



Aetna Better Health® of Illinois
Preferred Drug List
September 2024

This Formulary is up to date through the date of publication. Please notify Aetna Better Health of Illinois at ABHILPharmacy@AETNA.com or 1-866-329-4701 TTY: 711 with any mistakes in the formulary.

Pharmacy Program

Aetna Better Health® of Illinois is committed to providing high quality drug coverage to our members. We work with the Department of Healthcare and Family Services to include medications that treat many conditions and diseases. Aetna Better Health covers prescription and certain over-the-counter (OTC) medications when ordered by a network provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and maximum quantities.

Filling a Prescription

You can have your prescriptions filled at a network pharmacy. At the pharmacy, you will need to give the pharmacist your prescription and your ID card. You can find a pharmacy that is in the Aetna Better Health network by using the Find a Provider tool on **[AetnaBetterHealth.com/Illinois-Medicaid](https://www.aetnabetterhealth.com/illinois-medicaid)**. If you need help finding a pharmacy near you or if you have any questions about drug coverage, call us at **1-866-329-4701 TTY: 711**.

There is no cost for covered drugs.

If your medication is not on the preferred drug list or is on the preferred drug list but has limitations, you can:

1. Speak with your doctor about switching to a similar medication that is on the preferred drug list.
2. Request a prior authorization or speak to your doctor about submitting a prior authorization for you. You or your doctor may do this by submitting the medication prior authorization form, found on **[AetnaBetterHealth.com/Illinois-Medicaid](https://www.aetnabetterhealth.com/illinois-medicaid)**.

Generic Drugs

Generic drugs have the same active ingredient and work the same as brand name drugs. When preferred generic drugs are available, the brand name drug will not be covered without prior authorization.

Specialty Drugs

Specialty drugs are usually not available at retail pharmacies and require additional review and monitoring. These drugs are only covered when supplied by an Aetna Better Health network specialty pharmacy.

Pharmacy Benefit Exclusions

The following drug categories are not part of the Aetna Better Health pharmacy benefit:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Durable Medical Equipment (DME) products and medical supplies (unless listed on the PDL)
- Drugs and other agents used for cosmetic purposes or for hair growth

- Erectile dysfunction drugs prescribed to treat impotence
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- OTC products (unless listed on the PDL)
- Drugs not included in the Medicaid Drug Rebate Program, drug product data file (unless listed on the PDL)

Legend

P	Preferred Drug	Drugs preferred by Aetna Better Health
NP	Non-Preferred	Drugs not preferred by Aetna Better Health
AL	Age Limit	Drug is limited to specific age
PA	Prior Authorization	Prior Authorization required before prescription can be filled.
-	Smart Edit	Prior Authorization required before prescription can be filled. Criteria may be met automatically
QLL	Quantity Level Limit	There is a limit on the amount of drug covered per prescription or within a specific time frame.
ST	Step Therapy	Requires trial and failure of one or more preferred products prior to coverage.
OTC	Over-the-Counter	Over-the-Counter (OTC) products eligible for coverage with a valid prescription written by a licensed physician/clinician.

Aetna Better Health of Illinois Formulary Guide

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		Coverage Requirements and Limits
lowercase italics = Generic drugs	Drug Tier	= Diagnosis Required
UPPERCASE BOLD = Brand name drugs	Non – Preferred = Non – Preferred	AL = Age Restrictions
	Preferred = Preferred	OTC = OTC Medications
		PA = Prior Authorization Applies
		QL = Quantity Limits
		ST = Step Therapy Applies
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexiant - Drugs For The Nervous System		
*Adhd Agent - Selective Alpha Adrenergic Agonists*** - Drugs For Attention Deficit Disorder		
<i>clonidine hcl er</i>	Preferred	QL (120 EA per 30 days); AL (Min 6 Years)
<i>guanfacine hcl er</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
INTUNIV	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
*Adhd Agent - Selective Norepinephrine Reuptake Inhibitor*** - Drugs For Attention Deficit Disorder		
<i>atomoxetine hcl</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
QELBREE	Non – Preferred	
STRATTERA	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
*Amphetamine Mixtures*** - Drugs For Attention Deficit Disorder		
<i>amphetamine-dextroamphet er capsule extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 25 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 30 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 12.5 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 7.5 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphet-dextroamphetamine 3-bead er</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 10 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 12.5 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 15 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADDERALL TABLET 20 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 5 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 7.5 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
MYDAYIS	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>*Amphetamines*** - Drugs For Attention Deficit Disorder</i>		
<i>amphetamine sulfate</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 10 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 15 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 5 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dextroamphetamine sulfate oral solution</i>	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 10 mg oral</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 15 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 2.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 20 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 5 mg oral</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 7.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>lisdexamfetamine dimesylate</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methamphetamine hcl</i>	Non – Preferred	QL (5 EA per 1 day); AL (Min 6 Years)
ADZENYS XR-ODT	Non – Preferred	AL (Min 6 Years)
DESOXYN	Non – Preferred	QL (5 EA per 1 day); AL (Min 6 Years)
DEXEDRINE	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
DYANAVAL XR ORAL SUSPENSION EXTENDED RELEASE	Preferred	PA; AL (Min 6 Years)
DYANAVAL XR ORAL TABLET CHEWABLE EXTENDED RELEASE	Non – Preferred	PA; AL (Min 6 Years)
EVEKEO	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
PROCENTRA	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VYVANSE	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
XELSTRYM	Non – Preferred	
ZENZEDI TABLET 10 MG ORAL	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 15 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 2.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 20 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 5 MG ORAL	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 7.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>*Analeptics*** - Drugs For The Nervous System</i>		
<i>caffeine citrate</i>	Preferred	AL (Min 18 Years)
<i>*Dopamine And Norepinephrine Reuptake Inhibitors (Dnris)*** - Drugs For Sleep Disorder</i>		
SUNOSI	Non – Preferred	AL (Min 6 Years)
<i>*Histamine H3-Receptor Antagonist/Inverse Agonists*** - Drugs For Sleep Disorder</i>		
WAKIX	Non – Preferred	AL (Min 18 Years)
<i>*Stimulant Combinations*** - Drugs For Attention Deficit Disorder</i>		
AZSTARYS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Stimulants - Misc.*** - Drugs For Attention Deficit Disorder		
<i>armodafinil tablet 150 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 200 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 250 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 50 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
<i>dexmethylphenidate hcl</i>	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>dexmethylphenidate hcl er</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate</i>	Non – Preferred	PA; QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (cd)</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 10 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 20 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 40 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 60 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 18 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 27 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 27 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate hcl er (osm) tablet extended release 36 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 45 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 54 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 63 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 72 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (xr)</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er oral tablet extended release</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl oral solution</i>	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl oral tablet</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl oral tablet chewable</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>modafinil</i>	Preferred	AL (Min 17 Years)
APTENSIO XR	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 18 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 27 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 36 MG ORAL	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 54 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COTEMPLA XR-ODT	Non – Preferred	AL (Min 6 Years)
DAYTRANA	Preferred	PA; QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
FOCALIN XR	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
JORNAY PM	Preferred	PA; AL (Min 6 Years)
METHYLIN	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
NUVIGIL TABLET 150 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 200 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 250 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
PROVIGIL	Non – Preferred	AL (Min 17 Years)
QUILLICHEW ER	Non – Preferred	AL (Min 6 Years)
QUILLIVANT XR	Non – Preferred	AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 18 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 27 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 36 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 45 MG ORAL	Non – Preferred	AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 54 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 63 MG ORAL	Non – Preferred	AL (Min 6 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELEXXII TABLET EXTENDED RELEASE 72 MG ORAL	Non – Preferred	AL (Min 6 Years)
RITALIN	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
Amebicides - Drugs For Infections		
<i>*Amebicides*** - Drugs For Parasites</i>		
SOLOSEC	Non – Preferred	
Aminoglycosides - Drugs For Infections		
<i>*Aminoglycosides*** - Antibiotics</i>		
<i>amikacin sulfate</i>	Preferred	
<i>gentamicin in saline</i>	Preferred	
<i>gentamicin sulfate</i>	Preferred	
<i>neomycin sulfate</i>	Preferred	
<i>tobramycin nebulization solution 300 mg/4ml inhalation</i>	Non – Preferred	
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Non – Preferred	QL (10 ML per 1 day)
<i>tobramycin sulfate</i>	Preferred	
ARIKAYCE	Non – Preferred	
BETHKIS	Non – Preferred	
KITABIS PAK	Preferred	QL (10 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOBI	Non – Preferred	QL (10 ML per 1 day)
TOBI PODHALER	Non – Preferred	
Analgesics - Anti-Inflammatory - Drugs For Pain And Fever		
*Antirheumatic - Janus Kinase (Jak) Inhibitors*** - Arthritis And Pain Drugs		
OLUMIANT	Non – Preferred	
RINVOQ	Non – Preferred	
XELJANZ	Preferred	PA
XELJANZ XR	Preferred	PA
*Antirheumatic Antimetabolites*** - Arthritis And Pain Drugs		
OTREXUP	Non – Preferred	
RASUVO	Non – Preferred	
*Anti-Tnf-Alpha - Monoclonal Antibodies*** - Arthritis And Pain Drugs		
<i>adalimumab-aacf (2 pen)</i>	Non – Preferred	
<i>adalimumab-adaz</i>	Non – Preferred	
<i>adalimumab-adbm (2 pen)</i>	Non – Preferred	
<i>adalimumab-adbm (2 syringe)</i>	Non – Preferred	
<i>adalimumab-adbm(cd/uc/hs strt)</i>	Non – Preferred	
<i>adalimumab-adbm(ps/uv starter)</i>	Non – Preferred	
<i>adalimumab-fkjp (2 pen)</i>	Non – Preferred	
<i>adalimumab-fkjp (2 syringe)</i>	Non – Preferred	
ABRILADA (1 PEN)	Non – Preferred	
ABRILADA (2 PEN)	Non – Preferred	
ABRILADA (2 SYRINGE)	Non – Preferred	
AMJEVITA	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMJEVITA-PED 10KG TO <15KG	Non – Preferred	
AMJEVITA-PED 15KG TO <30KG	Non – Preferred	
CYLTEZO (2 PEN)	Non – Preferred	
CYLTEZO (2 SYRINGE)	Non – Preferred	
CYLTEZO-CD/UC/HS STARTER	Non – Preferred	
CYLTEZO-PSORIASIS/UV STARTER	Non – Preferred	
HADLIMA	Non – Preferred	
HADLIMA PUSHTOUCH	Non – Preferred	
HULIO (2 PEN)	Non – Preferred	
HULIO (2 SYRINGE)	Non – Preferred	
HUMIRA (2 PEN) PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS	Preferred	PA
HUMIRA (2 PEN) PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (3 EA per 180 days)
HUMIRA (2 SYRINGE)	Preferred	PA
HUMIRA-CD/UC/HS STARTER	Preferred	PA; QL (3 EA per 180 days)
HUMIRA-PSORIASIS/UEIT STARTER	Preferred	PA
HYRIMOZ	Non – Preferred	
HYRIMOZ-CROHNS/UC STARTER	Non – Preferred	
HYRIMOZ-PED<40KG CROHN STARTER	Non – Preferred	
HYRIMOZ-PED>/=40KG CROHN START	Non – Preferred	
HYRIMOZ-PLAQUE PSORIASIS START	Non – Preferred	
IDACIO (2 PEN)	Non – Preferred	
IDACIO (2 SYRINGE)	Non – Preferred	
IDACIO-CROHNS/UC STARTER	Non – Preferred	
IDACIO-PSORIASIS STARTER	Non – Preferred	
SIMPONI	Non – Preferred	
SIMPONI ARIA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
YUFLYMA (1 PEN)	Non – Preferred	
YUFLYMA (2 PEN)	Non – Preferred	
YUFLYMA (2 SYRINGE)	Non – Preferred	
YUFLYMA-CD/UC/HS STARTER	Non – Preferred	
YUSIMRY	Non – Preferred	
*Cyclooxygenase 2 (Cox-2) Inhibitors*** - Arthritis And Pain Drugs		
<i>celecoxib</i>	Preferred	QL (1 EA per 1 day)
CELEBREX	Non – Preferred	QL (1 EA per 1 day)
*Gold Compounds*** - Arthritis And Pain Drugs		
RIDAURA	Non – Preferred	
*Interleukin-1 Blockers*** - Arthritis And Pain Drugs		
ARCALYST	Non – Preferred	
*Interleukin-1 Receptor Antagonist (IL-1Ra)*** - Arthritis And Pain Drugs		
KINERET	Non – Preferred	
*Interleukin-1Beta Blockers*** - Arthritis And Pain Drugs		
ILARIS	Non – Preferred	
*Interleukin-6 Receptor Inhibitors*** - Arthritis And Pain Drugs		
ACTEMRA	Non – Preferred	
ACTEMRA ACTPEN	Non – Preferred	
KEVZARA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Nonsteroidal Anti-Inflammatory Agent Combinations*** - Arthritis And Pain Drugs		
<i>diclofenac-misoprostol</i>	Non – Preferred	
<i>ibuprofen-famotidine</i>	Non – Preferred	QL (4 EA per 1 day)
<i>naproxen-esomeprazole mg</i>	Non – Preferred	
ARTHROTEC	Non – Preferred	
DUEXIS	Non – Preferred	
VIMOVO	Non – Preferred	
*Nonsteroidal Anti-Inflammatory Agents (Nsaids)*** - Arthritis And Pain Drugs		
<i>cvs ibuprofen infants</i>	Preferred	OTC
<i>diclofenac potassium oral capsule</i>	Non – Preferred	
<i>diclofenac potassium tablet 25 mg oral</i>	Non – Preferred	
<i>diclofenac potassium tablet 50 mg oral</i>	Preferred	
<i>diclofenac sodium</i>	Preferred	
<i>diclofenac sodium er</i>	Preferred	
<i>ec-naproxen</i>	Preferred	
<i>etodolac</i>	Preferred	
<i>etodolac er</i>	Preferred	
<i>fenoprofen calcium</i>	Non – Preferred	
<i>flurbiprofen</i>	Preferred	
<i>ibuprofen oral capsule</i>	Preferred	OTC; QL (6 EA per 1 day)
<i>ibuprofen oral suspension</i>	Non – Preferred	
<i>ibuprofen oral tablet 200 mg</i>	Preferred	OTC; QL (6 EA per 1 day)
<i>ibuprofen tablet 400 mg oral</i>	Preferred	
<i>ibuprofen tablet 600 mg oral</i>	Preferred	
<i>ibuprofen tablet 800 mg oral</i>	Preferred	
<i>indomethacin</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>indomethacin er</i>	Preferred	
<i>ketoprofen er</i>	Non – Preferred	
<i>ketorolac tromethamine</i>	Preferred	QL (20 EA per 30 days)
<i>meclofenamate sodium</i>	Non – Preferred	
<i>mefenamic acid</i>	Non – Preferred	
<i>meloxicam oral capsule</i>	Non – Preferred	
<i>meloxicam oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>nabumetone</i>	Preferred	QL (4 EA per 1 day)
<i>naproxen</i>	Preferred	
<i>naproxen dr</i>	Preferred	
<i>naproxen sodium</i>	Preferred	
<i>naproxen sodium er</i>	Non – Preferred	
<i>oxaprozin</i>	Non – Preferred	
<i>piroxicam</i>	Non – Preferred	
<i>sulindac</i>	Preferred	
<i>tolmetin sodium</i>	Non – Preferred	
DAYPRO	Non – Preferred	
IBU	Preferred	
LOFENA	Non – Preferred	
MEDI-FIRST IBUPROFEN	Preferred	OTC; QL (6 EA per 1 day)
NALFON	Non – Preferred	
NAPRELAN	Non – Preferred	
RELAFEN DS	Non – Preferred	
<i>*Phosphodiesterase 4 (Pde4) Inhibitors*** - Arthritis And Pain Drugs</i>		
OTEZLA	Non – Preferred	
<i>*Pyrimidine Synthesis Inhibitors*** - Arthritis And Pain Drugs</i>		
<i>leflunomide</i>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARAVA	Non – Preferred	QL (1 EA per 1 day)
*Selective Costimulation Modulators*** - Arthritis And Pain Drugs		
ORENCIA	Non – Preferred	
ORENCIA CLICKJECT	Non – Preferred	
*Soluble Tumor Necrosis Factor Receptor Agents*** - Arthritis And Pain Drugs		
ENBREL MINI	Preferred	PA; QL (4 PEN per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	Preferred	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	Preferred	PA; QL (4 ML per 28 days)
ENBREL SURECLICK	Preferred	PA; QL (4 ML per 28 days)
Analgesics - Nonnarcotic - Drugs For Pain And Fever		
*Analgesics Other*** - Arthritis And Pain Drugs		
<i>acetaminophen</i>	Preferred	OTC
<i>acetaminophen childrens</i>	Preferred	OTC
<i>acetaminophen extra strength</i>	Preferred	OTC
<i>pain relief extra strength</i>	Preferred	OTC
<i>pain reliever</i>	Preferred	OTC
CHILDRENS MEDI-TABS	Preferred	OTC
*Analgesics-Sedatives*** - Arthritis And Pain Drugs		
<i>butalbital-acetaminophen oral capsule</i>	Non – Preferred	
<i>butalbital-acetaminophen tablet 50-300 mg oral</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>butalbital-acetaminophen tablet 50-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine capsule 50-300-40 mg oral</i>	Preferred	
<i>butalbital-apap-caffeine capsule 50-325-40 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine oral tablet</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-aspirin-caffeine</i>	Preferred	QL (6 EA per 1 day)
BAC	Preferred	QL (6 EA per 1 day)
ESGIC ORAL CAPSULE	Preferred	QL (6 EA per 1 day)
ESGIC ORAL TABLET	Non – Preferred	QL (6 EA per 1 day)
FIORICET	Non – Preferred	
*Salicylate Combinations*** - Arthritis And Pain Drugs		
<i>aspirin buf(cacarb-mgcarb-mgo)</i>	Preferred	OTC
*Salicylates*** - Arthritis And Pain Drugs		
<i>aspirin 81</i>	Preferred	OTC
<i>diflunisal</i>	Preferred	
<i>salsalate</i>	Preferred	
Analgesics - Opioid - Drugs For Pain And Fever		
*Codeine Combinations*** - Arthritis And Pain Drugs		
<i>acetaminophen-codeine oral solution</i>	Preferred	QL (20 ML per 1 day); AL (Min 18 Years)
<i>acetaminophen-codeine oral tablet</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>butalbital-apap-caff-cod</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>butalbital-asa-caff-codeine</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
ASCOMP-CODEINE	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
FIORICET/CODEINE	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
*Dihydrocodeine Combinations*** - Arthritis And Pain Drugs		
<i>apap-caff-dihydrocodeine</i>	Non – Preferred	
*Hydrocodone Combinations*** - Arthritis And Pain Drugs		
<i>hydrocodone-acetaminophen oral solution</i>	Preferred	QL (40 ML per 1 day)
<i>hydrocodone-acetaminophen tablet 10-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 10-325 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 5-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 5-325 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 7.5-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 7.5-325 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydrocodone-ibuprofen tablet 10-200 mg oral</i>	Preferred	
<i>hydrocodone-ibuprofen tablet 5-200 mg oral</i>	Preferred	
<i>hydrocodone-ibuprofen tablet 7.5-200 mg oral</i>	Preferred	QL (4 EA per 1 day)
*Opioid Agonists*** - Arthritis And Pain Drugs		
<i>codeine sulfate</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fentanyl</i>	Non – Preferred	
<i>fentanyl citrate buccal lozenge on a handle</i>	Non – Preferred	QL (4 EA per 1 day)
<i>fentanyl citrate buccal tablet</i>	Non – Preferred	
<i>hydrocodone bitartrate er</i>	Non – Preferred	
<i>hydromorphone hcl er</i>	Non – Preferred	
<i>hydromorphone hcl oral liquid</i>	Preferred	
<i>hydromorphone hcl rectal</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 4 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 8 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>levorphanol tartrate</i>	Non – Preferred	
<i>meperidine hcl</i>	Non – Preferred	
<i>methadone hcl oral concentrate</i>	Non – Preferred	QL (3 EA per 1 day)
<i>methadone hcl oral tablet soluble</i>	Non – Preferred	
<i>methadone hcl solution 10 mg/5ml oral</i>	Non – Preferred	QL (15 ML per 1 day)
<i>methadone hcl solution 5 mg/5ml oral</i>	Non – Preferred	QL (30 ML per 1 day)
<i>methadone hcl tablet 10 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>methadone hcl tablet 5 mg oral</i>	Non – Preferred	QL (6 EA per 1 day)
<i>morphine sulfate (concentrate)</i>	Preferred	QL (4.5 ML per 1 day)
<i>morphine sulfate er beads</i>	Non – Preferred	
<i>morphine sulfate er oral capsule extended release 24 hour</i>	Non – Preferred	
<i>morphine sulfate er tablet extended release 100 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 15 mg oral</i>	Preferred	PA; QL (6 EA per 1 day)
<i>morphine sulfate er tablet extended release 200 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 30 mg oral</i>	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>morphine sulfate er tablet extended release 60 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate oral solution</i>	Preferred	QL (45 ML per 1 day)
<i>morphine sulfate suppository 10 mg rectal</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate suppository 20 mg rectal</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate suppository 30 mg rectal</i>	Preferred	QL (3 EA per 1 day)
<i>morphine sulfate suppository 5 mg rectal</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate tablet 30 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl oral capsule</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl oral concentrate</i>	Preferred	QL (6 ML per 1 day)
<i>oxycodone hcl oral solution</i>	Preferred	QL (60 ML per 1 day)
<i>oxycodone hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl tablet 30 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxymorphone hcl</i>	Non – Preferred	
<i>oxymorphone hcl er</i>	Non – Preferred	QL (2 EA per 1 day)
<i>tramadol hcl (er biphasic)</i>	Non – Preferred	AL (Min 18 Years)
<i>tramadol hcl er</i>	Non – Preferred	AL (Min 18 Years)
<i>tramadol hcl oral solution</i>	Non – Preferred	AL (Min 18 Years)
<i>tramadol hcl tablet 100 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>tramadol hcl tablet 25 mg oral</i>	Non – Preferred	AL (Min 18 Years)
<i>tramadol hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day); AL (Min 18 Years)
CONZIP	Non – Preferred	AL (Min 18 Years)
DILAUDID ORAL LIQUID	Non – Preferred	
DILAUDID TABLET 2 MG ORAL	Non – Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DILAUDID TABLET 4 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
DILAUDID TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
FENTORA	Non – Preferred	
HYSINGLA ER	Non – Preferred	
METHADONE HCL INTENSOL	Non – Preferred	QL (3 ML per 1 day)
METHADOSE ORAL CONCENTRATE	Non – Preferred	QL (3 ML per 1 day)
METHADOSE ORAL TABLET SOLUBLE	Non – Preferred	
METHADOSE SUGAR-FREE	Non – Preferred	QL (3 ML per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 100 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 15 MG ORAL	Non – Preferred	PA; QL (6 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 200 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 30 MG ORAL	Non – Preferred	PA
MS CONTIN TABLET EXTENDED RELEASE 60 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
NUCYNTA	Non – Preferred	
NUCYNTA ER	Non – Preferred	
OXYCONTIN	Non – Preferred	
QDOLO	Non – Preferred	AL (Min 18 Years)
ROXICODONE	Non – Preferred	QL (4 EA per 1 day)
ROXYBOND	Non – Preferred	
XTAMPZA ER	Non – Preferred	
*Opioid Combinations*** - Arthritis And Pain Drugs		
<i>benzhydrocodone-acetaminophen</i>	Non – Preferred	
<i>nalocet</i>	Non – Preferred	
<i>oxycodone-acetaminophen oral solution</i>	Preferred	
<i>oxycodone-acetaminophen oral tablet</i>	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
APADAZ	Non – Preferred	
ENDOCET	Preferred	QL (4 EA per 1 day)
PERCOCET	Non – Preferred	QL (4 EA per 1 day)
PROLATE	Non – Preferred	
*Opioid Partial Agonists*** - Arthritis And Pain Drugs		
<i>buprenorphine hcl</i>	Preferred	
<i>buprenorphine hcl-naloxone hcl</i>	Preferred	
<i>buprenorphine patch weekly 10 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 15 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 20 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 5 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 7.5 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>butorphanol tartrate</i>	Non – Preferred	QL (2.5 ML per 30 days)
<i>pentazocine-naloxone hcl</i>	Non – Preferred	QL (4 EA per 1 day)
BELBUCA	Non – Preferred	
BRIXADI	Preferred	
BRIXADI (WEEKLY)	Preferred	
BUTRANS	Non – Preferred	QL (4 EA per 28 days)
SUBLOCADE	Preferred	
SUBOXONE	Preferred	
ZUBSOLV	Preferred	
*Tramadol Combinations*** - Arthritis And Pain Drugs		
<i>tramadol-acetaminophen</i>	Non – Preferred	AL (Min 18 Years)
SEGLENTIS	Non – Preferred	AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Androgens-Anabolic - Hormones		
*Androgens*** - Drugs For Men		
<i>testosterone cypionate</i>	Preferred	PA; QL (10 ML per 90 days)
<i>testosterone enanthate</i>	Preferred	PA; QL (5 ML per 60 days)
<i>testosterone gel 1.62 % transdermal</i>	Preferred	PA; QL (5 GM per 1 day)
<i>testosterone gel 10 mg/lact (2%) transdermal</i>	Preferred	PA; QL (120 GM per 30 days)
<i>testosterone gel 12.5 mg/lact (1%) transdermal</i>	Preferred	PA; QL (300 GM per 30 days)
<i>testosterone gel 20.25 mg/lact (1.62%) transdermal</i>	Preferred	PA; QL (5 GM per 1 day)
<i>testosterone gel 25 mg/2.5gm (1%) transdermal</i>	Preferred	PA; QL (2.5 GM per 1 day)
<i>testosterone gel 50 mg/5gm (1%) transdermal</i>	Preferred	PA; QL (10 GM per 1 day)
<i>testosterone transdermal solution</i>	Preferred	PA; QL (6 ML per 1 day)
Anorectal And Related Products - Rectal Preparations		
*Intrarectal Steroids*** - Rectal Preparations		
<i>budesonide</i>	Non – Preferred	
<i>hydrocortisone</i>	Preferred	
CORTENEMA	Non – Preferred	
CORTIFOAM	Non – Preferred	
UCERIS	Non – Preferred	
*Nitrate Vasodilating Agents*** - Rectal Preparations		
RECTIV	Non – Preferred	
*Rectal Anesthetic/Steroids*** - Rectal Preparations		
<i>lidocaine-hydrocort (perianal)</i>	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs

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Drug Tier

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Preferred = Preferred

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lidocaine-hydrocortisone ace</i>	Non – Preferred	
ANA-LEX	Non – Preferred	
LIDOCORT	Non – Preferred	
PROCTOFOAM HC	Non – Preferred	
*Rectal Combinations - Misc.*** - Rectal Preparations		
<i>hemorrhoidal</i>	Preferred	OTC
PREPARATION H	Preferred	OTC
*Rectal Local Anesthetics*** - Rectal Preparations		
<i>pramoxine hcl (perianal)</i>	Preferred	OTC
PROCTOFOAM	Preferred	OTC
*Rectal Steroids*** - Rectal Preparations		
<i>hydrocortisone (perianal)</i>	Preferred	
<i>hydrocortisone acetate</i>	Non – Preferred	
ANUSOL-HC	Non – Preferred	
PROCTO-MED HC	Preferred	
PROCTOSOL HC	Preferred	
PROCTOZONE-HC	Preferred	
Antacids - Drugs For The Stomach		
*Antacids - Aluminum Salts*** - Drugs For Ulcers And Stomach Acid		
<i>aluminum hydroxide gel</i>	Preferred	OTC
*Antacids - Bicarbonate*** - Drugs For Ulcers And Stomach Acid		
<i>sodium bicarbonate</i>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antacids - Calcium Salts*** - Drugs For Ulcers And Stomach Acid		
<i>calcium carbonate antacid</i>	Preferred	OTC
*Antacids - Magnesium Salts*** - Drugs For Ulcers And Stomach Acid		
<i>magnesium oxide</i>	Preferred	OTC
Anthelmintics - Drugs For Infections		
*Anthelmintics*** - Drugs For Parasites		
<i>albendazole</i>	Non – Preferred	
<i>benznidazole</i>	Non – Preferred	
<i>ivermectin</i>	Non – Preferred	
<i>praziquantel</i>	Preferred	
BILTRICIDE	Non – Preferred	
EGATEN	Non – Preferred	
EMVERM	Non – Preferred	
STROMECTOL	Non – Preferred	
Antianginal Agents - Drugs For The Heart		
*Antianginals-Other*** - Drugs For Angina		
<i>ranolazine er</i>	Non – Preferred	
ASPRUZYO SPRINKLE	Non – Preferred	
*Nitrates*** - Drugs For Angina		
<i>isosorbide dinitrate</i>	Preferred	
<i>isosorbide mononitrate</i>	Preferred	
<i>isosorbide mononitrate er tablet extended release 24 hour 120 mg oral</i>	Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>isosorbide mononitrate er tablet extended release 24 hour 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>isosorbide mononitrate er tablet extended release 24 hour 60 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>nitroglycerin sublingual</i>	Preferred	
<i>nitroglycerin transdermal</i>	Preferred	
<i>nitroglycerin translingual</i>	Non – Preferred	
ISORDIL TITRADOSE	Non – Preferred	
NITRO-BID	Preferred	
NITRO-DUR	Non – Preferred	
NITROLINGUAL	Non – Preferred	
NITROSTAT	Non – Preferred	
Antianxiety Agents - Drugs For The Nervous System		
*Antianxiety Agents - Misc.*** - Drugs For Anxiety		
<i>bupirone hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>bupirone hcl tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>bupirone hcl tablet 30 mg oral</i>	Preferred	
<i>bupirone hcl tablet 5 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>bupirone hcl tablet 7.5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>hydroxyzine hcl oral syrup</i>	Preferred	
<i>hydroxyzine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine hcl tablet 25 mg oral</i>	Preferred	
<i>hydroxyzine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>hydroxyzine pamoate</i>	Preferred	QL (4 EA per 1 day)
<i>meprobamate</i>	Non – Preferred	
VISTARIL	Non – Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Benzodiazepines*** - Drugs For Seizures / Personality Disorder / Nerve Pain		
<i>alprazolam er</i>	Non – Preferred	QL (2 EA per 1 day)
<i>alprazolam oral tablet dispersible</i>	Non – Preferred	
<i>alprazolam tablet 0.25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>alprazolam tablet 0.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>alprazolam tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>alprazolam tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>alprazolam xr</i>	Non – Preferred	QL (2 EA per 1 day)
<i>chlordiazepoxide hcl capsule 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlordiazepoxide hcl capsule 25 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>chlordiazepoxide hcl capsule 5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>clorazepate dipotassium tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>clorazepate dipotassium tablet 3.75 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>clorazepate dipotassium tablet 7.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diazepam oral concentrate</i>	Preferred	QL (10 ML per 1 day)
<i>diazepam oral solution</i>	Preferred	QL (10 ML per 1 day)
<i>diazepam oral tablet</i>	Preferred	QL (4 EA per 1 day)
<i>lorazepam oral concentrate</i>	Preferred	QL (2 ML per 1 day)
<i>lorazepam tablet 0.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>lorazepam tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lorazepam tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>oxazepam</i>	Preferred	QL (4 EA per 1 day)
ALPRAZOLAM INTENSOL	Preferred	
ATIVAN TABLET 0.5 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
ATIVAN TABLET 1 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
ATIVAN TABLET 2 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
DIAZEPAM INTENSOL	Preferred	QL (10 ML per 1 day)
LORAZEPAM INTENSOL	Preferred	QL (2 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOREEV XR	Non – Preferred	
XANAX TABLET 0.25 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
XANAX TABLET 0.5 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
XANAX TABLET 1 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
XANAX TABLET 2 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
XANAX XR	Non – Preferred	QL (2 EA per 1 day)
Antiarrhythmics - Drugs For The Heart		
*Antiarrhythmics Type I-A*** - Drugs For Abnormal Heart Rhythms		
<i>disopyramide phosphate</i>	Preferred	
<i>quinidine gluconate er</i>	Preferred	
<i>quinidine sulfate</i>	Preferred	
NORPACE	Non – Preferred	
NORPACE CR	Preferred	
*Antiarrhythmics Type I-B*** - Drugs For Abnormal Heart Rhythms		
<i>mexiletine hcl</i>	Preferred	
*Antiarrhythmics Type I-C*** - Drugs For Abnormal Heart Rhythms		
<i>flecainide acetate</i>	Preferred	
<i>propafenone hcl</i>	Preferred	
<i>propafenone hcl er</i>	Non – Preferred	
*Antiarrhythmics Type Iii*** - Drugs For Abnormal Heart Rhythms		
<i>amiodarone hcl</i>	Preferred	
<i>dofetilide</i>	Preferred	
MULTAQ	Non – Preferred	QL (2 EA per 1 day)
PACERONE	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TIKOSYN	Non – Preferred	
Antiasthmatic And Bronchodilator Agents - Drugs For The Lungs		
*5-Lipoxygenase Inhibitors*** - Drugs For Asthma/Copd		
<i>zileuton er</i>	Non – Preferred	
ZYFLO	Non – Preferred	
*Adrenergic Combinations*** - Drugs For Asthma/Copd		
<i>budesonide-formoterol fumarate</i>	Non – Preferred	QL (10.3 GM per 20 days)
<i>fluticasone furoate-vilanterol aerosol powder breath activated 100-25 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone furoate-vilanterol aerosol powder breath activated 200-25 mcg/act inhalation</i>	Non – Preferred	QL (1 Pack per 30 days)
<i>fluticasone-salmeterol aerosol powder breath activated 100-50 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 113-14 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone-salmeterol aerosol powder breath activated 232-14 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 500-50 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 55-14 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone-salmeterol inhalation aerosol</i>	Non – Preferred	
<i>ipratropium-albuterol</i>	Preferred	QL (18 ML per 1 day)
ADVAIR DISKUS	Preferred	
ADVAIR HFA AEROSOL 115-21 MCG/ACT INHALATION	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVAIR HFA AEROSOL 230-21 MCG/ACT INHALATION	Non – Preferred	
ADVAIR HFA AEROSOL 230-21 MCG/ACT INHALATION	Preferred	
ADVAIR HFA AEROSOL 45-21 MCG/ACT INHALATION	Preferred	
AIRDUO RESPICLICK 113/14	Preferred	
AIRDUO RESPICLICK 232/14	Preferred	
AIRDUO RESPICLICK 55/14	Preferred	
AIRSUPRA	Non – Preferred	
ANORO ELLIPTA	Preferred	
BEVESPI AEROSPHERE	Non – Preferred	QL (10.7 GM per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT INHALATION	Non – Preferred	QL (60 GM per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT INHALATION	Non – Preferred	QL (1 Pack per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH INHALATION	Non – Preferred	
BREYNA	Non – Preferred	QL (10.3 GM per 20 days)
BREZTRI AEROSPHERE	Non – Preferred	
COMBIVENT RESPIMAT	Non – Preferred	QL (8 GM per 28 days)
DUAKLIR PRESSAIR	Non – Preferred	
DULERA AEROSOL 100-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 200-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 50-5 MCG/ACT INHALATION	Preferred	
STIOLTO RESPIMAT	Non – Preferred	QL (1 CANISTER per 28 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMBICORT	Preferred	QL (10.3 GM per 20 days)
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT INHALATION	Non – Preferred	
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT INHALATION	Non – Preferred	
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 250-50 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 500-50 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
*Anti-IgE Monoclonal Antibodies*** - Drugs For Asthma/Copd		
XOLAIR	Preferred	PA
*Anti-Inflammatory Agents*** - Drugs For Asthma/Copd		
<i>cromolyn sodium</i>	Preferred	
*Beta Adrenergics*** - Drugs For Asthma/Copd		
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	Preferred	QL (36 GM per 30 days)
<i>albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083% inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 0.63 mg/3ml inhalation</i>	Preferred	QL (12 ML per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>albuterol sulfate nebulization solution 1.25 mg/3ml inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 2.5 mg/0.5ml inhalation</i>	Preferred	QL (2 ML per 1 day)
<i>albuterol sulfate oral</i>	Non – Preferred	
<i>arformoterol tartrate</i>	Non – Preferred	
<i>formoterol fumarate</i>	Non – Preferred	
<i>levalbuterol hcl</i>	Non – Preferred	
<i>levalbuterol tartrate</i>	Non – Preferred	QL (30 GM per 30 days)
<i>terbutaline sulfate</i>	Preferred	
BROVANA	Non – Preferred	
PERFOROMIST	Non – Preferred	
PROAIR RESPICLICK	Non – Preferred	
PROVENTIL HFA	Preferred	QL (36 GM per 30 days)
SEREVENT DISKUS	Preferred	QL (2 EA per 1 day)
STRIVERDI RESPIMAT	Non – Preferred	QL (4 GM per 28 days)
VENTOLIN HFA	Non – Preferred	QL (36 GM per 30 days)
XOPENEX HFA AEROSOL 45 MCG/ACT INHALATION	Non – Preferred	QL (30 GM per 30 days)
<i>*Bronchodilators - Anticholinergics*** - Drugs For Asthma/Copd</i>		
<i>ipratropium bromide</i>	Preferred	
<i>tiotropium bromide monohydrate</i>	Preferred	
ATROVENT HFA	Preferred	QL (26 GM per 30 days)
INCRUSE ELLIPTA	Preferred	
SPIRIVA HANDIHALER	Preferred	
SPIRIVA RESPIMAT	Preferred	
TUDORZA PRESSAIR	Non – Preferred	
YUPELRI	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Interleukin-5 Antagonists (Igg1 Kappa)*** - Drugs For Asthma/Copd		
FASENRA	Preferred	PA
FASENRA PEN	Preferred	PA
NUCALA	Preferred	PA
*Interleukin-5 Antagonists (Igg4 Kappa)*** - Drugs For Asthma/Copd		
CINQAIR	Non – Preferred	
*Leukotriene Receptor Antagonists*** - Drugs For Asthma/Copd		
<i>montelukast sodium</i>	Preferred	QL (1 EA per 1 day)
<i>zafirlukast</i>	Preferred	QL (2 EA per 1 day)
ACCOLATE	Non – Preferred	QL (2 EA per 1 day)
SINGULAIR	Non – Preferred	QL (1 EA per 1 day)
*Selective Phosphodiesterase 4 (Pde4) Inhibitors*** - Drugs For Asthma/Copd		
<i>roflumilast</i>	Non – Preferred	
DALIRESP	Non – Preferred	
*Steroid Inhalants*** - Drugs For Asthma/Copd		
<i>budesonide suspension 0.25 mg/2ml inhalation</i>	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
<i>budesonide suspension 0.5 mg/2ml inhalation</i>	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
<i>budesonide suspension 1 mg/2ml inhalation</i>	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
<i>fluticasone propionate diskus aerosol powder breath activated 100 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone propionate diskus aerosol powder breath activated 250 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone propionate diskus aerosol powder breath activated 50 mcg/act inhalation</i>	Non – Preferred	QL (60 EA Max Qty Per Fill Retail)
<i>fluticasone propionate hfa aerosol 110 mcg/act inhalation</i>	Preferred	QL (0.4 GM per 1 day)
<i>fluticasone propionate hfa aerosol 220 mcg/act inhalation</i>	Preferred	QL (0.4 GM per 1 day)
<i>fluticasone propionate hfa aerosol 44 mcg/act inhalation</i>	Preferred	QL (0.3534 GM per 1 day)
ALVESCO	Non – Preferred	
ARNUIITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT INHALATION	Non – Preferred	
ARNUIITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200 MCG/ACT INHALATION	Non – Preferred	
ARNUIITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION	Non – Preferred	
ARNUIITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	Non – Preferred	QL (1 EA per 1 day)
ASMANEX (120 METERED DOSES)	Preferred	
ASMANEX (14 METERED DOSES)	Preferred	
ASMANEX (30 METERED DOSES)	Preferred	
ASMANEX (60 METERED DOSES)	Preferred	
ASMANEX HFA	Non – Preferred	
PULMICORT	Non – Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
PULMICORT FLEXHALER	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QVAR REDHALER AEROSOL BREATH ACTIVATED 40 MCG/ACT INHALATION	Non – Preferred	QL (0.3533 GM per 1 day)
QVAR REDHALER AEROSOL BREATH ACTIVATED 80 MCG/ACT INHALATION	Non – Preferred	
<i>*Thymic Stromal Lymphopoietin (Tslp) Antagonists*** - Drugs For Asthma/Copd</i>		
TEZSPIRE	Non – Preferred	
<i>*Xanthines*** - Drugs For Asthma/Copd</i>		
<i>theophylline</i>	Preferred	
<i>theophylline er</i>	Preferred	
THEO-24	Preferred	
Anticoagulants - Drugs For The Blood		
<i>*Coumarin Anticoagulants*** - Drugs To Prevent Blood Clots</i>		
<i>warfarin sodium</i>	Preferred	
JANTOVEN	Preferred	
<i>*Direct Factor Xa Inhibitors*** - Drugs To Prevent Blood Clots</i>		
ELIQUIS	Preferred	QL (2 EA per 1 day)
ELIQUIS DVT/PE STARTER PACK	Preferred	QL (74 EA per 30 days)
SAVAYSA	Non – Preferred	
XARELTO ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
XARELTO STARTER PACK	Preferred	QL (51 EA per 30 days)
XARELTO TABLET 10 MG ORAL	Preferred	
XARELTO TABLET 15 MG ORAL	Preferred	QL (1 EA per 1 day)
XARELTO TABLET 2.5 MG ORAL	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XARELTO TABLET 20 MG ORAL	Preferred	
*Heparins And Heparinoid-Like Agents*** - Drugs To Prevent Blood Clots		
<i>heparin na (pork) lock flsh pf</i>	Preferred	
<i>heparin sod (pork) lock flush</i>	Preferred	
<i>heparin sodium (porcine)</i>	Preferred	
<i>heparin sodium (porcine) pf</i>	Preferred	
*Low Molecular Weight Heparins*** - Drugs To Prevent Blood Clots		
<i>enoxaparin sodium</i>	Preferred	
FRAGMIN	Preferred	
LOVENOX	Non – Preferred	
*Synthetic Heparinoid-Like Agents*** - Drugs To Prevent Blood Clots		
<i>fondaparinux sodium</i>	Preferred	
ARIXTRA	Non – Preferred	
*Thrombin Inhibitors - Selective Direct & Reversible*** - Drugs To Prevent Blood Clots		
<i>dabigatran etexilate mesylate</i>	Non – Preferred	
PRADAXA	Non – Preferred	
Anticonvulsants - Drugs For The Nervous System		
*Ampa Glutamate Receptor Antagonists*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
FYCOMPA	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Anticonvulsants - Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>clobazam</i>	Non – Preferred	
<i>clonazepam oral tablet</i>	Preferred	
<i>clonazepam oral tablet dispersible</i>	Non – Preferred	
<i>diazepam</i>	Preferred	QL (2 EA Max Qty Per Fill Retail)
KLONOPIN	Non – Preferred	
NAYZILAM	Non – Preferred	
ONFI	Non – Preferred	
SYMPAZAN	Non – Preferred	
VALTOCO 10 MG DOSE	Non – Preferred	
VALTOCO 15 MG DOSE	Non – Preferred	
VALTOCO 20 MG DOSE	Non – Preferred	
VALTOCO 5 MG DOSE	Non – Preferred	
*Anticonvulsants - Misc.*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>carbamazepine</i>	Preferred	
<i>carbamazepine er oral capsule extended release 12 hour</i>	Non – Preferred	QL (4 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 100 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 400 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>gabapentin oral capsule</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin oral solution</i>	Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gabapentin tablet 600 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin tablet 800 mg oral</i>	Preferred	QL (4.5 EA per 1 day)
<i>lacosamide</i>	Non – Preferred	
<i>lamotrigine er</i>	Non – Preferred	
<i>lamotrigine oral kit</i>	Non – Preferred	
<i>lamotrigine oral tablet dispersible</i>	Non – Preferred	
<i>lamotrigine starter kit-blue</i>	Non – Preferred	
<i>lamotrigine starter kit-green</i>	Non – Preferred	
<i>lamotrigine starter kit-orange</i>	Non – Preferred	
<i>lamotrigine tablet 100 mg oral</i>	Preferred	
<i>lamotrigine tablet 150 mg oral</i>	Preferred	
<i>lamotrigine tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lamotrigine tablet 25 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lamotrigine tablet chewable 25 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lamotrigine tablet chewable 5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>levetiracetam er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>levetiracetam er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>levetiracetam oral solution</i>	Preferred	
<i>levetiracetam tablet 1000 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>levetiracetam tablet 250 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>levetiracetam tablet 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>levetiracetam tablet 750 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxcarbazepine</i>	Preferred	
<i>pregabalin</i>	Preferred	
<i>primidone</i>	Preferred	
<i>rufinamide</i>	Non – Preferred	
<i>topiramate er</i>	Non – Preferred	
<i>topiramate oral capsule sprinkle</i>	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>topiramate tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>topiramate tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>topiramate tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>topiramate tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>zonisamide</i>	Preferred	QL (6 EA per 1 day)
APTIOM	Non – Preferred	
BANZEL	Non – Preferred	
BRIVIACT	Non – Preferred	
CARBATROL	Non – Preferred	QL (4 EA per 1 day)
DIACOMIT	Non – Preferred	
ELEPSIA XR	Non – Preferred	
EPIDIOLEX	Non – Preferred	
EPITOL	Preferred	
EPRONTIA	Non – Preferred	
FINTEPLA	Non – Preferred	
KEPPRA ORAL SOLUTION	Non – Preferred	
KEPPRA TABLET 1000 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
KEPPRA TABLET 250 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
KEPPRA TABLET 500 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
KEPPRA TABLET 750 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
LAMICTAL ODT	Non – Preferred	
LAMICTAL STARTER	Non – Preferred	
LAMICTAL TABLET 100 MG ORAL	Non – Preferred	
LAMICTAL TABLET 150 MG ORAL	Non – Preferred	
LAMICTAL TABLET 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
LAMICTAL TABLET 25 MG ORAL	Non – Preferred	QL (6 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAMICTAL TABLET CHEWABLE 25 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
LAMICTAL TABLET CHEWABLE 5 MG ORAL	Non – Preferred	QL (8 EA per 1 day)
LAMICTAL XR	Non – Preferred	
LYRICA	Non – Preferred	
MOTPOLY XR	Non – Preferred	
MYSOLINE	Non – Preferred	
NEURONTIN ORAL CAPSULE	Non – Preferred	QL (6 EA per 1 day)
NEURONTIN ORAL SOLUTION	Non – Preferred	
NEURONTIN TABLET 600 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
NEURONTIN TABLET 800 MG ORAL	Non – Preferred	QL (4.5 EA per 1 day)
OXTELLAR XR	Non – Preferred	
QUDEXY XR	Non – Preferred	
ROWEEPRA	Preferred	QL (6 EA per 1 day)
SPRITAM	Non – Preferred	
SUBVENITE STARTER KIT-BLUE	Non – Preferred	
SUBVENITE STARTER KIT-GREEN	Non – Preferred	
SUBVENITE STARTER KIT-ORANGE	Non – Preferred	
SUBVENITE TABLET 100 MG ORAL	Preferred	
SUBVENITE TABLET 150 MG ORAL	Preferred	
SUBVENITE TABLET 200 MG ORAL	Preferred	QL (2 EA per 1 day)
SUBVENITE TABLET 25 MG ORAL	Preferred	QL (6 EA per 1 day)
TEGRETOL	Non – Preferred	
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL	Non – Preferred	QL (10 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX SPRINKLE	Non – Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPAMAX TABLET 100 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX TABLET 25 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 50 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TRILEPTAL	Non – Preferred	
TROKENDI XR	Non – Preferred	
VIMPAT	Non – Preferred	
ZONISADE	Non – Preferred	
ZTALMY	Non – Preferred	
<i>*Carbamates*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
<i>felbamate</i>	Non – Preferred	
FELBATOL	Non – Preferred	
XCOPRI	Preferred	
XCOPRI (250 MG DAILY DOSE)	Preferred	
XCOPRI (350 MG DAILY DOSE)	Preferred	
<i>*Gaba Modulators*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
<i>tiagabine hcl tablet 12 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>tiagabine hcl tablet 16 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>tiagabine hcl tablet 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>tiagabine hcl tablet 4 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>vigabatrin</i>	Non – Preferred	
SABRIL	Non – Preferred	
VIGADRONE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Hydantoins*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
<i>phenytoin</i>	Preferred	
<i>phenytoin sodium extended</i>	Preferred	
DILANTIN	Non – Preferred	
DILANTIN INFATABS	Non – Preferred	
PHENYTEK	Preferred	
PHENYTOIN INFATABS	Preferred	
<i>*Succinimides*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
<i>ethosuximide</i>	Preferred	
<i>methsuximide</i>	Non – Preferred	
CELONTIN	Non – Preferred	
ZARONTIN	Non – Preferred	
<i>*Valproic Acid*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
<i>divalproex sodium</i>	Preferred	
<i>divalproex sodium er</i>	Preferred	
<i>valproic acid</i>	Preferred	
DEPAKOTE	Non – Preferred	
DEPAKOTE ER	Non – Preferred	
DEPAKOTE SPRINKLES	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidepressants - Drugs For The Nervous System		
*Alpha-2 Receptor Antagonists (Tetracyclics)*** - Drugs For Depression		
<i>mirtazapine</i>	Preferred	QL (1 EA per 1 day)
REMERON	Non – Preferred	QL (1 EA per 1 day)
REMERON SOLTAB	Non – Preferred	QL (1 EA per 1 day)
*Antidepressant - Miscellaneous Combinations*** - Drugs For Depression		
AUVELITY	Non – Preferred	
*Antidepressants - Misc.*** - Drugs For Depression		
<i>bupropion hcl</i>	Preferred	QL (3 EA per 1 day)
<i>bupropion hcl er (smoking det)</i>	Preferred	QL (2 EA per 1 day)
<i>bupropion hcl er (sr)</i>	Preferred	QL (2 EA per 1 day)
<i>bupropion hcl er (xl) tablet extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>bupropion hcl er (xl) tablet extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>bupropion hcl er (xl) tablet extended release 24 hour 450 mg oral</i>	Preferred	
APLENZIN	Non – Preferred	
FORFIVO XL	Non – Preferred	
WELLBUTRIN SR	Non – Preferred	QL (2 EA per 1 day)
WELLBUTRIN XL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Gaba Receptor Modulator - Neuroactive Steroid*** - Drugs For Depression		
ZURZUVAE	Non – Preferred	
*Monoamine Oxidase Inhibitors (Maois)*** - Drugs For Depression		
<i>phenelzine sulfate</i>	Preferred	
<i>tranylcypromine sulfate</i>	Preferred	
EMSAM	Non – Preferred	
MARPLAN	Non – Preferred	
NARDIL	Non – Preferred	
*N-Methyl-D-Aspartic Acid (Nmda) Receptor Antagonists*** - Drugs For Depression		
SPRAVATO (56 MG DOSE)	Non – Preferred	
SPRAVATO (84 MG DOSE)	Non – Preferred	
*Selective Serotonin Reuptake Inhibitors (Ssrís)*** - Drugs For Depression		
<i>citalopram hydrobromide oral capsule</i>	Non – Preferred	
<i>citalopram hydrobromide oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>citalopram hydrobromide tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>citalopram hydrobromide tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>citalopram hydrobromide tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>escitalopram oxalate oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>escitalopram oxalate oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>fluoxetine hcl capsule 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fluoxetine hcl capsule 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluoxetine hcl capsule 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluoxetine hcl oral capsule delayed release</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluoxetine hcl oral tablet</i>	Preferred	
<i>fluoxetine hcl solution 20 mg/5ml oral</i>	Preferred	
<i>fluoxetine hcl solution 20 mg/5ml oral</i>	Preferred	QL (150 ML per 30 days)
<i>fluvoxamine maleate er</i>	Non – Preferred	
<i>fluvoxamine maleate tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>fluvoxamine maleate tablet 25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fluvoxamine maleate tablet 50 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>paroxetine hcl er</i>	Non – Preferred	
<i>paroxetine hcl oral suspension</i>	Preferred	
<i>paroxetine hcl tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>paroxetine hcl tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>paroxetine hcl tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>paroxetine hcl tablet 40 mg oral</i>	Preferred	QL (1.5 EA per 1 day)
<i>sertraline hcl concentrate 20 mg/ml oral</i>	Preferred	QL (120 ML per 30 days)
<i>sertraline hcl oral capsule</i>	Non – Preferred	
<i>sertraline hcl oral tablet</i>	Preferred	QL (2 EA per 1 day)
CELEXA TABLET 10 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CELEXA TABLET 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CELEXA TABLET 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
LEXAPRO	Non – Preferred	QL (1 EA per 1 day)
PAXIL CR	Non – Preferred	
PAXIL ORAL SUSPENSION	Non – Preferred	
PAXIL TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PAXIL TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PAXIL TABLET 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
PAXIL TABLET 40 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
PROZAC CAPSULE 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROZAC CAPSULE 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
PROZAC CAPSULE 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZOLOFT ORAL CONCENTRATE	Non – Preferred	QL (120 ML per 30 days)
ZOLOFT ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
*Serotonin Modulators*** - Drugs For Depression		
<i>nefazodone hcl</i>	Non – Preferred	
<i>trazodone hcl</i>	Preferred	
<i>vilazodone hcl</i>	Non – Preferred	
TRINTELLIX	Non – Preferred	
VIIBRYD	Non – Preferred	
*Serotonin-Norepinephrine Reuptake Inhibitors (Snrts)*** - Drugs For Depression		
<i>desvenlafaxine er</i>	Non – Preferred	
<i>desvenlafaxine succinate er</i>	Non – Preferred	
<i>duloxetine hcl capsule delayed release particles 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 40 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 60 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>venlafaxine besylate er</i>	Preferred	
<i>venlafaxine hcl</i>	Preferred	
<i>venlafaxine hcl er oral capsule extended release 24 hour</i>	Preferred	QL (1 EA per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour</i>	Non – Preferred	
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 60 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DRIZALMA SPRINKLE	Non – Preferred	
EFFEXOR XR	Non – Preferred	QL (1 EA per 1 day)
FETZIMA	Non – Preferred	
FETZIMA TITRATION	Non – Preferred	
PRISTIQ	Non – Preferred	
<i>*Tricyclic Agents*** - Drugs For Depression</i>		
<i>amitriptyline hcl</i>	Preferred	
<i>amoxapine</i>	Non – Preferred	
<i>clomipramine hcl</i>	Preferred	
<i>desipramine hcl tablet 10 mg oral</i>	Preferred	
<i>desipramine hcl tablet 100 mg oral</i>	Preferred	
<i>desipramine hcl tablet 150 mg oral</i>	Preferred	
<i>desipramine hcl tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>desipramine hcl tablet 50 mg oral</i>	Preferred	
<i>desipramine hcl tablet 75 mg oral</i>	Preferred	
<i>doxepin hcl</i>	Preferred	
<i>imipramine hcl</i>	Preferred	
<i>imipramine pamoate</i>	Non – Preferred	
<i>nortriptyline hcl</i>	Preferred	
<i>protriptyline hcl</i>	Preferred	
<i>trimipramine maleate</i>	Non – Preferred	
ANAFRANIL	Non – Preferred	
NORPRAMIN TABLET 10 MG ORAL	Non – Preferred	
NORPRAMIN TABLET 25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
PAMELOR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidiabetics - Hormones		
*Alpha-Glucosidase Inhibitors*** - Drugs For Diabetes		
<i>acarbose</i>	Preferred	QL (3 EA per 1 day)
<i>miglitol</i>	Preferred	
*Antidiabetic - Amylin Analogs*** - Drugs For Diabetes		
SYMLINPEN 120	Non – Preferred	
SYMLINPEN 60	Non – Preferred	
*Biguanides*** - Drugs For Diabetes		
<i>metformin hcl er (mod)</i>	Non – Preferred	
<i>metformin hcl er (osm)</i>	Non – Preferred	
<i>metformin hcl er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>metformin hcl er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>metformin hcl oral solution</i>	Non – Preferred	
<i>metformin hcl tablet 1000 mg oral</i>	Preferred	
<i>metformin hcl tablet 500 mg oral</i>	Preferred	
<i>metformin hcl tablet 625 mg oral</i>	Non – Preferred	
<i>metformin hcl tablet 850 mg oral</i>	Preferred	
GLUMETZA	Non – Preferred	
*Diabetic Other*** - Drugs For Diabetes		
<i>diazoxide</i>	Preferred	
<i>glucagon emergency</i>	Non – Preferred	
BAQSIMI ONE PACK	Preferred	
BAQSIMI TWO PACK	Preferred	
GVOKE HYPOPEN 1-PACK	Preferred	
GVOKE HYPOPEN 2-PACK	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GVOKE KIT	Preferred	
GVOKE PFS	Preferred	
PROGLYCEM	Preferred	
ZEGALOGUE	Preferred	
*Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors*** - Drugs For Diabetes		
<i>alogliptin benzoate</i>	Non – Preferred	QL (1 EA per 1 day)
<i>saxagliptin hcl</i>	Non – Preferred	
JANUVIA	Preferred	QL (1 EA per 1 day)
ONGLYZA	Non – Preferred	
TRADJENTA	Preferred	QL (1 EA per 1 day)
ZITUVIO	Non – Preferred	
*Dipeptidyl Peptidase-4 Inhibitor-Biguanide Combinations*** - Drugs For Diabetes		
<i>alogliptin-metformin hcl</i>	Non – Preferred	
<i>saxagliptin-metformin er</i>	Non – Preferred	
JANUMET	Non – Preferred	QL (2 EA per 1 day)
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ORAL	Non – Preferred	
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
JENTADUETO	Non – Preferred	
JENTADUETO XR	Non – Preferred	
*Dopamine Receptor Agonists - Ergot Derivatives*** - Drugs For Diabetes		
CYCLOSET	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Dpp-4 Inhibitor-Thiazolidinedione Combinations*** - Drugs For Diabetes		
<i>alogliptin-pioglitazone</i>	Non – Preferred	QL (1 EA per 1 day)
*Human Insulin*** - Drugs For Diabetes		
<i>insulin asp prot & asp flexpen</i>	Non – Preferred	
<i>insulin aspart</i>	Non – Preferred	
<i>insulin aspart flexpen</i>	Non – Preferred	
<i>insulin aspart penfill</i>	Non – Preferred	
<i>insulin aspart prot & aspart</i>	Non – Preferred	
<i>insulin degludec</i>	Non – Preferred	
<i>insulin degludec flextouch</i>	Non – Preferred	
<i>insulin glargine</i>	Non – Preferred	
<i>insulin glargine max solostar</i>	Non – Preferred	
<i>insulin glargine solostar</i>	Non – Preferred	
<i>insulin glargine-yfqn</i>	Non – Preferred	
<i>insulin lispro</i>	Preferred	
<i>insulin lispro (1 unit dial)</i>	Preferred	
<i>insulin lispro junior kwikpen</i>	Preferred	QL (1 ML per 1 day)
<i>insulin lispro prot & lispro</i>	Preferred	
ADMELOG	Non – Preferred	
ADMELOG SOLOSTAR	Non – Preferred	
AFREZZA	Non – Preferred	
APIDRA	Non – Preferred	
APIDRA SOLOSTAR	Non – Preferred	
BASAGLAR KWIKPEN	Non – Preferred	
BASAGLAR TEMPO PEN	Non – Preferred	
FIASP	Non – Preferred	
FIASP FLEXTOUCH	Non – Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIASP PENFILL	Non – Preferred	
FIASP PUMPCART	Non – Preferred	
HUMALOG	Preferred	
HUMALOG JUNIOR KWIKPEN	Preferred	QL (1 ML per 1 day)
HUMALOG KWIKPEN	Preferred	
HUMALOG MIX 50/50	Preferred	
HUMALOG MIX 50/50 KWIKPEN	Preferred	
HUMALOG MIX 75/25	Preferred	
HUMALOG MIX 75/25 KWIKPEN	Preferred	
HUMALOG TEMPO PEN	Non – Preferred	
HUMULIN 70/30	Preferred	OTC
HUMULIN 70/30 KWIKPEN	Preferred	OTC
HUMULIN N	Preferred	OTC
HUMULIN N KWIKPEN	Preferred	OTC
HUMULIN R	Preferred	OTC
HUMULIN R U-500 (CONCENTRATED)	Preferred	
HUMULIN R U-500 KWIKPEN	Preferred	
LANTUS	Preferred	
LANTUS SOLOSTAR	Preferred	
LEVEMIR	Preferred	
LEVEMIR FLEXPEN	Preferred	
LYUMJEV	Non – Preferred	
LYUMJEV KWIKPEN	Non – Preferred	
LYUMJEV TEMPO PEN	Non – Preferred	
NOVOLIN 70/30	Non – Preferred	OTC
NOVOLIN 70/30 FLEXPEN	Non – Preferred	OTC
NOVOLIN 70/30 FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN 70/30 RELION	Non – Preferred	OTC
NOVOLIN N	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLIN N FLEXPEN	Non – Preferred	
NOVOLIN N FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN N RELION	Non – Preferred	OTC
NOVOLIN R	Non – Preferred	OTC
NOVOLIN R FLEXPEN	Non – Preferred	OTC
NOVOLIN R FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN R RELION	Non – Preferred	OTC
NOVOLOG	Non – Preferred	
NOVOLOG 70/30 FLEXPEN RELION	Non – Preferred	
NOVOLOG FLEXPEN	Non – Preferred	
NOVOLOG FLEXPEN RELION	Non – Preferred	
NOVOLOG MIX 70/30	Non – Preferred	
NOVOLOG MIX 70/30 FLEXPEN	Non – Preferred	
NOVOLOG MIX 70/30 RELION	Non – Preferred	
NOVOLOG PENFILL	Non – Preferred	
NOVOLOG RELION	Non – Preferred	
REZVOGLAR KWIKPEN	Non – Preferred	
SEMGLEE (YFGN)	Non – Preferred	
TOUJEO MAX SOLOSTAR	Non – Preferred	
TOUJEO SOLOSTAR	Non – Preferred	
TRESIBA	Non – Preferred	
TRESIBA FLEXTOUCH	Non – Preferred	
<i>*Incretin Mimetic Agents (Gip & Glp-1 Receptor Agonists)*** - Drugs For Diabetes</i>		
MOUNJARO	Non – Preferred	
<i>*Incretin Mimetic Agents (Glp-1 Receptor Agonists)*** - Drugs For Diabetes</i>		
BYDUREON BCISE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BYETTA 10 MCG PEN	Non – Preferred	
BYETTA 5 MCG PEN	Non – Preferred	
OZEMPIC (0.25 OR 0.5 MG/DOSE)	Non – Preferred	
OZEMPIC (1 MG/DOSE)	Non – Preferred	
OZEMPIC (2 MG/DOSE)	Non – Preferred	
RYBELSUS	Preferred	PA
TRULICITY	Preferred	Diagnosis Required
VICTOZA	Preferred	Diagnosis Required; QL (0.6 ML per 1 day)
<i>*Insulin-Incretin Mimetic Combinations*** - Drugs For Diabetes</i>		
SOLIQUA	Non – Preferred	
XULTOPHY	Non – Preferred	
<i>*Meglitinide Analogues*** - Drugs For Diabetes</i>		
<i>nateglinide</i>	Preferred	QL (3 EA per 1 day)
<i>repaglinide tablet 0.5 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>repaglinide tablet 1 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>repaglinide tablet 2 mg oral</i>	Non – Preferred	QL (8 EA per 1 day)
<i>*Progesterone Receptor Antagonists*** - Drugs For Diabetes</i>		
<i>mifepristone</i>	Non – Preferred	
KORLYM	Non – Preferred	
<i>*Sglt2 Inhibitor - Dpp-4 Inhibitor - Biguanide Comb*** - Drugs For Diabetes</i>		
TRIJARDY XR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SglT2 Inhibitor - Dpp-4 Inhibitor Combinations*** - Drugs For Diabetes		
GLYXAMBI	Non – Preferred	
QTERN	Non – Preferred	
STEGLUJAN	Non – Preferred	
*Sodium-Glucose Co-Transporter 2 (SglT2) Inhibitors*** - Drugs For Diabetes		
<i>dapagliflozin propanediol</i>	Non – Preferred	
FARXIGA	Preferred	
INVOKANA	Preferred	
JARDIANCE	Preferred	QL (1 EA per 1 day)
STEGLATRO	Non – Preferred	
*Sodium-Glucose Co-Transporter 2 Inhibitor-Biguanide Comb*** - Drugs For Diabetes		
<i>dapagliflozin pro-metformin er</i>	Non – Preferred	
INVOKAMET	Non – Preferred	
INVOKAMET XR	Non – Preferred	
SEGLUROMET	Non – Preferred	
SYNJARDY	Non – Preferred	
SYNJARDY XR	Non – Preferred	
XIGDUO XR	Non – Preferred	
*Sulfonylurea-Biguanide Combinations*** - Drugs For Diabetes		
<i>glipizide-metformin hcl tablet 2.5-250 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide-metformin hcl tablet 2.5-500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide-metformin hcl tablet 5-500 mg oral</i>	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glyburide-metformin tablet 1.25-250 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glyburide-metformin tablet 2.5-500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glyburide-metformin tablet 5-500 mg oral</i>	Preferred	QL (4 EA per 1 day)
*Sulfonylureas*** - Drugs For Diabetes		
<i>glimepiride tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glimepiride tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glimepiride tablet 4 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide</i>	Preferred	
<i>glipizide er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide er tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide</i>	Preferred	
<i>glyburide micronized tablet 1.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide micronized tablet 3 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide micronized tablet 6 mg oral</i>	Preferred	
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Sulfonylurea-Thiazolidinedione Combinations*** - Drugs For Diabetes		
<i>pioglitazone hcl-glimepiride</i>	Non – Preferred	
DUETACT	Non – Preferred	
*Thiazolidinedione-Biguanide Combinations*** - Drugs For Diabetes		
<i>pioglitazone hcl-metformin hcl</i>	Non – Preferred	
ACTOPLUS MET	Non – Preferred	
*Thiazolidinediones*** - Drugs For Diabetes		
<i>pioglitazone hcl</i>	Preferred	QL (1 EA per 1 day)
ACTOS	Non – Preferred	QL (1 EA per 1 day)
Antidiarrheal/Probiotic Agents - Drugs For The Stomach		
*Antidiarrheal/Probiotic Agents - Misc.*** - Drugs For Diarrhea		
<i>bismuth subsalicylate</i>	Preferred	OTC
<i>stomach relief extra strength</i>	Preferred	OTC
*Antiperistaltic Agents*** - Drugs For Diarrhea		
<i>diphenoxylate-atropine</i>	Preferred	
<i>loperamide hcl oral capsule</i>	Preferred	
<i>loperamide hcl oral tablet</i>	Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidotes And Specific Antagonists - Drugs For Overdose Or Poisoning		
<i>*Antidotes - Chelating Agents*** - Drugs For Overdose Or Poisoning</i>		
<i>deferasirox</i>	Non – Preferred	
<i>deferasirox granules</i>	Non – Preferred	
<i>deferiprone</i>	Non – Preferred	
CHEMET	Preferred	
EXJADE	Non – Preferred	
FERRIPROX	Non – Preferred	
FERRIPROX TWICE-A-DAY	Non – Preferred	
JADENU	Non – Preferred	
JADENU SPRINKLE	Non – Preferred	
<i>*Opioid Antagonists*** - Drugs For Overdose Or Poisoning</i>		
<i>nalmefene hcl</i>	Preferred	
<i>naloxone hcl</i>	Preferred	
<i>naltrexone hcl</i>	Preferred	
KLOXXADO	Preferred	
NARCAN	Preferred	
OPVEE	Preferred	
VIVITROL	Preferred	
ZIMHI	Preferred	
Antiemetics - Drugs For The Stomach		
<i>*5-Ht3 Receptor Antagonists*** - Drugs For Vomiting And Nausea</i>		
<i>granisetron hcl tablet 1 mg oral</i>	Non – Preferred	QL (8 EA per 28 days)

Coverage Requirements and Limits

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Drug Tier

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Preferred = Preferred

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QL = Quantity Limits

ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ondansetron</i>	Preferred	QL (3 EA per 1 day)
<i>ondansetron hcl oral solution</i>	Preferred	QL (50 ML Max Qty Per Fill Retail)
<i>ondansetron hcl oral tablet</i>	Preferred	QL (3 EA per 1 day)
ANZEMET	Non – Preferred	
SANCUSO	Non – Preferred	
*Antiemetic Combinations*** - Drugs For Vomiting And Nausea		
<i>doxylamine-pyridoxine</i>	Non – Preferred	
AKYNZEO	Non – Preferred	
BONJESTA	Non – Preferred	
DICLEGIS	Non – Preferred	
*Antiemetics - Anticholinergic*** - Drugs For Vomiting And Nausea		
<i>ft motion sickness</i>	Preferred	OTC
<i>meclizine hcl</i>	Preferred	
<i>scopolamine</i>	Preferred	
<i>trimethobenzamide hcl</i>	Non – Preferred	
ANTIVERT	Non – Preferred	
TRANSDERM-SCOP	Preferred	
*Antiemetics - Miscellaneous*** - Drugs For Vomiting And Nausea		
<i>dronabinol</i>	Non – Preferred	
MARINOL	Non – Preferred	
*Substance P/Neurokinin 1 (Nk1) Receptor Antagonists*** - Drugs For Vomiting And Nausea		
<i>aprepitant capsule 125 mg oral</i>	Preferred	QL (3 EA per 30 days)
<i>aprepitant capsule 40 mg oral</i>	Preferred	QL (3 EA per 30 days)
<i>aprepitant capsule 80 & 125 mg oral</i>	Preferred	QL (3 EA per 30 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aprepitant capsule 80 mg oral</i>	Preferred	QL (3 EA per 30 days)
<i>aprepitant oral</i>	Preferred	QL (3 EA per 30 days)
EMEND ORAL CAPSULE	Non – Preferred	QL (3 EA per 30 days)
EMEND ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
EMEND TRI-PACK	Non – Preferred	QL (3 EA per 30 days)
Antifungals - Drugs For Infections		
*Antifungal - Glucan Synthesis Inhibitors (Echinocandins)*** - Drugs For Fungus		
<i>micafungin sodium</i>	Preferred	
*Antifungal - Glucan Synthesis Inhibitors (Triterpenoids)*** - Antibiotics		
BREXAFEMME	Non – Preferred	
*Antifungals*** - Drugs For Fungus		
<i>flucytosine</i>	Non – Preferred	
<i>griseofulvin microsize</i>	Preferred	
<i>griseofulvin ultramicrosize</i>	Preferred	
<i>nystatin</i>	Preferred	QL (6 EA per 1 day)
<i>terbinafine hcl</i>	Preferred	QL (1 EA per 1 day)
ANCOBON	Non – Preferred	
*Imidazoles*** - Drugs For Fungus		
<i>ketoconazole</i>	Preferred	QL (1 EA per 1 day)
*Tetrazoles*** - Drugs For Fungus		
VIVJOA	Non – Preferred	
*Triazoles*** - Drugs For Fungus		
<i>fluconazole in sodium chloride</i>	Preferred	
<i>fluconazole oral suspension reconstituted</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluconazole tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluconazole tablet 150 mg oral</i>	Preferred	QL (14 EA per 28 days)
<i>fluconazole tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluconazole tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>itraconazole oral capsule</i>	Preferred	QL (4 EA per 1 day)
<i>itraconazole oral solution</i>	Non – Preferred	
<i>posaconazole</i>	Non – Preferred	
<i>tolsura</i>	Non – Preferred	
<i>voriconazole</i>	Non – Preferred	
CRESEMBA	Non – Preferred	
DIFLUCAN ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
DIFLUCAN ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
NOXAFIL	Non – Preferred	
SPORANOX ORAL CAPSULE	Non – Preferred	QL (4 EA per 1 day)
SPORANOX ORAL SOLUTION	Non – Preferred	
VFEND	Non – Preferred	
Antihistamines - Drugs For The Lungs		
*Antihistamines - Alkylamines*** - Drugs For Allergies		
<i>aller-chlor</i>	Preferred	OTC
<i>allergy</i>	Preferred	OTC
<i>allergy relief</i>	Preferred	OTC
<i>chlorpheniramine maleate</i>	Preferred	OTC
WAL-FINATE	Preferred	OTC
*Antihistamines - Ethanolamines*** - Drugs For Allergies		
<i>diphenhydramine hcl oral capsule</i>	Preferred	
<i>diphenhydramine hcl oral liquid</i>	Preferred	OTC; QL (20 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diphenhydramine hcl oral tablet</i>	Preferred	OTC
*Antihistamines - Non-Sedating*** - Drugs For Allergies		
<i>cetirizine hcl oral solution</i>	Preferred	
<i>cetirizine hcl oral tablet</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>cetirizine hcl oral tablet chewable</i>	Preferred	OTC
<i>fexofenadine hcl oral tablet 180 mg</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>fexofenadine hcl oral tablet 60 mg</i>	Preferred	OTC; QL (2 EA per 1 day)
<i>levocetirizine dihydrochloride</i>	Preferred	QL (1 EA per 1 day)
<i>loratadine oral solution</i>	Preferred	OTC; QL (240 ML Max Qty Per Fill Retail)
<i>loratadine oral tablet</i>	Preferred	OTC; QL (1 EA per 1 day)
*Antihistamines - Phenothiazines*** - Drugs For Allergies		
<i>promethazine hcl oral solution</i>	Preferred	QL (80 ML per 1 day); AL (Min 2 Years)
<i>promethazine hcl oral tablet</i>	Preferred	AL (Min 2 Years)
<i>promethazine hcl rectal</i>	Preferred	AL (Min 2 Years)
*Antihistamines - Piperidines*** - Drugs For Allergies		
<i>cyproheptadine hcl</i>	Preferred	
Antihyperlipidemics - Drugs For The Heart		
*Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb*** - Drugs For Cholesterol		
NEXLIZET	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors*** - Drugs For Cholesterol		
NEXLETOL	Non – Preferred	
*Antihyperlipidemics - Misc.*** - Drugs For Cholesterol		
<i>icosapent ethyl</i>	Non – Preferred	
<i>omega-3-acid ethyl esters</i>	Non – Preferred	QL (4 EA per 1 day)
LOVAZA	Non – Preferred	QL (4 EA per 1 day)
VASCEPA	Non – Preferred	
*Bile Acid Sequestrants*** - Drugs For Cholesterol		
<i>cholestyramine</i>	Preferred	
<i>cholestyramine light</i>	Preferred	
<i>colesevelam hcl</i>	Non – Preferred	
<i>colestipol hcl</i>	Non – Preferred	
COLESTID	Non – Preferred	
PREVALITE	Preferred	
QUESTRAN	Non – Preferred	
QUESTRAN LIGHT	Non – Preferred	
WELCHOL	Non – Preferred	
*Fibric Acid Derivatives*** - Drugs For Cholesterol		
<i>fenofibrate</i>	Preferred	
<i>fenofibrate micronized</i>	Preferred	
<i>fenofibric acid oral capsule delayed release</i>	Preferred	
<i>fenofibric acid oral tablet</i>	Non – Preferred	
<i>gemfibrozil</i>	Preferred	QL (2 EA per 1 day)
FENOGLIDE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOFEN	Non – Preferred	
LOPID	Non – Preferred	QL (2 EA per 1 day)
TRICOR	Non – Preferred	
TRILIPIX	Non – Preferred	
<i>*Hmg Coa Reductase Inhibitors*** - Drugs For Cholesterol</i>		
<i>atorvastatin calcium</i>	Preferred	QL (1 EA per 1 day)
<i>fluvastatin sodium</i>	Non – Preferred	QL (1 EA per 1 day)
<i>fluvastatin sodium er</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>pitavastatin calcium</i>	Non – Preferred	
<i>pravastatin sodium</i>	Preferred	QL (1 EA per 1 day)
<i>rosuvastatin calcium</i>	Preferred	QL (1 EA per 1 day)
<i>simvastatin</i>	Preferred	QL (1 EA per 1 day)
ALTOPREV	Non – Preferred	
ATORVALIQ	Non – Preferred	
CRESTOR	Non – Preferred	QL (1 EA per 1 day)
EZALLOR SPRINKLE	Non – Preferred	
LESCOL XL	Non – Preferred	QL (1 EA per 1 day)
LIPITOR	Non – Preferred	QL (1 EA per 1 day)
LIVALO	Non – Preferred	
ZOCOR	Non – Preferred	QL (1 EA per 1 day)
ZYPITAMAG	Non – Preferred	
<i>*Intest Cholest Absorp Inhib-Hmg Coa Reductase Inhib Comb*** - Drugs For Cholesterol</i>		
<i>ezetimibe-simvastatin</i>	Non – Preferred	
VYTORIN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Intestinal Cholesterol Absorption Inhibitors*** - Drugs For Cholesterol		
<i>ezetimibe</i>	Preferred	QL (1 EA per 1 day)
ZETIA	Non – Preferred	QL (1 EA per 1 day)
*Microsomal Triglyceride Transfer Protein Inhibitors*** - Drugs For Cholesterol		
JUXTAPID	Non – Preferred	
*Nicotinic Acid Derivatives*** - Drugs For Cholesterol		
<i>niacin er (antihyperlipidemic)</i>	Non – Preferred	
*Pcsk9 Inhibitors*** - Drugs For Cholesterol		
PRALUENT	Non – Preferred	
REPATHA	Non – Preferred	
REPATHA PUSHTRONEX SYSTEM	Non – Preferred	
REPATHA SURECLICK	Non – Preferred	
*Small Interfering Rna (Sirna) Pcsk9 Inhibitors*** - Drugs For Cholesterol		
LEQVIO	Non – Preferred	
Antihypertensives - Drugs For The Heart		
*Ace Inhibitor & Calcium Channel Blocker Combinations*** - Drugs For High Blood Pressure		
<i>amlodipine besy-benazepril hcl</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril-verapamil hcl er</i>	Preferred	
LOTREL	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Drug Tier

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Preferred = Preferred

AL = Age Restrictions

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QL = Quantity Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Ace Inhibitors & Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure		
<i>benazepril-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<i>captopril-hydrochlorothiazide</i>	Preferred	
<i>enalapril-hydrochlorothiazide tablet 10-25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>enalapril-hydrochlorothiazide tablet 5-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fosinopril sodium-hctz</i>	Preferred	
<i>lisinopril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lisinopril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lisinopril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>quinapril-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
ACCURETIC	Non – Preferred	QL (1 EA per 1 day)
LOTENSIN HCT	Non – Preferred	QL (1 EA per 1 day)
VASERETIC	Non – Preferred	QL (2 EA per 1 day)
ZESTORETIC TABLET 10-12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZESTORETIC TABLET 20-12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZESTORETIC TABLET 20-25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
*Ace Inhibitors*** - Drugs For High Blood Pressure		
<i>benazepril hcl</i>	Preferred	QL (2 EA per 1 day)
<i>captopril</i>	Preferred	QL (3 EA per 1 day)
<i>enalapril maleate oral solution</i>	Non – Preferred	
<i>enalapril maleate oral tablet</i>	Preferred	QL (2 EA per 1 day)
<i>fosinopril sodium</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril</i>	Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>moexipril hcl</i>	Preferred	
<i>perindopril erbumine tablet 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>perindopril erbumine tablet 4 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>perindopril erbumine tablet 8 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>quinapril hcl</i>	Preferred	QL (2 EA per 1 day)
<i>ramipril</i>	Preferred	QL (2 EA per 1 day)
<i>trandolapril tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril tablet 4 mg oral</i>	Preferred	QL (2 EA per 1 day)
ACCUPRIL	Non – Preferred	QL (2 EA per 1 day)
ALTACE	Non – Preferred	QL (2 EA per 1 day)
EPANED	Non – Preferred	
LOTENSIN	Non – Preferred	QL (2 EA per 1 day)
QBRELIS	Non – Preferred	
VASOTEC	Non – Preferred	QL (2 EA per 1 day)
ZESTRIL	Non – Preferred	QL (2 EA per 1 day)
*Agents For Pheochromocytoma*** - Drugs For High Blood Pressure		
<i>metyrosine</i>	Preferred	
<i>phenoxybenzamine hcl</i>	Non – Preferred	
DEMSEER	Preferred	
*Angiotensin II Receptor Antag & Ca Channel Blocker Comb*** - Drugs For High Blood Pressure		
<i>amlodipine besylate-valsartan</i>	Non – Preferred	QL (1 EA per 1 day)
<i>amlodipine-olmesartan</i>	Non – Preferred	
<i>telmisartan-amlodipine</i>	Non – Preferred	
AZOR	Non – Preferred	
EXFORGE	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Angiotensin II Receptor Antag & Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure		
<i>candesartan cilexetil-hctz</i>	Non – Preferred	QL (1 EA per 1 day)
<i>irbesartan-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium-hctz</i>	Preferred	QL (1 EA per 1 day)
<i>olmesartan medoxomil-hctz</i>	Non – Preferred	
<i>telmisartan-hctz</i>	Non – Preferred	
<i>valsartan-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
ATACAND HCT	Non – Preferred	QL (1 EA per 1 day)
AVALIDE	Non – Preferred	QL (1 EA per 1 day)
BENICAR HCT	Non – Preferred	
DIOVAN HCT	Non – Preferred	QL (1 EA per 1 day)
EDARBYCLOR	Non – Preferred	
HYZAAR	Non – Preferred	QL (1 EA per 1 day)
MICARDIS HCT	Non – Preferred	
*Angiotensin II Receptor Antagonists*** - Drugs For High Blood Pressure		
<i>candesartan cilexetil</i>	Non – Preferred	QL (1 EA per 1 day)
<i>irbesartan</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium tablet 100 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>losartan potassium tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>olmesartan medoxomil</i>	Non – Preferred	
<i>telmisartan</i>	Non – Preferred	
<i>valsartan oral solution</i>	Preferred	
<i>valsartan oral tablet</i>	Preferred	QL (1 EA per 1 day)
ATACAND	Non – Preferred	QL (1 EA per 1 day)
AVAPRO	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BENICAR	Non – Preferred	
COZAAR TABLET 100 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
COZAAR TABLET 25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
COZAAR TABLET 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DIOVAN	Non – Preferred	QL (1 EA per 1 day)
EDARBI	Non – Preferred	
MICARDIS	Non – Preferred	
*Angiotensin li Receptor Ant-Ca Channel Blocker-Thiazides*** - Drugs For High Blood Pressure		
<i>amlodipine-valsartan-hctz</i>	Non – Preferred	
<i>olmesartan-amlodipine-hctz</i>	Non – Preferred	
EXFORGE HCT	Non – Preferred	
TRIBENZOR	Non – Preferred	
*Antiadrenergics - Centrally Acting*** - Drugs For High Blood Pressure		
<i>clonidine</i>	Preferred	
<i>clonidine hcl</i>	Preferred	
<i>clonidine hcl er</i>	Non – Preferred	
<i>guanfacine hcl tablet 1 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>guanfacine hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>methyldopa</i>	Preferred	
*Antiadrenergics - Peripherally Acting*** - Drugs For High Blood Pressure		
<i>doxazosin mesylate tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 4 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 8 mg oral</i>	Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prazosin hcl</i>	Preferred	QL (4 EA per 1 day)
<i>terazosin hcl capsule 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>terazosin hcl capsule 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>terazosin hcl capsule 2 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>terazosin hcl capsule 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
CARDURA TABLET 1 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 2 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 4 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
*Beta Blocker & Diuretic Combinations*** - Drugs For High Blood Pressure		
<i>atenolol-chlorthalidone</i>	Preferred	
<i>bisoprolol-hydrochlorothiazide</i>	Preferred	
<i>metoprolol-hydrochlorothiazide</i>	Preferred	
TENORETIC 100	Non – Preferred	
TENORETIC 50	Non – Preferred	
*Direct Renin Inhibitors*** - Drugs For High Blood Pressure		
<i>aliskiren fumarate</i>	Non – Preferred	
TEKTURNA	Non – Preferred	
*Selective Aldosterone Receptor Antagonists (Saras)*** - Drugs For High Blood Pressure		
<i>eplerenone</i>	Non – Preferred	
INSPRA	Non – Preferred	
*Vasodilators*** - Drugs For High Blood Pressure		
<i>hydralazine hcl</i>	Preferred	
<i>minoxidil</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anti-Infective Agents - Misc. - Drugs For Infections		
*Anti-Infective Agents - Misc.*** - Drugs For Infections		
<i>metronidazole intravenous</i>	Preferred	
<i>metronidazole oral capsule</i>	Non – Preferred	
<i>metronidazole oral tablet</i>	Preferred	
<i>pentamidine isethionate</i>	Preferred	
<i>tinidazole</i>	Non – Preferred	
<i>trimethoprim</i>	Preferred	
AEMCOLO	Non – Preferred	
FLAGYL	Non – Preferred	
LIKMEZ	Non – Preferred	
NEBUPENT	Preferred	
XIFAXAN	Non – Preferred	
*Anti-Infective Misc. - Combinations*** - Antibiotics		
<i>sulfamethoxazole-trimethoprim</i>	Preferred	
BACTRIM	Non – Preferred	
BACTRIM DS	Non – Preferred	
SULFATRIM PEDIATRIC	Preferred	
*Antiprotozoal Agents*** - Drugs For Parasites		
<i>atovaquone</i>	Preferred	
<i>nitazoxanide</i>	Non – Preferred	
LAMPIT	Non – Preferred	
MEPRON	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Carbapenem Combinations*** - Antibiotics		
<i>imipenem-cilastatin</i>	Preferred	
*Carbapenems*** - Antibiotics		
<i>ertapenem sodium</i>	Preferred	
<i>meropenem</i>	Preferred	
<i>meropenem-sodium chloride</i>	Preferred	
*Glycopeptides*** - Antibiotics		
<i>vancomycin hcl capsule 125 mg oral</i>	Preferred	
<i>vancomycin hcl capsule 125 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>vancomycin hcl capsule 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>vancomycin hcl in dextrose</i>	Preferred	
<i>vancomycin hcl in nacl</i>	Preferred	
<i>vancomycin hcl intravenous</i>	Preferred	
<i>vancomycin hcl oral solution reconstituted</i>	Preferred	
FIRVANQ	Non – Preferred	
VANCOCIN CAPSULE 125 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
VANCOCIN CAPSULE 250 MG ORAL	Non – Preferred	QL (8 EA per 1 day)
*Leprostics*** - Antibiotics		
<i>dapsone</i>	Preferred	
*Lincosamides*** - Antibiotics		
<i>clindamycin hcl</i>	Preferred	
<i>clindamycin palmitate hcl</i>	Preferred	
<i>clindamycin phosphate</i>	Preferred	
<i>clindamycin phosphate in d5w</i>	Preferred	
<i>clindamycin phosphate in nacl</i>	Preferred	
CLEOCIN	Non – Preferred	
*Monobactams*** - Antibiotics		
<i>aztreonam</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CAYSTON	Non – Preferred	
*Oxazolidinones*** - Antibiotics		
<i>linezolid</i>	Non – Preferred	
SIVEXTRO	Non – Preferred	
ZYVOX	Non – Preferred	
*Urinary Anti-Infectives*** - Antibiotics		
<i>fosfomycin tromethamine</i>	Preferred	
<i>methenamine hippurate</i>	Preferred	
<i>methenamine mandelate</i>	Preferred	
<i>nitrofurantoin macrocrystal</i>	Preferred	
<i>nitrofurantoin monohyd macro</i>	Preferred	
<i>nitrofurantoin suspension 25 mg/5ml oral</i>	Preferred	
<i>nitrofurantoin suspension 50 mg/5ml oral</i>	Preferred	QL (1 ML per 1 day)
HIPREX	Non – Preferred	
MACROBID	Non – Preferred	
MACRODANTIN	Non – Preferred	
*Urinary Antiseptic-Antispasmodic &/Or Analgesics*** - Drugs For Infections		
<i>me/naphos/mb/hyo1</i>	Non – Preferred	
<i>uro-mp</i>	Non – Preferred	
URIBEL	Non – Preferred	
URIMAR-T	Non – Preferred	
UROGESIC-BLUE	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antimalarials - Drugs For Infections		
*Antimalarial Combinations*** - Drugs For Parasites		
<i>atovaquone-proguanil hcl tablet 250-100 mg oral</i>	Preferred	QL (12 EA Max Qty Per Fill Retail)
<i>atovaquone-proguanil hcl tablet 62.5-25 mg oral</i>	Preferred	QL (9 EA Max Qty Per Fill Retail)
COARTEM	Non – Preferred	
MALARONE TABLET 250-100 MG ORAL	Non – Preferred	QL (12 EA Max Qty Per Fill Retail)
MALARONE TABLET 62.5-25 MG ORAL	Non – Preferred	QL (9 EA Max Qty Per Fill Retail)
*Antimalarials*** - Drugs For Parasites		
<i>chloroquine phosphate</i>	Preferred	
<i>hydroxychloroquine sulfate</i>	Preferred	
<i>mefloquine hcl</i>	Preferred	
<i>primaquine phosphate</i>	Preferred	QL (28 EA Max Qty Per Fill Retail)
<i>pyrimethamine</i>	Non – Preferred	
<i>quinine sulfate</i>	Non – Preferred	
DARAPRIM	Non – Preferred	
KRINTAFEL	Non – Preferred	
QUALAQUIN	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antimyasthenic/Cholinergic Agents - Drugs For Nerves And Muscles		
*Antimyasthenic/Cholinergic Agents*** - Drugs For Nerves And Muscles		
<i>pyridostigmine bromide</i>	Preferred	
<i>pyridostigmine bromide er</i>	Preferred	
FIRDAPSE	Non – Preferred	
MESTINON	Non – Preferred	
Antimycobacterial Agents - Drugs For Infections		
*Antimycobacterial Agents*** - Antibiotics		
<i>cycloserine</i>	Preferred	
<i>ethambutol hcl</i>	Preferred	
<i>isoniazid</i>	Preferred	
<i>pretomanid</i>	Non – Preferred	
<i>pyrazinamide</i>	Preferred	
<i>rifabutin</i>	Preferred	
<i>rifampin</i>	Preferred	
MYAMBUTOL	Non – Preferred	
MYCOBUTIN	Non – Preferred	
PRIFTIN	Preferred	
SIRTURO	Non – Preferred	
TRECTOR	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastics And Adjunctive Therapies - Drugs For Cancer		
<i>*Alkylating Agents*** - Drugs For Cancer</i>		
MYLERAN	Preferred	
<i>*Androgen Biosynthesis Inhibitors*** - Drugs For Cancer</i>		
<i>abiraterone acetate</i>	Preferred	
YONSA	Non – Preferred	
ZYTIGA	Non – Preferred	
<i>*Antiadrenals*** - Drugs For Cancer</i>		
LYSODREN	Preferred	
<i>*Antiandrogens*** - Drugs For Cancer</i>		
<i>bicalutamide</i>	Preferred	QL (1 EA per 1 day)
<i>nilutamide</i>	Preferred	
CASODEX	Non – Preferred	QL (1 EA per 1 day)
ERLEADA	Non – Preferred	
NUBEQA	Non – Preferred	
XTANDI	Non – Preferred	
<i>*Antiestrogens*** - Drugs For Cancer</i>		
<i>tamoxifen citrate</i>	Preferred	
<i>toremifene citrate</i>	Preferred	
FARESTON	Non – Preferred	
SOLTAMOX	Preferred	
<i>*Antimetabolites*** - Drugs For Cancer</i>		
<i>capecitabine tablet 150 mg oral</i>	Non – Preferred	QL (140 EA per 21 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>capecitabine tablet 500 mg oral</i>	Non – Preferred	QL (154 EA per 21 days)
<i>mercaptopurine</i>	Preferred	
<i>methotrexate sodium (pf)</i>	Preferred	
<i>methotrexate sodium oral</i>	Preferred	
<i>methotrexate sodium solution 250 mg/10ml injection</i>	Preferred	QL (10 VIAL per 28 days)
<i>methotrexate sodium solution 50 mg/2ml injection</i>	Preferred	QL (4 VIAL per 28 days)
JYLAMVO	Non – Preferred	
ONUREG	Non – Preferred	
PURIXAN	Non – Preferred	
TABLOID	Preferred	
TREXALL	Preferred	
XATMEP	Non – Preferred	
XELODA TABLET 150 MG ORAL	Non – Preferred	QL (140 EA per 21 days)
XELODA TABLET 500 MG ORAL	Non – Preferred	QL (154 EA per 21 days)
<i>*Antineoplastic - Akt Inhibitors*** - Drugs For Cancer</i>		
TRUQAP	Non – Preferred	
<i>*Antineoplastic - Alk Inhibitors*** - Drugs For Cancer</i>		
ALECENSA	Non – Preferred	
ALUNBRIG	Non – Preferred	
LORBRENA	Non – Preferred	
XALKORI	Non – Preferred	
ZYKADIA	Non – Preferred	
<i>*Antineoplastic - Anti-Her2 Agents*** - Drugs For Cancer</i>		
TUKYSA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Antineoplastic - Bcl-2 Inhibitors*** - Drugs For Cancer</i>		
VENCLEXTA	Non – Preferred	
VENCLEXTA STARTING PACK	Non – Preferred	
<i>*Antineoplastic - Bcr-Abl Kinase Inhibitors*** - Drugs For Cancer</i>		
<i>imatinib mesylate tablet 100 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>imatinib mesylate tablet 400 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
BOSULIF	Non – Preferred	
GLEEVEC TABLET 100 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
GLEEVEC TABLET 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ICLUSIG	Non – Preferred	
SCEMBLIX	Non – Preferred	
SPRYCEL	Non – Preferred	QL (1 EA per 1 day)
TASIGNA	Non – Preferred	QL (4 EA per 1 day)
<i>*Antineoplastic - Braf Kinase Inhibitors*** - Drugs For Cancer</i>		
BRAFTOVI	Non – Preferred	
TAFINLAR	Non – Preferred	
ZELBORAF	Non – Preferred	
<i>*Antineoplastic - Btk Inhibitors*** - Drugs For Cancer</i>		
BRUKINSA	Non – Preferred	
CALQUENCE	Non – Preferred	
IMBRUVICA CAPSULE 140 MG ORAL	Non – Preferred	
IMBRUVICA CAPSULE 70 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
IMBRUVICA ORAL SUSPENSION	Non – Preferred	
IMBRUVICA TABLET 140 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
IMBRUVICA TABLET 280 MG ORAL	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMBRUVICA TABLET 420 MG ORAL	Non – Preferred	
JAYPIRCA	Non – Preferred	
*Antineoplastic - Egfr Inhibitors*** - Drugs For Cancer		
<i>erlotinib hcl</i>	Preferred	QL (1 EA per 1 day)
<i>gefitinib</i>	Preferred	
GILOTRIF	Non – Preferred	
IRESSA	Preferred	
TAGRISO	Non – Preferred	
TARCEVA	Non – Preferred	QL (1 EA per 1 day)
VIZIMPRO	Non – Preferred	
*Antineoplastic - Fgfr Kinase Inhibitors*** - Drugs For Cancer		
BALVERSA	Non – Preferred	
LYTGOBI (12 MG DAILY DOSE)	Non – Preferred	
LYTGOBI (16 MG DAILY DOSE)	Non – Preferred	
LYTGOBI (20 MG DAILY DOSE)	Non – Preferred	
PEMAZYRE	Non – Preferred	
*Antineoplastic - Hedgehog Pathway Inhibitors*** - Drugs For Cancer		
DAURISMO	Non – Preferred	
ERIVEDGE	Preferred	
ODOMZO	Non – Preferred	
*Antineoplastic - Histone Deacetylase Inhibitors*** - Drugs For Cancer		
ZOLINZA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antineoplastic - Hormonal And Related Agent Combinations*** - Drugs For Cancer		
AKEEGA	Non – Preferred	
*Antineoplastic - Immunomodulators*** - Drugs For Cancer		
POMALYST	Non – Preferred	
*Antineoplastic - Kras Inhibitors*** - Drugs For Cancer		
KRAZATI	Non – Preferred	
LUMAKRAS	Non – Preferred	
*Antineoplastic - Mek Inhibitors*** - Drugs For Cancer		
COTELLIC	Non – Preferred	
KOSELUGO	Non – Preferred	
MEKINIST	Non – Preferred	
MEKTOVI	Non – Preferred	
*Antineoplastic - Met Inhibitors*** - Drugs For Cancer		
TABRECTA	Non – Preferred	
TEPMETKO	Non – Preferred	
*Antineoplastic - Methyltransferase Inhibitors*** - Drugs For Cancer		
TAZVERIK	Non – Preferred	
*Antineoplastic - Mtor Kinase Inhibitors*** - Drugs For Cancer		
<i>everolimus oral tablet</i>	Non – Preferred	QL (1 EA per 1 day)
<i>everolimus oral tablet soluble</i>	Non – Preferred	
AFINITOR	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AFINITOR DISPERZ	Non – Preferred	
*Antineoplastic - Multikinase Inhibitors*** - Drugs For Cancer		
<i>lapatinib ditosylate</i>	Non – Preferred	
<i>pazopanib hcl</i>	Preferred	QL (4 EA per 1 day)
<i>sorafenib tosylate</i>	Preferred	QL (4 EA per 1 day)
<i>sunitinib malate capsule 12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>sunitinib malate capsule 25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>sunitinib malate capsule 37.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>sunitinib malate capsule 50 mg oral</i>	Preferred	QL (28 EA per 42 days)
CABOMETYX	Non – Preferred	QL (1 EA per 1 day)
CAPRELSA	Preferred	
COMETRIQ (100 MG DAILY DOSE)	Non – Preferred	
COMETRIQ (140 MG DAILY DOSE)	Non – Preferred	
COMETRIQ (60 MG DAILY DOSE)	Non – Preferred	
FOTIVDA	Non – Preferred	
NERLYNX	Non – Preferred	
NEXAVAR	Preferred	QL (4 EA per 1 day)
QINLOCK	Non – Preferred	
RYDAPT	Non – Preferred	
STIVARGA	Non – Preferred	
SUTENT CAPSULE 12.5 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 25 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 37.5 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 50 MG ORAL	Preferred	QL (28 EA per 42 days)
TURALIO	Non – Preferred	
TYKERB	Non – Preferred	QL (6 EA per 1 day)
VANFLYTA	Non – Preferred	
VOTRIENT	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XOSPATA	Non – Preferred	
<i>*Antineoplastic - Pdgfr-Alpha Inhibitors*** - Drugs For Cancer</i>		
AYVAKIT	Non – Preferred	
<i>*Antineoplastic - Proteasome Inhibitors*** - Drugs For Cancer</i>		
NINLARO	Non – Preferred	
<i>*Antineoplastic - Ret Inhibitors*** - Drugs For Cancer</i>		
GAVRETO	Non – Preferred	
RETEVMO	Non – Preferred	
<i>*Antineoplastic - Tropomyosin Receptor Kinase Inhibitors*** - Drugs For Cancer</i>		
AUGTYRO	Non – Preferred	
ROZLYTREK	Non – Preferred	
VITRAKVI	Non – Preferred	
<i>*Antineoplastic - Xpo1 Inhibitors*** - Drugs For Cancer</i>		
XPOVIO (100 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (60 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (60 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (80 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (80 MG TWICE WEEKLY)	Non – Preferred	
<i>*Antineoplastic Combinations*** - Drugs For Cancer</i>		
INQOVI	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LONSURF	Non – Preferred	
*Antineoplastics Misc.*** - Drugs For Cancer		
<i>hydroxyurea</i>	Preferred	
HYDREA	Non – Preferred	
MATULANE	Preferred	
*Aromatase Inhibitors*** - Drugs For Cancer		
<i>anastrozole</i>	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
<i>exemestane</i>	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
<i>letrozole</i>	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
ARIMIDEX	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
AROMASIN	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
FEMARA	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
*Cyclin-Dependent Kinases (Cdk) Inhibitors*** - Drugs For Cancer		
IBRANCE ORAL CAPSULE	Non – Preferred	QL (1 EA per 1 day)
IBRANCE ORAL TABLET	Non – Preferred	
KISQALI (200 MG DOSE)	Non – Preferred	
KISQALI (400 MG DOSE)	Non – Preferred	
KISQALI (600 MG DOSE)	Non – Preferred	
VERZENIO	Non – Preferred	QL (2 EA per 1 day)
*Estrogens-Antineoplastic*** - Drugs For Cancer		
EMCYT	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Folic Acid Antagonists Rescue Agents*** - Drugs For Cancer		
<i>leucovorin calcium</i>	Preferred	
*Gonadotropin Releasing Hormone (Gnrh) Antagonists*** - Drugs For Cancer		
ORGOVYX	Non – Preferred	
*Imidazotetrazines*** - Drugs For Cancer		
<i>temozolomide</i>	Preferred	
*Isocitrate Dehydrogenase-1 (ldh1) Inhibitors*** - Drugs For Cancer		
REZLIDHIA	Non – Preferred	
TIBSOVO	Non – Preferred	
*Isocitrate Dehydrogenase-2 (ldh2) Inhibitors*** - Drugs For Cancer		
IDHIFA	Non – Preferred	
*Janus Associated Kinase (Jak) Inhibitors*** - Drugs For Cancer		
INREBIC	Non – Preferred	
JAKAFI	Preferred	
OJJAARA	Non – Preferred	
VONJO	Non – Preferred	
*Mitotic Inhibitors*** - Drugs For Cancer		
<i>etoposide</i>	Preferred	
*Nitrogen Mustards And Related Analogues*** - Drugs For Cancer		
<i>cyclophosphamide</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKERAN	Preferred	
<i>*Ornithine Decarboxylase (Odc) Inhibitors*** - Drugs For Cancer</i>		
IWILFIN	Non – Preferred	
<i>*Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors*** - Drugs For Cancer</i>		
COPIKTRA	Non – Preferred	
PIQRAY (200 MG DAILY DOSE)	Non – Preferred	
PIQRAY (250 MG DAILY DOSE)	Non – Preferred	
PIQRAY (300 MG DAILY DOSE)	Non – Preferred	
ZYDELIG	Non – Preferred	
<i>*Poly (Adp-Ribose) Polymerase (Parp) Inhibitors*** - Drugs For Cancer</i>		
LYNPARZA	Non – Preferred	
RUBRACA	Non – Preferred	
TALZENNA	Non – Preferred	
ZEJULA	Non – Preferred	
<i>*Progestins-Antineoplastic*** - Drugs For Cancer</i>		
<i>megestrol acetate</i>	Preferred	
<i>*Retinoids*** - Drugs For Cancer</i>		
<i>tretinoin</i>	Preferred	
<i>*Selective Estrogen Receptor Degradors*** - Drugs For Cancer</i>		
ORSERDU	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Selective Retinoid X Receptor Agonists*** - Drugs For Cancer</i>		
<i>bexarotene</i>	Preferred	
TARGRETIN	Non – Preferred	
<i>*Topoisomerase I Inhibitors*** - Drugs For Cancer</i>		
HYCAMTIN	Preferred	
<i>*Urinary Tract Protective Agents*** - Drugs For Cancer</i>		
MESNEX	Preferred	
<i>*Vascular Endothelial Growth Factor (Vegf) Inhibitors*** - Drugs For Cancer</i>		
FRUZAQLA	Non – Preferred	
INLYTA	Non – Preferred	
LENVIMA (10 MG DAILY DOSE)	Non – Preferred	
LENVIMA (12 MG DAILY DOSE)	Non – Preferred	
LENVIMA (14 MG DAILY DOSE)	Non – Preferred	
LENVIMA (18 MG DAILY DOSE)	Non – Preferred	
LENVIMA (20 MG DAILY DOSE)	Non – Preferred	
LENVIMA (24 MG DAILY DOSE)	Non – Preferred	
LENVIMA (4 MG DAILY DOSE)	Non – Preferred	
LENVIMA (8 MG DAILY DOSE)	Non – Preferred	
<i>*Antiparkinson And Related Therapy Agents* - Drugs For The Nervous System</i>		
<i>*Adenosine Receptor Antagonist*** - Drugs For Parkinson</i>		
NOURIANZ	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antiparkinson Anticholinergics*** - Drugs For Parkinson		
<i>benztropine mesylate</i>	Preferred	
<i>trihexyphenidyl hcl</i>	Preferred	
*Antiparkinson Dopaminergics*** - Drugs For Parkinson		
<i>amantadine hcl</i>	Preferred	
<i>bromocriptine mesylate</i>	Preferred	
GOCOVRI	Non – Preferred	
INBRIJA	Non – Preferred	
OSMOLEX ER	Non – Preferred	
PARLODEL	Non – Preferred	
*Antiparkinson Monoamine Oxidase Inhibitors*** - Drugs For Parkinson		
<i>rasagiline mesylate</i>	Non – Preferred	
<i>selegiline hcl</i>	Preferred	
AZILECT	Non – Preferred	
XADAGO	Non – Preferred	
ZELAPAR	Non – Preferred	
*Central/Peripheral Comt Inhibitors*** - Drugs For Parkinson		
<i>tolcapone</i>	Non – Preferred	
TASMAR	Non – Preferred	
*Decarboxylase Inhibitors*** - Drugs For Parkinson		
<i>carbidopa</i>	Preferred	
LODOSYN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Levodopa Combinations*** - Drugs For Parkinson		
<i>carbidopa-levodopa er</i>	Preferred	
<i>carbidopa-levodopa oral tablet</i>	Preferred	
<i>carbidopa-levodopa oral tablet dispersible</i>	Non – Preferred	
<i>carbidopa-levodopa-entacapone</i>	Non – Preferred	
DHIVY	Non – Preferred	
RYTARY	Non – Preferred	
SINEMET	Non – Preferred	
STALEVO 150	Non – Preferred	QL (9 EA per 1 day)
*Nonergoline Dopamine Receptor Agonists*** - Drugs For Parkinson		
<i>apomorphine hcl</i>	Non – Preferred	
<i>pramipexole dihydrochloride</i>	Preferred	
<i>pramipexole dihydrochloride er</i>	Non – Preferred	
<i>ropinirole hcl</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 12 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 4 mg oral</i>	Non – Preferred	
<i>ropinirole hcl er tablet extended release 24 hour 6 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 8 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
APOKYN	Non – Preferred	
MIRAPEX ER	Non – Preferred	
NEUPRO	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Peripheral Comt Inhibitors*** - Drugs For Parkinson		
<i>entacapone</i>	Preferred	
ONGENTYS	Non – Preferred	
Antipsychotics/Antimanic Agents - Drugs For The Nervous System		
*Antimanic Agents*** - Drugs For Severe Mental Disorders		
<i>lithium</i>	Preferred	
<i>lithium carbonate capsule 150 mg oral</i>	Preferred	QL (16 EA per 1 day)
<i>lithium carbonate capsule 300 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>lithium carbonate capsule 600 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>lithium carbonate er tablet extended release 300 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>lithium carbonate er tablet extended release 450 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lithium carbonate oral tablet</i>	Preferred	QL (8 EA per 1 day)
LITHOBID	Non – Preferred	QL (8 EA per 1 day)
*Antipsychotics - Misc.*** - Drugs For Severe Mental Disorders		
<i>lurasidone hcl tablet 120 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 60 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 80 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ziprasidone hcl</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>ziprasidone mesylate</i>	Non – Preferred	AL (Min 18 Years)
CAPLYTA	Non – Preferred	AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL	Non – Preferred	AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL	Non – Preferred	QL (8 EA per 1 day); AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL	Non – Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
GEODON INTRAMUSCULAR	Non – Preferred	AL (Min 18 Years)
GEODON ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 60 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 80 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
NUPLAZID	Non – Preferred	AL (Min 8 Years)
VRAYLAR	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>*Benzisoxazoles*** - Drugs For Severe Mental Disorders</i>		
<i>paliperidone er tablet extended release 24 hour 1.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>paliperidone er tablet extended release 24 hour 3 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>paliperidone er tablet extended release 24 hour 6 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>paliperidone er tablet extended release 24 hour 9 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>risperidone microspheres er</i>	Non – Preferred	AL (Min 18 Years)
<i>risperidone oral solution</i>	Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
<i>risperidone tablet 0.25 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 1 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 2 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 3 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 4 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet dispersible 0.25 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 0.5 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 1 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 2 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 3 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet dispersible 4 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 1 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 10 MG ORAL	Non – Preferred	AL (Min 8 Years)
FANAPT TABLET 12 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FANAPT TABLET 2 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 4 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 6 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TITRATION PACK	Non – Preferred	QL (1 PACK per 90 days); AL (Min 8 Years)
INVEGA HAFYERA	Preferred	ST; AL (Min 18 Years)
INVEGA SUSTENNA	Preferred	AL (Min 18 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
INVEGA TRINZA	Preferred	AL (Min 18 Years)
PERSERIS	Preferred	AL (Min 18 Years)
RISPERDAL CONSTA	Non – Preferred	AL (Min 18 Years)
RISPERDAL ORAL SOLUTION	Non – Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 0.5 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 1 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 2 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 3 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 4 MG ORAL	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RYKINDO	Non – Preferred	AL (Min 18 Years)
UZEDY	Preferred	AL (Min 18 Years)
*Butyrophenones*** - Drugs For Severe Mental Disorders		
<i>haloperidol decanoate</i>	Preferred	AL (Min 18 Years)
<i>haloperidol lactate injection</i>	Preferred	QL (4 ML per 1 day); AL (Min 3 Years)
<i>haloperidol lactate oral</i>	Preferred	QL (50 ML per 1 day)
<i>haloperidol tablet 0.5 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>haloperidol tablet 1 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 10 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 2 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 20 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>haloperidol tablet 5 mg oral</i>	Preferred	QL (5 EA per 1 day)
*Dibenzodiazepines*** - Drugs For Severe Mental Disorders		
<i>clozapine tablet 100 mg oral</i>	Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 100 mg oral</i>	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 12.5 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>clozapine tablet dispersible 150 mg oral</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 200 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clozapine tablet dispersible 25 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 100 MG ORAL	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 25 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
VERSACLOZ	Non – Preferred	AL (Min 8 Years)
<i>*Dibenzo-Oxepino Pyrroles*** - Drugs For Severe Mental Disorders</i>		
<i>asenapine maleate</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SAPHRIS	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SECUADO	Non – Preferred	AL (Min 18 Years)
<i>*Dibenzothiazepines*** - Drugs For Severe Mental Disorders</i>		
<i>quetiapine fumarate er tablet extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 300 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 400 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 50 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 150 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 200 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>quetiapine fumarate tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>quetiapine fumarate tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 400 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 100 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 200 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 25 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 300 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 50 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Dibenzoxazepines*** - Drugs For Severe Mental Disorders		
<i>loxapine succinate capsule 10 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 25 mg oral</i>	Preferred	QL (10 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 5 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 50 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION	Non – Preferred	AL (Min 18 Years)
ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION	Preferred	AL (Min 18 Years)
*Dihydroindolones*** - Drugs For Severe Mental Disorders		
<i>molindone hcl</i>	Non – Preferred	
*Phenothiazines*** - Drugs For Severe Mental Disorders		
<i>chlorpromazine hcl injection</i>	Preferred	QL (2 ML per 1 day)
<i>chlorpromazine hcl oral concentrate</i>	Preferred	
<i>chlorpromazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>chlorpromazine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>fluphenazine decanoate</i>	Preferred	QL (8 ML per 28 days); AL (Min 18 Years)
<i>fluphenazine hcl injection</i>	Preferred	QL (4 ML per 1 day)
<i>fluphenazine hcl oral concentrate</i>	Preferred	QL (8 ML per 1 day)
<i>fluphenazine hcl oral elixir</i>	Preferred	QL (80 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluphenazine hcl tablet 1 mg oral</i>	Preferred	
<i>fluphenazine hcl tablet 10 mg oral</i>	Preferred	
<i>fluphenazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>fluphenazine hcl tablet 2.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>fluphenazine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>perphenazine tablet 16 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>perphenazine tablet 2 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>perphenazine tablet 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>perphenazine tablet 8 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>prochlorperazine</i>	Preferred	QL (2 EA per 1 day)
<i>prochlorperazine maleate tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>prochlorperazine maleate tablet 5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>thioridazine hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>thioridazine hcl tablet 100 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>thioridazine hcl tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>thioridazine hcl tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>trifluoperazine hcl tablet 1 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
COMPRO	Preferred	QL (2 EA per 1 day)
*Quinolinone Derivatives*** - Drugs For Severe Mental Disorders		
<i>aripiprazole oral solution</i>	Non – Preferred	AL (Min 8 Years)
<i>aripiprazole oral tablet</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>aripiprazole oral tablet dispersible</i>	Non – Preferred	AL (Min 8 Years)
ABILIFY	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ABILIFY ASIMTUFII	Preferred	AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE	Preferred	QL (1 SYRINGE per 28 days); AL (Min 18 Years)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	Preferred	QL (1 VIAL per 28 days); AL (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT	Non – Preferred	AL (Min 8 Years)
ABILIFY MYCITE STARTER KIT	Non – Preferred	AL (Min 8 Years)
ARISTADA INITIO	Preferred	QL (1 SYRINGE per 365 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 1064 MG/3.9ML INTRAMUSCULAR	Preferred	QL (1 SYRINGE per 56 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 441 MG/1.6ML INTRAMUSCULAR	Preferred	QL (1 SYRINGE per 28 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 662 MG/2.4ML INTRAMUSCULAR	Preferred	QL (2.4 ML per 28 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 882 MG/3.2ML INTRAMUSCULAR	Preferred	QL (3.2 ML per 28 days); AL (Min 18 Years)
REXULTI	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>*Thienbenzodiazepines*** - Drugs For Severe Mental Disorders</i>		
<i>olanzapine intramuscular</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 18 Years)
<i>olanzapine oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA INTRAMUSCULAR	Non – Preferred	QL (3 EA per 1 day); AL (Min 18 Years)
ZYPREXA RELPREVV	Non – Preferred	AL (Min 18 Years)
ZYPREXA TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA TABLET 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA TABLET 2.5 MG ORAL	Non – Preferred	AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYPREXA TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA TABLET 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA TABLET 7.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA ZYDIS	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
*Thioxanthenes*** - Drugs For Severe Mental Disorders		
<i>thiothixene</i>	Preferred	QL (6 EA per 1 day)
Antiseptics & Disinfectants - Antiseptics And Disinfectants		
*Chlorine Antiseptics*** - Antiseptics And Disinfectants		
<i>antiseptic skin cleanser</i>	Preferred	OTC
<i>chlorhexidine gluconate</i>	Preferred	OTC
<i>sm antiseptic skin cleanser</i>	Preferred	OTC
DYNA-HEX 4	Preferred	OTC
Antivirals - Drugs For Infections		
*Antiretroviral Combinations*** - Drugs For Viral Infections		
<i>abacavir sulfate-lamivudine</i>	Preferred	QL (1 EA per 1 day)
<i>efavirenz-emtricitab-tenofo df</i>	Preferred	
<i>efavirenz-lamivudine-tenofovir</i>	Non – Preferred	QL (1 EA per 1 day)
<i>emtricitabine-tenofovir df</i>	Preferred	QL (1 EA per 1 day)
<i>lamivudine-zidovudine</i>	Preferred	QL (2 EA per 1 day)
<i>lopinavir-ritonavir oral solution</i>	Preferred	QL (10 ML per 1 day)
<i>lopinavir-ritonavir oral tablet</i>	Preferred	
BIKTARVY TABLET 30-120-15 MG ORAL	Preferred	

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BIKTARVY TABLET 50-200-25 MG ORAL	Preferred	QL (1 EA per 1 day)
CABENUVA	Preferred	PA
CIMDUO	Non – Preferred	QL (1 EA per 1 day)
COMPLERA	Preferred	QL (1 EA per 1 day)
DELSTRIGO	Preferred	QL (1 EA per 1 day)
DESCOVY TABLET 120-15 MG ORAL	Preferred	
DESCOVY TABLET 200-25 MG ORAL	Preferred	QL (1 EA per 1 day)
DOVATO	Preferred	QL (1 EA per 1 day)
EPZICOM	Non – Preferred	QL (1 EA per 1 day)
EVOTAZ	Non – Preferred	
GENVOYA	Preferred	QL (1 EA per 1 day)
JULUCA	Non – Preferred	
KALETRA	Non – Preferred	QL (10 ML per 1 day)
ODEFSEY	Preferred	QL (1 EA per 1 day)
PREZCOBIX	Non – Preferred	
STRIBILD	Non – Preferred	
SYMFI	Preferred	QL (1 EA per 1 day)
SYMFI LO	Preferred	QL (1 EA per 1 day)
SYMTUZA	Preferred	
TRIUMEQ	Preferred	QL (1 EA per 1 day)
TRIUMEQ PD	Preferred	
TRUVADA	Preferred	QL (1 EA per 1 day)
<i>*Antiretrovirals - Capsid Inhibitors*** - Drugs For Viral Infections</i>		
SUNLENCA	Preferred	PA
<i>*Antiretrovirals - Ccr5 Antagonists (Entry Inhibitor)*** - Drugs For Viral Infections</i>		
<i>maraviroc</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELZENTRY	Non – Preferred	
<i>*Antiretrovirals - Cd4-Directed Post-Attachment Inhibitor*** - Drugs For Viral Infections</i>		
TROGARZO	Preferred	PA
<i>*Antiretrovirals - Fusion Inhibitors*** - Drugs For Viral Infections</i>		
FUZEON	Non – Preferred	QL (2 EA per 1 day)
<i>*Antiretrovirals - Gp120-Directed Attachment Inhibitor*** - Drugs For Viral Infections</i>		
RUKOBIA	Non – Preferred	
<i>*Antiretrovirals - Integrase Inhibitors*** - Drugs For Viral Infections</i>		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML	Preferred	
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR	Non – Preferred	
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR	Preferred	
ISENTRESS HD	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL PACKET	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET CHEWABLE	Preferred	QL (6 EA per 1 day)
TIVICAY	Preferred	QL (2 EA per 1 day)
TIVICAY PD	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antiretrovirals - Protease Inhibitors*** - Drugs For Viral Infections		
<i>atazanavir sulfate capsule 150 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>atazanavir sulfate capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>atazanavir sulfate capsule 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>darunavir</i>	Preferred	
<i>fosamprenavir calcium</i>	Preferred	QL (4 EA per 1 day)
<i>ritonavir</i>	Preferred	QL (12 EA per 1 day)
APTIVUS	Preferred	QL (4 EA per 1 day)
NORVIR ORAL PACKET	Preferred	
NORVIR ORAL TABLET	Preferred	QL (12 EA per 1 day)
PREZISTA	Preferred	
REYATAZ CAPSULE 200 MG ORAL	Preferred	QL (2 EA per 1 day)
REYATAZ CAPSULE 300 MG ORAL	Preferred	QL (1 EA per 1 day)
REYATAZ ORAL PACKET	Preferred	QL (6 EA per 1 day)
VIRACEPT TABLET 250 MG ORAL	Preferred	QL (10 EA per 1 day)
VIRACEPT TABLET 625 MG ORAL	Preferred	QL (4 EA per 1 day)
*Antiretrovirals - Rti-Non-Nucleoside Analogues*** - Drugs For Viral Infections		
<i>efavirenz capsule 200 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>efavirenz capsule 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>efavirenz oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>etravirine</i>	Preferred	
<i>nevirapine er</i>	Preferred	QL (1 EA per 1 day)
<i>nevirapine oral suspension</i>	Preferred	QL (40 ML per 1 day)
<i>nevirapine oral tablet</i>	Preferred	QL (2 EA per 1 day)
EDURANT	Preferred	QL (1 EA per 1 day)
INTELENCE TABLET 100 MG ORAL	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTELENCE TABLET 200 MG ORAL	Preferred	QL (2 EA per 1 day)
INTELENCE TABLET 25 MG ORAL	Preferred	QL (4 EA per 1 day)
PIFELTRO	Non – Preferred	
SUSTIVA	Preferred	QL (1 EA per 1 day)
*Antiretrovirals - Rti-Nucleoside Analogues-Purines*** - Drugs For Viral Infections		
<i>abacavir sulfate oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>abacavir sulfate oral tablet</i>	Preferred	QL (2 EA per 1 day)
ZIAGEN	Preferred	QL (30 ML per 1 day)
*Antiretrovirals - Rti-Nucleoside Analogues-Pyrimidines*** - Drugs For Viral Infections		
<i>emtricitabine</i>	Preferred	QL (1 EA per 1 day)
<i>lamivudine oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>lamivudine tablet 150 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lamivudine tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL CAPSULE	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL SOLUTION	Preferred	QL (24 ML per 1 day)
EPIVIR ORAL SOLUTION	Non – Preferred	QL (30 ML per 1 day)
EPIVIR TABLET 150 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
EPIVIR TABLET 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
*Antiretrovirals - Rti-Nucleoside Analogues-Thymidines*** - Drugs For Viral Infections		
<i>zidovudine oral capsule</i>	Preferred	QL (2 EA per 1 day)
<i>zidovudine oral syrup</i>	Preferred	QL (60 ML per 1 day)
<i>zidovudine oral tablet</i>	Preferred	QL (2 EA per 1 day)
RETROVIR ORAL CAPSULE	Non – Preferred	QL (2 EA per 1 day)
RETROVIR ORAL SYRUP	Non – Preferred	QL (60 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antiretrovirals - Rti-Nucleotide Analogues*** - Drugs For Viral Infections		
<i>tenofovir disoproxil fumarate</i>	Preferred	QL (1 EA per 1 day)
VIREAD ORAL POWDER	Preferred	QL (8 GM per 1 day)
VIREAD ORAL TABLET	Preferred	QL (1 EA per 1 day)
*Antiretrovirals Adjuvants*** - Drugs For Viral Infections		
TYBOST	Non – Preferred	
*Antiviral Combinations*** - Drugs For Infections		
PAXLOVID (150/100)	Preferred	AL (Min 12 Years)
PAXLOVID (300/100)	Preferred	AL (Min 12 Years)
*Cmv Agents*** - Drugs For Viral Infections		
<i>valganciclovir hcl oral solution reconstituted</i>	Non – Preferred	QL (2 ML per 1 day)
<i>valganciclovir hcl oral tablet</i>	Preferred	QL (2 EA per 1 day)
LIVTENCITY	Preferred	PA
PREVYMIS	Preferred	PA
VALCYTE	Non – Preferred	QL (2 EA per 1 day)
*Hepatitis B Agents*** - Drugs For Viral Infections		
<i>adefovir dipivoxil</i>	Non – Preferred	
<i>entecavir</i>	Preferred	QL (1 EA per 1 day)
<i>lamivudine</i>	Non – Preferred	QL (1 EA per 1 day)
BARACLUDE ORAL SOLUTION	Non – Preferred	
BARACLUDE ORAL TABLET	Non – Preferred	QL (1 EA per 1 day)
VEMLIDY	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Hepatitis C Agent - Combinations*** - Drugs For Viral Infections		
<i>ledipasvir-sofosbuvir</i>	Non – Preferred	
<i>sofosbuvir-velpatasvir</i>	Preferred	QL (1 EA per 1 day)
EPCLUSA ORAL PACKET	Non – Preferred	
EPCLUSA TABLET 200-50 MG ORAL	Non – Preferred	
EPCLUSA TABLET 400-100 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
HARVONI	Non – Preferred	
MAVYRET ORAL PACKET	Preferred	QL (5 EA per 1 day)
MAVYRET ORAL TABLET	Preferred	QL (3 EA per 1 day)
VOSEVI	Non – Preferred	
ZEPATIER	Non – Preferred	
*Hepatitis C Agents*** - Drugs For Viral Infections		
<i>ribavirin</i>	Preferred	
PEGASYS	Non – Preferred	QL (2 ML per 28 days)
SOVALDI	Non – Preferred	
*Herpes Agents - Purine Analogues*** - Drugs For Viral Infections		
<i>acyclovir capsule 200 mg oral</i>	Preferred	QL (50 EA per 30 days)
<i>acyclovir oral tablet</i>	Preferred	QL (2 EA per 1 day)
<i>acyclovir suspension 200 mg/5ml oral</i>	Preferred	QL (400 ML per 30 days)
<i>valacyclovir hcl tablet 1 gm oral</i>	Preferred	QL (30 EA per 30 days)
<i>valacyclovir hcl tablet 500 mg oral</i>	Preferred	QL (2 EA per 1 day)
SITAVIG	Non – Preferred	
VALTREX TABLET 1 GM ORAL	Non – Preferred	QL (30 EA per 30 days)
VALTREX TABLET 500 MG ORAL	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Herpes Agents - Thymidine Analogues*** - Drugs For Viral Infections		
<i>famciclovir</i>	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
*Influenza Agents*** - Drugs For Viral Infections		
<i>rimantadine hcl</i>	Non – Preferred	QL (14 EA Max Qty Per Fill Retail)
*Misc. Antivirals*** - Drugs For Viral Infections		
LAGEVRIO	Preferred	AL (Min 18 Years)
*Neuraminidase Inhibitors*** - Drugs For Viral Infections		
<i>oseltamivir phosphate capsule 30 mg oral</i>	Preferred	QL (20 EA per 30 days)
<i>oseltamivir phosphate capsule 45 mg oral</i>	Preferred	QL (10 EA per 30 days)
<i>oseltamivir phosphate capsule 75 mg oral</i>	Preferred	QL (10 EA per 30 days)
<i>oseltamivir phosphate oral suspension reconstituted</i>	Preferred	QL (180 ML per 30 days)
RELENZA DISKHALER	Preferred	QL (20 EA Max Qty Per Fill Retail)
TAMIFLU CAPSULE 30 MG ORAL	Non – Preferred	QL (20 EA per 30 days)
TAMIFLU CAPSULE 45 MG ORAL	Non – Preferred	QL (10 EA per 30 days)
TAMIFLU CAPSULE 75 MG ORAL	Non – Preferred	QL (10 EA per 30 days)
TAMIFLU ORAL SUSPENSION RECONSTITUTED	Non – Preferred	QL (180 ML per 30 days)
*Pa Endonuclease Inhibitors*** - Drugs For Viral Infections		
XOFLUZA (40 MG DOSE)	Non – Preferred	
XOFLUZA (80 MG DOSE)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Rsv Agents - Nucleoside Analogues*** - Drugs For Viral Infections		
<i>ribavirin</i>	Preferred	
VIRAZOLE	Non – Preferred	
Beta Blockers - Drugs For The Heart		
*Alpha-Beta Blockers*** - Drugs For High Blood Pressure		
<i>carvedilol</i>	Preferred	QL (2 EA per 1 day)
<i>carvedilol phosphate er</i>	Non – Preferred	
<i>labetalol hcl</i>	Preferred	
COREG	Non – Preferred	QL (2 EA per 1 day)
COREG CR	Non – Preferred	
*Beta Blockers Cardio-Selective*** - Drugs For High Blood Pressure		
<i>acebutolol hcl</i>	Preferred	
<i>atenolol</i>	Preferred	
<i>betaxolol hcl</i>	Preferred	
<i>bisoprolol fumarate tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>bisoprolol fumarate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 100 mg oral</i>	Preferred	QL (1.5 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 50 mg oral</i>	Preferred	QL (1.5 EA per 1 day)
<i>metoprolol tartrate</i>	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nebivolol hcl</i>	Non – Preferred	
BYSTOLIC	Non – Preferred	
KAPSPARGO SPRINKLE	Non – Preferred	
LOPRESSOR	Non – Preferred	
TENORMIN	Non – Preferred	
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
<i>*Beta Blockers Non-Selective*** - Drugs For High Blood Pressure</i>		
<i>nadolol</i>	Preferred	QL (2 EA per 1 day)
<i>pindolol</i>	Preferred	
<i>propranolol hcl</i>	Preferred	
<i>propranolol hcl er</i>	Preferred	QL (1 EA per 1 day)
<i>sotalol hcl</i>	Preferred	
<i>sotalol hcl (af)</i>	Non – Preferred	
<i>timolol maleate</i>	Preferred	
BETAPACE	Non – Preferred	
BETAPACE AF	Non – Preferred	
CORGARD	Non – Preferred	QL (2 EA per 1 day)
HEMANGEOL	Preferred	PA; AL (Max 1 Years)
INDERAL LA	Non – Preferred	QL (1 EA per 1 day)
INDERAL XL	Non – Preferred	
INNOPRAN XL	Non – Preferred	
SOTYLIZE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Calcium Channel Blockers - Drugs For The Heart		
*Calcium Channel Blockers*** - Drugs For High Blood Pressure		
<i>amlodipine besylate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>amlodipine besylate tablet 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>amlodipine besylate tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>diltiazem hcl</i>	Preferred	QL (4 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 360 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 420 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	
<i>diltiazem hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diltiazem hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	
<i>diltiazem hcl er coated beads capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er coated beads capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diltiazem hcl er coated beads capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er coated beads capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er coated beads capsule extended release 24 hour 360 mg oral</i>	Preferred	
<i>diltiazem hcl er oral capsule extended release 12 hour</i>	Preferred	QL (2 EA per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour</i>	Preferred	
<i>dilt-xr capsule extended release 24 hour 120 mg oral</i>	Preferred	
<i>dilt-xr capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>dilt-xr capsule extended release 24 hour 240 mg oral</i>	Preferred	
<i>felodipine er</i>	Preferred	QL (1 EA per 1 day)
<i>isradipine</i>	Non – Preferred	
<i>levamlodipine maleate</i>	Non – Preferred	
<i>nicardipine hcl</i>	Non – Preferred	
<i>nifedipine</i>	Preferred	
<i>nifedipine er</i>	Preferred	QL (1 EA per 1 day)
<i>nifedipine er osmotic release</i>	Preferred	QL (1 EA per 1 day)
<i>nimodipine</i>	Preferred	
<i>nisoldipine er</i>	Non – Preferred	
<i>verapamil hcl</i>	Preferred	QL (4 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>verapamil hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 360 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er oral tablet extended release</i>	Preferred	QL (2 EA per 1 day)
CARDIZEM	Non – Preferred	QL (4 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	
CARDIZEM LA	Non – Preferred	
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Preferred	QL (1 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Preferred	QL (3 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Preferred	QL (2 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Preferred	QL (1 EA per 1 day)
KATERZIA	Non – Preferred	
MATZIM LA	Preferred	
NORLIQVA	Non – Preferred	
NORVASC TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
NORVASC TABLET 2.5 MG ORAL	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NORVASC TABLET 5 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NYMALIZE	Non – Preferred	
PROCARDIA XL	Non – Preferred	QL (1 EA per 1 day)
SULAR	Non – Preferred	
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Preferred	QL (3 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Preferred	QL (2 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL	Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

***Cardiotonics* - Drugs For The Heart**

****Cardiac Glycosides*** - Drugs For The Heart***

<i>digoxin oral solution</i>	Preferred	
<i>digoxin tablet 125 mcg oral</i>	Preferred	
<i>digoxin tablet 250 mcg oral</i>	Preferred	
<i>digoxin tablet 62.5 mcg oral</i>	Non – Preferred	

***Cardiovascular Agents - Misc.* - Drugs For The Heart**

****Calcium Channel Blocker & Hmg Coa Reductase Inhibit Comb*** - Drugs For Cholesterol***

<i>amlodipine-atorvastatin</i>	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 10-10 MG ORAL	Non – Preferred	QL (1 EA per 28 days)
CADUET TABLET 10-20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 10-40 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 10-80 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 5-10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 5-20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 5-40 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CADUET TABLET 5-80 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
<i>*Cardiac Myosin Inhibitors*** - Drugs For The Heart</i>		
CAMZYOS	Non – Preferred	
<i>*Neprilysin Inhib (Arni)-Angiotensin li Recept Antag Comb*** - Drugs For High Blood Pressure</i>		
ENTRESTO	Preferred	QL (2 EA per 1 day)
<i>*Nitrate & Vasodilator Combinations*** - Drugs For High Blood Pressure</i>		
<i>isosorb dinitrate-hydralazine</i>	Preferred	
BIDIL	Preferred	
<i>*Prostaglandin Vasodilators*** - Drugs For High Blood Pressure</i>		
<i>epoprostenol sodium</i>	Preferred	PA
<i>treprostinil</i>	Non – Preferred	
FLOLAN	Preferred	PA
ORENITRAM	Non – Preferred	
ORENITRAM MONTH 1	Non – Preferred	
ORENITRAM MONTH 2	Non – Preferred	
ORENITRAM MONTH 3	Non – Preferred	
REMODULIN	Non – Preferred	
TYVASO	Non – Preferred	
TYVASO DPI MAINTENANCE KIT	Non – Preferred	
TYVASO DPI TITRATION KIT	Non – Preferred	
TYVASO REFILL KIT	Non – Preferred	
TYVASO STARTER KIT	Non – Preferred	
VELETRI	Non – Preferred	PA
VENTAVIS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Pulm Hyperten-Soluble Guanylate Cyclase Stimulator (Sgc)*** - Drugs For High Blood Pressure		
ADEMPAS	Non – Preferred	
*Pulmonary Hypertension - Endothelin Receptor Antagonists*** - Drugs For High Blood Pressure		
<i>ambrisentan</i>	Non – Preferred	PA; QL (1 EA per 1 day)
<i>bosentan</i>	Non – Preferred	PA; QL (2 EA per 1 day)
LETAIRIS	Preferred	PA; QL (1 EA per 1 day)
OPSUMIT	Non – Preferred	QL (1 EA per 1 day)
TRACLEER	Preferred	PA; QL (2 EA per 1 day)
*Pulmonary Hypertension - Phosphodiesterase Inhibitors*** - Drugs For High Blood Pressure		
<i>sildenafil citrate intravenous</i>	Non – Preferred	PA
<i>sildenafil citrate oral suspension reconstituted</i>	Non – Preferred	PA
<i>sildenafil citrate oral tablet</i>	Preferred	PA; QL (3 EA per 1 day)
<i>tadalafil (pah)</i>	Preferred	PA; QL (2 EA per 1 day)
ADCIRCA	Preferred	PA; QL (2 EA per 1 day)
REVATIO INTRAVENOUS	Non – Preferred	
REVATIO ORAL SUSPENSION RECONSTITUTED	Preferred	PA
REVATIO ORAL TABLET	Non – Preferred	PA; QL (3 EA per 1 day)
TADLIQ	Non – Preferred	
*Pulmonary Hypertension - Prostacyclin Receptor Agonist*** - Drugs For High Blood Pressure		
UPTRAVI	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UPTRAVI TITRATION	Non – Preferred	
<i>*Selective Cgmp Phosphodiesterase Type 5 Inhibitors*** - Drugs For The Heart</i>		
<i>tadalafil</i>	Non – Preferred	
CIALIS	Non – Preferred	
<i>*Sinus Node Inhibitors** - Drugs For High Blood Pressure</i>		
CORLANOR ORAL SOLUTION	Non – Preferred	
CORLANOR ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
<i>*Transthyretin Stabilizers*** - Drugs For The Heart</i>		
VYNDAMAX	Non – Preferred	
VYNDAQEL	Non – Preferred	
<i>*Vasoactive Soluble Guanylate Cyclase Stimulator (Sgc)*** - Drugs For Angina</i>		
VERQUVO TABLET 10 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 10 MG ORAL	Preferred	PA
VERQUVO TABLET 2.5 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 2.5 MG ORAL	Preferred	PA
VERQUVO TABLET 5 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 5 MG ORAL	Preferred	PA
<i>*Cephalosporins* - Drugs For Infections</i>		
<i>*Cephalosporin Combinations*** - Antibiotics</i>		
AVYCAZ	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Cephalosporins - 1St Generation*** - Antibiotics		
<i>cefadroxil</i>	Preferred	
<i>cefazolin sodium</i>	Preferred	
<i>cefazolin sodium-dextrose</i>	Preferred	
<i>cephalexin</i>	Preferred	
*Cephalosporins - 2Nd Generation*** - Antibiotics		
<i>cefaclor capsule 250 mg oral</i>	Preferred	
<i>cefaclor capsule 500 mg oral</i>	Preferred	QL (14 EA Max Qty Per Fill Retail)
<i>cefaclor er</i>	Non – Preferred	
<i>cefoxitin sodium</i>	Preferred	
<i>cefoxitin sodium-dextrose</i>	Preferred	
<i>cefprozil oral suspension reconstituted</i>	Preferred	
<i>cefprozil tablet 250 mg oral</i>	Non – Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>cefprozil tablet 500 mg oral</i>	Non – Preferred	
<i>cefuroxime axetil</i>	Preferred	
*Cephalosporins - 3Rd Generation*** - Antibiotics		
<i>cefdinir</i>	Preferred	
<i>cefixime oral capsule</i>	Preferred	QL (1 EA Max Qty Per Fill Retail)
<i>cefixime oral suspension reconstituted</i>	Non – Preferred	
<i>cefpodoxime proxetil</i>	Non – Preferred	
<i>ceftazidime</i>	Preferred	
<i>ceftriaxone sodium in dextrose</i>	Preferred	
<i>ceftriaxone sodium injection</i>	Preferred	QL (2 EA per 1 day)
<i>ceftriaxone sodium intravenous</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ceftriaxone sodium-dextrose</i>	Preferred	
TAZICEF	Preferred	
*Cephalosporins - 4Th Generation*** - Antibiotics		
<i>cefepime hcl</i>	Preferred	
<i>cefepime-dextrose</i>	Preferred	
Chemicals		
*Fixed Oils***		
<i>castor oil</i>	Preferred	
Contraceptives - Drugs For Women		
*Biphasic Contraceptives - Oral*** - Birth Control Pills		
<i>desogestrel-ethinyl estradiol</i>	Preferred	
<i>viorele</i>	Preferred	
AZURETTE	Preferred	
KARIVA	Preferred	
LO LOESTRIN FE	Preferred	
PIMTREA	Preferred	
SIMLIYA	Preferred	
VOLNEA	Preferred	
*Combination Contraceptives - Oral*** - Birth Control Pills		
<i>alyacen 1/35</i>	Preferred	
<i>briellyn</i>	Preferred	
<i>drospiren-eth estrad-levomefol</i>	Preferred	
<i>drospirenone-ethinyl estradiol</i>	Preferred	
<i>ethynodiol diac-eth estradiol</i>	Preferred	
<i>levonorgest-eth estradiol-iron</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad</i>	Preferred	
<i>marlissa</i>	Preferred	
<i>norethin ace-eth estrad-fe</i>	Preferred	
<i>norethindrone acet-ethinyl est</i>	Preferred	
<i>norethin-eth estradiol-fe</i>	Preferred	
<i>norgestimate-eth estradiol</i>	Preferred	
AFIRMELLE	Preferred	
ALTAVERA	Preferred	
APRI	Preferred	
AUBRA EQ	Preferred	
AUROVELA 1.5/30	Preferred	
AUROVELA 1/20	Preferred	
AUROVELA 24 FE	Preferred	
AUROVELA FE 1.5/30	Preferred	
AUROVELA FE 1/20	Preferred	
AVIANE	Preferred	
AYUNA	Preferred	
BALCOLTRA	Preferred	
BALZIVA	Preferred	
BEYAZ	Preferred	
BLISOVI 24 FE	Preferred	
BLISOVI FE 1.5/30	Preferred	
BLISOVI FE 1/20	Preferred	
CHARLOTTE 24 FE	Preferred	
CHATEAL EQ	Preferred	
CRYSSELLE-28	Preferred	
CYRED EQ	Preferred	
DASETTA 1/35	Preferred	
ELINEST	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENSKYCE	Preferred	
ESTARYLLA	Preferred	
FALMINA	Preferred	
FINZALA	Preferred	
GEMMILY	Preferred	
HAILEY 1.5/30	Preferred	
HAILEY 24 FE	Preferred	
HAILEY FE 1.5/30	Preferred	
HAILEY FE 1/20	Preferred	
ISIBLOOM	Preferred	
JASMIEL	Preferred	
JOYEAUX	Preferred	
JULEBER	Preferred	
JUNEL 1.5/30	Preferred	
JUNEL 1/20	Preferred	
JUNEL FE 1.5/30	Preferred	
JUNEL FE 1/20	Preferred	
JUNEL FE 24	Preferred	
KAITLIB FE	Preferred	
KALLIGA	Preferred	
KELNOR 1/35	Preferred	
KELNOR 1/50	Preferred	
KURVELO	Preferred	
LARIN 1.5/30	Preferred	
LARIN 1/20	Preferred	
LARIN 24 FE	Preferred	
LARIN FE 1.5/30	Preferred	
LARIN FE 1/20	Preferred	
LAYOLIS FE	Preferred	

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QL = Quantity Limits

ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LESSINA	Preferred	
LEVORA 0.15/30 (28)	Preferred	
LOESTRIN 1.5/30 (21)	Preferred	
LOESTRIN 1/20 (21)	Preferred	
LOESTRIN FE 1.5/30	Preferred	
LOESTRIN FE 1/20	Preferred	
LORYNA	Preferred	
LOW-OGESTREL	Preferred	
LO-ZUMANDIMINE	Preferred	
LUTERA	Preferred	
MERZEE	Preferred	
MIBELAS 24 FE	Preferred	
MICROGESTIN 1.5/30	Preferred	
MICROGESTIN 1/20	Preferred	
MICROGESTIN 24 FE	Preferred	
MICROGESTIN FE 1.5/30	Preferred	
MICROGESTIN FE 1/20	Preferred	
MILI	Preferred	
MONO-LINYAH	Preferred	
NECON 0.5/35 (28)	Preferred	
NEXTSTELLIS	Preferred	
NIKKI	Preferred	
NORTREL 0.5/35 (28)	Preferred	
NORTREL 1/35 (21)	Preferred	
NORTREL 1/35 (28)	Preferred	
NYLIA 1/35	Preferred	
NYMYO	Preferred	
OCELLA	Preferred	
PHILITH	Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PORTIA-28	Preferred	
RECLIPSEN	Preferred	
SAFYRAL	Preferred	
SPRINTEC 28	Preferred	
SRONYX	Preferred	
SYEDA	Preferred	
TARINA 24 FE	Preferred	
TARINA FE 1/20 EQ	Preferred	
TAYSOFY	Preferred	
TAYTULLA	Preferred	
TURQOZ	Preferred	
TYBLUME	Preferred	
TYDEMY	Preferred	
VESTURA	Preferred	
VIENVA	Preferred	
VYFEMLA	Preferred	
VYLIBRA	Preferred	
WERA	Preferred	
WYMZYA FE	Preferred	
YASMIN 28	Preferred	
YAZ	Preferred	
ZOVIA 1/35 (28)	Preferred	
ZUMANDIMINE	Preferred	
*Combination Contraceptives - Transdermal*** - Birth Control Pills		
<i>norelgestromin-eth estradiol</i>	Preferred	QL (3 EA per 28 days)
TWIRLA	Preferred	QL (3 EA per 28 days)
XULANE	Preferred	QL (3 EA per 28 days)
ZAFEMY	Preferred	QL (3 EA per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Combination Contraceptives - Vaginal*** - Birth Control Pills		
<i>etonogestrel-ethinyl estradiol ring 0.12-0.015 mg/24hr vaginal</i>	Preferred	QL (1 EA per 28 days)
ANNOVERA	Preferred	QL (1 EA per 28 days)
ELURYNG	Preferred	QL (1 EA per 28 days)
ENILLORING	Preferred	QL (1 EA per 28 days)
HALOETTE	Preferred	QL (1 EA per 28 days)
NUVARING RING 0.12-0.015 MG/24HR VAGINAL	Preferred	QL (1 EA per 28 days)
*Continuous Contraceptives - Oral*** - Birth Control Pills		
<i>levonorgestrel-ethinyl estrad</i>	Preferred	
AMETHYST	Preferred	
DOLISHALE	Preferred	
*Emergency Contraceptives*** - Birth Control Pills		
<i>levonorgestrel</i>	Preferred	OTC
CURAE	Preferred	OTC
ECONTRA ONE-STEP	Preferred	OTC
ELLA	Preferred	
HER STYLE	Preferred	OTC
MY CHOICE	Preferred	OTC
MY WAY	Preferred	OTC
NEW DAY	Preferred	OTC
OPTION 2	Preferred	OTC
*Extended-Cycle Contraceptives - Oral*** - Birth Control Pills		
<i>levonorgest-eth est & eth est</i>	Preferred	
<i>levonorgest-eth estrad 91-day</i>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASHLYNA	Preferred	QL (1 EA per 1 day)
CAMRESE	Preferred	QL (1 EA per 1 day)
CAMRESE LO	Preferred	QL (1 EA per 1 day)
DAYSEE	Preferred	QL (1 EA per 1 day)
ICLEVIA	Preferred	
INTROVALE	Preferred	
JAIMIESS	Preferred	QL (1 EA per 1 day)
JOLESSA	Preferred	
LOJAIMIESS	Preferred	QL (1 EA per 1 day)
RIVELSA	Preferred	
SETLAKIN	Preferred	
SIMPESSE	Preferred	QL (1 EA per 1 day)
*Four Phase Contraceptives - Oral*** - Birth Control Pills		
NATAZIA	Preferred	
*Progestin Contraceptives - Injectable*** - Birth Control Pills		
<i>medroxyprogesterone acetate</i>	Preferred	QL (1 ML per 84 days)
DEPO-PROVERA	Preferred	QL (1 ML per 84 days)
DEPO-SUBQ PROVERA 104	Preferred	
*Progestin Contraceptives - Oral*** - Birth Control Pills		
<i>norethindrone</i>	Preferred	QL (1 EA per 1 day)
CAMILA	Preferred	QL (1 EA per 1 day)
DEBLITANE	Preferred	QL (1 EA per 1 day)
ERRIN	Preferred	QL (1 EA per 1 day)
HEATHER	Preferred	QL (1 EA per 1 day)
INCASSIA	Preferred	QL (1 EA per 1 day)
JENCYCLA	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LYLEQ	Preferred	QL (1 EA per 1 day)
NORA-BE	Preferred	QL (1 EA per 1 day)
NORLYDA	Preferred	QL (1 EA per 1 day)
SHAROBEL	Preferred	QL (1 EA per 1 day)
SLYND	Preferred	
*Triphasic Contraceptives - Oral*** - Birth Control Pills		
<i>alyacen 7/7/7</i>	Preferred	
<i>levonorg-eth estrad triphasic</i>	Preferred	
<i>norethindron-ethinyl estrad-fe</i>	Preferred	
<i>norgestim-eth estrad triphasic</i>	Preferred	
ARANELLE	Preferred	
DASETTA 7/7/7	Preferred	
ENPRESSE-28	Preferred	
LEENA	Preferred	
LEVONEST	Preferred	
NORTREL 7/7/7	Preferred	
NYLIA 7/7/7	Preferred	
TILIA FE	Preferred	
TRI-ESTARYLLA	Preferred	
TRI-LEGEST FE	Preferred	
TRI-LINYAH	Preferred	
TRI-LO-ESTARYLLA	Preferred	
TRI-LO-MARZIA	Preferred	
TRI-LO-MILI	Preferred	
TRI-LO-SPRINTEC	Preferred	
TRI-MILI	Preferred	
TRINESSA (28)	Preferred	
TRI-NYMYO	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRI-SPRINTEC	Preferred	
TRIVORA (28)	Preferred	
TRI-VYLIBRA	Preferred	
TRI-VYLIBRA LO	Preferred	
VELIVET	Preferred	
Corticosteroids - Hormones		
*Glucocorticosteroids*** - Drugs For Inflammation		
<i>budesonide</i>	Non – Preferred	
<i>budesonide er</i>	Non – Preferred	
<i>cortisone acetate</i>	Non – Preferred	
<i>dexamethasone</i>	Preferred	
<i>dexamethasone sodium phosphate</i>	Preferred	
<i>hydrocortisone</i>	Preferred	
<i>methylprednisolone oral tablet</i>	Preferred	
<i>methylprednisolone oral tablet therapy pack</i>	Preferred	QL (21 EA Max Qty Per Fill Retail)
<i>prednisolone</i>	Preferred	
<i>prednisolone sodium phosphate oral tablet dispersible</i>	Non – Preferred	
<i>prednisolone sodium phosphate solution 10 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 15 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 20 mg/5ml oral</i>	Preferred	QL (150 ML Max Qty Per Fill Retail)
<i>prednisolone sodium phosphate solution 25 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 6.7 (5 base) mg/5ml oral</i>	Preferred	
<i>prednisone oral solution</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisone oral tablet</i>	Preferred	
<i>prednisone tablet therapy pack 10 mg (21) oral</i>	Preferred	
<i>prednisone tablet therapy pack 10 mg (48) oral</i>	Preferred	QL (48 EA Max Qty Per Fill Retail)
<i>prednisone tablet therapy pack 5 mg (21) oral</i>	Preferred	
<i>prednisone tablet therapy pack 5 mg (48) oral</i>	Preferred	QL (48 EA Max Qty Per Fill Retail)
AGAMREE	Non – Preferred	
ALKINDI SPRINKLE	Non – Preferred	
CORTEF	Non – Preferred	
DEXAMETHASONE INTENSOL	Preferred	
EMFLAZA	Non – Preferred	
HEMADY	Non – Preferred	
MEDROL ORAL TABLET	Non – Preferred	
MEDROL ORAL TABLET THERAPY PACK	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
PREDNISONE INTENSOL	Preferred	
RAYOS	Non – Preferred	
SOLU-CORTEF	Preferred	
TAPERDEX 12-DAY	Non – Preferred	
TAPERDEX 6-DAY	Non – Preferred	
TAPERDEX 7-DAY	Non – Preferred	
TARPEYO	Non – Preferred	
UCERIS	Non – Preferred	
<i>*Mineralocorticoids*** - Drugs For Inflammation</i>		
<i>fludrocortisone acetate</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cough/Cold/Allergy - Drugs For The Lungs		
*Antitussive - Nonnarcotic*** - Drugs For Allergies		
<i>benzonatate oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day); AL (Min 10 Years)
<i>benzonatate oral capsule 200 mg</i>	Preferred	QL (3 EA per 1 day); AL (Min 10 Years)
<i>cvs tussin maximum strength</i>	Preferred	OTC
<i>dextromethorphan polistirex er</i>	Preferred	OTC
*Antitussive-Antihistamine-Analgesic*** - Drugs For Cough And Cold		
CORICIDIN HBP NIGHTTIME COLD	Preferred	OTC
*Antitussive-Decongestant-Analgesic*** - Drugs For Cough And Cold		
<i>daytime cold/flu relief</i>	Preferred	OTC
*Antitussive-Expectorant*** - Drugs For Cough And Cold		
<i>cvs chest congest/cough child</i>	Preferred	OTC
<i>dextromethorphan-guaifenesin</i>	Preferred	OTC; QL (120 ML per 30 days)
<i>guaifenesin-codeine</i>	Preferred	OTC
*Decongestant & Antihistamine*** - Drugs For Cough And Cold		
<i>allergy relief d-24</i>	Preferred	OTC
<i>cetirizine-pseudoephedrine er</i>	Preferred	OTC; QL (2 EA per 1 day)
<i>cold & allergy</i>	Preferred	OTC
<i>loratadine-d 12hr</i>	Preferred	OTC; QL (2 EA per 1 day)
<i>promethazine vc</i>	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>rynex pse</i>	Preferred	OTC
LOHIST-D	Preferred	OTC
SUDOGEST SINUS/ALLERGY	Preferred	OTC
<i>*Decongestant W/ Expectorant*** - Drugs For Cough And Cold</i>		
<i>ed bron gp</i>	Preferred	OTC
<i>*Decongestant-Analgesic*** - Drugs For Cough And Cold</i>		
<i>cvs cold & sinus relief</i>	Preferred	OTC
<i>*Expectorants*** - Drugs For Cough And Cold</i>		
<i>guaifenesin</i>	Preferred	OTC
<i>guaifenesin er</i>	Preferred	OTC
<i>*Misc. Respiratory Inhalants*** - Drugs For Allergies</i>		
<i>sodium chloride</i>	Preferred	
<i>*Mucolytics*** - Drugs For The Lungs</i>		
<i>acetylcysteine</i>	Preferred	
<i>*Non-Narc Antitussive-Antihistamine*** - Drugs For Cough And Cold</i>		
<i>promethazine-dm</i>	Preferred	
<i>*Non-Narc Antitussive-Decongestant*** - Drugs For Cough And Cold</i>		
SUDAFED PE COLD & COUGH CHILD	Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Non-Narc Antitussive-Decongestant-Antihistamine*** - Drugs For Cough And Cold		
<i>pseudoeph-bromphen-dm</i>	Preferred	
*Opioid Antitussive-Antihistamine*** - Drugs For Cough And Cold		
<i>promethazine-codeine</i>	Preferred	QL (180 ML per 30 days); AL (Min 18 Years)
Dermatologicals - Drugs For The Skin		
*Acne Antibiotics*** - Drugs For The Skin		
<i>clindamycin phosphate external foam</i>	Non – Preferred	AL (Min 10 Years)
<i>clindamycin phosphate external gel</i>	Preferred	QL (2.5 GM per 1 day); AL (Min 10 Years)
<i>clindamycin phosphate external lotion</i>	Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years)
<i>clindamycin phosphate external solution</i>	Preferred	QL (2 ML per 1 day); AL (Min 10 Years)
<i>clindamycin phosphate external swab</i>	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
<i>dapsone</i>	Non – Preferred	AL (Min 10 Years)
<i>ery</i>	Non – Preferred	QL (2 EA per 1 day)
<i>erythromycin external gel</i>	Preferred	QL (1 GM per 1 day); AL (Min 10 Years)
<i>erythromycin external solution</i>	Preferred	QL (2 ML per 1 day); AL (Min 10 Years)
<i>sulfacetamide sodium (acne)</i>	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years)
ACZONE	Non – Preferred	AL (Min 10 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEOCIN-T	Non – Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years)
CLINDACIN	Non – Preferred	AL (Min 10 Years)
CLINDACIN ETZ	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
CLINDACIN-P	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
CLINDAGEL	Non – Preferred	QL (2.5 ML per 1 day); AL (Min 10 Years)
ERYGEL	Non – Preferred	QL (1 GM per 1 day); AL (Min 10 Years)
KLARON	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years)
*Acne Combinations*** - Drugs For The Skin		
<i>adapalene-benzoyl peroxide</i>	Non – Preferred	AL (Min 10 Years)
<i>benzoyl peroxide-erythromycin</i>	Preferred	AL (Min 10 Years)
<i>bp 10-1</i>	Non – Preferred	AL (Min 10 Years)
<i>clindamycin phos-benzoyl perox</i>	Non – Preferred	AL (Min 10 Years)
<i>clindamycin-tretinoin</i>	Non – Preferred	AL (Min 10 Years)
<i>sss 10-5</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sodium-sulfur</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sod-sulfur wash</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide-sulfur in urea</i>	Non – Preferred	AL (Min 10 Years)
ACANYA	Non – Preferred	AL (Min 10 Years)
AVAR CLEANSER	Non – Preferred	AL (Min 10 Years)
BENZAMYCIN	Non – Preferred	AL (Min 10 Years)
CABTREO	Non – Preferred	AL (Min 10 Years)
CLINDACIN ETZ	Non – Preferred	AL (Min 10 Years)
NEUAC	Non – Preferred	AL (Min 10 Years)
ONEXTON	Non – Preferred	AL (Min 10 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUMADAN	Non – Preferred	AL (Min 10 Years)
SUMADAN WASH	Non – Preferred	AL (Min 10 Years)
SUMAXIN	Non – Preferred	AL (Min 10 Years)
SUMAXIN CP	Non – Preferred	AL (Min 10 Years)
ZIANA	Non – Preferred	AL (Min 10 Years)
*Acne Products*** - Drugs For The Skin		
<i>adapalene cream 0.1 % external</i>	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>adapalene external gel</i>	Non – Preferred	AL (Min 10 Years)
<i>isotretinoin capsule 10 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 20 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 25 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 30 mg oral</i>	Non – Preferred	
<i>isotretinoin capsule 35 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 40 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>tazarotene</i>	Non – Preferred	AL (Min 10 Years)
<i>tretinoin cream 0.025 % external</i>	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>tretinoin cream 0.05 % external</i>	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>tretinoin cream 0.1 % external</i>	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>tretinoin gel 0.01 % external</i>	Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
<i>tretinoin gel 0.025 % external</i>	Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
<i>tretinoin gel 0.05 % external</i>	Preferred	AL (Min 10 Years)
<i>tretinoin microsphere</i>	Non – Preferred	AL (Min 10 Years)
<i>tretinoin microsphere pump</i>	Non – Preferred	AL (Min 10 Years)
ABSORICA CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABSORICA CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 25 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 30 MG ORAL	Non – Preferred	
ABSORICA CAPSULE 35 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA LD	Non – Preferred	AL (Min 10 Years)
ALTRENO	Non – Preferred	AL (Min 10 Years)
AMNESTEEM	Non – Preferred	AL (Min 12 Years)
ARAZLO	Non – Preferred	AL (Min 10 Years)
ATRALIN	Non – Preferred	AL (Min 10 Years)
CLARAVIS CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 30 MG ORAL	Non – Preferred	
CLARAVIS CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
FABIOR	Non – Preferred	AL (Min 10 Years)
RETIN-A EXTERNAL CREAM	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
RETIN-A EXTERNAL GEL	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
RETIN-A MICRO	Non – Preferred	AL (Min 10 Years)
RETIN-A MICRO PUMP	Non – Preferred	AL (Min 10 Years)
WINLEVI	Non – Preferred	AL (Min 10 Years)
ZENATANE CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 30 MG ORAL	Non – Preferred	
ZENATANE CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
<i>*Agents For External Genital And Perianal Warts*** - Drugs For The Skin</i>		
VEREGEN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antibiotic Mixtures Topical*** - Drugs For The Skin		
<i>goodsense first aid antibiotic</i>	Preferred	OTC
<i>ra antibiotic + pain relief</i>	Preferred	OTC
<i>ra antibiotic plus</i>	Preferred	OTC
<i>sm antibiotic plus pain relief</i>	Preferred	OTC
<i>sm triple antibiotic original</i>	Preferred	OTC
<i>triple antibiotic</i>	Preferred	OTC
<i>triple antibiotic pain relief</i>	Preferred	OTC
NEOSPORIN + PAIN RELIEF MAX ST	Preferred	OTC
NEOSPORIN PLUS PAIN RELIEF MS	Preferred	OTC
*Antibiotic Steroid Combinations - Topical*** - Drugs For The Skin		
NEO-SYNALAR	Non – Preferred	
*Antibiotics - Topical*** - Drugs For The Skin		
<i>gentamicin sulfate</i>	Preferred	
<i>mupirocin</i>	Preferred	QL (110 GM per 30 days)
<i>mupirocin calcium</i>	Non – Preferred	
*Antifungals - Topical Combinations*** - Drugs For The Skin		
<i>clotrimazole-betamethasone external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>clotrimazole-betamethasone external lotion</i>	Non – Preferred	
<i>miconazole-zinc oxide-petrolat</i>	Non – Preferred	
<i>nystatin-triamcinolone</i>	Non – Preferred	
MYCOZYL HC	Non – Preferred	
VUSION	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antifungals - Topical*** - Drugs For The Skin		
<i>ciclopirox external gel</i>	Non – Preferred	
<i>ciclopirox external shampoo</i>	Non – Preferred	QL (120 ML per 30 days)
<i>ciclopirox olamine external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>ciclopirox olamine external suspension</i>	Non – Preferred	QL (30 ML per 30 days)
<i>ciclopirox solution 8 % external</i>	Non – Preferred	QL (6.6 ML per 30 days)
<i>ciclopirox treatment</i>	Non – Preferred	
<i>naftifine hcl</i>	Non – Preferred	
<i>nystatin cream 100000 unit/gm external</i>	Preferred	QL (60 GM per 30 days)
<i>nystatin external powder</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>nystatin ointment 100000 unit/gm external</i>	Preferred	QL (60 GM per 30 days)
CICLODAN	Non – Preferred	QL (6.6 ML per 30 days)
KLAYESTA	Preferred	QL (60 GM Max Qty Per Fill Retail)
MYCOZYL AL	Non – Preferred	
NAFTIN	Non – Preferred	
NYAMYC	Preferred	QL (60 GM Max Qty Per Fill Retail)
NYSTOP	Preferred	QL (60 GM Max Qty Per Fill Retail)
*Anti-Inflammatory Agents - Topical*** - Drugs For The Skin		
<i>diclofenac epolamine</i>	Non – Preferred	
<i>diclofenac sodium gel 1 % external (rx)</i>	Non – Preferred	QL (200 GM per 30 days)
<i>diclofenac sodium solution 1.5 % external</i>	Non – Preferred	QL (10 ML per 1 day)
<i>diclofenac sodium solution 2 % external</i>	Non – Preferred	
FLECTOR	Non – Preferred	
LICART	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENNSAID	Non – Preferred	
*Anti-Inflammatory Combinations - Topical*** - Drugs For The Skin		
LEXTOL	Non – Preferred	
*Antineoplastic Alkylating Agents - Topical*** - Drugs For The Skin		
VALCHLOR	Non – Preferred	
*Antineoplastic Antimetabolites - Topical*** - Drugs For The Skin		
<i>fluorouracil</i>	Non – Preferred	
CARAC	Non – Preferred	
EFUDEX	Non – Preferred	
*Antineoplastic Or Premalignant Lesions - Topical Nsaid's*** - Drugs For The Skin		
<i>diclofenac sodium</i>	Non – Preferred	
*Antipruritic Combinations - Topical*** - Drugs For The Skin		
<i>anti-itch</i>	Preferred	OTC
*Antipruritics - Topical*** - Drugs For The Skin		
<i>doxepin hcl</i>	Non – Preferred	
PRUDOXIN	Non – Preferred	
ZONALON	Non – Preferred	
*Antipsoriatics - Systemic*** - Drugs For The Skin		
<i>acitretin</i>	Non – Preferred	
<i>methoxsalen rapid</i>	Non – Preferred	
BIMZELX	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COSENTYX	Preferred	PA
COSENTYX (300 MG DOSE)	Preferred	PA
COSENTYX SENSOREADY (300 MG)	Preferred	PA
COSENTYX SENSOREADY PEN	Preferred	PA
COSENTYX UNOREADY	Preferred	PA
ILUMYA	Non – Preferred	
SILIQ	Non – Preferred	
SKYRIZI	Non – Preferred	
SKYRIZI PEN	Non – Preferred	
SOTYKTU	Non – Preferred	
STELARA	Non – Preferred	
TALTZ	Non – Preferred	
TREMFYA	Non – Preferred	
*Antipsoriatics*** - Drugs For The Skin		
<i>calcipotriene external cream</i>	Preferred	QL (4 GM per 1 day)
<i>calcipotriene external foam</i>	Non – Preferred	
<i>calcipotriene external ointment</i>	Preferred	QL (4 GM per 1 day)
<i>calcipotriene external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>calcitriol</i>	Non – Preferred	
<i>tazarotene external cream</i>	Non – Preferred	QL (3 GM per 1 day)
<i>tazarotene external gel</i>	Non – Preferred	
SORILUX	Non – Preferred	
VTAMA	Non – Preferred	
ZORYVE	Non – Preferred	
*Antiseborrheic Products*** - Drugs For The Skin		
<i>selenium sulfide external lotion</i>	Preferred	
<i>selenium sulfide external shampoo</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium sulfacetamide wash</i>	Non – Preferred	
<i>sulfacetamide sodium</i>	Non – Preferred	
<i>sulfacetamide sodium (cleans)</i>	Non – Preferred	
ZORYVE	Non – Preferred	
*Antiviral Topical Combinations*** - Drugs For The Skin		
XERESE	Non – Preferred	
*Antivirals - Topical*** - Drugs For The Skin		
<i>acyclovir external cream</i>	Non – Preferred	
<i>acyclovir ointment 5 % external</i>	Non – Preferred	QL (15 GM per 30 days)
<i>penciclovir</i>	Non – Preferred	
DENAVIR	Non – Preferred	
ZOVIRAX EXTERNAL CREAM	Non – Preferred	
ZOVIRAX EXTERNAL OINTMENT	Non – Preferred	QL (15 GM per 30 days)
*Astringents*** - Drugs For The Skin		
XERAC AC	Non – Preferred	
*Atopic Dermatitis - Janus Kinase (Jak) Inhibitors*** - Drugs For The Skin		
CIBINQO	Non – Preferred	
OPZELURA	Non – Preferred	
*Atopic Dermatitis - Monoclonal Antibodies*** - Drugs For The Skin		
ADBRY	Non – Preferred	
DUPIXENT SOLUTION PEN-INJECTOR 200 MG/1.14ML SUBCUTANEOUS	Non – Preferred	PA
DUPIXENT SOLUTION PEN-INJECTOR 200 MG/1.14ML SUBCUTANEOUS	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUPIXENT SOLUTION PEN-INJECTOR 300 MG/2ML SUBCUTANEOUS	Non – Preferred	PA
DUPIXENT SOLUTION PEN-INJECTOR 300 MG/2ML SUBCUTANEOUS	Preferred	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	Preferred	PA
<i>*Burn Products*** - Drugs For The Skin</i>		
<i>mafenide acetate</i>	Preferred	
<i>silver sulfadiazine</i>	Preferred	
SILVADENE	Non – Preferred	
SSD	Preferred	
SULFAMYLON	Preferred	
<i>*Cauterizing Agent Combinations*** - Drugs For The Skin</i>		
ARZOL SILVER NIT APPLICATORS	Non – Preferred	
<i>*Cauterizing Agents*** - Drugs For The Skin</i>		
<i>silver nitrate</i>	Non – Preferred	
<i>*Corticosteroids - Topical*** - Drugs For The Skin</i>		
<i>alclometasone dipropionate</i>	Preferred	QL (60 GM per 30 days)
<i>amcinonide</i>	Non – Preferred	
<i>anti-itch maximum strength</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>betamethasone dipropionate aug external cream</i>	Non – Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>betamethasone dipropionate aug external gel</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate aug external lotion</i>	Non – Preferred	QL (120 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>betamethasone dipropionate aug external ointment</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate external lotion</i>	Non – Preferred	QL (120 ML per 30 days)
<i>betamethasone dipropionate external ointment</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone valerate external cream</i>	Preferred	QL (60 GM per 30 days)
<i>betamethasone valerate external foam</i>	Non – Preferred	
<i>betamethasone valerate external lotion</i>	Preferred	QL (120 ML per 30 days)
<i>betamethasone valerate external ointment</i>	Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>clobetasol propionate e</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate emulsion</i>	Non – Preferred	
<i>clobetasol propionate external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external foam</i>	Non – Preferred	
<i>clobetasol propionate external gel</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external liquid</i>	Non – Preferred	
<i>clobetasol propionate external lotion</i>	Non – Preferred	
<i>clobetasol propionate external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external shampoo</i>	Non – Preferred	
<i>clobetasol propionate solution 0.05 % external</i>	Preferred	QL (50 ML per 30 days)
<i>clocortolone pivalate</i>	Non – Preferred	
<i>desonide external cream</i>	Preferred	
<i>desonide external lotion</i>	Non – Preferred	
<i>desonide external ointment</i>	Preferred	
<i>desoximetasone</i>	Non – Preferred	

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<i>diflorasone diacetate</i>	Preferred	QL (60 GM per 30 days)
<i>fluocinolone acetonide body</i>	Preferred	
<i>fluocinolone acetonide cream 0.01 % external</i>	Preferred	
<i>fluocinolone acetonide cream 0.025 % external</i>	Preferred	QL (60 GM per 30 days)
<i>fluocinolone acetonide external ointment</i>	Preferred	QL (60 GM per 30 days)
<i>fluocinolone acetonide external solution</i>	Preferred	
<i>fluocinolone acetonide scalp</i>	Preferred	
<i>fluocinonide cream 0.05 % external</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide cream 0.1 % external</i>	Preferred	
<i>fluocinonide emulsified base</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide external gel</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>flurandrenolide</i>	Non – Preferred	
<i>fluticasone propionate external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluticasone propionate external lotion</i>	Non – Preferred	
<i>fluticasone propionate external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>gnp hydrocortisone max st</i>	Preferred	OTC
<i>gnp hydrocortisone plus</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>gnp hydrocortisone/aloe</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>halcinonide</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>halobetasol propionate external cream</i>	Preferred	QL (50 GM per 30 days)
<i>halobetasol propionate external foam</i>	Non – Preferred	
<i>halobetasol propionate ointment 0.05 % external</i>	Preferred	QL (50 GM per 30 days)
<i>hydrocortisone butyrate</i>	Non – Preferred	
<i>hydrocortisone complete kit</i>	Non – Preferred	
<i>hydrocortisone cream 1 % external (otc)</i>	Preferred	QL (454 GM Max Qty Per Fill Retail)
<i>hydrocortisone cream 1 % external (rx)</i>	Preferred	QL (454 GM Max Qty Per Fill Retail)
<i>hydrocortisone cream 2.5 % external</i>	Preferred	QL (90 GM per 30 days)
<i>hydrocortisone external cream 0.5 %</i>	Preferred	OTC
<i>hydrocortisone external lotion</i>	Preferred	QL (120 ML per 30 days)
<i>hydrocortisone max st</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>hydrocortisone max st/12 moist</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>hydrocortisone ointment 1 % external (otc)</i>	Preferred	QL (90 GM per 30 days)
<i>hydrocortisone ointment 1 % external (rx)</i>	Preferred	QL (90 GM per 30 days)
<i>hydrocortisone ointment 2.5 % external</i>	Preferred	QL (90 GM per 30 days)
<i>hydrocortisone valerate</i>	Preferred	
<i>hydrocortisone/aloe max str</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>instacort 5</i>	Preferred	OTC
<i>mometasone furoate external cream</i>	Preferred	QL (45 GM per 30 days)
<i>mometasone furoate external ointment</i>	Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>mometasone furoate external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>sm hydrocortisone</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>sm hydrocortisone max st</i>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm hydrocortisone plus</i>	Preferred	OTC; QL (454 GM Max Qty Per Fill Retail)
<i>triamcinolone acetonide cream 0.025 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide cream 0.1 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide cream 0.5 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide external aerosol solution</i>	Non – Preferred	
<i>triamcinolone acetonide lotion 0.025 % external</i>	Preferred	QL (120 ML per 30 days)
<i>triamcinolone acetonide lotion 0.1 % external</i>	Preferred	QL (120 ML per 30 days)
<i>triamcinolone acetonide ointment 0.025 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide ointment 0.05 % external</i>	Non – Preferred	
<i>triamcinolone acetonide ointment 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.5 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone in absorbase</i>	Non – Preferred	
APEXICON E	Non – Preferred	
BRYHALI	Non – Preferred	
CLODAN	Non – Preferred	
CLODERM	Non – Preferred	
CORDRAN	Non – Preferred	
DERMA-SMOOTH/FS BODY	Non – Preferred	
DERMA-SMOOTH/FS SCALP	Non – Preferred	
DIPROLENE OINTMENT 0.05 % EXTERNAL	Non – Preferred	QL (60 GM per 30 days)
HALOG	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYDROXYM	Non – Preferred	
LEXETTE	Non – Preferred	
LOCOID	Non – Preferred	
LOCOID LIPOCREAM	Non – Preferred	
PANDEL	Non – Preferred	
SYNALAR	Non – Preferred	QL (60 GM per 30 days)
TEXACORT	Non – Preferred	
TOPICORT	Non – Preferred	
TOVET	Non – Preferred	
ULTRAVATE	Non – Preferred	
VANOS	Non – Preferred	
*Depigmenting Agents*** - Drugs For The Skin		
<i>hydroquinone</i>	Preferred	
BLANCHE	Preferred	
*Emollient/Keratolytic Agents*** - Drugs For The Skin		
<i>urea cream 39 % external</i>	Preferred	
<i>urea cream 39.5 % external</i>	Preferred	
<i>urea cream 40 % external</i>	Preferred	QL (85 GM per 30 days)
<i>urea external lotion</i>	Preferred	QL (236.3 GM per 30 days)
DERMACINRX UREA	Preferred	
*Emollient/Keratolytic Combinations*** - Drugs For The Skin		
<i>urea hydrating</i>	Non – Preferred	
*Emollients*** - Drugs For The Skin		
<i>ammonium lactate external cream</i>	Non – Preferred	
<i>ammonium lactate external lotion</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMLACTIN DAILY	Preferred	OTC
*Imidazole-Related Antifungals - Topical*** - Drugs For The Skin		
<i>antifungal (clotrimazole)</i>	Preferred	OTC; QL (60 GM per 30 days)
<i>clotrimazole anti-fungal</i>	Preferred	OTC; QL (60 GM per 30 days)
<i>clotrimazole external cream</i>	Preferred	QL (60 GM per 30 days)
<i>clotrimazole external solution</i>	Non – Preferred	QL (30 ML per 30 days)
<i>econazole nitrate</i>	Preferred	QL (30 GM per 30 days)
<i>gnp athletes foot</i>	Preferred	OTC
<i>ketoconazole external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>ketoconazole external foam</i>	Non – Preferred	
<i>ketoconazole external shampoo</i>	Preferred	QL (120 ML Max Qty Per Fill Retail)
<i>luliconazole</i>	Non – Preferred	
<i>oxiconazole nitrate</i>	Non – Preferred	
<i>sm antifungal clotrimazole</i>	Preferred	OTC; QL (60 GM per 30 days)
ERTACZO	Non – Preferred	
JUBLIA	Non – Preferred	
KETODAN	Non – Preferred	
LUZU	Non – Preferred	
OXISTAT	Non – Preferred	
*Immunomodulators Imidazoquinolinamines - Topical*** - Drugs For The Skin		
<i>imiquimod cream 3.75 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>imiquimod cream 5 % external</i>	Preferred	QL (12 PACKET per 30 days); AL (Min 10 Years)
<i>imiquimod pump</i>	Non – Preferred	AL (Min 10 Years)
ZYCLARA	Non – Preferred	AL (Min 10 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYCLARA PUMP	Non – Preferred	AL (Min 10 Years)
<i>*Insect Repellents*** - Drugs For The Skin</i>		
<i>cvs insect repellent</i>	Preferred	OTC
COLEMAN 100 MAX CONTINUOUS SPR	Preferred	OTC
OFF ACTIVE	Preferred	OTC
OFF DEEP WOODS	Preferred	OTC
REPEL SPORTSMEN MAX	Preferred	OTC
SAWYER INSECT REPELLENT	Preferred	OTC
ULTRATHON INSECT REPELLENT	Preferred	OTC
<i>*Keratolytic/Antimitotic/Vesicant Agents*** - Drugs For The Skin</i>		
<i>bensal hp</i>	Non – Preferred	
<i>podofilox</i>	Preferred	
<i>salicylic acid external foam</i>	Non – Preferred	
<i>salicylic acid external gel</i>	Preferred	
<i>salicylic acid external ointment</i>	Preferred	
<i>salicylic acid wart remover</i>	Preferred	
CONDYLOX	Preferred	
PODOCON-25	Non – Preferred	
SALICATE	Non – Preferred	
SALYCIM	Non – Preferred	
YCANTH	Non – Preferred	
<i>*Keratolytic/Antimitotic/Vesicant Combinations*** - Drugs For The Skin</i>		
UREA-SALICYLIC ACID	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Local Anesthetics - Topical*** - Drugs For The Skin		
<i>lidocaine external patch</i>	Preferred	QL (3 EA per 1 day)
<i>lidocaine hcl cream 3 % external (rx)</i>	Preferred	
<i>lidocaine hcl cream 4.12 % external</i>	Non – Preferred	
<i>lidocaine hcl external solution</i>	Preferred	
<i>lidocaine hcl urethral/mucosal</i>	Preferred	
<i>lidocaine ointment 5 % external</i>	Preferred	QL (50 GM per 30 days)
DERMACINRX LIDOGEL	Non – Preferred	
GLYDO	Preferred	
LIDOCAN	Preferred	QL (3 EA per 1 day)
LIDODERM	Non – Preferred	QL (3 EA per 1 day)
LIDOREX	Non – Preferred	
LIDOTRAL	Non – Preferred	
LIDOTRAN	Non – Preferred	
LYDEXA	Non – Preferred	
QUTENZA	Non – Preferred	
QUTENZA (2 PATCH)	Non – Preferred	
QUTENZA (4 PATCH)	Non – Preferred	
ZTLIDO	Non – Preferred	
*Macrolide Immunosuppressants - Topical*** - Drugs For The Skin		
<i>pimecrolimus</i>	Preferred	PA
<i>tacrolimus</i>	Preferred	PA; ST
ELIDEL	Preferred	PA
HYFTOR	Non – Preferred	
*Misc. Dermatological Products*** - Drugs For The Skin		
ALADERM PLUS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYLATOPIC PLUS	Non – Preferred	
NUVAIL	Non – Preferred	
*Oxaborole-Related Antifungals - Topical*** - Drugs For The Skin		
<i>tavaborole</i>	Non – Preferred	
*Phosphodiesterase 4 (Pde4) Inhibitors - Topical*** - Drugs For The Skin		
EUCRISA	Preferred	PA
*Photodynamic Therapy Agents - Topical*** - Drugs For The Skin		
AMELUZ	Non – Preferred	
LEVULAN KERASTICK	Preferred	
*Rosacea Agents*** - Drugs For The Skin		
<i>azelaic acid</i>	Non – Preferred	
<i>brimonidine tartrate</i>	Non – Preferred	
<i>doxycycline</i>	Non – Preferred	
<i>ivermectin</i>	Non – Preferred	
<i>metronidazole</i>	Preferred	
FINACEA	Non – Preferred	
NORITATE	Non – Preferred	
RHOFADE	Non – Preferred	
*Scabicide Combinations*** - Drugs For The Skin		
<i>ft lice killing max st</i>	Preferred	OTC
<i>gnp lice treatment</i>	Preferred	OTC; QL (240 ML per 30 days)
<i>lice killing</i>	Preferred	OTC
<i>lice killing maximum strength</i>	Preferred	OTC; QL (240 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lice killing shampoo max str</i>	Preferred	OTC
<i>sm lice killing max strength</i>	Preferred	OTC; QL (240 ML per 30 days)
*Scabicides & Pediculicides*** - Drugs For The Skin		
<i>gnp lice treatment</i>	Preferred	OTC; QL (118 ML per 30 days)
<i>goodsense lice killing</i>	Preferred	OTC; QL (118 ML per 30 days)
<i>ivermectin</i>	Non – Preferred	
<i>malathion</i>	Non – Preferred	
<i>permethrin</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>sm lice treatment</i>	Preferred	OTC
<i>spinosad</i>	Non – Preferred	
CROTAN	Non – Preferred	
NATROBA	Preferred	
*Skin Cleansers*** - Drugs For The Skin		
HYCLODEX	Non – Preferred	
*Steroid-Local Anesthetic Combinations*** - Drugs For The Skin		
EPIFOAM	Non – Preferred	
RADIAURA	Non – Preferred	
*Tar Products*** - Drugs For The Skin		
<i>therapeutic</i>	Preferred	OTC
THERAPEUTIC T+PLUS	Preferred	OTC
*Topical Anesthetic Combinations*** - Drugs For The Skin		
<i>lidocaine-prilocaine</i>	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIDOTRAL-MENTHOL	Non – Preferred	
XYLIDERM	Non – Preferred	QL (10 EA per 1 day)
<i>*Topical Selective Retinoid X Receptor Agonists*** - Drugs For The Skin</i>		
<i>bexarotene</i>	Non – Preferred	
TARGRETIN	Preferred	
<i>*Topical Steroid Combinations*** - Drugs For The Skin</i>		
<i>calcipotriene-betameth diprop</i>	Non – Preferred	
DUOBRII	Non – Preferred	
ENSTILAR	Non – Preferred	
TACLONEX	Non – Preferred	
<i>*Wound Care Combinations*** - Drugs For The Skin</i>		
<i>bpcp</i>	Non – Preferred	
<i>*Wound Dressings*** - Drugs For The Skin</i>		
ACTICOAT FLEX 3 4"X4"	Preferred	
ALLEVYN ADHESIVE	Preferred	OTC
COMFORT-AID 1.5"X2.5"	Preferred	OTC
<i>*Wound Treatment - Gene Therapy*** - Drugs For The Skin</i>		
VYJUVEK	Non – Preferred	
<i>*Diagnostic Products*</i>		
<i>*Diagnostic Tests***</i>		
<i>blood glucose test</i>	Non – Preferred	OTC
<i>blood glucose test strips 333</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>cvs glucose meter test strips</i>	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diatruue plus test</i>	Non – Preferred	OTC
<i>easy plus ii glucose test</i>	Non – Preferred	OTC
<i>easy talk blood glucose test</i>	Non – Preferred	OTC
<i>easy talk plus ii test strips</i>	Non – Preferred	OTC
<i>easy trak blood glucose test</i>	Non – Preferred	OTC
<i>easy trak ii glucose test</i>	Non – Preferred	OTC
<i>element compact test</i>	Non – Preferred	OTC
<i>eq blood glucose test</i>	Non – Preferred	OTC
<i>ge100 blood glucose test</i>	Non – Preferred	OTC
<i>ght test</i>	Non – Preferred	OTC
<i>glucose meter test</i>	Non – Preferred	OTC
<i>gnp easy touch glucose test</i>	Non – Preferred	OTC
<i>goodsense blood glucose</i>	Non – Preferred	OTC
<i>ketone test</i>	Preferred	OTC
<i>groger blood glucose test</i>	Non – Preferred	OTC
<i>groger premium glucose test</i>	Non – Preferred	OTC
<i>liberty test</i>	Non – Preferred	OTC
<i>meijer blood glucose test</i>	Non – Preferred	OTC
<i>meijer essential glucose test</i>	Non – Preferred	OTC
<i>one drop test</i>	Non – Preferred	OTC
<i>pharmacist choice no coding</i>	Non – Preferred	OTC
<i>premium blood glucose test</i>	Non – Preferred	OTC
<i>pro voice v8/v9 glucose</i>	Non – Preferred	OTC
<i>tgt blood glucose test</i>	Non – Preferred	OTC
<i>true focus blood glucose strip</i>	Non – Preferred	OTC
<i>verasens blood glucose test</i>	Non – Preferred	OTC
ACCU-CHEK AVIVA PLUS	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK GUIDE	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK SMARTVIEW	Non – Preferred	OTC; QL (5 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCUTREND GLUCOSE	Non – Preferred	OTC
ADVANCE INTUITION TEST	Non – Preferred	OTC
ADVANCE MICRO-DRAW TEST	Non – Preferred	OTC
ADVOCATE REDI-CODE	Non – Preferred	OTC
ADVOCATE REDI-CODE+ TEST	Non – Preferred	OTC
ADVOCATE TEST	Non – Preferred	OTC
AGAMATRIX AMP TEST	Non – Preferred	OTC
AGAMATRIX JAZZ TEST	Non – Preferred	OTC
AGAMATRIX KEYNOTE TEST	Non – Preferred	OTC
AGAMATRIX PRESTO TEST	Non – Preferred	OTC
ASSURE 3 TEST	Non – Preferred	OTC
ASSURE 4 TEST	Non – Preferred	OTC
ASSURE II	Non – Preferred	OTC
ASSURE II CHECK	Non – Preferred	OTC
ASSURE PLATINUM	Non – Preferred	OTC
ASSURE PRISM MULTI TEST	Non – Preferred	OTC
ASSURE PRO TEST	Non – Preferred	OTC
BIOTEL CARE TEST STRIPS	Non – Preferred	OTC
BLULINK GLUCOSE TEST	Non – Preferred	OTC
CAREONE BLOOD GLUCOSE TEST	Non – Preferred	OTC
CARESENS N GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CARETOUCH TEST	Non – Preferred	OTC
CHEMSTRIP K	Preferred	OTC
CLEVER CHEK AUTO-CODE TEST	Non – Preferred	OTC
CLEVER CHEK AUTO-CODE VOICE	Non – Preferred	OTC
CLEVER CHEK TEST	Non – Preferred	OTC
CLEVER CHOICE AUTO-CODE TEST	Non – Preferred	OTC
CLEVER CHOICE MICRO TEST	Non – Preferred	OTC
CLEVER CHOICE NO CODING	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE TALK SYSTEM	Non – Preferred	OTC
CONTOUR NEXT TEST STRIP IN VITRO	Non – Preferred	OTC
CONTOUR NEXT TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
CONTOUR TEST STRIP IN VITRO	Non – Preferred	OTC
CONTOUR TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
COOL BLOOD GLUCOSE TEST STRIPS	Non – Preferred	OTC
CVS ADVANCED GLUCOSE TEST	Non – Preferred	OTC
D-CARE BLOOD GLUCOSE	Non – Preferred	
DIATHRIVE BLOOD GLUCOSE TEST	Non – Preferred	OTC
DIATHRIVE GLUCOSE TEST	Non – Preferred	OTC
DIATHRIVE+ GLUCOSE TEST	Non – Preferred	OTC
DUO-CARE TEST	Non – Preferred	OTC
EASY STEP TEST	Non – Preferred	OTC
EASY TOUCH HEALTHPRO GLUCOSE STRIP IN VITRO	Non – Preferred	OTC
EASY TOUCH HEALTHPRO GLUCOSE STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
EASY TOUCH TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
EASY TOUCH TEST STRIP IN VITRO	Non – Preferred	OTC
EASYGLUCO	Non – Preferred	OTC
EASYMAX 15 TEST	Non – Preferred	OTC
EASYMAX TEST	Non – Preferred	OTC
EASYPRO BLOOD GLUCOSE TEST	Non – Preferred	OTC
EASYPRO PLUS	Non – Preferred	OTC
ELEMENT TEST	Non – Preferred	OTC
EMBRACE BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC
EMBRACE BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
EMBRACE EVO BLOOD GLUCOSE TEST	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE PRO GLUCOSE TEST	Non – Preferred	OTC
EMBRACE TALK GLUCOSE TEST	Non – Preferred	OTC
EMBRACE WAVE BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
EVOLUTION AUTOCODE	Non – Preferred	OTC
FIFTY50 GLUCOSE TEST 2.0	Non – Preferred	OTC
FORA 6 CONNECT	Non – Preferred	OTC
FORA 6 CONNECT/GTEL TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA D15G BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA D20 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA D40/G31 BLOOD GLUCOSE	Non – Preferred	OTC
FORA G20 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA G30/PREM V10 GLUCOSE TEST	Non – Preferred	OTC
FORA GD20 TEST	Non – Preferred	OTC
FORA GD50 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA GTEL BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA TN'G ADVANCE PRO	Non – Preferred	OTC
FORA TN'G/TN'G VOICE	Non – Preferred	OTC
FORA V10 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA V12 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA V20 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA V30A BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORACARE GD40 TEST	Non – Preferred	OTC
FORACARE PREMIUM V10 TEST	Non – Preferred	OTC
FORACARE TEST N GO TEST	Non – Preferred	OTC
FREESTYLE INSULINX TEST	Non – Preferred	OTC
FREESTYLE LITE TEST	Non – Preferred	OTC
FREESTYLE PRECISION NEO TEST	Non – Preferred	OTC
FREESTYLE TEST	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENULTIMATE TEST	Non – Preferred	OTC
GLUCO PERFECT 3 TEST	Non – Preferred	OTC
GLUCOCARD 01 SENSOR PLUS	Non – Preferred	OTC
GLUCOCARD EXPRESSION TEST	Non – Preferred	OTC
GLUCOCARD SHINE TEST	Non – Preferred	OTC
GLUCOCARD VITAL TEST	Non – Preferred	OTC
GLUCOCARD X-SENSOR	Non – Preferred	OTC
GLUCOCOM TEST	Non – Preferred	OTC
GLUCONAVII BLOOD GLUCOSE TEST	Non – Preferred	OTC
GNP TRUE METRIX GLUCOSE STRIPS	Non – Preferred	OTC
GNP TRUETRACK SMART SYSTEM	Non – Preferred	OTC
GNP TRUETRACK TEST STRIPS	Non – Preferred	OTC
GOJJI BLOOD GLUCOSE TEST	Non – Preferred	OTC
GOJJI BLOOD TEST STRIP/LANCETS	Non – Preferred	OTC
HW EMBRACE PRO GLUCOSE TEST	Non – Preferred	OTC
HW EMBRACE TALK GLUCOSE TEST	Non – Preferred	OTC
IGLUCOSE TEST STRIPS	Non – Preferred	OTC
IN TOUCH BLOOD GLUCOSE TEST	Non – Preferred	OTC
INFINITY BLOOD GLUCOSE TEST	Non – Preferred	OTC
INFINITY VOICE	Non – Preferred	OTC
KROGER HEALTHPRO GLUCOSE TEST	Non – Preferred	OTC
LIBERTY NEXT GENERATION TEST	Non – Preferred	OTC
MEIJER TRUETEST TEST	Non – Preferred	OTC
MEIJER TRUETRACK TEST	Non – Preferred	OTC
MICRODOT TEST	Non – Preferred	OTC
MM EASY TOUCH GLUCOSE	Non – Preferred	OTC
MYGLUCOHEALTH TEST	Non – Preferred	OTC
NEUTEK 2TEK TEST	Non – Preferred	OTC
NOVA MAX GLUCOSE TEST	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ON CALL EXPRESS BLOOD GLUCOSE	Non – Preferred	OTC
ONETOUCH ULTRA	Preferred	OTC; QL (5 EA per 1 day)
ONETOUCH ULTRA TEST	Preferred	OTC; QL (5 EA per 1 day)
ONETOUCH VERIO STRIP IN VITRO	Non – Preferred	OTC
ONETOUCH VERIO STRIP IN VITRO	Preferred	OTC; QL (5 EA per 1 day)
OPTIUMEZ TEST	Non – Preferred	OTC
PHARMACIST CHOICE AUTOCODE	Non – Preferred	OTC
PIP BLOOD GLUCOSE TEST STRIP	Non – Preferred	OTC; QL (5 EA per 1 day)
POCKETCHEM EZ TEST	Non – Preferred	OTC
PRECISION XTRA BLOOD GLUCOSE	Non – Preferred	OTC
PRODIGY NO CODING BLOOD GLUC	Non – Preferred	OTC
PTS PANELS EGLU TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
QUICKTEK TEST	Non – Preferred	OTC
QUINTET AC BLOOD GLUCOSE TEST	Non – Preferred	OTC
QUINTET BLOOD GLUCOSE TEST	Non – Preferred	OTC
REFUAH PLUS BLOOD GLUCOSE TEST	Non – Preferred	OTC
RELION BLOOD GLUCOSE TEST	Non – Preferred	OTC
RELION CONFIRM/MICRO TEST	Non – Preferred	OTC
RELION KETONE TEST	Preferred	OTC
RELION PREMIER TEST	Non – Preferred	OTC
RELION PRIME TEST	Non – Preferred	OTC
RELION TRUE METRIX TEST STRIPS	Non – Preferred	OTC
RELION ULTIMA TEST	Non – Preferred	OTC
REXALL BLOOD GLUCOSE TEST	Non – Preferred	OTC
RIGHTEST GS100 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GS300 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GS550 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GT333 BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
RIGHTEST GT333 GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMART SENSE PREMIUM TEST	Non – Preferred	OTC
SMART SENSE VALUE TEST	Non – Preferred	OTC
SMARTEST BLOOD GLUCOSE TEST	Non – Preferred	OTC
SOLUS V2 TEST	Non – Preferred	OTC
SUPREME TEST	Non – Preferred	OTC
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC
TRUE METRIX PRO BLOOD GLUCOSE	Non – Preferred	OTC
TRUETEST TEST	Non – Preferred	OTC
TRUETRACK TEST	Non – Preferred	OTC
UNISTRIP1 GENERIC	Non – Preferred	OTC
VIVAGUARD INO TEST STRIPS	Non – Preferred	OTC
Digestive Aids - Drugs For The Stomach		
<i>*Digestive Enzymes*** - Drugs For The Stomach</i>		
CREON	Preferred	
PERTZYE	Non – Preferred	
VIOKACE	Non – Preferred	
ZENPEP	Preferred	
Diuretics - Drugs For The Heart		
<i>*Carbonic Anhydrase Inhibitors*** - Drugs For High Blood Pressure</i>		
<i>acetazolamide</i>	Preferred	
<i>acetazolamide er</i>	Preferred	
<i>dichlorphenamide</i>	Non – Preferred	
<i>methazolamide</i>	Preferred	
KEVEYIS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Diuretic Combinations*** - Drugs For High Blood Pressure		
<i>amiloride-hydrochlorothiazide</i>	Preferred	
<i>spironolactone-hctz</i>	Preferred	
<i>triamterene-hctz</i>	Preferred	
*Loop Diuretics*** - Drugs For High Blood Pressure		
<i>bumetanide</i>	Preferred	
<i>ethacrynic acid</i>	Preferred	
<i>furosemide</i>	Preferred	
<i>toremide</i>	Preferred	
BUMEX	Non – Preferred	
EDECIN	Non – Preferred	
LASIX	Non – Preferred	
*Potassium Sparing Diuretics*** - Drugs For High Blood Pressure		
<i>amiloride hcl</i>	Preferred	
<i>spironolactone oral suspension</i>	Non – Preferred	
<i>spironolactone oral tablet</i>	Preferred	
<i>triamterene</i>	Preferred	
ALDACTONE	Non – Preferred	
CAROSPIR	Non – Preferred	
*Thiazides And Thiazide-Like Diuretics*** - Drugs For High Blood Pressure		
<i>chlorthalidone</i>	Preferred	
<i>hydrochlorothiazide</i>	Preferred	
<i>indapamide</i>	Preferred	
<i>metolazone</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIURIL	Preferred	
THALITONE	Non – Preferred	
Endocrine And Metabolic Agents - Misc. - Hormones		
*Abortifacient - Progesterone Receptor Antagonists*** - Drugs For Women		
<i>mifepristone</i>	Preferred	
MIFEPREX	Preferred	
*Bisphosphonates*** - Drugs For Menopause And Bone Loss		
<i>alendronate sodium oral solution</i>	Preferred	QL (10.8 ML per 1 day)
<i>alendronate sodium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>alendronate sodium tablet 35 mg oral</i>	Preferred	QL (4 EA per 28 days)
<i>alendronate sodium tablet 5 mg oral</i>	Preferred	
<i>alendronate sodium tablet 70 mg oral</i>	Preferred	QL (4 EA per 28 days)
<i>ibandronate sodium tablet 150 mg oral</i>	Non – Preferred	QL (1 EA per 30 days)
<i>risedronate sodium</i>	Non – Preferred	
ACTONEL	Non – Preferred	
ATELVIA	Non – Preferred	
BINOSTO	Non – Preferred	
FOSAMAX	Non – Preferred	QL (4 EA per 28 days)
FOSAMAX PLUS D	Non – Preferred	
*Calcimimetic Agents*** - Drugs For Menopause And Bone Loss		
<i>cinacalcet hcl</i>	Non – Preferred	
SENSIPAR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Calcitonins*** - Drugs For Menopause And Bone Loss		
<i>calcitonin (salmon)</i>	Preferred	QL (3.7 ML per 30 days)
*Carnitine Replenisher - Agents*** - Drugs For Menopause And Bone Loss		
<i>levocarnitine</i>	Non – Preferred	
<i>levocarnitine sf</i>	Non – Preferred	
CARNITOR	Non – Preferred	
CARNITOR SF	Non – Preferred	
*Cortisol Synthesis Inhibitors*** - Hormones		
ISTURISA	Non – Preferred	
RECORLEV	Non – Preferred	
*Dopamine Receptor Agonists*** - Drugs For Women		
<i>cabergoline tablet 0.5 mg oral</i>	Preferred	QL (16 EA per 30 days)
*Fabry Disease - Agents*** - Drugs For Menopause And Bone Loss		
GALAFOLD	Non – Preferred	
*Gnrh/Lhrh Antagonists*** - Drugs For Women		
ORLISSA	Preferred	PA
*Growth Hormone Releasing Hormones (Ghrh)*** - Drugs For Growth		
EGRIFTA SV	Non – Preferred	
*Growth Hormones*** - Drugs For Growth		
GENOTROPIN	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENOTROPIN MINIQUICK	Preferred	PA
HUMATROPE	Non – Preferred	
NGENLA	Non – Preferred	
NORDITROPIN FLEXPRO	Non – Preferred	
NUTROPIN AQ NUSPIN 10	Non – Preferred	
NUTROPIN AQ NUSPIN 20	Non – Preferred	
NUTROPIN AQ NUSPIN 5	Non – Preferred	
OMNITROPE	Non – Preferred	
SAIZEN	Non – Preferred	
SEROSTIM	Non – Preferred	
SKYTROFA	Non – Preferred	
SOGROYA	Non – Preferred	
ZOMACTON	Non – Preferred	
<i>*Hereditary Tyrosinemia Type 1 (Ht-1) Treatment - Agents*** - Drugs For Menopause And Bone Loss</i>		
<i>nitisinone</i>	Preferred	
NITYR	Non – Preferred	
ORFADIN ORAL CAPSULE	Preferred	
ORFADIN ORAL SUSPENSION	Non – Preferred	
<i>*Homocystinuria Treatment - Agents*** - Drugs For Menopause And Bone Loss</i>		
<i>betaine</i>	Non – Preferred	
CYSTADANE	Non – Preferred	
<i>*Hyperammonemia Treatment - Agents*** - Drugs For Menopause And Bone Loss</i>		
<i>carglumic acid</i>	Preferred	PA
CARBAGLU	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Hyperparathyroid Treatment - Vitamin D Analogs*** - Drugs For Menopause And Bone Loss		
<i>calcitriol</i>	Preferred	
<i>doxercalciferol</i>	Preferred	
<i>paricalcitol</i>	Non – Preferred	QL (1 EA per 1 day)
RAYALDEE	Non – Preferred	
ROCALTROL	Non – Preferred	
ZEMPLAR	Non – Preferred	QL (1 EA per 1 day)
*Insulin-Like Growth Factors (Somatomedins)*** - Hormones		
INCRELEX	Non – Preferred	
*Lhrh/Gnrh Agonist Analog Pituitary Suppressants*** - Drugs For Women		
SYNAREL	Non – Preferred	
*Non-Steroidal Mineralocorticoid Receptor Antagonists*** - Hormones		
KERENDIA	Preferred	PA
*Phenylketonuria Treatment - Agents*** - Drugs For Menopause And Bone Loss		
<i>sapropterin dihydrochloride</i>	Non – Preferred	
JAVYGTOR	Non – Preferred	
KUVAN	Non – Preferred	
*Selective Estrogen Receptor Modulators (Serms)*** - Drugs For Menopause And Bone Loss		
<i>raloxifene hcl</i>	Non – Preferred	

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QL = Quantity Limits

ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVISTA	Non – Preferred	
OSPHENA	Non – Preferred	
*Selective Vasopressin V2-Receptor Antagonists*** - Hormones		
<i>tolvaptan</i>	Non – Preferred	
JYNARQUE	Non – Preferred	
SAMSCA	Non – Preferred	
*Somatostatic Agents*** - Drugs For Growth		
<i>lanreotide acetate</i>	Non – Preferred	
<i>octreotide acetate</i>	Non – Preferred	
MYCAPSSA	Non – Preferred	
SANDOSTATIN	Non – Preferred	
SANDOSTATIN LAR DEPOT	Non – Preferred	
SIGNIFOR	Non – Preferred	
SIGNIFOR LAR	Non – Preferred	
SOMATULINE DEPOT	Non – Preferred	
*Urea Cycle Disorder - Agents*** - Drugs For Menopause And Bone Loss		
<i>sodium phenylbutyrate</i>	Non – Preferred	
BUPHENYL	Non – Preferred	
OLPRUVA (2 GM DOSE)	Non – Preferred	
OLPRUVA (3 GM DOSE)	Non – Preferred	
OLPRUVA (4 GM DOSE)	Non – Preferred	
OLPRUVA (5 GM DOSE)	Non – Preferred	
OLPRUVA (6 GM DOSE)	Non – Preferred	
OLPRUVA (6.67 GM DOSE)	Non – Preferred	
PHEBURANE	Non – Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RAVICTI	Non – Preferred	
*Vasopressin*** - Hormones		
<i>desmopressin ace spray refrig</i>	Preferred	QL (5 ML per 30 days)
<i>desmopressin acetate</i>	Preferred	QL (3 EA per 1 day)
<i>desmopressin acetate spray solution 0.01 % nasal</i>	Preferred	QL (5 ML per 30 days)
DDAVP	Non – Preferred	QL (3 EA per 1 day)
NOCDURNA	Non – Preferred	
Estrogens - Hormones		
*Estrogen & Androgen*** - Drugs For Women		
<i>est estrogens-methyltest ds</i>	Preferred	
<i>est estrogens-methyltest hs</i>	Preferred	
*Estrogen & Progestin*** - Drugs For Women		
<i>estradiol-norethindrone acet</i>	Preferred	QL (1 EA per 1 day)
<i>norethindrone-eth estradiol</i>	Non – Preferred	QL (1 EA per 1 day)
ACTIVELLA	Non – Preferred	QL (1 EA per 1 day)
ANGELIQ	Non – Preferred	
BIJUVA	Non – Preferred	
CLIMARA PRO	Non – Preferred	
COMBIPATCH	Preferred	QL (8 PATCH per 28 days)
FYAVOLV	Non – Preferred	QL (1 EA per 1 day)
JINTELI	Non – Preferred	QL (1 EA per 1 day)
MIMVEY	Preferred	QL (1 EA per 1 day)
PREMPHASE	Preferred	QL (1 EA per 1 day)
PREMPRO	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Estrogen-Progestin-Gnrh Antagonist*** - Drugs For Woman		
MYFEMBREE	Preferred	PA
ORIAHNN	Preferred	PA
*Estrogens*** - Drugs For Women		
<i>estradiol oral</i>	Preferred	
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch weekly 0.025 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.05 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.06 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.075 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.1 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol transdermal gel</i>	Non – Preferred	
<i>estradiol valerate</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALORA	Non – Preferred	QL (8 EA per 28 days)
CLIMARA PATCH WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	
CLIMARA PATCH WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.06 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
DELESTROGEN	Non – Preferred	
DEPO-ESTRADIOL	Non – Preferred	
DIVIGEL	Non – Preferred	
DOTTI PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Preferred	QL (8 PATCH per 28 days)
DOTTI PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Preferred	QL (8 PATCH per 28 days)
DOTTI PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
DOTTI PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
DOTTI PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
ELESTRIN	Non – Preferred	
ESTRACE	Non – Preferred	
EVAMIST	Non – Preferred	
LYLLANA	Preferred	QL (8 EA per 28 days)
MENEST	Preferred	
MENOSTAR	Non – Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIVELLE PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
PREMARIN	Preferred	QL (1 EA per 1 day)
VIVELLE-DOT PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
VIVELLE-DOT PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
VIVELLE-DOT PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
VIVELLE-DOT PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
VIVELLE-DOT PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
<i>*Estrogen-Selective Estrogen Receptor Modulator Comb*** - Drugs For Women</i>		
DUAVEE	Non – Preferred	
Fluoroquinolones - Drugs For Infections		
<i>*Fluoroquinolones*** - Antibiotics</i>		
<i>ciprofloxacin hcl</i>	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin in d5w</i>	Preferred	
<i>levofloxacin in d5w</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levofloxacin intravenous</i>	Preferred	
<i>levofloxacin oral solution</i>	Preferred	QL (280 ML Max Qty Per Fill Retail); AL (Max 12 Years)
<i>levofloxacin oral tablet</i>	Preferred	QL (14 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>moxifloxacin hcl</i>	Preferred	AL (Min 16 Years)
<i>ofloxacin</i>	Non – Preferred	AL (Min 16 Years)
BAXDELA	Non – Preferred	AL (Min 16 Years)
CIPRO ORAL SUSPENSION RECONSTITUTED	Non – Preferred	AL (Min 16 Years)
CIPRO ORAL TABLET	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
Gastrointestinal Agents - Misc. - Drugs For The Stomach		
<i>*5-Ht4 Receptor Agonists*** - Drugs For The Stomach</i>		
MOTEGRITY	Non – Preferred	
<i>*Antiflatulents*** - Drugs For The Stomach</i>		
<i>gas relief</i>	Preferred	OTC
<i>simethicone</i>	Preferred	OTC
<i>*Bile Acid Synthesis Disorder Agents*** - Drugs For The Stomach</i>		
CHOLBAM	Non – Preferred	
<i>*Cic Agents - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For Constipation</i>		
TRULANCE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Farnesoid X Receptor (Fxr) Agonists*** - Drugs For The Stomach		
OICALIVA	Non – Preferred	
*Gallstone Solubilizing Agents*** - Drugs For The Stomach		
<i>ursodiol oral capsule</i>	Preferred	
<i>ursodiol oral tablet</i>	Non – Preferred	
CHENODAL	Non – Preferred	
RELTONE	Non – Preferred	
URSO FORTE	Non – Preferred	
*Gastrointestinal Antiallergy Agents*** - Drugs For The Stomach		
<i>cromolyn sodium</i>	Preferred	
GASTROCROM	Non – Preferred	
*Gastrointestinal Chloride Channel Activators*** - Drugs For Irritable Bowel Syndrome		
<i>lubiprostone</i>	Non – Preferred	QL (2 EA per 1 day)
AMITIZA	Non – Preferred	QL (2 EA per 1 day)
*Gastrointestinal Stimulants*** - Drugs For The Stomach		
<i>metoclopramide hcl oral solution</i>	Preferred	
<i>metoclopramide hcl oral tablet</i>	Preferred	
<i>metoclopramide hcl oral tablet dispersible</i>	Non – Preferred	
GIMOTI	Non – Preferred	
REGLAN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Glucagon-Like Peptide-2 (Glp-2) Analogs*** - Drugs For The Stomach		
GATTEX	Non – Preferred	
*Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For Constipation		
LINZESS	Non – Preferred	QL (1 EA per 1 day)
*Ibs Agent - Mu-Opioid Receptor Agonists*** - Drugs For Irritable Bowel Syndrome		
VIBERZI	Non – Preferred	
*Ibs Agent - Selective 5-Ht3 Receptor Antagonists*** - Drugs For Irritable Bowel Syndrome		
<i>alosetron hcl</i>	Non – Preferred	
LOTRONEX	Non – Preferred	
*Ibs Agent - Sodium/Hydrogen Exchanger 3 (Nhe3) Inhibitor*** - Drugs For Irritable Bowel Syndrome		
IBSRELA	Non – Preferred	
*Inflammatory Bowel Agents*** - Drugs For Inflammatory Bowel Disease		
<i>balsalazide disodium</i>	Preferred	
<i>mesalamine er oral capsule extended release</i>	Preferred	
<i>mesalamine er oral capsule extended release 24 hour</i>	Non – Preferred	QL (4 EA per 1 day)
<i>mesalamine oral capsule delayed release</i>	Non – Preferred	QL (6 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mesalamine rectal enema</i>	Preferred	
<i>mesalamine suppository 1000 mg rectal</i>	Preferred	QL (42 EA per 30 days)
<i>mesalamine tablet delayed release 1.2 gm oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>mesalamine tablet delayed release 800 mg oral</i>	Non – Preferred	QL (6 EA per 1 day)
<i>mesalamine-cleanser</i>	Non – Preferred	
<i>sulfasalazine</i>	Preferred	
APRISO	Non – Preferred	QL (4 EA per 1 day)
AZULFIDINE	Non – Preferred	
AZULFIDINE EN-TABS	Non – Preferred	
CANASA	Non – Preferred	QL (42 EA per 30 days)
COLAZAL	Non – Preferred	
DELZICOL	Non – Preferred	QL (6 EA per 1 day)
DIPENTUM	Non – Preferred	
LIALDA	Non – Preferred	QL (4 EA per 1 day)
PENTASA	Preferred	
ROWASA	Non – Preferred	
SFROWASA	Preferred	
<i>*Integrin Receptor Antagonists*** - Drugs For Inflammatory Bowel Disease</i>		
ENTYVIO	Non – Preferred	
<i>*Interleukin Antagonists*** - Drugs For Inflammatory Bowel Disease</i>		
OMVOH	Non – Preferred	
SKYRIZI	Non – Preferred	
STELARA	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Intestinal Acidifiers*** - Drugs For The Stomach</i>		
<i>enulose</i>	Preferred	
<i>generlac</i>	Preferred	
<i>lactulose encephalopathy</i>	Preferred	
<i>*Peripheral Opioid Receptor Antagonists*** - Drugs For The Stomach</i>		
<i>alvimopan</i>	Non – Preferred	
MOVANTIK	Non – Preferred	QL (1 EA per 1 day)
RELISTOR	Non – Preferred	
SYMPROIC	Non – Preferred	QL (1 EA per 1 day)
<i>*Phosphate Binder Agents*** - Drugs For The Stomach</i>		
<i>calcium acetate</i>	Preferred	
<i>calcium acetate (phos binder)</i>	Preferred	
<i>lanthanum carbonate</i>	Preferred	
<i>sevelamer carbonate oral packet</i>	Non – Preferred	
<i>sevelamer carbonate oral tablet</i>	Preferred	
<i>sevelamer hcl</i>	Preferred	
AURYXIA	Non – Preferred	QL (12 EA per 1 day)
CALPHRON	Preferred	OTC
FOSRENOL ORAL PACKET	Preferred	
FOSRENOL ORAL TABLET CHEWABLE	Non – Preferred	
RENVELA	Non – Preferred	
VELPHORO	Non – Preferred	
<i>*Tumor Necrosis Factor Alpha Blockers*** - Drugs For Inflammatory Bowel Disease</i>		
<i>infliximab</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVSOLA	Non – Preferred	
CIMZIA	Non – Preferred	
CIMZIA (2 SYRINGE)	Preferred	PA
CIMZIA STARTER KIT	Preferred	PA
INFLECTRA	Non – Preferred	
REMICADE	Non – Preferred	
RENFLEXIS	Non – Preferred	
Genitourinary Agents - Miscellaneous - Drugs For The Urinary System		
<i>*5-Alpha Reductase Inhibitors*** - Drugs For The Prostate</i>		
<i>dutasteride</i>	Non – Preferred	
<i>finasteride</i>	Preferred	QL (1 EA per 1 day)
AVODART	Non – Preferred	
PROSCAR	Non – Preferred	QL (1 EA per 1 day)
<i>*Alpha 1-Adrenoceptor Antagonists*** - Drugs For The Prostate</i>		
<i>alfuzosin hcl er</i>	Preferred	QL (1 EA per 1 day)
<i>silodosin</i>	Non – Preferred	
<i>tamsulosin hcl</i>	Preferred	QL (2 EA per 1 day)
CARDURA XL	Non – Preferred	
FLOMAX	Non – Preferred	QL (2 EA per 1 day)
RAPAFLO	Non – Preferred	
<i>*Citrates*** - Drugs For Infections</i>		
<i>cytra k crystals</i>	Non – Preferred	
<i>pot & sod cit-cit ac</i>	Non – Preferred	
<i>potassium citrate er</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>potassium citrate-citric acid</i>	Non – Preferred	
<i>sod citrate-citric acid solution 1.5-1 gm/15ml oral</i>	Preferred	QL (500 ML per 30 days)
<i>sod citrate-citric acid solution 3-2 gm/30ml oral</i>	Preferred	QL (500 ML per 30 days)
<i>sod citrate-citric acid solution 500-334 mg/5ml oral (rx)</i>	Preferred	QL (500 ML per 30 days)
<i>tricitrates</i>	Non – Preferred	
ORACIT	Preferred	
UROCIT-K 10	Non – Preferred	
UROCIT-K 15	Non – Preferred	
UROCIT-K 5	Non – Preferred	
<i>*Cystinosis Agents*** - Drugs For The Urinary System</i>		
CYSTAGON	Preferred	
PROCYSBI	Non – Preferred	
<i>*Genitourinary Irrigants*** - Drugs For The Urinary System</i>		
<i>sodium chloride</i>	Preferred	
<i>*Interstitial Cystitis Agents*** - Drugs For The Urinary System</i>		
ELMIRON	Non – Preferred	
<i>*Phosphates*** - Drugs For Infections</i>		
K-PHOS NO 2	Non – Preferred	
<i>*Prostatic Hypertrophy Agent Combinations*** - Drugs For The Prostate</i>		
<i>dutasteride-tamsulosin hcl</i>	Non – Preferred	
ENTADFI	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Urinary Analgesics*** - Drugs For Infections		
<i>phenazopyridine hcl</i>	Preferred	
PYRIDIUM	Non – Preferred	
*Urinary Stone Agents*** - Drugs For The Urinary System		
<i>tiopronin</i>	Non – Preferred	
LITHOSTAT	Non – Preferred	
THIOLA	Non – Preferred	
THIOLA EC	Non – Preferred	
Gout Agents - Drugs For Pain And Fever		
*Gout Agent Combinations*** - Gout Drugs		
<i>colchicine-probenecid</i>	Preferred	
*Gout Agents*** - Gout Drugs		
<i>allopurinol</i>	Preferred	
<i>colchicine capsule 0.6 mg oral</i>	Non – Preferred	QL (9 EA per 30 days)
<i>colchicine tablet 0.6 mg oral</i>	Non – Preferred	QL (9 EA per 30 days)
<i>febuxostat</i>	Non – Preferred	QL (1 EA per 1 day)
MITIGARE	Non – Preferred	QL (9 EA per 30 days)
ULORIC	Non – Preferred	QL (1 EA per 1 day)
*Uricosurics*** - Gout Drugs		
<i>probenecid</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hematological Agents - Misc. - Drugs For The Blood		
Agents For Congenital Thrombotic Thrombocytopenic Purpura - Drugs For The Blood		
<i>adzynma</i>	Non – Preferred	
*Antihemophilic Products - Monoclonal Antibodies*** - Drugs For The Blood		
HEMLIBRA	Preferred	PA
*Antihemophilic Products*** - Drugs To Prevent Bleeding		
<i>adynovate</i>	Preferred	PA
<i>obizur</i>	Preferred	PA
<i>rixubis</i>	Preferred	PA
ADVATE	Preferred	PA
AFSTYLA	Preferred	PA
ALPHANATE	Preferred	PA
ALPHANINE SD	Preferred	PA
ALPROLIX	Preferred	PA
BENEFIX	Preferred	PA
COAGADEX	Preferred	PA
CORIFACT	Preferred	PA
ELOCTATE	Preferred	PA
ESPEROCT	Preferred	PA
FEIBA	Preferred	PA
HEMOFIL M	Preferred	PA
HUMATE-P	Preferred	PA
IDELVION	Preferred	PA
IXINITY	Preferred	PA

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JIVI	Preferred	PA
KOATE	Preferred	PA
KOATE-DVI	Preferred	PA
KOGENATE FS	Preferred	PA
KOVALTRY	Preferred	PA
NOVOEIGHT	Preferred	PA
NOVOSEVEN RT	Preferred	PA
NUWIQ	Preferred	PA
PROFILNINE	Preferred	PA
REBINYN	Preferred	PA
RECOMBINATE	Preferred	PA
SEVENFACT	Preferred	PA
TRETTEN	Preferred	PA
VONVENDI	Preferred	PA
WILATE	Preferred	PA
XYNTHA	Preferred	PA
XYNTHA SOLOFUSE	Preferred	PA
<i>*Bradykinin B2 Receptor Antagonists*** - Drugs For The Blood</i>		
<i>icatibant acetate</i>	Non – Preferred	
FIRAZYR	Non – Preferred	
SAJAZIR	Non – Preferred	
<i>*C1 Esterase Inhibitors*** - Drugs For The Blood</i>		
BERINERT	Preferred	PA
CINRYZE	Non – Preferred	
HAEGARDA	Non – Preferred	
RUCONEST	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Complement C1 Inhibitors*** - Drugs For The Blood		
ENJAYMO	Non – Preferred	
*Complement C3 Inhibitors*** - Drugs For The Blood		
EMPAVELI	Non – Preferred	
*Complement C5 Inhibitors*** - Drugs For The Blood		
SOLIRIS	Non – Preferred	
ULTOMIRIS	Non – Preferred	
VEOPOZ	Non – Preferred	
ZILBRYSQ	Non – Preferred	
*Complement C5a Receptor Inhibitors*** - Drugs For The Blood		
TAVNEOS	Non – Preferred	
*Complement Factor B Inhibitors*** - Drugs For The Blood		
FABHALTA	Non – Preferred	
*Direct-Acting P2y12 Inhibitors*** - Drugs For The Blood		
BRILINTA	Preferred	
*Hematorheologic Agents*** - Drugs For The Blood		
<i>pentoxifylline er</i>	Preferred	
*Phosphodiesterase Iii Inhibitors*** - Drugs For The Blood		
<i>cilostazol</i>	Non – Preferred	

Coverage Requirements and Limits

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Drug Tier

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Preferred = Preferred

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QL = Quantity Limits

ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Plasma Kallikrein Inhibitors - Monoclonal Antibodies*** - Drugs For The Blood		
TAKHZYRO	Non – Preferred	
*Plasma Kallikrein Inhibitors*** - Drugs For The Blood		
KALBITOR	Non – Preferred	
ORLADEYO	Non – Preferred	
*Platelet Aggregation Inhibitor Combinations*** - Drugs For The Blood		
<i>aspirin-dipyridamole er</i>	Preferred	
*Platelet Aggregation Inhibitors*** - Drugs For The Blood		
<i>dipyridamole</i>	Preferred	
*Quinazoline Agents*** - Drugs For The Blood		
<i>anagrelide hcl</i>	Preferred	
AGRYLIN	Non – Preferred	
*Spleen Tyrosine Kinase (Syk) Inhibitors*** - Drugs For The Blood		
TAVALISSE	Non – Preferred	
*Thienopyridine Derivatives*** - Drugs For The Blood		
<i>clopidogrel bisulfate tablet 300 mg oral</i>	Preferred	QL (1 EA per 30 days)
<i>clopidogrel bisulfate tablet 75 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>prasugrel hcl</i>	Non – Preferred	
EFFIENT	Non – Preferred	
PLAVIX	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hematopoietic Agents - Drugs For Nutrition		
<i>*Agents For Sickle Cell Disease - Autologous Gene Therapy*** - Drugs For Nutrition</i>		
CASGEVY	Non – Preferred	
LYFGENIA	Non – Preferred	
<i>*Amino Acids*** - Drugs For Nutrition</i>		
ENDARI	Preferred	
<i>*Cobalamins*** - Drugs For Nutrition</i>		
<i>cyanocobalamin</i>	Preferred	
<i>*Cytotoxic Agents*** - Drugs For Nutrition</i>		
DROXIA	Preferred	
SIKLOS	Non – Preferred	
<i>*Erythroid Maturation Agents*** - Drugs For Nutrition</i>		
REBLOZYL	Non – Preferred	
<i>*Erythropoiesis-Stimulating Agents (Esas)*** - Drugs For Nutrition</i>		
ARANESP (ALBUMIN FREE)	Non – Preferred	
EPOGEN	Preferred	PA
MIRCERA	Non – Preferred	
PROCRIT	Preferred	PA
RETACRIT	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Folic Acid/Folates*** - Drugs For Nutrition		
<i>folic acid oral tablet 1 mg</i>	Preferred	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	Preferred	OTC
*Granulocyte Colony-Stimulating Factors (G-Csf)*** - Drugs For Nutrition		
<i>releuko</i>	Non – Preferred	
FULPHILA	Non – Preferred	
FYLNETRA	Non – Preferred	
GRANIX	Non – Preferred	
NEULASTA	Non – Preferred	
NEULASTA ONPRO	Non – Preferred	
NEUPOGEN	Preferred	
NIVESTYM	Non – Preferred	
NYVEPRIA	Non – Preferred	
ROLVEDON	Non – Preferred	
STIMUFEND	Non – Preferred	
UDENYCA	Non – Preferred	
UDENYCA ONBODY	Non – Preferred	
ZARXIO	Non – Preferred	
ZIEXTENZO	Non – Preferred	
*Granulocyte/Macrophage Colony-Stimulating Factor(Gm-Csf)*** - Drugs For Nutrition		
LEUKINE	Preferred	
*Hemoglobin S (Hbs) Polymerization Inhibitors*** - Drugs For Nutrition		
OXBRYTA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitors*** - Drugs For Nutrition</i>		
JESDUVROQ	Non – Preferred	
<i>*Iron*** - Drugs For Nutrition</i>		
<i>ferretts</i>	Preferred	OTC
<i>ferric x-150</i>	Preferred	OTC
<i>ferrous fumarate</i>	Preferred	OTC
<i>ferrous sulfate</i>	Preferred	OTC
<i>iron supplement</i>	Preferred	OTC
FERREX 150	Preferred	OTC
FERROCITE	Preferred	OTC
<i>*Selectin Blockers*** - Drugs For Nutrition</i>		
ADAKVEO	Non – Preferred	
<i>*Thrombopoietin (Tpo) Receptor Agonists*** - Drugs For Nutrition</i>		
DOPTELET	Non – Preferred	
MULPLETA	Non – Preferred	
NPLATE	Non – Preferred	
PROMACTA ORAL PACKET	Non – Preferred	
PROMACTA TABLET 12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROMACTA TABLET 25 MG ORAL	Non – Preferred	
PROMACTA TABLET 50 MG ORAL	Non – Preferred	
PROMACTA TABLET 75 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hemostatics - Drugs For The Blood		
*Hemostatics - Systemic*** - Drugs To Prevent Bleeding		
<i>aminocaproic acid</i>	Preferred	
<i>tranexamic acid</i>	Preferred	QL (28 EA per 30 days); AL (Min 12 Years)
Hypnotics/Sedatives/Sleep Disorder Agents - Drugs For The Nervous System		
*Antihistamine Hypnotics*** - Drugs For Insomnia		
<i>ra nighttime sleep aid</i>	Preferred	OTC
<i>ra sleep aid</i>	Preferred	OTC
<i>sleep aid</i>	Preferred	OTC
*Barbiturate Hypnotics*** - Drugs For Insomnia		
<i>phenobarbital</i>	Preferred	
*Benzodiazepine Hypnotics*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>estazolam</i>	Preferred	
<i>flurazepam hcl</i>	Non – Preferred	
<i>midazolam hcl</i>	Non – Preferred	
<i>quazepam</i>	Preferred	
<i>temazepam capsule 15 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 22.5 mg oral</i>	Preferred	
<i>temazepam capsule 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 7.5 mg oral</i>	Preferred	
<i>triazolam</i>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DORAL	Non – Preferred	
HALCION	Non – Preferred	
RESTORIL CAPSULE 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
RESTORIL CAPSULE 22.5 MG ORAL	Non – Preferred	
RESTORIL CAPSULE 30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
RESTORIL CAPSULE 7.5 MG ORAL	Non – Preferred	
<i>*Hypnotics - Tricyclic Agents*** - Drugs For Insomnia</i>		
<i>doxepin hcl</i>	Non – Preferred	
<i>*Non-Benzodiazepine - Gaba-Receptor Modulators*** - Drugs For Insomnia</i>		
<i>eszopiclone</i>	Non – Preferred	
<i>zaleplon</i>	Non – Preferred	
<i>zolpidem tartrate er</i>	Non – Preferred	
<i>zolpidem tartrate oral capsule</i>	Non – Preferred	
<i>zolpidem tartrate oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>zolpidem tartrate sublingual</i>	Non – Preferred	
AMBIEN	Non – Preferred	QL (1 EA per 1 day)
AMBIEN CR	Non – Preferred	
EDLUAR	Non – Preferred	
LUNESTA	Non – Preferred	
<i>*Orexin Receptor Antagonists*** - Drugs For Insomnia</i>		
BELSOMRA	Non – Preferred	
DAYVIGO	Non – Preferred	
QUVIVIQ	Non – Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Selective Melatonin Receptor Agonists*** - Drugs For Insomnia		
<i>ramelteon</i>	Non – Preferred	QL (1 EA per 1 day)
<i>tasimelteon</i>	Non – Preferred	
HETLIOZ	Non – Preferred	
HETLIOZ LQ	Non – Preferred	
ROZEREM	Non – Preferred	
Laxatives - Drugs For The Stomach		
*Bowel Evacuant Combinations*** - Drugs To Prevent Constipation		
<i>peg 3350-kcl-na bicarb-nacl</i>	Preferred	
<i>peg-3350/electrolytes</i>	Preferred	QL (4000 ML Max Qty Per Fill Retail)
*Bulk Laxatives*** - Drugs To Prevent Constipation		
<i>natural fiber laxative</i>	Preferred	OTC
<i>psyllium fiber</i>	Preferred	OTC
<i>qc natural vegetable</i>	Preferred	OTC
*Laxatives - Miscellaneous*** - Drugs To Prevent Constipation		
<i>glycerin (adult)</i>	Preferred	OTC
<i>polyethylene glycol 3350 oral packet</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>polyethylene glycol 3350 oral powder</i>	Preferred	QL (34 GM per 1 day)
*Laxatives & Dss*** - Drugs To Prevent Constipation		
<i>senna-docusate sodium</i>	Preferred	OTC
*Lubricant Laxatives*** - Drugs To Prevent Constipation		
<i>cvs mineral oil enema</i>	Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mineral oil heavy</i>	Preferred	
*Saline Laxative Mixtures*** - Drugs To Prevent Constipation		
<i>enema ready-to-use</i>	Preferred	OTC
*Saline Laxatives*** - Drugs To Prevent Constipation		
<i>magnesium citrate</i>	Preferred	OTC
<i>milk of magnesia</i>	Preferred	OTC
*Stimulant Laxatives*** - Drugs To Prevent Constipation		
<i>bisacodyl</i>	Preferred	OTC
<i>castor oil</i>	Preferred	OTC
<i>sennosides</i>	Preferred	OTC
*Surfactant Laxatives*** - Drugs To Prevent Constipation		
<i>docusate sodium oral capsule 100 mg</i>	Preferred	OTC
<i>docusate sodium oral capsule 250 mg</i>	Preferred	
<i>docusate sodium oral syrup</i>	Preferred	OTC
Macrolides - Drugs For Infections		
*Azithromycin*** - Antibiotics		
<i>azithromycin oral packet</i>	Preferred	
<i>azithromycin oral suspension reconstituted</i>	Preferred	QL (30 ML Max Qty Per Fill Retail)
<i>azithromycin tablet 250 mg oral</i>	Preferred	QL (6 EA Max Qty Per Fill Retail)
<i>azithromycin tablet 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>azithromycin tablet 600 mg oral</i>	Preferred	QL (8 EA per 28 days)
ZITHROMAX ORAL PACKET	Preferred	
ZITHROMAX ORAL SUSPENSION RECONSTITUTED	Non – Preferred	QL (30 ML Max Qty Per Fill Retail)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZITHROMAX TABLET 250 MG ORAL	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)
ZITHROMAX TABLET 500 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
ZITHROMAX TRI-PAK	Non – Preferred	QL (4 EA per 1 day)
ZITHROMAX Z-PAK	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)
*Clarithromycin*** - Antibiotics		
<i>clarithromycin er</i>	Preferred	QL (14 EA Max Qty Per Fill Retail)
<i>clarithromycin oral suspension reconstituted</i>	Preferred	QL (150 ML Max Qty Per Fill Retail)
<i>clarithromycin oral tablet</i>	Preferred	QL (28 EA Max Qty Per Fill Retail)
*Erythromycins*** - Antibiotics		
<i>erythromycin</i>	Preferred	
<i>erythromycin base</i>	Preferred	
<i>erythromycin ethylsuccinate</i>	Preferred	
E.E.S. 400	Preferred	
E.E.S. GRANULES	Preferred	
ERYPED 200	Preferred	
ERYPED 400	Preferred	
ERY-TAB	Preferred	
ERYTHROCIN STEARATE	Preferred	
*Fidaxomicin*** - Antibiotics		
DIFICID	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Devices And Supplies - Medical Supplies And Durable Medical Equipment		
<i>*Applicators, Cotton Balls, Etc*** - Medical Supplies And Durable Medical Equipment</i>		
<i>alcohol prep</i>	Preferred	OTC
<i>alcohol swabs</i>	Preferred	OTC
<i>cvs alcohol prep pads</i>	Preferred	OTC
<i>easy comfort alcohol pads</i>	Preferred	OTC
<i>eql alcohol swabs</i>	Preferred	OTC
<i>hm sterile alcohol prep</i>	Preferred	OTC
<i>pure comfort alcohol prep</i>	Preferred	OTC
<i>ra alcohol swabs</i>	Preferred	OTC
<i>sb alcohol prep</i>	Preferred	OTC
<i>sm alcohol prep</i>	Preferred	OTC
<i>sure comfort alcohol prep</i>	Preferred	OTC
ALCOHOL SWABSTICK	Preferred	OTC
CARETOUCH ALCOHOL PREP	Preferred	OTC
COMFORT TOUCH ALCOHOL PREP	Preferred	OTC
CURITY ALCOHOL PREPS	Preferred	OTC
EASY TOUCH ALCOHOL PREP MEDIUM	Preferred	OTC
RELION ALCOHOL SWABS	Preferred	OTC
WEBCOL ALCOHOL PREP LARGE	Preferred	OTC
<i>*Cervical Caps*** - Medical Supplies And Durable Medical Equipment</i>		
FEMCAP	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Condoms - Male*** - Medical Supplies And Durable Medical Equipment		
<i>aimsco lubricated</i>	Preferred	OTC
<i>kimono</i>	Preferred	OTC
<i>kimono micro thin</i>	Preferred	OTC
<i>kimono micro thin plus</i>	Preferred	OTC
<i>kimono plus</i>	Preferred	OTC
<i>kimono ps</i>	Preferred	OTC
<i>kimono ps plus</i>	Preferred	OTC
<i>kimono sensation</i>	Preferred	OTC
<i>kimono sensation plus</i>	Preferred	OTC
<i>maxx</i>	Preferred	OTC
<i>maxx plus</i>	Preferred	OTC
DUREX EXTRA SENSITIVE THIN	Preferred	OTC
FANTASY LUBRICATED	Preferred	OTC
FANTASY LUBRICATED/SPERMICIDE	Preferred	OTC
KAMELEON LUBRICATED	Preferred	OTC
KIMONO COLORS	Preferred	OTC
KIMONO MAXX-LARGE FLARE	Preferred	OTC
KIMONO SPECIAL	Preferred	OTC
REALITY LATEX CONDOMS	Preferred	OTC
REALITY LATEX/ULTRA TEXTURED	Preferred	OTC
REALITY LATEX/ULTRA THIN	Preferred	OTC
TRUSTEX COLOR CONDOMS + LUBE	Preferred	OTC
TRUSTEX LUB/RIBBED/STUDDED	Preferred	OTC
TRUSTEX LUB/SPERMICIDE EX ST	Preferred	OTC
TRUSTEX LUB/SPERMICIDE XL	Preferred	OTC
TRUSTEX LUBRICATED	Preferred	OTC
TRUSTEX LUBRICATED EX LARGE	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUSTEX LUBRICATED EXTRA ST	Preferred	OTC
TRUSTEX LUBRICATED/SPERMICIDE	Preferred	OTC
TRUSTEX NATURAL CONDOMS + LUBE	Preferred	OTC
TRUSTEX NON-LUBRICATED	Preferred	OTC
TRUSTEX RIA LUB/SPERMICIDE	Preferred	OTC
TRUSTEX RIA LUBRICATED	Preferred	OTC
TRUSTEX RIA NON-LUBRICATED	Preferred	OTC
TRUSTEX-NONOXYNOL-9/RIB/STUD	Preferred	OTC
<i>*Diaphragms*** - Medical Supplies And Durable Medical Equipment</i>		
OMNIFLEX DIAPHRAGM	Preferred	
WIDE-SEAL DIAPHRAGM 60	Preferred	
WIDE-SEAL DIAPHRAGM 65	Preferred	
WIDE-SEAL DIAPHRAGM 70	Preferred	
WIDE-SEAL DIAPHRAGM 75	Preferred	
WIDE-SEAL DIAPHRAGM 80	Preferred	
WIDE-SEAL DIAPHRAGM 85	Preferred	
WIDE-SEAL DIAPHRAGM 90	Preferred	
WIDE-SEAL DIAPHRAGM 95	Preferred	
<i>*Gauze Pads & Dressings*** - Medical Supplies And Durable Medical Equipment</i>		
<i>bandage new generation large</i>	Preferred	OTC
<i>cvs gauze</i>	Preferred	OTC
<i>cvs gauze pad sterile</i>	Preferred	OTC
<i>cvs gauze sterile</i>	Preferred	OTC
<i>eql gauze</i>	Preferred	OTC
<i>eql gauze sterile</i>	Preferred	OTC
<i>gauze pads</i>	Preferred	OTC
<i>gauze type vii medi-pak</i>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hm sterile pads</i>	Preferred	OTC
<i>qc border island gauze</i>	Preferred	OTC
<i>qc sterile pads</i>	Preferred	OTC
<i>ra sterile</i>	Preferred	OTC
<i>sm bandage roll</i>	Preferred	OTC
<i>sm gauze</i>	Preferred	OTC
<i>sm rolled gauze 2"x4.1yd</i>	Preferred	OTC
<i>sm rolled gauze 3"x4.1yd</i>	Preferred	OTC
<i>sm sterile</i>	Preferred	OTC
<i>sterile</i>	Preferred	OTC
<i>sterile bandage roll 2.25"x3yd</i>	Preferred	OTC
<i>sterile gauze</i>	Preferred	OTC
<i>stretch gauze bandage</i>	Preferred	OTC
<i>surgical gauze sponge</i>	Preferred	OTC
AMD FOAM DRESSING	Preferred	
AMD FOAM DRESSING TOPSHEET	Preferred	
BAND-AID GAUZE LARGE	Preferred	OTC
BAND-AID GAUZE MEDIUM	Preferred	OTC
BAND-AID GAUZE SMALL	Preferred	OTC
BAND-AID KLING ROLLED GAUZE LG	Preferred	OTC
BAND-AID KLING ROLLED GAUZE MD	Preferred	OTC
BAND-AID KLING ROLLED GAUZE SM	Preferred	OTC
COMPEED SKIN PROTECTOR DRESS	Preferred	OTC
COPA ISLAND BORDERED FOAM	Preferred	OTC
COPA PLUS HYDROPHILIC FOAM	Preferred	OTC
COVRSITE COVER DRESSING	Preferred	OTC
COVRSITE PLUS COMPOSITE DRESS	Preferred	OTC
CURITY ALL PURPOSE SPONGES	Preferred	OTC
CURITY AMD ANTIMICROBIAL SPNGE PAD 2"X2"	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CURITY AMD ANTIMICROBIAL SPNGE PAD 4"X4"	Preferred	
CURITY COVER SPONGE	Preferred	OTC
CURITY GAUZE	Preferred	OTC
CURITY GAUZE SPONGE	Preferred	OTC
CURITY NON-ADHERENT STRIPS	Preferred	OTC
CURITY SPONGES	Preferred	OTC
DERMACEA GAUZE SPONGE	Preferred	OTC
DERMACEA IV DRAIN SPONGES	Preferred	OTC
DERMACEA IV SPONGES	Preferred	OTC
DERMACEA NON-WOVEN SPONGES	Preferred	OTC
DERMACEA TYPE VII GAUZE	Preferred	OTC
EXCILON IV SPONGES	Preferred	OTC
J & J GAUZE	Preferred	OTC
KENDALL HYDROPHILIC FOAM DRESS	Preferred	OTC
KENDALL HYDROPHILIC FOAM PLUS	Preferred	OTC
MIRASORB SPONGES	Preferred	OTC
RESTORE CONTACT LAYER	Preferred	OTC
SOF-WIK	Preferred	OTC
THERAGAUZE	Preferred	OTC
*Glucose Monitoring Test Supplies*** - Medical Supplies And Durable Medical Equipment		
<i>blood glucose monitor system</i>	Non – Preferred	OTC
<i>blood glucose monitoring 333</i>	Non – Preferred	OTC
<i>blood glucose system pak</i>	Non – Preferred	OTC
<i>careone advanced lancing dev</i>	Preferred	OTC
<i>careone lancet thin 23g</i>	Preferred	OTC
<i>comfort assured lancets 28g</i>	Preferred	OTC
<i>comfort assured lancets 33g</i>	Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>control</i>	Preferred	OTC
<i>cvs lancets 21g</i>	Preferred	OTC
<i>cvs lancets micro thin 33g</i>	Preferred	OTC
<i>cvs lancets original</i>	Preferred	OTC
<i>cvs lancets thin 26g</i>	Preferred	OTC
<i>diabetes monitor digit add-on</i>	Non – Preferred	OTC
<i>diabetes monitor digit soln</i>	Non – Preferred	OTC
<i>diatrue plus blood glucose</i>	Non – Preferred	OTC
<i>easy mini eject lancing device</i>	Preferred	OTC
<i>easy mini lancing device</i>	Preferred	OTC
<i>easy plus ii control</i>	Preferred	OTC
<i>easy plus ii glucose system</i>	Non – Preferred	OTC
<i>easy talk blood glucose system</i>	Non – Preferred	OTC
<i>easy talk control</i>	Preferred	OTC
<i>easy trak blood glucose system</i>	Non – Preferred	OTC
<i>easy trak ii blood glucose sys</i>	Non – Preferred	OTC
<i>element compact control 2</i>	Preferred	OTC
<i>element compact control 3</i>	Preferred	OTC
<i>element compact glucose system</i>	Non – Preferred	OTC
<i>element compact v glucose sys</i>	Non – Preferred	OTC
<i>embrace lancing device/ejector</i>	Preferred	OTC
<i>eql color lancets 21g</i>	Preferred	OTC
<i>eql color lancets micro 33g</i>	Preferred	OTC
<i>eql super thin lancets 30g</i>	Preferred	OTC
<i>eql thin lancets 26g</i>	Preferred	OTC
<i>ge100 blood glucose system</i>	Non – Preferred	OTC
<i>ght blood glucose monitor</i>	Non – Preferred	OTC
<i>glucose control</i>	Preferred	OTC
<i>goodsense blood glucose</i>	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs

UPPERCASE BOLD = Brand name drugs

Drug Tier

Non – Preferred = Non – Preferred

Preferred = Preferred

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QL = Quantity Limits

ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>guardian sensor 3</i>	Non – Preferred	PA
<i>kroger blood glucose</i>	Non – Preferred	OTC
<i>kroger premium blood glucose</i>	Non – Preferred	OTC
<i>liberty blood glucose meter</i>	Non – Preferred	OTC
<i>meijer blood glucose</i>	Non – Preferred	OTC
<i>meijer essential blood glucose</i>	Non – Preferred	OTC
<i>meijer premium blood glucose</i>	Non – Preferred	OTC
<i>one drop blood glucose monitor</i>	Non – Preferred	OTC
<i>oval tape</i>	Non – Preferred	OTC
<i>pro voice v8 glucose system</i>	Non – Preferred	OTC
<i>pro voice v9 glucose system</i>	Non – Preferred	OTC
<i>safety lancet 30gl/pressure act</i>	Preferred	OTC
<i>safety lancets 28g</i>	Preferred	OTC
<i>select-lite device/lancets</i>	Preferred	OTC
<i>tgt blood glucose monitoring</i>	Non – Preferred	OTC
<i>verasens blood glucose meter</i>	Non – Preferred	OTC
<i>verasens blood glucose system</i>	Non – Preferred	OTC
ACCU-CHEK AVIVA	Preferred	OTC
ACCU-CHEK AVIVA PLUS	Non – Preferred	OTC
ACCU-CHEK FASTCLIX LANCET	Preferred	OTC
ACCU-CHEK FASTCLIX LANCETS	Preferred	OTC
ACCU-CHEK GUIDE	Non – Preferred	OTC
ACCU-CHEK GUIDE CONTROL	Preferred	OTC
ACCU-CHEK GUIDE ME	Non – Preferred	OTC
ACCU-CHEK SAFE-T PRO LANCETS	Preferred	OTC
ACCU-CHEK SMARTVIEW CONTROL	Preferred	OTC
ACCU-CHEK SOFTCLIX LANCET DEV	Preferred	OTC
ACCU-CHEK SOFTCLIX LANCETS	Preferred	OTC
ACCUTREND GLUCOSE CONTROL	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVANCE INTUITION METER	Non – Preferred	OTC
ADVANCE INTUITION MONITOR	Non – Preferred	OTC
ADVANCE MICRO-DRAW CONTROL	Preferred	OTC
ADVANCE MICRO-DRAW METER	Non – Preferred	OTC
ADVANCE MICRO-DRAW NORMAL	Preferred	OTC
ADVOCATE BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
ADVOCATE BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
ADVOCATE CONTROL SOLUTION	Preferred	OTC
ADVOCATE LANCETS	Preferred	OTC
ADVOCATE LANCETS 30G	Preferred	OTC
ADVOCATE LANCING DEVICE	Preferred	OTC
ADVOCATE RAPID-SAFE LANCING	Preferred	OTC
ADVOCATE REDI-CODE	Non – Preferred	OTC
ADVOCATE REDI-CODE+	Non – Preferred	OTC
ADVOCATE REDI-CODE+ CONTROL	Preferred	OTC
ADVOCATE SAFETY LANCETS	Preferred	OTC
ADVOCATE SAFETY LANCETS 26G	Preferred	OTC
AGAMATRIX AMP	Non – Preferred	OTC
AGAMATRIX CONTROL	Preferred	OTC
AGAMATRIX CONTROL LEVEL 2	Preferred	OTC
AGAMATRIX CONTROL LEVEL 4	Preferred	OTC
AGAMATRIX JAZZ WIRELESS 2	Non – Preferred	OTC
AGAMATRIX PRESTO	Non – Preferred	OTC
AGAMATRIX PRESTO PRO METER	Non – Preferred	OTC
ASSURE 3 CONTROL	Preferred	OTC
ASSURE 3 METER	Non – Preferred	OTC
ASSURE 4 CONTROL LEVEL 1 & 2	Preferred	OTC
ASSURE 4 METER	Non – Preferred	OTC
ASSURE PLATINUM METER	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASSURE PRISM MULTI METER	Non – Preferred	OTC
ASSURE PRO BLOOD GLUCOSE METER	Non – Preferred	OTC
AUTO-LANCET	Preferred	OTC
AUTO-LANCET MINI	Preferred	OTC
AUTOLET II CLINISAFE	Preferred	OTC
AUTOLET LANCING DEVICE	Preferred	OTC
AUTOLET LITE CLINISAFE	Preferred	OTC
AUTOLET LITE STARTER PACK	Preferred	OTC
AUTOLET MINI	Preferred	OTC
AUTOLET PLATFORMS	Preferred	OTC
AUTOLET PLUS	Preferred	OTC
BD LATITUDE DIABETES	Non – Preferred	OTC
BD LOGIC BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
BD MICROTAINER LANCETS	Preferred	
BIGFOOT UNITY PROGRAM	Non – Preferred	
BIOTEL CARE BLOOD GLUCOSE	Non – Preferred	OTC
BIOTEL CARE BLOOD GLUCOSE SYST	Non – Preferred	OTC
BLULINK GLUCOSE MONITORING SYS	Non – Preferred	OTC
CAREONE BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
CAREONE LANCET SUPER THIN 30G	Preferred	OTC
CARESENS LANCETS	Preferred	OTC
CARESENS N FELIZ	Non – Preferred	OTC
CARESENS N FELIZ BT	Non – Preferred	OTC
CARESENS N GLUCOSE SYSTEM	Non – Preferred	OTC
CARESENS N VOICE SYSTEM	Non – Preferred	OTC
CARETOUCH MONITOR SYSTEM	Non – Preferred	OTC
CARETOUCH SAFETY LANCETS	Preferred	OTC
CARETOUCH SAFETY LANCETS 26G	Preferred	OTC
CARETOUCH TWIST LANCETS 28G	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARETOUCH TWIST LANCETS 30G	Preferred	OTC
CARETOUCH TWIST LANCETS 33G	Preferred	OTC
CLEANLET LANCETS 28G	Preferred	OTC
CLEVER CHEK AUTO-CODE SYSTEM	Non – Preferred	OTC
CLEVER CHEK AUTO-CODE VOICE	Non – Preferred	OTC
CLEVER CHEK LANCETS	Preferred	OTC
CLEVER CHEK SYSTEM	Non – Preferred	OTC
CLEVER CHOICE AUTO-CODE SYSTEM	Non – Preferred	OTC
CLEVER CHOICE LANCETS 21G	Preferred	OTC
CLEVER CHOICE LANCETS 23G	Preferred	OTC
CLEVER CHOICE LANCETS 28G	Preferred	OTC
CLEVER CHOICE MICRO SYSTEM	Non – Preferred	OTC
CLEVER CHOICE MINI SYSTEM	Non – Preferred	OTC
CLEVER CHOICE TALK SYSTEM	Non – Preferred	OTC
COAGUCHEK LANCETS	Preferred	OTC
CONTOUR BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
CONTOUR CONTROL	Preferred	OTC
CONTOUR MONITOR	Non – Preferred	OTC
CONTOUR NEXT CONTROL	Preferred	OTC
CONTOUR NEXT EZ	Non – Preferred	OTC
CONTOUR NEXT GEN MONITOR	Non – Preferred	OTC
CONTOUR NEXT LINK	Non – Preferred	OTC
CONTOUR NEXT MONITOR	Non – Preferred	OTC
CONTOUR NEXT ONE	Non – Preferred	OTC
COOL MONITOR	Non – Preferred	OTC
COOL MONITOR KIT	Non – Preferred	OTC
CVS BLOOD GLUCOSE METER	Non – Preferred	OTC
D-CARE GLUCOMETER	Non – Preferred	
DEXCOM G6 RECEIVER	Preferred	PA; QL (1 EA per 365 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEXCOM G6 SENSOR	Preferred	PA; QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER	Preferred	PA; QL (1 EA per 90 days)
DEXCOM G7 RECEIVER	Preferred	PA; QL (1 EA per 365 days)
DEXCOM G7 SENSOR	Preferred	PA; QL (3 EA per 30 days)
DIATHRIVE BLOOD GLUCOSE METER	Non – Preferred	OTC
DIATHRIVE+ GLUCOSE MONITOR	Non – Preferred	OTC
EASY STEP CONTROL	Preferred	OTC
EASY STEP GLUCOSE MONITOR	Non – Preferred	OTC
EASY TOUCH GLUCOSE SYSTEM	Non – Preferred	OTC
EASY TOUCH HEALTHPRO GLUCOSE	Non – Preferred	OTC
EASY TOUCH LANCETS 21G	Preferred	OTC
EASY TOUCH LANCETS 23G	Preferred	OTC
EASY TOUCH LANCETS 26G	Preferred	OTC
EASY TOUCH LANCETS 28G	Preferred	OTC
EASY TOUCH LANCETS 28G/TWIST	Preferred	OTC
EASY TOUCH LANCETS 30G	Preferred	OTC
EASY TOUCH LANCETS 30G/TWIST	Preferred	OTC
EASY TOUCH LANCETS 32G	Preferred	OTC
EASY TOUCH LANCETS 32G/TWIST	Preferred	OTC
EASY TOUCH LANCETS 33G/TWIST	Preferred	OTC
EASY TOUCH LANCING DEVICE	Preferred	OTC
EASY TOUCH SAFETY LANCETS 21G	Preferred	OTC
EASY TOUCH SAFETY LANCETS 23G	Preferred	OTC
EASY TOUCH SAFETY LANCETS 26G	Preferred	OTC
EASY TOUCH SAFETY LANCETS 28G	Preferred	OTC
EASYGLUCO	Non – Preferred	OTC
EASYMAX NG BLOOD GLUCOSE	Non – Preferred	OTC
EASYMAX V BLOOD GLUCOSE	Non – Preferred	OTC
EASYPRO BLOOD GLUCOSE MONITOR	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASYPRO PLUS	Non – Preferred	OTC
ELEMENT AUTOCODE SYSTEM	Non – Preferred	OTC
ELEMENT CONTROL	Preferred	OTC
ELEMENT PLUS	Non – Preferred	OTC
EMBRACE BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
EMBRACE CONTROL	Preferred	OTC
EMBRACE EVO GLUCOSE MONITOR	Non – Preferred	OTC
EMBRACE EVO GLUCOSE MONITORING	Non – Preferred	OTC
EMBRACE PRO GLUCOSE METER	Non – Preferred	OTC
EMBRACE TALK BLOOD GLUCOSE	Non – Preferred	OTC
EMBRACE TALK MONITORING SYSTEM	Non – Preferred	OTC
EMBRACE WAVE BLOOD GLUCOSE	Non – Preferred	OTC
EMBRACE WAVE GLUCOSE METER	Non – Preferred	OTC
ENLITE GLUCOSE SENSOR	Non – Preferred	PA
EVERSENSE E3 SENSOR/HOLDER	Non – Preferred	PA
EVERSENSE E3 SMART TRANSMITTER	Non – Preferred	PA
EVERSENSE SENSOR/HOLDER	Non – Preferred	PA
EVERSENSE SMART TRANSMITTER	Non – Preferred	PA
EVOLUTION AUTOCODE	Non – Preferred	OTC
E-Z JECT LANCET MICRO-THIN 33G	Preferred	OTC
E-Z JECT LANCET SUPER THIN 30G	Preferred	OTC
E-Z JECT LANCETS	Preferred	OTC
E-Z JECT LANCETS 21G	Preferred	OTC
E-Z JECT LANCETS THIN 26G	Preferred	OTC
EZ-LETS LANCETS 21G	Preferred	OTC
EZ-LETS LANCETS 26G	Preferred	OTC
FIFTY50 GLUCOSE METER 2.0	Non – Preferred	OTC
FORA G20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA G30A BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA GD20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GD50 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GTEL BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA PREMIUM V10 BLE SYSTEM	Non – Preferred	OTC
FORA TEST N' GO MONITOR	Non – Preferred	OTC
FORA TN'G VOICE	Non – Preferred	OTC
FORA V10 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA V10/V12/D10/D20 TEST	Non – Preferred	OTC
FORA V12 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA V20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA V30A BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORACARE GD40 MONITOR	Non – Preferred	OTC
FORACARE PREMIUM V10	Non – Preferred	OTC
FORACARE TEST N GO MONITOR	Non – Preferred	OTC
FREESTYLE CONTROL SOLUTION	Preferred	OTC
FREESTYLE FREEDOM LITE	Non – Preferred	OTC
FREESTYLE LIBRE 14 DAY READER	Preferred	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR	Preferred	PA; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 READER	Preferred	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 2 SENSOR	Preferred	PA; QL (2 EA per 28 days)
FREESTYLE LIBRE 3 READER	Preferred	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 3 SENSOR	Preferred	PA; QL (2 EA per 28 days)
FREESTYLE LITE	Non – Preferred	OTC
FREESTYLE PRECISION NEO SYSTEM	Non – Preferred	OTC
GENTEEL CONTACT TIPS (BLUE)	Preferred	OTC
GENTEEL CONTACT TIPS (CLEAR)	Preferred	OTC
GENTEEL CONTACT TIPS (GREEN)	Preferred	OTC
GENTEEL CONTACT TIPS (ORANGE)	Preferred	OTC
GENTEEL CONTACT TIPS (RAINBOW)	Preferred	OTC

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENTEEL CONTACT TIPS (VIOLET)	Preferred	OTC
GENTEEL CONTACT TIPS (YELLOW)	Preferred	OTC
GENTEEL LANCING KIT (BLUE)	Preferred	OTC
GENTEEL NOZZLES	Preferred	OTC
GLUCO PERFECT 3 METER	Non – Preferred	OTC
GLUCOCARD 01 BLOOD GLUCOSE	Non – Preferred	OTC
GLUCOCARD 01-MINI GLUCOSE	Non – Preferred	OTC
GLUCOCARD EXPRESSION MONITOR	Non – Preferred	OTC
GLUCOCARD SHINE	Non – Preferred	OTC
GLUCOCARD SHINE CONNEX	Non – Preferred	OTC
GLUCOCARD SHINE EXPRESS	Non – Preferred	OTC
GLUCOCARD SHINE XL	Non – Preferred	OTC
GLUCOCARD VITAL MONITOR	Non – Preferred	OTC
GLUCOCARD X-METER	Non – Preferred	OTC
GLUCOCOM BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
GLUCOCOM MONITOR	Non – Preferred	OTC
GLUCONAVII BLOOD GLUCOSE SYS	Non – Preferred	OTC
GNP EASY TOUCH CONT HIGH/LOW	Preferred	OTC
GNP EASY TOUCH GLUCOSE METER	Non – Preferred	OTC
GNP TRUE METRIX AIR METER	Non – Preferred	OTC
GNP TRUE METRIX GLUCOSE METER	Non – Preferred	OTC
GUARDIAN 4 GLUCOSE SENSOR	Non – Preferred	PA
GUARDIAN 4 TRANSMITTER	Non – Preferred	PA
GUARDIAN CONNECT TRANSMITTER	Non – Preferred	PA
GUARDIAN LINK 3 TRANSMITTER	Non – Preferred	PA
GUARDIAN REAL-TIME CHARGER	Non – Preferred	
GUARDIAN REAL-TIME REPLACE PED	Non – Preferred	PA
GUARDIAN REAL-TIME TEST PLUG	Non – Preferred	
GUARDIAN SENSOR (3)	Non – Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEALTHPRO BLOOD GLUCOSE MONITO	Non – Preferred	OTC
HM EMBRACE TALK SYSTEM	Non – Preferred	OTC
HW EMBRACE PRO GLUCOSE METER	Non – Preferred	OTC
HW EMBRACE TALK BLOOD GLUCOSE	Non – Preferred	OTC
HYPOLANCE AST LANCING	Preferred	OTC
IGLUCOSE MONITORING SYSTEM	Non – Preferred	OTC
IN TOUCH	Non – Preferred	OTC
IN TOUCH GLUCOSE CONTROL	Preferred	OTC
INFINITY BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
INFINITY CONTROL	Preferred	OTC
INFINITY VOICE	Non – Preferred	OTC
KROGER HEALTHPRO CONTROL HI/LO	Preferred	OTC
LIBERTY NXT GENERATION MONITOR	Non – Preferred	OTC
MEIJER TRUE2GO BLOOD GLUCOSE	Non – Preferred	OTC
MEIJER TRUERESULT GLUCOSE SYS	Non – Preferred	OTC
MEIJER TRUETRACK GLUCOSE SYS	Non – Preferred	OTC
MICRODOT BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
MINILINK REAL-TIME TRANSMITTER	Non – Preferred	PA
MINIMED 630G GUARDIAN PRESS	Non – Preferred	PA
MM EASY TOUCH GLUCOSE METER	Non – Preferred	OTC
MULTI-LANCET DEVICE 2	Preferred	OTC
MYGLUCOHEALTH BLOOD GLUCOSE	Non – Preferred	OTC
NOVA MAX BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
ON CALL EXPRESS MONITORING SYS	Non – Preferred	OTC
ONETOUCH DELICA PLUS LANCET30G	Preferred	OTC
ONETOUCH DELICA PLUS LANCET33G	Preferred	OTC
ONETOUCH DELICA PLUS LANCING	Preferred	OTC
ONETOUCH ULTRA 2 KIT W/DEVICE	Non – Preferred	OTC
ONETOUCH ULTRA 2 KIT W/DEVICE	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONETOUCH ULTRA CONTROL	Preferred	OTC
ONETOUCH VERIO	Preferred	OTC
ONETOUCH VERIO FLEX SYSTEM DEVICE	Non – Preferred	OTC
ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE	Non – Preferred	OTC
ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE	Preferred	OTC; QL (5 EA per 1 day)
ONETOUCH VERIO REFLECT	Non – Preferred	OTC
PARADIGM REAL-TIME TRANSMITTER	Non – Preferred	PA
PERFECT LANCETS 28G	Preferred	OTC
PHARMACIST CHOICE AUTOCODE SYS	Non – Preferred	OTC
PHARMACIST CHOICE MINI SYSTEM	Non – Preferred	OTC
PIP BLOOD GLUCOSE MONITORING	Non – Preferred	OTC
POCKETCHEM EZ CONTROL	Preferred	OTC
POCKETCHEM EZ SYSTEM	Non – Preferred	OTC
POGO AUTOMATIC BLOOD GLUCOSE	Non – Preferred	OTC
PRECISION XTRA	Non – Preferred	OTC
PRODIGY AUTOCODE BLOOD GLUCOSE	Non – Preferred	OTC
PRODIGY CONTROL SOLUTION	Preferred	OTC
PRODIGY LANCING DEVICE	Preferred	OTC
PRODIGY NO CODING BLOOD GLUC	Non – Preferred	OTC
PRODIGY POCKET BLOOD GLUCOSE	Non – Preferred	OTC
PRODIGY VOICE BLOOD GLUCOSE	Non – Preferred	OTC
QUICKTEK	Non – Preferred	OTC
QUICKTEK/METER	Non – Preferred	OTC
QUINTET AC BLOOD GLUCOSE	Non – Preferred	OTC
QUINTET BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
REFUAH PLUS MONITORING SYSTEM	Non – Preferred	OTC
RELION ALL-IN-ONE	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELION CONFIRM GLUCOSE MONITOR	Non – Preferred	OTC
RELION LANCETS MICRO-THIN 33G	Preferred	OTC
RELION LANCETS THIN 26G	Preferred	OTC
RELION LANCETS ULTRA-THIN 30G	Preferred	OTC
RELION LANCING DEVICE	Preferred	OTC
RELION MICRO	Non – Preferred	OTC
RELION PREMIER BLU MONITOR	Non – Preferred	OTC
RELION PREMIER CLASSIC	Non – Preferred	OTC
RELION PREMIER COMPACT SYSTEM	Non – Preferred	OTC
RELION PREMIER VOICE MONITOR	Non – Preferred	OTC
RELION PRIME MONITOR	Non – Preferred	OTC
RELION TRUE MET AIR GLUC METER	Non – Preferred	OTC
RELION ULTIMA GLUCOSE SYSTEM	Non – Preferred	OTC
RELION ULTRA THIN LANCETS 30G	Preferred	OTC
RELION ULTRA THIN PLUS LANCETS	Preferred	OTC
REXALL BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
RIGHTEST ALTERNATE SITE ADAPT	Preferred	OTC
RIGHTEST GM100 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GM300 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GM550 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GT333 BLOOD GLUCOSE	Non – Preferred	OTC
SAFETY LANCETS	Preferred	OTC
SAFETY LANCETS 21G	Preferred	OTC
SMART SENSE PREMIUM SYSTEM	Non – Preferred	OTC
SMART SENSE VALUE GLUCOSE SYS	Non – Preferred	OTC
SMARTEST EJECT	Non – Preferred	OTC
SMARTEST EJECT STARTER	Non – Preferred	OTC
SMARTEST PERSONA STARTER	Non – Preferred	OTC
SMARTEST PRONTO STARTER	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMARTEST PROTEGE	Non – Preferred	OTC
SMARTEST PROTEGE STARTER	Non – Preferred	OTC
SOLUS V2 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
TEMPO REFILL	Non – Preferred	OTC
TEMPO WELCOME	Non – Preferred	
TRUE FOCUS BLOOD GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX AIR GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX GO GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX METER	Non – Preferred	OTC
TRUERESULT BLOOD GLUCOSE	Non – Preferred	OTC
TRUETRACK BLOOD GLUCOSE	Non – Preferred	OTC
TRUETRACK SMART SYSTEM	Non – Preferred	OTC
UNISTIK 1	Preferred	OTC
UNISTIK 2	Preferred	OTC
UNISTIK 2 COMFORT	Preferred	OTC
UNISTIK 2 EXTRA	Preferred	OTC
UNISTIK 2 NEONATAL	Preferred	OTC
UNISTIK 2 NORMAL	Preferred	OTC
UNISTIK 2 SUPER	Preferred	OTC
UNISTIK 3	Preferred	OTC
UNISTIK 3 COMFORT	Preferred	OTC
UNISTIK 3 EXTRA	Preferred	OTC
UNISTIK 3 NEONATAL	Preferred	OTC
UNISTIK 3 NORMAL	Preferred	OTC
UNISTIK CZT COMFORT	Preferred	OTC
UNISTIK CZT NORMAL	Preferred	OTC
VIVAGUARD INO GLUCOSE METER	Non – Preferred	OTC
VIVAGUARD INO SMART GLUC METER	Non – Preferred	OTC
WAVESENSE AMP	Non – Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Insulin Administration Supplies*** - Medical Supplies And Durable Medical Equipment</i>		
OMNIPOD 5 G6 INTRO (GEN 5)	Preferred	PA; QL (1 EA per 365 days)
OMNIPOD 5 G6 PODS (GEN 5)	Preferred	PA; QL (15 EA per 30 days)
OMNIPOD CLASSIC PODS (GEN 3)	Preferred	PA; QL (15 EA per 30 days)
OMNIPOD DASH INTRO (GEN 4)	Preferred	PA; QL (1 EA per 365 days)
OMNIPOD DASH PDM (GEN 4)	Preferred	PA; QL (1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	Preferred	PA; QL (15 EA per 30 days)
OMNIPOD GO	Non – Preferred	PA; QL (15 EA per 30 days)
V-GO 20	Non – Preferred	PA
V-GO 30	Non – Preferred	PA
V-GO 40	Non – Preferred	PA
<i>*Misc. Devices*** - Medical Supplies And Durable Medical Equipment</i>		
<i>14-count warmer</i>	Preferred	OTC
<i>2-way foley stabilization dev</i>	Preferred	
<i>3-in-1 bedside toilet</i>	Preferred	OTC
<i>adapter cap</i>	Preferred	
<i>adjust bath/shower seat</i>	Preferred	OTC
<i>adjust bath/shower seat/back</i>	Preferred	OTC
<i>adjust fold canelyork handle</i>	Preferred	OTC
<i>adjustable aluminum cane</i>	Preferred	OTC
<i>adjustable aluminum cane 3/4"</i>	Preferred	OTC
<i>adjustable aluminum cane 5/8"</i>	Preferred	OTC
<i>adjustable aluminum cane 7/8"</i>	Preferred	OTC
<i>adjustable folding cane</i>	Preferred	OTC
<i>adult push button alum crutch</i>	Preferred	OTC
<i>aluminum blanket support</i>	Preferred	OTC
<i>aluminum flip off seals 13mm</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aluminum flip off seals 20mm</i>	Preferred	
<i>amber glass bottle</i>	Preferred	
<i>amber glass vials 2ml</i>	Preferred	
<i>amber glass vials 2ml/13mm</i>	Preferred	
<i>autoclave air filter</i>	Preferred	
<i>autoclave paper 36" x 36"</i>	Preferred	
<i>autoclave printer paper</i>	Preferred	
<i>baby fridge</i>	Preferred	OTC
<i>bamboo cane</i>	Preferred	OTC
<i>bandage scissors</i>	Preferred	OTC
<i>bath/shower seat</i>	Preferred	OTC
<i>bathtub safety rail</i>	Preferred	OTC
<i>bed wedge</i>	Preferred	OTC
<i>beutlich ph test roll</i>	Preferred	OTC
<i>bi-focal magnifier</i>	Preferred	OTC
<i>blood collection tube holder</i>	Preferred	OTC
<i>blood pressure smart card</i>	Preferred	OTC
<i>bmi digital smart scale</i>	Preferred	OTC
<i>bottle 120ml/spray/cr plastic</i>	Preferred	
<i>bottle 2oz/blue glass/dropper</i>	Preferred	
<i>bottle 500ml/boston round/cap</i>	Preferred	
<i>bottle 8oz/boston round/cap</i>	Preferred	
<i>breast pump</i>	Preferred	OTC
<i>breathe comfort nasal irrigat</i>	Preferred	OTC
<i>breathe ease pulse oximeter</i>	Preferred	OTC
<i>cane holder</i>	Preferred	OTC
<i>cane tips</i>	Preferred	OTC
<i>cane tips 3/4"</i>	Preferred	OTC
<i>cane tips 7/8"</i>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cane tips for alum 3/4"</i>	Preferred	OTC
<i>cane tips for wood 3/4"</i>	Preferred	OTC
<i>cane tips for wood 5/8"</i>	Preferred	OTC
<i>cane tips for wood 7/8"</i>	Preferred	OTC
<i>cane wrist strap</i>	Preferred	OTC
<i>cervical pillow</i>	Preferred	OTC
<i>cervical pillow/cover</i>	Preferred	OTC
<i>chemo transfer pin</i>	Preferred	OTC
<i>classics rolling walker</i>	Preferred	OTC
<i>cleanroom tacky mat 18"x36"</i>	Preferred	
<i>clear glass vial 10ml</i>	Preferred	
<i>clear glass vials 2ml</i>	Preferred	
<i>comfort curve massage cushion</i>	Preferred	OTC
<i>commode bedside</i>	Preferred	OTC
<i>commode bedside/back</i>	Preferred	OTC
<i>commode pail</i>	Preferred	OTC
<i>commode splash guard</i>	Preferred	OTC
<i>contour fitted sheets</i>	Preferred	OTC
<i>contour mattress cover</i>	Preferred	OTC
<i>coverall boots/disposable/univ</i>	Preferred	
<i>coverall w/hood/3xl</i>	Preferred	
<i>coverall w/hood/small</i>	Preferred	
<i>coverall w/hood/xl</i>	Preferred	
<i>coverall w/hood/xxl</i>	Preferred	
<i>cvs alkaline batteries size aa</i>	Preferred	OTC
<i>cvs diabetic organizer</i>	Preferred	OTC
<i>cvs ear plugs</i>	Preferred	OTC
<i>dental guard</i>	Preferred	OTC
<i>deodorant tubes 2.65oz-caps</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dial-a-dose syringe 15ml</i>	Preferred	
<i>dial-a-dose syringe 30ml</i>	Preferred	
<i>dial-a-dose syringe 60ml</i>	Preferred	
<i>dispenser 50ml/foamer pump</i>	Preferred	
<i>dispenser md jar 50ml</i>	Preferred	
<i>dispenser md pen 6.5ml</i>	Preferred	
<i>dispenser md pump 0.5ml</i>	Preferred	
<i>dropping bottle 30ml</i>	Preferred	
<i>droptainer tip caps</i>	Preferred	OTC
<i>droptainers ophthalmic 3ml</i>	Preferred	
<i>droptainers ophthalmic 7ml</i>	Preferred	
<i>earpopper middle ear inflation</i>	Preferred	
<i>easy feed electric breast pump</i>	Preferred	OTC
<i>egg crate bed pad</i>	Preferred	OTC
<i>extendable bedside rail</i>	Preferred	OTC
<i>eye/ear dropper</i>	Preferred	OTC
<i>face shield full length</i>	Preferred	
<i>face shield full length/clear</i>	Preferred	
<i>filter 0.22 micron/73mm/1000ml</i>	Preferred	
<i>filter attachment</i>	Preferred	
<i>foil wrapper 3" x 3"</i>	Preferred	
<i>folding reacher</i>	Preferred	OTC
<i>foot massager</i>	Preferred	OTC
<i>head lice comb</i>	Preferred	OTC
<i>heelboot laundry bag</i>	Preferred	OTC
<i>heelboot liner large</i>	Preferred	OTC
<i>heelboot liner regular</i>	Preferred	OTC
<i>illusions aa breast prosthesis</i>	Preferred	
<i>illusions c breast prosthesis</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>indicator/biological test</i>	Preferred	
<i>lumbar cushion</i>	Preferred	OTC
<i>magnifier hands-free</i>	Preferred	OTC
ACU-LIFE CRUSHER/CONTAINER	Preferred	OTC
ADD-VANTAGE ADDAPTOR CONNECTOR	Preferred	
ALEVE TENS REFILL PADS	Preferred	OTC
ALL-BODY MASSAGE	Preferred	OTC
ALPHAMOP FOAM REPLACEMENT PADS	Preferred	
AMEDA ADAPTER CAP	Preferred	OTC
AMEDA BREAST FLANGE INSERT	Preferred	OTC
AMEDA ONE-HAND BREAST PUMP	Preferred	OTC
AMEDA PLATINUM BREAST PUMP	Preferred	OTC
AMEDA SILICONE TUBING	Preferred	OTC
AMEDA TUBING ADAPTER	Preferred	OTC
AMIELLE VAGINAL TRAINER	Preferred	
ANGEL WING BLOOD COLLECT SET	Preferred	
ANGEL WING LUER ADAPTER/HOLDER	Preferred	
ANGEL WING TRANSFER DEVICE	Preferred	
ANGEL WING TUBE HOLDER	Preferred	
APNEASTRIP	Preferred	
ARGYLE SARATOGA SUMP DRAIN	Preferred	
ARGYLE TRACH TUBE HOLDER	Preferred	OTC
AVOSTARTGRIP	Preferred	
CAREX WHEELCHAIR	Preferred	OTC
CINIS PREEMIE HALO LARGE	Preferred	OTC
CINIS PREEMIE HALO MEDIUM	Preferred	OTC
CINIS PREEMIE HALO SMALL	Preferred	OTC
CLEVER CHOICE HYDROTHERAPY SYS	Preferred	OTC
CLEVER CHOICE PULSE OXIMETER	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLINERE EARWAX CLEANERS	Preferred	OTC
COMAR PRESS-IN BOTTLE ADAPTERS	Preferred	
COMFORT FIT FLANGES LARGE	Preferred	OTC
COMFORT PERSONAL CLEANS CART	Preferred	OTC
COMFORT PERSONAL SHAMPOO CAP	Preferred	OTC
COMFORT PERSONAL WARMER 14-CT	Preferred	OTC
COMFORT PERSONAL WARMER 28-CT	Preferred	OTC
ECO-SMARTFUNNEL 186ML	Preferred	
E-Z LOCK RAISED TOILET SEAT	Preferred	OTC
EZY DOSE ADULT-LOCK PILL CUT	Preferred	OTC
HEAT THERAPY	Preferred	OTC
HURRIPAK PERIO IRRIGATION TIPS	Preferred	OTC
HURRIPAK PERIODONTAL ANESTHETI	Preferred	OTC
ICY DIAMOND TOTE CANVAS	Preferred	OTC
ICY DIAMOND TOTE NON LEATHER	Preferred	OTC
ICY HOT TENS THERAPY REFILL	Preferred	OTC
MAD NASAL	Preferred	
MAD NASAL ATOMIZATION DEVICE	Preferred	
<i>*Needles & Syringes*** - Medical Supplies And Durable Medical Equipment</i>		
<i>1st tier unifine pentips</i>	Non – Preferred	OTC
<i>1st tier unifine pentips plus</i>	Non – Preferred	OTC
<i>aq insulin syringe</i>	Non – Preferred	
<i>aqinject pen needle</i>	Non – Preferred	
<i>aum insulin safety pen needle</i>	Non – Preferred	OTC
<i>aum mini insulin pen needle</i>	Non – Preferred	OTC
<i>aum pen needle</i>	Non – Preferred	OTC
<i>aurora pen needles</i>	Non – Preferred	OTC
<i>careone insulin syringe</i>	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>careone unifine pentips plus</i>	Non – Preferred	OTC
<i>clickfine pen needles 31g x 8 mm</i>	Non – Preferred	OTC
<i>crono syringe</i>	Preferred	OTC
<i>dropsafe safety pen needles</i>	Non – Preferred	OTC
<i>drug mart unifine pentips</i>	Non – Preferred	OTC
<i>drug mart unifine pentips plus</i>	Non – Preferred	OTC
<i>easy comfort insulin syringe</i>	Non – Preferred	OTC
<i>easy comfort pen needles</i>	Non – Preferred	OTC
<i>easy glide pen needles</i>	Non – Preferred	OTC
<i>eql insulin syringe</i>	Non – Preferred	OTC
<i>global ease inject pen needles</i>	Non – Preferred	OTC
<i>global easy glide insulin syr</i>	Non – Preferred	OTC
<i>global easy glide pen needles</i>	Non – Preferred	OTC
<i>global inject ease insulin syr</i>	Non – Preferred	OTC
<i>global insulin syringes</i>	Non – Preferred	OTC
<i>gnp clickfine pen needles</i>	Non – Preferred	OTC
<i>gnp insulin syringe</i>	Non – Preferred	OTC
<i>gnp insulin syringes</i>	Non – Preferred	OTC
<i>gnp insulin syringes 28gx1/2"</i>	Non – Preferred	OTC
<i>gnp insulin syringes 29gx1/2"</i>	Non – Preferred	OTC
<i>gnp insulin syringes 30gx5/16"</i>	Non – Preferred	OTC
<i>gnp insulin syringes 31gx5/16"</i>	Non – Preferred	OTC
<i>gnp ulticare pen needles</i>	Non – Preferred	OTC
<i>gnp ultra com insulin syringe</i>	Non – Preferred	OTC
<i>goodsense clickfine pen needle</i>	Non – Preferred	OTC
<i>healthwise insulin syr/needle</i>	Non – Preferred	OTC
<i>healthwise micron pen needles</i>	Non – Preferred	OTC
<i>healthwise short pen needles</i>	Non – Preferred	OTC
<i>h-e-b incontrol pen needles</i>	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>insulin syringe</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 27g x 1/2" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 27g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 1/2" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 5/16" 0.3 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 30g x 5/16" 0.5 ml (otc)</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>insulin syringe-needle u-100 30g x 5/16" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 5/16" 1 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 1/4" 0.3 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 1/4" 0.5 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 1/4" 1 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 5/16" 0.3 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 5/16" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 31g x 5/16" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 31g x 5/16" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 31g x 5/16" 1 ml (rx)</i>	Non – Preferred	
<i>insupen pen needles</i>	Non – Preferred	OTC
<i>kinray insulin syringe</i>	Non – Preferred	OTC
<i>kmart valu insulin syringe 29g</i>	Non – Preferred	OTC
<i>kmart valu insulin syringe 30g</i>	Non – Preferred	OTC
<i>kroger insulin syringe</i>	Non – Preferred	OTC
<i>kroger pen needles</i>	Non – Preferred	OTC
<i>leader insulin syringe</i>	Non – Preferred	OTC
<i>longs insulin syringe</i>	Non – Preferred	OTC
<i>medic insulin syringe</i>	Non – Preferred	OTC
<i>medicine shoppe pen needles</i>	Non – Preferred	OTC
<i>meijer pen needles</i>	Non – Preferred	OTC
<i>mm insulin syringe/needle</i>	Non – Preferred	OTC
<i>ms insulin syringe</i>	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pc unifine pentips</i>	Non – Preferred	OTC
<i>pen needles 29g x 12mm</i>	Non – Preferred	OTC
<i>pen needles 30g x 5 mm (otc)</i>	Non – Preferred	
<i>pen needles 30g x 5 mm (rx)</i>	Non – Preferred	
<i>pen needles 30g x 8 mm</i>	Non – Preferred	OTC
<i>pen needles 31g x 5 mm (otc)</i>	Non – Preferred	
<i>pen needles 31g x 5 mm (rx)</i>	Non – Preferred	
<i>pen needles 31g x 6 mm</i>	Non – Preferred	OTC
<i>pen needles 31g x 8 mm (otc)</i>	Non – Preferred	
<i>pen needles 31g x 8 mm (rx)</i>	Non – Preferred	
<i>pen needles 32g x 4 mm (otc)</i>	Non – Preferred	
<i>pen needles 32g x 4 mm (rx)</i>	Non – Preferred	
<i>pen needles 32g x 5 mm</i>	Non – Preferred	OTC
<i>pen needles 32g x 6 mm</i>	Non – Preferred	OTC
<i>pen needles 33g x 4 mm</i>	Non – Preferred	OTC
<i>pen needles 5/16"</i>	Non – Preferred	OTC
<i>pip pen needles 31g x 5mm</i>	Non – Preferred	OTC
<i>pip pen needles 32g x 4mm</i>	Non – Preferred	OTC
<i>preferred plus insulin syringe</i>	Non – Preferred	OTC
<i>preferred plus unifine pentips</i>	Non – Preferred	OTC
<i>pro comfort pen needles 31g x 8 mm</i>	Non – Preferred	
<i>pro comfort pen needles 32g x 4 mm</i>	Non – Preferred	
<i>pro comfort pen needles 32g x 5 mm</i>	Non – Preferred	
<i>pro comfort pen needles 32g x 6 mm</i>	Non – Preferred	OTC
<i>pure comfort pen needle</i>	Non – Preferred	OTC
<i>pure comfort safety pen needle</i>	Non – Preferred	OTC
<i>px extra short pen needles</i>	Non – Preferred	OTC
<i>px insulin syringe</i>	Non – Preferred	OTC
<i>px mini pen needles</i>	Non – Preferred	OTC

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<i>px pen needle</i>	Non – Preferred	OTC
<i>qc pen needles</i>	Non – Preferred	OTC
<i>qc unifine pentips</i>	Non – Preferred	OTC
<i>ra insulin syringe</i>	Non – Preferred	OTC
<i>ra pen needles</i>	Non – Preferred	OTC
<i>raya sure pen needle</i>	Non – Preferred	OTC
<i>reality insulin syringe</i>	Non – Preferred	OTC
<i>safety pen needles</i>	Non – Preferred	OTC
<i>sb insulin syringe</i>	Non – Preferred	OTC
<i>sure comfort insulin syringe 28g x 1/2" 0.5 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 28g x 1/2" 1 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 29g x 1/2" 0.3 ml</i>	Non – Preferred	OTC
<i>sure comfort insulin syringe 29g x 1/2" 0.5 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 29g x 1/2" 1 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 0.3 ml</i>	Non – Preferred	OTC
<i>sure comfort insulin syringe 30g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 1 ml</i>	Non – Preferred	OTC
<i>sure comfort insulin syringe 30g x 5/16" 0.3 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 0.3 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 0.5 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 0.5 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 1 ml (otc)</i>	Non – Preferred	

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<i>sure comfort insulin syringe 30g x 5/16" 1 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 1/4" 0.3 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 1/4" 0.5 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 1/4" 1 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 0.3 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 0.3 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 0.5 ml</i>	Non – Preferred	OTC
<i>sure comfort insulin syringe 31g x 5/16" 1 ml</i>	Non – Preferred	OTC
<i>sure comfort pen needles 29g x 12.7mm</i>	Non – Preferred	OTC
<i>sure comfort pen needles 30g x 8 mm</i>	Non – Preferred	OTC
<i>sure comfort pen needles 31g x 5 mm</i>	Non – Preferred	OTC
<i>sure comfort pen needles 31g x 6 mm</i>	Non – Preferred	
<i>sure comfort pen needles 31g x 8 mm</i>	Non – Preferred	OTC
<i>sure comfort pen needles 32g x 4 mm (otc)</i>	Non – Preferred	
<i>sure comfort pen needles 32g x 4 mm (rx)</i>	Non – Preferred	
<i>sure comfort pen needles 32g x 6 mm</i>	Non – Preferred	OTC
<i>syringe luer lock</i>	Preferred	OTC
<i>syringe luer slip</i>	Preferred	OTC
<i>syringe/hypodermic safety</i>	Preferred	OTC
<i>techlite insulin syringe</i>	Non – Preferred	OTC
<i>today's health pen needles</i>	Non – Preferred	OTC
<i>today's health short pen needle</i>	Non – Preferred	OTC
<i>topcare clickfine pen needles</i>	Non – Preferred	OTC
<i>topcare ultra comfort ins syr</i>	Non – Preferred	OTC
<i>true comfort insulin syringe</i>	Non – Preferred	OTC
<i>true comfort pen needles</i>	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs

UPPERCASE BOLD = Brand name drugs

Drug Tier

Non – Preferred = Non – Preferred

Preferred = Preferred

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>true comfort pro insulin syr</i>	Non – Preferred	OTC
<i>true comfort pro pen needles</i>	Non – Preferred	OTC
<i>ultra comfort insulin syringe</i>	Non – Preferred	OTC
<i>ultracare insulin syringe</i>	Non – Preferred	OTC
<i>ultracare pen needles</i>	Non – Preferred	OTC
<i>value health insulin syringe</i>	Non – Preferred	OTC
<i>vp insulin syringe</i>	Non – Preferred	OTC
<i>wegmans unifine pentips plus</i>	Non – Preferred	OTC
<i>zevrx insulin syringe</i>	Non – Preferred	OTC
<i>zevrx pen needles</i>	Non – Preferred	OTC
ADVOCATE INSULIN PEN NEEDLES	Non – Preferred	OTC
ADVOCATE INSULIN SYRINGE	Non – Preferred	OTC
ASSURE ID DUO PRO PEN NEEDLES	Non – Preferred	OTC
ASSURE ID PRO PEN NEEDLES	Non – Preferred	OTC
ASSURE ID SAFETY PEN NEEDLES	Non – Preferred	OTC
AUM READYGARD DUO PEN NEEDLE	Non – Preferred	OTC
AUM SAFETY PEN NEEDLE	Non – Preferred	OTC
BD AUTOSHIELD DUO	Non – Preferred	OTC
BD ECLIPSE SYRINGE	Preferred	OTC
BD ECLIPSE SYRINGE/NEEDLE	Preferred	OTC
BD INSULIN SYR ULTRAFINE II	Non – Preferred	OTC
BD INSULIN SYRINGE	Non – Preferred	OTC
BD INSULIN SYRINGE HALF-UNIT	Non – Preferred	OTC
BD INSULIN SYRINGE MICROFINE	Non – Preferred	OTC
BD INSULIN SYRINGE U/F	Non – Preferred	OTC
BD INSULIN SYRINGE U/F 1/2UNIT	Non – Preferred	OTC
BD INSULIN SYRINGE ULTRAFINE	Non – Preferred	OTC
BD INTEGRA SYRINGE	Preferred	OTC
BD LUER-LOCK SYRINGE	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 1 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1-1/2" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1-1/2" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1-1/2" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1-1/2" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1-1/2" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 23G X 1" 3 ML (OTC)	Preferred	
BD LUER-LOK SYRINGE 23G X 1" 3 ML (RX)	Preferred	
BD LUER-LOK SYRINGE 23G X 1-1/2" 3 ML	Preferred	OTC

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE 25G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 25G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 25G X 5/8" 1 ML	Preferred	OTC
BD LUER-LOK SYRINGE 25G X 5/8" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 26G X 5/8" 3 ML	Preferred	OTC
BD PEN NEEDLE MICRO U/F	Non – Preferred	OTC
BD PEN NEEDLE MINI U/F	Non – Preferred	OTC
BD PEN NEEDLE NANO 2ND GEN	Non – Preferred	OTC
BD PEN NEEDLE NANO U/F	Non – Preferred	
BD PEN NEEDLE ORIGINAL U/F	Non – Preferred	OTC
BD PEN NEEDLE SHORT U/F	Non – Preferred	OTC
BD PLASTIPAK SYRINGE	Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML	Non – Preferred	
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML	Non – Preferred	OTC
BD SAFETYGLIDE SHIELDED NEEDLE	Preferred	OTC
BD SAFETYGLIDE SYRINGE/NEEDLE	Preferred	OTC
BD SYRINGE SLIP TIP	Preferred	OTC
BD SYRINGE/NEEDLE	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD VEO INSULIN SYR U/F 1/2UNIT	Non – Preferred	OTC
BD VEO INSULIN SYRINGE U/F	Non – Preferred	OTC
CAREFINE PEN NEEDLES	Non – Preferred	OTC
CARETOUCH INSULIN SYRINGE	Non – Preferred	OTC
CARETOUCH PEN NEEDLES	Non – Preferred	OTC
CLEVER CHOICE COMFORT EZ	Non – Preferred	OTC
CLICKFINE PEN NEEDLES 31G X 5 MM	Non – Preferred	OTC
CLICKFINE PEN NEEDLES 31G X 6 MM	Non – Preferred	OTC
CLICKFINE PEN NEEDLES 32G X 4 MM	Non – Preferred	OTC
COMFORT ASSIST INSULIN SYRINGE	Non – Preferred	OTC
COMFORT EZ INSULIN SYRINGE	Non – Preferred	OTC
COMFORT EZ MICRO PEN NEEDLES	Non – Preferred	OTC
COMFORT EZ PEN NEEDLES	Non – Preferred	OTC
COMFORT EZ PRO PEN NEEDLES	Non – Preferred	OTC
COMFORT EZ SHORT PEN NEEDLES	Non – Preferred	OTC
COMFORT TOUCH INSULIN PEN NEED	Non – Preferred	OTC
DIATHRIVE PEN NEEDLE	Non – Preferred	OTC
DROPLET INSULIN SYRINGE	Non – Preferred	OTC
DROPLET MICRON	Non – Preferred	OTC
DROPLET PEN NEEDLES	Non – Preferred	OTC
DROPSAFE SAFETY SYRINGE/NEEDLE	Non – Preferred	
EASY TOUCH FLIPLOCK INSULIN SY	Non – Preferred	OTC
EASY TOUCH FLIPLOCK SAFETY SYR	Preferred	OTC
EASY TOUCH FLURINGE	Preferred	OTC
EASY TOUCH FLURINGE FLIPLOCK	Preferred	OTC
EASY TOUCH FLURINGE SHEATHLOCK	Preferred	OTC
EASY TOUCH INSULIN SAFETY SYR	Non – Preferred	OTC
EASY TOUCH INSULIN SYRINGE	Non – Preferred	OTC
EASY TOUCH PEN NEEDLES	Non – Preferred	OTC

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SAFETY PEN NEEDLES	Non – Preferred	OTC
EASY TOUCH SAFETY SYRINGE	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 10 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 5 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 10 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 5 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 23G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 25G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 25G X 5/8" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML	Non – Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML	Non – Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML	Non – Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML	Non – Preferred	OTC
EASY TOUCH TB SHEATHLOCK SYR	Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE PEN NEEDLES	Non – Preferred	OTC
FIFTY50 PEN NEEDLES	Non – Preferred	OTC
FIFTY50 SUPERIOR COMFORT SYR	Non – Preferred	OTC
GLUCOPRO INSULIN SYRINGE	Non – Preferred	OTC
GNP ULTIGUARD SAFEPACK NEEDLE	Non – Preferred	OTC
GOODSENSE PEN NEEDLE PENFINE	Non – Preferred	OTC
H-E-B INCONTROL UNIFINE PENTIP	Non – Preferred	OTC
HM ULTICARE INSULIN SYRINGE	Non – Preferred	OTC
HM ULTICARE MINI PEN NEEDLES	Non – Preferred	OTC
HM ULTICARE SHORT PEN NEEDLES	Non – Preferred	OTC
INCONTROL ULTICARE PEN NEEDLES	Non – Preferred	OTC
LEADER UNIFINE PENTIPS	Non – Preferred	OTC
LEADER UNIFINE PENTIPS PLUS	Non – Preferred	OTC
LITETOUCH INSULIN SYRINGE	Non – Preferred	OTC
LITETOUCH PEN NEEDLES	Non – Preferred	OTC
LUER LOCK SAFETY SYRINGES	Preferred	OTC
MAGELLAN INSULIN SAFETY SYR	Non – Preferred	
MAGELLAN SYRINGE-SAFETY NEEDLE	Preferred	
MARATHON MEDICAL PENTIPS	Non – Preferred	
MAXICOMFORT II PEN NEEDLE	Non – Preferred	OTC
MAXI-COMFORT INSULIN SYRINGE	Non – Preferred	OTC
MAXI-COMFORT SAFETY PEN NEEDLE	Non – Preferred	OTC
MAXICOMFORT SYR 27G X 1/2"	Non – Preferred	OTC
MICRODOT PEN NEEDLE	Non – Preferred	OTC
MM PEN NEEDLES	Non – Preferred	OTC
MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML	Non – Preferred	OTC
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)	Non – Preferred	
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	
MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (OTC)	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML	Non – Preferred	OTC
MONOJECT INSULIN SYRINGE U-100 1 ML	Non – Preferred	
MONOJECT LIFESHIELD SYRINGE	Preferred	
MONOJECT MAGELLAN SYRINGE 18G X 1" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 18G X 1" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 20G X 1" 3 ML	Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 22G X 1" 3 ML	Preferred	OTC
MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 23G X 1" 1 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 23G X 1" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 25G X 1" 1 ML	Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT MAGELLAN SYRINGE 25G X 1" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 25G X 5/8" 1 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 25G X 5/8" 3 ML	Preferred	
MONOJECT SYRINGE 18G X 1" 12 ML (OTC)	Preferred	
MONOJECT SYRINGE 18G X 1" 12 ML (RX)	Preferred	
MONOJECT SYRINGE 20G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 20G X 1-1/2" 12 ML (OTC)	Preferred	OTC
MONOJECT SYRINGE 20G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 20G X 1-1/2" 6 ML	Preferred	
MONOJECT SYRINGE 20G X 3/4" 3 ML (RX)	Preferred	
MONOJECT SYRINGE 21G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 21G X 1" 6 ML	Preferred	
MONOJECT SYRINGE 21G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 21G X 1-1/2" 6 ML	Preferred	
MONOJECT SYRINGE 22G X 1" 3 ML	Preferred	OTC
MONOJECT SYRINGE 22G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 22G X 1-1/2" 6 ML	Preferred	
MONOJECT SYRINGE 23G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 1-1/4" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 5/8" 3 ML	Preferred	
MONOJECT SYRINGE 27G X 1-1/4" 3 ML	Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.3 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.5 ML	Non – Preferred	OTC
NOVOFINE PEN NEEDLE	Non – Preferred	OTC
NOVOFINE PLUS PEN NEEDLE	Non – Preferred	OTC
PENTIPS 29G X 12MM (OTC)	Non – Preferred	
PENTIPS 29G X 12MM (RX)	Non – Preferred	
PENTIPS 31G X 5 MM (OTC)	Non – Preferred	
PENTIPS 31G X 5 MM (RX)	Non – Preferred	
PENTIPS 31G X 6 MM	Non – Preferred	OTC
PENTIPS 31G X 8 MM (OTC)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENTIPS 31G X 8 MM (RX)	Non – Preferred	
PENTIPS 32G X 4 MM (OTC)	Non – Preferred	
PENTIPS 32G X 4 MM (RX)	Non – Preferred	
PENTIPS 32G X 6 MM	Non – Preferred	OTC
PRECISION SURE-DOSE SYRINGE	Non – Preferred	OTC
PREVENT DROPSAFE PEN NEEDLES	Non – Preferred	OTC
PREVENT SAFETY PEN NEEDLES	Non – Preferred	OTC
PRO COMFORT INSULIN SYRINGE	Non – Preferred	OTC
PRODIGY INSULIN SYRINGE	Non – Preferred	OTC
RELION INSULIN SYRINGE	Non – Preferred	OTC
RELION MINI PEN NEEDLES	Non – Preferred	OTC
RELION PEN NEEDLES	Non – Preferred	OTC
RELION SHORT PEN NEEDLES	Non – Preferred	OTC
SECURESAFE INSULIN SYRINGE	Non – Preferred	OTC
SECURESAFE SAFETY PEN NEEDLES	Non – Preferred	OTC
SECURESAFE SYRINGE/NEEDLE	Preferred	OTC
TECHLITE PEN NEEDLES	Non – Preferred	OTC
TECHLITE PLUS PEN NEEDLES	Non – Preferred	OTC
TRUEPLUS 5-BEVEL PEN NEEDLES	Preferred	OTC
TRUEPLUS INSULIN SYRINGE	Preferred	OTC
TRUEPLUS PEN NEEDLES	Preferred	OTC
ULTICARE INSULIN SAFETY SYR	Non – Preferred	
ULTICARE INSULIN SYR 1/2 UNIT	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 28G X 1/2" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 28G X 1/2" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 29G X 1/2" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.3 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.3 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (OTC)	Non – Preferred	
ULTICARE INSULIN SYRINGE 30G X 5/16" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 1/4" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (OTC)	Non – Preferred	
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (OTC)	Non – Preferred	
ULTICARE INSULIN SYRINGE 31G X 5/16" 1 ML	Non – Preferred	OTC
ULTICARE MICRO PEN NEEDLES	Non – Preferred	OTC
ULTICARE MINI PEN NEEDLES	Non – Preferred	OTC
ULTICARE PEN NEEDLES 29G X 12.7MM (OTC)	Non – Preferred	
ULTICARE PEN NEEDLES 31G X 5 MM	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs

UPPERCASE BOLD = Brand name drugs

Drug Tier

Non – Preferred = Non – Preferred

Preferred = Preferred

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE SHORT PEN NEEDLES 30G X 8 MM	Non – Preferred	OTC
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC)	Non – Preferred	
ULTICARE SYRINGE	Preferred	OTC
ULTICARE TUBERCULIN SAFETY SYR	Preferred	OTC
ULTIGUARD SAFEPAK PEN NEEDLE	Non – Preferred	OTC
ULTIGUARD SAFEPAK SYR/NEEDLE	Non – Preferred	OTC
ULTILET PEN NEEDLE	Non – Preferred	OTC
ULTRA FLO INSULIN PEN NEEDLES	Non – Preferred	OTC
ULTRA FLO INSULIN SYR 1/2 UNIT	Non – Preferred	OTC
ULTRA FLO INSULIN SYRINGE	Non – Preferred	OTC
ULTRA THIN PEN NEEDLES	Non – Preferred	OTC
ULTRA-THIN II INS SYR SHORT	Non – Preferred	OTC
ULTRA-THIN II INSULIN SYRINGE	Non – Preferred	OTC
ULTRA-THIN II MINI PEN NEEDLE	Non – Preferred	OTC
ULTRA-THIN II PEN NEEDLE SHORT	Non – Preferred	OTC
ULTRA-THIN II PEN NEEDLES	Non – Preferred	OTC
UNIFINE PENTIPS	Non – Preferred	OTC
UNIFINE PENTIPS PLUS	Non – Preferred	OTC
UNIFINE PROTECT PEN NEEDLE	Non – Preferred	OTC
UNIFINE SAFECONTROL PEN NEEDLE	Non – Preferred	OTC
UNIFINE ULTRA PEN NEEDLE	Non – Preferred	OTC
VANISHPOINT INSULIN SYRINGE	Non – Preferred	OTC
VANISHPOINT SAFETY SYRINGE	Preferred	OTC
VANISHPOINT SYRINGE	Preferred	OTC
VERIFINE INSULIN PEN NEEDLE	Non – Preferred	OTC
VERIFINE INSULIN SYRINGE	Non – Preferred	OTC
VERIFINE PLUS PEN NEEDLE	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Peak Flow Meters*** - Medical Supplies And Durable Medical Equipment</i>		
<i>breathe ease peak flow meter</i>	Preferred	OTC
<i>lung perform peak flow meter</i>	Preferred	OTC
<i>peak a-i-r flow meter</i>	Preferred	OTC
<i>peak flow meter universal rang</i>	Preferred	OTC
<i>pure comfort flow meter adult</i>	Preferred	OTC
<i>pure comfort flow meter child</i>	Preferred	OTC
AIRZONE PEAK FLOW METER	Preferred	OTC
ASSESS PEAK FLOW METER	Preferred	OTC
CLEVER CHOICE PEAK FLOW METER	Preferred	OTC
MICROLIFE DIGITAL PEAK FLOW	Preferred	OTC
MINI WRIGHT PEAK FLOW METER	Preferred	OTC
PEAK AIR PEAK FLOW METER	Preferred	OTC
PERSONAL BEST FULL RANGE	Preferred	OTC
PIKO 1	Preferred	OTC
POCKET PEAK FLOW METER	Preferred	OTC
POCKETPEAK PEAK FLOW METER	Preferred	OTC
TRUZONE PEAK FLOW METER	Preferred	
<i>*Respiratory Therapy Supplies*** - Medical Supplies And Durable Medical Equipment</i>		
<i>adult aerosol mask</i>	Preferred	OTC
<i>adult disposable</i>	Preferred	OTC
<i>breathe ease neb mask/child</i>	Preferred	
<i>breathe ease neb mask/infant</i>	Preferred	
<i>co monitor replacement pieces</i>	Preferred	
<i>disposable full range</i>	Preferred	
<i>disposable low range</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>disposable low rang/pediatric</i>	Preferred	
<i>disposable paper</i>	Preferred	OTC
<i>disposable universal range</i>	Preferred	
<i>expiratory mouthpiece</i>	Preferred	OTC
<i>filter air pp</i>	Preferred	
<i>full kit nebulizer set</i>	Preferred	
<i>nebulizer air tube/plugs</i>	Preferred	
<i>nose clip</i>	Preferred	OTC
<i>one-way valved expiratory</i>	Preferred	OTC
<i>one-way valved inspiratory</i>	Preferred	OTC
<i>ped disposable</i>	Preferred	OTC
<i>pediatric mouthpiece</i>	Preferred	OTC
<i>pharmacist choice mask wipes</i>	Preferred	OTC
<i>pillow mask/adult</i>	Preferred	
<i>pillow mask/child</i>	Preferred	
<i>pillow mask/pediatric</i>	Preferred	
<i>replacement air filter</i>	Preferred	
<i>replacement filters</i>	Preferred	OTC
<i>silicone mask/adult</i>	Preferred	
<i>silicone mask/infant</i>	Preferred	
<i>silicone mask/pediatric</i>	Preferred	
<i>sootheneb nbl 100 adult mask</i>	Preferred	OTC
<i>sootheneb nbl 100 child mask</i>	Preferred	OTC
<i>sootheneb nbl 100 med cup</i>	Preferred	OTC
<i>sootheneb nbl 100 mesh cap</i>	Preferred	OTC
<i>tubing/wing tip</i>	Preferred	OTC
ACE AEROSOL CLOUD ENHANCER	Preferred	
ACTIVITY POUCH	Preferred	
ADAPTER PED DISPOSABLE	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AEROBIKA	Preferred	
AEROTRACH PLUS	Preferred	
AIRS PEDIATRIC AEROSOL MASK	Preferred	
ALL FLOW 1000 PFT FILTER	Preferred	
BUBBLES THE FISH II PEDI MASK	Preferred	OTC
CARETOUCH 2 CPAP HOSE HANGER	Preferred	
CARETOUCH CPAP & BIPAP HOSE	Preferred	
CARETOUCH CPAP MASK WIPES	Preferred	
CARETOUCH CPAP PRE-WASH SOLN	Preferred	
CARETOUCH CPAP TUBE BRUSH	Preferred	
CARETOUCH UNIVERSL CPAP FILTER	Preferred	
EBASE CONTROLLER KIT	Preferred	
FLYP HYPERSONIQ CARTRIDGE	Preferred	OTC
IN-CHECK INSPIRATORY FLOW MTR	Preferred	
KOKO PEAK PRO MOUTHPIECE	Preferred	OTC
LITETOUCH MASK LARGE	Preferred	
ONE FLOW TESTER	Preferred	OTC
PARI ALTERA NEBULIZER HANDSET	Preferred	
PARI BABY CONVERSION KIT	Preferred	
PARI ERAPID NEBULIZER HANDSET	Preferred	
PARI EXPIRATORY FILTER SET	Preferred	
PARI MASK SET	Preferred	
PARI SOFT PLASTIC ADULT MASK	Preferred	
PARI SOFT PLASTIC PED MASK	Preferred	
PRONEB ULTRA FILTER SET	Preferred	OTC
SIDESTREAM ADULT FACE MASK	Preferred	
SIDESTREAM PEDIATRIC FACE MASK	Preferred	
WINDMILL TRAINER	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Sanitary Napkins & Tampons*** - Medical Supplies And Durable Medical Equipment		
<i>cvs maxi overnight</i>	Preferred	OTC
<i>eq maxi long super</i>	Preferred	OTC
ALWAYS MAXI MAXIMUM PROTECTION	Preferred	OTC
ALWAYS PANTILINERS/THONG	Preferred	OTC
ALWAYS ULTRA OVERNIGHT/WINGS	Preferred	OTC
ALWAYS ULTRA THIN	Preferred	OTC
KOTEX CURVED MAXI	Preferred	OTC
KOTEX LIGHTDAYS PANTILINERS	Preferred	OTC
KOTEX MAXI	Preferred	OTC
KOTEX MAXI OVERNITE	Preferred	OTC
KOTEX MAXI WITH WINGS	Preferred	OTC
KOTEX OVERNITE	Preferred	OTC
KOTEX SUPER MAXI	Preferred	OTC
KOTEX THIN MAXI	Preferred	OTC
KOTEX ULTRA COMPACT MAXI	Preferred	OTC
KOTEX ULTRA MAXI OVERNIGHT	Preferred	OTC
KOTEX ULTRA THIN MAXI	Preferred	OTC
KOTEX ULTRA THIN MAXI LONG	Preferred	OTC
*Spacer/Aerosol-Holding Chambers & Supplies*** - Medical Supplies And Durable Medical Equipment		
<i>breathe ease large</i>	Preferred	
<i>breathe ease medium</i>	Preferred	
<i>breathe ease small</i>	Preferred	
<i>eq space chamber anti-static</i>	Preferred	
<i>eq space chamber anti-static l</i>	Preferred	
<i>eq space chamber anti-static m</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eq space chamber anti-static s</i>	Preferred	
AEROCHAMBER MINI CHAMBER	Preferred	
AEROCHAMBER MV	Preferred	
AEROCHAMBER PLUS FLO-VU	Preferred	
AEROCHAMBER PLUS FLO-VU LARGE	Preferred	
AEROCHAMBER PLUS FLO-VU MEDIUM	Preferred	
AEROCHAMBER PLUS FLO-VU SMALL	Preferred	
AEROCHAMBER PLUS FLOW VU	Preferred	
AEROCHAMBER W/FLOWSIGNAL	Preferred	
AEROCHAMBER Z-STAT PLUS	Preferred	
AEROCHAMBER Z-STAT PLUS CHAMBR	Preferred	
AEROCHAMBER Z-STAT PLUS/LARGE	Preferred	
AEROCHAMBER Z-STAT PLUS/MEDIUM	Preferred	
CLEVER CHOICE HOLDING CHAMBER	Preferred	
COMPACT SPACE CHAMBER	Preferred	
COMPACT SPACE CHAMBER/LG MASK	Preferred	
COMPACT SPACE CHAMBER/MED MASK	Preferred	
EASIVENT	Preferred	
EASIVENT MASK LARGE	Preferred	
EASIVENT MASK MEDIUM	Preferred	
EASIVENT MASK SMALL	Preferred	
FLEXICHAMBER	Preferred	
FLEXICHAMBER ADULT MASK/SMALL	Preferred	
FLEXICHAMBER CHILD MASK/LARGE	Preferred	
FLEXICHAMBER CHILD MASK/SMALL	Preferred	
INSPIREASE	Preferred	
MASK VORTEX/CHILD/FROG	Preferred	OTC
MASK VORTEX/TODDLER/LADYBUG	Preferred	OTC
PANDA MASK LARGE	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PANDA MASK MEDIUM	Preferred	OTC
PANDA MASK SMALL	Preferred	OTC
PARI VORTEX ADULT MASK	Preferred	OTC
PEDIATRIC PANDA MASK	Preferred	OTC
VORTEX HOLD CHMBR/MASK/CHILD	Preferred	
Migraine Products - Drugs For The Nervous System		
<i>*Calcitonin Gene-Related Peptide Receptor Antag (Cgrp)*** - Drugs For Migraine Headaches</i>		
NURTEC	Preferred	PA
QULIPTA	Preferred	PA
UBRELVY	Preferred	PA; QL (50 EA per 365 days)
ZAVZPRET	Non – Preferred	
<i>*Cgrp Receptor Antagonists - Monocolonal Antibodies*** - Drugs For Migraine Headaches</i>		
AIMOVIG	Preferred	PA
AJOVY	Preferred	PA
EMGALITY	Preferred	PA
EMGALITY (300 MG DOSE)	Preferred	PA
VYEPTI	Non – Preferred	
<i>*Ergot Combinations*** - Drugs For Migraine Headaches</i>		
MIGERGOT	Preferred	
<i>*Migraine Products - Cyclooxygenase 2 (Cox-2) Inhibitors*** - Drugs For Migraine Headaches</i>		
ELYXYB	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Migraine Products - Nsaids*** - Drugs For Migraine Headaches		
<i>diclofenac potassium(migraine)</i>	Non – Preferred	
*Migraine Products*** - Drugs For Migraine Headaches		
<i>dihydroergotamine mesylate</i>	Non – Preferred	
MIGRANAL	Non – Preferred	
TRUDHESA	Non – Preferred	
*Selective Serotonin Agonist-Nsaid Combinations*** - Drugs For Migraine Headaches		
<i>sumatriptan-naproxen sodium</i>	Non – Preferred	
*Selective Serotonin Agonists 5-Ht(1)*** - Drugs For Migraine Headaches		
<i>almotriptan malate</i>	Non – Preferred	
<i>eletriptan hydrobromide</i>	Non – Preferred	
<i>frovatriptan succinate</i>	Non – Preferred	
<i>naratriptan hcl</i>	Non – Preferred	
<i>rizatriptan benzoate tablet 10 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>rizatriptan benzoate tablet 5 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>rizatriptan benzoate tablet dispersible 10 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>rizatriptan benzoate tablet dispersible 5 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan solution 20 mg/lact nasal</i>	Preferred	QL (6 EA per 30 days)
<i>sumatriptan solution 5 mg/lact nasal</i>	Preferred	QL (6 EA per 30 days)
<i>sumatriptan succinate refill solution cartridge 4 mg/0.5ml subcutaneous</i>	Preferred	QL (4 VIAL per 28 days)
<i>sumatriptan succinate refill solution cartridge 6 mg/0.5ml subcutaneous</i>	Preferred	QL (4 VIAL per 30 days)

Coverage Requirements and Limits

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ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml subcutaneous</i>	Preferred	QL (4 VIAL per 28 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml subcutaneous</i>	Preferred	QL (2 VIAL per 30 days)
<i>sumatriptan succinate subcutaneous solution</i>	Preferred	QL (4 VIAL per 28 days)
<i>sumatriptan succinate tablet 100 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan succinate tablet 25 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan succinate tablet 50 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>zolmitriptan</i>	Non – Preferred	
FROVA	Non – Preferred	
IMITREX	Non – Preferred	QL (9 EA per 30 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 4 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 ML per 28 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 6 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 VIAL per 30 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 4 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 EA per 28 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 6 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 VIAL per 30 days)
MAXALT	Non – Preferred	QL (9 EA per 30 days)
MAXALT-MLT TABLET DISPERSIBLE 10 MG ORAL	Non – Preferred	QL (9 EA per 30 days)
RELPAK	Non – Preferred	
TOSYMRA	Non – Preferred	
ZEMBRACE SYMTOUCH	Non – Preferred	
ZOMIG	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Selective Serotonin Agonists 5-Ht(1F)*** - Drugs For Migraine Headaches		
REYVOW	Non – Preferred	
Minerals & Electrolytes - Drugs For Nutrition		
*Calcium*** - Drugs For Nutrition		
<i>calcium carbonate oral tablet</i>	Preferred	OTC
<i>calcium carbonate oral tablet chewable</i>	Preferred	OTC
*Electrolytes Oral*** - Drugs For Nutrition		
ORALYTE	Preferred	OTC
REHYDRALYTE	Preferred	OTC
*Fluoride*** - Drugs For Nutrition		
<i>sodium fluoride</i>	Preferred	
*Magnesium*** - Drugs For Nutrition		
<i>magnesium oxide -mg supplement</i>	Preferred	OTC
*Phosphate*** - Drugs For Nutrition		
PHOSPHA 250 NEUTRAL	Preferred	
PHOSPHO-TRIN 250 NEUTRAL	Preferred	
*Potassium*** - Drugs For Nutrition		
<i>potassium chloride</i>	Preferred	
<i>potassium chloride crys er</i>	Preferred	
<i>potassium chloride er</i>	Preferred	
EFFER-K	Preferred	
KLOR-CON	Preferred	
KLOR-CON 10	Preferred	
KLOR-CON M10	Preferred	
KLOR-CON M15	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLOR-CON M20	Preferred	
KLOR-CON/EF	Preferred	
K-PRIME	Preferred	
*Sodium*** - Drugs For Nutrition		
<i>sodium chloride</i>	Preferred	
<i>sodium chloride (pf)</i>	Preferred	
Miscellaneous Therapeutic Classes - Vitamins And Minerals		
*Activated Phosphoinositide 3-Kinase Delta Syndrome Agent*** - Vitamins And Minerals		
JOENJA	Non – Preferred	
*Antileptotics*** - Vitamins And Minerals		
THALOMID	Non – Preferred	
*B-Lymphocyte Stimulator (Blys)- Specific Inhibitors*** - Vitamins And Minerals		
BENLYSTA	Non – Preferred	
*Chelating Agents*** - Vitamins And Minerals		
<i>penicillamine</i>	Preferred	
<i>trientine hcl</i>	Preferred	
CUPRIMINE	Non – Preferred	
CUVRIOR	Non – Preferred	
DEPEN TITRATABS	Preferred	
SYPRINE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Cyclosporine Analogs*** - Vitamins And Minerals		
<i>cyclosporine</i>	Preferred	
<i>cyclosporine modified</i>	Preferred	
GENGRAF	Preferred	
LUPKYNIS	Non – Preferred	
NEORAL	Non – Preferred	
SANDIMMUNE	Non – Preferred	
*Immunomodulators - Combinations*** - Vitamins And Minerals		
VYVGART HYTRULO	Non – Preferred	
*Immunomodulators For Myelodysplastic Syndromes*** - Vitamins And Minerals		
<i>lenalidomide</i>	Non – Preferred	QL (1 EA per 1 day)
REVLIMID	Non – Preferred	
*Inosine Monophosphate Dehydrogenase Inhibitors*** - Vitamins And Minerals		
<i>mycophenolate mofetil</i>	Preferred	
<i>mycophenolate sodium tablet delayed release 180 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>mycophenolate sodium tablet delayed release 360 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>mycophenolic acid tablet delayed release 180 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>mycophenolic acid tablet delayed release 360 mg oral</i>	Preferred	QL (4 EA per 1 day)
CELLCEPT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYFORTIC TABLET DELAYED RELEASE 180 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
MYFORTIC TABLET DELAYED RELEASE 360 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
<i>*Macrolide Immunosuppressants*** - Vitamins And Minerals</i>		
<i>everolimus</i>	Non – Preferred	
<i>sirolimus</i>	Preferred	
<i>tacrolimus</i>	Preferred	
ASTAGRAF XL	Non – Preferred	
ENVARUSUS XR	Non – Preferred	
PROGRAF	Non – Preferred	
RAPAMUNE	Non – Preferred	
ZORTRESS	Non – Preferred	
<i>*Neonatal Fc Receptor (FcγRn) Antagonists*** - Vitamins And Minerals</i>		
RYSTIGGO	Non – Preferred	
VYVGART	Non – Preferred	
<i>*Potassium Removing Agents*** - Vitamins And Minerals</i>		
<i>sodium polystyrene sulfonate</i>	Preferred	
LOKELMA	Non – Preferred	
SPS	Non – Preferred	
VELTASSA	Non – Preferred	
<i>*Purine Analogs*** - Vitamins And Minerals</i>		
<i>azathioprine tablet 100 mg oral</i>	Non – Preferred	
<i>azathioprine tablet 50 mg oral</i>	Preferred	
<i>azathioprine tablet 75 mg oral</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZASAN	Non – Preferred	
IMURAN	Non – Preferred	
*Rock Inhibitors*** - Vitamins And Minerals		
REZUROCK	Non – Preferred	
Mouth/Throat/Dental Agents - Drugs For The Mouth And Throat		
*Anesthetics Topical Oral*** - Drugs For The Mouth And Throat		
<i>lidocaine hcl</i>	Preferred	
<i>lidocaine viscous hcl</i>	Preferred	
*Anti-Infectives - Throat*** - Drugs For The Mouth And Throat		
<i>clotrimazole</i>	Preferred	
<i>nystatin</i>	Preferred	QL (120 ML Max Qty Per Fill Retail)
ORAVIG	Non – Preferred	
*Antiseptics - Mouth/Throat*** - Drugs For The Mouth And Throat		
<i>chlorhexidine gluconate</i>	Preferred	
*Dry Mouth Agents And Artificial Saliva*** - Drugs For The Mouth And Throat		
AQUORAL	Non – Preferred	
*Fluoride Dental Products*** - Drugs For The Mouth And Throat		
<i>sodium fluoride</i>	Non – Preferred	
<i>sodium fluoride 5000 plus</i>	Non – Preferred	
<i>sodium fluoride 5000 ppm</i>	Non – Preferred	
DENTA 5000 PLUS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DENTAGEL	Non – Preferred	
<i>*Protectants - Mouth/Throat*** - Drugs For The Mouth And Throat</i>		
GELX	Non – Preferred	
<i>*Saliva Stimulants*** - Drugs For The Mouth And Throat</i>		
<i>cevimeline hcl</i>	Non – Preferred	
<i>pilocarpine hcl</i>	Preferred	
EVOXAC	Non – Preferred	
<i>*Steroids - Mouth/Throat/Dental*** - Drugs For The Mouth And Throat</i>		
<i>triamcinolone acetonide</i>	Preferred	
ORALONE	Preferred	
Multivitamins - Drugs For Nutrition		
<i>*B-Complex W/ C & Folic Acid*** - Drugs For Nutrition</i>		
DIALYVITE	Preferred	
RENAL	Preferred	
<i>*Multiple Vitamins W/ Calcium*** - Drugs For Nutrition</i>		
<i>essential one daily multivit</i>	Preferred	OTC
<i>sm one daily essential</i>	Preferred	OTC
ONE-A-DAY WOMENS FORMULA	Preferred	OTC
<i>*Multiple Vitamins W/ Iron*** - Drugs For Nutrition</i>		
<i>multi-vitamin/iron</i>	Preferred	OTC
<i>*Multiple Vitamins W/ Minerals*** - Drugs For Nutrition</i>		
<i>i-vite</i>	Preferred	OTC

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>multipro</i>	Preferred	
KP VISION FORMULA	Preferred	OTC
MULTI COMPLETE	Preferred	OTC
*Multivitamins*** - Drugs For Nutrition		
ONE DAILY ESSENTIAL	Preferred	OTC
ONE-A-DAY ADULT VITACRAVES+DHA	Preferred	OTC
*Ped Multi Vitamins W/Fl & Fe*** - Drugs For Nutrition		
<i>multi-vit/iron/fluoride</i>	Preferred	OTC; AL (Max 13 Years)
<i>multi-vitamin/fluoride/iron</i>	Preferred	AL (Max 13 Years)
*Ped Mv W/ Fluoride*** - Drugs For Nutrition		
<i>multivitamin/fluoride oral solution 0.25 mg/ml</i>	Preferred	OTC; AL (Min 13 Years)
<i>multivitamin/fluoride oral solution 0.5 mg/ml</i>	Preferred	OTC; AL (Max 13 Years)
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	AL (Max 13 Years)
<i>multivitamin/fluoride tablet chewable 0.25 mg oral (rx)</i>	Preferred	AL (Max 13 Years)
<i>multivitamin/fluoride tablet chewable 0.5 mg oral (rx)</i>	Preferred	AL (Max 13 Years)
<i>multivitamin/fluoride tablet chewable 1 mg oral (rx)</i>	Preferred	AL (Max 13 Years)
QUFLORA PEDIATRIC	Preferred	AL (Max 13 Years)
*Ped Mv W/ Iron*** - Drugs For Nutrition		
FLINTSTONES W/IRON	Preferred	OTC; AL (Max 13 Years)
*Ped Vitamins Acd W/ Fluoride*** - Drugs For Nutrition		
<i>adclf (0.5mg/ml)</i>	Preferred	AL (Max 13 Years)

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<i>tri-vite/fluoride</i>	Preferred	AL (Max 13 Years)
<i>vitamins acd-fluoride</i>	Preferred	AL (Max 13 Years)
*Pediatric Multiple Vitamins*** - Drugs For Nutrition		
<i>childrens chewable vitamins</i>	Preferred	OTC; AL (Max 13 Years)
FLINTSTONES PLUS CALCIUM	Preferred	OTC; AL (Max 13 Years)
*Prenatal Mv & Min WIFe-Fa*** - Drugs For Nutrition		
<i>c-nate dha</i>	Non – Preferred	
<i>completenate</i>	Preferred	QL (100 EA per 90 days)
<i>m-natal plus</i>	Preferred	QL (100 EA per 90 days)
<i>natal pnv</i>	Non – Preferred	
<i>pnv-omega</i>	Non – Preferred	
<i>pnv-select</i>	Non – Preferred	
<i>prenatal</i>	Preferred	QL (100 EA per 90 days)
<i>prenatal plus vitamin/mineral</i>	Preferred	QL (100 EA per 90 days)
<i>relnate dha</i>	Non – Preferred	
<i>se-natal 19</i>	Preferred	QL (100 EA per 90 days)
<i>thrivite rx</i>	Preferred	
<i>trinatal rx 1</i>	Preferred	QL (100 EA per 90 days)
<i>wescap-c dha</i>	Non – Preferred	QL (100 EA per 90 days)
<i>wesnate dha</i>	Non – Preferred	
<i>westab plus</i>	Preferred	QL (100 EA per 90 days)
CITRANATAL B-CALM	Non – Preferred	
DERMACINRX PRETRATE	Non – Preferred	
ELITE-OB	Preferred	
ENBRACE HR	Non – Preferred	
FOLIVANE-OB	Non – Preferred	QL (90 EA per 100 days)
NESTABS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NESTABS DHA	Non – Preferred	
NIVA-PLUS	Preferred	QL (100 EA per 90 days)
OB COMPLETE	Preferred	
OB COMPLETE ONE	Non – Preferred	
OB COMPLETE PETITE	Non – Preferred	
OB COMPLETE PREMIER	Non – Preferred	
OB COMPLETE/DHA	Non – Preferred	
PRENATE ELITE	Non – Preferred	
PRENATRIX	Non – Preferred	QL (100 EA per 90 days)
PRENATRYL	Non – Preferred	QL (100 EA per 90 days)
PRIMACARE	Non – Preferred	
SELECT-OB	Non – Preferred	
TARON-C DHA	Non – Preferred	QL (100 EA per 90 days)
TRICARE	Preferred	QL (100 EA per 90 days)
VINATE DHA RF	Non – Preferred	
VITAFOL GUMMIES	Non – Preferred	
VITAFOL-NANO	Non – Preferred	
VITAFOL-OB	Preferred	QL (1 EA per 1 day)
VITAPEARL	Non – Preferred	
*Prenatal Mv & Min WIFe-Fa-Ca-Omega 3 Fish Oil*** - Drugs For Nutrition		
<i>complete natal dha</i>	Non – Preferred	QL (100 EA per 90 days)
<i>wesnatal dha complete</i>	Non – Preferred	QL (100 EA per 90 days)
*Prenatal Mv & Min WIFe-Fa-Dha*** - Drugs For Nutrition		
<i>pnv-dha</i>	Non – Preferred	
<i>pnv-dha+docusate</i>	Non – Preferred	
<i>prenaissance</i>	Non – Preferred	
<i>prenaissance plus</i>	Non – Preferred	

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<i>tristart dha</i>	Non – Preferred	
<i>wescap-pn dha</i>	Non – Preferred	
<i>westgel dha</i>	Non – Preferred	
CITRANATAL 90 DHA	Non – Preferred	
CITRANATAL ASSURE	Non – Preferred	
CITRANATAL HARMONY	Non – Preferred	
CITRANATAL MEDLEY	Non – Preferred	
NESTABS ONE	Non – Preferred	
PRENATE DHA	Non – Preferred	
PRENATE ENHANCE	Non – Preferred	
PRENATE ESSENTIAL	Non – Preferred	
PRENATE MINI	Non – Preferred	
PRENATE PIXIE	Non – Preferred	
PRENATE RESTORE	Non – Preferred	
SELECT-OB+DHA	Non – Preferred	
VITAFOL FE+	Non – Preferred	
VITAFOL ULTRA	Non – Preferred	
VITAFOL-OB+DHA	Non – Preferred	
VITAFOL-ONE	Non – Preferred	
VITAMEDMD ONE RX/QUATREFOLIC	Non – Preferred	
<i>*Prenatal Mv & Minerals WIFa Without Iron*** - Drugs For Nutrition</i>		
PRENATE	Non – Preferred	
<i>*Prenatal Vitamins*** - Drugs For Nutrition</i>		
PREMESISRX	Non – Preferred	
PRENATE AM	Non – Preferred	
VITAFOL STRIPS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Specialty Vitamins Products*** - Drugs For Nutrition		
<i>biotin plus keratin</i>	Preferred	OTC
CENTRUM SPECIALIST ENERGY	Preferred	OTC
Musculoskeletal Therapy Agents - Drugs For Muscles, Ligaments, Tendons, And Bones		
*Central Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>baclofen oral solution</i>	Non – Preferred	
<i>baclofen oral suspension</i>	Preferred	
<i>baclofen tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>baclofen tablet 20 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>baclofen tablet 5 mg oral</i>	Preferred	
<i>baclofen tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>carisoprodol tablet 250 mg oral</i>	Non – Preferred	
<i>carisoprodol tablet 350 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>chlorzoxazone</i>	Preferred	
<i>cyclobenzaprine hcl er</i>	Non – Preferred	
<i>cyclobenzaprine hcl tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>cyclobenzaprine hcl tablet 10 mg oral</i>	Preferred	
<i>cyclobenzaprine hcl tablet 5 mg oral</i>	Preferred	
<i>cyclobenzaprine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>cyclobenzaprine hcl tablet 7.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>metaxalone</i>	Non – Preferred	
<i>methocarbamol</i>	Preferred	QL (4 EA per 1 day)
<i>orphenadrine citrate er</i>	Preferred	QL (2 EA per 1 day)
<i>tizanidine hcl oral capsule</i>	Non – Preferred	
<i>tizanidine hcl tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)

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<i>tizanidine hcl tablet 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
AMRIX	Non – Preferred	
FEXMID	Preferred	QL (4 EA per 1 day)
FLEQSUVY	Non – Preferred	
LORZONE	Preferred	
LYVISPAH	Non – Preferred	
SOMA TABLET 250 MG ORAL	Non – Preferred	
SOMA TABLET 350 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
ZANAFLEX ORAL CAPSULE	Non – Preferred	
ZANAFLEX ORAL TABLET	Non – Preferred	QL (6 EA per 1 day)
<i>*Direct Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones</i>		
<i>dantrolene sodium</i>	Preferred	QL (4 EA per 1 day)
DANTRIUM	Non – Preferred	QL (4 EA per 1 day)
<i>*Muscle Relaxant Combinations*** - Drugs For Muscles, Ligaments, Tendons, And Bones</i>		
<i>norgesic forte</i>	Non – Preferred	
<i>orphenadrine-aspirin-caffeine</i>	Preferred	
NORGESIC	Preferred	
ORPHENGESIC FORTE	Preferred	
<i>*Retinoic Acid Receptor Gamma Selective Agonists*** - Drugs For Muscles, Ligaments, Tendons, And Bones</i>		
SOHONOS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nasal Agents - Systemic And Topical - Drugs For The Nose		
*Antihistamine-Steroid*** - Allergy		
<i>azelastine-fluticasone</i>	Non – Preferred	
DYMISTA	Non – Preferred	
RYALTRIS	Non – Preferred	
*Nasal Agents - Misc.*** - Allergy		
<i>saline nasal spray</i>	Preferred	OTC
*Nasal Anticholinergics*** - Allergy		
<i>ipratropium bromide solution 0.03 % nasal</i>	Non – Preferred	
<i>ipratropium bromide solution 0.06 % nasal</i>	Non – Preferred	QL (15 ML per 30 days)
*Nasal Antihistamines*** - Allergy		
<i>azelastine hcl solution 0.1 % nasal</i>	Preferred	QL (30 ML per 30 days)
<i>azelastine hcl solution 0.15 % nasal</i>	Preferred	
<i>azelastine hcl solution 137 mcg/spray nasal</i>	Preferred	QL (30 ML per 30 days)
<i>olopatadine hcl</i>	Preferred	
*Nasal Mast Cell Stabilizers*** - Allergy		
<i>cromolyn sodium</i>	Preferred	OTC
*Nasal Steroids*** - Allergy		
<i>allergy relief</i>	Preferred	OTC
<i>flunisolide</i>	Preferred	QL (1.6667 ML per 1 day)
<i>fluticasone propionate suspension 50 mcg/lact nasal (otc)</i>	Preferred	
<i>fluticasone propionate suspension 50 mcg/lact nasal (rx)</i>	Preferred	QL (16 GM Max Qty Per Fill Retail)
<i>mometasone furoate</i>	Non – Preferred	QL (1.1333 GM per 1 day)
<i>sm allergy relief</i>	Preferred	OTC
OMNARIS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROPEL MINI SDS	Non – Preferred	
QNASL	Non – Preferred	
QNASL CHILDRENS	Non – Preferred	
SINUVA	Non – Preferred	
XHANCE	Non – Preferred	
ZETONNA	Non – Preferred	
*Systemic Decongestants*** - Allergy		
<i>phenylephrine hcl</i>	Preferred	OTC
<i>pseudoephedrine hcl er</i>	Preferred	OTC
<i>pseudoephedrine hcl oral tablet 30 mg</i>	Preferred	OTC
<i>pseudoephedrine hcl oral tablet 60 mg</i>	Preferred	
SUDOGEST	Preferred	
Neuromuscular Agents - Drugs For Nerves And Muscles		
*Als Agent Combinations*** - Drugs For Nerves And Muscles		
RELYVRIO	Non – Preferred	
*Als Agents - Miscellaneous*** - Drugs For Nerves And Muscles		
RADICAVA ORS	Non – Preferred	
RADICAVA ORS STARTER KIT	Non – Preferred	
*Benzothiazoles*** - Drugs For Nerves And Muscles		
<i>riluzole</i>	Preferred	
EXSERVAN	Non – Preferred	
TEGLUTIK	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Rett Syndrome Agents - Glycine-Proline-Glutamate Analogs*** - Drugs For Nerves And Muscles		
DAYBUE	Non – Preferred	
Nutrients - Drugs For Nutrition		
*Carbohydrates*** - Drugs For Nutrition		
<i>dextrose</i>	Preferred	
Ophthalmic Agents - Drugs For The Eye		
*Alpha Adrenergic Agonist & Carbonic Anhydrase Inhib Comb*** - Drugs For Glaucoma		
SIMBRINZA	Non – Preferred	
*Artificial Tear And Lubricant Combinations*** - Drugs For The Eye		
<i>eye lubricant</i>	Preferred	OTC
EQ RESTORE PM	Preferred	OTC
GENTEAL TEARS NIGHT-TIME	Preferred	OTC
*Artificial Tear Solutions*** - Drugs For The Eye		
<i>just tears eye drops</i>	Preferred	OTC
<i>sm artificial tears</i>	Preferred	OTC
GENTEAL TEARS	Preferred	OTC
*Artificial Tears And Lubricants*** - Drugs For The Eye		
<i>polyvinyl alcohol</i>	Preferred	OTC; QL (15 ML Max Qty Per Fill Retail)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Beta-Blockers - Ophthalmic Combinations*** - Drugs For Glaucoma		
<i>brimonidine tartrate-timolol</i>	Non – Preferred	QL (10 ML per 30 days)
<i>dorzolamide hcl-timolol mal</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>dorzolamide hcl-timolol mal pf</i>	Non – Preferred	
COMBIGAN	Non – Preferred	QL (10 ML per 30 days)
COSOPT	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
COSOPT PF	Non – Preferred	
*Beta-Blockers - Ophthalmic*** - Drugs For Glaucoma		
<i>betaxolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>carteolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>levobunolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>timolol maleate (once-daily)</i>	Preferred	
<i>timolol maleate gel forming solution 0.25 % ophthalmic</i>	Preferred	
<i>timolol maleate gel forming solution 0.25 % ophthalmic</i>	Preferred	QL (5 ML per 30 days)
<i>timolol maleate gel forming solution 0.5 % ophthalmic</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>timolol maleate pf</i>	Non – Preferred	
<i>timolol maleate solution 0.25 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>timolol maleate solution 0.5 % ophthalmic</i>	Preferred	
<i>timolol maleate solution 0.5 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
BETIMOL	Non – Preferred	
BETOPTIC-S	Non – Preferred	
ISTALOL	Non – Preferred	
TIMOLOL MALEATE OCUDOSE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TIMOPTIC OCUDOSE	Non – Preferred	
*Cycloplegic Mydriatic Combinations*** - Drugs For The Eye		
CYCLOMYDRIL	Preferred	
*Cycloplegic Mydriatics*** - Drugs For The Eye		
<i>atropine sulfate ophthalmic ointment</i>	Preferred	QL (3.5 GM per 30 days)
<i>atropine sulfate solution 1 % ophthalmic</i>	Preferred	
<i>atropine sulfate solution 1 % ophthalmic</i>	Preferred	QL (5 ML per 30 days)
<i>cyclopentolate hcl</i>	Preferred	QL (6 ML per 30 days)
<i>phenylephrine hcl ophthalmic solution 2.5 %</i>	Non – Preferred	QL (2 EA per 30 days)
<i>phenylephrine hcl solution 10 % ophthalmic</i>	Non – Preferred	
<i>phenylephrine hcl solution 2.5 % ophthalmic</i>	Non – Preferred	
<i>phenylephrine hcl solution 2.5 % ophthalmic</i>	Non – Preferred	QL (2 EA per 30 days)
<i>tropicamide</i>	Preferred	QL (15 ML Max Qty Per Fill Retail)
CYCLOGYL SOLUTION 0.5 % OPHTHALMIC	Non – Preferred	
CYCLOGYL SOLUTION 1 % OPHTHALMIC	Non – Preferred	QL (6 ML per 30 days)
CYCLOGYL SOLUTION 2 % OPHTHALMIC	Non – Preferred	QL (5 ML per 30 days)
MYDRIACYL	Non – Preferred	QL (15 ML Max Qty Per Fill Retail)
*Lymphocyte Function-Associated Antigen-1 (Lfa-1) Antag*** - Anti-Infective/Anti-Inflammatories		
XIIDRA	Non – Preferred	
*Miotics - Cholinesterase Inhibitors*** - Drugs For Glaucoma		
PHOSPHOLINE IODIDE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Miotics - Direct Acting*** - Drugs For Glaucoma		
<i>pilocarpine hcl solution 1 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>pilocarpine hcl solution 2 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>pilocarpine hcl solution 4 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
VUITY	Non – Preferred	
*Ophthalmic Antiallergic*** - Drugs For Itchy Eye		
<i>azelastine hcl</i>	Preferred	QL (6 ML Max Qty Per Fill Retail)
<i>bepotastine besilate</i>	Non – Preferred	
<i>cromolyn sodium</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>epinastine hcl</i>	Non – Preferred	
<i>olopatadine hcl solution 0.1 % ophthalmic (rx)</i>	Non – Preferred	QL (5 ML per 30 days)
<i>olopatadine hcl solution 0.2 % ophthalmic (rx)</i>	Non – Preferred	
ALOMIDE	Non – Preferred	
BEPREVE	Non – Preferred	
ZERVIATE	Non – Preferred	
*Ophthalmic Antibiotics*** - Anti-Infective/Anti-Inflammatories		
<i>bacitracin</i>	Preferred	
<i>ciprofloxacin hcl</i>	Preferred	QL (5 ML per 30 days)
<i>erythromycin</i>	Preferred	
<i>gatifloxacin</i>	Non – Preferred	
<i>gentamicin sulfate</i>	Preferred	QL (5 ML per 30 days)
<i>moxifloxacin hcl</i>	Non – Preferred	
<i>moxifloxacin hcl (2x day)</i>	Non – Preferred	

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<i>ofloxacin solution 0.3 % ophthalmic</i>	Preferred	QL (5 ML per 30 days)
<i>tobramycin</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
AZASITE	Non – Preferred	
BESIVANCE	Non – Preferred	
CILOXAN	Preferred	QL (3.5 GM per 30 days)
OCUFLOX	Non – Preferred	QL (5 ML per 30 days)
TOBREX	Preferred	
VIGAMOX	Non – Preferred	
*Ophthalmic Antifungal*** - Drugs For The Eye		
NATACYN	Non – Preferred	
*Ophthalmic Anti-Infective Combinations*** - Anti-Infective/Anti-Inflammatories		
<i>bacitracin-polymyxin b</i>	Preferred	
<i>neomycin-bacitracin zn-polymyx ointment 3.5-400-10000 ophthalmic</i>	Preferred	
<i>neomycin-bacitracin zn-polymyx ointment 5-400-10000 ophthalmic</i>	Preferred	QL (7 GM per 30 days)
<i>neomycin-polymyxin-gramicidin</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>polymyxin b-trimethoprim</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
NEO-POLYCIN	Preferred	QL (7 GM per 30 days)
POLYCIN	Preferred	
*Ophthalmic Antiseptics*** - Anti-Infective/Anti-Inflammatories		
BETADINE OPHTHALMIC PREP	Non – Preferred	

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*Ophthalmic Antivirals*** - Anti-Infective/Anti-Inflammatories		
<i>trifluridine</i>	Preferred	QL (7.5 ML Max Qty Per Fill Retail)
ZIRGAN	Preferred	
*Ophthalmic Carbonic Anhydrase Inhibitors*** - Drugs For Glaucoma		
<i>brinzolamide</i>	Non – Preferred	QL (10 ML per 30 days)
<i>dorzolamide hcl solution 2 % ophthalmic</i>	Preferred	
<i>dorzolamide hcl solution 2 % ophthalmic</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
AZOPT SUSPENSION 1 % OPHTHALMIC	Non – Preferred	
AZOPT SUSPENSION 1 % OPHTHALMIC	Non – Preferred	QL (10 ML per 30 days)
*Ophthalmic Decongestants*** - Drugs For Itchy Eye		
<i>redness reliever eye drops</i>	Preferred	OTC; QL (15 ML Max Qty Per Fill Retail)
<i>sm eye drops</i>	Preferred	OTC; QL (15 ML Max Qty Per Fill Retail)
*Ophthalmic Diagnostic Products*** - Drugs For The Eye		
<i>fluorescein sodium/benoxinate</i>	Non – Preferred	
GLOSTRIPS	Non – Preferred	
*Ophthalmic Ectoparasiticide** - Anti-Infective/Anti-Inflammatories		
XDEMVY	Non – Preferred	
*Ophthalmic Immunomodulators*** - Anti-Infective/Anti-Inflammatories		
<i>cyclosporine</i>	Non – Preferred	
CEQUA	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESTASIS	Non – Preferred	
RESTASIS MULTIDOSE	Non – Preferred	
VERKAZIA	Non – Preferred	
VEVYE	Non – Preferred	
*Ophthalmic Kinase Inhibitors - Combinations*** - Drugs For Glaucoma		
ROCKLATAN	Non – Preferred	
*Ophthalmic Local Anesthetics*** - Drugs For The Eye		
<i>proparacaine hcl</i>	Non – Preferred	
<i>tetracaine hcl</i>	Non – Preferred	
AKTEN	Non – Preferred	
ALCAINE	Non – Preferred	
IHEEZO	Non – Preferred	
*Ophthalmic Nerve Growth Factors*** - Drugs For The Eye		
OXERVATE	Non – Preferred	
*Ophthalmic Nonsteroidal Anti-Inflammatory Agents*** - Anti-Infective/Anti-Inflammatories		
<i>bromfenac sodium</i>	Non – Preferred	
<i>bromfenac sodium (once-daily)</i>	Non – Preferred	
<i>diclofenac sodium</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>flurbiprofen sodium</i>	Preferred	QL (5 ML per 25 days)
<i>ketorolac tromethamine solution 0.4 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>ketorolac tromethamine solution 0.5 % ophthalmic</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACULAR	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
ACULAR LS	Non – Preferred	QL (10 ML per 30 days)
ACUVAIL	Non – Preferred	
BROMSITE	Non – Preferred	
ILEVRO	Non – Preferred	
NEVANAC	Non – Preferred	
PROLENSA	Non – Preferred	
*Ophthalmic Rho Kinase Inhibitors*** - Drugs For Glaucoma		
RHOPRESSA	Non – Preferred	
*Ophthalmic Selective Alpha Adrenergic Agonists*** - Drugs For Glaucoma		
<i>apraclonidine hcl</i>	Non – Preferred	
<i>brimonidine tartrate solution 0.1 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.15 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.2 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
ALPHAGAN P	Preferred	
IOPIDINE	Non – Preferred	
*Ophthalmic Steroid Combinations*** - Anti-Infective/Anti-Inflammatories		
<i>bacitra-neomycin-polymyxin-hc</i>	Preferred	
<i>neomycin-polymyxin-dexameth ointment 3.5-10000-0.1 ophthalmic</i>	Preferred	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	Preferred	QL (3.5 GM per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>neomycin-polymyxin-dexameth ophthalmic suspension</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>neomycin-polymyxin-hc</i>	Preferred	QL (7.5 ML per 30 days)
<i>sulfacetamide-prednisolone</i>	Non – Preferred	QL (5 ML per 30 days)
<i>tobramycin-dexamethasone suspension 0.3-0.1 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
MAXITROL OINTMENT 3.5-10000-0.1 OPTHALMIC	Non – Preferred	
MAXITROL OPTHALMIC OINTMENT 3.5-10000-0.1	Preferred	QL (3.5 GM per 30 days)
MAXITROL SUSPENSION 0.1 % OPTHALMIC	Non – Preferred	
MAXITROL SUSPENSION 3.5-10000-0.1 OPTHALMIC	Non – Preferred	QL (5 ML Max Qty Per Fill Retail)
NEO-POLYCIN HC	Preferred	
TOBRADEX	Non – Preferred	
TOBRADEX ST	Non – Preferred	
ZYLET	Non – Preferred	
*Ophthalmic Steroids*** - Anti-Infective/Anti-Inflammatories		
<i>dexamethasone sodium phosphate</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>difluprednate</i>	Non – Preferred	
<i>fluorometholone suspension 0.1 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>loteprednol etabonate ophthalmic gel</i>	Non – Preferred	
<i>loteprednol etabonate ophthalmic suspension</i>	Preferred	
<i>prednisolone acetate</i>	Preferred	QL (10 ML per 30 days)
<i>prednisolone sodium phosphate</i>	Preferred	QL (10 ML per 30 days)
ALREX	Preferred	
DEXTENZA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUREZOL	Non – Preferred	
EYSUVIS	Non – Preferred	
FLAREX	Preferred	
FML FORTE	Preferred	
FML LIQUIFILM	Non – Preferred	QL (10 ML per 30 days)
INVELTYS	Non – Preferred	
LOTEMAX	Non – Preferred	
LOTEMAX SM	Non – Preferred	
MAXIDEX	Preferred	
PRED FORTE	Non – Preferred	QL (10 ML per 30 days)
PRED MILD	Preferred	QL (10 ML per 30 days)
*Ophthalmic Sulfonamides*** - Anti-Infective/Anti-Inflammatories		
<i>sulfacetamide sodium ophthalmic ointment</i>	Preferred	
<i>sulfacetamide sodium ophthalmic solution</i>	Preferred	QL (15 ML Max Qty Per Fill Retail)
*Ophthalmics - Cystinosis Agents** - Drugs For The Eye		
CYSTADROPS	Non – Preferred	
CYSTARAN	Non – Preferred	
*Prostaglandins - Ophthalmic*** - Drugs For Glaucoma		
<i>bimatoprost</i>	Non – Preferred	
<i>latanoprost solution 0.005 % ophthalmic</i>	Preferred	QL (2.5 ML per 25 days)
<i>tafluprost (pf)</i>	Non – Preferred	
<i>travoprost (bak free)</i>	Non – Preferred	
IYUZEH	Non – Preferred	
LUMIGAN	Non – Preferred	
TRAVATAN Z	Non – Preferred	
VYZULTA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XALATAN	Non – Preferred	QL (2.5 ML per 25 days)
XELPROS	Non – Preferred	
ZIOPTAN	Non – Preferred	
Otic Agents - Drugs For The Ear		
*Otic Agents - Miscellaneous*** - Wax Removal		
<i>acetic acid</i>	Preferred	
*Otic Anti-Infectives*** - Antibiotics		
<i>ciprofloxacin hcl</i>	Non – Preferred	QL (28 EA per 30 days)
<i>ofloxacin solution 0.3 % otic</i>	Preferred	
<i>ofloxacin solution 0.3 % otic</i>	Preferred	QL (15 ML per 30 days)
*Otic Steroid-Anti-Infective Combinations*** - Anti-Infective/Anti-Inflammatories		
<i>ciprofloxacin-dexamethasone suspension 0.3-0.1 % otic</i>	Preferred	
<i>ciprofloxacin-dexamethasone suspension 0.3-0.1 % otic</i>	Preferred	QL (7.5 ML per 30 days)
<i>ciprofloxacin-fluocinolone pf</i>	Non – Preferred	
<i>neomycin-polymyxin-hc</i>	Preferred	QL (10 ML per 30 days)
CORTISPORIN-TC	Non – Preferred	
*Otic Steroids*** - Anti-Infective/Anti-Inflammatories		
<i>fluocinolone acetonide</i>	Non – Preferred	
<i>hydrocortisone-acetic acid</i>	Non – Preferred	
DERMOTIC	Non – Preferred	
FLAC	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Oxytocics - Hormones		
<i>*Oxytocics*** - Drugs For Women</i>		
<i>methylergonovine maleate</i>	Preferred	
METHERGINE	Preferred	
Passive Immunizing And Treatment Agents - Biological Agents		
<i>*Antiviral Monoclonal Antibodies*** - Biological Agents</i>		
SYNAGIS	Preferred	PA; QL (1 VIAL per 26 days)
<i>*Immune Serums*** - Biological Agents</i>		
GAMMAGARD	Preferred	PA
GAMUNEX-C	Preferred	PA
HIZENTRA	Preferred	PA
HYPERRHO S/D	Preferred	
MICRHOGAM ULTRA-FILTERED PLUS	Preferred	
PRIVIGEN	Preferred	PA
RHOGAM ULTRA-FILTERED PLUS	Preferred	
Penicillins - Drugs For Infections		
<i>*Aminopenicillins*** - Antibiotics</i>		
<i>amoxicillin</i>	Preferred	
<i>ampicillin</i>	Preferred	QL (4 EA per 1 day)
<i>ampicillin sodium</i>	Preferred	
<i>*Natural Penicillins*** - Antibiotics</i>		
<i>penicillin g pot in dextrose</i>	Preferred	
<i>penicillin g potassium</i>	Preferred	
<i>penicillin g sodium</i>	Preferred	
<i>penicillin v potassium</i>	Preferred	
BICILLIN L-A	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PFIZERPEN	Preferred	
*Penicillin Combinations*** - Antibiotics		
<i>amoxicillin-pot clavulanate er</i>	Non – Preferred	QL (28 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate oral suspension reconstituted</i>	Preferred	
<i>amoxicillin-pot clavulanate oral tablet chewable</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 250-125 mg oral</i>	Preferred	
<i>amoxicillin-pot clavulanate tablet 250-125 mg oral</i>	Preferred	QL (30 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 500-125 mg oral</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 875-125 mg oral</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>ampicillin-sulbactam sodium</i>	Preferred	
<i>piperacillin sod-tazobactam so</i>	Preferred	
AUGMENTIN	Preferred	
AUGMENTIN ES-600	Non – Preferred	
BICILLIN C-R	Preferred	
BICILLIN C-R 900/300	Preferred	
ZOSYN	Preferred	
*Penicillinase-Resistant Penicillins*** - Antibiotics		
<i>dicloxacillin sodium</i>	Preferred	
Pharmaceutical Adjuvants		
*Parenteral Vehicles***		
<i>saline bacteriostatic</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Semi Solid Vehicles***		
<i>polyethylene glycol 3350</i>	Preferred	
Progestins - Hormones		
*Progestins*** - Drugs For Women		
<i>medroxyprogesterone acetate</i>	Preferred	
<i>megestrol acetate</i>	Non – Preferred	
<i>norethindrone acetate</i>	Non – Preferred	
<i>progesterone intramuscular</i>	Preferred	
<i>progesterone oral</i>	Preferred	QL (2 EA per 1 day)
PROMETRIUM	Non – Preferred	QL (2 EA per 1 day)
PROVERA	Non – Preferred	
Psychotherapeutic And Neurological Agents - Misc. - Drugs For The Nervous System		
*Agents For Opioid Withdrawal*** - Drugs For The Nervous System		
LUCEMYRA	Preferred	
*Alcohol Deterrents*** - Drugs For The Nervous System		
<i>acamprosate calcium</i>	Preferred	
<i>disulfiram</i>	Preferred	
*Alzheimer's Treatment - Anti-Amyloid Antibodies*** - Drugs For Alzheimer's Disease		
ADUHELM	Non – Preferred	
LEQEMBI	Non – Preferred	
*Anti-Cataplectic Agents*** - Drugs For Sleep Disorder		
<i>sodium oxybate</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XYREM	Non – Preferred	
*Anti-Cataplectic Combinations*** - Drugs For Sleep Disorder		
XYWAV	Non – Preferred	
*Antidementia Agent Combinations*** - Drugs For Alzheimer's Disease		
NAMZARIC	Non – Preferred	
*Antisense Oligonucleotide (Aso) Inhibitor Agents*** - Drugs For The Nervous System		
TEGSEDI	Non – Preferred	
WAINUA	Non – Preferred	
*Benzodiazepines & Tricyclic Agents*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>chlordiazepoxide-amitriptyline</i>	Preferred	
*Cholinomimetics - Ache Inhibitors*** - Drugs For Alzheimer's Disease		
<i>donepezil hcl oral tablet dispersible</i>	Preferred	QL (1 EA per 1 day)
<i>donepezil hcl tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>donepezil hcl tablet 23 mg oral</i>	Preferred	
<i>donepezil hcl tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>galantamine hydrobromide er</i>	Non – Preferred	
<i>galantamine hydrobromide oral solution</i>	Non – Preferred	QL (2 ML per 1 day)
<i>galantamine hydrobromide oral tablet</i>	Non – Preferred	
<i>rivastigmine</i>	Non – Preferred	
<i>rivastigmine tartrate</i>	Non – Preferred	
ADLARITY	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARICEPT TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ARICEPT TABLET 23 MG ORAL	Non – Preferred	
ARICEPT TABLET 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
EXELON	Non – Preferred	
<i>*Fibromyalgia Agent - Snris*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
SAVELLA	Non – Preferred	
SAVELLA TITRATION PACK	Non – Preferred	QL (55 EA per 90 days)
<i>*Movement Disorder Drug Therapy*** - Drugs For The Nervous System</i>		
<i>tetrabenazine</i>	Non – Preferred	
AUSTEDO	Preferred	PA; QL (4 EA per 1 day)
AUSTEDO XR	Preferred	PA
INGREZZA	Preferred	PA
XENAZINE	Non – Preferred	
<i>*Ms Agents - Pyrimidine Synthesis Inhibitors*** - Drugs For Multiple Sclerosis</i>		
<i>teriflunomide</i>	Non – Preferred	QL (1 EA per 1 day)
AUBAGIO	Non – Preferred	QL (1 EA per 1 day)
<i>*Multiple Sclerosis Agents - Antimetabolites*** - Drugs For Multiple Sclerosis</i>		
MAVENCLAD (10 TABS)	Non – Preferred	
MAVENCLAD (4 TABS)	Non – Preferred	
MAVENCLAD (5 TABS)	Non – Preferred	
MAVENCLAD (6 TABS)	Non – Preferred	
MAVENCLAD (7 TABS)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVENCLAD (8 TABS)	Non – Preferred	
MAVENCLAD (9 TABS)	Non – Preferred	
<i>*Multiple Sclerosis Agents - Interferons*** - Drugs For Multiple Sclerosis</i>		
AVONEX PEN	Non – Preferred	QL (1 KIT per 28 days)
AVONEX PREFILLED	Non – Preferred	QL (1 SYRINGE per 28 days)
BETASERON	Preferred	QL (15 VIAL per 30 days)
EXTAVIA	Non – Preferred	QL (15 VIAL per 30 days)
PLEGRIDY	Non – Preferred	
PLEGRIDY STARTER PACK	Non – Preferred	
REBIF	Preferred	QL (12 ML per 30 days)
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS	Preferred	
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS	Preferred	QL (12 ML per 30 days)
REBIF REBIDOSE TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
REBIF TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
<i>*Multiple Sclerosis Agents - Monoclonal Antibodies*** - Drugs For Multiple Sclerosis</i>		
BRIUMVI	Non – Preferred	
KESIMPTA	Non – Preferred	
LEMTRADA	Non – Preferred	
OCREVUS	Non – Preferred	
TYSABRI	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Multiple Sclerosis Agents - Nrf2 Pathway Activators*** - Drugs For Multiple Sclerosis		
<i>dimethyl fumarate capsule delayed release 120 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate capsule delayed release 120 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate capsule delayed release 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate starter pack capsule delayed release therapy pack 120 & 240 mg oral</i>	Preferred	QL (60 EA per 90 days)
BAFIERTAM	Non – Preferred	
TECFIDERA ORAL CAPSULE DELAYED RELEASE	Preferred	QL (2 EA per 1 day)
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK	Preferred	QL (60 EA per 90 days)
VUMERITY	Non – Preferred	
*Multiple Sclerosis Agents - Potassium Channel Blockers*** - Drugs For Multiple Sclerosis		
<i>dalfampridine er</i>	Non – Preferred	
AMPYRA	Non – Preferred	
*Multiple Sclerosis Agents*** - Drugs For Multiple Sclerosis		
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	Non – Preferred	QL (1 ML per 1 day)
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	Non – Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Preferred	QL (1 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Preferred	
GLATOPA SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Non – Preferred	QL (1 ML per 1 day)
GLATOPA SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Non – Preferred	
*N-Methyl-D-Aspartate (Nmda) Receptor Antagonists*** - Drugs For Alzheimer's Disease		
<i>memantine hcl er</i>	Non – Preferred	
<i>memantine hcl oral solution</i>	Non – Preferred	
<i>memantine hcl tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>memantine hcl tablet 28 x 5 mg & 21 x 10 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>memantine hcl tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
NAMENDA TITRATION PAK	Non – Preferred	
NAMENDA XR	Non – Preferred	
*Phenothiazines & Tricyclic Agents*** - Drugs For Depression		
<i>perphenazine-amitriptyline</i>	Preferred	
*Postherpetic Neuralgia (Phn)/Neuropathic Pain Agents*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>gabapentin (once-daily)</i>	Non – Preferred	
<i>pregabalin er</i>	Non – Preferred	
GRALISE	Non – Preferred	
LYRICA CR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Premenstrual Dysphoric Disorder (Pmdd) Agents - SsrIs*** - Drugs For Depression		
<i>fluoxetine hcl (pmdd)</i>	Non – Preferred	
*Pseudobulbar Affect Agent Combinations*** - Drugs For Severe Mental Disorders		
NUDEXTA	Non – Preferred	
*Psychotherapeutic And Neurological Agents - Misc.*** - Drugs For Severe Mental Disorders		
<i>ergoloid mesylates</i>	Preferred	
<i>pimozide</i>	Preferred	
*Restless Leg Syndrome (RLS) Agents*** - Drugs For The Nervous System		
HORIZANT	Non – Preferred	
*Small Interfering Ribonucleic Acid (Sirna) Agents*** - Drugs For The Nervous System		
AMVUTTRA	Non – Preferred	
*Smoking Deterrents*** - Drugs For Depression		
<i>bupropion hcl er (smoking det)</i>	Preferred	
<i>ft nicotine lozenge 2 mg mouth/throat</i>	Preferred	OTC
<i>ft nicotine lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>ft nicotine mouth/throat gum</i>	Preferred	OTC
<i>gnp nicotine gum 2 mg mouth/throat</i>	Preferred	OTC
<i>gnp nicotine gum 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine mini</i>	Preferred	OTC; QL (200 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>gnp nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>gnp nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	OTC
<i>gnp nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine gum 2 mg mouth/throat</i>	Preferred	OTC
<i>goodsense nicotine gum 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine gum 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>hm nicotine polacrilex</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine mini lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine mini lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine patch 24 hour 14 mg/24hr transdermal (otc)</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine patch 24 hour 21 mg/24hr transdermal (otc)</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine patch 24 hour 7 mg/24hr transdermal (otc)</i>	Preferred	OTC
<i>nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	OTC
<i>nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	OTC
<i>nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine polacrilex mini</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine step 1 patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC
<i>nicotine step 1 patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine step 2 patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC
<i>nicotine step 2 patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine step 3</i>	Preferred	OTC
<i>nicotine transdermal kit</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine mouth/throat gum</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	OTC
<i>sm nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat gum</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>varenicline tartrate</i>	Preferred	
<i>varenicline tartrate (starter)</i>	Preferred	
<i>varenicline tartrate(continue)</i>	Preferred	
NICOTROL	Preferred	QL (3 INHALER per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NICOTROL NS	Preferred	QL (120 ML per 30 days)
*Sphingosine 1-Phosphate (S1p) Receptor Modulators*** - Drugs For Multiple Sclerosis		
<i> fingolimod hcl capsule 0.5 mg oral</i>	Non – Preferred	
<i> fingolimod hcl capsule 0.5 mg oral</i>	Non – Preferred	PA
<i> fingolimod hcl capsule 0.5 mg oral</i>	Non – Preferred	PA; QL (1 EA per 1 day)
GILENYA CAPSULE 0.25 MG ORAL	Non – Preferred	
GILENYA CAPSULE 0.5 MG ORAL	Preferred	PA
MAYZENT	Non – Preferred	
MAYZENT STARTER PACK	Non – Preferred	
PONVORY	Non – Preferred	
PONVORY STARTER PACK	Non – Preferred	
TASCENSO ODT	Non – Preferred	
ZEPOSIA	Non – Preferred	
ZEPOSIA 7-DAY STARTER PACK	Non – Preferred	
ZEPOSIA STARTER KIT	Non – Preferred	
*Thienbenzodiazepines & Opioid Antagonists*** - Drugs For Severe Mental Disorders		
LYBALVI	Non – Preferred	
*Thienbenzodiazepines & Ssrís*** - Drugs For Severe Mental Disorders		
<i> olanzapine-fluoxetine hcl</i>	Non – Preferred	QL (1 EA per 1 day)
SYMBYAX	Non – Preferred	QL (1 EA per 1 day)
*Vasomotor Symptom Agents - Ssrís*** - Drugs For The Nervous System		
<i> paroxetine mesylate</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Respiratory Agents - Misc. - Drugs For The Lungs		
*Cftr Potentiators*** - Drugs For Cystic Fibrosis		
KALYDECO	Non – Preferred	
*Cystic Fibrosis Agent - Combinations*** - Drugs For Cystic Fibrosis		
ORKAMBI	Non – Preferred	
SYMDEKO	Non – Preferred	
TRIKAFTA	Non – Preferred	
*Cystic Fibrosis Agents - Miscellaneous*** - Drugs For Cystic Fibrosis		
BRONCHITOL	Non – Preferred	
BRONCHITOL TOLERANCE TEST	Non – Preferred	
*Hydrolytic Enzymes*** - Drugs For The Lungs		
PULMOZYME	Preferred	QL (5 ML per 1 day)
*Pulmonary Fibrosis Agents - Kinase Inhibitors*** - Drugs For The Lungs		
OFEV	Non – Preferred	
*Pulmonary Fibrosis Agents*** - Drugs For The Lungs		
<i>pirfenidone</i>	Non – Preferred	
ESBRIET	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sulfonamides - Drugs For Infections		
*Sulfonamides*** - Antibiotics		
<i>sulfadiazine</i>	Preferred	
Tetracyclines - Drugs For Infections		
*Aminomethylcyclines*** - Antibiotics		
NUZYRA	Non – Preferred	
*Tetracyclines*** - Antibiotics		
<i>demeclocycline hcl</i>	Preferred	
<i>doxycycline hyclate intravenous</i>	Preferred	
<i>doxycycline hyclate oral capsule</i>	Preferred	
<i>doxycycline hyclate oral tablet</i>	Preferred	
<i>doxycycline hyclate oral tablet delayed release</i>	Non – Preferred	
<i>doxycycline monohydrate</i>	Preferred	
<i>minocycline hcl</i>	Preferred	
<i>minocycline hcl er</i>	Non – Preferred	
<i>tetracycline hcl</i>	Preferred	
DORYX MPC	Non – Preferred	
DOXY 100	Preferred	
MINOLIRA	Non – Preferred	
VIBRAMYCIN	Non – Preferred	
Thyroid Agents - Hormones		
*Antithyroid Agents*** - Drugs For Thyroid		
<i>methimazole</i>	Preferred	
<i>propylthiouracil</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Thyroid Hormones*** - Drugs For Thyroid		
<i>levothyroxine sodium oral capsule</i>	Non – Preferred	
<i>levothyroxine sodium oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>liothyronine sodium tablet 25 mcg oral</i>	Preferred	
<i>liothyronine sodium tablet 25 mcg oral</i>	Preferred	QL (2 EA per 1 day)
<i>liothyronine sodium tablet 5 mcg oral</i>	Preferred	
<i>liothyronine sodium tablet 5 mcg oral</i>	Preferred	QL (4 EA per 1 day)
<i>liothyronine sodium tablet 50 mcg oral</i>	Preferred	
<i>liothyronine sodium tablet 50 mcg oral</i>	Preferred	QL (2 EA per 1 day)
<i>niva thyroid</i>	Preferred	
<i>thyroid</i>	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 120 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 130 MG ORAL	Preferred	
ADTHYZA TABLET 15 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 16.25 MG ORAL	Preferred	
ADTHYZA TABLET 30 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 32.5 MG ORAL	Preferred	
ADTHYZA TABLET 60 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 65 MG ORAL	Preferred	
ADTHYZA TABLET 90 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 97.5 MG ORAL	Preferred	
ARMOUR THYROID	Preferred	QL (1 EA per 1 day)
CYTOMEL TABLET 25 MCG ORAL	Non – Preferred	QL (2 EA per 1 day)
CYTOMEL TABLET 5 MCG ORAL	Non – Preferred	QL (4 EA per 1 day)
CYTOMEL TABLET 50 MCG ORAL	Non – Preferred	QL (2 EA per 1 day)
ERMEZA	Non – Preferred	
EUTHYROX	Preferred	QL (1 EA per 1 day)
LEVO-T	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEVOXYL	Preferred	QL (1 EA per 1 day)
NP THYROID	Preferred	QL (1 EA per 1 day)
SYNTHROID	Non – Preferred	QL (1 EA per 1 day)
THYQUIDITY	Non – Preferred	
TIROSINT	Non – Preferred	
TIROSINT-SOL	Non – Preferred	
UNITHROID	Preferred	QL (1 EA per 1 day)
Toxoids - Biological Agents		
*Toxoid Combinations*** - Vaccines		
ADACEL	Preferred	AL (Min 19 Years)
BOOSTRIX	Preferred	AL (Min 19 Years)
INFANRIX	Preferred	AL (Min 19 Years)
TDVAX	Preferred	AL (Min 19 Years)
Ulcer Drugs/Antispasmodics/Anticholinergics - Drugs For The Stomach		
*Anticholinergic Combinations*** - Drugs For Stomach Cramps		
<i>belladonna alkaloids-opium</i>	Preferred	
<i>chlordiazepoxide-clidinium</i>	Non – Preferred	
LIBRAX	Non – Preferred	
*Antispasmodics*** - Drugs For Stomach Cramps		
<i>dicyclomine hcl</i>	Preferred	
*Belladonna Alkaloids*** - Drugs For Stomach Cramps		
<i>hyoscyamine sulfate</i>	Preferred	
<i>hyoscyamine sulfate er</i>	Preferred	
<i>oscimin</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEVSIN	Non – Preferred	
LEVSIN/SL	Non – Preferred	
NULEV	Preferred	
*H-2 Antagonists*** - Drugs For Ulcers And Stomach Acid		
<i>acid reducer maximum strength</i>	Preferred	OTC
<i>cimetidine</i>	Preferred	QL (2 EA per 1 day)
<i>famotidine maximum strength</i>	Preferred	OTC
<i>famotidine oral suspension reconstituted</i>	Preferred	
<i>famotidine tablet 20 mg oral (rx)</i>	Preferred	
<i>famotidine tablet 40 mg oral</i>	Preferred	
<i>famotidine tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>heartburn relief max st</i>	Preferred	OTC
<i>nizatidine</i>	Preferred	
PEPCID TABLET 20 MG ORAL	Non – Preferred	
PEPCID TABLET 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
*Misc. Anti-Ulcer*** - Drugs For Ulcers And Stomach Acid		
<i>sucralfate</i>	Preferred	
CARAFATE ORAL SUSPENSION	Preferred	
CARAFATE ORAL TABLET	Non – Preferred	
*Proton Pump Inhibitor-Antacid Combinations*** - Drugs For Ulcers And Stomach Acid		
<i>omeprazole-sodium bicarbonate</i>	Non – Preferred	
KONVOMEK	Non – Preferred	
ZEGERID	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Proton Pump Inhibitors*** - Drugs For Ulcers And Stomach Acid</i>		
<i>dexlansoprazole</i>	Non – Preferred	
<i>esomeprazole magnesium oral capsule delayed release</i>	Non – Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium oral packet</i>	Non – Preferred	
<i>lansoprazole capsule delayed release 15 mg oral (rx)</i>	Non – Preferred	
<i>lansoprazole capsule delayed release 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>lansoprazole oral tablet delayed release dispersible</i>	Preferred	AL (Max 10 Years)
<i>omeprazole</i>	Preferred	QL (2 EA per 1 day)
<i>pantoprazole sodium oral packet</i>	Non – Preferred	
<i>pantoprazole sodium tablet delayed release 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>pantoprazole sodium tablet delayed release 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>rabeprazole sodium</i>	Non – Preferred	QL (2 EA per 1 day)
ACIPHEX	Non – Preferred	QL (2 EA per 1 day)
DEXILANT	Non – Preferred	
FIRST PANTOPRAZOLE	Non – Preferred	
NEXIUM CAPSULE DELAYED RELEASE 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NEXIUM CAPSULE DELAYED RELEASE 40 MG ORAL	Non – Preferred	
NEXIUM ORAL PACKET	Non – Preferred	
PREVACID	Non – Preferred	QL (2 EA per 1 day)
PREVACID SOLUTAB	Non – Preferred	AL (Max 10 Years)
PRILOSEC	Non – Preferred	
PROTONIX ORAL PACKET	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTONIX TABLET DELAYED RELEASE 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROTONIX TABLET DELAYED RELEASE 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
*Quaternary Anticholinergics*** - Drugs For Stomach Cramps		
<i>glycopyrrolate</i>	Preferred	
<i>methscopolamine bromide</i>	Non – Preferred	
CUVPOSA	Non – Preferred	
GLYCATE	Non – Preferred	
ROBINUL	Non – Preferred	
ROBINUL-FORTE	Non – Preferred	
*Ulcer Anti-Infective W/ Bismuth Combinations*** - Drugs For Ulcers And Stomach Acid		
<i>bis subcit-metronid-tetracyc</i>	Non – Preferred	
<i>bismuth/metronidaz/tetracyclin</i>	Non – Preferred	
PYLERA	Non – Preferred	
*Ulcer Anti-Infective W/ Proton Pump Inhibitors*** - Drugs For Ulcers And Stomach Acid		
<i>amoxicill-clarithro-lansopraz</i>	Non – Preferred	
TALICIA	Non – Preferred	
*Ulcer Drugs - Prostaglandins*** - Drugs For Ulcers And Stomach Acid		
<i>misoprostol</i>	Preferred	
CYTOTEC	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Urinary Antispasmodics - Drugs For The Urinary System		
*Urinary Antispasmodic - Antimuscarinic (Anticholinergic)*** - Drugs For The Bladder		
<i>darifenacin hydrobromide er</i>	Non – Preferred	
<i>fesoterodine fumarate er</i>	Non – Preferred	
<i>oxybutynin chloride er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride oral solution</i>	Preferred	QL (20 ML per 1 day)
<i>oxybutynin chloride tablet 2.5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>oxybutynin chloride tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>solifenacin succinate</i>	Preferred	QL (1 EA per 1 day)
<i>tolterodine tartrate</i>	Non – Preferred	
<i>tolterodine tartrate er</i>	Non – Preferred	
<i>trospium chloride</i>	Non – Preferred	
<i>trospium chloride er</i>	Non – Preferred	
DETROL	Non – Preferred	
DETROL LA	Non – Preferred	
GELNIQUE	Non – Preferred	
OXYTROL	Non – Preferred	
TOVIAZ	Non – Preferred	
VESICARE	Non – Preferred	
VESICARE LS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Urinary Antispasmodics - Beta-3 Adrenergic Agonists*** - Drugs For The Bladder		
GEMTESA	Non – Preferred	
MYRBETRIQ	Non – Preferred	
*Urinary Antispasmodics - Cholinergic Agonists*** - Drugs For The Bladder		
<i>bethanechol chloride</i>	Preferred	
*Urinary Antispasmodics - Direct Muscle Relaxants*** - Drugs For The Bladder		
<i>flavoxate hcl</i>	Non – Preferred	
Vaccines - Biological Agents		
*Bacterial Vaccines*** - Vaccines		
BEXSERO	Preferred	AL (Min 19 Years)
MENVEO	Preferred	AL (Min 19 Years)
PNEUMOVAX 23	Preferred	AL (Min 19 Years)
PREVNAR 20	Preferred	AL (Min 19 Years)
TRUMENBA	Preferred	AL (Min 19 Years)
VAXNEUVANCE	Preferred	AL (Min 19 Years)
*Viral Vaccine Combinations*** - Vaccines		
TWINRIX	Preferred	AL (Min 19 Years)
*Viral Vaccines*** - Vaccines		
COMIRNATY	Preferred	AL (Min 3 Years)
ENGERIX-B	Preferred	AL (Min 19 Years)
FLUAD	Preferred	AL (Min 14 Years)
FLUMIST QUADRIVALENT	Preferred	AL (Min 14 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GARDASIL 9	Preferred	AL (Min 19 Years and Max 45 Years)
HAVRIX	Preferred	AL (Min 19 Years)
HEPLISAV-B	Preferred	AL (Min 19 Years)
PREHEVBRIO	Preferred	AL (Min 19 Years)
RECOMBIVAX HB	Preferred	AL (Min 19 Years)
VAQTA	Preferred	AL (Min 19 Years)
VARIVAX	Preferred	AL (Min 19 Years)
Vaginal And Related Products - Drugs For Women		
<i>*Imidazole-Related Antifungals*** - Drugs For Infections</i>		
<i>clotrimazole 3</i>	Preferred	OTC
<i>miconazole 3</i>	Preferred	QL (3 EA Max Qty Per Fill Retail)
<i>terconazole</i>	Preferred	
GYNAZOLE-1	Non – Preferred	
<i>*Miscellaneous Vaginal Combinations*** - Drugs For Infections</i>		
TRIMO-SAN	Non – Preferred	
<i>*Miscellaneous Vaginal Products*** - Drugs For Women</i>		
INTRAROSA	Non – Preferred	
<i>*Vaginal Anti-Infectives*** - Drugs For Infections</i>		
<i>clindamycin phosphate</i>	Preferred	
<i>metronidazole</i>	Preferred	
CLEOCIN	Non – Preferred	
CLINDESSE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUVESSA	Non – Preferred	
VANDAZOLE	Non – Preferred	
XACIATO	Non – Preferred	
<i>*Vaginal Contraceptive Ph Modulator - Combinations*** - Drugs For Women</i>		
PHEXXI	Preferred	
<i>*Vaginal Estrogens*** - Drugs For Women</i>		
<i>estradiol vaginal cream</i>	Preferred	
<i>estradiol vaginal tablet</i>	Non – Preferred	
ESTRACE	Non – Preferred	
ESTRING	Non – Preferred	
FEMRING	Non – Preferred	
IMVEXXY MAINTENANCE PACK	Non – Preferred	
IMVEXXY STARTER PACK	Non – Preferred	
PREMARIN	Preferred	QL (60 GM per 30 days)
VAGIFEM	Non – Preferred	
YUVAFEM	Non – Preferred	
<i>*Vaginal Progestins*** - Drugs For Women</i>		
CRINONE	Non – Preferred	
ENDOMETRIN	Preferred	
<i>*Vasopressors* - Drugs For The Heart</i>		
<i>*Anaphylaxis Therapy Agents*** - Drugs For Serious Allergic Reaction</i>		
<i>epinephrine</i>	Preferred	QL (4 UNIT per 365 days)
AUVI-Q SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML INJECTION	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUVI-Q SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML INJECTION	Preferred	QL (4 EA per 365 days)
AUVI-Q SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML INJECTION	Preferred	QL (4 EA per 365 days)
EPIPEN 2-PAK	Non – Preferred	QL (4 UNIT per 365 days)
EPIPEN JR 2-PAK	Non – Preferred	QL (4 EA per 365 days)
<i>*Neurogenic Orthostatic Hypotension (Noh) - Agents*** - Drugs For Serious Allergic Reaction</i>		
<i>droxidopa</i>	Non – Preferred	
NORTHERA	Non – Preferred	
<i>*Vasopressors*** - Drugs For Serious Allergic Reaction</i>		
<i>midodrine hcl</i>	Preferred	
Vitamins - Drugs For Nutrition		
<i>*Vitamin B-3*** - Drugs For Nutrition</i>		
<i>niacin</i>	Preferred	OTC
<i>niacin er</i>	Preferred	OTC
<i>*Vitamin D*** - Drugs For Nutrition</i>		
<i>ergocalciferol oral capsule</i>	Preferred	
<i>ergocalciferol oral solution</i>	Preferred	OTC
<i>vitamin d</i>	Preferred	OTC
<i>vitamin d (ergocalciferol)</i>	Preferred	
<i>*Vitamin K*** - Drugs For Nutrition</i>		
<i>phytonadione</i>	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs

UPPERCASE BOLD = Brand name drugs

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