

# **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](http://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.

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## LEGEND

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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.

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## 2022 ISNP COOPERATIVE ADVANTAGE (List of Covered Drugs)

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<b>ANTI - INFECTIVES</b>		
<b>ANTIFUNGAL AGENTS</b>		
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
<i>casprofungin acetate (50 mg recon soln, for iv soln 50 mg, 70 mg recon soln, for iv soln 70 mg)</i>	1-Covered	
<i>clotrimazole</i>	1-Covered	
CRESEMBA 186 MG CAP	1-Covered	PA
<i>fluconazole (for susp 10 mg/ml, for susp 40 mg/ml, tab 50 mg, tab 100 mg, tab 150 mg, tab 200 mg)</i>	1-Covered	
<i>fluconazole in nacl</i>	1-Covered	PA
<i>flucytosine</i>	1-Covered	
<i>griseofulvin microsize (susp 125 mg/5ml, tab 500 mg)</i>	1-Covered	
<i>griseofulvin ultramicrosize</i>	1-Covered	
<i>itraconazole cap 100 mg</i>	1-Covered	QL (120 PER 30 DAYS)
<i>itraconazole oral soln 10 mg/ml</i>	1-Covered	
<i>ketoconazole</i>	1-Covered	
<i>miconazole sodium (soln 50 mg, soln 100 mg)</i>	1-Covered	
NOXAFIL 40 MG/ML SUSPENSION	1-Covered	PA, QL (630 PER 30 DAYS)
<i>nystatin (mouth-throat)</i>	1-Covered	
<i>nystatin tab 500000 unit</i>	1-Covered	
<i>posaconazole</i>	1-Covered	PA, QL (96 PER 30 DAYS)
<i>terbinafine hcl</i>	1-Covered	
<i>voriconazole (for susp 40 mg/ml, tab 50 mg, tab 200 mg)</i>	1-Covered	PA
<i>voriconazole for inj 200 mg</i>	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
<b>ANTIVIRALS</b>		
<i>abacavir sulfate (soln 20 mg/ml (base equiv), tab 300 mg (base equiv))</i>	1-Covered	
<i>abacavir sulfate-lamivudine</i>	1-Covered	
<i>acyclovir (cap 200 mg, susp 200 mg/5ml, tab 400 mg, tab 800 mg)</i>	1-Covered	
<i>acyclovir sodium iv soln 50 mg/ml</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>adefovir dipivoxil</i>	1-Covered	
<i>amantadine hcl (cap 100 mg, soln 50 mg/5ml, tab 100 mg)</i>	1-Covered	
APTIVUS	1-Covered	
<i>atazanavir sulfate</i>	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	
<i>efavirenz</i>	1-Covered	
<i>efavirenz-emtricitabine-tenofovir disoproxil fumarate</i>	1-Covered	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	1-Covered	
<i>emtricitabine</i>	1-Covered	
<i>emtricitabine-tenofovir disoproxil fumarate</i>	1-Covered	
EMTRIVA 10 MG/ML SOLUTION	1-Covered	
<i>entecavir</i>	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)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
EPIVIR HBV 5 MG/ML SOLUTION	1-Covered	
<i>etravirine</i>	1-Covered	
EVOTAZ	1-Covered	
<i>famciclovir</i>	1-Covered	
<i>fosamprenavir calcium</i>	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	
<i>lamivudine (hbv)</i>	1-Covered	
<i>lamivudine (oral soln 10 mg/ml, tab 150 mg, tab 300 mg)</i>	1-Covered	
<i>lamivudine-zidovudine</i>	1-Covered	
LEXIVA 50 MG/ML SUSPENSION	1-Covered	
<i>lopinavir-ritonavir (soln 400-100 mg/5ml (80-20 mg/ml), tab 100-25 mg, tab 200-50 mg)</i>	1-Covered	
<i>maraviroc</i>	1-Covered	
<i>nevirapine (tab 200 mg, tab er 24hr 100 mg, tab er 24hr 400 mg, 50 mg/5ml suspension)</i>	1-Covered	
NEVIRAPINE ER	1-Covered	
NORVIR (80 MG/ML SOLUTION, 100 MG PACKET)	1-Covered	
ODEFSEY	1-Covered	
<i>oseltamivir phosphate (cap 30 mg (base equiv), cap 45 mg (base equiv), cap 75 mg (base equiv), for susp 6 mg/ml (base equiv))</i>	1-Covered	
PIFELTRO	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
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	
<i>ribavirin (hepatitis c)</i>	1-Covered	
RIMANTADINE HCL	1-Covered	
<i>ritonavir</i>	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	
<i>tenofovir disoproxil fumarate</i>	1-Covered	
TIVICAY	1-Covered	
TIVICAY PD	1-Covered	
TRIUMEQ	1-Covered	
TRIUMEQ PD	1-Covered	
TRIZIVIR	1-Covered	
<i>valacyclovir hcl tab 1 gm</i>	1-Covered	QL (120 PER 30 DAYS)
<i>valacyclovir hcl tab 500 mg</i>	1-Covered	QL (60 PER 30 DAYS)
<i>valganciclovir hcl (for soln 50 mg/ml (base equiv), tab 450 mg (base equivalent))</i>	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	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>zidovudine (cap 100 mg, syrup 10 mg/ml, tab 300 mg)</i>	1-Covered	
<b>CEPHALOSPORINS</b>		
<i>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)</i>	1-Covered	
CEFACLOR ER	1-Covered	
<i>cefadroxil (1 gm tab, cap 500 mg, for susp 250 mg/5ml, for susp 500 mg/5ml, tab 1 gm)</i>	1-Covered	
<i>cefazolin sodium (1 gm recon soln, for inj 1 gm, for inj 10 gm, for inj 500 mg)</i>	1-Covered	
<i>cefdinir (cap 300 mg, for susp 125 mg/5ml, for susp 250 mg/5ml)</i>	1-Covered	
<i>cefepime hcl (1 gm, 2 gm)</i>	1-Covered	
<i>cefixime (cap 400 mg, for susp 100 mg/5ml, for susp 200 mg/5ml)</i>	1-Covered	
<i>cefoxitin sodium</i>	1-Covered	PA
<i>cefpodoxime proxetil (for susp 50 mg/5ml, for susp 100 mg/5ml, tab 100 mg, tab 200 mg)</i>	1-Covered	
<i>cefprozil (for susp 125 mg/5ml, for susp 250 mg/5ml, tab 250 mg, tab 500 mg)</i>	1-Covered	
<i>ceftazidime</i>	1-Covered	PA
<i>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)</i>	1-Covered	
<i>cefuroxime axetil</i>	1-Covered	
<i>cefuroxime sodium</i>	1-Covered	PA
<i>cephalexin (cap 250 mg, cap 500 mg, for susp 125 mg/5ml, for susp 250 mg/5ml)</i>	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

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<b>ERYTHROMYCINS / OTHER MACROLIDES</b>		
<i>azithromycin (1 gm packet, for susp 100 mg/5ml, for susp 200 mg/5ml, tab 250 mg, tab 500 mg, tab 600 mg)</i>	1-Covered	
<i>azithromycin iv for soln 500 mg</i>	1-Covered	PA
<i>clarithromycin (125 mg/5ml recon susp, tab 250 mg, tab 500 mg, tab er 24hr 500 mg, 250 mg/5ml recon susp)</i>	1-Covered	
E.E.S. 400	1-Covered	
ERYTHROCIN LACTOBIONATE	1-Covered	PA
ERYTHROCIN STEARATE	1-Covered	
<i>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)</i>	1-Covered	
ERYTHROMYCIN ETHYLSUCCINATE 400 MG TAB	1-Covered	
<i>erythromycin lactobionate</i>	1-Covered	PA
<b>MISCELLANEOUS ANTIINFECTIVES</b>		
<i>albendazole</i>	1-Covered	
<i>amikacin sulfate inj 500 mg/2ml (250 mg/ml)</i>	1-Covered	PA
ARIKAYCE	1-Covered	PA, LA
<i>atovaquone</i>	1-Covered	
<i>atovaquone-proguanil hcl</i>	1-Covered	
<i>aztreonam (1 gm, 2 gm)</i>	1-Covered	PA
BENZNIDAZOLE	1-Covered	
CAYSTON	1-Covered	PA, LA, QL (84 PER 28 DAYS)
<i>chloroquine phosphate</i>	1-Covered	
<i>clindamycin hcl</i>	1-Covered	
<i>clindamycin palmitate hydrochloride</i>	1-Covered	
<i>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)</i>	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
<i>clindamycin phosphate in d5w</i>	1-Covered	PA
COARTEM	1-Covered	
<i>colistimethate sodium</i>	1-Covered	PA
<i>dapsone</i>	1-Covered	
<i>daptomycin (350 mg recon soln, for iv soln 350 mg, 500 mg recon soln, for iv soln 500 mg)</i>	1-Covered	
EMVERM	1-Covered	
<i>ertapenem sodium</i>	1-Covered	PA, QL (14 PER 14 DAYS)
<i>ethambutol hcl</i>	1-Covered	
<i>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)</i>	1-Covered	PA
<i>gentamicin sulfate inj 40 mg/ml</i>	1-Covered	PA
<i>hydroxychloroquine sulfate tab 200 mg</i>	1-Covered	
<i>imipenem-cilastatin (250 mg recon soln, intravenous for soln 250 mg, intravenous for soln 500 mg)</i>	1-Covered	PA
IMPAVIDO	1-Covered	PA
<i>isoniazid (50 mg/5ml syrup, 100 mg tab, tab 100 mg, tab 300 mg)</i>	1-Covered	
<i>ivermectin tab 3 mg</i>	1-Covered	
<i>linezolid (for susp 100 mg/5ml, tab 600 mg)</i>	1-Covered	
<i>linezolid iv soln 600 mg/300ml (2 mg/ml)</i>	1-Covered	PA
<i>mefloquine hcl</i>	1-Covered	
<i>meropenem iv for soln 1 gm</i>	1-Covered	PA, QL (30 PER 10 DAYS)
<i>meropenem iv for soln 500 mg</i>	1-Covered	PA, QL (10 PER 10 DAYS)
<i>metronidazole (tab 250 mg, tab 500 mg)</i>	1-Covered	
<i>metronidazole iv soln 500 mg/100ml</i>	1-Covered	PA
<i>neomycin sulfate</i>	1-Covered	
<i>nitazoxanide</i>	1-Covered	
<i>paromomycin sulfate</i>	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	
<i>pentamidine isethionate for nebulization soln 300 mg</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (1 PER 28 DAYS)
<i>pentamidine isethionate for soln 300 mg</i>	1-Covered	
<i>praziquantel</i>	1-Covered	
PRIFTIN	1-Covered	
<i>primaquine phosphate (26.3 (15 base) mg tab, tab 26.3 mg (15 mg base))</i>	1-Covered	
<i>pyrazinamide</i>	1-Covered	
<i>pyrimethamine</i>	1-Covered	PA
<i>quinine sulfate</i>	1-Covered	
<i>rifabutin</i>	1-Covered	
<i>rifampin</i>	1-Covered	
SIRTURO	1-Covered	PA, LA
STREPTOMYCIN SULFATE	1-Covered	PA
<i>tigecycline (50 mg recon soln, for iv soln 50 mg)</i>	1-Covered	PA
<i>tinidazole</i>	1-Covered	
TOBI PODHALER	1-Covered	QL (224 PER 28 DAYS)
<i>tobramycin nebu soln 300 mg/4ml</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (224 PER 28 DAYS)
<i>tobramycin nebu soln 300 mg/5ml</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (280 PER 28 DAYS)
<i>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))</i>	1-Covered	PA
TRECTOR	1-Covered	
<i>vancomycin hcl (for iv soln 1 gm (base equivalent), 750 mg recon soln, for iv soln 750 mg (base equivalent))</i>	1-Covered	PA, QL (20 PER 10 DAYS)
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	1-Covered	PA, QL (40 PER 10 DAYS)
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	1-Covered	PA, QL (80 PER 10 DAYS)
<i>vancomycin hcl for iv soln 10 gm (base equivalent)</i>	1-Covered	PA, QL (2 PER 10 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
<i>vancomycin hcl for iv soln 500 mg (base equivalent)</i>	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)
<b>PENICILLINS</b>		
<i>amoxicillin &amp; 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)</i>	1-Covered	
<i>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)</i>	1-Covered	
AMOXICILLIN-POT CLAVULANATE	1-Covered	
AMOXICILLIN-POT CLAVULANATE ER	1-Covered	
AMPICILLIN	1-Covered	
<i>ampicillin &amp; sulbactam sodium</i>	1-Covered	PA
<i>ampicillin sodium (1 gm recon soln, for inj 1 gm, for iv soln 10 gm, 125 mg recon soln)</i>	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
<i>dicloxacillin sodium</i>	1-Covered	
<i>nafcillin sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm, for iv soln 10 gm)</i>	1-Covered	PA
<i>oxacillin sodium</i>	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

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>penicillin g potassium</i>	1-Covered	PA
PENICILLIN G PROCAINE	1-Covered	PA
PENICILLIN G SODIUM	1-Covered	PA
<i>penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, tab 250 mg, tab 500 mg)</i>	1-Covered	
<i>piperacillin sodium-tazobactam sodium</i>	1-Covered	

## QUINOLONES

CIPRO (250 MG/5ML (5%) SUSP, 500 MG/5ML (10%) SUSP)	1-Covered	
<i>ciprofloxacin 200 mg/100ml in d5w</i>	1-Covered	PA
<i>ciprofloxacin hcl (100 mg tab, tab 250 mg (base equiv), tab 500 mg (base equiv), tab 750 mg (base equiv))</i>	1-Covered	
<i>levofloxacin (oral soln 25 mg/ml, tab 250 mg, tab 500 mg, tab 750 mg)</i>	1-Covered	
<i>levofloxacin in d5w (soln 500 mg/100ml, soln 750 mg/150ml)</i>	1-Covered	PA
<i>levofloxacin iv soln 25 mg/ml</i>	1-Covered	PA
MOXIFLOXACIN HCL 400 MG/250ML SOLUTION	1-Covered	PA
MOXIFLOXACIN HCL IN NAACL	1-Covered	PA
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	1-Covered	
<i>ofloxacin (300 mg tab, tab 400 mg)</i>	1-Covered	

## SULFA'S / RELATED AGENTS

<i>sulfadiazine (500 mg tab, tab 500 mg)</i>	1-Covered	
<i>sulfamethoxazole-trimethoprim (susp 200-40 mg/5ml, tab 400-80 mg, tab 800-160 mg)</i>	1-Covered	

## TETRACYCLINES

<i>demeclocycline hcl</i>	1-Covered	
<i>doxycycline (monohydrate) (cap 50 mg, cap 100 mg, for susp 25 mg/5ml, tab 50 mg, tab 75 mg, tab 100 mg)</i>	1-Covered	
<i>doxycycline hyclate (cap 50 mg, cap 100 mg, tab 20 mg, tab 50 mg)</i>	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
<i>doxycycline hyclate for inj 100 mg</i>	1-Covered	PA
<i>minocycline hcl (cap 50 mg, cap 75 mg, cap 100 mg, tab 50 mg, tab 75 mg, tab 100 mg)</i>	1-Covered	
<i>tetracycline hcl</i>	1-Covered	
VIBRAMYCIN 50 MG/5ML SYRUP	1-Covered	

#### URINARY TRACT AGENTS

<i>methenamine hippurate</i>	1-Covered	
<i>nitrofurantoin</i>	1-Covered	
<i>nitrofurantoin macrocrystal (line cap 50 mg, line cap 100 mg)</i>	1-Covered	
<i>nitrofurantoin monohyd macro</i>	1-Covered	
<i>trimethoprim (100 mg tab, tab 100 mg)</i>	1-Covered	

#### ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS

#### ADJUNCTIVE AGENTS

<i>leucovorin calcium (tab 5 mg, tab 10 mg, tab 15 mg, tab 25 mg)</i>	1-Covered	
MESNEX 400 MG TAB	1-Covered	
XGEVA	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>abiraterone acetate tab 250 mg</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
<i>abiraterone acetate tab 500 mg</i>	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)
<i>anastrozole</i>	1-Covered	
AYVAKIT	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
<i>azathioprine tab 50 mg</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
BALVERSA	1-Covered	PA - FOR NEW STARTS ONLY, LA
<i>bexarotene</i>	1-Covered	PA - FOR NEW STARTS ONLY
<i>bexarotene (topical)</i>	1-Covered	PA - FOR NEW STARTS ONLY
<i>bicalutamide</i>	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)
<i>cyclophosphamide (25 mg cap, 25 mg tab, cap 25 mg, 50 mg cap, 50 mg tab, cap 50 mg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine (cap 25 mg, cap 100 mg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine modified (for microemulsion) (cap 25 mg, cap 50 mg, cap 100 mg, oral soln 100 mg/ml)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
DAURISMO 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, 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
DAURISMO 25 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
DROXIA	1-Covered	
EMCYT	1-Covered	
ENVARBUS 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)
<i>erlotinib hcl (tab 100 mg (base equivalent), tab 150 mg (base equivalent))</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>everolimus (immunosuppressant)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>everolimus (tab 2.5 mg, tab 5 mg, tab 7.5 mg, tab 10 mg)</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
<i>everolimus (tab susp 2 mg, tab susp 3 mg, tab susp 5 mg)</i>	1-Covered	PA - FOR NEW STARTS ONLY
<i>exemestane</i>	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)
<i>hydroxyurea</i>	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
<i>imatinib mesylate tab 100 mg (base equivalent)</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
<i>imatinib mesylate tab 400 mg (base equivalent)</i>	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)
<i>lapatinib ditosylate</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
<i>lenalidomide</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (28 PER 28 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
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
<i>letrozole</i>	1-Covered	
LEUKERAN	1-Covered	
<i>leuprolide acetate inj kit 5 mg/ml</i>	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	
<i>megestrol acetate (appetite)</i>	1-Covered	PA
<i>megestrol acetate (tab 20 mg, tab 40 mg)</i>	1-Covered	PA - FOR NEW STARTS ONLY
<i>megestrol acetate susp 40 mg/ml</i>	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
<i>mercaptopurine</i>	1-Covered	
<i>methotrexate sodium (inj 50 mg/2ml (25 mg/ml), inj pf 50 mg/2ml (25 mg/ml), tab 2.5 mg (base equiv))</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate mofetil (cap 250 mg, for oral susp 200 mg/ml, tab 500 mg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate sodium</i>	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)
<i>nilutamide</i>	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)
<i>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))</i>	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)

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

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
SCSEMBLIX 20 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (600 PER 30 DAYS)
SCSEMBLIX 40 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (300 PER 30 DAYS)
SIGNIFOR	1-Covered	PA
<i>sirolimus (oral soln 1 mg/ml, tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
SOLTAMOX	1-Covered	
<i>sorafenib tosylate</i>	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)
<i>sunitinib malate</i>	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
<i>tacrolimus (cap 0.5 mg, cap 1 mg, cap 5 mg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE

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

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)
<i>tamoxifen citrate</i>	1-Covered	
TARGETIN 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
<i>toremifene citrate</i>	1-Covered	
TRELSTAR MIXJECT	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>tretinoin (chemotherapy)</i>	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)

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

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)

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

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)
<i>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)</i>	1-Covered	
CELONTIN	1-Covered	
<i>clobazam (tab 10 mg, tab 20 mg)</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>clobazam suspension 2.5 mg/ml</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (480 PER 30 DAYS)
<i>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)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>clonazepam (orally disintegrating tab 2 mg, tab 2 mg)</i>	1-Covered	QL (300 PER 30 DAYS)
DIACOMIT	1-Covered	PA - FOR NEW STARTS ONLY, LA

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
DIAZEPAM (2.5 MG GEL, 10 MG GEL, 20 MG GEL)	1-Covered	
DILANTIN 30 MG CAP	1-Covered	
<i>divalproex sodium</i>	1-Covered	
EPIDIOLEX	1-Covered	PA - FOR NEW STARTS ONLY, LA
EPRONTIA	1-Covered	PA - FOR NEW STARTS ONLY
<i>ethosuximide (cap 250 mg, soln 250 mg/5ml)</i>	1-Covered	
<i>felbamate (susp 600 mg/5ml, tab 400 mg, tab 600 mg)</i>	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)
<i>gabapentin (cap 100 mg, cap 400 mg)</i>	1-Covered	QL (270 PER 30 DAYS)
<i>gabapentin cap 300 mg</i>	1-Covered	QL (360 PER 30 DAYS)
<i>gabapentin oral soln 250 mg/5ml</i>	1-Covered	QL (2160 PER 30 DAYS)
<i>gabapentin tab 600 mg</i>	1-Covered	QL (180 PER 30 DAYS)
<i>gabapentin tab 800 mg</i>	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)
<i>lacosamide (tab 100 mg, tab 150 mg, tab 200 mg)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>lacosamide oral solution 10 mg/ml</i>	1-Covered	QL (1200 PER 30 DAYS)
<i>lacosamide tab 50 mg</i>	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
<i>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) &amp; 100 mg (7) starter kit, tab 35 x 25 mg starter kit, tab 84 x 25 mg &amp; 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) &amp; 50 mg (14) &amp; 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)</i>	1-Covered	
<i>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)</i>	1-Covered	
NAYZILAM	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
<i>oxcarbazepine (susp 300 mg/5ml (60 mg/ml), tab 150 mg, tab 300 mg, tab 600 mg)</i>	1-Covered	
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>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)</i>	1-Covered	PA - FOR NEW STARTS ONLY
<i>phenytoin (chew tab 50 mg, susp 125 mg/5ml)</i>	1-Covered	
<i>phenytoin sodium extended</i>	1-Covered	
<i>pregabalin (cap 225 mg, cap 300 mg)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>pregabalin (cap 25 mg, cap 50 mg, cap 75 mg, cap 100 mg, cap 150 mg, cap 200 mg)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>pregabalin soln 20 mg/ml</i>	1-Covered	QL (900 PER 30 DAYS)
<i>primidone</i>	1-Covered	
<i>rufinamide (susp 40 mg/ml, tab 200 mg, tab 400 mg)</i>	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
<i>tiagabine hcl</i>	1-Covered	
<i>topiramate (sprinkle cap 15 mg, sprinkle cap 25 mg, tab 25 mg, tab 50 mg, tab 100 mg, tab 200 mg)</i>	1-Covered	PA - FOR NEW STARTS ONLY
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	1-Covered	
<i>valproic acid</i>	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)
<i>vigabatrin</i>	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)
<i>zonisamide</i>	1-Covered	PA - FOR NEW STARTS ONLY
<b>ANTIPARKINSONISM AGENTS</b>		
<i>benztropine mesylate (tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	1-Covered	PA
<i>bromocriptine mesylate</i>	1-Covered	
<i>carbidopa</i>	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
<i>carbidopa-levodopa (carbidopa &amp; levodopa orally disintegrating tab 10-100 mg, carbidopa &amp; levodopa orally disintegrating tab 25-100 mg, carbidopa &amp; levodopa orally disintegrating tab 25-250 mg, carbidopa &amp; levodopa tab 10-100 mg, carbidopa &amp; levodopa tab 25-100 mg, carbidopa &amp; levodopa tab 25-250 mg, carbidopa &amp; levodopa tab er 25-100 mg, carbidopa &amp; 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)</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>entacapone</i>	1-Covered	
KYNMOBI	1-Covered	PA, QL (150 PER 30 DAYS)
NEUPRO	1-Covered	
<i>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)</i>	1-Covered	
<i>rasagiline mesylate</i>	1-Covered	
<i>ropinirole hydrochloride</i>	1-Covered	
<i>selegiline hcl</i>	1-Covered	
<b>MIGRAINE / CLUSTER HEADACHE THERAPY</b>		
AIMOVIG	1-Covered	PA, QL (1 PER 30 DAYS)
AJOVY	1-Covered	PA, QL (1.5 PER 30 DAYS)
<i>dihydroergotamine mesylate nasal spray 4 mg/ml</i>	1-Covered	QL (8 PER 28 DAYS)
<i>eletriptan hydrobromide</i>	1-Covered	QL (18 PER 28 DAYS)
EMGALITY	1-Covered	PA, QL (2 PER 30 DAYS)
<i>ergotamine w/ caffeine</i>	1-Covered	
<i>naratriptan hcl</i>	1-Covered	QL (18 PER 28 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
NURTEC	1-Covered	PA, QL (16 PER 30 DAYS)
<i>rizatriptan benzoate</i>	1-Covered	QL (36 PER 28 DAYS)
<i>sumatriptan nasal spray 20 mg/act</i>	1-Covered	QL (18 PER 28 DAYS)
<i>sumatriptan nasal spray 5 mg/act</i>	1-Covered	QL (36 PER 28 DAYS)
<i>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)</i>	1-Covered	QL (8 PER 28 DAYS)
<i>sumatriptan succinate (tab 25 mg, tab 50 mg, tab 100 mg)</i>	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)
<i>zolmitriptan (orally disintegrating tab 2.5 mg, orally disintegrating tab 5 mg, tab 2.5 mg, tab 5 mg)</i>	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)
<i>dalfampridine</i>	1-Covered	PA, QL (60 PER 30 DAYS)
<i>dimethyl fumarate capsule delayed release 120 mg</i>	1-Covered	PA, QL (14 PER 30 DAYS)
<i>dimethyl fumarate capsule delayed release 240 mg</i>	1-Covered	PA, QL (60 PER 30 DAYS)
<i>dimethyl fumarate capsule dr starter pack 120 mg &amp; 240 mg</i>	1-Covered	PA, QL (120 PER 180 DAYS)
<i>donepezil hydrochloride</i>	1-Covered	
FIRDAPSE	1-Covered	PA, LA
<i>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)</i>	1-Covered	
GILENYA 0.5 MG CAP	1-Covered	PA, QL (30 PER 30 DAYS)
<i>glatiramer acetate soln prefilled syringe 20 mg/ml</i>	1-Covered	PA, QL (30 PER 30 DAYS)
<i>glatiramer acetate soln prefilled syringe 40 mg/ml</i>	1-Covered	PA, QL (12 PER 28 DAYS)

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

DRUG NAME	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)
<i>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)</i>	1-Covered	PA
NAMZARIC	1-Covered	PA
NUEDEXTA	1-Covered	PA
<i>rivastigmine</i>	1-Covered	
<i>rivastigmine tartrate</i>	1-Covered	
<i>tetrabenazine tab 12.5 mg</i>	1-Covered	PA, QL (240 PER 30 DAYS)
<i>tetrabenazine tab 25 mg</i>	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

<i>baclofen (tab 5 mg, tab 10 mg, tab 20 mg)</i>	1-Covered	
<i>cyclobenzaprine hcl (tab 5 mg, tab 10 mg)</i>	1-Covered	PA
<i>dantrolene sodium (cap 25 mg, cap 50 mg, cap 100 mg)</i>	1-Covered	
<i>pyridostigmine bromide (tab 60 mg, tab er 180 mg)</i>	1-Covered	
<i>tizanidine hcl (tab 2 mg (base equivalent), tab 4 mg (base equivalent))</i>	1-Covered	

#### NARCOTIC ANALGESICS

<i>acetaminophen w/ codeine (tab 300-15 mg, tab 300-30 mg)</i>	1-Covered	QL (360 PER 30 OVER TIME)
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	1-Covered	QL (4500 PER 30 OVER TIME)
<i>acetaminophen w/ codeine tab 300-60 mg</i>	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
APAP-CAFF-DIHYDROCODEINE	1-Covered	QL (300 PER 30 OVER TIME)
BELBUCA	1-Covered	PA, QL (60 PER 30 OVER TIME)
<i>buprenorphine</i>	1-Covered	PA, QL (4 PER 28 OVER TIME)
<i>buprenorphine hcl (tab 2 mg (base equiv), tab 8 mg (base equiv))</i>	1-Covered	
<i>fentanyl (patch 12 mcg/hr, patch 25 mcg/hr, patch 50 mcg/hr, patch 75 mcg/hr, patch 100 mcg/hr)</i>	1-Covered	PA, QL (10 PER 30 OVER TIME)
<i>fentanyl citrate (a 200 mcg, a 400 mcg, a 600 mcg, a 800 mcg, a 1200 mcg, a 1600 mcg)</i>	1-Covered	PA, QL (120 PER 30 OVER TIME)
<i>hydrocodone-acetaminophen (tab 5-300 mg, tab 7.5-300 mg, tab 10-300 mg)</i>	1-Covered	QL (390 PER 30 OVER TIME)
<i>hydrocodone-acetaminophen (tab 5-325 mg, tab 7.5-325 mg, tab 10-325 mg)</i>	1-Covered	QL (360 PER 30 OVER TIME)
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	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)
<i>hydromorphone hcl (tab 2 mg, tab 4 mg, tab 8 mg)</i>	1-Covered	QL (180 PER 30 OVER TIME)
<i>hydromorphone hcl (tab er 8 mg, tab er 12 mg, tab er 16 mg, tab er 32 mg)</i>	1-Covered	PA, QL (60 PER 30 OVER TIME)
<i>hydromorphone hcl liqd 1 mg/ml</i>	1-Covered	QL (2400 PER 30 OVER TIME)
HYDROMORPHONE HCL PF 10 MG/ML SOLUTION	1-Covered	QL (240 PER 30 OVER TIME)
<i>hydromorphone hcl preservative free (pf) inj 10 mg/ml</i>	1-Covered	QL (240 PER 30 OVER TIME)
<i>methadone hcl (10 mg/5ml solution, soln 10 mg/5ml)</i>	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)
<i>methadone hcl tab 10 mg</i>	1-Covered	PA, QL (120 PER 30 OVER TIME)
<i>methadone hcl tab 5 mg</i>	1-Covered	PA, QL (240 PER 30 OVER TIME)
<i>morphine sulfate (15 mg tab, tab 15 mg, 30 mg tab, tab 30 mg)</i>	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
<i>morphine sulfate (oral soln 10 mg/5ml, 20 mg/5ml solution, oral soln 20 mg/5ml, oral soln 100 mg/5ml (20 mg/ml))</i>	1-Covered	QL (900 PER 30 OVER TIME)
<i>morphine sulfate (tab er 15 mg, tab er 30 mg, tab er 60 mg, tab er 100 mg, tab er 200 mg)</i>	1-Covered	PA, QL (120 PER 30 OVER TIME)
<i>oxycodone hcl (cap 5 mg, tab 5 mg)</i>	1-Covered	QL (360 PER 30 OVER TIME)
<i>oxycodone hcl (conc 100 mg/5ml (20 mg/ml), tab 10 mg, tab 15 mg, tab 20 mg, tab 30 mg)</i>	1-Covered	QL (180 PER 30 OVER TIME)
<i>oxycodone hcl soln 5 mg/5ml</i>	1-Covered	QL (1200 PER 30 OVER TIME)
<i>oxycodone w/ acetaminophen</i>	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

<i>buprenorphine hcl-naloxone hcl dihydrate (-naloxone film 2-0.5 mg (base equiv), -naloxone tab 2-0.5 mg (base equiv))</i>	1-Covered	QL (360 PER 30 OVER TIME)
<i>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))</i>	1-Covered	QL (90 PER 30 OVER TIME)
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	1-Covered	QL (60 PER 30 OVER TIME)
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	1-Covered	QL (10 PER 28 OVER TIME)
<i>celecoxib</i>	1-Covered	
<i>diclofenac potassium tab 50 mg</i>	1-Covered	
<i>diclofenac sodium</i>	1-Covered	
<i>diclofenac sodium gel 1%</i>	1-Covered	QL (1000 PER 28 OVER TIME)
<i>diclofenac w/ misoprostol</i>	1-Covered	
<i>diflunisal</i>	1-Covered	
<i>etodolac</i>	1-Covered	
<i>flurbiprofen tab 100 mg</i>	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
<i>ibuprofen (susp 100 mg/5ml, tab 400 mg, tab 600 mg, tab 800 mg)</i>	1-Covered	
KLOXXADO	1-Covered	
<i>meloxicam tab 15 mg</i>	1-Covered	
<i>meloxicam tab 7.5 mg</i>	1-Covered	QL (30 PER 30 DAYS)
<i>nabumetone</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>naltrexone hcl</i>	1-Covered	
<i>naproxen (susp 125 mg/5ml, tab 250 mg, tab 375 mg, tab 500 mg, tab ec 375 mg, tab ec 500 mg)</i>	1-Covered	
<i>naproxen sodium (tab 275 mg, tab 550 mg)</i>	1-Covered	
NARCAN	1-Covered	
<i>oxaprozin</i>	1-Covered	
<i>piroxicam</i>	1-Covered	
<i>sulindac</i>	1-Covered	
<i>tramadol hcl tab 50 mg</i>	1-Covered	QL (240 PER 30 OVER TIME)
<i>tramadol-acetaminophen</i>	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)
<i>amitriptyline hcl</i>	1-Covered	
AMOXAPINE	1-Covered	
<i>amphetamine-dextroamphetamine</i>	1-Covered	
<i>aripiprazole (tab 10 mg, tab 15 mg)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>aripiprazole (tab 2 mg, tab 5 mg, tab 10 mg, tab 15 mg, tab 20 mg, tab 30 mg)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>aripiprazole oral solution 1 mg/ml</i>	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
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)
<i>armodafinil</i>	1-Covered	PA
<i>asenapine maleate</i>	1-Covered	QL (60 PER 30 DAYS)
<i>atomoxetine hcl (cap 10 mg (base equiv), cap 18 mg (base equiv), cap 25 mg (base equiv), cap 40 mg (base equiv))</i>	1-Covered	QL (60 PER 30 DAYS)
<i>atomoxetine hcl (cap 60 mg (base equiv), cap 80 mg (base equiv), cap 100 mg (base equiv))</i>	1-Covered	QL (30 PER 30 DAYS)
<i>bupropion hcl (tab 75 mg, tab 100 mg)</i>	1-Covered	
<i>bupropion hcl (tab er 100 mg, tab er 150 mg, tab er 200 mg)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>bupropion hcl tab er 24hr 150 mg</i>	1-Covered	QL (90 PER 30 DAYS)
<i>bupropion hcl tab er 24hr 300 mg</i>	1-Covered	QL (30 PER 30 DAYS)
<i>bupropion hcl</i>	1-Covered	
CAPLYTA	1-Covered	QL (30 PER 30 DAYS)
<i>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)</i>	1-Covered	
<i>citalopram hydrobromide (tab 10 mg (base equiv), tab 20 mg (base equiv), tab 40 mg (base equiv))</i>	1-Covered	QL (30 PER 30 DAYS)
<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	1-Covered	
<i>clomipramine hcl</i>	1-Covered	
<i>clonidine hcl (adhd)</i>	1-Covered	
<i>clorazepate dipotassium tab 15 mg</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
<i>clorazepate dipotassium tab 3.75 mg</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
<i>clorazepate dipotassium tab 7.5 mg</i>	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
<i>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)</i>	1-Covered	
<i>desipramine hcl</i>	1-Covered	
<i>desvenlafaxine succinate</i>	1-Covered	QL (30 PER 30 DAYS)
<i>diazepam (tab 2 mg, tab 5 mg, tab 10 mg)</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
<i>diazepam conc 5 mg/ml</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)
<i>diazepam oral soln 1 mg/ml</i>	1-Covered	PA - FOR NEW STARTS ONLY, QL (1200 PER 30 DAYS)
<i>doxepin hcl (cap 10 mg, cap 25 mg, cap 50 mg, cap 75 mg, cap 100 mg, cap 150 mg, conc 10 mg/ml)</i>	1-Covered	
<i>doxepin hcl (sleep)</i>	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)
<i>duloxetine hcl (cap 20 mg (base eq), cap 30 mg (base eq), cap 60 mg (base eq))</i>	1-Covered	QL (60 PER 30 DAYS)
EMSAM	1-Covered	
<i>escitalopram oxalate (tab 5 mg (base equiv), tab 10 mg (base equiv), tab 20 mg (base equiv))</i>	1-Covered	QL (30 PER 30 DAYS)
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	1-Covered	
<i>eszopiclone</i>	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)
<i>fluoxetine hcl cap 10 mg</i>	1-Covered	QL (30 PER 30 DAYS)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>fluoxetine hcl cap 20 mg</i>	1-Covered	QL (90 PER 30 DAYS)
<i>fluoxetine hcl cap 40 mg</i>	1-Covered	QL (60 PER 30 DAYS)
<i>fluoxetine hcl solution 20 mg/5ml</i>	1-Covered	
<i>fluoxetine hcl tab 10 mg</i>	1-Covered	QL (240 PER 30 DAYS)
<i>fluoxetine hcl tab 20 mg</i>	1-Covered	QL (120 PER 30 DAYS)
<i>fluphenazine decanoate</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>fluvoxamine maleate (cap er 24hr 100 mg, cap er 24hr 150 mg, tab 50 mg)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>fluvoxamine maleate tab 100 mg</i>	1-Covered	QL (90 PER 30 DAYS)
<i>fluvoxamine maleate tab 25 mg</i>	1-Covered	QL (30 PER 30 DAYS)
FORFIVO XL	1-Covered	QL (30 PER 30 DAYS)
<i>haloperidol</i>	1-Covered	
<i>haloperidol decanoate</i>	1-Covered	
<i>haloperidol lactate</i>	1-Covered	
HETLIOZ	1-Covered	PA, QL (30 PER 30 DAYS)
<i>imipramine hcl</i>	1-Covered	
<i>imipramine pamoate</i>	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)

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

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)
<i>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)</i>	1-Covered	
<i>lorazepam (conc 2 mg/ml, tab 2 mg)</i>	1-Covered	PA, QL (150 PER 30 DAYS)
<i>lorazepam (tab 0.5 mg, tab 1 mg)</i>	1-Covered	PA, QL (90 PER 30 DAYS)
<i>loxapine succinate</i>	1-Covered	
MARPLAN	1-Covered	
<i>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)</i>	1-Covered	
<i>mirtazapine</i>	1-Covered	
<i>modafinil</i>	1-Covered	PA
MOLINDONE HCL	1-Covered	
NEFAZODONE HCL	1-Covered	
<i>nortriptyline hcl (10 mg/5ml solution, cap 10 mg, cap 25 mg, cap 50 mg, cap 75 mg)</i>	1-Covered	
NUPLAZID (10 MG TAB, 34 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
<i>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)</i>	1-Covered	QL (30 PER 30 DAYS)

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

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

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>risperidone soln 1 mg/ml</i>	1-Covered	
SECUADO	1-Covered	QL (30 PER 30 DAYS)
<i>sertraline hcl (tab 50 mg, tab 100 mg)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>sertraline hcl oral concentrate for solution 20 mg/ml</i>	1-Covered	
<i>sertraline hcl tab 25 mg</i>	1-Covered	QL (30 PER 30 DAYS)
<i>thioridazine hcl</i>	1-Covered	
<i>thiothixene</i>	1-Covered	
<i>tranylcypromine sulfate</i>	1-Covered	
<i>trazodone hcl</i>	1-Covered	
<i>trifluoperazine hcl</i>	1-Covered	
<i>trimipramine maleate</i>	1-Covered	
TRINTELLIX	1-Covered	QL (30 PER 30 DAYS)
<i>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))</i>	1-Covered	QL (90 PER 30 DAYS)
<i>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))</i>	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)
<i>vilazodone hcl</i>	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)
<i>zaleplon cap 10 mg</i>	1-Covered	QL (60 PER 30 DAYS)
<i>zaleplon cap 5 mg</i>	1-Covered	QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>ziprasidone hcl</i>	1-Covered	QL (60 PER 30 DAYS)
<i>ziprasidone mesylate</i>	1-Covered	
<i>zolidem tartrate (tab 5 mg, tab 10 mg)</i>	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

<i>amiodarone hcl (tab 100 mg, tab 200 mg, tab 400 mg)</i>	1-Covered
<i>dofetilide</i>	1-Covered
<i>flecainide acetate</i>	1-Covered
<i>mexiletine hcl</i>	1-Covered
<i>propafenone hcl</i>	1-Covered
<i>quinidine sulfate (200 mg tab, tab 200 mg, 300 mg tab, tab 300 mg)</i>	1-Covered
<i>sotalol hcl (afib/af)</i>	1-Covered
<i>sotalol hcl (tab 80 mg, tab 120 mg, tab 160 mg, tab 240 mg)</i>	1-Covered

### ANTIHYPERTENSIVE THERAPY

<i>acebutolol hcl</i>	1-Covered
<i>aliskiren fumarate</i>	1-Covered
<i>amiloride &amp; hydrochlorothiazide</i>	1-Covered
<i>amiloride hcl</i>	1-Covered
<i>amlodipine besylate</i>	1-Covered
<i>amlodipine besylate-benazepril hcl</i>	1-Covered
<i>amlodipine besylate-olmesartan medoxomil</i>	1-Covered
<i>amlodipine besylate-valsartan</i>	1-Covered
<i>atenolol</i>	1-Covered
<i>atenolol &amp; chlorthalidone</i>	1-Covered
<i>benazepril &amp; hydrochlorothiazide</i>	1-Covered
<i>benazepril hcl</i>	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
<i>betaxolol hcl</i>	1-Covered	
BIDIL	1-Covered	QL (180 PER 30 DAYS)
<i>bisoprolol &amp; hydrochlorothiazide</i>	1-Covered	
<i>bisoprolol fumarate</i>	1-Covered	
<i>bumetanide (inj 0.25 mg/ml, tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	1-Covered	
BYSTOLIC	1-Covered	
<i>candesartan cilexetil</i>	1-Covered	
<i>candesartan cilexetil-hydrochlorothiazide</i>	1-Covered	
<i>captopril</i>	1-Covered	
<i>carvedilol</i>	1-Covered	
<i>chlorthalidone</i>	1-Covered	
<i>clonidine</i>	1-Covered	QL (4 PER 28 DAYS)
<i>clonidine hcl</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>diltiazem hcl coated beads</i>	1-Covered	
<i>diltiazem hcl extended release beads</i>	1-Covered	
<i>doxazosin mesylate (tab 1 mg, tab 2 mg, tab 4 mg)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>doxazosin mesylate tab 8 mg</i>	1-Covered	QL (60 PER 30 DAYS)
EDARBI	1-Covered	
EDARBYCLOR	1-Covered	
<i>enalapril maleate &amp; hydrochlorothiazide</i>	1-Covered	
<i>enalapril maleate (tab 2.5 mg, tab 5 mg, tab 10 mg, tab 20 mg)</i>	1-Covered	
<i>eplerenone</i>	1-Covered	
<i>ethacrynic acid</i>	1-Covered	
<i>felodipine</i>	1-Covered	
<i>fosinopril sodium</i>	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
<i>fosinopril sodium &amp; hydrochlorothiazide</i>	1-Covered	
<i>furosemide (8 mg/ml solution, inj 10 mg/ml, oral soln 10 mg/ml, tab 20 mg, tab 40 mg, tab 80 mg)</i>	1-Covered	
<i>hydralazine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 100 mg)</i>	1-Covered	
<i>hydrochlorothiazide</i>	1-Covered	
<i>indapamide</i>	1-Covered	
<i>irbesartan</i>	1-Covered	
<i>irbesartan-hydrochlorothiazide</i>	1-Covered	
<i>isosorbide dinitrate-hydralazine hcl</i>	1-Covered	QL (180 PER 30 DAYS)
<i>isradipine</i>	1-Covered	
KERENDIA	1-Covered	PA, QL (30 PER 30 DAYS)
<i>labetalol hcl (tab 100 mg, tab 200 mg, tab 300 mg)</i>	1-Covered	
<i>lisinopril</i>	1-Covered	
<i>lisinopril &amp; hydrochlorothiazide</i>	1-Covered	
<i>losartan potassium</i>	1-Covered	
<i>losartan potassium &amp; hydrochlorothiazide</i>	1-Covered	
<i>metolazone</i>	1-Covered	
<i>metoprolol &amp; hydrochlorothiazide</i>	1-Covered	
<i>metoprolol succinate</i>	1-Covered	
<i>metoprolol tartrate (tab 25 mg, tab 37.5 mg, tab 50 mg, tab 75 mg, tab 100 mg)</i>	1-Covered	
<i>metyrosine</i>	1-Covered	PA
<i>minoxidil</i>	1-Covered	
<i>moexipril hcl</i>	1-Covered	
<i>nadolol</i>	1-Covered	
<i>nebivolol hcl</i>	1-Covered	
<i>nicardipine hcl (cap 20 mg, cap 30 mg)</i>	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
<i>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)</i>	1-Covered	
<i>nimodipine</i>	1-Covered	
<i>nisoldipine</i>	1-Covered	
NISOLDIPINE ER	1-Covered	
<i>olmesartan medoxomil</i>	1-Covered	
<i>olmesartan medoxomil-amlodipine-hydrochlorothiazide</i>	1-Covered	
<i>olmesartan medoxomil-hydrochlorothiazide</i>	1-Covered	
<i>perindopril erbumine</i>	1-Covered	
<i>pindolol</i>	1-Covered	
<i>prazosin hcl</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>quinapril hcl</i>	1-Covered	
<i>quinapril-hydrochlorothiazide</i>	1-Covered	
<i>ramipril</i>	1-Covered	
<i>spironolactone</i>	1-Covered	
<i>spironolactone &amp; hydrochlorothiazide</i>	1-Covered	
<i>telmisartan</i>	1-Covered	
<i>telmisartan-amlodipine</i>	1-Covered	
<i>telmisartan-hydrochlorothiazide</i>	1-Covered	
<i>terazosin hcl (cap 1 mg (base equivalent), cap 2 mg (base equivalent), cap 5 mg (base equivalent))</i>	1-Covered	QL (30 PER 30 DAYS)
<i>terazosin hcl cap 10 mg (base equivalent)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>timolol maleate (tab 5 mg, tab 10 mg, tab 20 mg)</i>	1-Covered	
<i>torseamide</i>	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
<i>trandolapril</i>	1-Covered	
<i>trandolapril-verapamil hcl</i>	1-Covered	
TRANDOLAPRIL-VERAPAMIL HCL ER	1-Covered	
<i>triamterene &amp; hydrochlorothiazide</i>	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
<i>valsartan (tab 40 mg, tab 80 mg, tab 160 mg, tab 320 mg)</i>	1-Covered	
<i>valsartan-hydrochlorothiazide</i>	1-Covered	
<i>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)</i>	1-Covered	
VERAPAMIL HCL ER	1-Covered	
<b>COAGULATION THERAPY</b>		
<i>aspirin-dipyridamole</i>	1-Covered	
BRILINTA	1-Covered	
CABLIVI	1-Covered	PA, LA
<i>cilostazol</i>	1-Covered	
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>dabigatran etexilate mesylate</i>	1-Covered	
<i>dipyridamole (tab 25 mg, tab 50 mg, tab 75 mg)</i>	1-Covered	
DOPTELET	1-Covered	PA, LA
ELIQUIS	1-Covered	
ELIQUIS DVT/PE STARTER PACK	1-Covered	
<i>enoxaparin sodium (soln syr 100 mg/ml, soln syr 150 mg/ml)</i>	1-Covered	QL (28 PER 28 DAYS)
<i>enoxaparin sodium (soln syr 30 mg/0.3ml, soln syr 60 mg/0.6ml)</i>	1-Covered	QL (16.8 PER 28 DAYS)
<i>enoxaparin sodium (soln syr 80 mg/0.8ml, soln syr 120 mg/0.8ml)</i>	1-Covered	QL (22.4 PER 28 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
<i>enoxaparin sodium inj soln pref syr 40 mg/0.4ml</i>	1-Covered	QL (11.2 PER 28 DAYS)
<i>fondaparinux sodium</i>	1-Covered	
<i>heparin sodium (porcine) (1000 unit/ml, 5000 unit/ml, 10000 unit/ml, 20000 unit/ml)</i>	1-Covered	
MULPLETA	1-Covered	PA
<i>pentoxifylline</i>	1-Covered	
<i>prasugrel hcl</i>	1-Covered	
PROMACTA	1-Covered	PA, LA
<i>warfarin sodium</i>	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

<i>amlodipine besylate-atorvastatin calcium</i>	1-Covered	QL (30 PER 30 DAYS)
<i>atorvastatin calcium</i>	1-Covered	QL (30 PER 30 DAYS)
<i>cholestyramine (powder 4 gm/dose, powder packets 4 gm)</i>	1-Covered	
<i>cholestyramine light (powder 4 gm/dose, powder packets 4 gm)</i>	1-Covered	
<i>choline fenofibrate</i>	1-Covered	
<i>colesevelam hcl</i>	1-Covered	
<i>colestipol hcl (granule packets 5 gm, granules 5 gm, tab 1 gm)</i>	1-Covered	
<i>ezetimibe</i>	1-Covered	
<i>ezetimibe-simvastatin</i>	1-Covered	QL (30 PER 30 DAYS)
<i>fenofibrate (tab 48 mg, tab 54 mg, tab 145 mg, tab 160 mg)</i>	1-Covered	
<i>fenofibrate micronized (cap 43 mg, cap 67 mg, cap 134 mg, cap 200 mg)</i>	1-Covered	
<i>fluvastatin sodium cap 20 mg (base equivalent)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>fluvastatin sodium cap 40 mg (base equivalent)</i>	1-Covered	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
<i>gemfibrozil</i>	1-Covered	
<i>icosapent ethyl</i>	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)
<i>lovastatin (tab 20 mg, tab 40 mg)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>lovastatin tab 10 mg</i>	1-Covered	QL (30 PER 30 DAYS)
NEXLETOL	1-Covered	PA
NEXLIZET	1-Covered	PA
<i>niacin (antihyperlipidemic) (500 mg tab, tab er 500 mg (antihyperlipidemic), tab er 750 mg (antihyperlipidemic), tab er 1000 mg (antihyperlipidemic))</i>	1-Covered	
<i>omega-3-acid ethyl esters</i>	1-Covered	
<i>pravastatin sodium</i>	1-Covered	QL (30 PER 30 DAYS)
REPATHA	1-Covered	PA, QL (3 PER 28 DAYS)
REPATHA PUSHRONEX SYSTEM	1-Covered	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	1-Covered	PA, QL (3 PER 28 DAYS)
<i>rosuvastatin calcium</i>	1-Covered	QL (30 PER 30 DAYS)
<i>simvastatin (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg, tab 80 mg)</i>	1-Covered	QL (30 PER 30 DAYS)
VASCEPA	1-Covered	
<b>MISCELLANEOUS CARDIOVASCULAR AGENTS</b>		
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)
<i>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))</i>	1-Covered	
ENTRESTO	1-Covered	QL (60 PER 30 DAYS)
LANOXIN 62.5 MCG TAB	1-Covered	
<i>ranolazine</i>	1-Covered	
VECAMYL	1-Covered	
VERQUVO	1-Covered	QL (30 PER 30 DAYS)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
VYNDAMAX	1-Covered	PA
VYNDAQEL	1-Covered	PA

## NITRATES

<i>isosorbide dinitrate (tab 5 mg, tab 10 mg, tab 20 mg, tab 30 mg)</i>	1-Covered	
<i>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)</i>	1-Covered	
NITRO-BID	1-Covered	
<i>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))</i>	1-Covered	

## DERMATOLOGICALS/TOPICAL THERAPY

### ANTIPSORIATIC / ANTISEBORRHEIC

<i>acitretin</i>	1-Covered	
<i>calcipotriene (cream, oint, soln (50 mcg/ml))</i>	1-Covered	QL (120 PER 30 OVER TIME)
<i>calcipotriene-betamethasone dipropionate</i>	1-Covered	QL (400 PER 30 OVER TIME)
CALCITRIOL 3 MCG/GM OINTMENT	1-Covered	
<i>selenium sulfide lotion 2.5%</i>	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)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>diclofenac sodium (actinic keratoses)</i>	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	
<i>fluorouracil (topical)</i>	1-Covered	
<i>imiquimod cream 5%</i>	1-Covered	
<i>lactic acid (ammonium lactate) (cream, lotion)</i>	1-Covered	
<i>lidocaine hcl (mouth-throat)</i>	1-Covered	
<i>lidocaine hcl soln 4%</i>	1-Covered	
<i>lidocaine oint 5%</i>	1-Covered	QL (36 PER 30 OVER TIME)
<i>lidocaine patch 5%</i>	1-Covered	PA
<i>lidocaine-prilocaine (cream 2.5-2.5%, cream kit 2.5-2.5%)</i>	1-Covered	QL (30 PER 30 OVER TIME)
<i>methoxsalen rapid (10 mg cap, cap 10 mg)</i>	1-Covered	
PANRETIN	1-Covered	PA - FOR NEW STARTS ONLY
<i>pimecrolimus</i>	1-Covered	PA, QL (100 PER 30 OVER TIME)
<i>podofilox</i>	1-Covered	
REGRANEX	1-Covered	
SANTYL	1-Covered	
<i>silver sulfadiazine</i>	1-Covered	
<i>tacrolimus (topical)</i>	1-Covered	PA, QL (100 PER 30 OVER TIME)
VALCHLOR	1-Covered	PA - FOR NEW STARTS ONLY
<b>THERAPY FOR ACNE</b>		
<i>azelaic acid</i>	1-Covered	
<i>clindamycin phosphate (topical) (gel, lotion, soln)</i>	1-Covered	QL (120 PER 30 OVER TIME)
ERY	1-Covered	
<i>erythromycin soln 2%</i>	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
<i>isotretinoin</i>	1-Covered	
<i>ivermectin (rosacea)</i>	1-Covered	
IVERMECTIN 1 % CREAM	1-Covered	
<i>metronidazole (topical) (cream 0.75%, gel 0.75%, gel 1%, lotion 0.75%)</i>	1-Covered	
<i>tazarotene cream 0.1%</i>	1-Covered	PA
TAZORAC (0.05 % CREAM, 0.05 % GEL, 0.1 % GEL)	1-Covered	PA
<i>tretinoin</i>	1-Covered	PA

#### TOPICAL ANTIBACTERIALS

<i>gentamicin sulfate (topical)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>mafenide acetate</i>	1-Covered	
<i>mupirocin</i>	1-Covered	QL (44 PER 30 DAYS)
<i>sulfacetamide sodium (acne)</i>	1-Covered	
SULFAMYLON	1-Covered	

#### TOPICAL ANTIFUNGALS

<i>ciclopirox gel 0.77%</i>	1-Covered	QL (45 PER 28 OVER TIME)
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	1-Covered	QL (90 PER 28 OVER TIME)
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	1-Covered	QL (60 PER 28 OVER TIME)
<i>ciclopirox shampoo 1%</i>	1-Covered	QL (120 PER 28 OVER TIME)
<i>ciclopirox solution 8%</i>	1-Covered	
<i>clotrimazole cream 1%</i>	1-Covered	QL (45 PER 28 OVER TIME)
<i>clotrimazole soln 1%</i>	1-Covered	QL (30 PER 28 OVER TIME)
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	1-Covered	QL (45 PER 28 OVER TIME)
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	1-Covered	QL (60 PER 28 OVER TIME)
<i>econazole nitrate</i>	1-Covered	QL (85 PER 28 OVER TIME)
<i>ketconazole cream 2%</i>	1-Covered	QL (60 PER 28 OVER TIME)
<i>ketconazole shampoo 2%</i>	1-Covered	QL (120 PER 28 OVER TIME)
<i>naftifine hcl (1 % cream, cream 1%, cream 2%)</i>	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)
<i>nystatin (topical) (cream 100000 unit/gm, oint 100000 unit/gm)</i>	1-Covered	QL (30 PER 28 OVER TIME)
<i>nystatin topical powder 100000 unit/gm</i>	1-Covered	QL (180 PER 30 DAYS)
<i>nystatin-triamcinolone</i>	1-Covered	QL (60 PER 28 OVER TIME)
<i>tavaborole</i>	1-Covered	

## TOPICAL ANTIVIRALS

<i>acyclovir oint 5%</i>	1-Covered	PA, QL (30 PER 30 DAYS)
DENAVIR	1-Covered	QL (5 PER 30 DAYS)

## TOPICAL CORTICOSTEROIDS

<i>alclometasone dipropionate</i>	1-Covered	
<i>betamethasone dipropionate (topical) (cream, lotion, oint)</i>	1-Covered	
BETAMETHASONE DIPROPIONATE AUG	1-Covered	
<i>betamethasone dipropionate augmented (cream, lotion, oint)</i>	1-Covered	
<i>betamethasone valerate (cream (base equivalent), lotion (base equivalent), oint (base equivalent))</i>	1-Covered	
<i>clobetasol propionate (cream, gel, oint)</i>	1-Covered	QL (120 PER 28 OVER TIME)
<i>clobetasol propionate (foam, soln)</i>	1-Covered	QL (100 PER 28 OVER TIME)
<i>clobetasol propionate emollient base</i>	1-Covered	QL (120 PER 28 OVER TIME)
<i>clobetasol propionate lotion 0.05%</i>	1-Covered	QL (118 PER 28 OVER TIME)
<i>clobetasol propionate shampoo 0.05%</i>	1-Covered	QL (236 PER 28 OVER TIME)
<i>desonide (cream, gel, lotion, oint)</i>	1-Covered	
<i>fluocinolone acetonide (cream 0.01%, cream 0.025%, oil 0.01% (body oil), oil 0.01% (scalp oil), oint 0.025%, soln 0.01%)</i>	1-Covered	
<i>fluocinonide (cream, gel, oint, soln)</i>	1-Covered	QL (120 PER 30 OVER TIME)
<i>halobetasol propionate (cream, oint)</i>	1-Covered	
<i>hydrocortisone (topical) (cream 1%, cream 2.5%, lotion 2.5%, oint 1%, oint 2.5%)</i>	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
<i>mometasone furoate (cream, oint, solution (lotion))</i>	1-Covered	
PREDNICARBATE	1-Covered	
<i>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%)</i>	1-Covered	
<b>TOPICAL SCABICIDES / PEDICULICIDES</b>		
CROTAN	1-Covered	
<i>malathion</i>	1-Covered	
<i>permethrin</i>	1-Covered	
<b>DIAGNOSTICS / MISCELLANEOUS AGENTS</b>		
<b>MISCELLANEOUS AGENTS</b>		
<i>*sodium polystyrene sulfonate powder**</i>	1-Covered	
<i>acamprosate calcium</i>	1-Covered	
<i>anagrelide hcl</i>	1-Covered	
CARBAGLU	1-Covered	PA, LA
<i>carglumic acid</i>	1-Covered	PA
<i>cevimeline hcl</i>	1-Covered	
CHEMET	1-Covered	PA
CLINIMIX/DEXTROSE (4.25/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>deferasirox</i>	1-Covered	PA
<i>deferiprone (tab 500 mg, tab 1000 mg)</i>	1-Covered	PA
<i>dextrose (5%, 10%)</i>	1-Covered	
<i>dextrose w/ sodium chloride (w/ 0.2%, w/ 0.4, w/ 0.9%)</i>	1-Covered	
DEXTROSE-NACL (2.5-0.45 % SOLUTION, 10-0.2 % SOLUTION, 10-0.45 % SOLUTION)	1-Covered	
<i>disulfiram</i>	1-Covered	
<i>droxidopa</i>	1-Covered	PA
FERRIPROX (100 MG/ML SOLUTION, 500 MG TAB, 1000 MG TAB)	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
FERRIPROX TWICE-A-DAY	1-Covered	PA
INCRELEX	1-Covered	LA
<i>levocarnitine (metabolic modifiers) (oral soln 1 gm/10ml (10%), tab 330 mg)</i>	1-Covered	
LOKELMA	1-Covered	
<i>midodrine hcl</i>	1-Covered	
<i>nitisinone</i>	1-Covered	PA
<i>pilocarpine hcl (oral)</i>	1-Covered	
PROLASTIN-C	1-Covered	PA, LA
RAVICTI	1-Covered	PA
REVCOVI	1-Covered	PA, LA
<i>riluzole</i>	1-Covered	PA
<i>risedronate sodium tab 30 mg</i>	1-Covered	QL (30 PER 30 DAYS)
<i>sevelamer carbonate tab 800 mg</i>	1-Covered	QL (270 PER 30 DAYS)
<i>sodium chloride (gu irrigant)</i>	1-Covered	
<i>sodium chloride (iv soln, preservative free (pf) inj)</i>	1-Covered	
<i>sodium phenylbutyrate (oral powder 3 gm/teaspoonful, tab 500 mg)</i>	1-Covered	PA
SPS	1-Covered	
<i>trientine hcl</i>	1-Covered	PA
VELTASSA	1-Covered	
XURIDEN	1-Covered	PA

#### SMOKING DETERRENENTS

APO-VARENICLINE	1-Covered
<i>bupropion hcl (smoking deterrent)</i>	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
<b>EAR, NOSE / THROAT MEDICATIONS</b>		
<b>MISCELLANEOUS AGENTS</b>		
<i>azelastine hcl</i>	1-Covered	QL (60 PER 30 DAYS)
<i>chlorhexidine gluconate (mouth-throat)</i>	1-Covered	
<i>ipratropium bromide (nasal)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>triamcinolone acetonide (mouth)</i>	1-Covered	
<b>MISCELLANEOUS OTIC PREPARATIONS</b>		
<i>acetic acid (otic)</i>	1-Covered	
CIPROFLOXACIN HCL 0.2 % SOLUTION	1-Covered	
<i>fluocinolone acetonide (otic)</i>	1-Covered	
<i>hydrocortisone w/acetic acid</i>	1-Covered	
<i>ofloxacin (otic)</i>	1-Covered	
<b>OTIC STEROID / ANTIBIOTIC</b>		
<i>ciprofloxacin-dexamethasone</i>	1-Covered	
<i>neomycin-polymyxin-hc (otic)</i>	1-Covered	
<b>ENDOCRINE/DIABETES</b>		
<b>ADRENAL HORMONES</b>		
<i>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)</i>	1-Covered	
<i>fludrocortisone acetate</i>	1-Covered	
<i>hydrocortisone</i>	1-Covered	
<i>methylprednisolone (tab 4 mg, tab 8 mg, tab 16 mg, tab 32 mg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	1-Covered	
<i>prednisolone</i>	1-Covered	
<i>prednisolone sodium phosphate (sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base), 25 mg/5ml solution)</i>	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
<i>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))</i>	1-Covered	
PREDNISONE INTENSOL	1-Covered	
<b>ANTITHYROID AGENTS</b>		
<i>methimazole</i>	1-Covered	
<i>propylthiouracil</i>	1-Covered	
<b>DIABETES THERAPY</b>		
<i>acarbose tab 100 mg</i>	1-Covered	QL (90 PER 30 DAYS)
<i>acarbose tab 25 mg</i>	1-Covered	QL (360 PER 30 DAYS)
<i>acarbose tab 50 mg</i>	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)
<i>diazoxide</i>	1-Covered	
FARXIGA 10 MG TAB	1-Covered	QL (30 PER 30 DAYS)
FARXIGA 5 MG TAB	1-Covered	QL (60 PER 30 DAYS)
<i>glimepiride tab 1 mg</i>	1-Covered	QL (240 PER 30 DAYS)
<i>glimepiride tab 2 mg</i>	1-Covered	QL (120 PER 30 DAYS)
<i>glimepiride tab 4 mg</i>	1-Covered	QL (60 PER 30 DAYS)
<i>glipizide (tab 10 mg, tab er 24hr 5 mg)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>glipizide (tab 5 mg, tab er 24hr 2.5 mg)</i>	1-Covered	QL (240 PER 30 DAYS)
<i>glipizide tab er 24hr 10 mg</i>	1-Covered	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
<i>glipizide-metformin hcl (tab 2.5-500 mg, tab 5-500 mg)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	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	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>metformin hcl tab 1000 mg</i>	1-Covered	QL (75 PER 30 DAYS)
<i>metformin hcl tab 500 mg</i>	1-Covered	QL (150 PER 30 DAYS)
<i>metformin hcl tab 850 mg</i>	1-Covered	QL (90 PER 30 DAYS)
<i>metformin hcl tab er 24hr 500 mg</i>	1-Covered	QL (120 PER 30 DAYS)
<i>metformin hcl tab er 24hr 750 mg</i>	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)
<i>nateglinide tab 120 mg</i>	1-Covered	QL (90 PER 30 DAYS)
<i>nateglinide tab 60 mg</i>	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	
<i>pioglitazone hcl</i>	1-Covered	QL (30 PER 30 DAYS)
PRO COMFORT PEN NEEDLES	1-Covered	
QTERN	1-Covered	QL (30 PER 30 DAYS)
<i>repaglinide tab 0.5 mg</i>	1-Covered	QL (960 PER 30 DAYS)
<i>repaglinide tab 1 mg</i>	1-Covered	QL (480 PER 30 DAYS)
<i>repaglinide tab 2 mg</i>	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)

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

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)
<i>cabergoline</i>	1-Covered	
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	1-Covered	
<i>calcitriol (cap 0.25 mcg, cap 0.5 mcg, oral soln 1 mcg/ml)</i>	1-Covered	
CERDELGA	1-Covered	PA
<i>cinacalcet hcl</i>	1-Covered	PA
<i>danazol</i>	1-Covered	
<i>desmopressin acetate (tab 0.1 mg, tab 0.2 mg)</i>	1-Covered	
<i>desmopressin acetate spray</i>	1-Covered	
<i>desmopressin acetate spray refrigerated</i>	1-Covered	
<i>doxercalciferol (cap 0.5 mcg, cap 1 mcg, cap 2.5 mcg)</i>	1-Covered	
KORLYM	1-Covered	PA
<i>miglustat</i>	1-Covered	PA, LA

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
MYALEPT	1-Covered	PA, LA
NATPARA	1-Covered	PA, LA
<i>oxandrolone</i>	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)
<i>paricalcitol (cap 1 mcg, cap 2 mcg, cap 4 mcg)</i>	1-Covered	
SAMSCA 15 MG TAB	1-Covered	PA
<i>sapropterin dihydrochloride</i>	1-Covered	PA
SOMAVERT	1-Covered	PA
SYNAREL	1-Covered	PA
<i>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%))</i>	1-Covered	PA, QL (300 PER 30 DAYS)
<i>testosterone (gel 20.25 mg/act (1.62%), gel 40.5 mg/2.5gm (1.62%))</i>	1-Covered	PA, QL (150 PER 30 DAYS)
<i>testosterone cypionate (im inj in oil 100 mg/ml, 200 mg/ml solution, im inj in oil 200 mg/ml)</i>	1-Covered	PA
<i>testosterone enanthate (200 mg/ml solution, im inj in oil 200 mg/ml)</i>	1-Covered	PA - FOR NEW STARTS ONLY
<i>testosterone td gel 10mg/act (2%)</i>	1-Covered	PA, QL (120 PER 30 DAYS)
<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i>	1-Covered	PA, QL (37.5 PER 30 DAYS)
<i>testosterone td soln 30 mg/act</i>	1-Covered	PA, QL (180 PER 30 DAYS)
<i>tolvaptan (15 mg tab, tab 15 mg, tab 30 mg)</i>	1-Covered	PA

## THYROID HORMONES

<i>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)</i>	1-Covered	
<i>liothyronine sodium (tab 5 mcg, tab 25 mcg, tab 50 mcg)</i>	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
<b>GASTROENTEROLOGY</b>		
<b>ANTIDIARRHEALS / ANTISPASMODICS</b>		
<i>dicyclomine hcl (cap 10 mg, oral soln 10 mg/5ml, tab 20 mg)</i>	1-Covered	
<i>diphenoxylate w/ atropine</i>	1-Covered	
DIPHENOXYLATE-ATROPINE	1-Covered	
<i>glycopyrrolate (tab 1 mg, 1.5 mg tab, tab 2 mg)</i>	1-Covered	
<i>loperamide hcl</i>	1-Covered	
<b>MISCELLANEOUS GASTROINTESTINAL AGENTS</b>		
<i>alosetron hcl</i>	1-Covered	PA
<i>aprepitant</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>balsalazide disodium</i>	1-Covered	
<i>betaine</i>	1-Covered	
<i>budesonide</i>	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	
<i>cromolyn sodium (mastocytosis)</i>	1-Covered	
CYSTADANE	1-Covered	
DIPENTUM	1-Covered	
<i>dronabinol</i>	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	
<i>granisetron hcl tab 1 mg</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>hydrocortisone (intrarectal)</i>	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
<i>hydrocortisone (rectal)</i>	1-Covered	
<i>lactulose (encephalopathy)</i>	1-Covered	
<i>lactulose solution 10 gm/15ml</i>	1-Covered	
LINZESS	1-Covered	QL (30 PER 30 DAYS)
<i>meclizine hcl (tab 12.5 mg, tab 25 mg)</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>mesalamine w/ cleanser</i>	1-Covered	
<i>metoclopramide hcl (soln 5 mg/5ml (10 mg/10ml) (base equiv), tab 5 mg (base equivalent), tab 10 mg (base equivalent))</i>	1-Covered	
MOTEGRITY	1-Covered	ST, QL (30 PER 30 DAYS)
MOVANTIK	1-Covered	QL (30 PER 30 DAYS)
OICALIVA	1-Covered	PA, LA, QL (30 PER 30 DAYS)
<i>ondansetron</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ondansetron hcl (oral soln 4 mg/5ml, tab 4 mg, tab 8 mg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1-Covered	
<i>peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid</i>	1-Covered	
<i>peg 3350-potassium chloride-sod bicarbonate-sod chloride</i>	1-Covered	
PENTASA	1-Covered	
<i>prochlorperazine</i>	1-Covered	
<i>prochlorperazine maleate</i>	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	
<i>scopolamine</i>	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
<i>sulfasalazine</i>	1-Covered	
TRULANCE	1-Covered	
<i>ursodiol (cap 300 mg, tab 250 mg, tab 500 mg)</i>	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

<i>cimetidine</i>	1-Covered	
<i>cimetidine hcl (300 mg/5ml solution, soln 300 mg/5ml)</i>	1-Covered	
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	1-Covered	
<i>famotidine (for susp 40 mg/5ml, tab 20 mg, tab 40 mg)</i>	1-Covered	
<i>lansoprazole cap delayed release 15 mg</i>	1-Covered	QL (30 PER 30 DAYS)
<i>lansoprazole cap delayed release 30 mg</i>	1-Covered	
<i>misoprostol</i>	1-Covered	
NIZATIDINE (150 MG CAP, CAP 150 MG, 300 MG CAP, CAP 300 MG)	1-Covered	
<i>omeprazole (cap 10 mg, cap 20 mg)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>omeprazole cap delayed release 40 mg</i>	1-Covered	
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1-Covered	
<i>sucralfate (susp 1 gm/10ml, tab 1 gm)</i>	1-Covered	

## IMMUNOLOGY, VACCINES / BIOTECHNOLOGY

### BIOTECHNOLOGY DRUGS

ACTIMMUNE	1-Covered	PA - TO CONFIRM PART D COVERAGE
ARCALYST	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
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
<b>MUSCULOSKELETAL / RHEUMATOLOGY</b>		
<b>GOUT THERAPY</b>		
<i>allopurinol (tab 100 mg, tab 300 mg)</i>	1-Covered	
<i>colchicine tab 0.6 mg</i>	1-Covered	
<i>colchicine w/ probenecid</i>	1-Covered	
<i>febuxostat</i>	1-Covered	
<i>probenecid</i>	1-Covered	
<b>OSTEOPOROSIS THERAPY</b>		
<i>alendronate sodium (70 mg/75ml solution, oral soln 70 mg/75ml)</i>	1-Covered	QL (300 PER 28 DAYS)
<i>alendronate sodium (tab 35 mg, tab 70 mg)</i>	1-Covered	QL (4 PER 28 DAYS)
<i>alendronate sodium tab 10 mg</i>	1-Covered	QL (30 PER 30 DAYS)
FOSAMAX PLUS D	1-Covered	ST, QL (4 PER 28 DAYS)
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	1-Covered	QL (1 PER 30 DAYS)
PROLIA	1-Covered	PA, QL (1 PER 180 OVER TIME)
<i>raloxifene hcl</i>	1-Covered	
<i>risedronate sodium (tab 35 mg, tab delayed release 35 mg)</i>	1-Covered	QL (4 PER 28 DAYS)
<i>risedronate sodium tab 150 mg</i>	1-Covered	QL (1 PER 30 DAYS)
<i>risedronate sodium tab 5 mg</i>	1-Covered	QL (30 PER 30 DAYS)
TERIPARATIDE (RECOMBINANT)	1-Covered	PA, QL (2.48 PER 28 DAYS)
<b>OTHER RHEUMATOLOGICALS</b>		
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)

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

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/UEIT STARTER	1-Covered	PA, QL (3 PER 180 DAYS)
<i>leflunomide</i>	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)
<i>penicillamine tab 250 mg</i>	1-Covered	PA
RIDAURA	1-Covered	
RINVOO (15 MG TAB ER, 30 MG TAB ER)	1-Covered	PA, QL (30 PER 30 DAYS)
RINVOO 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
<b>OBSTETRICS / GYNECOLOGY</b>		
<b>ESTROGENS / PROGESTINS</b>		
CRINONE 4 % GEL	1-Covered	
CRINONE 8 % GEL	1-Covered	PA
DEPO-SUBQ PROVERA 104	1-Covered	
DUAVEE	1-Covered	
<i>estradiol &amp; norethindrone acetate</i>	1-Covered	PA
<i>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)</i>	1-Covered	PA, QL (4 PER 28 DAYS)
<i>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)</i>	1-Covered	PA, QL (8 PER 28 DAYS)
<i>estradiol (tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	1-Covered	PA
<i>estradiol vaginal (cream 0.1 mg/gm, tab 10 mcg)</i>	1-Covered	
<i>estradiol valerate</i>	1-Covered	
ESTRING	1-Covered	
<i>medroxyprogesterone acetate</i>	1-Covered	
<i>medroxyprogesterone acetate (contraceptive)</i>	1-Covered	
MENEST (0.3 MG TAB, 0.625 MG TAB, 1.25 MG TAB)	1-Covered	PA
<i>norethindrone (contraceptive)</i>	1-Covered	
<i>norethindrone acetate</i>	1-Covered	
<i>norethindrone acetate-ethinyl estradiol</i>	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	
<i>progesterone (cap 100 mg, cap 200 mg)</i>	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
<b>MISCELLANEOUS OB/GYN</b>		
CLEOCIN 100 MG SUPPOS	1-Covered	
<i>clindamycin phosphate vaginal</i>	1-Covered	
<i>etonogestrel-ethinyl estradiol</i>	1-Covered	
<i>metronidazole vaginal</i>	1-Covered	
<i>norelgestromin-ethinyl estradiol</i>	1-Covered	
<i>terconazole vaginal (cream 0.4%, cream 0.8%, suppos 80 mg)</i>	1-Covered	
<i>tranexamic acid tab 650 mg</i>	1-Covered	
VANDAZOLE	1-Covered	
<b>ORAL CONTRACEPTIVES / RELATED AGENTS</b>		
<i>desogestrel &amp; ethinyl estradiol</i>	1-Covered	
<i>desogestrel-ethinyl estradiol (biphasic)</i>	1-Covered	
<i>drospirenone-ethinyl estradiol</i>	1-Covered	
<i>ethynodiol diacet &amp; eth estrad</i>	1-Covered	
<i>levonorgestrel &amp; eth estradiol</i>	1-Covered	
<i>levonorgestrel-eth estradiol (triphasic)</i>	1-Covered	
<i>levonorgestrel-ethinyl estradiol (91-day)</i>	1-Covered	
<i>levonorgestrel-ethinyl estradiol (continuous)</i>	1-Covered	
<i>norethin acet &amp; estrad-fe (ace-ethinyl tab 1 mg-20 mcg (24), aceethinyl tab 1 mg-20 mcg, aceethinyl tab 1.5 mg-30 mcg)</i>	1-Covered	
<i>norethindrone &amp; eth estradiol (tab 0.5 mcg, tab 1 mcg)</i>	1-Covered	
<i>norethindrone acet &amp; eth estra</i>	1-Covered	
<i>norethindrone acetate-ethinyl estradiol-fe</i>	1-Covered	
<i>norethindrone-eth estradiol (triphasic)</i>	1-Covered	
<i>norgestimate-ethinyl estradiol</i>	1-Covered	
<i>norgestimate-ethinyl estradiol (triphasic)</i>	1-Covered	
<i>norgestrel &amp; ethinyl estradiol</i>	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
VELIVET	1-Covered	

## OPHTHALMOLOGY

### ANTIBIOTICS

AZASITE	1-Covered	
BACITRACIN 500 UNIT/GM OINTMENT	1-Covered	
<i>bacitracin-polymyxin b (ophth)</i>	1-Covered	
BESIVANCE	1-Covered	
<i>ciprofloxacin hcl (ophth)</i>	1-Covered	
<i>erythromycin (ophth)</i>	1-Covered	QL (3.5 PER 14 DAYS)
<i>gatifloxacin (ophth)</i>	1-Covered	
GENTAK	1-Covered	QL (3.5 PER 30 DAYS)
<i>gentamicin sulfate (ophth)</i>	1-Covered	QL (70 PER 30 DAYS)
<i>levofloxacin (ophth)</i>	1-Covered	
MOXIFLOXACIN HCL (2X DAY)	1-Covered	
<i>moxifloxacin hcl (ophth)</i>	1-Covered	
NATACYN	1-Covered	
<i>neomycin-bacitracin zn-polymyxin</i>	1-Covered	
NEOMYCIN-POLYMYXIN-GRAMICIDIN	1-Covered	
NEOSPORIN	1-Covered	
<i>ofloxacin (ophth)</i>	1-Covered	
<i>polymyxin b-trimethoprim</i>	1-Covered	
<i>tobramycin (ophth)</i>	1-Covered	QL (10 PER 14 DAYS)

### ANTIVIRALS

TRIFLURIDINE	1-Covered	
ZIRGAN	1-Covered	

### BETA-BLOCKERS

<i>betaxolol hcl (ophth)</i>	1-Covered	
CARTEOLOL HCL	1-Covered	
<i>levobunolol hcl (0.5 % solution, ophth soln 0.5%)</i>	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
TIMOLOL MALEATE (0.25 % GEL F SOLN, 0.5 % GEL F SOLN)	1-Covered	
<i>timolol maleate (ophth) (gel forming soln 0.25%, gel forming soln 0.5%, soln 0.25%, soln 0.5%)</i>	1-Covered	
<b>MISCELLANEOUS OPHTHALMOLOGICS</b>		
ATROPINE SULFATE 1 % SOLUTION	1-Covered	
<i>atropine sulfate ophth soln 1%</i>	1-Covered	
<i>azelastine hcl (ophth)</i>	1-Covered	
<i>bepotastine besilate</i>	1-Covered	
BLEPHAMIDE S.O.P.	1-Covered	
<i>cromolyn sodium (ophth)</i>	1-Covered	
<i>cyclosporine (ophth)</i>	1-Covered	QL (60 PER 30 DAYS)
CYSTARAN	1-Covered	PA
<i>epinastine hcl (ophth)</i>	1-Covered	
<i>olopatadine hcl</i>	1-Covered	
OXERVATE	1-Covered	PA
<i>pilocarpine hcl</i>	1-Covered	
RESTASIS	1-Covered	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	1-Covered	QL (5.5 PER 30 DAYS)
<i>sulfacetamide sod-prednisolone</i>	1-Covered	
<i>sulfacetamide sodium (ophth)</i>	1-Covered	
SULFACETAMIDE SODIUM 10 % OINTMENT	1-Covered	
SULFACETAMIDE-PREDNISOLONE	1-Covered	
XIIDRA	1-Covered	QL (60 PER 30 DAYS)
<b>NON-STEROIDAL ANTI-INFLAMMATORY AGENTS</b>		
<i>bromfenac sodium (ophth)</i>	1-Covered	
BROMSITE	1-Covered	
<i>diclofenac sodium (ophth)</i>	1-Covered	
<i>flurbiprofen sodium (0.03 % solution, ophth soln 0.03%)</i>	1-Covered	
<i>ketorolac tromethamine (ophth)</i>	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	
<b>ORAL DRUGS FOR GLAUCOMA</b>		
<i>acetazolamide</i>	1-Covered	
<i>methazolamide</i>	1-Covered	
<b>OTHER GLAUCOMA DRUGS</b>		
<i>brimonidine tartrate-timolol maleate</i>	1-Covered	
COMBIGAN	1-Covered	
<i>dorzolamide hcl ophth soln 2%</i>	1-Covered	
<i>dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml</i>	1-Covered	
<i>latanoprost ophth soln 0.005%</i>	1-Covered	
LUMIGAN	1-Covered	
RHOPRESSA	1-Covered	
ROCKLATAN	1-Covered	
SIMBRINZA	1-Covered	
<i>travoprost</i>	1-Covered	
<b>STEROID-ANTIBIOTIC COMBINATIONS</b>		
<i>bacitracin-poly-neomycin-hc</i>	1-Covered	
<i>neomycin-polymy-dexameth (oint, susp)</i>	1-Covered	
NEOMYCIN-POLYMYXIN-HC	1-Covered	
TOBRADEX 0.3-0.1 % OINTMENT	1-Covered	QL (3.5 PER 14 DAYS)
<i>tobramycin-dexamethasone</i>	1-Covered	QL (10 PER 14 DAYS)
<b>STEROIDS</b>		
ALREX	1-Covered	
DEXAMETHASONE SODIUM PHOSPHATE 0.1 % SOLUTION	1-Covered	
EYSUVIS	1-Covered	PA, QL (8.3 PER 14 DAYS)
<i>fluorometholone (ophth)</i>	1-Covered	
INVELTYS	1-Covered	
<i>loteprednol etabonate (gel, susp)</i>	1-Covered	
PREDNISOLONE ACETATE	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
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	1-Covered	
<b>SYMPATHOMIMETICS</b>		
ALPHAGAN P 0.1 % SOLUTION	1-Covered	
<i>apraclonidine hcl</i>	1-Covered	
<i>brimonidine tartrate</i>	1-Covered	
IOPIDINE 1 % SOLUTION	1-Covered	
<b>RESPIRATORY AND ALLERGY</b>		
<b>ANTI-HISTAMINE / ANTI-ALLERGENIC AGENTS</b>		
<i>cetirizine hcl</i>	1-Covered	
<i>epinephrine (anaphylaxis) (solution 0.15 mg/0.3ml (1:2000), solution 0.3 mg/0.3ml (1:1000))</i>	1-Covered	QL (2 PER 30 DAYS)
<i>hydroxyzine hcl (tab 10 mg, tab 25 mg, tab 50 mg)</i>	1-Covered	PA
<i>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</i>	1-Covered	
<i>levocetirizine dihydrochloride tab 5 mg</i>	1-Covered	QL (30 PER 30 DAYS)
<i>promethazine hcl (syrup 6.25 mg/5ml, tab 12.5 mg, tab 25 mg, tab 50 mg)</i>	1-Covered	PA
SYMJEPI	1-Covered	QL (2 PER 30 DAYS)
<b>PULMONARY AGENTS</b>		
<i>acetylcysteine</i>	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)
<i>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))</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>albuterol sulfate (syrup 2 mg/5ml, tab 2 mg, tab 4 mg)</i>	1-Covered	
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</i>	1-Covered	QL (17 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
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)
<i>ambrisentan</i>	1-Covered	PA, LA
<i>arformoterol tartrate</i>	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)
<i>bosentan</i>	1-Covered	PA, LA
BREO ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE	1-Covered	QL (10.7 PER 30 DAYS)
<i>budesonide (inhalation) (susp 0.25 mg/2ml, susp 0.5 mg/2ml)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (120 PER 30 DAYS)
<i>budesonide inhalation susp 1 mg/2ml</i>	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)
<i>cromolyn sodium</i>	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)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>flunisolide (nasal)</i>	1-Covered	QL (50 PER 30 DAYS)
<i>fluticasone propionate (nasal)</i>	1-Covered	QL (16 PER 30 DAYS)
<i>formoterol fumarate</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>icatibant acetate</i>	1-Covered	PA
<i>ipratropium bromide</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ipratropium-albuterol</i>	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)
<i>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))</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>mometasone furoate (nasal)</i>	1-Covered	QL (34 PER 30 DAYS)
<i>montelukast sodium</i>	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
<i>pirfenidone tab 267 mg</i>	1-Covered	PA, QL (270 PER 30 DAYS)
<i>pirfenidone tab 801 mg</i>	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)

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>sildenafil citrate tab 20 mg</i>	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)
<i>tadalafil (pulmonary hypertension)</i>	1-Covered	PA, QL (60 PER 30 DAYS)
<i>terbutaline sulfate (tab 2.5 mg, tab 5 mg)</i>	1-Covered	
THEO-24	1-Covered	
<i>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)</i>	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)
<i>zafirlukast</i>	1-Covered	
ZYFLO	1-Covered	

## UROLOGICALS

### ANTICHOLINERGICS / ANTISPASMODICS

<i>fesoterodine fumarate</i>	1-Covered
<i>flavoxate hcl</i>	1-Covered
MYRBETRIQ (8 MG/ML SRER, 25 MG TAB ER 24H, 50 MG TAB ER 24H)	1-Covered
<i>oxybutynin chloride (syrup 5 mg/5ml, tab 5 mg, tab er 24hr 10 mg, tab er 24hr 15 mg, tab er 24hr 5 mg)</i>	1-Covered
<i>tolterodine tartrate</i>	1-Covered
TOVIAZ	1-Covered
<i>tropium chloride tab 20 mg</i>	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
<b>BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY</b>		
<i>alfuzosin hcl</i>	1-Covered	
<i>dutasteride</i>	1-Covered	
<i>dutasteride-tamsulosin hcl</i>	1-Covered	
<i>finasteride</i>	1-Covered	
<i>silodosin</i>	1-Covered	
<i>tamsulosin hcl</i>	1-Covered	
<b>MISCELLANEOUS UROLOGICALS</b>		
<i>bethanechol chloride</i>	1-Covered	
CYSTAGON	1-Covered	PA, LA
ELMIRON	1-Covered	
<i>potassium citrate (alkalinizer)</i>	1-Covered	
<b>VITAMINS, HEMATINICS / ELECTROLYTES</b>		
<b>ELECTROLYTES</b>		
<i>calcium acetate (phosphate binder)</i>	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	
<i>magnesium sulfate inj 50%</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>potassium chloride 20 meq/l (0.15%) in dextrose 5% inj</i>	1-Covered	
POTASSIUM CHLORIDE ER	1-Covered	
<i>potassium chloride in dextrose &amp; sodium chloride</i>	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
POTASSIUM CHLORIDE IN NA <sub>2</sub> CO <sub>3</sub> (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	
<i>potassium chloride microencapsulated crystals er</i>	1-Covered	
<i>sodium chloride (soln 0.45%, soln 3%, soln 5%)</i>	1-Covered	

#### MISCELLANEOUS NUTRITION PRODUCTS

<i>amino acid infusion</i>	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	

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

DRUG NAME	TIER	REQUIREMENTS/LIMITS
CITRANATAL BLOOM	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	
<i>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)</i>	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	

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

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	

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

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abacavir sulfate	3	alosetron hcl	56
abacavir sulfate-lamivudine	3	ALPHAGAN P	68
ABELCET	2	ALREX	67
ABILIFY MAINTENA	30	ALUNBRIG	12
abiraterone acetate	12	ALVESCO	69
acamprosate calcium	48	amantadine hcl	3
acarbose	51	AMBISOME	2
acebutolol hcl	37	ambrisentan	69
acetaminophen w/ codeine	27	amikacin sulfate	7
acetazolamide	67	amiloride & hydrochlorothiazide	37
acetic acid (otic)	50	amiloride hcl	37
acetylcysteine	68	amino acid infusion	73
acitretin	44	amiodarone hcl	37
ACTEMRA	61	amitriptyline hcl	30
ACTEMRA ACTPEN	61	amlodipine besylate	37
ACTHIB	59	amlodipine besylate-atorvastatin calcium	42
ACTIMMUNE	58	amlodipine besylate-benazepril hcl	37
acyclovir	3	amlodipine besylate-olmesartan medoxomil	37
acyclovir sodium	3	amlodipine besylate-valsartan	37
acyclovir topical	47	AMOXAPINE	30
ADACEL	59	amoxicillin	10
ADBRY	44	amoxicillin & pot clavulanate	10
adefovir dipivoxil	3	AMOXICILLIN-POT CLAVULANATE	10
ADEMPAS	68	AMOXICILLIN-POT CLAVULANATE ER	10
ADVAIR DISKUS	68	amphetamine-dextroamphetamine	30
ADVAIR HFA	68	AMPHOTERICIN B	2
AFINITOR	12	AMPICILLIN	10
AFINITOR DISPERZ	12	ampicillin & sulbactam sodium	10
AIMOVIG	25	AMPICILLIN SODIUM	10
AJOVY	25	AMPICILLIN-SULBACTAM SODIUM	10
albendazole	7	anagrelide hcl	48
albuterol sulfate	68	anastrozole	12
alclometasone dipropionate	47	ANDRODERM	54
ALCOH-GLOVE CONTOURED WIPE	51	APAP-CAFF-DIHYDROCODEINE	28
ALECENSA	12	APO-VARENICLINE	49
alendronate sodium	61	apraclonidine hcl	68
alfuzosin hcl	72	aprepitant	56
aliskiren fumarate	37	APTIOM	21
allopurinol	61	APTIVUS	3
		ARCALYST	58
		arformoterol tartrate	69

ARIKAYCE	7	bacitracin-polymyxin b (ophth)	65
aripiprazole	30	baclofen	27
ARISTADA	31	BAFIERTAM	26
ARISTADA INITIO	31	BAL-CARE DHA	73
armodafinil	31	balsalazide disodium	56
ARNUITY ELLIPTA	69	BALVERSA	13
asenapine maleate	31	BAQSIMI ONE PACK	51
ASMANEX (120 METERED DOSES)	69	BAQSIMI TWO PACK	51
ASMANEX (30 METERED DOSES)	69	BARACLUDE	3
ASMANEX (60 METERED DOSES)	69	BCG VACCINE	59
ASMANEX HFA	69	BD INSULIN SYRINGE U-500	51
aspirin-dipyridamole	41	BD PEN NEEDLE NANO U/F	51
ASSURE ID INSULIN SAFETY SYR	51	BD SAFETYGLIDE INSULIN SYRINGE	51
ATABEX EC	73	BELBUCA	28
atazanavir sulfate	3	benazepril & hydrochlorothiazide	37
atenolol	37	benazepril hcl	37
atenolol & chlorthalidone	37	BENLYSTA	61
atomoxetine hcl	31	BENZNIDAZOLE	7
atorvastatin calcium	42	benztropine mesylate	24
atovaquone	7	bepotastine besilate	66
atovaquone-proguanil hcl	7	BESIVANCE	65
ATROPINE SULFATE	66	BESREMI	59
atropine sulfate (ophthalmic)	66	betaine	56
ATROVENT HFA	69	betamethasone dipropionate (topical)	47
AUBAGIO	26	BETAMETHASONE DIPROPIONATE AUG	47
AVONEX PEN	59	betamethasone dipropionate augmented	47
AVONEX PREFILLED	59	betamethasone valerate	47
AYVAKIT	12	BETASERON	59
AZASITE	65	betaxolol hcl	38
azathioprine	13	betaxolol hcl (ophth)	65
azelaic acid	45	bethanechol chloride	72
azelastine hcl	50	bexarotene	13
azelastine hcl (ophth)	66	bexarotene (topical)	13
AZESCHEW PRENATAL/POSTNATAL	73	BEXSERO	59
AZESCO	73	bicalutamide	13
azithromycin	7	BICILLIN C-R	10
aztreonam	7	BICILLIN C-R 900/300	10
		BICILLIN L-A	10
<b>B</b>		BIDIL	38
BACITRACIN	65	BIKTARVY	3
bacitracin-poly-neomycin-hc	67	bisoprolol & hydrochlorothiazide	38

bisoprolol fumarate	38	calcium acetate (phosphate binder)	72
BLEPHAMIDE S.O.P.	66	CALQUENCE	13
BOOSTRIX	59	candesartan cilexetil	38
bosentan	69	candesartan cilexetil-hydrochlorothiazide	38
BOSULIF	13	CAPLYTA	31
BRAFTOVI	13	CAPRELSA	13
BREO ELLIPTA	69	captopril	38
BREZTRI AEROSPHERE	69	CARBAGLU	48
BRILINTA	41	carbamazepine	21
brimonidine tartrate	68	carbidopa	24
brimonidine tartrate-timolol maleate	67	carbidopa-levodopa	25
BRIVIACT	21	CARBIDOPA-LEVODOPA-ENTACAPONE	25
bromfenac sodium (ophth)	66	carglumic acid	48
bromocriptine mesylate	24	CARTEOLOL HCL	65
BROMSITE	66	carvedilol	38
BRUKINSA	13	casprofungin acetate	2
budesonide	56	CAYSTON	7
budesonide (inhalation)	69	cefaclor	6
bumetanide	38	CEFACTOR ER	6
buprenorphine	28	cefadroxil	6
buprenorphine hcl	28	CEFAZOLIN SODIUM	6
buprenorphine hcl-naloxone hcl dihydrate	29	cefdinir	6
bupropion hcl	31	cefepime hcl	6
bupropion hcl (smoking deterrent)	49	cefixime	6
bupirone hcl	31	cefoxitin sodium	6
butorphanol tartrate	29	cefpodoxime proxetil	6
BYDUREON BCISE	51	cefprozil	6
BYETTA 10 MCG PEN	51	ceftazidime	6
BYETTA 5 MCG PEN	51	ceftriaxone sodium	6
BYSTOLIC	38	cefuroxime axetil	6
		cefuroxime sodium	6
		celecoxib	29
<b>C</b>		CELONTIN	21
C-NATE DHA	73	cephalexin	6
cabergoline	54	CERDELGA	54
CABLIVI	41	cetirizine hcl	68
CABOMETYX	13	cevimeline hcl	48
calcipotriene	44	CHEMET	48
calcipotriene-betamethasone dipropionate	44	CHENODAL	56
calcitonin (salmon)	54	chlorhexidine gluconate (mouth-throat)	50
CALCITRIOL	44	chloroquine phosphate	7
calcitriol	54		

chlorpromazine hcl.....	31	CLINIMIX/DEXTROSE (4.25/5).....	48
chlorthalidone.....	38	CLINIMIX/DEXTROSE (5/15).....	73
CHOLBAM.....	56	CLINIMIX/DEXTROSE (5/20).....	73
cholestyramine.....	42	clobazam.....	21
cholestyramine light.....	42	clobetasol propionate.....	47
choline fenofibrate.....	42	clobetasol propionate emollient base.....	47
CIBINQO.....	44	clomipramine hcl.....	31
ciclopirox.....	46	clonazepam.....	21
ciclopirox olamine.....	46	clonidine.....	38
cilostazol.....	41	clonidine hcl.....	38
CIMDUO.....	3	clonidine hcl (adhd).....	31
cimetidine.....	58	clopidogrel bisulfate.....	41
CIMETIDINE HCL.....	58	clorazepate dipotassium.....	31
CIMZIA.....	56	clotrimazole.....	2
CIMZIA PREFILLED.....	56	clotrimazole (topical).....	46
CIMZIA STARTER KIT.....	56	clotrimazole w/ betamethasone.....	46
cinacalcet hcl.....	54	CLOZAPINE.....	32
CINRYZE.....	69	CO-NATAL FA.....	74
CIPRO.....	11	COARTEM.....	8
ciprofloxacin hcl.....	11	colchicine.....	61
CIPROFLOXACIN HCL.....	50	colchicine w/ probenecid.....	61
ciprofloxacin hcl (ophth).....	65	colesevelam hcl.....	42
ciprofloxacin in d5w.....	11	colestipol hcl.....	42
ciprofloxacin-dexamethasone.....	50	colistimethate sodium.....	8
citalopram hydrobromide.....	31	COMBIGAN.....	67
CITRANATAL 90 DHA.....	73	COMBIVENT RESPIMAT.....	69
CITRANATAL ASSURE.....	73	COMETRIQ (100 MG DAILY DOSE).....	13
CITRANATAL B-CALM.....	73	COMETRIQ (140 MG DAILY DOSE).....	13
CITRANATAL BLOOM.....	74	COMETRIQ (60 MG DAILY DOSE).....	13
CITRANATAL DHA.....	74	COMPLERA.....	3
CITRANATAL HARMONY.....	74	COMPLETE NATAL DHA.....	74
CITRANATAL RX.....	74	COMPLETENATE.....	74
clarithromycin.....	7	CONCEPT DHA.....	74
CLEOCIN.....	64	CONCEPT OB.....	74
clindamycin hcl.....	7	COPIKTRA.....	13
clindamycin palmitate hydrochloride.....	7	CORLANOR.....	43
clindamycin phosphate.....	7	COTELLIC.....	13
clindamycin phosphate (topical).....	45	CREON.....	56
clindamycin phosphate in d5w.....	8	CRESEMBA.....	2
clindamycin phosphate vaginal.....	64	CRINONE.....	63
CLINIMIX/DEXTROSE (4.25/10).....	73	cromolyn sodium.....	69

cromolyn sodium (mastocytosis) . . . . .	56	dextrose w/ sodium chloride . . . . .	48
cromolyn sodium (ophth) . . . . .	66	DEXTROSE-NACL . . . . .	48
CROTAN . . . . .	48	DIACOMIT . . . . .	21
cyclobenzaprine hcl . . . . .	27	DIAZEPAM . . . . .	22
CYCLOPHOSPHAMIDE . . . . .	13	diazepam . . . . .	32
cyclosporine . . . . .	13	diazoxide . . . . .	51
cyclosporine (ophth) . . . . .	66	diclofenac potassium . . . . .	29
cyclosporine modified (for microemulsion) . . . . .	13	diclofenac sodium . . . . .	29
CYSTADANE . . . . .	56	diclofenac sodium (actinic keratoses) . . . . .	45
CYSTAGON . . . . .	72	diclofenac sodium (ophth) . . . . .	66
CYSTARAN . . . . .	66	diclofenac sodium (topical) . . . . .	29
		diclofenac w/ misoprostol . . . . .	29
<b>D</b>		dicloxacillin sodium . . . . .	10
dabigatran etexilate mesylate . . . . .	41	dicyclomine hcl . . . . .	56
dalfampridine . . . . .	26	diflunisal . . . . .	29
DALIRESP . . . . .	69	digoxin . . . . .	43
danazol . . . . .	54	dihydroergotamine mesylate . . . . .	25
dantrolene sodium . . . . .	27	DILANTIN . . . . .	22
dapsone . . . . .	8	diltiazem hcl . . . . .	38
DAPTACEL . . . . .	59	diltiazem hcl coated beads . . . . .	38
daptomycin . . . . .	8	diltiazem hcl extended release beads . . . . .	38
DAURISMO . . . . .	13	dimethyl fumarate . . . . .	26
deferasirox . . . . .	48	DIPENTUM . . . . .	56
deferiprone . . . . .	48	diphenoxylate w/ atropine . . . . .	56
DELSTRIGO . . . . .	3	DIPHENOXYLATE-ATROPINE . . . . .	56
demeclocycline hcl . . . . .	11	DIPHThERIA-TETANUS TOXOIDS DT . . . . .	59
DENAVIR . . . . .	47	dipyridamole . . . . .	41
DEPO-SUBQ PROVERA 104 . . . . .	63	disulfiram . . . . .	48
DERMACINRX PRETRATE . . . . .	74	divalproex sodium . . . . .	22
DESCOVY . . . . .	3	dofetilide . . . . .	37
desipramine hcl . . . . .	32	donepezil hydrochloride . . . . .	26
desmopressin acetate . . . . .	54	DOPTELET . . . . .	41
desmopressin acetate spray . . . . .	54	dorzolamide hcl . . . . .	67
desmopressin acetate spray refrigerated . . . . .	54	dorzolamide hcl-timolol maleate . . . . .	67
desogestrel & ethinyl estradiol . . . . .	64	DOTHELLE DHA . . . . .	74
desogestrel-ethinyl estradiol (biphasic) . . . . .	64	DOVATO . . . . .	3
desonide . . . . .	47	doxazosin mesylate . . . . .	38
desvenlafaxine succinate . . . . .	32	doxepin hcl . . . . .	32
DEXAMETHASONE . . . . .	50	doxepin hcl (sleep) . . . . .	32
DEXAMETHASONE SODIUM PHOSPHATE . . . . .	67	doxercalciferol . . . . .	54
dextrose . . . . .	48	doxycycline (monohydrate) . . . . .	11

doxycycline hyclate	11	ENBRACE HR	74
DRIZALMA SPRINKLE	32	ENBREL	61
dronabinol	56	ENBREL MINI	61
drospirenone-ethinyl estradiol	64	ENBREL SURECLICK	61
DROXIA	14	ENGERIX-B	59
droxidopa	48	enoxaparin sodium	41
DUAVEE	63	entacapone	25
DUET DHA 400	74	entecavir	3
DUET DHA BALANCED	74	ENTRESTO	43
DULERA	69	ENVARUSUS XR	14
duloxetine hcl	32	EPCLUSA	3
DUPIXENT	45	EPIDIOLEX	22
dutasteride	72	epinastine hcl (ophth)	66
dutasteride-tamsulosin hcl	72	epinephrine (anaphylaxis)	68
<b>E</b>		EPIVIR HBV	4
E.E.S. 400	7	epiphenone	38
econazole nitrate	46	EPRONTIA	22
EDARBI	38	ergotamine w/ caffeine	25
EDARBYCLOR	38	ERIVEDGE	14
EDURANT	3	ERLEADA	14
efavirenz	3	erlotinib hcl	14
efavirenz-emtricitabine-tenofovir disoproxil fumarate	3	ertapenem sodium	8
efavirenz-lamivudine-tenofovir disoproxil fumarate	3	ERY	45
eletriptan hydrobromide	25	ERYTHROCIN LACTOBIONATE	7
ELIQUIS	41	ERYTHROCIN STEARATE	7
ELIQUIS DVT/PE STARTER PACK	41	erythromycin (acne aid)	45
ELITE-OB	74	erythromycin (ophth)	65
ELMIRON	72	erythromycin base	7
EMCYT	14	ERYTHROMYCIN ETHYLSUCCINATE	7
EMEND	56	erythromycin lactobionate	7
EMGALITY	25	ESBRIET	69
EMSAM	32	escitalopram oxalate	32
emtricitabine	3	esomeprazole magnesium	58
emtricitabine-tenofovir disoproxil fumarate	3	estradiol	63
EMTRIVA	3	estradiol & norethindrone acetate	63
EMVERM	8	estradiol vaginal	63
enalapril maleate	38	estradiol valerate	63
enalapril maleate & hydrochlorothiazide	38	ESTRING	63
		eszopiclone	32
		ethacrynic acid	38
		ethambutol hcl	8

ethosuximide	22	FLOVENT DISKUS	69
ethynodiol diacet & eth estrad	64	FLOVENT HFA	69
etodolac	29	fluconazole	2
etonogestrel-ethinyl estradiol	64	fluconazole in nacl	2
etravirine	4	flucytosine	2
everolimus	14	fludrocortisone acetate	50
everolimus (immunosuppressant)	14	flunisolide (nasal)	70
EVOTAZ	4	fluocinolone acetonide	47
exemestane	14	fluocinolone acetonide (otic)	50
EXKIVITY	14	fluocinonide	47
EYSUVIS	67	fluorometholone (ophth)	67
ezetimibe	42	FLUOROURACIL	45
ezetimibe-simvastatin	42	fluorouracil (topical)	45
<b>F</b>		FLUOXETINE HCL	32
famciclovir	4	fluoxetine hcl	32
famotidine	58	FLUOXETINE HCL (PMDD)	32
FANAPT	32	fluphenazine decanoate	33
FANAPT TITRATION PACK	32	fluphenazine hcl	33
FARXIGA	51	flurbiprofen	29
FASENRA	69	flurbiprofen sodium	66
FASENRA PEN	69	fluticasone propionate (nasal)	70
febuxostat	61	fluvastatin sodium	42
felbamate	22	fluvoxamine maleate	33
felodipine	38	FOLET DHA	74
fenofibrate	42	FOLET ONE	74
fenofibrate micronized	42	FOLIVANE-OB	74
fentanyl	28	fondaparinux sodium	42
fentanyl citrate	28	FORFIVO XL	33
FERRIPROX	48	formoterol fumarate	70
FERRIPROX TWICE-A-DAY	49	FOSAMAX PLUS D	61
fesoterodine fumarate	71	fosamprenavir calcium	4
FETZIMA	32	fosinopril sodium	38
FETZIMA TITRATION	32	fosinopril sodium & hydrochlorothiazide	39
finasteride	72	FOTIVDA	14
FINTEPLA	22	furosemide	39
FIRDAPSE	26	FUZEON	4
FIRMAGON	14	FYCOMPA	22
FIRMAGON (240 MG DOSE)	14	<b>G</b>	
flavoxate hcl	71	gabapentin	22
flecainide acetate	37	galantamine hydrobromide	26

GARDASIL 9	59	HUMALOG	52
gatifloxacin (ophth)	65	HUMALOG JUNIOR KWIKPEN	52
GATTEX	56	HUMALOG KWIKPEN	52
GAVILYTE-C	56	HUMALOG MIX 50/50	52
GAVRETO	14	HUMALOG MIX 50/50 KWIKPEN	52
gemfibrozil	43	HUMALOG MIX 75/25	52
GENTAK	65	HUMALOG MIX 75/25 KWIKPEN	52
gentamicin in saline	8	HUMIRA	61
gentamicin sulfate	8	HUMIRA PEDIATRIC CROHNS START	62
gentamicin sulfate (ophth)	65	HUMIRA PEN	62
gentamicin sulfate (topical)	46	HUMIRA PEN-CD/UC/HS STARTER	62
GENVOYA	4	HUMIRA PEN-PEDIATRIC UC START	62
GILENYA	26	HUMIRA PEN-PS/UV/ADOL HS START	62
GILOTRIF	14	HUMIRA PEN-PSOR/UEIT STARTER	62
glatiramer acetate	26	HUMULIN R U-500 (CONCENTRATED)	52
glimepiride	51	HUMULIN R U-500 KWIKPEN	52
glipizide	51	hydralazine hcl	39
glipizide-metformin hcl	52	hydrochlorothiazide	39
glycopyrrolate	56	hydrocodone-acetaminophen	28
GLYXAMBI	52	HYDROCODONE-IBUPROFEN	28
GRALISE	22	hydrocortisone	50
granisetron hcl	56	hydrocortisone (intrarectal)	56
griseofulvin microsize	2	hydrocortisone (rectal)	57
griseofulvin ultramicrosize	2	hydrocortisone (topical)	47
GVOKE HYPOPEN 1-PACK	52	hydrocortisone w/acetic acid	50
GVOKE HYPOPEN 2-PACK	52	hydromorphone hcl	28
GVOKE KIT	52	HYDROMORPHONE HCL PF	28
GVOKE PFS	52	hydroxychloroquine sulfate	8
		hydroxyurea	14
		hydroxyzine hcl	68
<b>H</b>			
halobetasol propionate	47	<b>I</b>	
haloperidol	33	ibandronate sodium	61
haloperidol decanoate	33	IBRANCE	14
haloperidol lactate	33	ibuprofen	30
HARVONI	4	icatibant acetate	70
HAVRIX	59	ICLUSIG	14
HEMENATAL OB	74	icosapent ethyl	43
HEMENATAL OB + DHA	74	IDHIFA	14
heparin sodium (porcine)	42	imatinib mesylate	15
HETLIOZ	33	IMBRUVICA	15
HIBERIX	59		

imipenem-cilastatin	8	ivermectin	8
imipramine hcl	33	IVERMECTIN	46
imipramine pamoate	33	ivermectin (rosacea)	46
imiquimod	45	IXIARO	60
IMOVAX RABIES	59		
IMPAVIDO	8	<b>J</b>	
INATAL GT	74	JAKAFI	15
INCRELEX	49	JANUMET	52
indapamide	39	JANUMET XR	52
INFANRIX	59	JANUVIA	52
INGREZZA	27	JARDIANCE	52
INLYTA	15	JULUCA	4
INQOVI	15	JUXTAPID	43
INREBIC	15		
INTELENCE	4	<b>K</b>	
INTRALIPID	73	KALYDECO	70
INTRON A	59	KCL IN DEXTROSE-NACL	72
INVEGA HAFYERA	33	KCL-LACTATED RINGERS-D5W	72
INVEGA SUSTENNA	33	KERENDIA	39
INVEGA TRINZA	33	ketoconazole	2
INVELTYS	67	ketoconazole (topical)	46
IOPIDINE	68	ketorolac tromethamine (ophth)	66
IPOL	60	KINRIX	60
ipratropium bromide	70	KISQALI (200 MG DOSE)	15
ipratropium bromide (nasal)	50	KISQALI (400 MG DOSE)	15
ipratropium-albuterol	70	KISQALI (600 MG DOSE)	15
irbesartan	39	KISQALI FEMARA (400 MG DOSE)	15
irbesartan-hydrochlorothiazide	39	KISQALI FEMARA (600 MG DOSE)	15
IRESSA	15	KISQALI FEMARA(200 MG DOSE)	15
ISENTRESS	4	KLOXXADO	30
ISENTRESS HD	4	KOMBIGLYZE XR	52
ISOLYTE-P IN D5W	73	KORLYM	54
ISOLYTE-S	73	KOSHER PRENATAL PLUS IRON	74
ISOLYTE-S PH 7.4	73	KYNMOBI	25
ISONIAZID	8		
isosorbide dinitrate	44	<b>L</b>	
isosorbide dinitrate-hydralazine hcl	39	labetalol hcl	39
isosorbide mononitrate	44	lacosamide	22
isotretinoin	46	lactic acid (ammonium lactate)	45
isradipine	39	lactulose	57
itraconazole	2	lactulose (encephalopathy)	57

lamivudine	4	lidocaine hcl	45
lamivudine (hbv)	4	lidocaine hcl (mouth-throat)	45
lamivudine-zidovudine	4	lidocaine-prilocaine	45
lamotrigine	23	linezolid	8
LANOXIN	43	LINZESS	57
lansoprazole	58	liothyronine sodium	55
LANTUS	52	lisinopril	39
LANTUS SOLOSTAR	52	lisinopril & hydrochlorothiazide	39
lapatinib ditosylate	15	lithium carbonate	34
latanoprost	67	LIVALO	43
LATUDA	34	LOKELMA	49
leflunomide	62	LONSURF	16
lenalidomide	15	loperamide hcl	56
LENVIMA (10 MG DAILY DOSE)	16	lopinavir-ritonavir	4
LENVIMA (12 MG DAILY DOSE)	16	lorazepam	34
LENVIMA (14 MG DAILY DOSE)	16	LORBRENA	16
LENVIMA (18 MG DAILY DOSE)	16	losartan potassium	39
LENVIMA (20 MG DAILY DOSE)	16	losartan potassium & hydrochlorothiazide	39
LENVIMA (24 MG DAILY DOSE)	16	loteprednol etabonate	67
LENVIMA (4 MG DAILY DOSE)	16	lovastatin	43
LENVIMA (8 MG DAILY DOSE)	16	loxapine succinate	34
letrozole	16	LUMAKRAS	16
leucovorin calcium	12	LUMIGAN	67
LEUKERAN	16	LUPRON DEPOT (1-MONTH)	16
LEUKINE	59	LUPRON DEPOT (3-MONTH)	16
leuprolide acetate	16	LUPRON DEPOT (4-MONTH)	16
levalbuterol hcl	70	LUPRON DEPOT (6-MONTH)	16
levetiracetam	23	LYNPARZA	16
levobunolol hcl	65	LYSODREN	16
levocarnitine (metabolic modifiers)	49	LYUMJEV	52
levocetirizine dihydrochloride	68	LYUMJEV KWIKPEN	52
levofloxacin	11		
levofloxacin (ophth)	65	<b>M</b>	
levofloxacin in d5w	11	M-M-R II	60
levonorgestrel & eth estradiol	64	M-NATAL PLUS	74
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levonorgestrel-ethinyl estradiol (91-day)	64	MAGELLAN INSULIN SAFETY SYR	52
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naproxen sodium	30	nilutamide	17
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NARCAN	30	NINLARO	17
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VOTRIENT	20	XPOVIO (60 MG TWICE WEEKLY)	20
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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](http://www.group-health.com/cooperative-advantage).