* | 1-Covered | |
| *mimvey* | 1-Covered | |
| *mono-linyah* | 1-Covered | |
| *necon 0.5/35 (28)* | 1-Covered | |
| *nikki* | 1-Covered | |
| *norelgestromin-eth estradiol* | 1-Covered | |
| *norethin ace-eth estrad-fe (1-20 mg-mcg tab, 1-20 mg-mcg(24) tab, 1.5-30 mg-mcg tab)* | 1-Covered | |
| *norethin-eth estradiol-fe 0.4-35 mg-mcg chew tab* | 1-Covered | |
| *norethindron-ethinyl estrad-fe* | 1-Covered | |
| *norethindrone acet-ethinyl est* | 1-Covered | |
| *norgestim-eth estrad triphasic* | 1-Covered | |
| *norgestimate-eth estradiol* | 1-Covered | |
| *nortrel 0.5/35 (28)* | 1-Covered | |
| *nortrel 1/35 (21)* | 1-Covered | |
| *nortrel 1/35 (28)* | 1-Covered | |
| *nortrel 7/7/7* | 1-Covered | |
| *nylia 1/35* | 1-Covered | |
| *nylia 7/7/7* | 1-Covered | |
| *nymyo* | 1-Covered | |
| *ocella* | 1-Covered | |
| *philith* | 1-Covered | |
| *pimtrea* | 1-Covered | |
| *pirmella 1/35* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *portia-28* | 1-Covered | |
| PREMARIN (0.3 MG TAB, 0.45 MG TAB, 0.625 MG TAB, 0.625 MG/GM CREAM, 0.9 MG TAB, 1.25 MG TAB) | 1-Covered | |
| PREMPHASE | 1-Covered | |
| PREMPRO | 1-Covered | |
| *previfem* | 1-Covered | |
| *reclipsen* | 1-Covered | |
| *setlakin* | 1-Covered | |
| *simliya* | 1-Covered | |
| *sprintec 28* | 1-Covered | |
| *sronyx* | 1-Covered | |
| *syeda* | 1-Covered | |
| *tarina 24 fe* | 1-Covered | |
| *tarina fe 1/20 eq* | 1-Covered | |
| *tilia fe* | 1-Covered | |
| *tri femynor* | 1-Covered | |
| *tri-estarylla* | 1-Covered | |
| *tri-legest fe* | 1-Covered | |
| *tri-linyah* | 1-Covered | |
| *tri-lo-estarylla* | 1-Covered | |
| *tri-lo-marzia* | 1-Covered | |
| *tri-lo-mili* | 1-Covered | |
| *tri-lo-sprintec* | 1-Covered | |
| *tri-mili* | 1-Covered | |
| *tri-nymyo* | 1-Covered | |
| *tri-sprintec* | 1-Covered | |
| *tri-vylibra* | 1-Covered | |
| *tri-vylibra lo* | 1-Covered | |
| *trivora (28)* | 1-Covered | |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *turqoz* | 1-Covered | |
| *velivet* | 1-Covered | |
| *vestura* | 1-Covered | |
| *vienva* | 1-Covered | |
| *viorele* | 1-Covered | |
| *volnea* | 1-Covered | |
| *vyfemla* | 1-Covered | |
| *vylibra* | 1-Covered | |
| *wera* | 1-Covered | |
| *wymzya fe* | 1-Covered | |
| *xulane* | 1-Covered | |
| *yuvafem* | 1-Covered | |
| *zafemy* | 1-Covered | |
| *zarah* | 1-Covered | |
| *zovia 1/35 (28)* | 1-Covered | |
| *zumandimine* | 1-Covered | |
| **HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS), OTHER** | | |
| *lopreeza* | 1-Covered | |
| **PROGESTINS** | | |
| *camila* | 1-Covered | |
| *deblitane* | 1-Covered | |
| DEPO-SUBQ PROVERA 104 | 1-Covered | |
| *emzahh* | 1-Covered | |
| *errin* | 1-Covered | |
| *heather* | 1-Covered | |
| *incassia* | 1-Covered | |
| *jencycla* | 1-Covered | |
| *lyleq* | 1-Covered | |
| *lyza* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml susp prsyr, 150 mg/ml suspension)* | 1-Covered | |
| *megestrol acetate (20 mg tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension, 800 mg/20ml suspension)* | 1-Covered | |
| *nora-be* | 1-Covered | |
| *norethindrone* | 1-Covered | |
| *norethindrone acetate* | 1-Covered | |
| *norlyda* | 1-Covered | |
| *norlyroc* | 1-Covered | |
| *progesterone (100 mg cap, 200 mg cap)* | 1-Covered | |
| *sharobel* | 1-Covered | |
| **SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS** | | |
| DUAVEE | 1-Covered | |
| *raloxifene hcl* | 1-Covered | QL (30 PER 30 DAYS) |
| **HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)** | | |
| *euthyrox* | 1-Covered | |
| *levothyroxine sodium (25 mcg tab, 50 mcg tab, 75 mcg tab, 88 mcg tab, 100 mcg tab, 112 mcg tab, 125 mcg tab, 137 mcg tab, 150 mcg tab, 175 mcg tab, 200 mcg tab, 300 mcg tab)* | 1-Covered | |
| *levoxyl* | 1-Covered | |
| *liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)* | 1-Covered | |
| SYNTHROID | 1-Covered | |
| *unithroid* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)** | | |
| LANREOTIDE ACETATE | 1-Covered | |
| LUPRON DEPOT-PED (1-MONTH) (11.25 MG KIT, 15 MG KIT) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| LUPRON DEPOT-PED (3-MONTH) 30 MG KIT | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *mifepristone* | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *octreotide acetate (50 mcg/ml soln prsyr, 100 mcg/ml soln prsyr, 500 mcg/ml soln prsyr)* | 1-Covered | |
| SOMATULINE DEPOT | 1-Covered | NDS (Non-Extended Day Supply) |
| **HORMONAL AGENTS, SUPPRESSANT (ADRENAL)** | | |
| LYSODREN | 1-Covered | NDS (Non-Extended Day Supply) |
| RECORLEV | 1-Covered | PA, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **HORMONAL AGENTS, SUPPRESSANT (PITUITARY)** | | |
| *cabergoline* | 1-Covered | |
| ELIGARD | 1-Covered | PA3 |
| FIRMAGON | 1-Covered | PA3 |
| FIRMAGON (240 MG DOSE) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *leuprolide acetate* | 1-Covered | PA3 |
| LEUPROLIDE ACETATE (3 MONTH) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| LUPRON DEPOT (1-MONTH) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| LUPRON DEPOT (3-MONTH) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| LUPRON DEPOT (4-MONTH) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| LUPRON DEPOT (6-MONTH) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| LUPRON DEPOT-PED (1-MONTH) 7.5 MG KIT | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| LUPRON DEPOT-PED (3-MONTH) 11.25 MG (PED) KIT | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| LUPRON DEPOT-PED (6-MONTH) | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *octreotide acetate (50 mcg/ml solution, 100 mcg/ml solution, 200 mcg/ml solution, 500 mcg/ml solution, 1000 mcg/ml solution)* | 1-Covered | |
| ORGOVYX | 1-Covered | PA2, NDS (Non-Extended Day Supply) |
| SIGNIFOR | 1-Covered | NDS (Non-Extended Day Supply) |
| SOMAVERT | 1-Covered | NDS (Non-Extended Day Supply) |
| SYNAREL | 1-Covered | NDS (Non-Extended Day Supply) |
| TRELSTAR MIXJECT (3.75 MG RECON SUSP, 22.5 MG RECON SUSP) | 1-Covered | PA3 |
| TRELSTAR MIXJECT 11.25 MG RECON SUSP | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| **HORMONAL AGENTS, SUPPRESSANT (THYROID)** | | |
| **ANTITHYROID AGENTS** | | |
| *methimazole (5 mg tab, 10 mg tab)* | 1-Covered | |
| *propylthiouracil* | 1-Covered | |
| **IMMUNOLOGICAL AGENTS** | | |
| **ANGIOEDEMA AGENTS** | | |
| CINRYZE | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HAEGARDA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *icatibant acetate* | 1-Covered | PA, QL (27 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *sajazir* | 1-Covered | PA, QL (27 PER 30 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **IMMUNOGLOBULINS** | | |
| ATGAM | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| BIVIGAM | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| FLEBOGAMMA DIF | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| GAMMAGARD | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| GAMMAGARD S/D LESS IGA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| GAMMAKED | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| GAMMAPLEX | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| GAMUNEX-C | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| OCTAGAM | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| PANZYGA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| PRIVIGEN | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| THYMOGLOBULIN | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| **IMMUNOLOGICAL AGENTS, OTHER** | | |
| ARCALYST | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| BENLYSTA (120 MG RECON SOLN, 400 MG RECON SOLN) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| BENLYSTA (200 MG/ML SOLN A-INJ, 200 MG/ML SOLN PRSYR) | 1-Covered | PA, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| DUPIXENT | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| OTEZLA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| RIDAURA | 1-Covered | NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| SKYRIZI (150 MG/ML SOLN PRSYR, 360 MG/2.4ML SOLN CART, 600 MG/10ML SOLUTION) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| SKYRIZI PEN | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| STELARA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| TALTZ | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| XELJANZ (1 MG/ML SOLUTION, 5 MG TAB, 10 MG TAB) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| XELJANZ XR | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| XOLAIR (75 MG/0.5ML SOLN A-INJ, 75 MG/0.5ML SOLN PRSYR, 150 MG RECON SOLN, 150 MG/ML SOLN A-INJ, 150 MG/ML SOLN PRSYR, 300 MG/2ML SOLN A-INJ, 300 MG/2ML SOLN PRSYR) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| **IMMUNOSTIMULANTS** | | |
| ACTIMMUNE | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| PEGASYS | 1-Covered | NDS (Non-Extended Day Supply) |
| **IMMUNOSUPPRESSANTS** | | |
| ADALIMUMAB-AACF (2 PEN) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| AVSOLA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *azathioprine 50 mg tab* | 1-Covered | PA3 |
| AZATHIOPRINE SODIUM | 1-Covered | PA3 |
| *cyclosporine (25 mg cap, 50 mg/ml solution, 100 mg cap)* | 1-Covered | PA3 |
| *cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)* | 1-Covered | PA3 |
| ENBREL (25 MG RECON SOLN, 25 MG/0.5ML SOLN PRSYR, 25 MG/0.5ML SOLUTION, 50 MG/ML SOLN PRSYR) | 1-Covered | PA, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| ENBREL MINI | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| ENBREL SURECLICK | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| ENVARSUS XR | 1-Covered | PA3 |
| *everolimus (0.5 mg tab, 0.75 mg tab, 1 mg tab)* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *everolimus 0.25 mg tab* | 1-Covered | PA3 |
| *gengraf (25 mg cap, 100 mg cap, 100 mg/ml solution)* | 1-Covered | PA3 |
| HUMIRA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA (2 PEN) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA (2 SYRINGE) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA PEDIATRIC CROHNS START | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA PEN | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA PEN-CD/UC/HS STARTER | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA PEN-PEDIATRIC UC START | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA PEN-PSOR/UVEIT STARTER | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| HUMIRA-PS/UV/ADOL HS STARTER | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| IDACIO | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| IDACIO FOR CROHNS DISEASE/UC | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| IDACIO FOR PLAQUE PSORIASIS | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| INFLECTRA | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *leflunomide 10 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *leflunomide 20 mg tab* | 1-Covered | QL (150 PER 30 DAYS) |
| *methotrexate sodium (1 gm recon soln, 2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution, 1000 mg/40ml solution)* | 1-Covered | |
| *methotrexate sodium (pf)* | 1-Covered | |
| *mycophenolate mofetil (250 mg cap, 500 mg recon soln, 500 mg tab)* | 1-Covered | PA3 |
| *mycophenolate mofetil 200 mg/ml recon susp* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *mycophenolate mofetil hcl* | 1-Covered | PA3 |
| *mycophenolate sodium* | 1-Covered | PA3 |
| *mycophenolic acid* | 1-Covered | PA3 |
| NULOJIX | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| OTREXUP | 1-Covered | |
| PROGRAF (0.2 MG PACKET, 1 MG PACKET) | 1-Covered | PA3 |
| RASUVO | 1-Covered | |
| RENFLEXIS | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| REZUROCK | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| RINVOQ | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| SANDIMMUNE 100 MG/ML SOLUTION | 1-Covered | PA3 |
| SIMULECT 20 MG RECON SOLN | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *sirolimus (0.5 mg tab, 1 mg tab, 2 mg tab)* | 1-Covered | PA3 |
| *sirolimus 1 mg/ml solution* | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)* | 1-Covered | PA3 |
| TREXALL | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| XATMEP | 1-Covered | |
| **VACCINES** | | |
| ABRYSVO | 1-Covered | |
| ACTHIB | 1-Covered | |
| ADACEL | 1-Covered | |
| AREXVY | 1-Covered | |
| BCG VACCINE | 1-Covered | |
| BEXSERO | 1-Covered | |
| BOOSTRIX | 1-Covered | |
| DAPTACEL | 1-Covered | |
| DIPHTHERIA-TETANUS TOXOIDS DT | 1-Covered | |
| ENGERIX-B | 1-Covered | PA3 |
| GARDASIL 9 | 1-Covered | |
| HAVRIX | 1-Covered | |
| HEPLISAV-B | 1-Covered | PA3 |
| HIBERIX | 1-Covered | |
| IMOVAX RABIES | 1-Covered | |
| INFANRIX | 1-Covered | |
| IPOL | 1-Covered | |
| IXCHIQ | 1-Covered | |
| IXIARO | 1-Covered | |
| JYNNEOS | 1-Covered | PA3 |
| KINRIX | 1-Covered | |
| M-M-R II | 1-Covered | |
| MENACTRA | 1-Covered | |
| MENQUADFI | 1-Covered | |
| MENVEO (RECON SOLN, SOLUTION) | 1-Covered | |
| PEDIARIX | 1-Covered | |
| PEDVAX HIB | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| PENTACEL | 1-Covered | |
| PREHEVBRIO | 1-Covered | PA3 |
| PRIORIX | 1-Covered | |
| PROQUAD | 1-Covered | |
| QUADRACEL | 1-Covered | |
| RABAVERT | 1-Covered | |
| RECOMBIVAX HB | 1-Covered | PA3 |
| ROTARIX | 1-Covered | |
| ROTATEQ | 1-Covered | |
| SHINGRIX | 1-Covered | |
| TDVAX | 1-Covered | |
| TENIVAC | 1-Covered | |
| TICOVAC | 1-Covered | |
| TRUMENBA | 1-Covered | |
| TWINRIX | 1-Covered | |
| TYPHIM VI | 1-Covered | |
| VAQTA | 1-Covered | |
| VARIVAX | 1-Covered | |
| YF-VAX | 1-Covered | |
| **INFLAMMATORY BOWEL DISEASE AGENTS** | | |
| **AMINOSALICYLATES** | | |
| *balsalazide disodium* | 1-Covered | |
| *mesalamine (1.2 gm tab dr, 4 gm enema, 400 mg cap dr, 800 mg tab dr)* | 1-Covered | |
| *mesalamine er 0.375 gm cap er 24h* | 1-Covered | |
| *mesalamine-cleanser* | 1-Covered | |
| *sulfasalazine* | 1-Covered | |
| **GLUCOCORTICOIDS** | | |
| *budesonide 3 mg cp dr part* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *budesonide er* | 1-Covered | NDS (Non-Extended Day Supply) |
| *hydrocortisone (5 mg tab, 10 mg tab, 20 mg tab, 100 mg/60ml enema)* | 1-Covered | |
| **METABOLIC BONE DISEASE AGENTS** | | |
| *alendronate sodium (35 mg tab, 70 mg tab)* | 1-Covered | QL (4 PER 28 DAYS) |
| *alendronate sodium 10 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| *alendronate sodium 70 mg/75ml solution* | 1-Covered | |
| *calcitonin (salmon) 200 unit/act solution* | 1-Covered | |
| *calcitriol (0.25 mcg cap, 0.5 mcg cap)* | 1-Covered | |
| *calcitriol oral soln 1 mcg/ml* | 1-Covered | |
| *cinacalcet hcl (30 mg tab, 60 mg tab)* | 1-Covered | PA3, QL (60 PER 30 DAYS) |
| *cinacalcet hcl 90 mg tab* | 1-Covered | PA3, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *doxercalciferol (0.5 mcg cap, 1 mcg cap, 2.5 mcg cap)* | 1-Covered | |
| FORTEO | 1-Covered | PA, QL (2.4 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *ibandronate sodium 150 mg tab* | 1-Covered | QL (1 PER 30 DAYS) |
| NATPARA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *paricalcitol (1 mcg cap, 2 mcg cap, 4 mcg cap)* | 1-Covered | |
| PROLIA | 1-Covered | QL (1 PER 180 DAYS) |
| RAYALDEE | 1-Covered | NDS (Non-Extended Day Supply) |
| *risedronate sodium (35 mg tab, 35 mg tab dr)* | 1-Covered | QL (4 PER 28 DAYS) |
| *risedronate sodium (5 mg tab, 30 mg tab)* | 1-Covered | QL (30 PER 30 DAYS) |
| *risedronate sodium 150 mg tab* | 1-Covered | QL (1 PER 28 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *teriparatide* | 1-Covered | PA, QL (2.4 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| *teriparatide (recombinant) 600 mcg/2.4ml soln pen* | 1-Covered | PA, QL (2.4 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| TERIPARATIDE (RECOMBINANT) 620 MCG/2.48ML SOLN PEN | 1-Covered | PA, QL (2.48 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| XGEVA | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)* | 1-Covered | PA3 |
| **MISCELLANEOUS THERAPEUTIC AGENTS** | | |
| BD ALCOHOL PADS | 1-Covered | |
| CLINOLIPID | 1-Covered | PA3 |
| GAUZE PADS & DRESSINGS - PADS 2 X 2 | 1-Covered | |
| INSULIN PEN NEEDLE (NOVO/BD/ULTIMED/OWEN/TRIVIDIA) | 1-Covered | |
| INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC) | 1-Covered | |
| INSULIN SYRINGE (DISP) U-100 1 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC) | 1-Covered | |
| INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC) | 1-Covered | |
| ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD | 1-Covered | |
| NEEDLES, INSULIN DISP., SAFETY | 1-Covered | |
| PENBRAYA | 1-Covered | |
| *sterile water for irrigation* | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **OPHTHALMIC AGENTS** | | |
| **OPHTHALMIC AGENTS, OTHER** | | |
| *ak-poly-bac* | 1-Covered | |
| *atropine sulfate 1 % solution* | 1-Covered | |
| *bacitra-neomycin-polymyxin-hc* | 1-Covered | |
| *bacitracin-polymyxin b* | 1-Covered | |
| COMBIGAN | 1-Covered | |
| *cyclopentolate hcl* | 1-Covered | |
| *dorzolamide hcl-timolol mal* | 1-Covered | |
| *dorzolamide hcl-timolol mal pf* | 1-Covered | |
| *neo-polycin* | 1-Covered | |
| *neo-polycin hc* | 1-Covered | |
| *neomycin-bacitracin zn-polymyx* | 1-Covered | |
| *neomycin-polymyxin-dexameth (3.5-10000-0.1 ointment, 3.5-10000-0.1 suspension)* | 1-Covered | |
| *neomycin-polymyxin-gramicidin* | 1-Covered | |
| *neomycin-polymyxin-hc 3.5-10000-1 suspension* | 1-Covered | |
| OXERVATE | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| *polycin* | 1-Covered | |
| *proparacaine hcl* | 1-Covered | |
| RESTASIS | 1-Covered | QL (60 PER 30 DAYS) |
| RESTASIS MULTIDOSE | 1-Covered | QL (5.5 PER 28 DAYS) |
| ROCKLATAN | 1-Covered | |
| *sulfacetamide-prednisolone* | 1-Covered | |
| TOBRADEX 0.3-0.1 % OINTMENT | 1-Covered | |
| *tobramycin-dexamethasone* | 1-Covered | |
| XIIDRA | 1-Covered | QL (60 PER 30 DAYS) |
| ZYLET | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **OPHTHALMIC ANTI-ALLERGY AGENTS** | | |
| ALOMIDE | 1-Covered | |
| *azelastine hcl 0.05 % solution* | 1-Covered | |
| *cromolyn sodium 4 % solution* | 1-Covered | |
| *epinastine hcl* | 1-Covered | |
| *olopatadine hcl 0.1 % solution* | 1-Covered | |
| **OPHTHALMIC ANTI-INFECTIVES** | | |
| AZASITE | 1-Covered | |
| *bacitracin 500 unit/gm ointment* | 1-Covered | |
| *erythromycin 5 mg/gm ointment* | 1-Covered | |
| *gatifloxacin* | 1-Covered | |
| *gentak* | 1-Covered | |
| *gentamicin sulfate 0.3 % solution* | 1-Covered | |
| *levofloxacin 0.5 % solution* | 1-Covered | |
| *moxifloxacin hcl (2x day)* | 1-Covered | |
| *moxifloxacin hcl 0.5 % solution* | 1-Covered | |
| NATACYN | 1-Covered | |
| *ofloxacin 0.3 % solution* | 1-Covered | |
| *polymyxin b-trimethoprim* | 1-Covered | |
| *sulfacetamide sodium (10 % ointment, 10 % solution)* | 1-Covered | |
| *tobramycin 0.3 % solution* | 1-Covered | |
| ZIRGAN | 1-Covered | |
| **OPHTHALMIC ANTI-INFLAMMATORIES** | | |
| *bromfenac sodium (once-daily)* | 1-Covered | |
| *dexamethasone sodium phosphate 0.1 % solution* | 1-Covered | |
| *diclofenac sodium 0.1 % solution* | 1-Covered | |
| *difluprednate* | 1-Covered | |
| FLAREX | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *fluorometholone* | 1-Covered | |
| *flurbiprofen sodium* | 1-Covered | |
| ILEVRO | 1-Covered | |
| *ketorolac tromethamine (0.4 % solution, 0.5 % solution)* | 1-Covered | |
| *loteprednol etabonate (0.5 % gel, 0.5 % suspension)* | 1-Covered | |
| *prednisolone acetate* | 1-Covered | |
| PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION | 1-Covered | |
| PROLENSA | 1-Covered | |
| **OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS** | | |
| *betaxolol hcl 0.5 % solution* | 1-Covered | |
| *carteolol hcl* | 1-Covered | |
| *levobunolol hcl* | 1-Covered | |
| *timolol maleate (0.25 % gel f soln, 0.25 % solution, 0.5 % (daily) solution, 0.5 % gel f soln, 0.5 % solution)* | 1-Covered | |
| **OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER** | | |
| *acetazolamide er* | 1-Covered | |
| ALPHAGAN P 0.1 % SOLUTION | 1-Covered | |
| *apraclonidine hcl* | 1-Covered | |
| *brimonidine tartrate (0.1 % solution, 0.15 % solution, 0.2 % solution)* | 1-Covered | |
| *brinzolamide* | 1-Covered | |
| *dorzolamide hcl* | 1-Covered | |
| *methazolamide* | 1-Covered | |
| *pilocarpine hcl (1 % solution, 2 % solution, 4 % solution)* | 1-Covered | |
| RHOPRESSA | 1-Covered | |
| SIMBRINZA | 1-Covered | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| **OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS** | | |
| *bimatoprost* | 1-Covered | |
| *latanoprost* | 1-Covered | |
| LUMIGAN | 1-Covered | |
| *travoprost (bak free)* | 1-Covered | |
| **OTIC AGENTS** | | |
| CIPRODEX | 1-Covered | |
| *ciprofloxacin hcl 0.2 % solution* | 1-Covered | |
| *ciprofloxacin-dexamethasone* | 1-Covered | |
| *flac* | 1-Covered | |
| *fluocinolone acetonide 0.01 % oil* | 1-Covered | |
| *hydrocortisone-acetic acid* | 1-Covered | |
| *neomycin-polymyxin-hc (1 % solution, 3.5-10000-1 solution)* | 1-Covered | |
| **RESPIRATORY TRACT/PULMONARY AGENTS** | | |
| **ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS** | | |
| ARNUITY ELLIPTA | 1-Covered | QL (30 PER 30 DAYS) |
| *budesonide (0.25 mg/2ml suspension, 0.5 mg/2ml suspension, 1 mg/2ml suspension)* | 1-Covered | PA3 |
| *flunisolide* | 1-Covered | QL (50 PER 30 DAYS) |
| *fluticasone propionate 50 mcg/act suspension* | 1-Covered | QL (16 PER 30 DAYS) |
| *fluticasone propionate diskus (50 mcg/act aer pow ba, 100 mcg/act aer pow ba)* | 1-Covered | QL (60 PER 30 DAYS) |
| *fluticasone propionate diskus 250 mcg/act aer pow ba* | 1-Covered | QL (240 PER 30 DAYS) |
| *fluticasone propionate hfa (110 mcg/act aerosol, 220 mcg/act aerosol)* | 1-Covered | QL (24 PER 30 DAYS) |
| *fluticasone propionate hfa 44 mcg/act aerosol* | 1-Covered | QL (22 PER 30 DAYS) |

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *mometasone furoate 50 mcg/act suspension* | 1-Covered | QL (34 PER 30 DAYS) |
| PULMICORT FLEXHALER | 1-Covered | QL (2 PER 30 DAYS) |
| **ANTIHISTAMINES** | | |
| *azelastine hcl (0.1 % solution, 0.15 % solution, 137 mcg/spray solution)* | 1-Covered | |
| *cetirizine hcl (1 mg/ml solution, 5 mg/5ml solution)* | 1-Covered | |
| *cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)* | 1-Covered | |
| *desloratadine 5 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| *diphenhydramine hcl 50 mg/ml solution* | 1-Covered | |
| *hydroxyzine hcl (10 mg tab, 10 mg/5ml syrup, 25 mg tab, 50 mg tab)* | 1-Covered | |
| *levocetirizine dihydrochloride 2.5 mg/5ml solution* | 1-Covered | |
| *levocetirizine dihydrochloride 5 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| *olopatadine hcl 0.6 % solution* | 1-Covered | |
| *promethazine hcl 6.25 mg/5ml solution* | 1-Covered | PA |
| **ANTILEUKOTRIENES** | | |
| *montelukast sodium* | 1-Covered | QL (30 PER 30 DAYS) |
| *zafirlukast 10 mg tab* | 1-Covered | QL (120 PER 30 DAYS) |
| *zafirlukast 20 mg tab* | 1-Covered | QL (60 PER 30 DAYS) |
| **BRONCHODILATORS, ANTICHOLINERGIC** | | |
| ATROVENT HFA | 1-Covered | QL (25.8 PER 30 DAYS) |
| *ipratropium bromide (0.03 % solution, 0.06 % solution)* | 1-Covered | |
| *ipratropium bromide 0.02 % solution* | 1-Covered | PA3 |
| SPIRIVA HANDIHALER | 1-Covered | QL (30 PER 30 DAYS) |
| SPIRIVA RESPIMAT | 1-Covered | QL (4 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *tiotropium bromide monohydrate* | 1-Covered | QL (30 PER 30 DAYS) |
| YUPELRI | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| **BRONCHODILATORS, SYMPATHOMIMETIC** | | |
| *albuterol sulfate (0.63 mg/3ml nebu soln, 1.25 mg/3ml nebu soln, (2.5 mg/3ml) 0.083% nebu soln, 2.5 mg/0.5ml nebu soln, (5 mg/ml) 0.5% nebu soln)* | 1-Covered | PA3 |
| *albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab)* | 1-Covered | |
| *albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)* | 1-Covered | QL (17 PER 30 DAYS) |
| *albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)* | 1-Covered | QL (17 PER 30 DAYS) |
| *albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)* | 1-Covered | QL (36 PER 30 DAYS) |
| *arformoterol tartrate* | 1-Covered | PA3 |
| *epinephrine (0.15 mg/0.15ml soln a-inj, 0.15 mg/0.3ml soln a-inj, 0.3 mg/0.3ml soln a-inj)* | 1-Covered | |
| *formoterol fumarate* | 1-Covered | PA3 |
| *levalbuterol hcl (0.31 mg/3ml nebu soln, 0.63 mg/3ml nebu soln, 1.25 mg/0.5ml nebu soln, 1.25 mg/3ml nebu soln)* | 1-Covered | PA3 |
| *levalbuterol tartrate* | 1-Covered | QL (30 PER 30 DAYS) |
| SEREVENT DISKUS | 1-Covered | QL (60 PER 30 DAYS) |
| STRIVERDI RESPIMAT | 1-Covered | QL (4 PER 30 DAYS) |
| *terbutaline sulfate (2.5 mg tab, 5 mg tab)* | 1-Covered | |
| **CYSTIC FIBROSIS AGENTS** | | |
| BRONCHITOL | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| CAYSTON | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| KALYDECO | 1-Covered | PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| ORKAMBI (75-94 MG PACKET, 100-125 MG PACKET, 150-188 MG PACKET) | 1-Covered | PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| ORKAMBI 100-125 MG TAB | 1-Covered | PA, QL (112 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| ORKAMBI 200-125 MG TAB | 1-Covered | PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| PULMOZYME | 1-Covered | PA3, NDS (Non-Extended Day Supply) |
| *tobramycin 300 mg/5ml nebu soln* | 1-Covered | PA3, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| TRIKAFTA (50-25-37.5 & 75 MG TAB THPK, 100-50-75 & 150 MG TAB THPK) | 1-Covered | PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| TRIKAFTA (80-40-60 & 59.5 MG THER PACK, 100-50-75 & 75 MG THER PACK) | 1-Covered | PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply) |
| **MAST CELL STABILIZERS** | | |
| *cromolyn sodium 20 mg/2ml nebu soln* | 1-Covered | PA3 |
| **PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE** | | |
| DALIRESP | 1-Covered | |
| *elixophyllin* | 1-Covered | |
| *roflumilast* | 1-Covered | |
| *theophylline* | 1-Covered | |
| *theophylline er* | 1-Covered | |
| **PULMONARY ANTIHYPERTENSIVES** | | |
| ADEMPAS | 1-Covered | PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *alyq* | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *ambrisentan* | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *bosentan* | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| OPSUMIT | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *sildenafil citrate 20 mg tab* | 1-Covered | PA, QL (90 PER 30 DAYS) |
| *tadalafil (pah)* | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| TRACLEER 32 MG TAB SOL | 1-Covered | PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| UPTRAVI (200 & 800 MCG TAB THPK, 200 MCG TAB, 400 MCG TAB, 600 MCG TAB, 800 MCG TAB, 1000 MCG TAB, 1200 MCG TAB, 1400 MCG TAB, 1600 MCG TAB) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| VENTAVIS | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| **PULMONARY FIBROSIS AGENTS** | | |
| OFEV | 1-Covered | PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *pirfenidone (267 mg cap, 267 mg tab)* | 1-Covered | PA, QL (270 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *pirfenidone (534 mg tab, 801 mg tab)* | 1-Covered | PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| **RESPIRATORY TRACT AGENTS, OTHER** | | |
| *acetylcysteine (10 % solution, 20 % solution)* | 1-Covered | PA3 |
| ADVAIR HFA | 1-Covered | QL (12 PER 30 DAYS) |
| ANORO ELLIPTA | 1-Covered | QL (60 PER 30 DAYS) |
| BEVESPI AEROSPHERE | 1-Covered | QL (10.7 PER 30 DAYS) |
| BREO ELLIPTA | 1-Covered | QL (60 PER 30 DAYS) |
| *breyna* | 1-Covered | QL (10.3 PER 30 DAYS) |
| BREZTRI AEROSPHERE | 1-Covered | QL (10.7 PER 30 DAYS) |
| *budesonide-formoterol fumarate* | 1-Covered | QL (10.2 PER 30 DAYS) |
| COMBIVENT RESPIMAT | 1-Covered | QL (4 PER 30 DAYS) |
| DULERA | 1-Covered | QL (13 PER 30 DAYS) |
| FASENRA 30 MG/ML SOLN PRSYR | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| FASENRA PEN | 1-Covered | PA, NDS (Non-Extended Day Supply) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *fluticasone-salmeterol (100-50 mcg/act aer pow ba, 250-50 mcg/act aer pow ba, 500-50 mcg/act aer pow ba)* | 1-Covered | QL (60 PER 30 DAYS) |
| *ipratropium-albuterol* | 1-Covered | PA3 |
| NUCALA (40 MG/0.4ML SOLN PRSYR, 100 MG RECON SOLN, 100 MG/ML SOLN A-INJ, 100 MG/ML SOLN PRSYR) | 1-Covered | PA, NDS (Non-Extended Day Supply) |
| TRELEGY ELLIPTA | 1-Covered | QL (60 PER 30 DAYS) |
| **SKELETAL MUSCLE RELAXANTS** | | |
| BOTOX | 1-Covered | PA |
| *carisoprodol 350 mg tab* | 1-Covered | PA, QL (120 PER 30 DAYS) |
| *cyclobenzaprine hcl 10 mg tab* | 1-Covered | PA, QL (90 PER 30 DAYS) |
| *cyclobenzaprine hcl 5 mg tab* | 1-Covered | PA, QL (180 PER 30 DAYS) |
| *methocarbamol (500 mg tab, 750 mg tab)* | 1-Covered | PA |
| XEOMIN | 1-Covered | PA |
| **SLEEP DISORDER AGENTS** | | |
| **SLEEP PROMOTING AGENTS** | | |
| *doxepin hcl (3 mg tab, 6 mg tab)* | 1-Covered | QL (30 PER 30 DAYS) |
| *eszopiclone* | 1-Covered | PA, QL (30 PER 30 DAYS) |
| HETLIOZ | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| HETLIOZ LQ | 1-Covered | PA, QL (158 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *ramelteon* | 1-Covered | QL (30 PER 30 DAYS) |
| *tasimelteon* | 1-Covered | PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| *temazepam (15 mg cap, 30 mg cap)* | 1-Covered | QL (30 PER 30 DAYS) |
| *zaleplon* | 1-Covered | PA, QL (30 PER 30 DAYS) |
| *zolpidem tartrate 10 mg tab* | 1-Covered | PA, QL (30 PER 30 DAYS) |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|---|---|
| *zolpidem tartrate 5 mg tab* | 1-Covered | QL (30 PER 30 DAYS) |
| *zolpidem tartrate er* | 1-Covered | PA, QL (30 PER 30 DAYS) |
| **WAKEFULNESS PROMOTING AGENTS** | | |
| *armodafinil* | 1-Covered | PA, QL (30 PER 30 DAYS) |
| *modafinil 100 mg tab* | 1-Covered | PA, QL (30 PER 30 DAYS) |
| *modafinil 200 mg tab* | 1-Covered | PA, QL (60 PER 30 DAYS) |
| XYREM | 1-Covered | PA, QL (540 PER 30 DAYS), NDS (Non-Extended Day Supply) |
| XYWAV | 1-Covered | PA, QL (540 PER 30 DAYS), NDS (Non-Extended Day Supply) |

# Index of Drugs

## A

## B

## C

## D

## E

## F

## G



## H

## J



## K

## L

## M

## N

## Q



## R

## S

## T

## U



## V

## W



## X



## Y



## Z

This formulary was updated on 06/01/2024. For more recent information or other questions, please contact Jefferson Health Plans at 1-866-901-8000 (TTY 1-877-454-8477), or visit www.JeffersonHealthPlans.com/Medicare. From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday.

Jefferson Health Plans contracts with Medicare to offer HMO, HMO-DSNP, and PPO plans. Our HMO-DSNP also has a contract with the Pennsylvania State Medicaid program. Enrollment in our plans depends on contract renewal.

Y0170_MCE-540RX-5772.A_C

06/01/2024

**Jefferson Health Plans**
1101 Market Street, Suite 3000
Philadelphia, PA 19107

**1-866-901-8000 (TTY 1-877-454-8477)**

**www.JeffersonHealthPlans.com/Medicare**

Jefferson
Health Plans