Cooperative Advantage (HMO-DSNP)

2023 Formulary

(List of Covered Drugs)

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

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This formulary was updated on 12/1/2023. For more recent information or other questions, please contact Cooperative Advantage Member Service at 1-888-203-7770 or, or, for TTY/TDD: 1-800-947-3529, 7 days per week from October 1 - March 31 and 8:00 a.m. - 8:00 p.m. Monday - Friday from April 1 - September 30, or visit www.group-health.com/cooperative-advantage.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

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 Cooperative Advantage. When it refers to "plan" or "our plan," it means Cooperative Advantage.

This document includes a partial list of the drugs (formulary) for our plan which is current as of 12/1/2023. For a complete, 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, 2023, and from time to time during the year.

What is the Cooperative Advantage Formulary?

A formulary is a list of covered drugs selected by Cooperative Advantage 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. Cooperative Advantage will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Cooperative Advantage network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but Cooperative Advantage 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 Cooperative Advantage's 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 make changes based on new clinical guidelines. If we remove drugs from our formulary, or 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 Cooperative Advantage's Formulary."

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 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 12/1/2023. To get updated information about the drugs covered by Cooperative Advantage please contact us. Our contact information appears on the front and back cover pages.

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 2. 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 95. 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?

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

- **Quantity Limits:** For certain drugs, Cooperative Advantage limits the amount of the drug that Cooperative Advantage will cover. For example, Cooperative Advantage provides 30 capsules per 30-day prescription for Fluoxetine. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Cooperative Advantage 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, Cooperative Advantage may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Cooperative Advantage 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 Web site. 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 Cooperative Advantage 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 Cooperative Advantage's formulary?" on page V for information about how to request an exception.

What are over-the-counter (OTC) drugs?

OTC drugs are not covered under Cooperative Advantage, but some OTC drugs may be covered under Medicaid.

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 Services and ask if your drug is covered.

If you learn that Cooperative Advantage does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Cooperative Advantage. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Cooperative Advantage.

- You can ask Cooperative Advantage 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 Cooperative Advantage's Formulary?

You can ask Cooperative Advantage 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.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Cooperative Advantage 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, Cooperative Advantage will only approve your request for an exception if the alternative drugs included on the plan's formulary, 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 experience a level of care change (such as being admitted to a long-term care facility), Cooperative Advantage will provide at least a 31-day supply (unless the prescription is written for less) with refills provided.

For more information

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

If you have questions about Cooperative Advantage, 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.

Cooperative Advantage's Formulary

The comprehensive formulary below provides coverage information about some of the drugs covered by Cooperative Advantage. If you have trouble finding your drug in the list, turn to the Index that begins on page 95.

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

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

The formulary may change at any time. You will receive notice when necessary.

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.
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.
LA	Limited Access	This prescription drug is limited to certain pharmacies.
NDS	Non-Extended Day Supply	May only be filled for up to a one month supply.
V	Vaccine	Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.
IC	Insulin Cap	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET 5 MG/ML SUSPENSION	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMPHOTERICIN B 50 MG RECON SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE
caspofungin acetate (50 mg recon soln, for iv soln 50 mg)	1-Covered	NDS
caspofungin acetate (70 mg recon soln, for iv soln 70 mg)	1-Covered	
clotrimazole troche 10 mg	1-Covered	
CRESEMBA (74.5 MG CAP, 186 MG CAP)	1-Covered	PA
fluconazole (for susp 10 mg/ml, for susp 40 mg/ml, tab 50 mg, tab 100 mg, tab 150 mg, tab 200 mg)	1-Covered	
fluconazole in nacl (200 mg/100ml, 400 mg/200ml)	1-Covered	PA
flucytosine (cap 250 mg, cap 500 mg)	1-Covered	NDS
griseofulvin microsize (susp 125 mg/5ml, tab 500 mg)	1-Covered	
griseofulvin ultramicrosize (tab 125 mg, tab 250 mg)	1-Covered	
itraconazole cap 100 mg	1-Covered	QL (120 PER 30 DAYS)
itraconazole oral soln 10 mg/ml	1-Covered	
ketoconazole tab 200 mg	1-Covered	
micafungin sodium (50 mg recon soln, for iv soln 50 mg, 100 mg recon soln, for iv soln 100 mg)	1-Covered	NDS
nystatin susp 100000 unit/ml	1-Covered	
nystatin tab 500000 unit	1-Covered	
posaconazole tab delayed release 100 mg	1-Covered	PA, QL (96 PER 30 DAYS), NDS
terbinafine hcl tab 250 mg	1-Covered	
voriconazole (200 mg recon soln, for inj 200 mg)	1-Covered	PA, NDS

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
voriconazole (tab 50 mg, tab 200 mg)	1-Covered	PA
voriconazole for susp 40 mg/ml	1-Covered	PA, NDS
ANTIVIRALS		
abacavir sulfate (soln 20 mg/ml (base equiv), tab 300 mg (base equiv))	1-Covered	
abacavir sulfate-lamivudine tab 600-300 mg	1-Covered	
acyclovir (cap 200 mg, susp 200 mg/5ml, tab 400 mg, tab 800 mg)	1-Covered	
acyclovir sodium iv soln 50 mg/ml	1-Covered	PA - TO CONFIRM PART D COVERAGE
adefovir dipivoxil tab 10 mg	1-Covered	
amantadine hcl (cap 100 mg, soln 50 mg/5ml, tab 100 mg)	1-Covered	
APTIVUS 250 MG CAP	1-Covered	NDS
atazanavir sulfate (cap 150 mg (base equiv), cap 200 mg (base equiv), cap 300 mg (base equiv))	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	NDS
BIKTARVY (30-120-15 MG TAB, 50-200-25 MG TAB)	1-Covered	NDS
CIMDUO 300-300 MG TAB	1-Covered	NDS
COMPLERA 200-25-300 MG TAB	1-Covered	
darunavir (tab 600 mg, tab 800 mg)	1-Covered	NDS
DELSTRIGO 100-300-300 MG TAB	1-Covered	NDS
DESCOVY (120-15 MG TAB, 200-25 MG TAB)	1-Covered	NDS
DOVATO 50-300 MG TAB	1-Covered	NDS
EDURANT 25 MG TAB	1-Covered	NDS
efavirenz (50 mg cap, 200 mg cap, tab 600 mg)	1-Covered	
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	1-Covered	NDS
efavirenz-lamivudine-tenofovir disoproxil fumarate (tab 400-300-300 mg, tab 600-300-300 mg)	1-Covered	NDS
emtricitabine caps 200 mg	1-Covered	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
emtricitabine-tenofovir disoproxil fumarate (tab 100-150 mg, tab 133-200 mg, tab 167-250 mg, tab 200-300 mg)	1-Covered	NDS
EMTRIVA 10 MG/ML SOLUTION	1-Covered	
entecavir (tab 0.5 mg, tab 1 mg)	1-Covered	
EPCLUSA (150-37.5 MG PACKET, 400-100 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS), NDS
EPCLUSA (200-50 MG PACKET, 200-50 MG TAB)	1-Covered	PA, QL (56 PER 28 DAYS), NDS
etravirine (tab 100 mg, tab 200 mg)	1-Covered	NDS
EVOTAZ 300-150 MG TAB	1-Covered	NDS
famciclovir (tab 125 mg, tab 250 mg, tab 500 mg)	1-Covered	
fosamprenavir calcium tab 700 mg (base equiv)	1-Covered	NDS
FUZEON 90 MG RECON SOLN	1-Covered	NDS
GENVOYA 150-150-200-10 MG TAB	1-Covered	NDS
HARVONI (33.75-150 MG PACKET, 90-400 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS), NDS
HARVONI 45-200 MG PACKET	1-Covered	PA, QL (56 PER 28 DAYS), NDS
INTELENCE 25 MG TAB	1-Covered	
ISENTRESS (100 MG CHEW TAB, 100 MG PACKET, 400 MG TAB)	1-Covered	NDS
ISENTRESS 25 MG CHEW TAB	1-Covered	
ISENTRESS HD 600 MG TAB	1-Covered	NDS
JULUCA 50-25 MG TAB	1-Covered	NDS
lamivudine (oral soln 10 mg/ml, tab 150 mg, tab 300 mg)	1-Covered	
lamivudine tab 100 mg (hbv)	1-Covered	
lamivudine-zidovudine tab 150-300 mg	1-Covered	
LEXIVA 50 MG/ML SUSPENSION	1-Covered	
lopinavir-ritonavir (soln 400-100 mg/5ml (80-20 mg/ml), tab 100-25 mg, tab 200-50 mg)	1-Covered	
maraviroc (tab 150 mg, tab 300 mg)	1-Covered	NDS
nevirapine (tab er 24hr 400 mg, 50 mg/5ml suspension, tab 200 mg)	1-Covered	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
NORVIR (80 MG/ML SOLUTION, 100 MG PACKET)	1-Covered	
ODEFSEY 200-25-25 MG TAB	1-Covered	NDS
oseltamivir phosphate (cap 30 mg (base equiv), cap 45 mg (base equiv), cap 75 mg (base equiv), for susp 6 mg/ml (base equiv))	1-Covered	
PIFELTRO 100 MG TAB	1-Covered	NDS
PREVYMIS (240 MG TAB, 480 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS
PREZCOBIX 800-150 MG TAB	1-Covered	NDS
PREZISTA (100 MG/ML SUSPENSION, 600 MG TAB, 800 MG TAB)	1-Covered	NDS
PREZISTA (75 MG TAB, 150 MG TAB)	1-Covered	
RELENZA DISKHALER 5 MG/ACT AER POW BA	1-Covered	
REYATAZ 50 MG PACKET	1-Covered	NDS
RIBAVIRIN (200 MG CAP, 200 MG TAB)	1-Covered	
ribavirin (hepatitis c) (cap 200 mg, tab 200 mg)	1-Covered	
RIMANTADINE HCL 100 MG TAB	1-Covered	
ritonavir tab 100 mg	1-Covered	
RUKOBIA 600 MG TAB ER 12H	1-Covered	NDS
SELZENTRY (20 MG/ML SOLUTION, 25 MG TAB, 75 MG TAB)	1-Covered	
STRIBILD 150-150-200-300 MG TAB	1-Covered	NDS
SUNLENCA (4 X 300 MG TAB, 5 X 300 MG TAB)	1-Covered	NDS
SYMTUZA 800-150-200-10 MG TAB	1-Covered	
tenofovir disoproxil fumarate tab 300 mg	1-Covered	
TIVICAY (25 MG TAB, 50 MG TAB)	1-Covered	NDS
TIVICAY 10 MG TAB	1-Covered	
TIVICAY PD 5 MG TAB SOL	1-Covered	NDS
TRIUMEQ 600-50-300 MG TAB	1-Covered	NDS
TRIUMEQ PD 60-5-30 MG TAB SOL	1-Covered	NDS

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
TRIZIVIR 300-150-300 MG TAB	1-Covered	NDS
valacyclovir hcl tab 1 gm	1-Covered	QL (120 PER 30 DAYS)
valacyclovir hcl tab 500 mg	1-Covered	QL (60 PER 30 DAYS)
valganciclovir hcl for soln 50 mg/ml (base equiv)	1-Covered	NDS
valganciclovir hcl tab 450 mg (base equivalent)	1-Covered	
VEMLIDY 25 MG TAB	1-Covered	NDS
VIRACEPT (250 MG TAB, 625 MG TAB)	1-Covered	NDS
VIREAD (40 MG/GM POWDER, 150 MG TAB, 200 MG TAB, 250 MG TAB)	1-Covered	NDS
VOSEVI 400-100-100 MG TAB	1-Covered	PA, QL (28 PER 28 DAYS), NDS
XOFLUZA (40 MG DOSE) 1 X 40 MG TAB THPK	1-Covered	
XOFLUZA (80 MG DOSE) 1 X 80 MG TAB THPK	1-Covered	
zidovudine (cap 100 mg, syrup 10 mg/ml, tab 300 mg)	1-Covered	
CEPHALOSPORINS		
cefaclor (250 mg cap, 250 mg/5ml recon susp, cap 250 mg, 500 mg cap, cap 500 mg)	1-Covered	
CEFACLOR ER 500 MG TAB ER 12H	1-Covered	
cefadroxil (cap 500 mg, for susp 250 mg/5ml, for susp 500 mg/5ml)	1-Covered	
cefazolin sodium (1 gm recon soln, for inj 1 gm, for inj 10 gm, for inj 500 mg)	1-Covered	
cefdinir (cap 300 mg, for susp 125 mg/5ml, for susp 250 mg/5ml)	1-Covered	
cefepime hcl (inj 1 gm, inj 2 gm, iv soln 2 gm)	1-Covered	
cefixime (cap 400 mg, for susp 100 mg/5ml, for susp 200 mg/5ml)	1-Covered	
cefoxitin sodium (soln 1 gm, soln 2 gm, soln 10 gm)	1-Covered	PA
cefpodoxime proxetil (for susp 50 mg/5ml, for susp 100 mg/5ml, tab 100 mg, tab 200 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
cefprozil (for susp 125 mg/5ml, for susp 250 mg/5ml, tab 250 mg, tab 500 mg)	1-Covered	
ceftazidime (inj 1 gm, inj 6 gm, iv soln 2 gm)	1-Covered	PA
ceftriaxone sodium (inj 1 gm, inj 2 gm, inj 10 gm, inj 250 mg, inj 500 mg, iv soln 1 gm, iv soln 2 gm)	1-Covered	
cefuroxime axetil (tab 250 mg, tab 500 mg)	1-Covered	
cefuroxime sodium (inj 750 mg, iv soln 1.5 gm)	1-Covered	PA
cephalexin (cap 250 mg, cap 500 mg, for susp 125 mg/5ml, for susp 250 mg/5ml)	1-Covered	
TAZICEF (1 GM SOLN, 6 GM SOLN)	1-Covered	PA
TEFLARO (400 MG SOLN, 600 MG SOLN)	1-Covered	PA, NDS
ERYTHROMYCINS / OTHER MACROLIDES		
azithromycin (1 gm packet, for susp 100 mg/5ml, for susp 200 mg/5ml, tab 250 mg, tab 500 mg, tab 600 mg)	1-Covered	
azithromycin iv for soln 500 mg	1-Covered	PA
clarithromycin (tab 250 mg, tab 500 mg, tab er 24hr 500 mg, 125 mg/5ml recon susp, 250 mg/5ml recon susp)	1-Covered	
DIFICID 200 MG TAB	1-Covered	QL (20 PER 10 OVER TIME), NDS
E.E.S. 400 400 MG TAB	1-Covered	
ERYTHROCIN STEARATE 250 MG TAB	1-Covered	
erythromycin base (250 mg cp dr part, tab 250 mg, tab 500 mg, tab delayed release 250 mg, tab delayed release 333 mg, tab delayed release 500 mg, w/ delayed release particles cap 250 mg)	1-Covered	
ERYTHROMYCIN ETHYLSUCCINATE 400 MG TAB	1-Covered	
ERYTHROMYCIN STEARATE 250 MG TAB	1-Covered	
MISCELLANEOUS ANTIINFECTIVES		
albendazole tab 200 mg	1-Covered	NDS
amikacin sulfate inj 500 mg/2ml (250 mg/ml)	1-Covered	PA

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ARIKAYCE 590 MG/8.4ML SUSPENSION	1-Covered	PA, LA
atovaquone susp 750 mg/5ml	1-Covered	NDS
atovaquone-proguanil hcl (tab 62.5-25 mg, tab 250-100 mg)	1-Covered	
aztreonam (1 gm, 2 gm)	1-Covered	PA
CAYSTON 75 MG RECON SOLN	1-Covered	PA, LA, QL (84 PER 56 OVER TIME), NDS
chloroquine phosphate (tab 250 mg, tab 500 mg)	1-Covered	
clindamycin hcl (cap 75 mg, cap 150 mg, cap 300 mg)	1-Covered	
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	1-Covered	
clindamycin phosphate (inj 300 mg/2ml, inj 600 mg/4ml, inj 900 mg/6ml, iv soln 300 mg/2ml, iv soln 600 mg/4ml, iv soln 900 mg/6ml)	1-Covered	PA
clindamycin phosphate in d5w (soln 300 mg/50ml, soln 600 mg/50ml, soln 900 mg/50ml)	1-Covered	PA
COARTEM 20-120 MG TAB	1-Covered	
colistimethate sod for inj 150 mg (colistin base activity)	1-Covered	PA, QL (30 PER 10 OVER TIME)
dapsone (tab 25 mg, tab 100 mg)	1-Covered	
daptomycin (350 mg recon soln, for iv soln 350 mg, 500 mg recon soln, for iv soln 500 mg)	1-Covered	NDS
EMVERM 100 MG CHEW TAB	1-Covered	NDS
ertapenem sodium for inj 1 gm (base equivalent)	1-Covered	PA, QL (14 PER 14 OVER TIME)
ethambutol hcl (tab 100 mg, tab 400 mg)	1-Covered	
gentamicin in saline (0.8-0.9 mg/ml-% solution, 1-0.9 mg/ml-% solution, inj 1.2 mg/ml, 1.6-0.9 mg/ml-% solution)	1-Covered	PA
gentamicin sulfate inj 40 mg/ml	1-Covered	PA
hydroxychloroquine sulfate tab 200 mg	1-Covered	
imipenem-cilastatin (250 mg recon soln, intravenous for soln 250 mg, intravenous for soln 500 mg)	1-Covered	PA

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
isoniazid (syrup 50 mg/5ml, 100 mg tab, tab 100 mg, tab 300 mg)	1-Covered	
ivermectin tab 3 mg	1-Covered	PA, QL (20 PER 30 OVER TIME)
linezolid for susp 100 mg/5ml	1-Covered	NDS
linezolid iv soln 600 mg/300ml (2 mg/ml)	1-Covered	PA
linezolid tab 600 mg	1-Covered	
mefloquine hcl tab 250 mg	1-Covered	
meropenem iv for soln 1 gm	1-Covered	PA, QL (30 PER 10 OVER TIME)
meropenem iv for soln 500 mg	1-Covered	PA, QL (10 PER 10 OVER TIME)
metronidazole (500 mg/100ml solution, iv soln 500 mg/100ml)	1-Covered	PA
metronidazole (tab 250 mg, tab 500 mg)	1-Covered	
neomycin sulfate tab 500 mg	1-Covered	
nitazoxanide tab 500 mg	1-Covered	NDS
paromomycin sulfate cap 250 mg	1-Covered	
pentamidine isethionate (inj soln 300 mg, soln 300 mg)	1-Covered	
pentamidine isethionate for nebulization soln 300 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (1 PER 28 DAYS)
praziquantel tab 600 mg	1-Covered	
PRIFTIN 150 MG TAB	1-Covered	
primaquine phosphate (26.3 (15 base) mg tab, tab 26.3 mg (15 mg base))	1-Covered	
pyrazinamide tab 500 mg	1-Covered	
pyrimethamine tab 25 mg	1-Covered	PA, NDS
quinine sulfate cap 324 mg	1-Covered	
rifabutin cap 150 mg	1-Covered	
rifampin (cap 150 mg, cap 300 mg, for inj 600 mg)	1-Covered	
SIRTURO (20 MG TAB, 100 MG TAB)	1-Covered	PA, LA, NDS
STREPTOMYCIN SULFATE 1 GM RECON SOLN	1-Covered	PA, QL (60 PER 30 OVER TIME), NDS
tigecycline (50 mg recon soln, for iv soln 50 mg)	1-Covered	PA, NDS

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
tinidazole (tab 250 mg, tab 500 mg)	1-Covered	
TOBI PODHALER 28 MG CAP	1-Covered	QL (224 PER 56 OVER TIME), NDS
tobramycin nebu soln 300 mg/4ml	1-Covered	PA, QL (224 PER 28 OVER TIME), NDS
tobramycin nebu soln 300 mg/5ml	1-Covered	PA, QL (280 PER 28 OVER TIME), NDS
tobramycin sulfate (for inj 1.2 gm, inj 1.2 gm/30ml (40 mg/ml) (base equiv), 10 mg/ml solution, inj 80 mg/2ml (40 mg/ml) (base equiv))	1-Covered	PA
TRECATOR 250 MG TAB	1-Covered	
vancomycin hcl (750 mg recon soln, for iv soln 750 mg (base equivalent))	1-Covered	PA, QL (27 PER 10 OVER TIME)
vancomycin hcl cap 125 mg (base equivalent)	1-Covered	PA, QL (40 PER 10 OVER TIME)
vancomycin hcl cap 250 mg (base equivalent)	1-Covered	PA, QL (80 PER 10 OVER TIME)
vancomycin hcl for iv soln 1 gm (base equivalent)	1-Covered	PA, QL (20 PER 10 OVER TIME)
vancomycin hcl for iv soln 10 gm (base equivalent)	1-Covered	PA, QL (2 PER 10 OVER TIME)
vancomycin hcl for iv soln 500 mg (base equivalent)	1-Covered	PA, QL (10 PER 10 OVER TIME)
XIFAXAN 200 MG TAB	1-Covered	QL (9 PER 30 OVER TIME), NDS
XIFAXAN 550 MG TAB	1-Covered	QL (90 PER 30 DAYS), NDS
PENICILLINS		
amoxicillin & pot clavulanate (k for susp 200-28.5 mg/5ml, k for susp 250-62.5 mg/5ml, k for susp 400-57 mg/5ml, k for susp 600-42.9 mg/5ml, k tab 250-125 mg, k tab 500-125 mg, k tab 875-125 mg)	1-Covered	
amoxicillin (125 mg chew tab, (trihydrate) cap 250 mg, (trihydrate) cap 500 mg, (trihydrate) for susp 125 mg/5ml, (trihydrate) for susp 200 mg/5ml, (trihydrate) for susp 250 mg/5ml, 250 mg chew tab, (trihydrate) for susp 400 mg/5ml, (trihydrate) tab 500 mg, (trihydrate) tab 875 mg)	1-Covered	
AMOXICILLIN-POT CLAVULANATE (200-28.5 MG TAB, 400-57 MG TAB)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
AMOXICILLIN-POT CLAVULANATE ER 1000-62.5 MG TAB ER 12H	1-Covered	
ampicillin & sulbactam sodium (inj 1.5 (1-0.5) gm, inj 3 (2-1) gm, iv soln 15 (10-5) gm)	1-Covered	PA
ampicillin (500 mg cap, cap 500 mg)	1-Covered	
ampicillin sodium (1 gm recon soln, for inj 1 gm, for iv soln 10 gm, 125 mg recon soln)	1-Covered	PA
AMPICILLIN-SULBACTAM SODIUM (1.5 (1-0.5) GM SOLN, 3 (2-1) GM SOLN)	1-Covered	PA
AUGMENTIN 125-31.25 MG/5ML RECON SUSP	1-Covered	
BICILLIN C-R 1200000 UNIT/2ML SUSPENSION	1-Covered	PA
BICILLIN C-R 900/300 900000-300000 UNIT/2ML SUSPENSION	1-Covered	PA
BICILLIN L-A (600000 UNIT/ML SUSP, 1200000 UNIT/2ML SUSP, 2400000 UNIT/4ML SUSP)	1-Covered	PA
dicloxacillin sodium (cap 250 mg, cap 500 mg)	1-Covered	
nafcillin sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm)	1-Covered	PA
nafcillin sodium for iv soln 10 gm	1-Covered	PA, NDS
oxacillin sodium (inj 1 gm (base equivalent), inj 2 gm (base equivalent), iv soln 10 gm (base equivalent))	1-Covered	PA
OXACILLIN SODIUM IN DEXTROSE (1 GM/50ML SOLUTION, 2 GM/50ML SOLUTION)	1-Covered	PA
PENICILLIN G POT IN DEXTROSE (40000 UNIT/ML SOLUTION, 60000 UNIT/ML SOLUTION)	1-Covered	PA
penicillin g potassium (5000000, 20000000)	1-Covered	PA
PENICILLIN G SODIUM 5000000 UNIT RECON SOLN	1-Covered	PA
penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, tab 250 mg, tab 500 mg)	1-Covered	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
piperacillin sodium-tazobactam sodium (na 3.375 gm (3-0.375 gm), sod 2.25 gm (2-0.25 gm), sod 4.5 gm (4-0.5 gm), sod 13.5 gm (12-1.5 gm), sod 40.5 gm (36-4.5 gm))	1-Covered	
QUINOLONES		
CIPRO (250 MG/5ML (5%) SUSP, 500 MG/5ML (10%) SUSP)	1-Covered	
ciprofloxacin 200 mg/100ml in d5w	1-Covered	PA
ciprofloxacin hcl (100 mg tab, tab 250 mg (base equiv), tab 500 mg (base equiv), tab 750 mg (base equiv))	1-Covered	
levofloxacin (25 mg/ml solution, oral soln 25 mg/ml, tab 250 mg, tab 500 mg, tab 750 mg)	1-Covered	
levofloxacin in d5w (soln 500 mg/100ml, soln 750 mg/150ml)	1-Covered	PA
MOXIFLOXACIN HCL 400 MG/250ML SOLUTION	1-Covered	PA
MOXIFLOXACIN HCL IN NACL 400 MG/250ML SOLUTION	1-Covered	PA
moxifloxacin hcl tab 400 mg (base equiv)	1-Covered	
SULFA'S / RELATED AGENTS		
sulfadiazine (500 mg tab, tab 500 mg)	1-Covered	
sulfamethoxazole-trimethoprim (susp 200-40 mg/5ml, tab 400-80 mg, tab 800-160 mg)	1-Covered	
TETRACYCLINES		
demeclocycline hcl (tab 150 mg, tab 300 mg)	1-Covered	
doxycycline (monohydrate) (cap 50 mg, cap 100 mg, for susp 25 mg/5ml, tab 50 mg, tab 75 mg, tab 100 mg)	1-Covered	
doxycycline hyclate (cap 50 mg, cap 100 mg, tab 20 mg, tab 50 mg, tab 100 mg)	1-Covered	
doxycycline hyclate for inj 100 mg	1-Covered	PA
minocycline hcl (cap 50 mg, cap 75 mg, cap 100 mg, tab 50 mg, tab 75 mg, tab 100 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
tetracycline hcl (cap 250 mg, cap 500 mg)	1-Covered	
URINARY TRACT AGENTS		
methenamine hippurate tab 1 gm	1-Covered	
nitrofurantoin macrocrystal (line cap 50 mg, line cap 100 mg)	1-Covered	
nitrofurantoin monohydrate macrocrystalline cap 100 mg	1-Covered	
nitrofurantoin susp 25 mg/5ml	1-Covered	
trimethoprim (100 mg tab, tab 100 mg)	1-Covered	
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
leucovorin calcium (tab 5 mg, tab 10 mg, tab 15 mg, tab 25 mg)	1-Covered	
MESNEX 400 MG TAB	1-Covered	NDS
XGEVA 120 MG/1.7ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
abiraterone acetate tab 250 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
abiraterone acetate tab 500 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
ALECENSA 150 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS), NDS
ALUNBRIG (90 MG TAB, 180 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
ALUNBRIG 30 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
ALUNBRIG 90 & 180 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 180 OVER TIME), NDS
anastrozole tab 1 mg	1-Covered	
AYVAKIT (25 MG TAB, 50 MG TAB, 100 MG TAB, 200 MG TAB, 300 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
azathioprine tab 50 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE
BALVERSA (3 MG TAB, 4 MG TAB, 5 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
bexarotene cap 75 mg	1-Covered	PA - FOR NEW STARTS ONLY, NDS
bexarotene gel 1%	1-Covered	PA - FOR NEW STARTS ONLY, NDS
bicalutamide tab 50 mg	1-Covered	
BOSULIF (400 MG TAB, 500 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
BOSULIF 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS
BRAFTOVI 75 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 PER 30 DAYS), NDS
BRUKINSA 80 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
CABOMETYX (20 MG TAB, 40 MG TAB, 60 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
CALQUENCE (100 MG CAP, 100 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS), NDS
CAPRELSA 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS), NDS
CAPRELSA 300 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
COMETRIQ (100 MG DAILY DOSE) 80 & 20 MG KIT	1-Covered	PA - FOR NEW STARTS ONLY, QL (56 PER 28 DAYS), NDS
COMETRIQ (140 MG DAILY DOSE) 3 X 20 MG & 80 MG KIT	1-Covered	PA - FOR NEW STARTS ONLY, QL (112 PER 28 DAYS), NDS
COMETRIQ (60 MG DAILY DOSE) 20 MG KIT	1-Covered	PA - FOR NEW STARTS ONLY, QL (84 PER 28 DAYS), NDS
COPIKTRA (15 MG CAP, 25 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS), NDS
COTELLIC 20 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (63 PER 28 OVER TIME), NDS
cyclophosphamide (25 mg cap, 25 mg tab, cap 25 mg, 50 mg cap, 50 mg tab, cap 50 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine (cap 25 mg, cap 100 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine modified (for microemulsion) (cap 25 mg, cap 50 mg, cap 100 mg, oral soln 100 mg/ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE
DAURISMO 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
DAURISMO 25 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
DROXIA (200 MG CAP, 300 MG CAP, 400 MG CAP)	1-Covered	
EMCYT 140 MG CAP	1-Covered	NDS
ENVARSUS XR (0.75 MG TAB ER, 1 MG TAB ER, 4 MG TAB ER)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ERIVEDGE 150 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
ERLEADA 240 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
ERLEADA 60 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
erlotinib hcl (tab 100 mg (base equivalent), tab 150 mg (base equivalent))	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
erlotinib hcl tab 25 mg (base equivalent)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
everolimus (immunosuppressant) (tab 0.25 mg, tab 0.5 mg, tab 0.75 mg, tab 1 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
everolimus (tab 2.5 mg, tab 5 mg, tab 7.5 mg, tab 10 mg)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
everolimus tab for oral susp 2 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (330 PER 30 DAYS), NDS
everolimus tab for oral susp 3 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS), NDS
everolimus tab for oral susp 5 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS), NDS
exemestane tab 25 mg	1-Covered	
EXKIVITY 40 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
FIRMAGON (240 MG DOSE) 120 MG/VIAL RECON SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
FIRMAGON 80 MG RECON SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE
FOTIVDA (0.89 MG CAP, 1.34 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (21 PER 28 OVER TIME), NDS
GAVRETO 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
gefitinib tab 250 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
GILOTRIF (20 MG TAB, 30 MG TAB, 40 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
GLEOSTINE (10 MG CAP, 40 MG CAP, 100 MG CAP)	1-Covered	
hydroxyurea cap 500 mg	1-Covered	
IBRANCE (75 MG CAP, 75 MG TAB, 100 MG CAP, 100 MG TAB, 125 MG CAP, 125 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (21 PER 28 OVER TIME), NDS
ICLUSIG (10 MG TAB, 15 MG TAB, 30 MG TAB, 45 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
IDHIFA (50 MG TAB, 100 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
imatinib mesylate tab 100 mg (base equivalent)	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS), NDS
imatinib mesylate tab 400 mg (base equivalent)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
IMBRUVICA (70 MG CAP, 140 MG TAB, 280 MG TAB, 420 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
IMBRUVICA 140 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
IMBRUVICA 70 MG/ML SUSPENSION	1-Covered	PA - FOR NEW STARTS ONLY, QL (324 PER 30 DAYS), NDS
INLYTA 1 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS), NDS
INLYTA 5 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
INQOVI 35-100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (5 PER 28 OVER TIME), NDS
INREBIC 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
IRESSA 250 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
JAKAFI (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB, 25 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
JAYPIRCA 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
JAYPIRCA 50 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
KISQALI (200 MG DOSE) 200 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (21 PER 28 OVER TIME), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
KISQALI (400 MG DOSE) 200 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (42 PER 28 OVER TIME), NDS
KISQALI (600 MG DOSE) 200 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (63 PER 28 OVER TIME), NDS
KISQALI FEMARA (400 MG DOSE) 200 & 2.5 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (70 PER 28 OVER TIME), NDS
KISQALI FEMARA (600 MG DOSE) 200 & 2.5 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (91 PER 28 OVER TIME), NDS
KISQALI FEMARA(200 MG DOSE) 200 & 2.5 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (49 PER 28 OVER TIME), NDS
KRAZATI 200 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS), NDS
lapatinib ditosylate tab 250 mg (base equiv)	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS), NDS
lenalidomide (cap 5 mg, cap 10 mg, cap 15 mg, cap 20 mg, cap 25 mg, caps 2.5 mg)	1-Covered	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS), NDS
LENVIMA (10 MG DAILY DOSE) 10 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LENVIMA (12 MG DAILY DOSE) 3 X 4 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LENVIMA (14 MG DAILY DOSE) 10 & 4 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LENVIMA (18 MG DAILY DOSE) 10 MG & 2 X 4 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LENVIMA (20 MG DAILY DOSE) 2 X 10 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LENVIMA (24 MG DAILY DOSE) 2 X 10 MG & 4 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LENVIMA (4 MG DAILY DOSE) 4 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LENVIMA (8 MG DAILY DOSE) 2 X 4 MG CAP THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
letrozole tab 2.5 mg	1-Covered	
LEUKERAN 2 MG TAB	1-Covered	NDS
leuprolide acetate inj kit 5 mg/ml	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LONSURF (15-6.14 MG TAB, 20-8.19 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LORBRENA 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
LORBRENA 25 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS
LUMAKRAS (120 MG TAB, 320 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LUPRON DEPOT (1-MONTH) (3.75 MG KIT, 7.5 MG KIT)	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LUPRON DEPOT (3-MONTH) (11.25 MG KIT, 22.5 MG KIT)	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LUPRON DEPOT (4-MONTH) 30 MG KIT	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LUPRON DEPOT (6-MONTH) 45 MG KIT	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LUPRON DEPOT-PED (1-MONTH) 7.5 MG KIT	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LUPRON DEPOT-PED (3-MONTH) 11.25 MG (PED) KIT	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LUPRON DEPOT-PED (6-MONTH) 45 MG KIT	1-Covered	PA - FOR NEW STARTS ONLY, NDS
LYNPARZA (100 MG TAB, 150 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
LYSODREN 500 MG TAB	1-Covered	NDS
LYTGOBI (12 MG DAILY DOSE) 4 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
LYTGOBI (16 MG DAILY DOSE) 4 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
LYTGOBI (20 MG DAILY DOSE) 4 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
MATULANE 50 MG CAP	1-Covered	NDS
megestrol acetate (tab 20 mg, tab 40 mg)	1-Covered	PA - FOR NEW STARTS ONLY
megestrol acetate susp 40 mg/ml	1-Covered	PA
megestrol acetate susp 625 mg/5ml	1-Covered	PA
MEKINIST 0.05 MG/ML RECON SOLN	1-Covered	PA - FOR NEW STARTS ONLY, QL (1200 PER 30 DAYS), NDS
MEKINIST 0.5 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS
MEKINIST 2 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
MEKTOVI 15 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 PER 30 DAYS), NDS

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
mercaptopurine tab 50 mg	1-Covered	
methotrexate sodium (inj 50 mg/2ml (25 mg/ml), inj pf 50 mg/2ml (25 mg/ml), tab 2.5 mg (base equiv))	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolate mofetil (cap 250 mg, tab 500 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolate mofetil for oral susp 200 mg/ml	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
mycophenolate sodium (tab dr 180 mg (mycophenolic equiv), tab dr 360 mg (mycophenolic equiv))	1-Covered	PA - TO CONFIRM PART D COVERAGE
NERLYNX 40 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
nilutamide tab 150 mg	1-Covered	PA - FOR NEW STARTS ONLY, NDS
NINLARO (2.3 MG CAP, 3 MG CAP, 4 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (3 PER 28 OVER TIME), NDS
NUBEQA 300 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
octreotide acetate (inj 50 mcg/ml (0.05 mg/ml), inj 100 mcg/ml (0.1 mg/ml), 200 mcg/ml solution, inj 200 mcg/ml (0.2 mg/ml))	1-Covered	PA
octreotide acetate (inj 500 mcg/ml (0.5 mg/ml), 1000 mcg/ml solution, inj 1000 mcg/ml (1 mg/ml))	1-Covered	PA, NDS
ODOMZO 200 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
OJJAARA (100 MG TAB, 150 MG TAB, 200 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
ONUREG (200 MG TAB, 300 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (14 PER 28 OVER TIME)
ORGOVYX 120 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 28 DAYS), NDS
ORSERDU 345 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
ORSERDU 86 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS
PEMAZYRE (4.5 MG TAB, 9 MG TAB, 13.5 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (14 PER 21 OVER TIME), NDS
PIQRAY (200 MG DAILY DOSE) 200 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
PIQRAY (250 MG DAILY DOSE) 200 & 50 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
PIQRAY (300 MG DAILY DOSE) 2 X 150 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS
POMALYST (1 MG CAP, 2 MG CAP, 3 MG CAP, 4 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
PROGRAF (0.2 MG, 1 MG)	1-Covered	PA - TO CONFIRM PART D COVERAGE
PURIXAN 2000 MG/100ML SUSPENSION	1-Covered	NDS
QINLOCK 50 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (90 PER 30 DAYS), NDS
RETEVMO 40 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 PER 30 DAYS), NDS
RETEVMO 80 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
REVLIMID (2.5 MG CAP, 5 MG CAP, 10 MG CAP, 15 MG CAP, 20 MG CAP, 25 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (28 PER 28 DAYS), NDS
REZLIDHIA 150 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
ROZLYTREK 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (150 PER 30 DAYS), NDS
ROZLYTREK 200 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS
RUBRACA (200 MG TAB, 250 MG TAB, 300 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
RYDAPT 25 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, NDS
SANDIMMUNE 100 MG/ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
SCEMBLIX 20 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (600 PER 30 DAYS), NDS
SCEMBLIX 40 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (300 PER 30 DAYS), NDS
SIGNIFOR (0.3 MG/ML SOLUTION, 0.6 MG/ML SOLUTION, 0.9 MG/ML SOLUTION)	1-Covered	PA, NDS
sirolimus (tab 0.5 mg, tab 1 mg, tab 2 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
sirolimus oral soln 1 mg/ml	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
SOLTAMOX 10 MG/5ML SOLUTION	1-Covered	NDS

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
sorafenib tosylate tab 200 mg (base equivalent)	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
SPRYCEL (20 MG TAB, 70 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
SPRYCEL (50 MG TAB, 80 MG TAB, 100 MG TAB, 140 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
STIVARGA 40 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (84 PER 28 OVER TIME), NDS
sunitinib malate (cap 12.5 mg (base equivalent), cap 25 mg (base equivalent), cap 37.5 mg (base equivalent), cap 50 mg (base equivalent))	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
SYNRIBO 3.5 MG RECON SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
TABLOID 40 MG TAB	1-Covered	
TABRECTA (150 MG TAB, 200 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS
tacrolimus (cap 0.5 mg, cap 1 mg, cap 5 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
TAFINLAR (50 MG CAP, 75 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
TAFINLAR 10 MG TAB SOL	1-Covered	PA - FOR NEW STARTS ONLY, QL (840 PER 28 DAYS), NDS
TAGRISSO (40 MG TAB, 80 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
TALZENNA (0.1 MG CAP, 0.35 MG CAP, 0.5 MG CAP, 0.75 MG CAP, 1 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
TALZENNA 0.25 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS
tamoxifen citrate (tab 10 mg (base equivalent), tab 20 mg (base equivalent))	1-Covered	
TASIGNA (150 MG CAP, 200 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (112 PER 28 DAYS), NDS
TASIGNA 50 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
TAZVERIK 200 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
TEPMETKO 225 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
THALOMID (150 MG CAP, 200 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (56 PER 28 DAYS), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
THALOMID (50 MG CAP, 100 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS), NDS
TIBSOVO 250 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, NDS
toremifene citrate tab 60 mg (base equivalent)	1-Covered	NDS
TRELSTAR MIXJECT (3.75 MG SUSP, 11.25 MG SUSP, 22.5 MG SUSP)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
tretinoin cap 10 mg	1-Covered	NDS
TUKYSA 150 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
TUKYSA 50 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (300 PER 30 DAYS), NDS
TURALIO 125 MG CAP	1-Covered	PA, LA, QL (120 PER 30 DAYS), NDS
VANFLYTA (17.7 MG TAB, 26.5 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (56 PER 28 DAYS), NDS
VENCLEXTA 10 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS)
VENCLEXTA 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS), NDS
VENCLEXTA 50 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
VENCLEXTA STARTING PACK 10 & 50 & 100 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (42 PER 180 OVER TIME), NDS
VERZENIO (50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS), NDS
VITRAKVI 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS), NDS
VITRAKVI 20 MG/ML SOLUTION	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (300 PER 30 DAYS), NDS
VITRAKVI 25 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 PER 30 DAYS), NDS
VIZIMPRO (15 MG TAB, 30 MG TAB, 45 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS
VONJO 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
VOTRIENT 200 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
WELIREG 40 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
XALKORI (200 MG CAP, 250 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
XATMEP 2.5 MG/ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
XERMELO 250 MG TAB	1-Covered	PA, LA, QL (90 PER 30 DAYS), NDS
XOSPATA 40 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (60 MG TWICE WEEKLY) 20 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (80 MG TWICE WEEKLY) 20 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, LA
XTANDI (40 MG CAP, 40 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
XTANDI 80 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
YONSA 125 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS), NDS
ZEJULA (100 MG CAP, 100 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (90 PER 30 DAYS), NDS
ZEJULA (200 MG TAB, 300 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS), NDS
ZELBORAF 240 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS), NDS
ZOLINZA 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, NDS
ZYDELIG (100 MG TAB, 150 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
ZYKADIA 150 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM (600 MG TAB, 800 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
APTIOM 200 MG TAB	1-Covered	QL (180 PER 30 DAYS)
APTIOM 400 MG TAB	1-Covered	QL (90 PER 30 DAYS)
BRIVIACT (10 MG TAB, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS
BRIVIACT 10 MG/ML SOLUTION	1-Covered	QL (600 PER 30 DAYS), NDS
carbamazepine (cap er 12hr 100 mg, cap er 12hr 200 mg, cap er 12hr 300 mg, chew tab 100 mg, susp 100 mg/5ml, tab 200 mg, tab er 12hr 100 mg, tab er 12hr 200 mg, tab er 12hr 400 mg)	1-Covered	
CELONTIN 300 MG CAP	1-Covered	
clobazam (tab 10 mg, tab 20 mg)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
clobazam suspension 2.5 mg/ml	1-Covered	PA - FOR NEW STARTS ONLY, QL (480 PER 30 DAYS)
clonazepam (orally disintegrating tab 0.125 mg, orally disintegrating tab 0.25 mg, orally disintegrating tab 0.5 mg, orally disintegrating tab 1 mg, tab 0.5 mg, tab 1 mg)	1-Covered	QL (90 PER 30 DAYS)
clonazepam (orally disintegrating tab 2 mg, tab 2 mg)	1-Covered	QL (300 PER 30 DAYS)
DIACOMIT (250 MG CAP, 250 MG PACKET, 500 MG CAP, 500 MG PACKET)	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
diazepam (anticonvulsant) (rectal gel 10 mg, rectal gel 20 mg)	1-Covered	
DIAZEPAM 2.5 MG GEL	1-Covered	
DILANTIN 30 MG CAP	1-Covered	
divalproex sodium (cap delayed release sprinkle 125 mg, tab delayed release 125 mg, tab delayed release 250 mg, tab delayed release 500 mg, tab er 24 hr 250 mg, tab er 24 hr 500 mg)	1-Covered	
EPIDIOLEX 100 MG/ML SOLUTION	1-Covered	PA - FOR NEW STARTS ONLY, LA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
EPRONTIA 25 MG/ML SOLUTION	1-Covered	PA - FOR NEW STARTS ONLY
ethosuximide (cap 250 mg, soln 250 mg/5ml)	1-Covered	
felbamate (tab 400 mg, tab 600 mg)	1-Covered	
felbamate susp 600 mg/5ml	1-Covered	NDS
FINTEPLA 2.2 MG/ML SOLUTION	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (360 PER 30 DAYS), NDS
FYCOMPA (4 MG TAB, 6 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS
FYCOMPA (8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS
FYCOMPA 0.5 MG/ML SUSPENSION	1-Covered	QL (720 PER 30 DAYS), NDS
FYCOMPA 2 MG TAB	1-Covered	QL (60 PER 30 DAYS)
gabapentin (cap 100 mg, cap 400 mg)	1-Covered	QL (270 PER 30 DAYS)
gabapentin cap 300 mg	1-Covered	QL (360 PER 30 DAYS)
gabapentin oral soln 250 mg/5ml	1-Covered	QL (2160 PER 30 DAYS)
gabapentin tab 600 mg	1-Covered	QL (180 PER 30 DAYS)
gabapentin tab 800 mg	1-Covered	QL (120 PER 30 DAYS)
GRALISE (450 MG TAB, 750 MG TAB, 900 MG TAB)	1-Covered	PA, QL (60 PER 30 DAYS)
GRALISE 300 MG TAB	1-Covered	PA, QL (30 PER 30 DAYS)
GRALISE 600 MG TAB	1-Covered	PA, QL (90 PER 30 DAYS)
lacosamide (10 mg/ml solution, oral solution 10 mg/ml)	1-Covered	QL (1200 PER 30 DAYS), NDS
lacosamide (tab 100 mg, tab 150 mg, tab 200 mg)	1-Covered	QL (60 PER 30 DAYS)
lacosamide tab 50 mg	1-Covered	QL (120 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
lamotrigine (orally disintegrating tab 25 mg, orally disintegrating tab 50 mg, orally disintegrating tab 100 mg, orally disintegrating tab 200 mg, tab 25 mg, tab 25 mg (42) & 100 mg (7) starter kit, tab 35 x 25 mg starter kit, tab 84 x 25 mg & 14 x 100 mg starter kit, tab 100 mg, tab 150 mg, tab 200 mg, tab chewable dispersible 5 mg, tab chewable dispersible 25 mg, tab disint 21 x 25 mg & 7 x 50 mg titration kit, tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit, tab disint 42 x 50mg & 14 x 100mg titration kit, tab er 24hr 100 mg, tab er 24hr 200 mg, tab er 24hr 25 mg, tab er 24hr 250 mg, tab er 24hr 300 mg, tab er 24hr 50 mg)	1-Covered	
levetiracetam (oral soln 100 mg/ml, tab 250 mg, tab 500 mg, tab 750 mg, tab 1000 mg, tab er 24hr 500 mg, tab er 24hr 750 mg)	1-Covered	
methsuximide cap 300 mg	1-Covered	
NAYZILAM 5 MG/0.1ML SOLUTION	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 OVER TIME), NDS
oxcarbazepine (susp 300 mg/5ml (60 mg/ml), tab 150 mg, tab 300 mg, tab 600 mg)	1-Covered	
pantoprazole sodium ec tab 20 mg (base equiv)	1-Covered	QL (30 PER 30 DAYS)
phenobarbital (elixir 20 mg/5ml, tab 15 mg, tab 16.2 mg, tab 30 mg, tab 32.4 mg, tab 60 mg, tab 64.8 mg, tab 97.2 mg, tab 100 mg)	1-Covered	PA - FOR NEW STARTS ONLY
phenytoin (chew tab 50 mg, susp 125 mg/5ml)	1-Covered	
phenytoin sodium extended (cap 100 mg, cap 200 mg, cap 300 mg)	1-Covered	
pregabalin (cap 225 mg, cap 300 mg)	1-Covered	QL (60 PER 30 DAYS)
pregabalin (cap 25 mg, cap 50 mg, cap 75 mg, cap 100 mg, cap 150 mg, cap 200 mg)	1-Covered	QL (90 PER 30 DAYS)
pregabalin soln 20 mg/ml	1-Covered	QL (900 PER 30 DAYS)
primidone (tab 50 mg, 125 mg tab, tab 250 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
rufinamide (susp 40 mg/ml, tab 400 mg)	1-Covered	PA - FOR NEW STARTS ONLY, NDS
rufinamide tab 200 mg	1-Covered	PA - FOR NEW STARTS ONLY
SPRITAM (250 MG TAB, 500 MG TAB, 750 MG TAB, 1000 MG TAB)	1-Covered	
SYMPAZAN (10 MG, 20 MG)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS
SYMPAZAN 5 MG FILM	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
tiagabine hcl (tab 2 mg, tab 4 mg, tab 12 mg, tab 16 mg)	1-Covered	
topiramate (sprinkle cap 15 mg, sprinkle cap 25 mg, tab 25 mg, tab 50 mg, tab 100 mg, tab 200 mg)	1-Covered	PA - FOR NEW STARTS ONLY
valproate sodium oral soln 250 mg/5ml (base equiv)	1-Covered	
valproic acid cap 250 mg	1-Covered	
VALTOCO 10 MG DOSE 10 MG/0.1ML LIQUID	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 OVER TIME), NDS
VALTOCO 15 MG DOSE 7.5 MG/0.1ML LIQD THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 OVER TIME), NDS
VALTOCO 20 MG DOSE 10 MG/0.1ML LIQD THPK	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 OVER TIME), NDS
VALTOCO 5 MG DOSE 5 MG/0.1ML LIQUID	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 OVER TIME), NDS
vigabatrin (powd pack 500 mg, tab 500 mg)	1-Covered	LA, NDS
XCOPRI (14 X 150 MG & 14 X200 MG TAB, 14 X 50 MG & 14 X100 MG TAB)	1-Covered	QL (28 PER 180 OVER TIME), NDS
XCOPRI (150 MG TAB, 200 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS
XCOPRI (250 MG DAILY DOSE) 100 & 150 MG TAB THPK	1-Covered	QL (56 PER 28 DAYS), NDS
XCOPRI (350 MG DAILY DOSE) 150 & 200 MG TAB THPK	1-Covered	QL (56 PER 28 DAYS), NDS
XCOPRI 100 MG TAB	1-Covered	QL (120 PER 30 DAYS), NDS
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	1-Covered	QL (28 PER 180 OVER TIME)
XCOPRI 50 MG TAB	1-Covered	QL (240 PER 30 DAYS), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ZONISADE 100 MG/5ML SUSPENSION	1-Covered	PA - FOR NEW STARTS ONLY, NDS
zonisamide (cap 25 mg, cap 50 mg, cap 100 mg)	1-Covered	PA - FOR NEW STARTS ONLY
ZTALMY 50 MG/ML SUSPENSION	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (1080 PER 30 DAYS), NDS
ANTIPARKINSONISM AGENTS		
APOKYN 30 MG/3ML SOLN CART	1-Covered	PA, LA, QL (90 PER 30 DAYS), NDS
apomorphine hcl soln cartridge 30 mg/3ml	1-Covered	PA, QL (90 PER 30 DAYS), NDS
benztropine mesylate (tab 0.5 mg, tab 1 mg, tab 2 mg)	1-Covered	PA
bromocriptine mesylate (cap 5 mg (base equivalent), tab 2.5 mg (base equivalent))	1-Covered	
carbidopa tab 25 mg	1-Covered	
carbidopa-levodopa (carbidopa & levodopa orally disintegrating tab 10-100 mg, carbidopa & levodopa orally disintegrating tab 25-100 mg, carbidopa & levodopa orally disintegrating tab 25-250 mg, carbidopa & levodopa tab 10-100 mg, carbidopa & levodopa tab 25-100 mg, carbidopa & levodopa tab 25-250 mg, carbidopa & levodopa tab er 25-100 mg, carbidopa & levodopa tab er 50-200 mg, carbidopa-levodopa 10-100 mg tab disp, carbidopa-levodopa 25-100 mg tab disp, carbidopa-levodopa 25-250 mg tab disp)	1-Covered	
carbidopa-levodopa-entacapone (12.5-50-200 mg tab, tabs 12.5-50-200 mg, 18.75-75-200 mg tab, tabs 18.75-75-200 mg, tabs 25-100-200 mg, tabs 31.25-125-200 mg, 37.5-150-200 mg tab, tabs 37.5-150-200 mg, tabs 50-200-200 mg)	1-Covered	
entacapone tab 200 mg	1-Covered	
NEUPRO (1 MG/PATCH, 2 MG/PATCH, 3 MG/PATCH, 4 MG/PATCH, 6 MG/PATCH, 8 MG/PATCH)	1-Covered	
pramipexole dihydrochloride (tab 0.125 mg, tab 0.25 mg, tab 0.5 mg, tab 0.75 mg, tab 1 mg, tab 1.5 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
rasagiline mesylate (tab 0.5 mg (base equiv), tab 1 mg (base equiv))	1-Covered	
ropinirole hydrochloride (tab 0.25 mg, tab 0.5 mg, tab 1 mg, tab 2 mg, tab 3 mg, tab 4 mg, tab 5 mg, tab er 24hr 12 mg (base equivalent), tab er 24hr 2 mg (base equivalent), tab er 24hr 4 mg (base equivalent), tab er 24hr 6 mg (base equivalent), tab er 24hr 8 mg (base equivalent))	1-Covered	
selegiline hcl (cap 5 mg, tab 5 mg)	1-Covered	
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG (70 MG/ML SOLN, 140 MG/ML SOLN)	1-Covered	PA, QL (1 PER 30 DAYS)
dihydroergotamine mesylate nasal spray 4 mg/ml	1-Covered	QL (8 PER 28 OVER TIME), NDS
eletriptan hydrobromide (tab 20 mg (base equivalent), tab 40 mg (base equivalent))	1-Covered	QL (18 PER 28 OVER TIME)
EMGALITY (120 MG/ML SOLN A-INJ, 120 MG/ML SOLN PRSYR)	1-Covered	PA, QL (2 PER 30 DAYS)
ergotamine w/ caffeine tab 1-100 mg	1-Covered	
naratriptan hcl (tab 1 mg (base equiv), tab 2.5 mg (base equiv))	1-Covered	QL (18 PER 28 OVER TIME)
NURTEC 75 MG TAB DISP	1-Covered	PA, QL (16 PER 30 OVER TIME)
rizatriptan benzoate (oral disintegrating tab 5 mg (base eq), oral disintegrating tab 10 mg (base eq), tab 5 mg (base equivalent), tab 10 mg (base equivalent))	1-Covered	QL (36 PER 28 OVER TIME)
sumatriptan nasal spray 20 mg/act	1-Covered	QL (18 PER 28 OVER TIME)
sumatriptan nasal spray 5 mg/act	1-Covered	QL (36 PER 28 OVER TIME)
sumatriptan succinate (inj 6 mg/0.5ml, solution auto-injector 4 mg/0.5ml, solution auto-injector 6 mg/0.5ml, solution cartridge 4 mg/0.5ml)	1-Covered	QL (8 PER 28 OVER TIME)
sumatriptan succinate (tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	QL (18 PER 28 OVER TIME)
UBRELVY (50 MG TAB, 100 MG TAB)	1-Covered	PA, QL (20 PER 30 OVER TIME)
zolmitriptan (orally disintegrating tab 2.5 mg, orally disintegrating tab 5 mg, tab 2.5 mg, tab 5 mg)	1-Covered	QL (18 PER 28 OVER TIME)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
MISCELLANEOUS NEUROLOGICAL THERAPY		
AUBAGIO (7 MG TAB, 14 MG TAB)	1-Covered	PA, QL (30 PER 30 DAYS), NDS
dalfampridine tab er 12hr 10 mg	1-Covered	PA, QL (60 PER 30 DAYS)
dimethyl fumarate capsule delayed release 120 mg	1-Covered	PA, QL (14 PER 30 DAYS), NDS
dimethyl fumarate capsule delayed release 240 mg	1-Covered	PA, QL (60 PER 30 DAYS), NDS
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	1-Covered	PA, QL (120 PER 180 OVER TIME), NDS
donepezil hydrochloride (orally disintegrating tab 5 mg, orally disintegrating tab 10 mg, tab 5 mg, tab 10 mg, tab 23 mg)	1-Covered	
fingolimod hcl cap 0.5 mg (base equiv)	1-Covered	PA, QL (30 PER 30 DAYS), NDS
FIRDAPSE 10 MG TAB	1-Covered	PA, LA, NDS
galantamine hydrobromide (4 mg/ml solution, cap er 24hr 16 mg, cap er 24hr 24 mg, cap er 24hr 8 mg, tab 4 mg, tab 8 mg, tab 12 mg)	1-Covered	
GILENYA 0.5 MG CAP	1-Covered	PA, QL (30 PER 30 DAYS), NDS
glatiramer acetate soln prefilled syringe 20 mg/ml	1-Covered	PA, QL (30 PER 30 DAYS), NDS
glatiramer acetate soln prefilled syringe 40 mg/ml	1-Covered	PA, QL (12 PER 28 DAYS), NDS
INGREZZA (40 MG CAP, 60 MG CAP, 80 MG CAP)	1-Covered	PA, LA, QL (30 PER 30 DAYS), NDS
INGREZZA 40 & 80 MG CAP THPK	1-Covered	PA, LA, QL (28 PER 180 OVER TIME), NDS
memantine hcl (cap er 24hr 14 mg, cap er 24hr 21 mg, cap er 24hr 28 mg, cap er 24hr 7 mg, oral solution 2 mg/ml, tab 5 mg, tab 10 mg)	1-Covered	PA
NAMZARIC (7 & 14 & 21 &28 -10 MG CP24 THPK, 7-10 MG CAP ER 24H, 14-10 MG CAP ER 24H, 21-10 MG CAP ER 24H, 28-10 MG CAP ER 24H)	1-Covered	PA
NUEDEXTA 20-10 MG CAP	1-Covered	PA, NDS
rivastigmine (patch 4.6 mg/, patch 9.5 mg/, patch 13.3 mg/)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
rivastigmine tartrate (cap 1.5 mg (base equivalent), cap 3 mg (base equivalent), cap 4.5 mg (base equivalent), cap 6 mg (base equivalent))	1-Covered	
teriflunomide (tab 7 mg, tab 14 mg)	1-Covered	PA, QL (30 PER 30 DAYS), NDS
tetrabenazine tab 12.5 mg	1-Covered	PA, QL (240 PER 30 DAYS), NDS
tetrabenazine tab 25 mg	1-Covered	PA, QL (120 PER 30 DAYS), NDS
VUMERITY (STARTER) 231 MG CAP DR	1-Covered	PA, QL (120 PER 30 DAYS), NDS
VUMERITY 231 MG CAP DR	1-Covered	PA, QL (120 PER 30 DAYS), NDS
ZEPOSIA 0.92 MG CAP	1-Covered	PA, QL (30 PER 30 DAYS), NDS
ZEPOSIA 7-DAY STARTER PACK 4 X 0.23MG & 3 X 0.46MG CAP THPK	1-Covered	PA, QL (7 PER 180 OVER TIME), NDS
ZEPOSIA STARTER KIT 0.23MG &0.46MG 0.92MG(21) CAP THPK	1-Covered	PA, QL (28 PER 180 OVER TIME), NDS
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
baclofen (tab 5 mg, tab 10 mg, tab 20 mg)	1-Covered	
cyclobenzaprine hcl (tab 5 mg, tab 10 mg)	1-Covered	PA
dantrolene sodium (cap 25 mg, cap 50 mg, cap 100 mg)	1-Covered	
pyridostigmine bromide (tab 60 mg, tab er 180 mg)	1-Covered	
tizanidine hcl (tab 2 mg (base equivalent), tab 4 mg (base equivalent))	1-Covered	
NARCOTIC ANALGESICS		
acetaminophen w/ codeine (tab 300-15 mg, tab 300-30 mg)	1-Covered	QL (360 PER 30 OVER TIME)
acetaminophen w/ codeine soln 120-12 mg/5ml	1-Covered	QL (4500 PER 30 OVER TIME)
acetaminophen w/ codeine tab 300-60 mg	1-Covered	QL (180 PER 30 OVER TIME)
BELBUCA (75 MCG, 150 MCG, 300 MCG, 450 MCG, 600 MCG, 750 MCG, 900 MCG)	1-Covered	PA, QL (60 PER 30 OVER TIME)
buprenorphine (patch 5 mcg/hr, patch 7.5 mcg/hr, patch 10 mcg/hr, patch 15 mcg/hr, patch 20 mcg/hr)	1-Covered	PA, QL (4 PER 28 OVER TIME)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
buprenorphine hcl (tab 2 mg (base equiv), tab 8 mg (base equiv))	1-Covered	
fentanyl (patch 12 mcg/hr, patch 25 mcg/hr, patch 50 mcg/hr, patch 75 mcg/hr, patch 100 mcg/hr)	1-Covered	PA, QL (10 PER 30 OVER TIME)
fentanyl citrate (a 400 mcg, a 600 mcg, a 800 mcg, a 1200 mcg, a 1600 mcg)	1-Covered	PA, QL (120 PER 30 OVER TIME), NDS
fentanyl citrate lozenge on a handle 200 mcg	1-Covered	PA, QL (120 PER 30 OVER TIME)
hydrocodone-acetaminophen (tab 5-300 mg, tab 7.5-300 mg, tab 10-300 mg)	1-Covered	QL (390 PER 30 OVER TIME)
hydrocodone-acetaminophen (tab 5-325 mg, tab 7.5-325 mg, tab 10-325 mg)	1-Covered	QL (360 PER 30 OVER TIME)
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1-Covered	QL (5550 PER 30 OVER TIME)
hydrocodone-ibuprofen (5-200 mg tab, tab 5-200 mg, tab 7.5-200 mg, 10-200 mg tab, tab 10-200 mg)	1-Covered	QL (50 PER 30 OVER TIME)
hydromorphone hcl (tab 2 mg, tab 4 mg, tab 8 mg)	1-Covered	QL (180 PER 30 OVER TIME)
hydromorphone hcl (tab er 8 mg, tab er 12 mg, tab er 16 mg, tab er 32 mg)	1-Covered	PA, QL (60 PER 30 OVER TIME)
hydromorphone hcl liqd 1 mg/ml	1-Covered	QL (2400 PER 30 OVER TIME)
HYDROMORPHONE HCL PF 10 MG/ML SOLUTION	1-Covered	
hydromorphone hcl preservative free (pf) inj 10 mg/ml	1-Covered	
methadone hcl (10 mg/5ml solution, soln 10 mg/5ml)	1-Covered	PA, QL (600 PER 30 OVER TIME)
methadone hcl (5 mg/5ml solution, soln 5 mg/5ml)	1-Covered	PA, QL (1200 PER 30 OVER TIME)
methadone hcl tab 10 mg	1-Covered	PA, QL (120 PER 30 OVER TIME)
methadone hcl tab 5 mg	1-Covered	PA, QL (240 PER 30 OVER TIME)
morphine sulfate (15 mg tab, tab 15 mg, 30 mg tab, tab 30 mg)	1-Covered	QL (180 PER 30 OVER TIME)
morphine sulfate (oral soln 10 mg/5ml, 20 mg/5ml solution, oral soln 20 mg/5ml, oral soln 100 mg/5ml (20 mg/ml))	1-Covered	QL (900 PER 30 OVER TIME)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
morphine sulfate (tab er 15 mg, tab er 30 mg, tab er 60 mg, tab er 100 mg, tab er 200 mg)	1-Covered	PA, QL (120 PER 30 OVER TIME)
oxycodone hcl (cap 5 mg, tab 5 mg)	1-Covered	QL (360 PER 30 OVER TIME)
oxycodone hcl (conc 100 mg/5ml (20 mg/ml), tab 10 mg, tab 15 mg, tab 20 mg, tab 30 mg)	1-Covered	QL (180 PER 30 OVER TIME)
oxycodone hcl soln 5 mg/5ml	1-Covered	QL (1200 PER 30 OVER TIME)
oxycodone w/ acetaminophen (tab 5-325 mg, tab 7.5-325 mg, tab 10-325 mg)	1-Covered	QL (360 PER 30 OVER TIME)
oxycodone w/ acetaminophen tab 2.5-325 mg	1-Covered	QL (360 PER 30 OVER TIME), NDS
OXYCONTIN (10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG)	1-Covered	PA, QL (90 PER 30 OVER TIME)
OXYCONTIN 80 MG TB12 DETER	1-Covered	PA, QL (60 PER 30 OVER TIME), NDS
NON-NARCOTIC ANALGESICS		
buprenorphine hcl-naloxone hcl dihydrate (-naloxone film 2-0.5 mg (base equiv), -naloxone tab 2-0.5 mg (base equiv))	1-Covered	QL (360 PER 30 OVER TIME)
buprenorphine hcl-naloxone hcl dihydrate (-naloxone film 4-1 mg (base equiv), -naloxone film 8-2 mg (base equiv), -naloxone tab 8-2 mg (base equiv))	1-Covered	QL (90 PER 30 OVER TIME)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1-Covered	QL (60 PER 30 OVER TIME)
butorphanol tartrate nasal soln 10 mg/ml	1-Covered	QL (10 PER 28 OVER TIME)
celecoxib (cap 50 mg, cap 100 mg, cap 200 mg, cap 400 mg)	1-Covered	
diclofenac potassium tab 50 mg	1-Covered	
diclofenac sodium (tab delayed release 25 mg, tab delayed release 50 mg, tab delayed release 75 mg, tab er 24hr 100 mg)	1-Covered	
diclofenac sodium (topical) (gel, gel (1.16% diethylamine equiv))	1-Covered	QL (1000 PER 28 OVER TIME)
diclofenac w/ misoprostol (tab 50-0.2 mg, tab 75-0.2 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
diflunisal tab 500 mg	1-Covered	
etodolac (cap 200 mg, cap 300 mg, tab 400 mg, tab 500 mg, tab er 24hr 400 mg, tab er 24hr 500 mg, tab er 24hr 600 mg)	1-Covered	
flurbiprofen tab 100 mg	1-Covered	
ibuprofen (susp 100 mg/5ml, tab 400 mg, tab 600 mg, tab 800 mg)	1-Covered	
meloxicam tab 15 mg	1-Covered	
meloxicam tab 7.5 mg	1-Covered	QL (30 PER 30 DAYS)
nabumetone (tab 500 mg, tab 750 mg)	1-Covered	
naloxone hcl (0.4 mg/ml soln cart, inj 0.4 mg/ml, nasal spray 4 mg/0.1ml, soln prefilled syringe 2 mg/2ml)	1-Covered	
naltrexone hcl tab 50 mg	1-Covered	
naproxen (tab 250 mg, tab 375 mg, tab 500 mg, tab ec 375 mg, tab ec 500 mg)	1-Covered	
naproxen sodium (tab 275 mg, tab 550 mg)	1-Covered	
oxaprozin tab 600 mg	1-Covered	
piroxicam (cap 10 mg, cap 20 mg)	1-Covered	
sulindac (tab 150 mg, tab 200 mg)	1-Covered	
tramadol hcl tab 50 mg	1-Covered	QL (240 PER 30 OVER TIME)
tramadol-acetaminophen tab 37.5-325 mg	1-Covered	QL (240 PER 30 OVER TIME)
VENNGEL ONE 1 % KIT	1-Covered	QL (1000 PER 28 OVER TIME)
VIVITROL 380 MG RECON SUSP	1-Covered	NDS
ZUBSOLV (0.7-0.18 MG TAB, 1.4-0.36 MG TAB, 2.9-0.71 MG TAB, 5.7-1.4 MG TAB, 11.4-2.9 MG TAB)	1-Covered	QL (30 PER 30 OVER TIME)
ZUBSOLV 8.6-2.1 MG SL TAB	1-Covered	QL (60 PER 30 OVER TIME)
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR	1-Covered	QL (2.4 PER 56 OVER TIME), NDS
ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR	1-Covered	QL (3.2 PER 56 OVER TIME), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG PRSYR, 400 MG SRER)	1-Covered	QL (1 PER 28 DAYS), NDS
amitriptyline hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 75 mg, tab 100 mg, tab 150 mg)	1-Covered	
amoxapine (tab 25 mg, tab 50 mg, tab 100 mg, tab 150 mg)	1-Covered	
amphetamine-dextroamphetamine (cap er 24hr 10 mg, cap er 24hr 15 mg, cap er 24hr 20 mg, cap er 24hr 25 mg, cap er 24hr 30 mg, cap er 24hr 5 mg, tab 5 mg, tab 7.5 mg, tab 10 mg, tab 12.5 mg, tab 15 mg, tab 20 mg, tab 30 mg)	1-Covered	
aripiprazole (tab 10 mg, tab 15 mg)	1-Covered	QL (60 PER 30 DAYS), NDS
aripiprazole (tab 2 mg, tab 5 mg, tab 10 mg, tab 15 mg, tab 20 mg, tab 30 mg)	1-Covered	QL (30 PER 30 DAYS)
aripiprazole oral solution 1 mg/ml	1-Covered	
ARISTADA 1064 MG/3.9ML PRSYR	1-Covered	QL (3.9 PER 56 OVER TIME), NDS
ARISTADA 441 MG/1.6ML PRSYR	1-Covered	QL (1.6 PER 28 DAYS), NDS
ARISTADA 662 MG/2.4ML PRSYR	1-Covered	QL (2.4 PER 28 DAYS), NDS
ARISTADA 882 MG/3.2ML PRSYR	1-Covered	QL (3.2 PER 28 DAYS), NDS
ARISTADA INITIO 675 MG/2.4ML PRSYR	1-Covered	QL (4.8 PER 365 OVER TIME), NDS
armodafinil (tab 50 mg, tab 150 mg, tab 200 mg, tab 250 mg)	1-Covered	PA, QL (30 PER 30 DAYS)
asenapine maleate (tab 2.5 mg (base equiv), tab 5 mg (base equiv), tab 10 mg (base equiv))	1-Covered	QL (60 PER 30 DAYS)
atomoxetine hcl (cap 10 mg (base equiv), cap 18 mg (base equiv), cap 25 mg (base equiv), cap 40 mg (base equiv))	1-Covered	QL (60 PER 30 DAYS)
atomoxetine hcl (cap 60 mg (base equiv), cap 80 mg (base equiv), cap 100 mg (base equiv))	1-Covered	QL (30 PER 30 DAYS)
AUVELITY 45-105 MG TAB ER	1-Covered	ST, QL (60 PER 30 DAYS), NDS
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	1-Covered	QL (60 PER 30 DAYS)
bupropion hcl (tab 75 mg, tab 100 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
bupropion hcl (tab er 100 mg, tab er 150 mg, tab er 200 mg)	1-Covered	QL (60 PER 30 DAYS)
bupropion hcl tab er 24hr 150 mg	1-Covered	QL (90 PER 30 DAYS)
bupropion hcl tab er 24hr 300 mg	1-Covered	QL (30 PER 30 DAYS)
buspirone hcl (tab 5 mg, tab 7.5 mg, tab 10 mg, tab 15 mg, tab 30 mg)	1-Covered	
CAPLYTA (10.5 MG CAP, 21 MG CAP, 42 MG CAP)	1-Covered	QL (30 PER 30 DAYS)
chlorpromazine hcl (tab 10 mg, tab 25 mg, 30 mg/ml conc, tab 50 mg, 100 mg/ml conc, tab 100 mg, tab 200 mg)	1-Covered	
citalopram hydrobromide (tab 10 mg (base equiv), tab 20 mg (base equiv), tab 40 mg (base equiv))	1-Covered	QL (30 PER 30 DAYS)
citalopram hydrobromide oral soln 10 mg/5ml	1-Covered	
clomipramine hcl (cap 25 mg, cap 50 mg, cap 75 mg)	1-Covered	
clonidine hcl tab er 12hr 0.1 mg	1-Covered	
clorazepate dipotassium tab 15 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
clorazepate dipotassium tab 3.75 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
clorazepate dipotassium tab 7.5 mg	1-Covered	PA - FOR NEW STARTS ONLY, QL (360 PER 30 DAYS)
clozapine (12.5 mg tab disp, orally disintegrating tab 25 mg, orally disintegrating tab 100 mg, orally disintegrating tab 150 mg, orally disintegrating tab 200 mg, tab 25 mg, tab 50 mg, tab 100 mg, 150 mg tab disp, 200 mg tab disp, tab 200 mg)	1-Covered	
desipramine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 75 mg, tab 100 mg, tab 150 mg)	1-Covered	
desvenlafaxine succinate (tab er 25 mg (base equiv), tab er 50 mg (base equiv), tab er 100 mg (base equiv))	1-Covered	QL (30 PER 30 DAYS)
diazepam (oral soln 1 mg/ml, 5 mg/5ml solution)	1-Covered	PA - FOR NEW STARTS ONLY, QL (1200 PER 30 DAYS)
diazepam (tab 2 mg, tab 5 mg, tab 10 mg)	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
diazepam conc 5 mg/ml	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)
doxepin hcl (cap 10 mg, cap 25 mg, cap 50 mg, cap 75 mg, cap 100 mg, cap 150 mg, conc 10 mg/ml)	1-Covered	
doxepin hcl (sleep) (tab 3 mg (base equiv), tab 6 mg (base equiv))	1-Covered	QL (30 PER 30 DAYS)
duloxetine hcl (cap 20 mg (base eq), cap 30 mg (base eq), cap 60 mg (base eq))	1-Covered	QL (60 PER 30 DAYS)
EMSAM (6 MG/PATCH, 9 MG/PATCH, 12 MG/PATCH)	1-Covered	NDS
escitalopram oxalate (tab 5 mg (base equiv), tab 10 mg (base equiv), tab 20 mg (base equiv))	1-Covered	QL (30 PER 30 DAYS)
escitalopram oxalate soln 5 mg/5ml (base equiv)	1-Covered	
eszopiclone (tab 1 mg, tab 2 mg, tab 3 mg)	1-Covered	QL (30 PER 30 DAYS)
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
FANAPT TITRATION PACK 1 & 2 & 4 & 6 MG TAB	1-Covered	QL (8 PER 180 OVER TIME)
FETZIMA (20 MG CAP ER, 40 MG CAP ER, 80 MG CAP ER, 120 MG CAP ER)	1-Covered	QL (30 PER 30 DAYS)
FETZIMA TITRATION 20 & 40 MG CP24 THPK	1-Covered	QL (28 PER 180 OVER TIME)
FLUOXETINE HCL (PMDD) 10 MG TAB	1-Covered	QL (240 PER 30 DAYS)
FLUOXETINE HCL (PMDD) 20 MG TAB	1-Covered	QL (120 PER 30 DAYS)
FLUOXETINE HCL 90 MG CAP DR	1-Covered	QL (4 PER 28 DAYS)
fluoxetine hcl cap 10 mg	1-Covered	QL (30 PER 30 DAYS)
fluoxetine hcl cap 20 mg	1-Covered	QL (90 PER 30 DAYS)
fluoxetine hcl cap 40 mg	1-Covered	QL (60 PER 30 DAYS)
fluoxetine hcl solution 20 mg/5ml	1-Covered	
fluoxetine hcl tab 10 mg	1-Covered	QL (240 PER 30 DAYS)
fluoxetine hcl tab 20 mg	1-Covered	QL (120 PER 30 DAYS)
fluphenazine decanoate inj 25 mg/ml	1-Covered	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
fluphenazine hcl (tab 1 mg, 2.5 mg/5ml elixir, 2.5 mg/ml solution, tab 2.5 mg, 5 mg/ml conc, tab 5 mg, tab 10 mg)	1-Covered	
fluvoxamine maleate (cap er 24hr 100 mg, cap er 24hr 150 mg, tab 50 mg)	1-Covered	QL (60 PER 30 DAYS)
fluvoxamine maleate tab 100 mg	1-Covered	QL (90 PER 30 DAYS)
fluvoxamine maleate tab 25 mg	1-Covered	QL (30 PER 30 DAYS)
haloperidol (tab 0.5 mg, tab 1 mg, tab 2 mg, tab 5 mg, tab 10 mg, tab 20 mg)	1-Covered	
haloperidol decanoate (soln 50 mg/ml, soln 100 mg/ml)	1-Covered	
haloperidol lactate (inj 5 mg/ml, oral conc 2 mg/ml)	1-Covered	
HETLIOZ 20 MG CAP	1-Covered	PA, QL (30 PER 30 DAYS), NDS
imipramine hcl (tab 10 mg, tab 25 mg, tab 50 mg)	1-Covered	
imipramine pamoate (cap 75 mg, cap 100 mg, cap 125 mg, cap 150 mg)	1-Covered	
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	1-Covered	QL (3.5 PER 180 OVER TIME), NDS
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	1-Covered	QL (5 PER 180 OVER TIME), NDS
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	1-Covered	QL (0.75 PER 28 DAYS), NDS
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	1-Covered	QL (1 PER 28 DAYS), NDS
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	1-Covered	QL (1.5 PER 28 DAYS), NDS
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
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	1-Covered	QL (0.88 PER 90 OVER TIME), NDS
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	1-Covered	QL (1.32 PER 90 OVER TIME), NDS
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	1-Covered	QL (1.75 PER 90 OVER TIME), NDS
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	1-Covered	QL (2.63 PER 90 OVER TIME), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
LATUDA (20 MG TAB, 40 MG TAB, 60 MG TAB, 120 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
LATUDA 80 MG TAB	1-Covered	QL (60 PER 30 DAYS)
LITHIUM 8 MEQ/5ML SOLUTION	1-Covered	
lithium carbonate (150 mg cap, cap 150 mg, 300 mg cap, cap 300 mg, cap 600 mg, tab 300 mg, tab er 300 mg, tab er 450 mg, 600 mg cap)	1-Covered	
lorazepam (conc 2 mg/ml, tab 2 mg)	1-Covered	PA, QL (150 PER 30 DAYS)
lorazepam (tab 0.5 mg, tab 1 mg)	1-Covered	PA, QL (90 PER 30 DAYS)
loxapine succinate (cap 5 mg, cap 10 mg, cap 25 mg, cap 50 mg)	1-Covered	
lurasidone hcl (tab 20 mg, tab 40 mg, tab 60 mg, tab 120 mg)	1-Covered	QL (30 PER 30 DAYS), NDS
lurasidone hcl tab 80 mg	1-Covered	QL (60 PER 30 DAYS), NDS
MARPLAN 10 MG TAB	1-Covered	
methylphenidate hcl (cap er 24hr 10 mg (la), cap er 24hr 20 mg (la), cap er 24hr 30 mg (la), cap er 24hr 40 mg (la), cap er 24hr 60 mg (la), chew tab 2.5 mg, chew tab 5 mg, chew tab 10 mg, soln 5 mg/5ml, soln 10 mg/5ml, tab 5 mg, tab 10 mg, tab 20 mg, tab er 10 mg, tab er 20 mg)	1-Covered	
mirtazapine (orally disintegrating tab 15 mg, orally disintegrating tab 30 mg, orally disintegrating tab 45 mg, tab 7.5 mg, tab 15 mg, tab 30 mg, tab 45 mg)	1-Covered	
modafinil tab 100 mg	1-Covered	PA, QL (30 PER 30 DAYS)
modafinil tab 200 mg	1-Covered	PA, QL (60 PER 30 DAYS)
MOLINDONE HCL (5 MG TAB, 10 MG TAB, 25 MG TAB)	1-Covered	
NEFAZODONE HCL (50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB, 250 MG TAB)	1-Covered	
nortriptyline hcl (cap 10 mg, cap 25 mg, cap 50 mg, cap 75 mg, soln 10 mg/5ml)	1-Covered	
NUPLAZID (10 MG TAB, 34 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
olanzapine (orally disintegrating tab 5 mg, orally disintegrating tab 10 mg, orally disintegrating tab 15 mg, orally disintegrating tab 20 mg, tab 2.5 mg, tab 5 mg, tab 7.5 mg, tab 10 mg, tab 15 mg, tab 20 mg)	1-Covered	QL (30 PER 30 DAYS)
olanzapine for im inj 10 mg	1-Covered	
olanzapine-fluoxetine hcl (cap 3-25 mg, cap 6-25 mg, cap 6-50 mg, cap 12-25 mg, cap 12-50 mg)	1-Covered	
paliperidone (tab er 1.5 mg, tab er 3 mg, tab er 9 mg)	1-Covered	QL (30 PER 30 DAYS)
paliperidone tab er 24hr 6 mg	1-Covered	QL (60 PER 30 DAYS)
paroxetine hcl (tab 10 mg, tab 20 mg, tab 40 mg)	1-Covered	QL (30 PER 30 DAYS)
paroxetine hcl (tab 30 mg, tab er 24hr 12.5 mg, tab er 24hr 25 mg, tab er 24hr 37.5 mg)	1-Covered	QL (60 PER 30 DAYS)
paroxetine hcl oral susp 10 mg/5ml (base equiv)	1-Covered	
perphenazine (tab 2 mg, tab 4 mg, tab 8 mg, tab 16 mg)	1-Covered	
PERSERIS (90 MG, 120 MG)	1-Covered	QL (1 PER 30 DAYS), NDS
phenelzine sulfate (15 mg tab, tab 15 mg)	1-Covered	
PIMOZIDE (1 MG TAB, 2 MG TAB)	1-Covered	
protriptyline hcl (tab 5 mg, tab 10 mg)	1-Covered	
quetiapine fumarate (tab 25 mg, tab 50 mg, tab 100 mg, tab 200 mg)	1-Covered	QL (90 PER 30 DAYS)
quetiapine fumarate (tab 300 mg, tab 400 mg, tab er 24hr 300 mg, tab er 24hr 400 mg, tab er 24hr 50 mg)	1-Covered	QL (60 PER 30 DAYS)
quetiapine fumarate (tab er 150 mg, tab er 200 mg)	1-Covered	QL (30 PER 30 DAYS)
ramelteon tab 8 mg	1-Covered	QL (30 PER 30 DAYS)
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB, 2 MG TAB, 3 MG TAB, 4 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
RISPERDAL CONSTA (12.5 MG, 25 MG)	1-Covered	QL (2 PER 28 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
RISPERDAL CONSTA (37.5 MG, 50 MG)	1-Covered	QL (2 PER 28 DAYS), NDS
risperidone (0.25 mg tab disp, orally disintegrating tab 0.5 mg, orally disintegrating tab 1 mg, orally disintegrating tab 2 mg, orally disintegrating tab 3 mg, tab 0.25 mg, tab 0.5 mg, tab 1 mg, tab 2 mg, tab 3 mg)	1-Covered	QL (60 PER 30 DAYS)
risperidone (orally disintegrating tab 4 mg, tab 4 mg)	1-Covered	QL (120 PER 30 DAYS)
risperidone soln 1 mg/ml	1-Covered	
SECUADO (3.8 MG/PATCH, 5.7 MG/PATCH, 7.6 MG/PATCH)	1-Covered	QL (30 PER 30 DAYS), NDS
sertraline hcl (tab 50 mg, tab 100 mg)	1-Covered	QL (60 PER 30 DAYS)
sertraline hcl oral concentrate for solution 20 mg/ml	1-Covered	
sertraline hcl tab 25 mg	1-Covered	QL (30 PER 30 DAYS)
SODIUM OXYBATE 500 MG/ML SOLUTION	1-Covered	PA, LA, QL (540 PER 30 DAYS), NDS
tasimelteon capsule 20 mg	1-Covered	PA, QL (30 PER 30 DAYS), NDS
thioridazine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	
thiothixene (cap 1 mg, cap 2 mg, cap 5 mg, cap 10 mg)	1-Covered	
tranylcypromine sulfate tab 10 mg	1-Covered	
trazodone hcl (tab 50 mg, tab 100 mg, tab 150 mg, tab 300 mg)	1-Covered	
trifluoperazine hcl (tab 1 mg (base equivalent), tab 2 mg (base equivalent), tab 5 mg (base equivalent), tab 10 mg (base equivalent))	1-Covered	
trimipramine maleate (cap 25 mg, cap 50 mg, cap 100 mg)	1-Covered	
TRINTELLIX (5 MG TAB, 10 MG TAB, 20 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
UZEDY 100 MG/0.28ML SUSP PRSYR	1-Covered	QL (0.28 PER 28 OVER TIME), NDS
UZEDY 125 MG/0.35ML SUSP PRSYR	1-Covered	QL (0.35 PER 28 OVER TIME), NDS
UZEDY 150 MG/0.42ML SUSP PRSYR	1-Covered	QL (0.42 PER 56 OVER TIME), NDS
UZEDY 200 MG/0.56ML SUSP PRSYR	1-Covered	QL (0.56 PER 56 OVER TIME), NDS

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
UZEDY 250 MG/0.7ML SUSP PRSYR	1-Covered	QL (0.7 PER 56 OVER TIME), NDS
UZEDY 50 MG/0.14ML SUSP PRSYR	1-Covered	QL (0.14 PER 28 OVER TIME), NDS
UZEDY 75 MG/0.21ML SUSP PRSYR	1-Covered	QL (0.21 PER 28 OVER TIME), NDS
venlafaxine hcl (cap er 24hr 75 mg (base equivalent), tab 25 mg (base equivalent), tab 37.5 mg (base equivalent), tab 50 mg (base equivalent), tab 75 mg (base equivalent), tab 100 mg (base equivalent))	1-Covered	QL (90 PER 30 DAYS)
venlafaxine hcl (cap er 37.5 mg (base equivalent), cap er 150 mg (base equivalent))	1-Covered	QL (30 PER 30 DAYS)
VERSACLOZ 50 MG/ML SUSPENSION	1-Covered	NDS
VIIBRYD STARTER PACK 10 & 20 MG KIT	1-Covered	QL (30 PER 180 OVER TIME)
vilazodone hcl (tab 10 mg, tab 20 mg, tab 40 mg)	1-Covered	QL (30 PER 30 DAYS)
VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	1-Covered	QL (30 PER 30 DAYS)
VRAYLAR 1.5 & 3 MG CAP THPK	1-Covered	QL (7 PER 180 OVER TIME)
XYREM 500 MG/ML SOLUTION	1-Covered	PA, LA, QL (540 PER 30 DAYS), NDS
zaleplon cap 10 mg	1-Covered	QL (60 PER 30 DAYS)
zaleplon cap 5 mg	1-Covered	QL (30 PER 30 DAYS)
ziprasidone hcl (cap 20 mg, cap 40 mg, cap 60 mg, cap 80 mg)	1-Covered	QL (60 PER 30 DAYS)
ziprasidone mesylate for inj 20 mg (base equivalent)	1-Covered	
zolpidem tartrate (tab 5 mg, tab 10 mg)	1-Covered	QL (30 PER 30 DAYS)
ZYPREXA RELPREVV 210 MG RECON SUSP	1-Covered	QL (2 PER 28 DAYS)

CARDIOVASCULAR, HYPERTENSION / LIPIDS

ANTIARRHYTHMIC AGENTS

amiodarone hcl (tab 100 mg, tab 200 mg, tab 400 mg)	1-Covered	
dofetilide (cap 125 mcg (0.125 mg), cap 250 mcg (0.25 mg), cap 500 mcg (0.5 mg))	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
flecainide acetate (tab 50 mg, tab 100 mg, tab 150 mg)	1-Covered	
mexiletine hcl (cap 150 mg, cap 200 mg, cap 250 mg)	1-Covered	
propafenone hcl (cap er 12hr 225 mg, cap er 12hr 325 mg, cap er 12hr 425 mg, tab 150 mg, tab 225 mg, tab 300 mg)	1-Covered	
quinidine sulfate (200 mg tab, tab 200 mg, 300 mg tab, tab 300 mg)	1-Covered	
sotalol hcl (afib/afl) (tab 80 mg, tab 120 mg, tab 160 mg)	1-Covered	
sotalol hcl (tab 80 mg, tab 120 mg, tab 160 mg, tab 240 mg)	1-Covered	
ANTIHYPERTENSIVE THERAPY		
acebutolol hcl (cap 200 mg, cap 400 mg)	1-Covered	
aliskiren fumarate (tab 150 mg (base equivalent), tab 300 mg (base equivalent))	1-Covered	
amiloride & hydrochlorothiazide tab 5-50 mg	1-Covered	
amiloride hcl tab 5 mg	1-Covered	
AMILORIDE-HYDROCHLOROTHIAZIDE 5-50 MG TAB	1-Covered	
amlodipine besylate (tab 2.5 mg (base equivalent), tab 5 mg (base equivalent), tab 10 mg (base equivalent))	1-Covered	
amlodipine besylate-benazepril hcl (cap 2.5-10 mg, cap 5-10 mg, cap 5-20 mg, cap 5-40 mg, cap 10-20 mg, cap 10-40 mg)	1-Covered	
amlodipine besylate-olmesartan medoxomil (tab 5-20 mg, tab 5-40 mg, tab 10-20 mg, tab 10-40 mg)	1-Covered	
amlodipine besylate-valsartan (tab 5-160 mg, tab 5-320 mg, tab 10-160 mg, tab 10-320 mg)	1-Covered	
amlodipine-valsartan-hydrochlorothiazide (tab 5-160-12.5 mg, tab 5-160-25 mg, tab 10-160-12.5 mg, tab 10-160-25 mg, tab 10-320-25 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
atenolol & chlorthalidone (tab 50-25 mg, tab 100-25 mg)	1-Covered	
atenolol (tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	
benazepril & hydrochlorothiazide (tab 5-6.25 mg, tab 10-12.5 mg, tab 20-12.5 mg, tab 20-25 mg)	1-Covered	
benazepril hcl (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg)	1-Covered	
betaxolol hcl (tab 10 mg, tab 20 mg)	1-Covered	
bisoprolol & hydrochlorothiazide (tab 2.5-6.25 mg, tab 5-6.25 mg, tab 10-6.25 mg)	1-Covered	
bisoprolol fumarate (tab 5 mg, tab 10 mg)	1-Covered	
bumetanide (inj 0.25 mg/ml, tab 0.5 mg, tab 1 mg, tab 2 mg)	1-Covered	
candesartan cilexetil (tab 4 mg, tab 8 mg, tab 16 mg, tab 32 mg)	1-Covered	
candesartan cilexetil-hydrochlorothiazide (tab 16-12.5 mg, tab 32-12.5 mg, tab 32-25 mg)	1-Covered	
captopril (tab 12.5 mg, tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	
carvedilol (tab 3.125 mg, tab 6.25 mg, tab 12.5 mg, tab 25 mg)	1-Covered	
chlorthalidone (tab 25 mg, tab 50 mg)	1-Covered	
clonidine (patch 0.1 mg/24hr, patch 0.2 mg/24hr, patch 0.3 mg/24hr)	1-Covered	QL (4 PER 28 DAYS)
clonidine hcl (tab 0.1 mg, tab 0.2 mg, tab 0.3 mg)	1-Covered	
diltiazem hcl (cap er 12hr 120 mg, cap er 12hr 60 mg, cap er 12hr 90 mg, cap er 24hr 120 mg, cap er 24hr 180 mg, cap er 24hr 240 mg, tab 30 mg, tab 60 mg, tab 90 mg, tab 120 mg, tab er 24hr 120 mg, tab er 24hr 180 mg, tab er 24hr 240 mg, tab er 24hr 300 mg, tab er 24hr 360 mg, tab er 24hr 420 mg)	1-Covered	
diltiazem hcl coated beads (cap er 120 mg, cap er 180 mg, cap er 240 mg, cap er 300 mg, cap er 360 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
diltiazem hcl extended release beads (cap er 120 mg, cap er 180 mg, cap er 240 mg, cap er 300 mg, cap er 360 mg, cap er 420 mg)	1-Covered	
doxazosin mesylate (tab 1 mg, tab 2 mg, tab 4 mg)	1-Covered	QL (30 PER 30 DAYS)
doxazosin mesylate tab 8 mg	1-Covered	QL (60 PER 30 DAYS)
EDARBI (40 MG TAB, 80 MG TAB)	1-Covered	
EDARBYCLOR (40-12.5 MG TAB, 40-25 MG TAB)	1-Covered	
enalapril maleate & hydrochlorothiazide (tab 5-12.5 mg, tab 10-25 mg)	1-Covered	
enalapril maleate (tab 2.5 mg, tab 5 mg, tab 10 mg, tab 20 mg)	1-Covered	
eplerenone (tab 25 mg, tab 50 mg)	1-Covered	
felodipine (tab er 2.5 mg, tab er 5 mg, tab er 10 mg)	1-Covered	
fosinopril sodium & hydrochlorothiazide (tab 10-12.5 mg, tab 20-12.5 mg)	1-Covered	
fosinopril sodium (tab 10 mg, tab 20 mg, tab 40 mg)	1-Covered	
furosemide (8 mg/ml solution, inj 10 mg/ml, oral soln 10 mg/ml, tab 20 mg, tab 40 mg, tab 80 mg)	1-Covered	
hydralazine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	
hydrochlorothiazide (cap 12.5 mg, tab 12.5 mg, tab 25 mg, tab 50 mg)	1-Covered	
indapamide (tab 1.25 mg, tab 2.5 mg)	1-Covered	
irbesartan (tab 75 mg, tab 150 mg, tab 300 mg)	1-Covered	
irbesartan-hydrochlorothiazide (tab 150-12.5 mg, tab 300-12.5 mg)	1-Covered	
isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg	1-Covered	QL (180 PER 30 DAYS)
isradipine (cap 2.5 mg, cap 5 mg)	1-Covered	
KERENDIA (10 MG TAB, 20 MG TAB)	1-Covered	PA, QL (30 PER 30 DAYS)
labetalol hcl (tab 100 mg, tab 200 mg, tab 300 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
lisinopril & hydrochlorothiazide (tab 10-12.5 mg, tab 20-12.5 mg, tab 20-25 mg)	1-Covered	
lisinopril (tab 2.5 mg, tab 5 mg, tab 10 mg, tab 20 mg, tab 30 mg, tab 40 mg)	1-Covered	
losartan potassium & hydrochlorothiazide (tab 50-12.5 mg, tab 100-12.5 mg, tab 100-25 mg)	1-Covered	
losartan potassium (tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	
metolazone (tab 2.5 mg, tab 5 mg, tab 10 mg)	1-Covered	
metoprolol & hydrochlorothiazide (tab 50-25 mg, tab 100-25 mg, tab 100-50 mg)	1-Covered	
metoprolol succinate (tab er 25 mg (tartrate equiv), tab er 50 mg (tartrate equiv), tab er 100 mg (tartrate equiv), tab er 200 mg (tartrate equiv))	1-Covered	
metoprolol tartrate (tab 25 mg, tab 37.5 mg, tab 50 mg, tab 75 mg, tab 100 mg)	1-Covered	
metyrosine cap 250 mg	1-Covered	PA, NDS
minoxidil (tab 2.5 mg, tab 10 mg)	1-Covered	
moexipril hcl (tab 7.5 mg, tab 15 mg)	1-Covered	
nadolol (tab 20 mg, tab 40 mg, tab 80 mg)	1-Covered	
nebivolol hcl (tab 2.5 mg (base equivalent), tab 5 mg (base equivalent), tab 10 mg (base equivalent), tab 20 mg (base equivalent))	1-Covered	
nicardipine hcl (cap 20 mg, cap 30 mg)	1-Covered	
nifedipine (tab er 30 mg, tab er 60 mg, tab er 90 mg, tab er osmotic release 30 mg, tab er osmotic release 60 mg, tab er osmotic release 90 mg)	1-Covered	
nimodipine cap 30 mg	1-Covered	
nisoldipine (tab er 8.5 mg, tab er 17 mg, tab er 34 mg)	1-Covered	
NISOLDIPINE ER (20 MG TAB ER, 25.5 MG TAB ER, 30 MG TAB ER, 40 MG TAB ER)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
olmesartan medoxomil (tab 5 mg, tab 20 mg, tab 40 mg)	1-Covered	
olmesartan medoxomil-amlodipine-hydrochlorothiazide (tab 20-5-12.5 mg, tab 40-10-12.5 mg, tab 40-10-25 mg, tab 40-5-12.5 mg, tab 40-5-25 mg)	1-Covered	
olmesartan medoxomil-hydrochlorothiazide (tab 20-12.5 mg, tab 40-12.5 mg, tab 40-25 mg)	1-Covered	
perindopril erbumine (tab 2 mg, tab 4 mg, 8 mg tab, tab 8 mg)	1-Covered	
pindolol (tab 5 mg, tab 10 mg)	1-Covered	
prazosin hcl (cap 1 mg, cap 2 mg, cap 5 mg)	1-Covered	
propranolol hcl (cap er 24hr 120 mg, cap er 24hr 160 mg, cap er 24hr 60 mg, cap er 24hr 80 mg, oral soln 20 mg/5ml, tab 10 mg, tab 20 mg, 40 mg/5ml solution, tab 40 mg, tab 60 mg, tab 80 mg)	1-Covered	
quinapril hcl (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg)	1-Covered	
ramipril (cap 1.25 mg, cap 2.5 mg, cap 5 mg, cap 10 mg)	1-Covered	
spironolactone & hydrochlorothiazide tab 25-25 mg	1-Covered	
spironolactone (tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	
telmisartan (tab 20 mg, tab 40 mg, tab 80 mg)	1-Covered	
telmisartan-amlodipine (40-10 mg tab, 40-5 mg tab, tab 40-10 mg, tab 40-5 mg, 80-10 mg tab, 80-5 mg tab, tab 80-10 mg, tab 80-5 mg)	1-Covered	
telmisartan-hydrochlorothiazide (tab 40-12.5 mg, tab 80-12.5 mg, tab 80-25 mg)	1-Covered	
terazosin hcl (cap 1 mg (base equivalent), cap 2 mg (base equivalent), cap 5 mg (base equivalent))	1-Covered	QL (30 PER 30 DAYS)
terazosin hcl cap 10 mg (base equivalent)	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
timolol maleate (tab 5 mg, tab 10 mg, tab 20 mg)	1-Covered	
torsemide (tab 5 mg, tab 10 mg, tab 20 mg, tab 100 mg)	1-Covered	
trandolapril (tab 1 mg, tab 2 mg, tab 4 mg)	1-Covered	
trandolapril-verapamil hcl (tab er 2-180 mg, tab er 2-240 mg, tab er 4-240 mg)	1-Covered	
TRANDOLAPRIL-VERAPAMIL HCL ER (1-240 MG TAB ER, 2-180 MG TAB ER, 2-240 MG TAB ER, 4-240 MG TAB ER)	1-Covered	
triamterene & hydrochlorothiazide (cap 37.5-25 mg, tab 37.5-25 mg, tab 75-50 mg)	1-Covered	
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, LA, NDS
valsartan (tab 40 mg, tab 80 mg, tab 160 mg, tab 320 mg)	1-Covered	
valsartan-hydrochlorothiazide (tab 80-12.5 mg, tab 160-12.5 mg, tab 160-25 mg, tab 320-12.5 mg, tab 320-25 mg)	1-Covered	
verapamil hcl (cap er 24hr 120 mg, cap er 24hr 180 mg, cap er 24hr 200 mg, cap er 24hr 240 mg, tab 40 mg, tab 80 mg, tab 120 mg, tab er 120 mg, tab er 180 mg, tab er 240 mg)	1-Covered	
VERAPAMIL HCL ER (100 MG CAP ER, 200 MG CAP ER, 300 MG CAP ER, 360 MG CAP ER)	1-Covered	
COAGULATION THERAPY		
aspirin-dipyridamole cap er 12hr 25-200 mg	1-Covered	
BRILINTA (60 MG TAB, 90 MG TAB)	1-Covered	
CABLIVI 11 MG KIT	1-Covered	PA, LA, NDS
cilostazol (tab 50 mg, tab 100 mg)	1-Covered	
clopidogrel bisulfate tab 75 mg (base equiv)	1-Covered	QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
dabigatran etexilate mesylate (cap 75 mg (eq), cap 150 mg (eq))	1-Covered	
dipyridamole (tab 25 mg, tab 50 mg, tab 75 mg)	1-Covered	
DOPTELET 20 MG TAB	1-Covered	PA, LA, NDS
ELIQUIS (2.5 MG TAB, 5 MG TAB)	1-Covered	
ELIQUIS DVT/PE STARTER PACK 5 MG TAB THPK	1-Covered	
enoxaparin sodium (soln syr 100 mg/ml, soln syr 150 mg/ml)	1-Covered	QL (28 PER 28 DAYS)
enoxaparin sodium (soln syr 30 mg/0.3ml, soln syr 60 mg/0.6ml)	1-Covered	QL (16.8 PER 28 DAYS)
enoxaparin sodium (soln syr 80 mg/0.8ml, soln syr 120 mg/0.8ml)	1-Covered	QL (22.4 PER 28 DAYS)
enoxaparin sodium inj soln pref syr 40 mg/0.4ml	1-Covered	QL (11.2 PER 28 DAYS)
fondaparinux sodium (5 mg/0.4ml, 7.5 mg/0.6ml, 10 mg/0.8ml)	1-Covered	NDS
fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml	1-Covered	
heparin sodium (porcine) (1000 unit/ml, 5000 unit/ml, 10000 unit/ml, 20000 unit/ml)	1-Covered	
pentoxifylline tab er 400 mg	1-Covered	
prasugrel hcl (tab 5 mg (base equiv), tab 10 mg (base equiv))	1-Covered	
PROMACTA (12.5 MG PACKET, 12.5 MG TAB, 25 MG PACKET, 25 MG TAB, 50 MG TAB, 75 MG TAB)	1-Covered	PA, LA, NDS
warfarin sodium (tab 1 mg, tab 2 mg, tab 2.5 mg, tab 3 mg, tab 4 mg, tab 5 mg, tab 6 mg, tab 7.5 mg, tab 10 mg)	1-Covered	
XARELTO (1 MG/ML RECON SUSP, 2.5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB)	1-Covered	
XARELTO STARTER PACK 15 & 20 MG TAB THPK	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
LIPID/CHOLESTEROL LOWERING AGENTS		
amlodipine besylate-atorvastatin calcium (tab 2.5-10 mg, tab 2.5-20 mg, tab 2.5-40 mg, tab 5-10 mg, tab 5-20 mg, tab 5-40 mg, tab 5-80 mg, tab 10-10 mg, tab 10-20 mg, tab 10-40 mg, tab 10-80 mg)	1-Covered	QL (30 PER 30 DAYS)
atorvastatin calcium (tab 10 mg (base equivalent), tab 20 mg (base equivalent), tab 40 mg (base equivalent), tab 80 mg (base equivalent))	1-Covered	QL (30 PER 30 DAYS)
cholestyramine (powder 4 gm/dose, powder packets 4 gm)	1-Covered	
cholestyramine light (powder 4 gm/dose, powder packets 4 gm)	1-Covered	
choline fenofibrate (cap dr 45 mg (fenofibric equiv), cap dr 135 mg (fenofibric equiv))	1-Covered	
colesevelam hcl (packet for susp 3.75 gm, tab 625 mg)	1-Covered	
colestipol hcl (granule packets 5 gm, granules 5 gm, tab 1 gm)	1-Covered	
ezetimibe tab 10 mg	1-Covered	
ezetimibe-simvastatin (tab 10-10 mg, tab 10-20 mg, tab 10-40 mg, tab 10-80 mg)	1-Covered	QL (30 PER 30 DAYS)
fenofibrate (tab 48 mg, tab 54 mg, tab 145 mg, tab 160 mg)	1-Covered	
fenofibrate micronized (cap 43 mg, cap 67 mg, cap 134 mg, cap 200 mg)	1-Covered	
fluvastatin sodium cap 20 mg (base equivalent)	1-Covered	QL (30 PER 30 DAYS)
fluvastatin sodium cap 40 mg (base equivalent)	1-Covered	QL (60 PER 30 DAYS)
gemfibrozil tab 600 mg	1-Covered	
icosapent ethyl (cap 0.5 gm, cap 1 gm)	1-Covered	
JUXTAPID (5 MG CAP, 10 MG CAP, 20 MG CAP, 30 MG CAP)	1-Covered	PA, LA, NDS
LIVALO (1 MG TAB, 2 MG TAB, 4 MG TAB)	1-Covered	ST, QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
lovastatin (tab 20 mg, tab 40 mg)	1-Covered	QL (60 PER 30 DAYS)
lovastatin tab 10 mg	1-Covered	QL (30 PER 30 DAYS)
NEXLETOL 180 MG TAB	1-Covered	PA
NEXLIZET 180-10 MG TAB	1-Covered	PA
niacin (antihyperlipidemic) (500 mg tab, tab er 500 mg (antihyperlipidemic), tab er 750 mg (antihyperlipidemic), tab er 1000 mg (antihyperlipidemic))	1-Covered	
omega-3-acid ethyl esters cap 1 gm	1-Covered	
pravastatin sodium (tab 10 mg, tab 20 mg, tab 40 mg, tab 80 mg)	1-Covered	QL (30 PER 30 DAYS)
REPATHA 140 MG/ML SOLN PRSYR	1-Covered	PA, QL (6 PER 28 DAYS)
REPATHA PUSHTRONEX SYSTEM 420 MG/3.5ML SOLN CART	1-Covered	PA, QL (7 PER 28 DAYS)
REPATHA SURECLICK 140 MG/ML SOLN A-INJ	1-Covered	PA, QL (6 PER 28 DAYS)
rosuvastatin calcium (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg)	1-Covered	QL (30 PER 30 DAYS)
simvastatin (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg, tab 80 mg)	1-Covered	QL (30 PER 30 DAYS)
VASCEPA 0.5 GM CAP	1-Covered	
MISCELLANEOUS CARDIOVASCULAR AGENTS		
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 (0.05 mg/ml solution, oral soln 0.05 mg/ml, tab 62.5 mcg (0.0625 mg), tab 125 mcg (0.125 mg), tab 250 mcg (0.25 mg))	1-Covered	
ENTRESTO (24-26 MG TAB, 49-51 MG TAB, 97-103 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
ranolazine (tab er 500 mg, tab er 1000 mg)	1-Covered	
VECAMYL 2.5 MG TAB	1-Covered	NDS
VERQUVO (2.5 MG TAB, 5 MG TAB, 10 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
VYNDAMAX 61 MG CAP	1-Covered	PA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
NITRATES		
isosorbide dinitrate (tab 5 mg, tab 10 mg, tab 20 mg, tab 30 mg)	1-Covered	
isosorbide mononitrate (10 mg tab, tab 10 mg, 20 mg tab, tab 20 mg, tab er 24hr 120 mg, tab er 24hr 30 mg, tab er 24hr 60 mg)	1-Covered	
NITRO-BID 2 % OINTMENT	1-Covered	
nitroglycerin (sl tab 0.3 mg, sl tab 0.4 mg, sl tab 0.6 mg, td patch 24hr 0.1 mg/hr, td patch 24hr 0.2 mg/hr, td patch 24hr 0.4 mg/hr, td patch 24hr 0.6 mg/hr, tl soln 0.4 mg/spray (400 mcg/spray))	1-Covered	
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
acitretin (cap 10 mg, cap 17.5 mg, cap 25 mg)	1-Covered	
calcipotriene (cream, oint, soln (50 mcg/ml))	1-Covered	QL (120 PER 30 OVER TIME)
CALCITRIOL 3 MCG/GM OINTMENT	1-Covered	
selenium sulfide lotion 2.5%	1-Covered	
SKYRIZI 150 MG/ML SOLN PRSYR	1-Covered	PA, QL (2 PER 28 DAYS), NDS
SKYRIZI PEN 150 MG/ML SOLN A-INJ	1-Covered	PA, QL (2 PER 28 DAYS), NDS
STELARA (45 MG/0.5ML SOLN PRSYR, 45 MG/0.5ML SOLUTION)	1-Covered	PA, QL (0.5 PER 28 DAYS), NDS
STELARA 90 MG/ML SOLN PRSYR	1-Covered	PA, QL (1 PER 28 DAYS), NDS
TALTZ (80 MG/ML SOLN A-INJ, 80 MG/ML SOLN PRSYR)	1-Covered	PA, QL (1 PER 28 DAYS), NDS
MISCELLANEOUS DERMATOLOGICALS		
ADBRY 150 MG/ML SOLN PRSYR	1-Covered	PA, QL (6 PER 28 DAYS), NDS
CIBINQO (50 MG TAB, 100 MG TAB, 200 MG TAB)	1-Covered	PA, QL (30 PER 30 DAYS), NDS
diclofenac sodium (actinic keratoses) gel 3%	1-Covered	PA, QL (100 PER 28 OVER TIME)
DUPIXENT (200 MG/1.14ML SOLN PEN, 200 MG/1.14ML SOLN PRSYR)	1-Covered	PA, QL (4.56 PER 28 DAYS), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
DUPIXENT (300 MG/2ML SOLN PEN, 300 MG/2ML SOLN PRSYR)	1-Covered	PA, QL (8 PER 28 DAYS), NDS
DUPIXENT 100 MG/0.67ML SOLN PRSYR	1-Covered	PA, QL (1.34 PER 28 DAYS), NDS
FLUOROURACIL (2 % SOLUTION, 5 % SOLUTION)	1-Covered	
fluorouracil cream 5%	1-Covered	
imiquimod cream 5%	1-Covered	
lactic acid (ammonium lactate) (cream, lotion)	1-Covered	
lidocaine hcl soln 4%	1-Covered	
lidocaine hcl viscous soln 2%	1-Covered	
lidocaine oint 5%	1-Covered	QL (36 PER 30 OVER TIME)
lidocaine patch 5%	1-Covered	PA, QL (90 PER 30 DAYS)
lidocaine-prilocaine (cream 2.5-2.5%, cream kit 2.5-2.5%)	1-Covered	QL (30 PER 30 OVER TIME)
methoxsalen rapid (10 mg cap, cap 10 mg)	1-Covered	NDS
PANRETIN 0.1 % GEL	1-Covered	PA - FOR NEW STARTS ONLY, NDS
pimecrolimus cream 1%	1-Covered	PA, QL (100 PER 30 OVER TIME)
podofilox (0.5 % solution, soln 0.5%)	1-Covered	
REGRANEX 0.01 % GEL	1-Covered	NDS
SANTYL 250 UNIT/GM OINTMENT	1-Covered	QL (180 PER 30 OVER TIME)
silver sulfadiazine cream 1%	1-Covered	
tacrolimus (topical) (0.03%, 0.1%)	1-Covered	PA, QL (100 PER 30 OVER TIME)
VALCHLOR 0.016 % GEL	1-Covered	PA - FOR NEW STARTS ONLY, NDS
THERAPY FOR ACNE		
azelaic acid gel 15%	1-Covered	
clindamycin phosphate (topical) (gel, lotion, soln)	1-Covered	QL (120 PER 30 OVER TIME)
ERY 2 % PAD	1-Covered	
erythromycin soln 2%	1-Covered	
isotretinoin (cap 10 mg, cap 20 mg, cap 25 mg, cap 30 mg, cap 35 mg, cap 40 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
IVERMECTIN 1 % CREAM	1-Covered	QL (60 PER 30 OVER TIME)
ivermectin cream 1%	1-Covered	QL (60 PER 30 OVER TIME)
metronidazole (topical) (cream 0.75%, gel 0.75%, gel 1%, lotion 0.75%)	1-Covered	
tazarotene (cream 0.1%, gel 0.05%, gel 0.1%)	1-Covered	PA
tretinoin (cream 0.025%, cream 0.05%, cream 0.1%, gel 0.01%, gel 0.025%, gel 0.05%)	1-Covered	PA
TOPICAL ANTIBACTERIALS		
gentamicin sulfate (topical) (cream, oint)	1-Covered	QL (60 PER 30 OVER TIME)
mupirocin oint 2%	1-Covered	QL (44 PER 30 OVER TIME)
sulfacetamide sodium lotion 10% (acne)	1-Covered	
TOPICAL ANTIFUNGALS		
ciclopirox gel 0.77%	1-Covered	QL (100 PER 28 OVER TIME)
ciclopirox olamine cream 0.77% (base equiv)	1-Covered	QL (90 PER 28 OVER TIME)
ciclopirox olamine susp 0.77% (base equiv)	1-Covered	QL (60 PER 28 OVER TIME)
ciclopirox shampoo 1%	1-Covered	QL (120 PER 28 OVER TIME)
ciclopirox solution 8%	1-Covered	QL (6.6 PER 28 OVER TIME)
clotrimazole cream 1%	1-Covered	QL (45 PER 28 OVER TIME)
clotrimazole soln 1%	1-Covered	QL (30 PER 28 OVER TIME)
clotrimazole w/ betamethasone cream 1-0.05%	1-Covered	QL (45 PER 28 OVER TIME)
clotrimazole w/ betamethasone lotion 1-0.05%	1-Covered	QL (60 PER 28 OVER TIME)
econazole nitrate cream 1%	1-Covered	QL (85 PER 28 OVER TIME)
ketoconazole cream 2%	1-Covered	QL (60 PER 28 OVER TIME)
ketoconazole shampoo 2%	1-Covered	QL (120 PER 28 OVER TIME)
naftifine hcl (1 % cream, cream 1%, cream 2%, gel 2%)	1-Covered	QL (60 PER 28 OVER TIME)
NAFTIN 2 % GEL	1-Covered	QL (60 PER 28 OVER TIME)
nystatin (topical) (cream 100000 unit/gm, oint 100000 unit/gm)	1-Covered	QL (30 PER 28 OVER TIME)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
nystatin topical powder 100000 unit/gm	1-Covered	QL (180 PER 30 OVER TIME)
nystatin-triamcinolone (cream 100000-0.1 unit/gm-%, oint 100000-0.1 unit/gm-%)	1-Covered	QL (60 PER 28 OVER TIME)
TOPICAL ANTIVIRALS		
acyclovir oint 5%	1-Covered	PA, QL (30 PER 30 OVER TIME)
DENAVIR 1 % CREAM	1-Covered	QL (5 PER 30 OVER TIME)
penciclovir cream 1%	1-Covered	QL (5 PER 30 OVER TIME)
TOPICAL CORTICOSTEROIDS		
alclometasone dipropionate (cream, oint)	1-Covered	
betamethasone dipropionate (topical) (cream, lotion, oint)	1-Covered	
BETAMETHASONE DIPROPIONATE AUG 0.05 % GEL	1-Covered	
betamethasone dipropionate augmented (cream, lotion, oint)	1-Covered	
betamethasone valerate (cream (base equivalent), lotion (base equivalent), oint (base equivalent))	1-Covered	
clobetasol propionate (cream, gel, oint)	1-Covered	QL (120 PER 28 OVER TIME)
clobetasol propionate (foam, soln)	1-Covered	QL (100 PER 28 OVER TIME)
clobetasol propionate emollient base cream 0.05%	1-Covered	QL (120 PER 28 OVER TIME)
clobetasol propionate lotion 0.05%	1-Covered	QL (118 PER 28 OVER TIME)
clobetasol propionate shampoo 0.05%	1-Covered	QL (236 PER 28 OVER TIME)
desonide (cream, gel, lotion, oint)	1-Covered	
fluocinolone acetonide (cream 0.01%, cream 0.025%, oil 0.01% (body oil), oil 0.01% (scalp oil), oint 0.025%, soln 0.01%)	1-Covered	
fluocinonide (cream, gel, oint, soln)	1-Covered	QL (120 PER 30 OVER TIME)
fluocinonide emulsified base cream 0.05%	1-Covered	QL (120 PER 30 OVER TIME)
halobetasol propionate (cream, oint)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
mometasone furoate (cream, oint, solution (lotion))	1-Covered	
triamcinolone acetonide (topical) (cream 0.025%, cream 0.1%, cream 0.5%, lotion 0.025%, lotion 0.1%, oint 0.025%, oint 0.1%, oint 0.5%)	1-Covered	
TOPICAL SCABICIDES / PEDICULICIDES		
CROTAN 10 % LOTION	1-Covered	
malathion lotion 0.5%	1-Covered	
permethrin cream 5%	1-Covered	
DIAGNOSTICS / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
sodium polystyrene sulfonate powder*	1-Covered	
acamprosate calcium tab delayed release 333 mg	1-Covered	
anagrelide hcl (cap 0.5 mg, cap 1 mg)	1-Covered	
carglumic acid soluble tab 200 mg	1-Covered	PA, NDS
cevimeline hcl cap 30 mg	1-Covered	
CHEMET 100 MG CAP	1-Covered	PA
CLINIMIX/DEXTROSE (4.25/5) 4.25 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
deferasirox (granules packet 90 mg, granules packet 180 mg, granules packet 360 mg, tab 180 mg, tab 360 mg, tab for oral susp 125 mg, tab for oral susp 250 mg, tab for oral susp 500 mg)	1-Covered	PA, NDS
deferasirox tab 90 mg	1-Covered	PA
deferiprone (tab 500 mg, tab 1000 mg)	1-Covered	PA, NDS
dextrose (5%, 10%)	1-Covered	
dextrose w/ sodium chloride (w/ 0.2%, w/ 0.4, w/ 0.9%)	1-Covered	
DEXTROSE-NACL (2.5-0.45 % SOLUTION, 10-0.2 % SOLUTION, 10-0.45 % SOLUTION)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
disulfiram (tab 250 mg, tab 500 mg)	1-Covered	
droxidopa (cap 100 mg, cap 200 mg, cap 300 mg)	1-Covered	PA, NDS
INCRELEX 40 MG/4ML SOLUTION	1-Covered	LA, NDS
levocarnitine (metabolic modifiers) (oral soln 1 gm/10ml (10%), tab 330 mg)	1-Covered	
LOKELMA (5 GM, 10 GM)	1-Covered	
midodrine hcl (tab 2.5 mg, tab 5 mg, tab 10 mg)	1-Covered	
nitisinone (cap 2 mg, cap 5 mg, cap 10 mg, cap 20 mg)	1-Covered	PA, NDS
pilocarpine hcl (oral) (tab 5 mg, tab 7.5 mg)	1-Covered	
PROLASTIN-C (1000 MG RECON SOLN, 1000 MG/20ML SOLUTION)	1-Covered	PA, LA, NDS
RAVICTI 1.1 GM/ML LIQUID	1-Covered	PA, NDS
REVCOVI 2.4 MG/1.5ML SOLUTION	1-Covered	PA, LA, NDS
riluzole tab 50 mg	1-Covered	PA
risedronate sodium tab 30 mg	1-Covered	QL (30 PER 30 DAYS)
sevelamer carbonate tab 800 mg	1-Covered	QL (270 PER 30 DAYS)
sodium chloride (0.9 % solution, iv soln 0.9%, preservative free (pf) inj 0.9%)	1-Covered	
sodium chloride irrigation soln 0.9%	1-Covered	
sodium phenylbutyrate (oral powder 3 gm/teaspoonful, tab 500 mg)	1-Covered	PA, NDS
SPS 15 GM/60ML SUSPENSION	1-Covered	
trientine hcl cap 250 mg	1-Covered	PA, NDS
VELPHORO 500 MG CHEW TAB	1-Covered	QL (180 PER 30 DAYS), NDS
VELTASSA (8.4 GM, 16.8 GM, 25.2 GM)	1-Covered	
SMOKING DETERRENTS		
APO-VARENICLINE (0.5 MG TAB, 1 MG TAB)	1-Covered	
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	1-Covered	
NICOTROL 10 MG INHALER	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
NICOTROL NS 10 MG/ML SOLUTION	1-Covered	
varenicline tartrate (tab 0.5 mg (base equiv), tab 1 mg (base equiv), tab 11 x 0.5 mg & 42 x 1 mg start pack)	1-Covered	
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine hcl nasal spray 0.1% (137 mcg/spray)	1-Covered	QL (60 PER 30 DAYS)
chlorhexidine gluconate soln 0.12%	1-Covered	
ipratropium bromide (nasal) (nasal soln 0.03% (21 mcg/spray), nasal soln 0.06% (42 mcg/spray))	1-Covered	QL (30 PER 30 DAYS)
triamcinolone acetonide dental paste 0.1%	1-Covered	
MISCELLANEOUS OTIC PREPARATIONS		
acetic acid otic soln 2%	1-Covered	
CIPROFLOXACIN HCL 0.2 % SOLUTION	1-Covered	
fluocinolone acetonide (otic) oil 0.01%	1-Covered	
hydrocortisone w/ acetic acid otic soln 1-2%	1-Covered	
HYDROCORTISONE-ACETIC ACID 1-2 % SOLUTION	1-Covered	
ofloxacin otic soln 0.3%	1-Covered	
OTIC STEROID / ANTIBIOTIC		
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1-Covered	
neomycin-polymyxin-hc (otic) (soln 1%, susp 3.5 mg/ml-10000 unit/ml-1%)	1-Covered	
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
dexamethasone (0.5 mg/5ml solution, tab 0.5 mg, 0.75 mg tab, tab 0.75 mg, tab 1 mg, tab 1.5 mg, 2 mg tab, tab 2 mg, tab 4 mg, tab 6 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
fludrocortisone acetate tab 0.1 mg	1-Covered	
hydrocortisone (tab 5 mg, tab 10 mg, tab 20 mg)	1-Covered	
methylprednisolone (tab 4 mg, tab 8 mg, tab 16 mg, tab 32 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
methylprednisolone tab therapy pack 4 mg (21)	1-Covered	
prednisolone (15 mg/5ml solution, soln 15 mg/5ml)	1-Covered	
prednisolone sodium phosphate (sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base), 25 mg/5ml solution, oral soln 25 mg/5ml (base eq))	1-Covered	
prednisone (tab 1 mg, tab 2.5 mg, 5 mg/5ml solution, tab 5 mg, 10 mg (21) tab thpk, tab 10 mg, tab 20 mg, tab 50 mg, tab therapy pack 5 mg (21), tab therapy pack 5 mg (48), tab therapy pack 10 mg (21), tab therapy pack 10 mg (48))	1-Covered	
PREDNISONE INTENSOL 5 MG/ML CONC	1-Covered	
ANTITHYROID AGENTS		
methimazole (tab 5 mg, tab 10 mg)	1-Covered	
propylthiouracil tab 50 mg	1-Covered	
DIABETES THERAPY		
acarbose tab 100 mg	1-Covered	QL (90 PER 30 DAYS)
acarbose tab 25 mg	1-Covered	QL (360 PER 30 DAYS)
acarbose tab 50 mg	1-Covered	QL (180 PER 30 DAYS)
ALCOH-GLOVE CONTOURED WIPE PAD	1-Covered	
BAQSIMI ONE PACK 3 MG/DOSE POWDER	1-Covered	
BAQSIMI TWO PACK 3 MG/DOSE POWDER	1-Covered	
BYDUREON BCISE 2 MG/0.85ML A-INJ	1-Covered	PA, QL (4 PER 28 DAYS)
BYETTA 10 MCG PEN 10 MCG/0.04ML SOLN PEN	1-Covered	PA, QL (2.4 PER 30 DAYS)
BYETTA 5 MCG PEN 5 MCG/0.02ML SOLN PEN	1-Covered	PA, QL (1.2 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
diazoxide susp 50 mg/ml	1-Covered	
FARXIGA 10 MG TAB	1-Covered	QL (30 PER 30 DAYS)
FARXIGA 5 MG TAB	1-Covered	QL (60 PER 30 DAYS)
glimepiride tab 1 mg	1-Covered	QL (240 PER 30 DAYS)
glimepiride tab 2 mg	1-Covered	QL (120 PER 30 DAYS)
glimepiride tab 4 mg	1-Covered	QL (60 PER 30 DAYS)
glipizide (tab 10 mg, tab er 24hr 5 mg)	1-Covered	QL (120 PER 30 DAYS)
glipizide (tab 5 mg, tab er 24hr 2.5 mg)	1-Covered	QL (240 PER 30 DAYS)
glipizide tab er 24hr 10 mg	1-Covered	QL (60 PER 30 DAYS)
glipizide-metformin hcl (tab 2.5-500 mg, tab 5-500 mg)	1-Covered	QL (120 PER 30 DAYS)
glipizide-metformin hcl tab 2.5-250 mg	1-Covered	QL (240 PER 30 DAYS)
GLYXAMBI (10-5 MG TAB, 25-5 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
GVOKE HYPOPEN 1-PACK (0.5 MG/0.1ML SOLN, 1 MG/0.2ML SOLN)	1-Covered	
GVOKE HYPOPEN 2-PACK (0.5 MG/0.1ML SOLN, 1 MG/0.2ML SOLN)	1-Covered	
GVOKE KIT 1 MG/0.2ML SOLUTION	1-Covered	
GVOKE PFS (0.5 MG/0.1ML SOLN, 1 MG/0.2ML SOLN)	1-Covered	
HUMALOG (100 UNIT/ML SOLN CART, 100 UNIT/ML SOLUTION)	1-Covered	IC
HUMALOG JUNIOR KWIKPEN 100 UNIT/ML SOLN PEN	1-Covered	IC
HUMALOG KWIKPEN (100 UNIT/ML SOLN PEN, 200 UNIT/ML SOLN PEN)	1-Covered	IC
HUMALOG MIX 50/50 (50-50) 100 UNIT/ML SUSPENSION	1-Covered	IC
HUMALOG MIX 50/50 KWIKPEN (50-50) 100 UNIT/ML SUSP PEN	1-Covered	IC
HUMALOG MIX 75/25 (75-25) 100 UNIT/ML SUSPENSION	1-Covered	IC
HUMALOG MIX 75/25 KWIKPEN (75-25) 100 UNIT/ML SUSP PEN	1-Covered	IC
HUMULIN R U-500 (CONCENTRATED) 500 UNIT/ML SOLUTION	1-Covered	IC

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
HUMULIN R U-500 KWIKPEN 500 UNIT/ML SOLN PEN	1-Covered	IC
INPEFA 200 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS)
INSULIN LISPRO 100 UNIT/ML SOLUTION	1-Covered	IC
JANUMET (50-1000 MG TAB, 50-500 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
JANUMET XR (50-1000 MG TAB ER, 50-500 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
JANUMET XR 100-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
JANUVIA (25 MG TAB, 50 MG TAB, 100 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
JARDIANCE (10 MG TAB, 25 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
KOMBIGLYZE XR (5-1000 MG TAB ER, 5-500 MG TAB ER)	1-Covered	QL (30 PER 30 DAYS)
KOMBIGLYZE XR 2.5-1000 MG TAB ER 24H	1-Covered	QL (60 PER 30 DAYS)
LANTUS 100 UNIT/ML SOLUTION	1-Covered	IC
LANTUS SOLOSTAR 100 UNIT/ML SOLN PEN	1-Covered	IC
LYUMJEV 100 UNIT/ML SOLUTION	1-Covered	IC
LYUMJEV KWIKPEN (100 UNIT/ML SOLN PEN, 200 UNIT/ML SOLN PEN)	1-Covered	IC
metformin hcl tab 1000 mg	1-Covered	QL (75 PER 30 DAYS)
metformin hcl tab 500 mg	1-Covered	QL (150 PER 30 DAYS)
metformin hcl tab 850 mg	1-Covered	QL (90 PER 30 DAYS)
metformin hcl tab er 24hr 500 mg	1-Covered	QL (120 PER 30 DAYS)
metformin hcl tab er 24hr 750 mg	1-Covered	QL (60 PER 30 DAYS)
MOUNJARO (2.5 MG/0.5ML SOLN PEN, 5 MG/0.5ML SOLN PEN, 7.5 MG/0.5ML SOLN PEN, 10 MG/0.5ML SOLN PEN, 12.5 MG/0.5ML SOLN PEN, 15 MG/0.5ML SOLN PEN)	1-Covered	PA, QL (2 PER 28 DAYS)
nateglinide tab 120 mg	1-Covered	QL (90 PER 30 DAYS)
nateglinide tab 60 mg	1-Covered	QL (180 PER 30 DAYS)
ONGLYZA (2.5 MG TAB, 5 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN	1-Covered	PA, QL (3 PER 28 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
OZEMPIC (1 MG/DOSE) 4 MG/3ML SOLN PEN	1-Covered	PA, QL (3 PER 28 DAYS)
OZEMPIC (2 MG/DOSE) 8 MG/3ML SOLN PEN	1-Covered	PA, QL (3 PER 28 DAYS)
pioglitazone hcl (tab 15 mg (base equiv), tab 30 mg (base equiv), tab 45 mg (base equiv))	1-Covered	QL (30 PER 30 DAYS)
QTERN (5-5 MG TAB, 10-5 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
repaglinide tab 0.5 mg	1-Covered	QL (960 PER 30 DAYS)
repaglinide tab 1 mg	1-Covered	QL (480 PER 30 DAYS)
repaglinide tab 2 mg	1-Covered	QL (240 PER 30 DAYS)
RYBELSUS (3 MG TAB, 7 MG TAB, 14 MG TAB)	1-Covered	PA, QL (30 PER 30 DAYS)
saxagliptin hcl (tab 2.5 mg (base equiv), tab 5 mg (base equiv))	1-Covered	QL (30 PER 30 DAYS)
saxagliptin-metformin hcl (tab er 5-1000 mg, tab er 5-500 mg)	1-Covered	QL (30 PER 30 DAYS)
saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg	1-Covered	QL (60 PER 30 DAYS)
SEGLUROMET (2.5-1000 MG TAB, 7.5-1000 MG TAB, 7.5-500 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
SEGLUROMET 2.5-500 MG TAB	1-Covered	QL (120 PER 30 DAYS)
SOLIQUA 100-33 UNT-MCG/ML SOLN PEN	1-Covered	QL (90 PER 30 DAYS), IC
STEGLATRO (5 MG TAB, 15 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
SYMLINPEN 120 2700 MCG/2.7ML SOLN PEN	1-Covered	PA, QL (10.8 PER 30 DAYS), NDS
SYMLINPEN 60 1500 MCG/1.5ML SOLN PEN	1-Covered	PA, QL (6 PER 30 DAYS), NDS
SYNJARDY (5-1000 MG TAB, 5-500 MG TAB, 12.5-1000 MG TAB, 12.5-500 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
TOUJEO MAX SOLOSTAR 300 UNIT/ML SOLN PEN	1-Covered	IC
TOUJEO SOLOSTAR 300 UNIT/ML SOLN PEN	1-Covered	IC
TRIJARDY XR (10-5-1000 MG TAB ER, 25-5-1000 MG TAB ER)	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	TIER	REQUIREMENTS/LIMITS
TRIJARDY XR (5-2.5-1000 MG TAB ER, 12.5-2.5-1000 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
TRULICITY (0.75 MG/0.5ML SOLN PEN, 1.5 MG/0.5ML SOLN PEN, 3 MG/0.5ML SOLN PEN, 4.5 MG/0.5ML SOLN PEN)	1-Covered	PA, QL (2 PER 28 DAYS)
VICTOZA 18 MG/3ML SOLN PEN	1-Covered	PA, QL (9 PER 30 DAYS)
XIGDUO XR (10-1000 MG TAB ER, 10-500 MG TAB ER)	1-Covered	QL (30 PER 30 DAYS)
XIGDUO XR (2.5-1000 MG TAB ER, 5-1000 MG TAB ER, 5-500 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
ZEGALOGUE (0.6 MG/0.6ML SOLN A-INJ, 0.6 MG/0.6ML SOLN PRSYR)	1-Covered	
MISCELLANEOUS HORMONES		
cabergoline tab 0.5 mg	1-Covered	
calcitonin (salmon) nasal soln 200 unit/act	1-Covered	
calcitriol (cap 0.25 mcg, cap 0.5 mcg, oral soln 1 mcg/ml)	1-Covered	
cinacalcet hcl (tab 30 mg (base equiv), tab 60 mg (base equiv), tab 90 mg (base equiv))	1-Covered	PA
danazol (cap 50 mg, cap 100 mg, cap 200 mg)	1-Covered	
desmopressin acetate (tab 0.1 mg, tab 0.2 mg)	1-Covered	
desmopressin acetate nasal spray soln 0.01%	1-Covered	
desmopressin acetate nasal spray soln 0.01% (refrigerated)	1-Covered	
doxercalciferol (cap 0.5 mcg, cap 1 mcg, cap 2.5 mcg)	1-Covered	
KORLYM 300 MG TAB	1-Covered	PA, NDS
MYALEPT 11.3 MG RECON SOLN	1-Covered	PA, LA, NDS
NATPARA (25 MCG, 50 MCG, 75 MCG, 100 MCG)	1-Covered	PA, LA, NDS
paricalcitol (cap 1 mcg, cap 2 mcg, cap 4 mcg)	1-Covered	
sapropterin dihydrochloride (powder packet 100 mg, powder packet 500 mg, tab 100 mg)	1-Covered	PA, NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
SOMAVERT (10 MG SOLN, 15 MG SOLN, 20 MG SOLN, 25 MG SOLN, 30 MG SOLN)	1-Covered	PA, NDS
SYNAREL 2 MG/ML SOLUTION	1-Covered	PA, NDS
testosterone (12.5 mg/act (1%) gel, td gel 12.5 mg/act (1%), td gel 25 mg/2.5gm (1%), 50 mg/5gm (1%) gel, td gel 50 mg/5gm (1%))	1-Covered	PA, QL (300 PER 30 DAYS)
testosterone (gel 20.25 mg/act (1.62%), gel 40.5 mg/2.5gm (1.62%))	1-Covered	PA, QL (150 PER 30 DAYS)
testosterone cypionate (im inj in oil 100 mg/ml, 200 mg/ml solution, im inj in oil 200 mg/ml)	1-Covered	PA
testosterone enanthate (200 mg/ml solution, im inj in oil 200 mg/ml)	1-Covered	PA - FOR NEW STARTS ONLY
testosterone td gel 10mg/act (2%)	1-Covered	PA, QL (120 PER 30 DAYS)
testosterone td gel 20.25 mg/1.25gm (1.62%)	1-Covered	PA, QL (37.5 PER 30 DAYS)
testosterone td soln 30 mg/act	1-Covered	PA, QL (180 PER 30 DAYS)
tolvaptan (15 mg tab, tab 15 mg, tab 30 mg)	1-Covered	PA, NDS
THYROID HORMONES		
levothyroxine sodium (tab 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)	1-Covered	
liothyronine sodium (tab 5 mcg, tab 25 mcg, tab 50 mcg)	1-Covered	
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
dicyclomine hcl (cap 10 mg, oral soln 10 mg/5ml, tab 20 mg)	1-Covered	
diphenoxylate w/ atropine tab 2.5-0.025 mg	1-Covered	
DIPHENOXYLATE-ATROPINE 2.5-0.025 MG/5ML LIQUID	1-Covered	
glycopyrrolate (tab 1 mg, 1.5 mg tab, tab 2 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
loperamide hcl cap 2 mg	1-Covered	
MISCELLANEOUS GASTROINTESTINAL AGENTS		
betaine powder for oral solution**	1-Covered	NDS
mesalamine rectal enema 4 gm & cleanser wipe kit*	1-Covered	
alosetron hcl (tab 0.5 mg (base equiv), tab 1 mg (base equiv))	1-Covered	PA, NDS
aprepitant (capsule 40 mg, capsule 80 mg, capsule 125 mg, capsule therapy pack 80 & 125 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
balsalazide disodium cap 750 mg	1-Covered	
budesonide delayed release particles cap 3 mg	1-Covered	
budesonide tab er 24hr 9 mg	1-Covered	NDS
CHENODAL 250 MG TAB	1-Covered	PA, LA, NDS
CHOLBAM 250 MG CAP	1-Covered	PA, NDS
CHOLBAM 50 MG CAP	1-Covered	PA, QL (120 PER 30 DAYS), NDS
CIMZIA (2 X 200 MG KIT, 2 X 200 MG/ML PREF SY KT)	1-Covered	PA, QL (2 PER 28 DAYS), NDS
CIMZIA STARTER KIT 6 X 200 MG/ML PREF SY KT	1-Covered	PA, QL (2 PER 28 DAYS), NDS
CREON (3000-9500 DR, 6000 DR, 6000-19000 DR, 12000 DR, 24000-76000 DR, 36000 DR)	1-Covered	
cromolyn sodium oral conc 100 mg/5ml	1-Covered	
dronabinol (cap 2.5 mg, cap 5 mg, cap 10 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
EMEND 125 MG/5ML RECON SUSP	1-Covered	PA - TO CONFIRM PART D COVERAGE
GATTEX 5 MG KIT	1-Covered	PA, NDS
GAVILYTE-C 240 GM RECON SOLN	1-Covered	
granisetron hcl tab 1 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE
hydrocortisone enema 100 mg/60ml	1-Covered	
hydrocortisone perianal cream 2.5%	1-Covered	
lactulose (encephalopathy) solution 10 gm/15ml	1-Covered	
lactulose solution 10 gm/15ml	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
LINZESS (72 MCG CAP, 145 MCG CAP, 290 MCG CAP)	1-Covered	QL (30 PER 30 DAYS)
lubiprostone (cap 8 mcg, cap 24 mcg)	1-Covered	QL (60 PER 30 DAYS)
meclizine hcl (tab 12.5 mg, tab 25 mg)	1-Covered	
mesalamine (cap dr 400 mg, cap er 24hr 0.375 gm, enema 4 gm, suppos 1000 mg, tab delayed release 1.2 gm, 800 mg tab dr, tab delayed release 800 mg)	1-Covered	
mesalamine cap er 500 mg	1-Covered	NDS
metoclopramide hcl (soln 5 mg/5ml (10 mg/10ml) (base equiv), tab 5 mg (base equivalent), tab 10 mg (base equivalent))	1-Covered	
MOTEGRITY (1 MG TAB, 2 MG TAB)	1-Covered	ST, QL (30 PER 30 DAYS)
MOVANTIK (12.5 MG TAB, 25 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
OCALIVA (5 MG TAB, 10 MG TAB)	1-Covered	PA, LA, QL (30 PER 30 DAYS)
ondansetron (tab 4 mg, tab 8 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ondansetron hcl (oral soln 4 mg/5ml, tab 4 mg, tab 8 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	1-Covered	
peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm	1-Covered	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1-Covered	
PENTASA 250 MG CAP ER	1-Covered	
PENTASA 500 MG CAP ER	1-Covered	NDS
prochlorperazine maleate (tab 5 mg (base equivalent), tab 10 mg (base equivalent))	1-Covered	
prochlorperazine suppos 25 mg	1-Covered	
RECTIV 0.4 % OINTMENT	1-Covered	
RELISTOR 12 MG/0.6ML SOLUTION	1-Covered	QL (18 PER 30 DAYS), NDS
RELISTOR 8 MG/0.4ML SOLUTION	1-Covered	QL (12 PER 30 DAYS), NDS
SANCUSO 3.1 MG/24HR PATCH	1-Covered	NDS
scopolamine td patch 72hr 1 mg/3days	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
SKYRIZI 180 MG/1.2ML SOLN CART	1-Covered	PA, QL (1.2 PER 56 OVER TIME), NDS
SKYRIZI 360 MG/2.4ML SOLN CART	1-Covered	PA, QL (2.4 PER 56 OVER TIME), NDS
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	1-Covered	
SUCRAID 8500 UNIT/ML SOLUTION	1-Covered	PA, NDS
sulfasalazine (tab 500 mg, tab delayed release 500 mg)	1-Covered	
TRULANCE 3 MG TAB	1-Covered	
ursodiol (cap 300 mg, tab 250 mg, tab 500 mg)	1-Covered	
VARUBI (180 MG DOSE) 2 X 90 MG TAB THPK	1-Covered	PA - TO CONFIRM PART D COVERAGE
VIBERZI (75 MG TAB, 100 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS
VIOKACE (10440-39150 TAB, 20880 TAB)	1-Covered	
ZENPEP (3000-10000 DR, 5000-24000 DR, 10000-32000 DR, 15000-47000 DR, 20000-63000 DR, 25000-79000 DR, 40000-126000 DR)	1-Covered	
ULCER THERAPY		
cimetidine (tab 200 mg, tab 300 mg, tab 400 mg, tab 800 mg)	1-Covered	
esomeprazole magnesium cap delayed release 20 mg (base eq)	1-Covered	QL (30 PER 30 DAYS)
esomeprazole magnesium cap delayed release 40 mg (base eq)	1-Covered	
famotidine (for susp 40 mg/5ml, tab 20 mg, tab 40 mg)	1-Covered	
lansoprazole cap delayed release 15 mg	1-Covered	QL (30 PER 30 DAYS)
lansoprazole cap delayed release 30 mg	1-Covered	
misoprostol (tab 100 mcg, tab 200 mcg)	1-Covered	
nizatidine (150 mg cap, cap 150 mg, 300 mg cap, cap 300 mg)	1-Covered	
omeprazole (cap 10 mg, cap 20 mg)	1-Covered	QL (30 PER 30 DAYS)
omeprazole cap delayed release 40 mg	1-Covered	
pantoprazole sodium ec tab 20 mg (base equiv)	1-Covered	QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
pantoprazole sodium ec tab 40 mg (base equiv)	1-Covered	
sucralfate (1 gm/10ml suspension, susp 1 gm/10ml, tab 1 gm)	1-Covered	

IMMUNOLOGY, VACCINES / BIOTECHNOLOGY

BIOTECHNOLOGY DRUGS

ACTIMMUNE 2000000 UNIT/0.5ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
ARCALYST 220 MG RECON SOLN	1-Covered	PA, NDS
AVONEX PEN 30 MCG/0.5ML AUT-IJ KIT	1-Covered	PA, QL (1 PER 28 DAYS), NDS
AVONEX PREFILLED 30 MCG/0.5ML PREF SY KT	1-Covered	PA, QL (1 PER 28 DAYS), NDS
BESREMI 500 MCG/ML SOLN PRSYR	1-Covered	PA - FOR NEW STARTS ONLY, LA, NDS
BETASERON 0.3 MG KIT	1-Covered	PA, QL (14 PER 28 DAYS), NDS
LEUKINE 250 MCG RECON SOLN	1-Covered	PA, NDS
NIVESTYM (300 MCG/0.5ML SOLN PRSYR, 300 MCG/ML SOLUTION, 480 MCG/0.8ML SOLN PRSYR, 480 MCG/1.6ML SOLUTION)	1-Covered	PA, NDS
NYVEPRIA 6 MG/0.6ML SOLN PRSYR	1-Covered	PA, NDS
OMNITROPE (5 MG/1.5ML SOLN CART, 5.8 MG RECON SOLN, 10 MG/1.5ML SOLN CART)	1-Covered	PA, NDS
PEGASYS 180 MCG/0.5ML SOLN PRSYR	1-Covered	QL (2 PER 28 DAYS), NDS
PEGASYS 180 MCG/ML SOLUTION	1-Covered	QL (4 PER 28 DAYS), NDS
PLEGRIDY (125 MCG/0.5ML SOLN PEN, 125 MCG/0.5ML SOLN PRSYR)	1-Covered	PA, QL (1 PER 28 DAYS), NDS
PROCRIT (2000 UNIT/ML SOLUTION, 3000 UNIT/ML SOLUTION, 4000 UNIT/ML SOLUTION, 10000 UNIT/ML SOLUTION)	1-Covered	PA
PROCRIT (20000 UNIT/ML SOLUTION, 40000 UNIT/ML SOLUTION)	1-Covered	PA, NDS
RETACRIT (2000 UNIT/ML SOLUTION, 3000 UNIT/ML SOLUTION, 4000 UNIT/ML SOLUTION, 10000 UNIT/ML SOLUTION, 20000 UNIT/ML SOLUTION)	1-Covered	PA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
RETACRIT 40000 UNIT/ML SOLUTION	1-Covered	PA, NDS
ZARXIO (300 MCG/0.5ML SOLN, 480 MCG/0.8ML SOLN)	1-Covered	PA, NDS
ZIEXTENZO 6 MG/0.6ML SOLN PRSYR	1-Covered	PA, NDS
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ABRYSVO 120 MCG/0.5ML RECON SOLN	1-Covered	V
ACTHIB RECON SOLN	1-Covered	V
ADACEL 5-2-15.5 LF-MCG/0.5 SUSPENSION	1-Covered	V
AREXVY 120 MCG/0.5ML RECON SUSP	1-Covered	V
BCG VACCINE 50 MG RECON SOLN	1-Covered	V
BEXSERO SUSP PRSYR	1-Covered	V
BOOSTRIX (5-2.5-18.5 LF-MCG/0.5 SUSP PRSYR, 5-2.5-18.5 LF-MCG/0.5 SUSPENSION)	1-Covered	V
DAPTACEL 23-15-5 SUSPENSION	1-Covered	
DIPHTHERIA-TETANUS TOXOIDS DT 25-5 LFU/0.5ML SUSPENSION	1-Covered	
ENGERIX-B (10 MCG/0.5ML SUSP PRSYR, 10 MCG/0.5ML SUSPENSION, 20 MCG/ML SUSP PRSYR, 20 MCG/ML SUSPENSION)	1-Covered	PA - TO CONFIRM PART D COVERAGE, V
GARDASIL 9 (SUSP PRSYR, SUSPENSION)	1-Covered	V
HAVRIX (720 U/0.5ML SUSPENSION, 1440 U/ML SUSPENSION)	1-Covered	V
HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	1-Covered	PA - TO CONFIRM PART D COVERAGE
HIBERIX 10 MCG RECON SOLN	1-Covered	V
IMOVAX RABIES 2.5 UNIT/ML RECON SUSP	1-Covered	V
INFANRIX 25-58-10 SUSPENSION	1-Covered	
IPOL INJECTABLE	1-Covered	V
IXIARO SUSPENSION	1-Covered	V
JYNNEOS 0.5 ML SUSPENSION	1-Covered	PA - TO CONFIRM PART D COVERAGE
KINRIX 0.5 ML SUSP PRSYR	1-Covered	
M-M-R II RECON SOLN	1-Covered	V

DRUG NAME	TIER	REQUIREMENTS/LIMITS
MENACTRA SOLUTION	1-Covered	V
MENQUADFI SOLUTION	1-Covered	V
MENVEO RECON SOLN	1-Covered	V
PEDIARIX SUSP PRSYR	1-Covered	
PEDVAX HIB 7.5 MCG/0.5ML SUSPENSION	1-Covered	V
PENTACEL RECON SUSP	1-Covered	
PREHEVBRIO 10 MCG/ML SUSPENSION	1-Covered	PA - TO CONFIRM PART D COVERAGE, V
PRIORIX RECON SUSP	1-Covered	V
PRIVIGEN 20 GM/200ML SOLUTION	1-Covered	PA, NDS
PROQUAD RECON SUSP	1-Covered	
QUADRACEL (0.5 ML SUSP PRSYR, SUSPENSION)	1-Covered	
RABAVERT RECON SUSP	1-Covered	V
RECOMBIVAX HB (5 MCG/0.5ML SUSP PRSYR, 5 MCG/0.5ML SUSPENSION, 10 MCG/ML SUSP PRSYR, 10 MCG/ML SUSPENSION, 40 MCG/ML SUSPENSION)	1-Covered	PA - TO CONFIRM PART D COVERAGE, V
ROTARIX (RECON SUSP, SUSPENSION)	1-Covered	
ROTATEQ SOLUTION	1-Covered	
SHINGRIX 50 MCG/0.5ML RECON SUSP	1-Covered	V
TDVAX 2-2 LF/0.5ML SUSPENSION	1-Covered	V
TENIVAC 5-2 LFU INJECTABLE	1-Covered	V
TICOVAC (1.2 MCG/0.25ML SUSP, 2.4 MCG/0.5ML SUSP)	1-Covered	
TRUMENBA SUSP PRSYR	1-Covered	V
TWINRIX 720-20 ELU-MCG/ML SUSP PRSYR	1-Covered	V
TYPHIM VI (25 MCG/0.5ML SOLN PRSYR, 25 MCG/0.5ML SOLUTION)	1-Covered	V
VAQTA (25 UNIT/0.5ML SUSPENSION, 50 UNIT/ML SUSPENSION)	1-Covered	V
VARIVAX 1350 PFU/0.5ML INJECTABLE	1-Covered	V
YF-VAX INJECTABLE	1-Covered	V

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
MISCELLANEOUS SUPPLIES		
ASSURE ID INSULIN SAFETY SYR (X 1/2" 0.5 ML, X 1/2" 1 ML)	1-Covered	
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML MISC	1-Covered	
BD PEN NEEDLE NANO U/F 32G X 4 MM MISC	1-Covered	
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML MISC	1-Covered	
MAGELLAN INSULIN SAFETY SYR (29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML)	1-Covered	
MARATHON MEDICAL PENTIPS (29G X 12MM, 31G X 5 MM, 31G X 8 MM, 32G X 4 MM)	1-Covered	
MONOJECT INSULIN SYRINGE (27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, U-100 1 ML)	1-Covered	
MONOJECT ULTRA COMFORT SYRINGE (28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML)	1-Covered	
PENTIPS (29G X 12MM, 31G X 5 MM, 31G X 8 MM, 32G X 4 MM)	1-Covered	
PRO COMFORT PEN NEEDLES (31G X 8, 32G X 4, 32G X 5)	1-Covered	
SURE COMFORT INSULIN SYRINGE (28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 1/4" 0.3 ML, 31G X 1/4" 0.5 ML, 31G X 1/4" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML)	1-Covered	
ULTICARE INSULIN SAFETY SYR (X 1/2" 0.5 ML, X 1/2" 1 ML)	1-Covered	
ULTILET INSULIN SYRINGE 31G X 15/64" 0.3 ML MISC	1-Covered	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
allopurinol (tab 100 mg, tab 300 mg)	1-Covered	
colchicine tab 0.6 mg	1-Covered	
colchicine w/ probenecid tab 0.5-500 mg	1-Covered	
febuxostat (tab 40 mg, tab 80 mg)	1-Covered	
probenecid tab 500 mg	1-Covered	
OSTEOPOROSIS THERAPY		
alendronate sodium (tab 35 mg, tab 70 mg)	1-Covered	QL (4 PER 28 DAYS)
alendronate sodium oral soln 70 mg/75ml	1-Covered	QL (300 PER 28 DAYS)
alendronate sodium tab 10 mg	1-Covered	QL (30 PER 30 DAYS)
FOSAMAX PLUS D (70-2800 TAB, 70-5600 TAB)	1-Covered	ST, QL (4 PER 28 DAYS)
ibandronate sodium tab 150 mg (base equivalent)	1-Covered	QL (1 PER 30 DAYS)
PROLIA 60 MG/ML SOLN PRSYR	1-Covered	PA, QL (1 PER 180 OVER TIME)
raloxifene hcl tab 60 mg	1-Covered	
risedronate sodium (tab 35 mg, tab delayed release 35 mg)	1-Covered	QL (4 PER 28 DAYS)
risedronate sodium tab 150 mg	1-Covered	QL (1 PER 30 DAYS)
risedronate sodium tab 5 mg	1-Covered	QL (30 PER 30 DAYS)
TERIPARATIDE (RECOMBINANT) 620 MCG/2.48ML SOLN PEN	1-Covered	PA, QL (2.48 PER 28 DAYS), NDS
OTHER RHEUMATOLOGICALS		
ACTEMRA 162 MG/0.9ML SOLN PRSYR	1-Covered	PA, QL (3.6 PER 28 DAYS), NDS
ACTEMRA ACTPEN 162 MG/0.9ML SOLN A-INJ	1-Covered	PA, QL (3.6 PER 28 DAYS), NDS
ADALIMUMAB-ADAZ (40 MG/0.4ML SOLN A-INJ, 40 MG/0.4ML SOLN PRSYR)	1-Covered	PA, QL (1.6 PER 28 DAYS), NDS
AMJEVITA (40 MG/0.8ML SOLN A-INJ, 40 MG/0.8ML SOLN PRSYR)	1-Covered	PA, QL (6 PER 28 DAYS), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
AMJEVITA 10 MG/0.2ML SOLN PRSYR	1-Covered	PA, QL (0.4 PER 28 DAYS), NDS
AMJEVITA 20 MG/0.4ML SOLN PRSYR	1-Covered	PA, QL (2 PER 28 DAYS), NDS
BENLYSTA (200 MG/ML SOLN A-INJ, 200 MG/ML SOLN PRSYR)	1-Covered	PA, NDS
CYLTEZO (10 MG/0.2ML, 20 MG/0.4ML)	1-Covered	PA, QL (2 PER 28 DAYS), NDS
CYLTEZO (40 MG/0.8ML AUT-IJ KIT, 40 MG/0.8ML PREF SY KT)	1-Covered	PA, QL (4 PER 28 DAYS), NDS
CYLTEZO-CD/UC/HS STARTER 40 MG/0.8ML AUT-IJ KIT	1-Covered	PA, QL (6 PER 180 OVER TIME), NDS
CYLTEZO-PSORIASIS STARTER 40 MG/0.8ML AUT-IJ KIT	1-Covered	PA, QL (4 PER 180 OVER TIME), NDS
ENBREL (25 MG/0.5ML SOLN PRSYR, 25 MG/0.5ML SOLUTION, 50 MG/ML SOLN PRSYR)	1-Covered	PA, QL (8 PER 28 DAYS), NDS
ENBREL MINI 50 MG/ML SOLN CART	1-Covered	PA, QL (8 PER 28 DAYS), NDS
ENBREL SURECLICK 50 MG/ML SOLN A-INJ	1-Covered	PA, QL (8 PER 28 DAYS), NDS
HUMIRA (10 MG/0.1ML, 20 MG/0.2ML)	1-Covered	PA, QL (2 PER 28 DAYS), NDS
HUMIRA (40 MG/0.4ML, 40 MG/0.8ML)	1-Covered	PA, QL (4 PER 28 DAYS), NDS
HUMIRA PEDIATRIC CROHNS START 80 MG/0.8ML & 40MG/0.4ML PREF SY KT	1-Covered	PA, QL (2 PER 180 OVER TIME), NDS
HUMIRA PEDIATRIC CROHNS START 80 MG/0.8ML PREF SY KT	1-Covered	PA, QL (3 PER 180 OVER TIME), NDS
HUMIRA PEN (40 MG/0.4ML PEN KIT, 40 MG/0.8ML PEN KIT)	1-Covered	PA, QL (4 PER 28 DAYS), NDS
HUMIRA PEN 80 MG/0.8ML PEN KIT	1-Covered	PA, QL (2 PER 28 DAYS), NDS
HUMIRA PEN-CD/UC/HS STARTER 40 MG/0.8ML PEN KIT	1-Covered	PA, QL (6 PER 180 OVER TIME), NDS
HUMIRA PEN-CD/UC/HS STARTER 80 MG/0.8ML PEN KIT	1-Covered	PA, QL (3 PER 180 OVER TIME), NDS
HUMIRA PEN-PEDIATRIC UC START 80 MG/0.8ML PEN KIT	1-Covered	PA, QL (4 PER 180 OVER TIME), NDS
HUMIRA PEN-PS/UV/ADOL HS START 40 MG/0.8ML PEN KIT	1-Covered	PA, QL (4 PER 180 OVER TIME), NDS
HUMIRA PEN-PSOR/UVEIT STARTER 80 MG/0.8ML & 40MG/0.4ML PEN KIT	1-Covered	PA, QL (3 PER 180 OVER TIME), NDS
HYRIMOZ (40 MG/0.4ML SOLN A-INJ, 40 MG/0.4ML SOLN PRSYR, 80 MG/0.8ML SOLN A-INJ)	1-Covered	PA, QL (1.6 PER 28 DAYS), NDS

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
HYRIMOZ 10 MG/0.1 ML SOLN PRSYR	1-Covered	PA, QL (0.2 PER 28 DAYS), NDS
HYRIMOZ 20 MG/0.2ML SOLN PRSYR	1-Covered	PA, QL (0.4 PER 28 DAYS), NDS
HYRIMOZ-CROHNS/UC STARTER PACK 80 MG/0.8ML SOLN A-INJ	1-Covered	PA, QL (2.4 PER 180 OVER TIME), NDS
HYRIMOZ-PED CROHNS STARTER 80 MG/0.8ML & 40MG/0.4ML SOLN PRSYR	1-Covered	PA, QL (1.2 PER 180 OVER TIME), NDS
HYRIMOZ-PED CROHNS STARTER 80 MG/0.8ML SOLN PRSYR	1-Covered	PA, QL (2.4 PER 180 OVER TIME), NDS
HYRIMOZ-PLAQUE PSORIASIS START 80 MG/0.8ML & 40MG/0.4ML SOLN A-INJ	1-Covered	PA, QL (1.6 PER 180 OVER TIME), NDS
leflunomide (tab 10 mg, tab 20 mg)	1-Covered	QL (30 PER 30 DAYS)
ORENCIA 125 MG/ML SOLN PRSYR	1-Covered	PA, QL (4 PER 28 DAYS), NDS
ORENCIA 50 MG/0.4ML SOLN PRSYR	1-Covered	PA, QL (1.6 PER 28 DAYS), NDS
ORENCIA 87.5 MG/0.7ML SOLN PRSYR	1-Covered	PA, QL (2.8 PER 28 DAYS), NDS
ORENCIA CLICKJECT 125 MG/ML SOLN A-INJ	1-Covered	PA, QL (4 PER 28 DAYS), NDS
OTEZLA 10 & 20 & 30 MG TAB THPK	1-Covered	PA, QL (55 PER 180 OVER TIME), NDS
OTEZLA 30 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS), NDS
penicillamine tab 250 mg	1-Covered	PA, NDS
RIDAURA 3 MG CAP	1-Covered	NDS
RINVOQ (15 MG TAB ER, 30 MG TAB ER)	1-Covered	PA, QL (30 PER 30 DAYS), NDS
RINVOQ 45 MG TAB ER 24H	1-Covered	PA, QL (84 PER 180 OVER TIME), NDS
SAVELLA (12.5 MG TAB, 25 MG TAB, 50 MG TAB, 100 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
SAVELLA TITRATION PACK 12.5 & 25 & 50 MG MISC	1-Covered	QL (55 PER 180 OVER TIME)
XELJANZ (5 MG TAB, 10 MG TAB)	1-Covered	PA, QL (60 PER 30 DAYS), NDS
XELJANZ 1 MG/ML SOLUTION	1-Covered	PA, QL (300 PER 30 DAYS), NDS
XELJANZ XR (11 MG TAB ER, 22 MG TAB ER)	1-Covered	PA, QL (30 PER 30 DAYS), NDS

OBSTETRICS / GYNECOLOGY

ESTROGENS / PROGESTINS

DEPO-SUBQ PROVERA 104 104 MG/0.65ML SUSP PRSYR	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
DUAVEE 0.45-20 MG TAB	1-Covered	
estradiol & norethindrone acetate (tab 0.5-0.1 mg, tab 1-0.5 mg)	1-Covered	PA
estradiol (patch 0.025 mg/24hr, patch 0.0375 mg/24hr (37.5 mcg/24hr), patch 0.05 mg/24hr, patch 0.06 mg/24hr, patch 0.075 mg/24hr, patch 0.1 mg/24hr)	1-Covered	PA, QL (4 PER 28 DAYS)
estradiol (patch 0.025 mg/24hr, patch 0.0375 mg/24hr, patch 0.05 mg/24hr, patch 0.075 mg/24hr, patch 0.1 mg/24hr)	1-Covered	PA, QL (8 PER 28 DAYS)
estradiol (tab 0.5 mg, tab 1 mg, tab 2 mg)	1-Covered	PA
estradiol vaginal (cream 0.1 mg/gm, tab 10 mcg)	1-Covered	
estradiol valerate (in 10 mg/ml, in 20 mg/ml, in 40 mg/ml)	1-Covered	
ESTRING (2 MG, 7.5 MCG/24HR)	1-Covered	
medroxyprogesterone acetate (contraceptive) (susp 150 mg/ml, susp prefilled syr 150 mg/ml)	1-Covered	
medroxyprogesterone acetate (tab 2.5 mg, tab 5 mg, tab 10 mg)	1-Covered	
MENEST (0.3 MG TAB, 0.625 MG TAB, 1.25 MG TAB, 2.5 MG TAB)	1-Covered	PA
norethindrone acetate tab 5 mg	1-Covered	
norethindrone acetate-ethinyl estradiol (tab 0.5 mg-2.5 mcg, tab 1 mg-5 mcg)	1-Covered	PA
norethindrone tab 0.35 mg	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 0.625-5 MG TAB	1-Covered	
PREMPRO (0.3-1.5 MG TAB, 0.45-1.5 MG TAB, 0.625-2.5 MG TAB, 0.625-5 MG TAB)	1-Covered	
progesterone (cap 100 mg, cap 200 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
MISCELLANEOUS OB/GYN		
clindamycin phosphate vaginal cream 2%	1-Covered	
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr	1-Covered	
metronidazole vaginal gel 0.75%	1-Covered	
NEXPLANON 68 MG IMPLANT	1-Covered	
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	1-Covered	
TERCONAZOLE 0.8 % CREAM	1-Covered	
terconazole vaginal (cream 0.4%, cream 0.8%, suppos 80 mg)	1-Covered	
tranexamic acid tab 650 mg	1-Covered	
VANDAZOLE 0.75 % GEL	1-Covered	
ORAL CONTRACEPTIVES / RELATED AGENTS		
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	1-Covered	
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	1-Covered	
drospirenone-ethinyl estradiol (tab 3-0.02 mg, tab 3-0.03 mg)	1-Covered	
ethynodiol diacet & eth estrad (tab 1 mg-35 mcg, tab 1 mg-50 mcg)	1-Covered	
levonorgestrel & eth estradiol (tab 0.1 mg-20 mcg, tab 0.15 mg-30 mcg)	1-Covered	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	1-Covered	
levonorgestrel-ethinyl estradiol (91-day) (levonor-eth tab 0.15-0.02/0.025/0.03 mg &eth 0.01 mg, levonorg-eth tab 0.1-0.02mg(84) & eth tab 0.01mg(7), levonorg-eth tab 0.15-0.03mg(84) & eth tab 0.01mg(7), levonorgrel & ethinyl radiol (91-day) tab 0.15-0.03 mg)	1-Covered	
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	1-Covered	
norethin acet & estrad-fe (ace-ethinyl tab 1 mg-20 mcg (24), aceethinyl tab 1 mg-20 mcg, aceethinyl tab 1.5 mg-30 mcg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
norethindrone & eth estradiol (tab 0.5 mcg, tab 1 mcg)	1-Covered	
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	1-Covered	
norethindrone acet & eth estra (tab 1 mg-20 mcg, tab 1.5 mg-30 mcg)	1-Covered	
norethindrone-eth estradiol (triphasic) (tab 0.5-35/0.75-35/1-35, tab 0.5-35/1-35/0.5-35)	1-Covered	
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	1-Covered	
norgestimate-ethinyl estradiol (triphasic) (tab 0.18-25/0.215-25/0.25-25, tab 0.18-35/0.215-35/0.25-35)	1-Covered	
norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg	1-Covered	
VELIVET 0.1/0.125/0.15 -0.025 MG TAB	1-Covered	
OPHTHALMOLOGY		
ANTIBIOTICS		
AZASITE 1 % SOLUTION	1-Covered	
BACITRACIN 500 UNIT/GM OINTMENT	1-Covered	
bacitracin-polymyxin b ophth oint	1-Covered	
BESIVANCE 0.6 % SUSPENSION	1-Covered	
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	1-Covered	
erythromycin ophth oint 5 mg/gm	1-Covered	QL (3.5 PER 14 OVER TIME)
gatifloxacin ophth soln 0.5%	1-Covered	
gentamicin sulfate ophth soln 0.3%	1-Covered	QL (70 PER 30 OVER TIME)
LEVOFLOXACIN 0.5 % SOLUTION	1-Covered	
levofloxacin ophth soln 0.5%	1-Covered	
moxifloxacin hcl ophth soln 0.5% (base equiv)	1-Covered	
NATACYN 5 % SUSPENSION	1-Covered	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	1-Covered	NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
NEOMYCIN-POLYMYXIN-GRAMICIDIN 1.75-10000-.025 SOLUTION	1-Covered	
ofloxacin ophth soln 0.3%	1-Covered	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1-Covered	
tobramycin ophth soln 0.3%	1-Covered	QL (10 PER 14 OVER TIME)
ANTIVIRALS		
TRIFLURIDINE 1 % SOLUTION	1-Covered	
ZIRGAN 0.15 % GEL	1-Covered	
BETA-BLOCKERS		
BETAXOLOL HCL 0.5 % SOLUTION	1-Covered	
betaxolol hcl ophth soln 0.5%	1-Covered	
CARTEOLOL HCL 1 % SOLUTION	1-Covered	
levobunolol hcl (0.5 % solution, ophth soln 0.5%)	1-Covered	
timolol maleate (ophth) (gel forming soln 0.25%, gel forming soln 0.5%, soln 0.25%, soln 0.5%)	1-Covered	
MISCELLANEOUS OPHTHALMOLOGICS		
ATROPINE SULFATE 1 % SOLUTION	1-Covered	
atropine sulfate ophth soln 1%	1-Covered	
azelastine hcl ophth soln 0.05%	1-Covered	
bepotastine besilate ophth soln 1.5%	1-Covered	
CROMOLYN SODIUM 4 % SOLUTION	1-Covered	
cromolyn sodium ophth soln 4%	1-Covered	
cyclosporine (ophth) emulsion 0.05%	1-Covered	QL (60 PER 30 DAYS)
CYSTARAN 0.44 % SOLUTION	1-Covered	PA, NDS
epinastine hcl ophth soln 0.05%	1-Covered	
olopatadine hcl ophth soln 0.1% (base equivalent)	1-Covered	
OXERVATE 0.002 % SOLUTION	1-Covered	PA
PHOSPHOLINE IODIDE 0.125 % RECON SOLN	1-Covered	
pilocarpine hcl (soln 1%, soln 2%, soln 4%)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
SULFACETAMIDE SODIUM 10 % OINTMENT	1-Covered	
sulfacetamide sodium ophth soln 10%	1-Covered	
SULFACETAMIDE-PREDNISOLONE 10-0.23 % SOLUTION	1-Covered	
XDEMVY 0.25 % SOLUTION	1-Covered	PA, QL (10 PER 42 OVER TIME), NDS
XIIDRA 5 % SOLUTION	1-Covered	QL (60 PER 30 DAYS)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	1-Covered	
BROMSITE 0.075 % SOLUTION	1-Covered	
diclofenac sodium ophth soln 0.1%	1-Covered	
FLURBIPROFEN SODIUM 0.03 % SOLUTION	1-Covered	
ketorolac tromethamine (ophth) (soln 0.4%, soln 0.5%)	1-Covered	
PROLENSA 0.07 % SOLUTION	1-Covered	
ORAL DRUGS FOR GLAUCOMA		
acetazolamide (cap er 12hr 500 mg, tab 125 mg, tab 250 mg)	1-Covered	
methazolamide (tab 25 mg, tab 50 mg)	1-Covered	
OTHER GLAUCOMA DRUGS		
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	1-Covered	
dorzolamide hcl ophth soln 2%	1-Covered	
dorzolamide hcl-timolol maleate (soln 2-0.5%, soln 22.3-6.8 mg/ml)	1-Covered	
latanoprost ophth soln 0.005%	1-Covered	
LUMIGAN 0.01 % SOLUTION	1-Covered	
RHOPRESSA 0.02 % SOLUTION	1-Covered	
ROCKLATAN 0.02-0.005 % SOLUTION	1-Covered	
SIMBRINZA 1-0.2 % SUSPENSION	1-Covered	
tafluprost preservative free (pf) ophth soln 0.0015%	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
travoprost ophth soln 0.004% (benzalkonium free) (bak free)	1-Covered	
STEROID-ANTIBIOTIC COMBINATIONS		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	1-Covered	
neomycin-polymy-dexameth (oint, susp)	1-Covered	
NEOMYCIN-POLYMYXIN-HC 3.5-10000-1 SUSPENSION	1-Covered	
TOBRADEX 0.3-0.1 % OINTMENT	1-Covered	QL (3.5 PER 14 OVER TIME)
tobramycin-dexamethasone ophth susp 0.3-0.1%	1-Covered	QL (10 PER 14 OVER TIME)
STEROIDS		
ALREX 0.2 % SUSPENSION	1-Covered	
DEXAMETHASONE SODIUM PHOSPHATE 0.1 % SOLUTION	1-Covered	
fluorometholone ophth susp 0.1%	1-Covered	
INVELTYS 1 % SUSPENSION	1-Covered	
loteprednol etabonate (0.5 % gel, ophth gel 0.5%, ophth susp 0.5%)	1-Covered	
PREDNISOLONE ACETATE 1 % SUSPENSION	1-Covered	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	1-Covered	
SYMPATHOMIMETICS		
ALPHAGAN P 0.1 % SOLUTION	1-Covered	
apraclonidine hcl (0.5 % solution, ophth soln 0.5% (base equivalent))	1-Covered	
brimonidine tartrate (soln 0.15%, soln 0.2%)	1-Covered	
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGENIC AGENTS		
cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)	1-Covered	
epinephrine (anaphylaxis) (solution 0.15 mg/0.3ml (1:2000), solution 0.3 mg/0.3ml (1:1000))	1-Covered	QL (2 PER 30 OVER TIME)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
hydroxyzine hcl (tab 10 mg, tab 25 mg, tab 50 mg)	1-Covered	PA
levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)	1-Covered	
levocetirizine dihydrochloride tab 5 mg	1-Covered	QL (30 PER 30 DAYS)
promethazine hcl (syrup 6.25 mg/5ml, tab 12.5 mg, tab 25 mg, tab 50 mg)	1-Covered	PA
SYMJEPI (0.15 MG/0.3ML SOLN, 0.3 MG/0.3ML SOLN)	1-Covered	QL (2 PER 30 OVER TIME)
PULMONARY AGENTS		
acetylcysteine (soln 10%, soln 20%)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ADEMPAS (0.5 MG TAB, 1 MG TAB, 1.5 MG TAB, 2 MG TAB, 2.5 MG TAB)	1-Covered	PA, LA, NDS
ADVAIR HFA (45-21 MCG/ACT, 115-21 MCG/ACT, 230-21 MCG/ACT)	1-Covered	QL (12 PER 30 DAYS)
albuterol sulfate (soln 0.083% (2.5 mg/3ml), soln 0.5% (5 mg/ml), soln 0.63 mg/3ml (base equiv), soln 1.25 mg/3ml (base equiv), 2.5 mg/0.5ml soln, (5 mg/ml) 0.5% soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
albuterol sulfate (syrup 2 mg/5ml, tab 2 mg, tab 4 mg)	1-Covered	
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	1-Covered	QL (17 PER 30 DAYS)
ALVESCO 160 MCG/ACT AERO SOLN	1-Covered	QL (12.2 PER 30 DAYS)
ALVESCO 80 MCG/ACT AERO SOLN	1-Covered	QL (6.1 PER 30 DAYS)
ambrisentan (tab 5 mg, tab 10 mg)	1-Covered	PA, LA, NDS
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
ASMANEX (120 METERED DOSES) 220 MCG/ACT AER POW BA	1-Covered	QL (2 PER 30 DAYS)
ASMANEX (30 METERED DOSES) (110 MCG/ACT, 220 MCG/ACT)	1-Covered	QL (1 PER 30 DAYS)
ASMANEX (60 METERED DOSES) 220 MCG/ACT AER POW BA	1-Covered	QL (1 PER 30 DAYS)
ASMANEX HFA (50 MCG/ACT, 100 MCG/ACT, 200 MCG/ACT)	1-Covered	QL (13 PER 30 DAYS)
ATROVENT HFA 17 MCG/ACT AERO SOLN	1-Covered	QL (25.8 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
BEVESPI AEROSPHERE 9-4.8 MCG/ACT AEROSOL	1-Covered	QL (10.7 PER 30 DAYS)
bosentan (tab 62.5 mg, tab 125 mg)	1-Covered	PA, LA, NDS
BREO ELLIPTA (50-25 MCG/INH, 100-25 MCG/ACT, 200-25 MCG/ACT)	1-Covered	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACT AEROSOL	1-Covered	QL (10.7 PER 30 DAYS)
budesonide (inhalation) (susp 0.25 mg/2ml, susp 0.5 mg/2ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (120 PER 30 DAYS)
budesonide inhalation susp 1 mg/2ml	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
BUDESONIDE-FORMOTEROL FUMARATE 160-4.5 MCG/ACT AEROSOL	1-Covered	QL (10.2 PER 30 DAYS)
budesonide-formoterol fumarate dihydrate (80-4.5 mcg/act, 160-4.5 mcg/act)	1-Covered	QL (10.2 PER 30 DAYS)
CINRYZE 500 UNIT RECON SOLN	1-Covered	PA, NDS
COMBIVENT RESPIMAT 20-100 MCG/ACT AERO SOLN	1-Covered	QL (8 PER 30 DAYS)
cromolyn sodium soln nebu 20 mg/2ml	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
DALIRESP (250 MCG TAB, 500 MCG TAB)	1-Covered	PA, QL (30 PER 30 DAYS)
DULERA (50-5 MCG/ACT, 100-5 MCG/ACT, 200-5 MCG/ACT)	1-Covered	QL (13 PER 30 DAYS)
ESBRIET 267 MG CAP	1-Covered	PA, QL (270 PER 30 DAYS), NDS
FASENRA 30 MG/ML SOLN PRSYR	1-Covered	PA, QL (1 PER 28 DAYS), NDS
FASENRA PEN 30 MG/ML SOLN A-INJ	1-Covered	PA, QL (1 PER 28 DAYS), NDS
FLOVENT DISKUS (50 MCG/ACT, 100 MCG/ACT)	1-Covered	QL (60 PER 30 DAYS)
FLOVENT DISKUS 250 MCG/ACT AER POW BA	1-Covered	QL (240 PER 30 DAYS)
FLOVENT HFA 110 MCG/ACT AEROSOL	1-Covered	QL (12 PER 30 DAYS)
FLOVENT HFA 220 MCG/ACT AEROSOL	1-Covered	QL (24 PER 30 DAYS)
FLOVENT HFA 44 MCG/ACT AEROSOL	1-Covered	QL (10.6 PER 30 DAYS)
flunisolide nasal soln 25 mcg/act (0.025%)	1-Covered	QL (50 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
fluticasone propionate nasal susp 50 mcg/act	1-Covered	QL (16 PER 30 DAYS)
fluticasone-salmeterol (powder 100-50 mcg/act, powder 250-50 mcg/act, powder 500-50 mcg/act)	1-Covered	QL (60 PER 30 DAYS)
formoterol fumarate soln nebu 20 mcg/2ml	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
icatibant acetate subcutaneous soln pref syr 30 mg/3ml	1-Covered	PA, NDS
ipratropium bromide inhal soln 0.02%	1-Covered	PA - TO CONFIRM PART D COVERAGE
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1-Covered	PA - TO CONFIRM PART D COVERAGE
KALYDECO (13.4 MG, 25 MG, 50 MG, 75 MG)	1-Covered	PA, QL (56 PER 28 DAYS), NDS
KALYDECO 150 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS), NDS
levalbuterol hcl (soln 0.31 mg/3ml (base equiv), soln 0.63 mg/3ml (base equiv), soln 1.25 mg/3ml (base equiv), soln conc 1.25 mg/0.5ml (base equiv))	1-Covered	PA - TO CONFIRM PART D COVERAGE
mometasone furoate nasal susp 50 mcg/act	1-Covered	QL (34 PER 30 DAYS)
montelukast sodium (chew tab 4 mg (base equiv), chew tab 5 mg (base equiv), oral granules packet 4 mg (base equiv), tab 10 mg (base equiv))	1-Covered	
NUCALA (100 MG RECON SOLN, 100 MG/ML SOLN A-INJ, 100 MG/ML SOLN PRSYR)	1-Covered	PA, LA, QL (3 PER 28 DAYS), NDS
NUCALA 40 MG/0.4ML SOLN PRSYR	1-Covered	PA, LA, QL (0.4 PER 28 DAYS), NDS
OFEV (100 MG CAP, 150 MG CAP)	1-Covered	PA, QL (60 PER 30 DAYS), NDS
OPSUMIT 10 MG TAB	1-Covered	PA, LA, NDS
ORKAMBI (100-125 MG TAB, 200-125 MG TAB)	1-Covered	PA, QL (112 PER 28 DAYS), NDS
ORKAMBI (75-94 MG, 100-125 MG, 150-188 MG)	1-Covered	PA, QL (56 PER 28 DAYS), NDS
ORLADEYO (110 MG CAP, 150 MG CAP)	1-Covered	PA, LA, NDS
pirfenidone (cap 267 mg, tab 267 mg)	1-Covered	PA, QL (270 PER 30 DAYS), NDS
pirfenidone tab 801 mg	1-Covered	PA, QL (90 PER 30 DAYS), NDS
PULMICORT FLEXHALER 180 MCG/ACT AER POW BA	1-Covered	QL (2 PER 30 DAYS)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
PULMICORT FLEXHALER 90 MCG/ACT AER POW BA	1-Covered	QL (1 PER 30 DAYS)
PULMOZYME 2.5 MG/2.5ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS
QVAR REDIHALER 40 MCG/ACT AERO BA	1-Covered	QL (10.6 PER 30 DAYS)
QVAR REDIHALER 80 MCG/ACT AERO BA	1-Covered	QL (21.2 PER 30 DAYS)
roflumilast (tab 250 mcg, tab 500 mcg)	1-Covered	PA, QL (30 PER 30 DAYS)
sildenafil citrate tab 20 mg	1-Covered	PA, QL (90 PER 30 DAYS)
SPIRIVA HANDIHALER 18 MCG CAP	1-Covered	QL (90 PER 90 DAYS)
SPIRIVA RESPIMAT (1.25 MCG/ACT SOLN, 2.5 MCG/ACT SOLN)	1-Covered	QL (4 PER 30 DAYS)
STIOLTO RESPIMAT 2.5-2.5 MCG/ACT AERO SOLN	1-Covered	QL (4 PER 30 DAYS)
STRIVERDI RESPIMAT 2.5 MCG/ACT AERO SOLN	1-Covered	QL (4 PER 30 DAYS)
SYMBICORT (80-4.5 MCG/ACT, 160-4.5 MCG/ACT)	1-Covered	QL (10.2 PER 30 DAYS)
SYMDEKO (50-75 & 75 MG TAB, 100-150 & 150 MG TAB)	1-Covered	PA, QL (56 PER 28 DAYS), NDS
tadalafil tab 20 mg (pah)	1-Covered	PA, QL (60 PER 30 DAYS), NDS
terbutaline sulfate (tab 2.5 mg, tab 5 mg)	1-Covered	
THEO-24 (100 MG CAP ER, 200 MG CAP ER, 300 MG CAP ER, 400 MG CAP ER)	1-Covered	
theophylline (elixir 80 mg/15ml, soln 80 mg/15ml, tab er 12hr 300 mg, tab er 12hr 450 mg, tab er 24hr 400 mg, tab er 24hr 600 mg)	1-Covered	
THEOPHYLLINE ER 300 MG TAB ER 12H	1-Covered	
tiotropium bromide monohydrate inhal cap 18 mcg (base equiv)	1-Covered	QL (90 PER 90 DAYS)
TRELEGY ELLIPTA (100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT)	1-Covered	QL (60 PER 30 DAYS)
TRIKAFTA (50-25-37.5 & 75 MG TAB, 100-50-75 & 150 MG TAB)	1-Covered	PA, QL (84 PER 28 DAYS), NDS
TRIKAFTA (80-40-60 & 59.5 MG, 100-50-75 & 75 MG)	1-Covered	PA, QL (56 PER 28 DAYS), NDS

DRUG NAME	TIER	REQUIREMENTS/LIMITS
XOLAIR (150 MG RECON SOLN, 150 MG/ML SOLN PRSYR)	1-Covered	PA, LA, QL (8 PER 28 DAYS), NDS
XOLAIR 75 MG/0.5ML SOLN PRSYR	1-Covered	PA, LA, QL (1 PER 28 DAYS), NDS
zafirlukast (tab 10 mg, tab 20 mg)	1-Covered	
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
fesoterodine fumarate (tab er 4 mg, tab er 8 mg)	1-Covered	
flavoxate hcl tab 100 mg	1-Covered	
MYRBETRIQ (8 MG/ML SRER, 25 MG TAB ER 24H, 50 MG TAB ER 24H)	1-Covered	
oxybutynin chloride (solution 5 mg/5ml, tab 5 mg, tab er 24hr 10 mg, tab er 24hr 15 mg, tab er 24hr 5 mg)	1-Covered	
tolterodine tartrate (cap er 24hr 2 mg, cap er 24hr 4 mg, tab 1 mg, tab 2 mg)	1-Covered	
trospium chloride tab 20 mg	1-Covered	
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
alfuzosin hcl tab er 24hr 10 mg	1-Covered	
dutasteride cap 0.5 mg	1-Covered	
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	1-Covered	
finasteride tab 5 mg	1-Covered	
silodosin (cap 4 mg, cap 8 mg)	1-Covered	
tamsulosin hcl cap 0.4 mg	1-Covered	
MISCELLANEOUS UROLOGICALS		
bethanechol chloride (tab 5 mg, tab 10 mg, tab 25 mg, tab 50 mg)	1-Covered	
CYSTAGON (50 MG CAP, 150 MG CAP)	1-Covered	PA, LA
ELMIRON 100 MG CAP	1-Covered	
potassium citrate (alkalinizer) (tab er 5 (540 mg), tab er 10 (1080 mg), tab er 15 (1620 mg))	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
calcium acetate (phosphate binder) (cap 667 mg (169 mg ca), tab 667 mg)	1-Covered	QL (360 PER 30 DAYS)
KCL (0.149%) IN NACL (20-0.45 MEQ/L-% SOLUTION, 20-0.9 MEQ/L-% SOLUTION)	1-Covered	
KCL (0.298%) IN NACL 40-0.9 MEQ/L-% SOLUTION	1-Covered	
KCL IN DEXTROSE-NACL 40-5-0.9 MEQ/L-%-% SOLUTION	1-Covered	
KCL-LACTATED RINGERS-D5W 20 MEQ/L SOLUTION	1-Covered	
magnesium sulfate inj 50%	1-Covered	
potassium chloride (cap er 8 meq, inj 2 meq/ml, 10 meq/100ml solution, cap er 10 meq, inj 10 meq/100ml, 20 meq/100ml solution, inj 20 meq/100ml, inj 40 meq/100ml, oral soln 10% (20 meq/15ml), oral soln 20% (40 meq/15ml), powder packet 20 meq, tab er 8 meq (600 mg), tab er 10 meq, tab er 20 meq (1500 mg), 40 meq/100ml solution)	1-Covered	
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj	1-Covered	
POTASSIUM CHLORIDE ER 8 MEQ TAB ER	1-Covered	
potassium chloride in dextrose & sodium chloride (10 meq/l (0.07)0.4, 20 meq/l (0.1)0.2%, 20 meq/l (0.1)0.4, 20 meq/l (0.1)0.9%, 30 meq/l (0.224%)0.4, 40 meq/l (0.3%)0.4, 40 meq/l (0.3%)0.9%)	1-Covered	
potassium chloride in nacl (20-0.45 meq/l-% solution, 20-0.9 meq/l-% solution, kcl 20 meq/l (0.15%)0.45% inj, kcl 20 meq/l (0.15%)0.9% inj, 40-0.9 meq/l-% solution, kcl 40 meq/l (0.3%)0.9% inj)	1-Covered	
potassium chloride microencapsulated crystals er (er tab 10, er tab 15, er tab 20)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
sodium chloride (iv soln 0.45%, iv soln 0.9%, iv soln 3%, iv soln 5%, preservative free (pf) inj 0.9%)	1-Covered	
MISCELLANEOUS NUTRITION PRODUCTS		
amino acid infusion 15%**	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/10) 4.25 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/15) 5 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/20) 5 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
INTRALIPID 20 % EMULSION	1-Covered	PA - TO CONFIRM PART D COVERAGE
ISOLYTE-P IN D5W SOLUTION	1-Covered	
ISOLYTE-S SOLUTION	1-Covered	
ISOLYTE-S PH 7.4 SOLUTION	1-Covered	
PLASMA-LYTE 148 SOLUTION	1-Covered	
PLASMA-LYTE A SOLUTION	1-Covered	
PREMASOL 10 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRAVASOL 10 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
TROPHAMINE 10 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
VITAMINS / HEMATINICS		
ATABEX EC 29-1 MG TAB DR	1-Covered	
ATABEX OB 29-1 MG TAB	1-Covered	
AZESCHEW PRENATAL/POSTNATAL 13-1 MG CHEW TAB	1-Covered	
AZESCO 13-1 MG TAB	1-Covered	
BAL-CARE DHA 27-1 & 430 MG MISC	1-Covered	
C-NATE DHA 28-1-200 MG CAP	1-Covered	
CITRANATAL 90 DHA 90-1 & 300 MG MISC	1-Covered	
CITRANATAL ASSURE 35-1 & 300 MG MISC	1-Covered	
CITRANATAL B-CALM 20-1 MG & 2 X 25 MG MISC	1-Covered	
CITRANATAL BLOOM 90-1 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	TIER	REQUIREMENTS/LIMITS
CITRANATAL BLOOM DHA 90-1 & 300 MG MISC	1-Covered	
CITRANATAL DHA 27-1 & 250 MG MISC	1-Covered	
CITRANATAL ESSENCE 35-1 & 300 MG THER PACK	1-Covered	
CITRANATAL HARMONY 27-1-260 MG CAP	1-Covered	
CITRANATAL MEDLEY 27-1-200 MG CAP	1-Covered	
CITRANATAL RX 27-1 MG TAB	1-Covered	
CO-NATAL FA TAB	1-Covered	
COMPLETE NATAL DHA 29-1-200 & 200 MG MISC	1-Covered	
COMPLETENATE 29-1 MG CHEW TAB	1-Covered	
CONCEPT DHA 53.5-38-1 MG CAP	1-Covered	
CONCEPT OB 130-92.4-1 MG CAP	1-Covered	
DERMACINRX PRETRATE 1 MG TAB	1-Covered	
DOTHELLE DHA 53.5-38-1 MG CAP	1-Covered	
DUET DHA 400 25-1 & 400 MG MISC	1-Covered	
DUET DHA BALANCED 25-1 & 267 MG MISC	1-Covered	
ELITE-OB 50-1.25 MG TAB	1-Covered	
ENBRACE HR CAP	1-Covered	
FOLET DHA 38-1 & 350 MG THER PACK	1-Covered	
FOLET ONE 38-1-225 MG CAP	1-Covered	
FOLIVANE-OB 85-1 MG CAP	1-Covered	
INATAL GT TAB	1-Covered	
JENLIVA PRENATAL/POSTNATAL 1 MG CAP	1-Covered	
KOSHER PRENATAL PLUS IRON 30-1 MG TAB	1-Covered	
M-NATAL PLUS 27-1 MG TAB	1-Covered	
MARNATAL-F 60-1 MG CAP	1-Covered	
MULTI-MAC 15-0.75-1 MG TAB	1-Covered	
MYNATAL (90-1 MG TAB, CAP)	1-Covered	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
MYNATAL ADVANCE TAB	1-Covered	
MYNATAL PLUS TAB	1-Covered	
MYNATAL-Z TAB	1-Covered	
MYNATE 90 PLUS TAB ER	1-Covered	
NATACHEW 28-1 MG CHEW TAB	1-Covered	
NATALVIT TAB	1-Covered	
NATELLE ONE 28-1-250 MG CAP	1-Covered	
NEEVO DHA 27-1.13 MG CAP	1-Covered	
NEONATAL + DHA 29-1 & 200 MG MISC	1-Covered	
NEONATAL 19 1 MG TAB	1-Covered	
NEONATAL COMPLETE (27-1 MG TAB, 29-1 MG TAB)	1-Covered	
NEONATAL FE 90-1 MG TAB	1-Covered	
NEONATAL PLUS 27-1 MG TAB	1-Covered	
NESTABS 32-1 MG TAB	1-Covered	
NESTABS DHA 32-1 MG MISC	1-Covered	
NESTABS ONE 38-1-225 MG CAP	1-Covered	
NEXA PLUS 29-1.25-350 MG CAP	1-Covered	
NIVA-PLUS 27-1 MG TAB	1-Covered	
O-CAL FA 27-1 MG TAB	1-Covered	
O-CAL PRENATAL TAB	1-Covered	
OB COMPLETE 50-1.25 MG TAB	1-Covered	
OB COMPLETE ONE 50-1-476 MG CAP	1-Covered	
OB COMPLETE PETITE 35-5-1-200 MG CAP	1-Covered	
OB COMPLETE PREMIER 30-20-1 MG TAB	1-Covered	
OB COMPLETE/DHA 30-10-1-200 MG CAP	1-Covered	
OBSTETRIX EC (WITH DOCUSATE) 29-1 MG TAB	1-Covered	
OBSTETRIX ONE (WITH DOCUSATE) 38-1-225 MG CAP	1-Covered	
ONE VITE WOMENS PLUS 27-1 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	TIER	REQUIREMENTS/LIMITS
PNV PRENATAL PLUS MULTIVIT+DHA 27-1 & 312 MG MISC	1-Covered	
PNV PRENATAL PLUS MULTIVITAMIN 27-1 MG TAB	1-Covered	
PNV TABS 20-1 20-1 MG TAB	1-Covered	
PNV TABS 29-1 29-1 MG TAB	1-Covered	
PNV-DHA 27-0.6-0.4-300 MG CAP	1-Covered	
PNV-DHA+DOCUSATE 27-1.25-300 MG CAP	1-Covered	
PNV-OMEGA 28-0.6-0.4-340 MG CAP	1-Covered	
PNV-SELECT 27-0.6-0.4 MG TAB	1-Covered	
PR NATAL 400 29-1-200 & 400 MG MISC	1-Covered	
PR NATAL 400 EC 29-1-200 & 400 MG (DR) MISC	1-Covered	
PR NATAL 430 29-1-200 & 430 MG MISC	1-Covered	
PR NATAL 430 EC 29-1-200 & 430 MG (DR) MISC	1-Covered	
PREGEN DHA 28-1-35 MG CAP	1-Covered	
PREGENNA 20-1 MG TAB	1-Covered	
PREMESISRX 1 MG TAB	1-Covered	
PRENA 1 TRUE 30-1.4 & 300 MG MISC	1-Covered	
PRENA1 1.4 MG CHEW TAB	1-Covered	
PRENA1 PEARL 30-1.4-200 MG CAP ER	1-Covered	
PRENAISSANCE 29-1.25-325 MG CAP	1-Covered	
PRENAISSANCE PLUS 28-1-250 MG CAP	1-Covered	
PRENARA 15-1 MG CAP	1-Covered	
PRENATAL (27-0.8 MG TAB, 27-1 MG TAB)	1-Covered	
PRENATAL + DHA 27-1 & 250 MG THER PACK	1-Covered	
PRENATAL 19 (29-1 MG CHEW TAB, 29-1 MG TAB, CHEW TAB)	1-Covered	
PRENATAL LOW IRON 27-1 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	TIER	REQUIREMENTS/LIMITS
PRENATAL PLUS 27-1 MG TAB	1-Covered	
PRENATAL PLUS IRON 29-1 MG TAB	1-Covered	
PRENATAL PLUS VITAMIN/MINERAL 27-1 MG TAB	1-Covered	
PRENATAL PLUS/IRON 27-1 MG TAB	1-Covered	
PRENATAL VITAMIN PLUS LOW IRON 27-1 MG TAB	1-Covered	
PRENATAL-U 106.5-1 MG CAP	1-Covered	
PRENATAL/FOLIC ACID TAB	1-Covered	
PRENATE 0.6-0.4 MG CHEW TAB	1-Covered	
PRENATE AM 1 MG TAB	1-Covered	
PRENATE DHA 18-0.6-0.4-300 MG CAP	1-Covered	
PRENATE ELITE 20-0.6-0.4 MG TAB	1-Covered	
PRENATE ENHANCE 28-0.6-0.4-400 MG CAP	1-Covered	
PRENATE ESSENTIAL 18-0.6-0.4-300 MG CAP	1-Covered	
PRENATE MINI 18-0.6-0.4-350 MG CAP	1-Covered	
PRENATE PIXIE 10-0.6-0.4-200 MG CAP	1-Covered	
PRENATE RESTORE 27-0.6-0.4-400 MG CAP	1-Covered	
PRENATRIX 27-1 MG TAB	1-Covered	
PRENATRYL 27-1 MG TAB	1-Covered	
PRENATVITE COMPLETE 1 MG TAB	1-Covered	
PRENATVITE PLUS 1 MG TAB	1-Covered	
PRENATVITE RX 0.8 MG TAB	1-Covered	
PREPLUS 27-1 MG TAB	1-Covered	
PRETAB 29-1 MG TAB	1-Covered	
PRIMACARE 30-1-470 MG CAP	1-Covered	
PROVIDA DHA 16-16-1.25-110 MG CAP	1-Covered	
PROVIDA OB 20-20-1.25 MG CAP	1-Covered	
R-NATAL OB 20-1-320 MG CAP	1-Covered	
RELNATE DHA 28-1-200 MG CAP	1-Covered	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
SE-NATAL 19 (29-1 MG CHEW TAB, 29-1 MG TAB)	1-Covered	
SELECT-OB (29-0.6-0.4 MG TAB, 29-1 MG TAB)	1-Covered	
SELECT-OB+DHA 29-1 & 250 MG MISC	1-Covered	
sodium fluoride (chew tab 0.25 mg f (from 0.55 mg naf), chew tab 0.5 mg f (from 1.1 mg naf), chew tab 1 mg f (from 2.2 mg naf), 2.2 (1 f) mg tab)	1-Covered	
TARON-BC 20-1 MG & 2 X 25 MG MISC	1-Covered	
TARON-C DHA 35-1 MG CAP	1-Covered	
TARON-PREX 30-1.2-265 MG CAP	1-Covered	
THRIVITE RX 29-1 MG TAB	1-Covered	
TL FOLATE 27-0.5-0.5 MG TAB	1-Covered	
TL-CARE DHA 27-1-500 MG CAP	1-Covered	
TL-SELECT 29-1.25-325 MG CAP	1-Covered	
TRI-TABS DHA 32-1 MG MISC	1-Covered	
TRICARE TAB	1-Covered	
TRICARE PRENATAL DHA ONE 27-1-500 MG CAP	1-Covered	
TRINATAL RX 1 60-1 MG TAB	1-Covered	
TRINATE TAB	1-Covered	
TRINAZ 12-1 MG TAB	1-Covered	
TRISTART DHA 31-0.6-0.4-200 MG CAP	1-Covered	
TRISTART FREE 33-1 MG CAP	1-Covered	
TRISTART ONE 35-1-215 MG CAP	1-Covered	
TRIVEEN-DUO DHA 29-1-200 & 300 MG MISC	1-Covered	
ULTIMATECARE ONE 27-1 MG CAP	1-Covered	
VENA-BAL DHA 27-1 & 430 MG MISC	1-Covered	
VINATE DHA RF 27-1.13 MG CAP	1-Covered	
VINATE II 29-1 MG TAB	1-Covered	
VINATE ONE 60-1 MG TAB	1-Covered	
VIRT-C DHA 53.5-38-1 MG CAP	1-Covered	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
VIRT-NATE DHA 28-1-200 MG CAP	1-Covered	
VIRT-PN DHA 27-0.6-0.4-300 MG CAP	1-Covered	
VIRT-PN PLUS 28-0.6-0.4-340 MG CAP	1-Covered	
VITAFOL FE+ (90-0.6-0.4-200 MG CAP, 90-1-200 & 50 MG CAP THPK)	1-Covered	
VITAFOL GUMMIES 3.33-0.333-34.8 MG CHEW TAB	1-Covered	
VITAFOL STRIPS 1 MG FILM	1-Covered	
VITAFOL ULTRA 29-0.6-0.4-200 MG CAP	1-Covered	
VITAFOL-NANO 18-0.6-0.4 MG TAB	1-Covered	
VITAFOL-OB TAB	1-Covered	
VITAFOL-OB+DHA 65-1 & 250 MG MISC	1-Covered	
VITAFOL-ONE 29-1-200 MG CAP	1-Covered	
VITAMEDMD ONE RX/QUATREFOLIC 30-0.6-0.4-200 MG CAP	1-Covered	
VITAMEDMD REDICHEW RX 1.4 MG CHEW TAB	1-Covered	
VITAPEARL 30-1.4-200 MG CAP ER	1-Covered	
VITATHELY WITH GINGER 27-1 MG TAB	1-Covered	
VITATRUE 30-1.4 & 300 MG MISC	1-Covered	
VIVA DHA 28-1-200 MG CAP	1-Covered	
VOL-NATE 28-1 MG TAB	1-Covered	
VOL-PLUS 27-1 MG TAB	1-Covered	
VOL-TAB RX 29-1 MG TAB	1-Covered	
VP-PNV-DHA 28-1-215.8 MG CAP	1-Covered	
WESCAP-C DHA 53.5-38-1 MG CAP	1-Covered	
WESCAP-PN DHA 27-0.6-0.4-300 MG CAP	1-Covered	
WESNATE DHA 28-1-200 MG CAP	1-Covered	
WESTAB PLUS 27-1 MG TAB	1-Covered	
WESTGEL DHA 31-0.6-0.4-200 MG CAP	1-Covered	
ZALVIT 13-1 MG TAB	1-Covered	
ZATEAN-PN DHA 27-0.6-0.4-300 MG CAP	1-Covered	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ZATEAN-PN PLUS 28-0.6-0.4-340 MG CAP	1-Covered	
ZIPHEX 13-1 MG TAB	1-Covered	

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This formulary was updated on 12/1/2023. For more recent information or other questions, please contact Cooperative Advantage Member Service at 1-888-203-7770 or, or, for TTY/ TDD: (800)-947-3529, 7 days per week from October 1 - March 31 and 8:00 a.m. - 8:00 p.m. Monday - Friday from April 1 - September 30, or visit www.group-health.com/cooperative-advantage.