Cooperative Advantage (HMO-ISNP)

2022 Formulary

(List of Covered Drugs)

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

Formulary File Submission ID 00022556, Version Number 18

This formulary was updated on 12/1/2022. For more recent information or other questions, please contact Cooperative Advantage Member Service at 1-888-203-7770 or, or, for TTY/TDD: 711, 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.

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 12/1/2022. 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, 2022, 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 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 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 12/1/2022. 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 79. 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 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 79.

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.
S	Specialty Drug	Specialty drugs are high-cost drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMBISOME	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMPHOTERICIN B	1-Covered	PA - TO CONFIRM PART D COVERAGE
caspofungin acetate (50 mg recon soln, for iv soln 50 mg, 70 mg recon soln, for iv soln 70 mg)	1-Covered	
clotrimazole	1-Covered	
CRESEMBA 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	1-Covered	PA
flucytosine	1-Covered	
griseofulvin microsize (susp 125 mg/5ml, tab 500 mg)	1-Covered	
griseofulvin ultramicrosize	1-Covered	
itraconazole cap 100 mg	1-Covered	QL (120 PER 30 DAYS)
itraconazole oral soln 10 mg/ml	1-Covered	
ketoconazole	1-Covered	
micafungin sodium (soln 50 mg, soln 100 mg)	1-Covered	
NOXAFIL 40 MG/ML SUSPENSION	1-Covered	PA, QL (630 PER 30 DAYS)
nystatin (mouth-throat)	1-Covered	
nystatin tab 500000 unit	1-Covered	
posaconazole	1-Covered	PA, QL (96 PER 30 DAYS)
terbinafine hcl	1-Covered	
voriconazole (for susp 40 mg/ml, tab 50 mg, tab 200 mg)	1-Covered	PA
voriconazole for inj 200 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
ANTIVIRALS		
abacavir sulfate (soln 20 mg/ml (base equiv), tab 300 mg (base equiv))	1-Covered	
abacavir sulfate-lamivudine	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	1-Covered	
amantadine hcl (cap 100 mg, soln 50 mg/5ml, tab 100 mg)	1-Covered	
APTIVUS	1-Covered	
atazanavir sulfate	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	
BIKTARVY	1-Covered	
CIMDUO	1-Covered	
COMPLERA	1-Covered	
DELSTRIGO	1-Covered	
DESCOVY 200-25 MG TAB	1-Covered	
DOVATO	1-Covered	
EDURANT	1-Covered	
efavirenz	1-Covered	
efavirenz-emtricitabine-tenofovir disoproxil fumarate	1-Covered	
efavirenz-lamivudine-tenofovir disoproxil fumarate	1-Covered	
emtricitabine	1-Covered	
emtricitabine-tenofovir disoproxil fumarate	1-Covered	
EMTRIVA 10 MG/ML SOLUTION	1-Covered	
entecavir	1-Covered	
EPCLUSA (150-37.5 MG PACKET, 400-100 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS)
EPCLUSA (200-50 MG PACKET, 200-50 MG TAB)	1-Covered	PA, QL (56 PER 28 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
EPIVIR HBV 5 MG/ML SOLUTION	1-Covered	
etravirine	1-Covered	
EVOTAZ	1-Covered	
famciclovir	1-Covered	
fosamprenavir calcium	1-Covered	
FUZEON	1-Covered	
GENVOYA	1-Covered	
HARVONI (33.75-150 MG PACKET, 90-400 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS)
HARVONI 45-200 MG PACKET	1-Covered	PA, QL (56 PER 28 DAYS)
INTELENCE 25 MG TAB	1-Covered	
ISENTRESS	1-Covered	
ISENTRESS HD	1-Covered	
JULUCA	1-Covered	
lamivudine (hbv)	1-Covered	
lamivudine (oral soln 10 mg/ml, tab 150 mg, tab 300 mg)	1-Covered	
lamivudine-zidovudine	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	1-Covered	
nevirapine (tab 200 mg, tab er 24hr 100 mg, tab er 24hr 400 mg, 50 mg/5ml suspension)	1-Covered	
NEVIRAPINE ER	1-Covered	
NORVIR (80 MG/ML SOLUTION, 100 MG PACKET)	1-Covered	
ODEFSEY	1-Covered	
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	1-Covered	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
PREVYMIS (240 MG TAB, 480 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
PREZCOBIX	1-Covered	
PREZISTA (75 MG TAB, 100 MG/ML SUSPENSION, 150 MG TAB, 600 MG TAB, 800 MG TAB)	1-Covered	
RELENZA DISKHALER	1-Covered	
REYATAZ 50 MG PACKET	1-Covered	
ribavirin (hepatitis c)	1-Covered	
RIMANTADINE HCL	1-Covered	
ritonavir	1-Covered	
RUKOBIA	1-Covered	
SELZENTRY (20 MG/ML SOLUTION, 25 MG TAB, 75 MG TAB, 150 MG TAB, 300 MG TAB)	1-Covered	
STRIBILD	1-Covered	
SYMTUZA	1-Covered	
tenofovir disoproxil fumarate	1-Covered	
TIVICAY	1-Covered	
TIVICAY PD	1-Covered	
TRIUMEQ	1-Covered	
TRIUMEQ PD	1-Covered	
TRIZIVIR	1-Covered	
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), tab 450 mg (base equivalent))	1-Covered	
VEMLIDY	1-Covered	
VIRACEPT	1-Covered	
VIREAD (40 MG/GM POWDER, 150 MG TAB, 200 MG TAB, 250 MG TAB)	1-Covered	
VOSEVI	1-Covered	PA, QL (28 PER 28 DAYS)
XOFLUZA (40 MG DOSE)	1-Covered	
XOFLUZA (80 MG DOSE)	1-Covered	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
zidovudine (cap 100 mg, syrup 10 mg/ml, tab 300 mg)	1-Covered	
CEPHALOSPORINS		
cefaclor (125 mg/5ml recon susp, 250 mg cap, 250 mg/5ml recon susp, cap 250 mg, 375 mg/5ml recon susp, 500 mg cap, cap 500 mg)	1-Covered	
CEFACLOR ER	1-Covered	
cefadroxil (1 gm tab, cap 500 mg, for susp 250 mg/5ml, for susp 500 mg/5ml, tab 1 gm)	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 (1 gm, 2 gm)	1-Covered	
cefixime (cap 400 mg, for susp 100 mg/5ml, for susp 200 mg/5ml)	1-Covered	
cefoxitin sodium	1-Covered	PA
cefpodoxime proxetil (for susp 50 mg/5ml, for susp 100 mg/5ml, tab 100 mg, tab 200 mg)	1-Covered	
cefprozil (for susp 125 mg/5ml, for susp 250 mg/5ml, tab 250 mg, tab 500 mg)	1-Covered	
ceftazidime	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	1-Covered	
cefuroxime sodium	1-Covered	PA
cephalexin (cap 250 mg, cap 500 mg, for susp 125 mg/5ml, for susp 250 mg/5ml)	1-Covered	
SUPRAX (100 MG CHEW TAB, 200 MG CHEW TAB, 500 MG/5ML RECON SUSP)	1-Covered	
TAZICEF (1 GM SOLN, 6 GM SOLN)	1-Covered	PA
TEFLARO	1-Covered	PA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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 (125 mg/5ml recon susp, tab 250 mg, tab 500 mg, tab er 24hr 500 mg, 250 mg/5ml recon susp)	1-Covered	
E.E.S. 400	1-Covered	
ERYTHROCIN LACTOBIONATE	1-Covered	PA
ERYTHROCIN STEARATE	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 lactobionate	1-Covered	PA
MISCELLANEOUS ANTIINFECTIVES		
albendazole	1-Covered	
amikacin sulfate inj 500 mg/2ml (250 mg/ml)	1-Covered	PA
ARIKAYCE	1-Covered	PA, LA
atovaquone	1-Covered	
atovaquone-proguanil hcl	1-Covered	
aztreonam (1 gm, 2 gm)	1-Covered	PA
BENZNIDAZOLE	1-Covered	
CAYSTON	1-Covered	PA, LA, QL (84 PER 28 DAYS)
chloroquine phosphate	1-Covered	
clindamycin hcl	1-Covered	
clindamycin palmitate hydrochloride	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

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
clindamycin phosphate in d5w	1-Covered	PA
COARTEM	1-Covered	
colistimethate sodium	1-Covered	PA
dapsone	1-Covered	
daptomycin (350 mg recon soln, for iv soln 350 mg, 500 mg recon soln, for iv soln 500 mg)	1-Covered	
EMVERM	1-Covered	
ertapenem sodium	1-Covered	PA, QL (14 PER 14 DAYS)
ethambutol hcl	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
IMPAVIDO	1-Covered	PA
isoniazid (50 mg/5ml syrup, 100 mg tab, tab 100 mg, tab 300 mg)	1-Covered	
ivermectin tab 3 mg	1-Covered	
linezolid (for susp 100 mg/5ml, tab 600 mg)	1-Covered	
linezolid iv soln 600 mg/300ml (2 mg/ml)	1-Covered	PA
mefloquine hcl	1-Covered	
meropenem iv for soln 1 gm	1-Covered	PA, QL (30 PER 10 DAYS)
meropenem iv for soln 500 mg	1-Covered	PA, QL (10 PER 10 DAYS)
metronidazole (tab 250 mg, tab 500 mg)	1-Covered	
metronidazole iv soln 500 mg/100ml	1-Covered	PA
neomycin sulfate	1-Covered	
nitazoxanide	1-Covered	
paromomycin sulfate	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
PASER	1-Covered	
pentamidine isethionate for nebulization soln 300 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (1 PER 28 DAYS)
pentamidine isethionate for soln 300 mg	1-Covered	
praziquantel	1-Covered	
PRIFTIN	1-Covered	
primaquine phosphate (26.3 (15 base) mg tab, tab 26.3 mg (15 mg base))	1-Covered	
pyrazinamide	1-Covered	
pyrimethamine	1-Covered	PA
quinine sulfate	1-Covered	
rifabutin	1-Covered	
rifampin	1-Covered	
SIRTURO	1-Covered	PA, LA
STREPTOMYCIN SULFATE	1-Covered	PA
tigecycline (50 mg recon soln, for iv soln 50 mg)	1-Covered	PA
tinidazole	1-Covered	
TOBI PODHALER	1-Covered	QL (224 PER 28 DAYS)
tobramycin nebu soln 300 mg/4ml	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (224 PER 28 DAYS)
tobramycin nebu soln 300 mg/5ml	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (280 PER 28 DAYS)
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	1-Covered	
vancomycin hcl (for iv soln 1 gm (base equivalent), 750 mg recon soln, for iv soln 750 mg (base equivalent))	1-Covered	PA, QL (20 PER 10 DAYS)
vancomycin hcl cap 125 mg (base equivalent)	1-Covered	PA, QL (40 PER 10 DAYS)
vancomycin hcl cap 250 mg (base equivalent)	1-Covered	PA, QL (80 PER 10 DAYS)
vancomycin hcl for iv soln 10 gm (base equivalent)	1-Covered	PA, QL (2 PER 10 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
vancomycin hcl for iv soln 500 mg (base equivalent)	1-Covered	PA, QL (10 PER 10 DAYS)
XIFAXAN 200 MG TAB	1-Covered	QL (9 PER 30 DAYS)
XIFAXAN 550 MG TAB	1-Covered	QL (90 PER 30 DAYS)
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, k tab er 12hr 1000-62.5 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	1-Covered	
AMOXICILLIN-POT CLAVULANATE ER	1-Covered	
AMPICILLIN	1-Covered	
ampicillin & sulbactam sodium	1-Covered	PA
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-Covered	PA
BICILLIN C-R	1-Covered	PA
BICILLIN C-R 900/300	1-Covered	PA
BICILLIN L-A	1-Covered	PA
dicloxacillin sodium	1-Covered	
nafcillin sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm, for iv soln 10 gm)	1-Covered	PA
oxacillin sodium	1-Covered	PA
OXACILLIN SODIUM IN DEXTROSE	1-Covered	PA
PENICILLIN G POT IN DEXTROSE (40000 UNIT/ML SOLUTION, 60000 UNIT/ML SOLUTION)	1-Covered	PA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
penicillin g potassium	1-Covered	PA
PENICILLIN G PROCAINE	1-Covered	PA
PENICILLIN G SODIUM	1-Covered	PA
penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, tab 250 mg, tab 500 mg)	1-Covered	
piperacillin sodium-tazobactam sodium	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 (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
levofloxacin iv soln 25 mg/ml	1-Covered	PA
MOXIFLOXACIN HCL 400 MG/250ML SOLUTION	1-Covered	PA
MOXIFLOXACIN HCL IN NACL	1-Covered	PA
moxifloxacin hcl tab 400 mg (base equiv)	1-Covered	
ofloxacin (300 mg tab, tab 400 mg)	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	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)	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
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	
tetracycline hcl	1-Covered	
VIBRAMYCIN 50 MG/5ML SYRUP	1-Covered	
URINARY TRACT AGENTS		
methenamine hippurate	1-Covered	
nitrofurantoin	1-Covered	
nitrofurantoin macrocrystal (line cap 50 mg, line cap 100 mg)	1-Covered	
nitrofurantoin monohyd macro	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	
XGEVA	1-Covered	PA - TO CONFIRM PART D COVERAGE
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)
AFINITOR 10 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
AFINITOR DISPERZ	1-Covered	PA - FOR NEW STARTS ONLY
ALECENSA	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)
ALUNBRIG (90 & 180 MG TAB THPK, 90 MG TAB, 180 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ALUNBRIG 30 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
anastrozole	1-Covered	
AYVAKIT	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
azathioprine tab 50 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE
BALVERSA	1-Covered	PA - FOR NEW STARTS ONLY, LA
bexarotene	1-Covered	PA - FOR NEW STARTS ONLY
bexarotene (topical)	1-Covered	PA - FOR NEW STARTS ONLY
bicalutamide	1-Covered	
BOSULIF (400 MG TAB, 500 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
BOSULIF 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
BRAFTOVI 75 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 PER 30 DAYS)
BRUKINSA	1-Covered	PA - FOR NEW STARTS ONLY, LA
CABOMETYX	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS)
CALQUENCE (100 MG CAP, 100 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS)
CAPRELSA 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS)
CAPRELSA 300 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS)
COMETRIQ (100 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (56 PER 28 DAYS)
COMETRIQ (140 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (112 PER 28 DAYS)
COMETRIQ (60 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (84 PER 28 DAYS)
COPIKTRA	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS)
COTELLIC	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (63 PER 28 DAYS)
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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
DAURISMO 25 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
DROXIA	1-Covered	
EMCYT	1-Covered	
ENVARSUS XR	1-Covered	PA - TO CONFIRM PART D COVERAGE
ERIVEDGE	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ERLEADA	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
erlotinib hcl (tab 100 mg (base equivalent), tab 150 mg (base equivalent))	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
erlotinib hcl tab 25 mg (base equivalent)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
everolimus (immunosuppressant)	1-Covered	PA - TO CONFIRM PART D COVERAGE
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)
everolimus (tab susp 2 mg, tab susp 3 mg, tab susp 5 mg)	1-Covered	PA - FOR NEW STARTS ONLY
exemestane	1-Covered	
EXKIVITY	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
FIRMAGON	1-Covered	PA - TO CONFIRM PART D COVERAGE
FIRMAGON (240 MG DOSE)	1-Covered	PA - TO CONFIRM PART D COVERAGE
FOTIVDA	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (21 PER 28 DAYS)
GAVRETO	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
GILOTRIF	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
hydroxyurea	1-Covered	
IBRANCE	1-Covered	PA - FOR NEW STARTS ONLY, QL (21 PER 28 DAYS)
ICLUSIG	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
IDHIFA	1-Covered	PA - FOR NEW STARTS ONLY, LA, 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
imatinib mesylate tab 100 mg (base equivalent)	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
imatinib mesylate tab 400 mg (base equivalent)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
IMBRUVICA (70 MG CAP, 140 MG TAB, 280 MG TAB, 420 MG TAB, 560 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
IMBRUVICA 140 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
IMBRUVICA 70 MG/ML SUSPENSION	1-Covered	PA - FOR NEW STARTS ONLY, QL (324 PER 30 DAYS)
INLYTA 1 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
INLYTA 5 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
INQOVI	1-Covered	PA - FOR NEW STARTS ONLY, QL (5 PER 28 DAYS)
INREBIC	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
IRESSA	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
JAKAFI	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
KISQALI (200 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (21 PER 28 DAYS)
KISQALI (400 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (42 PER 28 DAYS)
KISQALI (600 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (63 PER 28 DAYS)
KISQALI FEMARA (400 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (70 PER 28 DAYS)
KISQALI FEMARA (600 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (91 PER 28 DAYS)
KISQALI FEMARA(200 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, QL (49 PER 28 DAYS)
lapatinib ditosylate	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
lenalidomide	1-Covered	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
LENVIMA (10 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
LENVIMA (12 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
LENVIMA (14 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
LENVIMA (18 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
LENVIMA (20 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
LENVIMA (24 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
LENVIMA (4 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
LENVIMA (8 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
letrozole	1-Covered	
LEUKERAN	1-Covered	
leuprolide acetate inj kit 5 mg/ml	1-Covered	PA - FOR NEW STARTS ONLY
LONSURF	1-Covered	PA - FOR NEW STARTS ONLY
LORBRENA 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
LORBRENA 25 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
LUMAKRAS	1-Covered	PA - FOR NEW STARTS ONLY
LUPRON DEPOT (1-MONTH)	1-Covered	PA - FOR NEW STARTS ONLY
LUPRON DEPOT (3-MONTH)	1-Covered	PA - FOR NEW STARTS ONLY
LUPRON DEPOT (4-MONTH)	1-Covered	PA - FOR NEW STARTS ONLY
LUPRON DEPOT (6-MONTH)	1-Covered	PA - FOR NEW STARTS ONLY
LYNPARZA	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
LYSODREN	1-Covered	
MATULANE	1-Covered	
megestrol acetate (appetite)	1-Covered	PA
megestrol acetate (tab 20 mg, tab 40 mg)	1-Covered	PA - FOR NEW STARTS ONLY
megestrol acetate susp 40 mg/ml	1-Covered	PA
MEKINIST 0.5 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
MEKINIST 2 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
MEKTOVI	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 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
mercaptopurine	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, for oral susp 200 mg/ml, tab 500 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolate sodium	1-Covered	PA - TO CONFIRM PART D COVERAGE
NERLYNX	1-Covered	PA - FOR NEW STARTS ONLY, LA
NEXAVAR	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
nilutamide	1-Covered	PA - FOR NEW STARTS ONLY
NINLARO	1-Covered	PA - FOR NEW STARTS ONLY, QL (3 PER 28 DAYS)
NUBEQA	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
octreotide acetate (50 mcg/ml soln prsyr, inj 50 mcg/ml (0.05 mg/ml), 100 mcg/ml soln prsyr, inj 100 mcg/ml (0.1 mg/ml), 200 mcg/ml solution, inj 200 mcg/ml (0.2 mg/ml), 500 mcg/ml soln prsyr, inj 500 mcg/ml (0.5 mg/ml), 1000 mcg/ml solution, inj 1000 mcg/ml (1 mg/ml))	1-Covered	PA
ODOMZO	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS)
ONUREG	1-Covered	PA - FOR NEW STARTS ONLY, QL (14 PER 14 DAYS)
ORGOVYX	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (32 PER 30 DAYS)
PEMAZYRE	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (14 PER 21 DAYS)
PIQRAY (200 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
PIQRAY (250 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
PIQRAY (300 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY
POMALYST	1-Covered	PA - FOR NEW STARTS ONLY, LA
PROGRAF (0.2 MG, 1 MG)	1-Covered	PA - TO CONFIRM PART D COVERAGE
PURIXAN	1-Covered	
QINLOCK	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (90 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
RETEVMO 40 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 PER 30 DAYS)
RETEVMO 80 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
REVLIMID	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (28 PER 28 DAYS)
ROZLYTREK 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (150 PER 30 DAYS)
ROZLYTREK 200 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
RUBRACA	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
RYDAPT	1-Covered	PA - FOR NEW STARTS ONLY
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)
SCEMBLIX 40 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (300 PER 30 DAYS)
SIGNIFOR	1-Covered	PA
sirolimus (oral soln 1 mg/ml, tab 0.5 mg, tab 1 mg, tab 2 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE
SOLTAMOX	1-Covered	
sorafenib tosylate	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
SPRYCEL (20 MG TAB, 70 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
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)
STIVARGA	1-Covered	PA - FOR NEW STARTS ONLY, QL (84 PER 28 DAYS)
sunitinib malate	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
SYNRIBO	1-Covered	PA - TO CONFIRM PART D COVERAGE
TABLOID	1-Covered	
TABRECTA	1-Covered	PA - FOR NEW STARTS ONLY
tacrolimus (cap 0.5 mg, cap 1 mg, cap 5 mg)	1-Covered	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
TAFINLAR	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
TAGRISSO	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS)
TALZENNA (0.5 MG CAP, 0.75 MG CAP, 1 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
TALZENNA 0.25 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
tamoxifen citrate	1-Covered	
TARGRETIN 1 % GEL	1-Covered	PA - FOR NEW STARTS ONLY
TASIGNA (150 MG CAP, 200 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (112 PER 28 DAYS)
TASIGNA 50 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
TAZVERIK	1-Covered	PA - FOR NEW STARTS ONLY, LA
TEPMETKO	1-Covered	PA - FOR NEW STARTS ONLY, LA
THALOMID	1-Covered	PA - FOR NEW STARTS ONLY
TIBSOVO	1-Covered	PA - FOR NEW STARTS ONLY
toremifene citrate	1-Covered	
TRELSTAR MIXJECT	1-Covered	PA - TO CONFIRM PART D COVERAGE
tretinoin (chemotherapy)	1-Covered	
TRUSELTIQ (100MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (21 PER 21 DAYS)
TRUSELTIQ (125MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (42 PER 21 DAYS)
TRUSELTIQ (50MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (42 PER 21 DAYS)
TRUSELTIQ (75MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (63 PER 21 DAYS)
TUKYSA 150 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (120 PER 30 DAYS)
TUKYSA 50 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (300 PER 30 DAYS)
TURALIO	1-Covered	PA, LA, QL (120 PER 30 DAYS)
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)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
VENCLEXTA 50 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (30 PER 30 DAYS)
VENCLEXTA STARTING PACK	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (42 PER 30 DAYS)
VERZENIO	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS)
VITRAKVI 100 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (60 PER 30 DAYS)
VITRAKVI 20 MG/ML SOLUTION	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (300 PER 30 DAYS)
VITRAKVI 25 MG CAP	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (180 PER 30 DAYS)
VIZIMPRO	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
VONJO	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
VOTRIENT	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
WELIREG	1-Covered	PA - FOR NEW STARTS ONLY, LA
XALKORI	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
XATMEP	1-Covered	PA - TO CONFIRM PART D COVERAGE
XERMELO	1-Covered	PA, LA, QL (90 PER 30 DAYS)
XOSPATA	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (100 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (40 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (40 MG TWICE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (60 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (60 MG TWICE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (80 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, LA
XPOVIO (80 MG TWICE WEEKLY)	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)
XTANDI 80 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
YONSA	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
ZEJULA	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (90 PER 30 DAYS)
ZELBORAF	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)
ZOLINZA	1-Covered	PA - FOR NEW STARTS ONLY
ZORTRESS 1 MG TAB	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZYDELIG	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
ZYKADIA 150 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
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)
BRIVIACT 10 MG/ML SOLUTION	1-Covered	QL (600 PER 30 DAYS)
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	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	1-Covered	PA - FOR NEW STARTS ONLY, LA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
DIAZEPAM (2.5 MG GEL, 10 MG GEL, 20 MG GEL)	1-Covered	
DILANTIN 30 MG CAP	1-Covered	
divalproex sodium	1-Covered	
EPIDIOLEX	1-Covered	PA - FOR NEW STARTS ONLY, LA
EPRONTIA	1-Covered	PA - FOR NEW STARTS ONLY
ethosuximide (cap 250 mg, soln 250 mg/5ml)	1-Covered	
felbamate (susp 600 mg/5ml, tab 400 mg, tab 600 mg)	1-Covered	
FINTEPLA	1-Covered	PA - FOR NEW STARTS ONLY, LA, QL (360 PER 30 DAYS)
FYCOMPA (2 MG TAB, 4 MG TAB, 6 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
FYCOMPA (8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
FYCOMPA 0.5 MG/ML SUSPENSION	1-Covered	QL (720 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 300 MG TAB	1-Covered	PA, QL (30 PER 30 DAYS)
GRALISE 600 MG TAB	1-Covered	PA, QL (90 PER 30 DAYS)
lacosamide (tab 100 mg, tab 150 mg, tab 200 mg)	1-Covered	QL (60 PER 30 DAYS)
lacosamide oral solution 10 mg/ml	1-Covered	QL (1200 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 25 (14) & 50 mg (14) & 100 mg (7) 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	
NAYZILAM	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
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	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	1-Covered	
rufinamide (susp 40 mg/ml, tab 200 mg, tab 400 mg)	1-Covered	PA - FOR NEW STARTS ONLY
SPRITAM	1-Covered	
SYMPAZAN	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 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
tiagabine hcl	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	1-Covered	
VALTOCO 10 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 15 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 20 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 5 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
vigabatrin	1-Covered	LA
VIMPAT (100 MG TAB, 150 MG TAB, 200 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
VIMPAT 10 MG/ML SOLUTION	1-Covered	QL (1200 PER 30 DAYS)
VIMPAT 50 MG TAB	1-Covered	QL (120 PER 30 DAYS)
XCOPRI (14 X 12.5 MG & 14 X 25 MG TAB, 14 X 150 MG & 14 X200 MG TAB, 14 X 50 MG & 14 X100 MG TAB)	1-Covered	QL (56 PER 28 DAYS)
XCOPRI (150 MG TAB, 200 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
XCOPRI (250 MG DAILY DOSE)	1-Covered	QL (56 PER 28 DAYS)
XCOPRI (350 MG DAILY DOSE)	1-Covered	QL (56 PER 28 DAYS)
XCOPRI 100 MG TAB	1-Covered	QL (120 PER 30 DAYS)
XCOPRI 50 MG TAB	1-Covered	QL (240 PER 30 DAYS)
zonisamide	1-Covered	PA - FOR NEW STARTS ONLY
ANTIPARKINSONISM AGENTS		
benztropine mesylate (tab 0.5 mg, tab 1 mg, tab 2 mg)	1-Covered	PA
bromocriptine mesylate	1-Covered	
carbidopa	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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	1-Covered	
KYNMOBI	1-Covered	PA, QL (150 PER 30 DAYS)
NEUPRO	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	
rasagiline mesylate	1-Covered	
ropinirole hydrochloride	1-Covered	
selegiline hcl	1-Covered	
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG	1-Covered	PA, QL (1 PER 30 DAYS)
AJOVY	1-Covered	PA, QL (1.5 PER 30 DAYS)
dihydroergotamine mesylate nasal spray 4 mg/ml	1-Covered	QL (8 PER 28 DAYS)
eletriptan hydrobromide	1-Covered	QL (18 PER 28 DAYS)
EMGALITY	1-Covered	PA, QL (2 PER 30 DAYS)
ergotamine w/ caffeine	1-Covered	
naratriptan hcl	1-Covered	QL (18 PER 28 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
NURTEC	1-Covered	PA, QL (16 PER 30 DAYS)
rizatriptan benzoate	1-Covered	QL (36 PER 28 DAYS)
sumatriptan nasal spray 20 mg/act	1-Covered	QL (18 PER 28 DAYS)
sumatriptan nasal spray 5 mg/act	1-Covered	QL (36 PER 28 DAYS)
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, solution cartridge 6 mg/0.5ml)	1-Covered	QL (8 PER 28 DAYS)
sumatriptan succinate (tab 25 mg, tab 50 mg, tab 100 mg)	1-Covered	QL (18 PER 28 DAYS)
SUMATRIPTAN SUCCINATE REFILL	1-Covered	QL (8 PER 28 DAYS)
TRUDHESA	1-Covered	ST, QL (8 PER 28 DAYS)
UBRELVY	1-Covered	PA, QL (20 PER 30 DAYS)
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 DAYS)
MISCELLANEOUS NEUROLOGICAL THERAPY		
AUBAGIO	1-Covered	PA, QL (30 PER 30 DAYS)
BAFIERTAM	1-Covered	PA, QL (120 PER 30 DAYS)
dalfampridine	1-Covered	PA, QL (60 PER 30 DAYS)
dimethyl fumarate capsule delayed release 120 mg	1-Covered	PA, QL (14 PER 30 DAYS)
dimethyl fumarate capsule delayed release 240 mg	1-Covered	PA, QL (60 PER 30 DAYS)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	1-Covered	PA, QL (120 PER 180 DAYS)
donepezil hydrochloride	1-Covered	
FIRDAPSE	1-Covered	PA, LA
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)
glatiramer acetate soln prefilled syringe 20 mg/ml	1-Covered	PA, QL (30 PER 30 DAYS)
glatiramer acetate soln prefilled syringe 40 mg/ml	1-Covered	PA, QL (12 PER 28 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
INGREZZA (40 MG CAP, 60 MG CAP, 80 MG CAP)	1-Covered	PA, LA, QL (30 PER 30 DAYS)
INGREZZA 40 & 80 MG CAP THPK	1-Covered	PA, LA, QL (28 PER 28 DAYS)
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	1-Covered	PA
NUEDEXTA	1-Covered	PA
rivastigmine	1-Covered	
rivastigmine tartrate	1-Covered	
tetrabenazine tab 12.5 mg	1-Covered	PA, QL (240 PER 30 DAYS)
tetrabenazine tab 25 mg	1-Covered	PA, QL (120 PER 30 DAYS)
VUMERITY	1-Covered	PA, QL (120 PER 30 DAYS)
VUMERITY (STARTER)	1-Covered	PA, QL (120 PER 30 DAYS)
ZEPOSIA	1-Covered	PA, QL (30 PER 30 DAYS)
ZEPOSIA 7-DAY STARTER PACK	1-Covered	PA, QL (7 PER 30 DAYS)
ZEPOSIA STARTER KIT	1-Covered	PA, QL (37 PER 30 DAYS)
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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
APAP-CAFF-DIHYDROCODEINE	1-Covered	QL (300 PER 30 OVER TIME)
BELBUCA	1-Covered	PA, QL (60 PER 30 OVER TIME)
buprenorphine	1-Covered	PA, QL (4 PER 28 OVER TIME)
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 200 mcg, a 400 mcg, a 600 mcg, a 800 mcg, a 1200 mcg, a 1600 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	QL (240 PER 30 OVER TIME)
hydromorphone hcl preservative free (pf) inj 10 mg/ml	1-Covered	QL (240 PER 30 OVER TIME)
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)

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 (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)
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	1-Covered	QL (360 PER 30 OVER TIME)
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)
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	1-Covered	
diclofenac potassium tab 50 mg	1-Covered	
diclofenac sodium	1-Covered	
diclofenac sodium gel 1%	1-Covered	QL (1000 PER 28 OVER TIME)
diclofenac w/ misoprostol	1-Covered	
diflunisal	1-Covered	
etodolac	1-Covered	
flurbiprofen tab 100 mg	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ibuprofen (susp 100 mg/5ml, tab 400 mg, tab 600 mg, tab 800 mg)	1-Covered	
KLOXXADO	1-Covered	
meloxicam tab 15 mg	1-Covered	
meloxicam tab 7.5 mg	1-Covered	QL (30 PER 30 DAYS)
nabumetone	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	1-Covered	
naproxen (susp 125 mg/5ml, 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	
NARCAN	1-Covered	
oxaprozin	1-Covered	
piroxicam	1-Covered	
sulindac	1-Covered	
tramadol hcl tab 50 mg	1-Covered	QL (240 PER 30 OVER TIME)
tramadol-acetaminophen	1-Covered	QL (240 PER 30 OVER TIME)
VIVITROL	1-Covered	
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 MAINTENA	1-Covered	QL (1 PER 28 DAYS)
amitriptyline hcl	1-Covered	
AMOXAPINE	1-Covered	
amphetamine-dextroamphetamine	1-Covered	
aripiprazole (tab 10 mg, tab 15 mg)	1-Covered	QL (60 PER 30 DAYS)
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	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ARISTADA 1064 MG/3.9ML PRSYR	1-Covered	QL (3.9 PER 56 OVER TIME)
ARISTADA 441 MG/1.6ML PRSYR	1-Covered	QL (1.6 PER 28 DAYS)
ARISTADA 662 MG/2.4ML PRSYR	1-Covered	QL (2.4 PER 28 DAYS)
ARISTADA 882 MG/3.2ML PRSYR	1-Covered	QL (3.2 PER 28 DAYS)
ARISTADA INITIO	1-Covered	QL (4.8 PER 365 OVER TIME)
armodafinil	1-Covered	PA
asenapine maleate	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)
bupropion hcl (tab 75 mg, tab 100 mg)	1-Covered	
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	1-Covered	
CAPLYTA	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	1-Covered	
clonidine hcl (adhd)	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)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
clozapine (12.5 mg tab disp, orally disintegrating tab 25 mg, orally disintegrating tab 100 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	1-Covered	
desvenlafaxine succinate	1-Covered	QL (30 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)
diazepam conc 5 mg/ml	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)
diazepam oral soln 1 mg/ml	1-Covered	PA - FOR NEW STARTS ONLY, QL (1200 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)	1-Covered	QL (30 PER 30 DAYS)
DRIZALMA SPRINKLE (20 MG CAP DR, 30 MG CAP DR, 60 MG CAP DR)	1-Covered	QL (60 PER 30 DAYS)
DRIZALMA SPRINKLE 40 MG CAP DR	1-Covered	QL (90 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	1-Covered	
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	1-Covered	QL (30 PER 30 DAYS)
FANAPT	1-Covered	QL (60 PER 30 DAYS)
FANAPT TITRATION PACK	1-Covered	QL (8 PER 28 DAYS)
FETZIMA	1-Covered	QL (30 PER 30 DAYS)
FETZIMA TITRATION	1-Covered	QL (28 PER 28 DAYS)
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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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	1-Covered	
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)
FORFIVO XL	1-Covered	QL (30 PER 30 DAYS)
haloperidol	1-Covered	
haloperidol decanoate	1-Covered	
haloperidol lactate	1-Covered	
HETLIOZ	1-Covered	PA, QL (30 PER 30 DAYS)
imipramine hcl	1-Covered	
imipramine pamoate	1-Covered	
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	1-Covered	QL (3.5 PER 180 OVER TIME)
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	1-Covered	QL (5 PER 180 OVER TIME)
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	1-Covered	QL (0.75 PER 28 DAYS)
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	1-Covered	QL (1 PER 28 DAYS)
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	1-Covered	QL (1.5 PER 28 DAYS)
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)
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	1-Covered	QL (0.88 PER 90 OVER TIME)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	1-Covered	QL (1.32 PER 90 OVER TIME)
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	1-Covered	QL (1.75 PER 90 OVER TIME)
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	1-Covered	QL (2.63 PER 90 OVER TIME)
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 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	1-Covered	
MARPLAN	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	1-Covered	
modafinil	1-Covered	PA
MOLINDONE HCL	1-Covered	
NEFAZODONE HCL	1-Covered	
nortriptyline hcl (10 mg/5ml solution, cap 10 mg, cap 25 mg, cap 50 mg, cap 75 mg)	1-Covered	
NUPLAZID (10 MG TAB, 34 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
olanzapine for im inj 10 mg	1-Covered	
olanzapine-fluoxetine hcl	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	
PAXIL 10 MG/5ML SUSPENSION	1-Covered	
perphenazine	1-Covered	
PERSERIS	1-Covered	QL (1 PER 30 DAYS)
phenelzine sulfate (15 mg tab, tab 15 mg)	1-Covered	
PIMOZIDE	1-Covered	
protriptyline hcl	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	1-Covered	QL (30 PER 30 DAYS)
REXULTI	1-Covered	QL (30 PER 30 DAYS)
RISPERDAL CONSTA	1-Covered	QL (2 PER 28 DAYS)
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)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
risperidone soln 1 mg/ml	1-Covered	
SECUADO	1-Covered	QL (30 PER 30 DAYS)
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)
thioridazine hcl	1-Covered	
thiothixene	1-Covered	
tranylcypromine sulfate	1-Covered	
trazodone hcl	1-Covered	
trifluoperazine hcl	1-Covered	
trimipramine maleate	1-Covered	
TRINTELLIX	1-Covered	QL (30 PER 30 DAYS)
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), tab er 37.5 mg (base equivalent), tab er 75 mg (base equivalent), tab er 150 mg (base equivalent), tab er 225 mg (base equivalent))	1-Covered	QL (30 PER 30 DAYS)
VERSACLOZ	1-Covered	
VIIBRYD	1-Covered	QL (30 PER 30 DAYS)
VIIBRYD STARTER PACK	1-Covered	QL (30 PER 30 DAYS)
vilazodone hcl	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 30 DAYS)
XYREM	1-Covered	PA, LA, QL (540 PER 30 DAYS)
zaleplon cap 10 mg	1-Covered	QL (60 PER 30 DAYS)
zaleplon cap 5 mg	1-Covered	QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ziprasidone hcl	1-Covered	QL (60 PER 30 DAYS)
ziprasidone mesylate	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	1-Covered	
flecainide acetate	1-Covered	
mexiletine hcl	1-Covered	
propafenone hcl	1-Covered	
quinidine sulfate (200 mg tab, tab 200 mg, 300 mg tab, tab 300 mg)	1-Covered	
sotalol hcl (afib/afl)	1-Covered	
sotalol hcl (tab 80 mg, tab 120 mg, tab 160 mg, tab 240 mg)	1-Covered	
ANTIHYPERTENSIVE THERAPY		
acebutolol hcl	1-Covered	
aliskiren fumarate	1-Covered	
amiloride & hydrochlorothiazide	1-Covered	
amiloride hcl	1-Covered	
amlodipine besylate	1-Covered	
amlodipine besylate-benazepril hcl	1-Covered	
amlodipine besylate-olmesartan medoxomil	1-Covered	
amlodipine besylate-valsartan	1-Covered	
atenolol	1-Covered	
atenolol & chlorthalidone	1-Covered	
benazepril & hydrochlorothiazide	1-Covered	
benazepril hcl	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
betaxolol hcl	1-Covered	
BIDIL	1-Covered	QL (180 PER 30 DAYS)
bisoprolol & hydrochlorothiazide	1-Covered	
bisoprolol fumarate	1-Covered	
bumetanide (inj 0.25 mg/ml, tab 0.5 mg, tab 1 mg, tab 2 mg)	1-Covered	
BYSTOLIC	1-Covered	
candesartan cilexetil	1-Covered	
candesartan cilexetil-hydrochlorothiazide	1-Covered	
captopril	1-Covered	
carvedilol	1-Covered	
chlorthalidone	1-Covered	
clonidine	1-Covered	QL (4 PER 28 DAYS)
clonidine hcl	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)	1-Covered	
diltiazem hcl coated beads	1-Covered	
diltiazem hcl extended release beads	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	1-Covered	
EDARBYCLOR	1-Covered	
enalapril maleate & hydrochlorothiazide	1-Covered	
enalapril maleate (tab 2.5 mg, tab 5 mg, tab 10 mg, tab 20 mg)	1-Covered	
eplerenone	1-Covered	
ethacrynic acid	1-Covered	
felodipine	1-Covered	
fosinopril sodium	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
fosinopril sodium & hydrochlorothiazide	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	1-Covered	
indapamide	1-Covered	
irbesartan	1-Covered	
irbesartan-hydrochlorothiazide	1-Covered	
isosorbide dinitrate-hydralazine hcl	1-Covered	QL (180 PER 30 DAYS)
isradipine	1-Covered	
KERENDIA	1-Covered	PA, QL (30 PER 30 DAYS)
labetalol hcl (tab 100 mg, tab 200 mg, tab 300 mg)	1-Covered	
lisinopril	1-Covered	
lisinopril & hydrochlorothiazide	1-Covered	
losartan potassium	1-Covered	
losartan potassium & hydrochlorothiazide	1-Covered	
metolazone	1-Covered	
metoprolol & hydrochlorothiazide	1-Covered	
metoprolol succinate	1-Covered	
metoprolol tartrate (tab 25 mg, tab 37.5 mg, tab 50 mg, tab 75 mg, tab 100 mg)	1-Covered	
metyrosine	1-Covered	PA
minoxidil	1-Covered	
moexipril hcl	1-Covered	
nadolol	1-Covered	
nebivolol hcl	1-Covered	
nicardipine hcl (cap 20 mg, cap 30 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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	1-Covered	
nisoldipine	1-Covered	
NISOLDIPINE ER	1-Covered	
olmesartan medoxomil	1-Covered	
olmesartan medoxomil-amlodipine-hydrochlorothiazide	1-Covered	
olmesartan medoxomil-hydrochlorothiazide	1-Covered	
perindopril erbumine	1-Covered	
pindolol	1-Covered	
prazosin hcl	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	1-Covered	
quinapril-hydrochlorothiazide	1-Covered	
ramipril	1-Covered	
spironolactone	1-Covered	
spironolactone & hydrochlorothiazide	1-Covered	
telmisartan	1-Covered	
telmisartan-amlodipine	1-Covered	
telmisartan-hydrochlorothiazide	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)
timolol maleate (tab 5 mg, tab 10 mg, tab 20 mg)	1-Covered	
torsemide	1-Covered	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
trandolapril	1-Covered	
trandolapril-verapamil hcl	1-Covered	
TRANDOLAPRIL-VERAPAMIL HCL ER	1-Covered	
triamterene & hydrochlorothiazide	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
valsartan (tab 40 mg, tab 80 mg, tab 160 mg, tab 320 mg)	1-Covered	
valsartan-hydrochlorothiazide	1-Covered	
verapamil hcl (cap er 24hr 100 mg, cap er 24hr 120 mg, cap er 24hr 180 mg, cap er 24hr 200 mg, cap er 24hr 240 mg, cap er 24hr 300 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	1-Covered	
COAGULATION THERAPY		
aspirin-dipyridamole	1-Covered	
BRILINTA	1-Covered	
CABLIVI	1-Covered	PA, LA
cilostazol	1-Covered	
clopidogrel bisulfate tab 75 mg (base equiv)	1-Covered	QL (30 PER 30 DAYS)
dabigatran etexilate mesylate	1-Covered	
dipyridamole (tab 25 mg, tab 50 mg, tab 75 mg)	1-Covered	
DOPTELET	1-Covered	PA, LA
ELIQUIS	1-Covered	
ELIQUIS DVT/PE STARTER PACK	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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
enoxaparin sodium inj soln pref syr 40 mg/0.4ml	1-Covered	QL (11.2 PER 28 DAYS)
fondaparinux sodium	1-Covered	
heparin sodium (porcine) (1000 unit/ml, 5000 unit/ml, 10000 unit/ml, 20000 unit/ml)	1-Covered	
MULPLETA	1-Covered	PA
pentoxifylline	1-Covered	
prasugrel hcl	1-Covered	
PROMACTA	1-Covered	PA, LA
warfarin sodium	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	1-Covered	
LIPID/CHOLESTEROL LOWERING AGENTS		
amlodipine besylate-atorvastatin calcium	1-Covered	QL (30 PER 30 DAYS)
atorvastatin calcium	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	1-Covered	
colesevelam hcl	1-Covered	
colestipol hcl (granule packets 5 gm, granules 5 gm, tab 1 gm)	1-Covered	
ezetimibe	1-Covered	
ezetimibe-simvastatin	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)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
gemfibrozil	1-Covered	
icosapent ethyl	1-Covered	
JUXTAPID (5 MG CAP, 10 MG CAP, 20 MG CAP, 30 MG CAP)	1-Covered	PA, LA
LIVALO	1-Covered	QL (30 PER 30 DAYS)
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	1-Covered	PA
NEXLIZET	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	1-Covered	
pravastatin sodium	1-Covered	QL (30 PER 30 DAYS)
REPATHA	1-Covered	PA, QL (3 PER 28 DAYS)
REPATHA PUSHTRONEX SYSTEM	1-Covered	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	1-Covered	PA, QL (3 PER 28 DAYS)
rosuvastatin calcium	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	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	1-Covered	QL (60 PER 30 DAYS)
LANOXIN 62.5 MCG TAB	1-Covered	
ranolazine	1-Covered	
VECAMYL	1-Covered	
VERQUVO	1-Covered	QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
VYNDAMAX	1-Covered	PA
VYNDAQEL	1-Covered	PA
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	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	1-Covered	
calcipotriene (cream, oint, soln (50 mcg/ml))	1-Covered	QL (120 PER 30 OVER TIME)
calcipotriene-betamethasone dipropionate	1-Covered	QL (400 PER 30 OVER TIME)
CALCITRIOL 3 MCG/GM OINTMENT	1-Covered	
selenium sulfide lotion 2.5%	1-Covered	
SKYRIZI (150 MG DOSE)	1-Covered	PA, QL (2 PER 28 DAYS)
SKYRIZI 150 MG/ML SOLN PRSYR	1-Covered	PA, QL (2 PER 28 DAYS)
SKYRIZI PEN	1-Covered	PA, QL (2 PER 28 DAYS)
STELARA (45 MG/0.5ML SOLN PRSYR, 45 MG/0.5ML SOLUTION)	1-Covered	PA, QL (0.5 PER 28 DAYS)
STELARA 90 MG/ML SOLN PRSYR	1-Covered	PA, QL (1 PER 28 DAYS)
TALTZ	1-Covered	PA, QL (1 PER 28 DAYS)
MISCELLANEOUS DERMATOLOGICALS		
ADBRY	1-Covered	PA, QL (6 PER 28 DAYS)
CIBINQO	1-Covered	PA, QL (30 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
diclofenac sodium (actinic keratoses)	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)
DUPIXENT (300 MG/2ML SOLN PEN, 300 MG/2ML SOLN PRSYR)	1-Covered	PA, QL (8 PER 28 DAYS)
DUPIXENT 100 MG/0.67ML SOLN PRSYR	1-Covered	PA, QL (1.34 PER 28 DAYS)
FLUOROURACIL (2 % SOLUTION, 5 % SOLUTION)	1-Covered	
fluorouracil (topical)	1-Covered	
imiquimod cream 5%	1-Covered	
lactic acid (ammonium lactate) (cream, lotion)	1-Covered	
lidocaine hcl (mouth-throat)	1-Covered	
lidocaine hcl soln 4%	1-Covered	
lidocaine oint 5%	1-Covered	QL (36 PER 30 OVER TIME)
lidocaine patch 5%	1-Covered	PA
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	
PANRETIN	1-Covered	PA - FOR NEW STARTS ONLY
pimecrolimus	1-Covered	PA, QL (100 PER 30 OVER TIME)
podofilox	1-Covered	
REGRANEX	1-Covered	
SANTYL	1-Covered	
silver sulfadiazine	1-Covered	
tacrolimus (topical)	1-Covered	PA, QL (100 PER 30 OVER TIME)
VALCHLOR	1-Covered	PA - FOR NEW STARTS ONLY
THERAPY FOR ACNE		
azelaic acid	1-Covered	
clindamycin phosphate (topical) (gel, lotion, soln)	1-Covered	QL (120 PER 30 OVER TIME)
ERY	1-Covered	
erythromycin soln 2%	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
isotretinoin	1-Covered	
ivermectin (rosacea)	1-Covered	
IVERMECTIN 1 % CREAM	1-Covered	
metronidazole (topical) (cream 0.75%, gel 0.75%, gel 1%, lotion 0.75%)	1-Covered	
tazarotene cream 0.1%	1-Covered	PA
TAZORAC (0.05 % CREAM, 0.05 % GEL, 0.1 % GEL)	1-Covered	PA
tretinoin	1-Covered	PA
TOPICAL ANTIBACTERIALS		
gentamicin sulfate (topical)	1-Covered	QL (60 PER 30 DAYS)
mafenide acetate	1-Covered	
mupirocin	1-Covered	QL (44 PER 30 DAYS)
sulfacetamide sodium (acne)	1-Covered	
SULFAMYLON	1-Covered	
TOPICAL ANTIFUNGALS		
ciclopirox gel 0.77%	1-Covered	QL (45 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	
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	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%)	1-Covered	QL (60 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
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)
nystatin topical powder 100000 unit/gm	1-Covered	QL (180 PER 30 DAYS)
nystatin-triamcinolone	1-Covered	QL (60 PER 28 OVER TIME)
tavaborole	1-Covered	
TOPICAL ANTIVIRALS		
acyclovir oint 5%	1-Covered	PA, QL (30 PER 30 DAYS)
DENAVIR	1-Covered	QL (5 PER 30 DAYS)
TOPICAL CORTICOSTEROIDS		
alclometasone dipropionate	1-Covered	
betamethasone dipropionate (topical) (cream, lotion, oint)	1-Covered	
BETAMETHASONE DIPROPIONATE AUG	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	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)
halobetasol propionate (cream, oint)	1-Covered	
hydrocortisone (topical) (cream 1%, cream 2.5%, lotion 2.5%, oint 1%, oint 2.5%)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
mometasone furoate (cream, oint, solution (lotion))	1-Covered	
PREDNICARBATE	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	1-Covered	
malathion	1-Covered	
permethrin	1-Covered	
DIAGNOSTICS / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
sodium polystyrene sulfonate powder*	1-Covered	
acamprosate calcium	1-Covered	
anagrelide hcl	1-Covered	
CARBAGLU	1-Covered	PA, LA
carglumic acid	1-Covered	PA
cevimeline hcl	1-Covered	
CHEMET	1-Covered	PA
CLINIMIX/DEXTROSE (4.25/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
deferasirox	1-Covered	PA
deferiprone (tab 500 mg, tab 1000 mg)	1-Covered	PA
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	
disulfiram	1-Covered	
droxidopa	1-Covered	PA
FERRIPROX (100 MG/ML SOLUTION, 500 MG TAB, 1000 MG TAB)	1-Covered	PA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
FERRIPROX TWICE-A-DAY	1-Covered	PA
INCRELEX	1-Covered	LA
levocarnitine (metabolic modifiers) (oral soln 1 gm/10ml (10%), tab 330 mg)	1-Covered	
LOKELMA	1-Covered	
midodrine hcl	1-Covered	
nitisinone	1-Covered	PA
pilocarpine hcl (oral)	1-Covered	
PROLASTIN-C	1-Covered	PA, LA
RAVICTI	1-Covered	PA
REVCOVI	1-Covered	PA, LA
riluzole	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 (gu irrigant)	1-Covered	
sodium chloride (iv soln, preservative free (pf) inj)	1-Covered	
sodium phenylbutyrate (oral powder 3 gm/teaspoonful, tab 500 mg)	1-Covered	PA
SPS	1-Covered	
trientine hcl	1-Covered	PA
VELTASSA	1-Covered	
XURIDEN	1-Covered	PA
SMOKING DETERRENTS		
APO-VARENICLINE	1-Covered	
bupropion hcl (smoking deterrent)	1-Covered	
NICOTROL	1-Covered	
NICOTROL NS	1-Covered	
VARENICLINE TARTRATE	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
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine hcl	1-Covered	QL (60 PER 30 DAYS)
chlorhexidine gluconate (mouth-throat)	1-Covered	
ipratropium bromide (nasal)	1-Covered	QL (30 PER 30 DAYS)
triamcinolone acetonide (mouth)	1-Covered	
MISCELLANEOUS OTIC PREPARATIONS		
acetic acid (otic)	1-Covered	
CIPROFLOXACIN HCL 0.2 % SOLUTION	1-Covered	
fluocinolone acetonide (otic)	1-Covered	
hydrocortisone w/acetic acid	1-Covered	
ofloxacin (otic)	1-Covered	
OTIC STEROID / ANTIBIOTIC		
ciprofloxacin-dexamethasone	1-Covered	
neomycin-polymyxin-hc (otic)	1-Covered	
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
dexamethasone (0.5 mg tab, elixir 0.5 mg/5ml, tab 0.5 mg, 0.75 mg tab, tab 0.75 mg, 1 mg tab, tab 1.5 mg, tab 2 mg, tab 4 mg, tab 6 mg)	1-Covered	
fludrocortisone acetate	1-Covered	
hydrocortisone	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	1-Covered	
prednisolone sodium phosphate (sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base), 25 mg/5ml solution)	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
prednisone (tab 1 mg, tab 2.5 mg, 5 mg/5ml solution, tab 5 mg, 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	1-Covered	
ANTITHYROID AGENTS		
methimazole	1-Covered	
propylthiouracil	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	1-Covered	
ASSURE ID INSULIN SAFETY SYR	1-Covered	
BAQSIMI ONE PACK	1-Covered	
BAQSIMI TWO PACK	1-Covered	
BD INSULIN SYRINGE U-500	1-Covered	
BD PEN NEEDLE NANO U/F	1-Covered	
BD SAFETYGLIDE INSULIN SYRINGE	1-Covered	
BYDUREON BCISE	1-Covered	PA, QL (4 PER 28 DAYS)
BYETTA 10 MCG PEN	1-Covered	PA, QL (2.4 PER 30 DAYS)
BYETTA 5 MCG PEN	1-Covered	PA, QL (1.2 PER 30 DAYS)
diazoxide	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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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	1-Covered	QL (30 PER 30 DAYS)
GVOKE HYPOPEN 1-PACK	1-Covered	
GVOKE HYPOPEN 2-PACK	1-Covered	
GVOKE KIT	1-Covered	
GVOKE PFS	1-Covered	
HUMALOG	1-Covered	
HUMALOG JUNIOR KWIKPEN	1-Covered	
HUMALOG KWIKPEN	1-Covered	
HUMALOG MIX 50/50	1-Covered	
HUMALOG MIX 50/50 KWIKPEN	1-Covered	
HUMALOG MIX 75/25	1-Covered	
HUMALOG MIX 75/25 KWIKPEN	1-Covered	
HUMULIN R U-500 (CONCENTRATED)	1-Covered	
HUMULIN R U-500 KWIKPEN	1-Covered	
JANUMET	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	1-Covered	QL (30 PER 30 DAYS)
JARDIANCE	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	1-Covered	
LANTUS SOLOSTAR	1-Covered	
LYUMJEV	1-Covered	
LYUMJEV KWIKPEN	1-Covered	
MAGELLAN INSULIN SAFETY SYR	1-Covered	
MARATHON MEDICAL PENTIPS	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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)
MONOJECT INSULIN SYRINGE	1-Covered	
MONOJECT ULTRA COMFORT SYRINGE	1-Covered	
MOUNJARO	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	1-Covered	QL (30 PER 30 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE)	1-Covered	PA, QL (1.5 PER 28 DAYS)
OZEMPIC (1 MG/DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
OZEMPIC (2 MG/DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
PENTIPS	1-Covered	
pioglitazone hcl	1-Covered	QL (30 PER 30 DAYS)
PRO COMFORT PEN NEEDLES	1-Covered	
QTERN	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	1-Covered	PA, QL (30 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	1-Covered	QL (90 PER 30 DAYS)
STEGLATRO	1-Covered	QL (30 PER 30 DAYS)
SYMLINPEN 120	1-Covered	PA, QL (10.8 PER 30 DAYS)
SYMLINPEN 60	1-Covered	PA, QL (6 PER 30 DAYS)
SYNJARDY	1-Covered	QL (60 PER 30 DAYS)
SYNJARDY XR (5-1000 MG TAB ER, 10-1000 MG TAB ER, 12.5-1000 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
SYNJARDY XR 25-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
TOUJEO MAX SOLOSTAR	1-Covered	
TOUJEO SOLOSTAR	1-Covered	
TRIJARDY XR (10-5-1000 MG TAB ER, 25-5-1000 MG TAB ER)	1-Covered	QL (30 PER 30 DAYS)
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	1-Covered	PA, QL (2 PER 28 DAYS)
ULTICARE INSULIN SAFETY SYR	1-Covered	
VICTOZA	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)
XULTOPHY	1-Covered	QL (15 PER 30 DAYS)
ZEGALOGUE	1-Covered	
MISCELLANEOUS HORMONES		
ANDRODERM	1-Covered	PA, QL (30 PER 30 DAYS)
cabergoline	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	
CERDELGA	1-Covered	PA
cinacalcet hcl	1-Covered	PA
danazol	1-Covered	
desmopressin acetate (tab 0.1 mg, tab 0.2 mg)	1-Covered	
desmopressin acetate spray	1-Covered	
desmopressin acetate spray refrigerated	1-Covered	
doxercalciferol (cap 0.5 mcg, cap 1 mcg, cap 2.5 mcg)	1-Covered	
KORLYM	1-Covered	PA
miglustat	1-Covered	PA, LA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
MYALEPT	1-Covered	PA, LA
NATPARA	1-Covered	PA, LA
oxandrolone	1-Covered	PA
PALYNZIQ 10 MG/0.5ML SOLN PRSYR	1-Covered	PA, LA, QL (15 PER 30 DAYS)
PALYNZIQ 2.5 MG/0.5ML SOLN PRSYR	1-Covered	PA, LA, QL (4 PER 30 DAYS)
PALYNZIQ 20 MG/ML SOLN PRSYR	1-Covered	PA, LA, QL (60 PER 30 DAYS)
paricalcitol (cap 1 mcg, cap 2 mcg, cap 4 mcg)	1-Covered	
SAMSCA 15 MG TAB	1-Covered	PA
sapropterin dihydrochloride	1-Covered	PA
SOMAVERT	1-Covered	PA
SYNAREL	1-Covered	PA
testosterone (25 mg/2.5gm (1%) gel, 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
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	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
dicyclomine hcl (cap 10 mg, oral soln 10 mg/5ml, tab 20 mg)	1-Covered	
diphenoxylate w/ atropine	1-Covered	
DIPHENOXYLATE-ATROPINE	1-Covered	
glycopyrrolate (tab 1 mg, 1.5 mg tab, tab 2 mg)	1-Covered	
loperamide hcl	1-Covered	
MISCELLANEOUS GASTROINTESTINAL AGENTS		
alosetron hcl	1-Covered	PA
aprepitant	1-Covered	PA - TO CONFIRM PART D COVERAGE
balsalazide disodium	1-Covered	
betaine	1-Covered	
budesonide	1-Covered	
CHENODAL	1-Covered	PA, LA
CHOLBAM 250 MG CAP	1-Covered	PA
CHOLBAM 50 MG CAP	1-Covered	PA, QL (120 PER 30 DAYS)
CIMZIA	1-Covered	PA, QL (2 PER 28 DAYS)
CIMZIA PREFILLED	1-Covered	PA, QL (2 PER 28 DAYS)
CIMZIA STARTER KIT	1-Covered	PA, QL (2 PER 28 DAYS)
CREON	1-Covered	
cromolyn sodium (mastocytosis)	1-Covered	
CYSTADANE	1-Covered	
DIPENTUM	1-Covered	
dronabinol	1-Covered	PA - TO CONFIRM PART D COVERAGE
EMEND 125 MG/5ML RECON SUSP	1-Covered	PA - TO CONFIRM PART D COVERAGE
GATTEX	1-Covered	PA
GAVILYTE-C	1-Covered	
granisetron hcl tab 1 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE
hydrocortisone (intrarectal)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
hydrocortisone (rectal)	1-Covered	
lactulose (encephalopathy)	1-Covered	
lactulose solution 10 gm/15ml	1-Covered	
LINZESS	1-Covered	QL (30 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, cap er 500 mg, enema 4 gm, suppos 1000 mg, tab delayed release 1.2 gm, tab delayed release 800 mg)	1-Covered	
mesalamine w/ cleanser	1-Covered	
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-Covered	ST, QL (30 PER 30 DAYS)
MOVANTIK	1-Covered	QL (30 PER 30 DAYS)
OCALIVA	1-Covered	PA, LA, QL (30 PER 30 DAYS)
ondansetron	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-ascorbic acid	1-Covered	
peg 3350-potassium chloride-sod bicarbonate-sod chloride	1-Covered	
PENTASA	1-Covered	
prochlorperazine	1-Covered	
prochlorperazine maleate	1-Covered	
RECTIV	1-Covered	
RELISTOR 12 MG/0.6ML SOLUTION	1-Covered	QL (18 PER 30 DAYS)
RELISTOR 8 MG/0.4ML SOLUTION	1-Covered	QL (12 PER 30 DAYS)
SANCUSO	1-Covered	
scopolamine	1-Covered	
SKYRIZI 360 MG/2.4ML SOLN CART	1-Covered	PA, QL (2.4 PER 56 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
SUCRAID	1-Covered	PA
sulfasalazine	1-Covered	
TRULANCE	1-Covered	
ursodiol (cap 300 mg, tab 250 mg, tab 500 mg)	1-Covered	
VARUBI (180 MG DOSE)	1-Covered	PA - TO CONFIRM PART D COVERAGE
VIBERZI	1-Covered	QL (60 PER 30 DAYS)
VIOKACE	1-Covered	
ZENPEP	1-Covered	
ULCER THERAPY		
cimetidine	1-Covered	
cimetidine hcl (300 mg/5ml solution, soln 300 mg/5ml)	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	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 40 mg (base equiv)	1-Covered	
sucralfate (susp 1 gm/10ml, tab 1 gm)	1-Covered	
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE	1-Covered	PA - TO CONFIRM PART D COVERAGE
ARCALYST	1-Covered	PA

DRUG NAME	TIER	REQUIREMENTS/LIMITS
AVONEX PEN	1-Covered	PA, QL (1 PER 28 DAYS)
AVONEX PREFILLED	1-Covered	PA, QL (1 PER 28 DAYS)
BESREMI	1-Covered	PA - FOR NEW STARTS ONLY, LA
BETASERON	1-Covered	PA, QL (14 PER 28 DAYS)
INTRON A	1-Covered	PA - TO CONFIRM PART D COVERAGE
LEUKINE	1-Covered	PA
NIVESTYM	1-Covered	PA
NYVEPRIA	1-Covered	PA
OMNITROPE (5 MG/1.5ML SOLN CART, 5.8 MG RECON SOLN, 10 MG/1.5ML SOLN CART)	1-Covered	PA
PEGASYS 180 MCG/0.5ML SOLN PRSYR	1-Covered	QL (2 PER 28 DAYS)
PEGASYS 180 MCG/ML SOLUTION	1-Covered	QL (4 PER 28 DAYS)
PLEGRIDY	1-Covered	PA, QL (1 PER 28 DAYS)
PROCRIT	1-Covered	PA
RETACRIT	1-Covered	PA
ZARXIO	1-Covered	PA
ZIEXTENZO	1-Covered	PA
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB	1-Covered	
ADACEL	1-Covered	
BCG VACCINE	1-Covered	
BEXSERO	1-Covered	
BOOSTRIX	1-Covered	
DAPTACEL	1-Covered	
DIPHTHERIA-TETANUS TOXOIDS DT	1-Covered	
ENGERIX-B	1-Covered	PA - TO CONFIRM PART D COVERAGE
GARDASIL 9	1-Covered	
HAVRIX	1-Covered	
HIBERIX	1-Covered	
IMOVAX RABIES	1-Covered	
INFANRIX	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
IPOL	1-Covered	
IXIARO	1-Covered	
KINRIX	1-Covered	
M-M-R II	1-Covered	
MENACTRA	1-Covered	
MENQUADFI	1-Covered	
MENVEO RECON SOLN	1-Covered	
PEDIARIX	1-Covered	
PEDVAX HIB	1-Covered	
PENTACEL	1-Covered	
PREHEVBRIO	1-Covered	PA - TO CONFIRM PART D COVERAGE
PRIORIX	1-Covered	
PRIVIGEN 20 GM/200ML SOLUTION	1-Covered	PA
PROQUAD	1-Covered	
QUADRACEL	1-Covered	
RABAVERT	1-Covered	
RECOMBIVAX HB	1-Covered	PA - TO CONFIRM PART D COVERAGE
ROTARIX	1-Covered	
ROTATEQ	1-Covered	
SHINGRIX	1-Covered	
TDVAX	1-Covered	
TENIVAC	1-Covered	
TICOVAC	1-Covered	
TRUMENBA	1-Covered	
TWINRIX	1-Covered	
TYPHIM VI	1-Covered	
VAQTA	1-Covered	
VARIVAX	1-Covered	
YF-VAX	1-Covered	

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

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	1-Covered	
febuxostat	1-Covered	
probenecid	1-Covered	
OSTEOPOROSIS THERAPY		
alendronate sodium (70 mg/75ml solution, oral soln 70 mg/75ml)	1-Covered	QL (300 PER 28 DAYS)
alendronate sodium (tab 35 mg, tab 70 mg)	1-Covered	QL (4 PER 28 DAYS)
alendronate sodium tab 10 mg	1-Covered	QL (30 PER 30 DAYS)
FOSAMAX PLUS D	1-Covered	ST, QL (4 PER 28 DAYS)
ibandronate sodium tab 150 mg (base equivalent)	1-Covered	QL (1 PER 30 DAYS)
PROLIA	1-Covered	PA, QL (1 PER 180 OVER TIME)
raloxifene hcl	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)	1-Covered	PA, QL (2.48 PER 28 DAYS)
OTHER RHEUMATOLOGICALS		
ACTEMRA 162 MG/0.9ML SOLN PRSYR	1-Covered	PA, QL (3.6 PER 28 DAYS)
ACTEMRA ACTPEN	1-Covered	PA, QL (3.6 PER 28 DAYS)
BENLYSTA (200 MG/ML SOLN A-INJ, 200 MG/ML SOLN PRSYR)	1-Covered	PA
ENBREL	1-Covered	PA, QL (8 PER 28 DAYS)
ENBREL MINI	1-Covered	PA, QL (8 PER 28 DAYS)
ENBREL SURECLICK	1-Covered	PA, QL (8 PER 28 DAYS)
HUMIRA (10 MG/0.1ML, 20 MG/0.2ML)	1-Covered	PA, QL (2 PER 28 DAYS)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
HUMIRA (40 MG/0.4ML, 40 MG/0.8ML)	1-Covered	PA, QL (4 PER 28 DAYS)
HUMIRA PEDIATRIC CROHNS START 80 MG/0.8ML & 40MG/0.4ML PREF SY KT	1-Covered	PA, QL (2 PER 180 DAYS)
HUMIRA PEDIATRIC CROHNS START 80 MG/0.8ML PREF SY KT	1-Covered	PA, QL (3 PER 180 DAYS)
HUMIRA PEN (40 MG/0.4ML PEN KIT, 40 MG/0.8ML PEN KIT)	1-Covered	PA, QL (4 PER 28 DAYS)
HUMIRA PEN 80 MG/0.8ML PEN KIT	1-Covered	PA, QL (2 PER 28 DAYS)
HUMIRA PEN-CD/UC/HS STARTER 40 MG/0.8ML PEN KIT	1-Covered	PA, QL (6 PER 180 DAYS)
HUMIRA PEN-CD/UC/HS STARTER 80 MG/0.8ML PEN KIT	1-Covered	PA, QL (3 PER 180 DAYS)
HUMIRA PEN-PEDIATRIC UC START	1-Covered	PA, QL (4 PER 28 DAYS)
HUMIRA PEN-PS/UV/ADOL HS START	1-Covered	PA, QL (4 PER 180 DAYS)
HUMIRA PEN-PSOR/UVEIT STARTER	1-Covered	PA, QL (3 PER 180 DAYS)
leflunomide	1-Covered	QL (30 PER 30 DAYS)
ORENCIA 125 MG/ML SOLN PRSYR	1-Covered	PA, QL (4 PER 28 DAYS)
ORENCIA 50 MG/0.4ML SOLN PRSYR	1-Covered	PA, QL (1.6 PER 28 DAYS)
ORENCIA 87.5 MG/0.7ML SOLN PRSYR	1-Covered	PA, QL (2.8 PER 28 DAYS)
ORENCIA CLICKJECT	1-Covered	PA, QL (4 PER 28 DAYS)
OTEZLA 10 & 20 & 30 MG TAB THPK	1-Covered	PA, QL (55 PER 28 DAYS)
OTEZLA 30 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS)
penicillamine tab 250 mg	1-Covered	PA
RIDAURA	1-Covered	
RINVOQ (15 MG TAB ER, 30 MG TAB ER)	1-Covered	PA, QL (30 PER 30 DAYS)
RINVOQ 45 MG TAB ER 24H	1-Covered	PA, QL (56 PER 180 OVER TIME)
SAVELLA	1-Covered	QL (60 PER 30 DAYS)
SAVELLA TITRATION PACK	1-Covered	QL (55 PER 30 DAYS)
XELJANZ (5 MG TAB, 10 MG TAB)	1-Covered	PA, QL (60 PER 30 DAYS)
XELJANZ 1 MG/ML SOLUTION	1-Covered	PA, QL (300 PER 30 DAYS)
XELJANZ XR	1-Covered	PA, 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
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
CRINONE 4 % GEL	1-Covered	
CRINONE 8 % GEL	1-Covered	PA
DEPO-SUBQ PROVERA 104	1-Covered	
DUAVEE	1-Covered	
estradiol & norethindrone acetate	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	1-Covered	
ESTRING	1-Covered	
medroxyprogesterone acetate	1-Covered	
medroxyprogesterone acetate (contraceptive)	1-Covered	
MENEST (0.3 MG TAB, 0.625 MG TAB, 1.25 MG TAB)	1-Covered	PA
norethindrone (contraceptive)	1-Covered	
norethindrone acetate	1-Covered	
norethindrone acetate-ethinyl estradiol	1-Covered	PA
PREMARIN (0.3 MG TAB, 0.45 MG TAB, 0.625 MG TAB, 0.625 MG/GM CREAM, 0.9 MG TAB, 1.25 MG TAB)	1-Covered	
PREMPHASE	1-Covered	
PREMPRO	1-Covered	
progesterone (cap 100 mg, cap 200 mg)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
MISCELLANEOUS OB/GYN		
CLEOCIN 100 MG SUPPOS	1-Covered	
clindamycin phosphate vaginal	1-Covered	
etonogestrel-ethinyl estradiol	1-Covered	
metronidazole vaginal	1-Covered	
norelgestromin-ethinyl estradiol	1-Covered	
terconazole vaginal (cream 0.4%, cream 0.8%, suppos 80 mg)	1-Covered	
tranexamic acid tab 650 mg	1-Covered	
VANDAZOLE	1-Covered	
ORAL CONTRACEPTIVES / RELATED AGENTS		
desogestrel & ethinyl estradiol	1-Covered	
desogestrel-ethinyl estradiol (biphasic)	1-Covered	
drospirenone-ethinyl estradiol	1-Covered	
ethynodiol diacet & eth estrad	1-Covered	
levonorgestrel & eth estradiol	1-Covered	
levonorgestrel-eth estradiol (triphasic)	1-Covered	
levonorgestrel-ethinyl estradiol (91-day)	1-Covered	
levonorgestrel-ethinyl estradiol (continuous)	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	
norethindrone & eth estradiol (tab 0.5 mcg, tab 1 mcg)	1-Covered	
norethindrone acet & eth estra	1-Covered	
norethindrone acetate-ethinyl estradiol-fe	1-Covered	
norethindrone-eth estradiol (triphasic)	1-Covered	
norgestimate-ethinyl estradiol	1-Covered	
norgestimate-ethinyl estradiol (triphasic)	1-Covered	
norgestrel & ethinyl estradiol	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
VELIVET	1-Covered	
OPHTHALMOLOGY		
ANTIBIOTICS		
AZASITE	1-Covered	
BACITRACIN 500 UNIT/GM OINTMENT	1-Covered	
bacitracin-polymyxin b (ophth)	1-Covered	
BESIVANCE	1-Covered	
ciprofloxacin hcl (ophth)	1-Covered	
erythromycin (ophth)	1-Covered	QL (3.5 PER 14 DAYS)
gatifloxacin (ophth)	1-Covered	
GENTAK	1-Covered	QL (3.5 PER 30 DAYS)
gentamicin sulfate (ophth)	1-Covered	QL (70 PER 30 DAYS)
levofloxacin (ophth)	1-Covered	
MOXIFLOXACIN HCL (2X DAY)	1-Covered	
moxifloxacin hcl (ophth)	1-Covered	
NATACYN	1-Covered	
neomycin-bacitracin zn-polymyxin	1-Covered	
NEOMYCIN-POLYMYXIN-GRAMICIDIN	1-Covered	
NEOSPORIN	1-Covered	
ofloxacin (ophth)	1-Covered	
polymyxin b-trimethoprim	1-Covered	
tobramycin (ophth)	1-Covered	QL (10 PER 14 DAYS)
ANTIVIRALS		
TRIFLURIDINE	1-Covered	
ZIRGAN	1-Covered	
BETA-BLOCKERS		
betaxolol hcl (ophth)	1-Covered	
CARTEOLOL HCL	1-Covered	
levobunolol hcl (0.5 % solution, ophth soln 0.5%)	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
TIMOLOL MALEATE (0.25 % GEL F SOLN, 0.5 % GEL F SOLN)	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)	1-Covered	
bepotastine besilate	1-Covered	
BLEPHAMIDE S.O.P.	1-Covered	
cromolyn sodium (ophth)	1-Covered	
cyclosporine (ophth)	1-Covered	QL (60 PER 30 DAYS)
CYSTARAN	1-Covered	PA
epinastine hcl (ophth)	1-Covered	
olopatadine hcl	1-Covered	
OXERVATE	1-Covered	PA
pilocarpine hcl	1-Covered	
RESTASIS	1-Covered	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	1-Covered	QL (5.5 PER 30 DAYS)
sulfacetamide sod-prednisolone	1-Covered	
sulfacetamide sodium (ophth)	1-Covered	
SULFACETAMIDE SODIUM 10 % OINTMENT	1-Covered	
SULFACETAMIDE-PREDNISOLONE	1-Covered	
XIIDRA	1-Covered	QL (60 PER 30 DAYS)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
bromfenac sodium (ophth)	1-Covered	
BROMSITE	1-Covered	
diclofenac sodium (ophth)	1-Covered	
flurbiprofen sodium (0.03 % solution, ophth soln 0.03%)	1-Covered	
ketorolac tromethamine (ophth)	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
PROLENSA	1-Covered	
ORAL DRUGS FOR GLAUCOMA		
acetazolamide	1-Covered	
methazolamide	1-Covered	
OTHER GLAUCOMA DRUGS		
brimonidine tartrate-timolol maleate	1-Covered	
COMBIGAN	1-Covered	
dorzolamide hcl ophth soln 2%	1-Covered	
dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml	1-Covered	
latanoprost ophth soln 0.005%	1-Covered	
LUMIGAN	1-Covered	
RHOPRESSA	1-Covered	
ROCKLATAN	1-Covered	
SIMBRINZA	1-Covered	
travoprost	1-Covered	
STEROID-ANTIBIOTIC COMBINATIONS		
bacitracin-poly-neomycin-hc	1-Covered	
neomycin-polymy-dexameth (oint, susp)	1-Covered	
NEOMYCIN-POLYMYXIN-HC	1-Covered	
TOBRADEX 0.3-0.1 % OINTMENT	1-Covered	QL (3.5 PER 14 DAYS)
tobramycin-dexamethasone	1-Covered	QL (10 PER 14 DAYS)
STEROIDS		
ALREX	1-Covered	
DEXAMETHASONE SODIUM PHOSPHATE 0.1 % SOLUTION	1-Covered	
EYSUVIS	1-Covered	PA, QL (8.3 PER 14 DAYS)
fluorometholone (ophth)	1-Covered	
INVELTYS	1-Covered	
loteprednol etabonate (gel, susp)	1-Covered	
PREDNISOLONE ACETATE	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	1-Covered	
SYMPATHOMIMETICS		
ALPHAGAN P 0.1 % SOLUTION	1-Covered	
apraclonidine hcl	1-Covered	
brimonidine tartrate	1-Covered	
IOPIDINE 1 % SOLUTION	1-Covered	
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGENIC AGENTS		
cetirizine hcl	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 DAYS)
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	1-Covered	QL (2 PER 30 DAYS)
PULMONARY AGENTS		
acetylcysteine	1-Covered	PA - TO CONFIRM PART D COVERAGE
ADEMPAS	1-Covered	PA, LA
ADVAIR DISKUS	1-Covered	QL (60 PER 30 DAYS)
ADVAIR HFA	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))	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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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	1-Covered	PA, LA
arformoterol tartrate	1-Covered	PA - TO CONFIRM PART D COVERAGE
ARNUITY ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
ASMANEX (120 METERED DOSES)	1-Covered	QL (2 PER 30 DAYS)
ASMANEX (30 METERED DOSES)	1-Covered	QL (1 PER 30 DAYS)
ASMANEX (60 METERED DOSES)	1-Covered	QL (1 PER 30 DAYS)
ASMANEX HFA	1-Covered	QL (13 PER 30 DAYS)
ATROVENT HFA	1-Covered	QL (25.8 PER 30 DAYS)
bosentan	1-Covered	PA, LA
BREO ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE	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)
CINRYZE	1-Covered	PA
COMBIVENT RESPIMAT	1-Covered	QL (8 PER 30 DAYS)
cromolyn sodium	1-Covered	PA - TO CONFIRM PART D COVERAGE
DALIRESP	1-Covered	PA, QL (30 PER 30 DAYS)
DULERA	1-Covered	QL (13 PER 30 DAYS)
ESBRIET (267 MG CAP, 267 MG TAB)	1-Covered	PA, QL (270 PER 30 DAYS)
ESBRIET 801 MG TAB	1-Covered	PA, QL (90 PER 30 DAYS)
FASENRA	1-Covered	PA, QL (1 PER 28 DAYS)
FASENRA PEN	1-Covered	PA, QL (1 PER 28 DAYS)
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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
flunisolide (nasal)	1-Covered	QL (50 PER 30 DAYS)
fluticasone propionate (nasal)	1-Covered	QL (16 PER 30 DAYS)
formoterol fumarate	1-Covered	PA - TO CONFIRM PART D COVERAGE
icatibant acetate	1-Covered	PA
ipratropium bromide	1-Covered	PA - TO CONFIRM PART D COVERAGE
ipratropium-albuterol	1-Covered	PA - TO CONFIRM PART D COVERAGE
KALYDECO (25 MG, 50 MG, 75 MG)	1-Covered	PA, QL (56 PER 28 DAYS)
KALYDECO 150 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS)
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)	1-Covered	QL (34 PER 30 DAYS)
montelukast sodium	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)
NUCALA 40 MG/0.4ML SOLN PRSYR	1-Covered	PA, LA, QL (0.4 PER 28 DAYS)
OFEV	1-Covered	PA, QL (60 PER 30 DAYS)
OPSUMIT	1-Covered	PA, LA
ORKAMBI (100-125 MG TAB, 200-125 MG TAB)	1-Covered	PA, QL (112 PER 28 DAYS)
ORKAMBI (100-125 MG, 150-188 MG)	1-Covered	PA, QL (56 PER 28 DAYS)
ORLADEYO	1-Covered	PA, LA
pirfenidone tab 267 mg	1-Covered	PA, QL (270 PER 30 DAYS)
pirfenidone tab 801 mg	1-Covered	PA, QL (90 PER 30 DAYS)
PULMICORT FLEXHALER 180 MCG/ACT AER POW BA	1-Covered	QL (2 PER 30 DAYS)
PULMICORT FLEXHALER 90 MCG/ACT AER POW BA	1-Covered	QL (1 PER 30 DAYS)
PULMOZYME	1-Covered	PA - TO CONFIRM PART D COVERAGE
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)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
sildenafil citrate tab 20 mg	1-Covered	PA, QL (90 PER 30 DAYS)
SPIRIVA HANDIHALER	1-Covered	QL (90 PER 90 DAYS)
SPIRIVA RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
STIOLTO RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
STRIVERDI RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
SYMBICORT	1-Covered	QL (10.2 PER 30 DAYS)
SYMDEKO	1-Covered	PA, QL (56 PER 28 DAYS)
tadalafil (pulmonary hypertension)	1-Covered	PA, QL (60 PER 30 DAYS)
terbutaline sulfate (tab 2.5 mg, tab 5 mg)	1-Covered	
THEO-24	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	
TRELEGY ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
TRIKAFTA	1-Covered	PA, QL (84 PER 28 DAYS)
XOLAIR (150 MG RECON SOLN, 150 MG/ML SOLN PRSYR)	1-Covered	PA, LA, QL (8 PER 28 DAYS)
XOLAIR 75 MG/0.5ML SOLN PRSYR	1-Covered	PA, LA, QL (1 PER 28 DAYS)
zafirlukast	1-Covered	
ZYFLO	1-Covered	

UROLOGICALS

ANTICHOLINERGICS / ANTISPASMODICS

fesoterodine fumarate	1-Covered	
flavoxate hcl	1-Covered	
MYRBETRIQ (8 MG/ML SRER, 25 MG TAB ER 24H, 50 MG TAB ER 24H)	1-Covered	
oxybutynin chloride (syrup 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	1-Covered	
TOVIAZ	1-Covered	
trospium chloride tab 20 mg	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
alfuzosin hcl	1-Covered	
dutasteride	1-Covered	
dutasteride-tamsulosin hcl	1-Covered	
finasteride	1-Covered	
silodosin	1-Covered	
tamsulosin hcl	1-Covered	
MISCELLANEOUS UROLOGICALS		
bethanechol chloride	1-Covered	
CYSTAGON	1-Covered	PA, LA
ELMIRON	1-Covered	
potassium citrate (alkalinizer)	1-Covered	
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
calcium acetate (phosphate binder)	1-Covered	QL (360 PER 30 DAYS)
KCL IN DEXTROSE-NACL 40-5-0.9 MEQ/L-%-% SOLUTION	1-Covered	
KCL-LACTATED RINGERS-D5W	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	1-Covered	
potassium chloride in dextrose & sodium chloride	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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	1-Covered	
sodium chloride (soln 0.45%, soln 3%, soln 5%)	1-Covered	
MISCELLANEOUS NUTRITION PRODUCTS		
amino acid infusion	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/10)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/15)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/20)	1-Covered	PA - TO CONFIRM PART D COVERAGE
INTRALIPID 20 % EMULSION	1-Covered	PA - TO CONFIRM PART D COVERAGE
ISOLYTE-P IN D5W	1-Covered	
ISOLYTE-S	1-Covered	
ISOLYTE-S PH 7.4	1-Covered	
PLASMA-LYTE 148	1-Covered	
PLASMA-LYTE A	1-Covered	
PREMASOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRAVASOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
TROPHAMINE 10 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
VITAMINS / HEMATINICS		
ATABEX EC	1-Covered	
AZESCHEW PRENATAL/POSTNATAL	1-Covered	
AZESCO	1-Covered	
BAL-CARE DHA	1-Covered	
C-NATE DHA	1-Covered	
CITRANATAL 90 DHA	1-Covered	
CITRANATAL ASSURE	1-Covered	
CITRANATAL B-CALM	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
CITRANATAL BLOOM	1-Covered	
CITRANATAL DHA	1-Covered	
CITRANATAL HARMONY	1-Covered	
CITRANATAL RX	1-Covered	
CO-NATAL FA	1-Covered	
COMPLETE NATAL DHA	1-Covered	
COMPLETENATE	1-Covered	
CONCEPT DHA	1-Covered	
CONCEPT OB	1-Covered	
DERMACINRX PRETRATE	1-Covered	
DOTHELLE DHA	1-Covered	
DUET DHA 400	1-Covered	
DUET DHA BALANCED	1-Covered	
ELITE-OB	1-Covered	
ENBRACE HR	1-Covered	
FOLET DHA	1-Covered	
FOLET ONE	1-Covered	
FOLIVANE-OB	1-Covered	
HEMENATAL OB	1-Covered	
HEMENATAL OB + DHA	1-Covered	
INATAL GT	1-Covered	
KOSHER PRENATAL PLUS IRON	1-Covered	
M-NATAL PLUS	1-Covered	
MARNATAL-F	1-Covered	
MULTI-MAC	1-Covered	
MYNATAL	1-Covered	
MYNATAL ADVANCE	1-Covered	
MYNATAL PLUS	1-Covered	
MYNATAL-Z	1-Covered	
MYNATE 90 PLUS	1-Covered	
NATACHEW	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
NATALVIT	1-Covered	
NATELLE ONE	1-Covered	
NEEVO DHA	1-Covered	
NEONATAL + DHA	1-Covered	
NEONATAL COMPLETE 29-1 MG TAB	1-Covered	
NEONATAL FE	1-Covered	
NEONATAL PLUS	1-Covered	
NESTABS	1-Covered	
NESTABS ABC	1-Covered	
NESTABS DHA	1-Covered	
NESTABS ONE	1-Covered	
NEXA PLUS	1-Covered	
NIVA-PLUS	1-Covered	
O-CAL FA	1-Covered	
O-CAL PRENATAL	1-Covered	
OB COMPLETE	1-Covered	
OB COMPLETE ONE	1-Covered	
OB COMPLETE PETITE	1-Covered	
OB COMPLETE PREMIER	1-Covered	
OB COMPLETE/DHA	1-Covered	
OBSTETRIX DHA	1-Covered	
OBSTETRIX EC	1-Covered	
OBSTETRIX ONE	1-Covered	
PNV OB+DHA	1-Covered	
PNV TABS 20-1	1-Covered	
PNV TABS 29-1	1-Covered	
PNV-DHA	1-Covered	
PNV-DHA+DOCUSATE	1-Covered	
PNV-OMEGA	1-Covered	
PNV-SELECT	1-Covered	
PR NATAL 400	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
PR NATAL 400 EC	1-Covered	
PR NATAL 430	1-Covered	
PR NATAL 430 EC	1-Covered	
PREGEN DHA	1-Covered	
PREGENNA	1-Covered	
PRENA 1 TRUE	1-Covered	
PRENA1	1-Covered	
PRENA1 PEARL	1-Covered	
PRENAISSANCE	1-Covered	
PRENAISSANCE PLUS	1-Covered	
PRENATABS RX	1-Covered	
PRENATAL	1-Covered	
PRENATAL 19	1-Covered	
PRENATAL PLUS	1-Covered	
PRENATAL PLUS IRON	1-Covered	
PRENATAL PLUS VITAMIN/MINERAL	1-Covered	
PRENATAL VITAMIN PLUS LOW IRON	1-Covered	
PRENATAL-U	1-Covered	
PRENATE	1-Covered	
PRENATE AM	1-Covered	
PRENATE DHA	1-Covered	
PRENATE ELITE	1-Covered	
PRENATE ENHANCE	1-Covered	
PRENATE ESSENTIAL	1-Covered	
PRENATE MINI	1-Covered	
PRENATE PIXIE	1-Covered	
PRENATE RESTORE	1-Covered	
PRENATRIX	1-Covered	
PRENATRYL	1-Covered	
PREPLUS	1-Covered	
PRETAB	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
PRIMACARE	1-Covered	
PROVIDA DHA	1-Covered	
PROVIDA OB	1-Covered	
PUREFE OB PLUS	1-Covered	
R-NATAL OB	1-Covered	
SE-NATAL 19	1-Covered	
SELECT-OB	1-Covered	
SELECT-OB+DHA	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	1-Covered	
TARON-C DHA	1-Covered	
TARON-PREX	1-Covered	
THRIVITE RX	1-Covered	
TL FOLATE	1-Covered	
TL-CARE DHA	1-Covered	
TL-SELECT	1-Covered	
TRI-TABS DHA	1-Covered	
TRICARE	1-Covered	
TRICARE PRENATAL DHA ONE 0.8 MG CAP	1-Covered	
TRINATAL RX 1	1-Covered	
TRINATE	1-Covered	
TRINAZ	1-Covered	
TRISTART DHA	1-Covered	
TRIVEEN-DUO DHA	1-Covered	
ULTIMATECARE ONE	1-Covered	
VENA-BAL DHA	1-Covered	
VINATE DHA RF	1-Covered	
VINATE II	1-Covered	
VINATE M	1-Covered	

DRUG NAME	TIER	REQUIREMENTS/LIMITS
VINATE ONE	1-Covered	
VIRT-C DHA	1-Covered	
VIRT-NATE DHA	1-Covered	
VIRT-PN	1-Covered	
VIRT-PN DHA	1-Covered	
VIRT-PN PLUS	1-Covered	
VITAFOL FE+	1-Covered	
VITAFOL GUMMIES	1-Covered	
VITAFOL ULTRA	1-Covered	
VITAFOL-NANO	1-Covered	
VITAFOL-OB	1-Covered	
VITAFOL-OB+DHA	1-Covered	
VITAFOL-ONE	1-Covered	
VITAMEDMD ONE RX/QUATREFOLIC	1-Covered	
VITAMEDMD REDICHEW RX	1-Covered	
VITAPEARL	1-Covered	
VITATRUE	1-Covered	
VIVA DHA	1-Covered	
VOL-NATE	1-Covered	
VOL-PLUS	1-Covered	
VOL-TAB RX	1-Covered	
VP-HEME OB + DHA	1-Covered	
VP-PNV-DHA	1-Covered	
WESCAP-C DHA	1-Covered	
WESCAP-PN DHA	1-Covered	
WESNATE DHA	1-Covered	
WESTAB PLUS	1-Covered	
WESTGEL DHA	1-Covered	
ZALVIT	1-Covered	
ZATEAN-PN DHA	1-Covered	
ZATEAN-PN PLUS	1-Covered	

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This formulary was updated on 12/1/2022. For more recent information or other questions, please contact Cooperative Advantage Member Service at 1-888-203-7770 or, or, for TTY/ TDD: 711, 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.