CHRISTUS Health Plan

CHRISTUS ELITE
EMPLOYER SPONSORED PLANS

2027 Formulary

CHRISTUS ELITE EMPLOYER SPONSORED PLANS COVERS MEMBERS WITH THE FOLLOWING PLANS:

- Bronze HMO 8500 HSA
- Bronze HMO Enhanced 7500
- Silver HMO 3000
- Silver HMO 6500
- Silver HMO 3100
- Silver HMO 6150 HSA
- Silver HMO Enhanced 5300
- Gold HMO 2250
- Gold HMO 3500 HSA
- Gold HMO Enhanced
- Platinum HMO 350
- Platinum HMO Enhanced 2250
- Platinum HMO 1800 HSA

CHRISTUS Elite
2027 Employer Sponsored Plans
5 Tier Formulary

Revised: 10/15/2026

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

This formulary was updated on 10/15/2026. For more recent information or other questions, please contact CHRISTUS Health Plan Member Services at 1-844-282-3025 (TTY users should call 711), 8 a.m. – 5 p.m. (local time), Monday - Friday, or visit www.christushealthplan.org.

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

When this Drug List (formulary) refers to "we," "us", or "our," it means CHRISTUS Health Plan.

This document includes a Drug List (formulary) for our plan which is current as of 10/15/2026. *For* an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2027, and from time to time during the year.

What is the CHRISTUS Health Plan formulary?

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

Can the formulary change?

Most changes in drug coverage happen on January 1, but CHRISTUS Health Plan may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. Updates to the formulary are posted monthly to our website here: https://www.christushealthplan.org/member-resources/individual-families/pharmacy.

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

  We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

  If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled "How do I request an exception to the CHRISTUS Health Plan's formulary?"

Some of these drug types may be new to you. For more information, see the section below titled "What are original biological products and how are they related to biosimilars?"

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a new generic drug to replace a brand-name drug currently on the formulary, or add a new biosimilar to replace an original biological product currently on the formulary, or add new restrictions or move a drug we are keeping on the formulary to a higher cost-sharing tier or both after we add a corresponding drug. We may make changes based on new clinical guidelines.

  If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the CHRISTUS Health Plan's formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2027 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2027 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 10/15/2026. To get updated information about the drugs covered by CHRISTUS Health Plan please contact us. Our contact information appears on the front and back cover pages.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 3. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. If you know what your drug is used for,

look for the category name in the list that begins on 3. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 65. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

CHRISTUS Health Plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** CHRISTUS Health Plan requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from CHRISTUS Health Plan based on specific criteria before you fill your prescriptions. If you don't get approval, CHRISTUS Health Plan may not cover the drug.

- **Quantity Limits:** For certain drugs, CHRISTUS Health Plan limits the amount of the drug that CHRISTUS Health Plan will cover. For example, CHRISTUS Health Plan provides 10 tablets per 30-day prescription for a specific medication. This may be in addition to a standard one-month or three-month supply.

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

B unless you try Drug A first. If Drug A does not work for you, CHRISTUS Health Plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

What if my drug is not on the formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that CHRISTUS Health Plan does not cover your drug, you have two options:

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

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

How do I request an exception to CHRISTUS Health Plan's formulary?

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

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

- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, CHRISTUS Health Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

- You can ask us to cover a formulary drug at a lower cost-sharing level. If a similar drug is available on a lower tier the cost can be requested to match the cost of that lower tier.

Generally, CHRISTUS Health Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or, formulary exception, including an exception to a coverage restriction. ***When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.*** Generally, we must make our decision within 72

hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

For more information

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

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

CHRISTUS Health Plan is a licensed HMO offering products in Texas and Louisiana. CHRISTUS Health Plan is the registered tradename of CHRISTUS Health Plan Louisiana, a licensed HMO providing products in Louisiana.

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1.844.856.0826, TTY 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1.844.856.0826, TTY 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1.844.856.0826 (711) أو تحدث إلى مقدم الخدمة.

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1.844.856.0826（文本电话：711）或咨询您的服务提供商。

ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1.844.856.0826, TTY 711 ou parlez à votre fournisseur.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1.844.856.0826, TTY 711 an oder sprechen Sie mit Ihrem Provider.

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1.844.856.0826, TTY 711 પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1.844.856.0826, TTY 711 पर कॉल करें या अपने प्रदाता से बात करें।

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1.844.856.0826, TTY 711 までお電話ください。または、ご利用の事業者にご相談ください。

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1.844.856.0826, TTY 711 번으로 전화하거나 서비스 제공업체에 문의하십시오.

ຊົນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1.844.856.0826, TTY 711 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1.844.856.0826 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

ATENÇÃO: Se você fala Português, serviços gratuitos de assestência lingüística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1.844.856.0826, TTY 711 ou fale com seu proveedor.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1.844.856.0826, TTY 711 или обратитесь к своему поставщику услуг.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1.844.856.0826, TTY 711 o makipag-usap sa iyong provider.

หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1.844.856.0826, TTY 711 หรือปรึกษาผู้ให้บริการของคุณ

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1.844.856.0826, TTY 711 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1.844.856.0826 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

List of Abbreviations

AGE - Age Limit. Certain medications may only be covered for members within specific age ranges.

GNDR - Gender Edit. The edit is typically used for drugs that are generally associated with a specific sex or gender-based clinical indication.

LA: Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.

OTC: Over the Counter. An OTC drug is a non-prescription drug.

QL: Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover.

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

Cost-Sharing Tiers for Drugs on the Formulary

Every drug on our plan's Formulary is in a cost-sharing tier. In general, the higher the tier, the higher your cost for the drug. The amount you pay for drugs in each cost-sharing tier is shown in your Summary of Benefits and Coverage.

Employer Sponsored Plans Tiering

Cost Level	Cost-Sharing Tier	Requirements/Limits
Lowest Cost-Sharing Tier	Tier 1	Preferred Generic Drugs
	Tier 2	Non-Preferred Generic Drugs
	Tier 3	Preferred Brand Drugs
	Tier 4	Non-Preferred Brand Drugs
Highest Cost-Sharing Tier	Tier 5	Specialty Drugs

The CHRISTUS Health Plan formulary that begins on the next page provides coverage information about the drugs covered by CHRISTUS Health Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 65.

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

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

5T STND Effective 01/01/2027

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
COX-2 INHIBITORS		
celecoxib	1	
GOUT		
allopurinol	1	
colchicine	1	
colchicine w/ probenecid	1	
febuxostat	1	ST; PA**
probenecid	1	
NSAIDS		
diclofenac potassium	1	
diclofenac sodium	1	
diclofenac sodium (topical)	1	QL (300g every 30 days), OTC
etodolac	1	
flurbiprofen	1	
ibuprofen	1	
ketorolac tromethamine soln	1	
ketorolac tromethamine tabs	1	QL (20 tabs every 30 days)
meclofenamate sodium	1	
mefenamic acid	1	
meloxicam	1	
nabumetone	1	
naproxen	1	
oxaprozin	1	
piroxicam	1	
sulindac	1	
voltaren arthritis pain	1	QL (300g every 30 days), OTC
NSAIDS, COMBINATIONS		
diclofenac w/ misoprostol	1	
OPIOID ANALGESICS		
acetaminophen w/ codeine soln	1	ST, QL (2700 mL every 30 days); Subject to initial 7-day limit
acetaminophen w/ codeine tabs	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
acetaminophen w/ codeine tabs	1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit

Drug Name	Drug Tier	Requirements/Limits
acetaminophen w/ codeine tabs	1	ST, QL (400 tabs every 30 days); Subject to initial 7-day limit
acetaminophen-caff-dihydrocod	1	ST, QL (300 caps every 30 days); Subject to initial 7-day limit
butorphanol tartrate 1mg/ml, 2mg/ml	1	
butorphanol tartrate 10mg/ml	1	QL (2 bottles every 30 days)
codeine sulfate 30mg	1	ST, QL (42 tabs every 30 days); Subject to initial 7-day limit
CODEINE SULFATE 60MG	3	ST, QL (42 tabs every 30 days); Subject to initial 7-day limit
endocet tab 2.5-325	1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit
endocet tab 5-325mg	1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit
endocet tab 7.5-325	1	ST, QL (240 tabs every 30 days); Subject to initial 7-day limit
endocet tab 10-325mg	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
fentanyl 12mcg/hr, 25mcg/hr, 37.5mcg/hr	1	ST, QL (10 patches every 30 days)
fentanyl 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr	1	ST, PA; High Strength Requires PA
hydrocodone bitartrate 20mg, 30mg, 40mg, 60mg, 80mg	1	ST, QL (30 tabs every 30 days)
hydrocodone bitartrate 100mg, 120mg	1	ST, PA; High Strength Requires PA
hydrocodone-acetaminophen soln	1	ST, QL (2700 mL every 30 days); Subject to initial 7-day limit
hydrocodone-acetaminophen tabs	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
hydrocodone-acetaminophen tabs	1	ST, QL (240 tabs every 30 days); Subject to initial 7-day limit
hydrocodone-ibuprofen	1	ST, QL (50 tabs every 30 days); Subject to initial 7-day limit
hydromorphone hcl soln	1	

Drug Name	Drug Tier	Requirements/Limits
hydromorphone hcl tabs 2mg	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
hydromorphone hcl tabs 4mg	1	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit
hydromorphone hcl tabs 8mg	1	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit
hydromorphone hcl tb24 8mg, 12mg, 16mg	1	ST, QL (30 tabs every 30 days)
hydromorphone hcl tb24 32mg	1	ST, PA; High Strength Requires PA
methadone hcl conc	1	QL (30 mL every 30 days); (indicated for opioid addiction)
methadone hcl soln 5mg/5ml	1	ST, QL (450 mL every 30 days)
methadone hcl soln 10mg/5ml	1	ST, QL (225 mL every 30 days)
methadone hcl tabs 5mg	1	ST, QL (90 tabs every 30 days)
methadone hcl tabs 10mg	1	ST, QL (30 tabs every 30 days)
methadone hydrochloride i	1	ST, QL (45 mL every 30 days); (generic of Methadone Intensol, indicated for pain)
methadose	1	QL (9 tabs every 30 days)
morphine sulfate soln 4mg/ml, 10mg/ml	1	
morphine sulfate soln 10mg/5ml	1	ST, QL (900 mL every 30 days); Subject to initial 7-day limit
morphine sulfate soln 20mg/5ml	1	ST, QL (675 mL every 30 days); Subject to initial 7-day limit
morphine sulfate soln 100mg/5ml	1	ST, QL (135 mL every 30 days); Subject to initial 7-day limit
morphine sulfate tabs 15mg	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
morphine sulfate tabs 30mg	1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit
morphine sulfate tbcr 15mg, 30mg	1	ST, QL (90 tabs every 30 days)
morphine sulfate tbcr 60mg, 100mg, 200mg	1	ST, PA; High Strength Requires PA

Drug Name	Drug Tier	Requirements/Limits
morphine sulfate beads 30mg, 45mg, 60mg, 75mg, 90mg	1	ST, QL (30 caps every 30 days)
morphine sulfate beads 120mg	1	ST, PA; High Strength Requires PA
nalbuphine hcl	1	
NUCYNTA 50MG	3	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit
NUCYNTA 75MG	3	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit
NUCYNTA 100MG	3	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit
NUCYNTA ER 50MG, 100MG	3	ST, QL (60 tabs every 30 days)
NUCYNTA ER 150MG, 200MG, 250MG	3	ST, PA; High Strength Requires PA
oxycodone hcl caps	1	ST, QL (180 caps every 30 days); Subject to initial 7-day limit
oxycodone hcl conc	1	ST, QL (90 mL every 30 days); Subject to initial 7-day limit
oxycodone hcl soln	1	ST, QL (900 mL every 30 days); Subject to initial 7-day limit
oxycodone hcl tabs 5mg, 10mg	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
oxycodone hcl tabs 15mg	1	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit
oxycodone hcl tabs 20mg	1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit
oxycodone hcl tabs 30mg	1	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit
oxycodone w/ acetaminophen	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
oxycodone w/ acetaminophen	1	ST, QL (240 tabs every 30 days); Subject to initial 7-day limit
oxycodone w/ acetaminophen	1	ST, QL (360 tabs every 30 days); Subject to initial 7-day limit

Drug Name	Drug Tier	Requirements/Limits
oxymorphone hcl tabs 5mg	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
oxymorphone hcl tabs 10mg	1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit
oxymorphone hcl tb12 5mg, 7.5mg, 10mg, 15mg	1	ST, QL (60 tabs every 30 days)
oxymorphone hcl tb12 20mg, 30mg, 40mg	1	ST, PA; High Strength Requires PA
tapentadol hcl 50mg	1	ST, QL (120 tabs every 30 days); Subject to initial 7-day limit
tapentadol hcl 75mg	1	ST, QL (90 tabs every 30 days); Subject to initial 7-day limit
tapentadol hcl 100mg	1	ST, QL (60 tabs every 30 days); Subject to initial 7-day limit
tramadol hcl tabs	1	ST, QL (180 tabs every 30 days); Subject to initial 7-day limit
tramadol hcl tb24 100mg	1	ST, QL (30 tabs every 30 days)
tramadol hcl tb24 200mg, 300mg	1	ST, PA; High Strength Requires PA
tramadol-acetaminophen	1	ST, QL (40 tabs every 30 days); Subject to initial 7-day limit
XTAMPZA ER 9MG, 13.5MG, 18MG, 27MG	2	ST, QL (60 caps every 30 days)
XTAMPZA ER 36MG	2	ST, PA; High Strength Requires Prior Auth
OPIOID PARTIAL AGONISTS		
BELBUCA 75MCG, 150MCG, 300MCG, 450MCG	2	ST, QL (60 films every 30 days)
BELBUCA 600MCG, 750MCG, 900MCG	2	ST, PA; High Strength Requires Prior Auth
buprenorphine 5mcg/hr, 7.5mcg/hr, 10mcg/hr	1	ST, QL (4 patches every 30 days)
buprenorphine 15mcg/hr, 20mcg/hr	1	ST, PA; High Strength Requires Prior Auth
buprenorphine hcl	1	
SUBLOCADE	4	

Drug Name	Drug Tier	Requirements/Limits
SALICYLATES		
aspirin ec adult low dose	0	QL (100 tabs every 30 days), OTC; $0 copay for members at risk for preeclampsia, otherwise not covered
diflunisal	1	
goodsense aspirin	0	QL (100 tabs every 30 days), OTC; $0 copay for members at risk for preeclampsia, otherwise not covered
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.)	1	
ANTI-INFECTIVES		
ANTHELMINTICS		
albendazole	3	QL (336 tabs every 365 days)
EMVERM	3	QL (12 tabs every 365 days)
ivermectin	1	
praziquantel	1	QL (24 tabs every 365 days)
ANTI-BACTERIALS - MISCELLANEOUS		
amikacin sulfate	1	
fosfomycin tromethamine	1	
gentamicin sulfate	1	
neomycin sulfate	1	
sulfadiazine	1	
tinidazole	1	
tobramycin sulfate soln	1	QL (36 mL every day); Initial limit allows up to a 10 day course every 365 days
tobramycin sulfate solr	1	QL (2 vials every day); Initial limit allows up to a 10 day course every 365 days
ANTIFUNGALS		
amphotericin b	1	QL (3 vials every day); Initial limit allows up to a 14 day course every 365 days
CRESEMBA	3	
fluconazole	1	
griseofulvin microsize	1	
griseofulvin ultramicrosize	1	
itraconazole	1	PA
nystatin	1	
posaconazole susp	1	PA
posaconazole tbec	3	PA

Drug Name	Drug Tier	Requirements/Limits
terbinafine hcl	1	
voriconazole	3	PA
ANTIMALARIALS		
atovaquone-proguanil hcl	1	
chloroquine phosphate	1	
COARTEM	3	
KRINTAFEL	3	
mefloquine hcl	1	
primaquine phosphate	1	
quinine sulfate	1	
ANTIRETROVIRAL AGENTS		
abacavir sulfate soln	1	QL (900 mL every 30 days)
abacavir sulfate tabs	1	QL (60 tabs every 30 days)
APRETUDE	0	QL (2 vials every 90 days)
APTIVUS	2	QL (120 caps every 30 days)
atazanavir sulfate 150mg, 300mg	1	QL (30 caps every 30 days)
atazanavir sulfate 200mg	1	QL (60 caps every 30 days)
darunavir 600mg	1	QL (60 tabs every 30 days)
darunavir 800mg	1	QL (30 tabs every 30 days)
EDURANT PED	2	QL (180 tabs every 30 days)
efavirenz	1	QL (30 tabs every 30 days)
emtricitabine	1	QL (30 caps every 30 days)
EMTRIVA	2	QL (680 ml every 28 days)
etravirine 100mg	1	QL (120 tabs every 30 days)
etravirine 200mg	1	QL (60 tabs every 30 days)
fosamprenavir calcium	1	QL (120 tabs every 30 days)
INTELENCE	2	QL (120 tabs every 30 days)
ISENTRESS CHEW	2	QL (180 tabs every 30 days)
ISENTRESS PACK	2	QL (60 packets every 30 days)
ISENTRESS TABS	2	QL (120 tabs every 30 days)
ISENTRESS HD	2	QL (60 tabs every 30 days)
lamivudine soln	1	QL (960 ml every 30 days)
lamivudine tabs 150mg	1	QL (60 tabs every 30 days)
lamivudine tabs 300mg	1	QL (30 tabs every 30 days)
maraviroc 150mg	1	QL (60 tabs every 30 days)
maraviroc 300mg	1	QL (120 tabs every 30 days)
nevirapine susp	1	QL (1200 mL every 30 days)
nevirapine tabs	1	QL (60 tabs every 30 days)
nevirapine tb24	1	QL (30 tabs every 30 days)
NORVIR	2	QL (360 packets every 30 days)
PREZISTA SUSP	2	QL (400 ml every 30 days)

Drug Name	Drug Tier	Requirements/Limits
PREZISTA TABS 75MG	2	QL (300 tabs every 30 days)
PREZISTA TABS 150MG	2	QL (180 tabs every 30 days)
RETROVIR IV INFUSION	2	
REYATAZ	2	QL (180 packets every 30 days)
rilpivirine hcl	1	QL (60 tabs every 30 days)
ritonavir	1	QL (360 tabs every 30 days)
SELZENTRY	2	QL (1840 mL every 30 days)
tenofovir disoproxil fumarate	1	QL (30 tabs every 30 days)
TIVICAY	2	QL (60 tabs every 30 days)
TIVICAY PD	2	QL (360 tabs every 30 days)
TROGARZO	4	
VIREAD POWD	2	QL (240 gm every 30 days)
VIREAD TABS	2	QL (30 tabs every 30 days)
YEZTUGO SOLN	2	QL (4 vials every 168 days)
YEZTUGO TABS	2	QL (8 tabs every 4 days)
zidovudine caps	1	QL (180 caps every 30 days)
zidovudine syrp	1	QL (1920 ml every 30 days)
zidovudine tabs	1	QL (60 tabs every 30 days)
ANTIRETROVIRAL COMBINATION AGENTS		
abacavir sulfate-lamivudine	1	QL (30 tabs every 30 days)
BIKTARVY	2	QL (30 tabs every 30 days)
CABENUVA	5	PA, QL (1 kit every 30 days)
CABENUVA	5	PA, QL (1 kit every 60 days); Loading dose of 1 kit in 30 days allowed for initial fill
CIMDUO	2	QL (30 tabs every 30 days)
DELSTRIGO	2	QL (30 tabs every 30 days)
DESCOVY	0	QL (30 tabs every 30 days); $0 copay when medically necessary for pre-exposure prophylaxis; copay applies for treatment
DESCOVY	3	QL (30 tabs every 30 days)
DOVATO	2	QL (30 tabs every 30 days)
efavirenz-emtricitabine-tenofovir disoproxil fumarate	1	QL (30 tabs every 30 days)
efavirenz-lamivudine-tenofovir disoproxil fumarate	1	QL (30 tabs every 30 days)
emtricitabine-tenofovir disoproxil fumarate	0	QL (30 tabs every 30 days); $0 copay when medically necessary for pre-exposure prophylaxis; copay applies for treatment
emtricitabine-tenofovir disoproxil fumarate	1	QL (30 tabs every 30 days)
GENVOYA	2	QL (30 tabs every 30 days)

Drug Name	Drug Tier	Requirements/Limits
KALETRA	2	QL (480 ml every 30 days)
lamivudine-zidovudine	1	QL (60 tabs every 30 days)
lopinavir-ritonavir	1	QL (120 tabs every 30 days)
lopinavir-ritonavir	1	QL (300 tabs every 30 days)
ODEFSEY	2	QL (30 tabs every 30 days)
PREZCOBIX	3	QL (30 tabs every 30 days)
SYMTUZA	3	QL (30 tabs every 30 days)
TRIUMEQ	3	QL (30 tabs every 30 days)
TRIUMEQ PD	3	QL (180 tabs every 30 days)
ANTITUBERCULAR AGENTS		
cycloserine	1	
ethambutol hcl	1	
isoniazid	1	
PRETOMANID	3	
PRIFTIN	2	
pyrazinamide	1	
rifabutin	1	
rifampin	1	
SIRTURO	3	
ANTIVIRALS		
acyclovir	1	
cidofovir	1	
famciclovir	1	
oseltamivir phosphate caps 30mg	1	QL (40 caps every 90 days)
oseltamivir phosphate caps 45mg, 75mg	1	QL (20 caps every 90 days)
oseltamivir phosphate susr	1	QL (360 mL every 90 days)
PAXLOVID	2	QL (22 tabs every 30 days)
PAXLOVID	2	QL (40 tabs every 30 days)
PAXLOVID	2	QL (60 tabs every 30 days)
RELENZA DISKHALER	2	QL (2 inhalers every 90 days)
rimantadine hydrochloride	1	
valacyclovir hcl	1	
valganciclovir hcl solr	4	PA, QL (1144 mL every 30 days)
valganciclovir hcl tabs	4	PA, QL (120 tabs every 30 days)
XERESE	3	PA
CEPHALOSPORINS		
cefaclor	1	
cefadroxil	1	
cefazolin sodium	1	
cefdinir	1	
cefepime hcl	1	

Drug Name	Drug Tier	Requirements/Limits
cefixime	1	
cefpodoxime proxetil	1	
cefprozil	1	
ceftazidime	1	
ceftriaxone sodium 1gm, 2gm, 250mg, 500mg	1	QL (2 vials every day); Initial limit allows up to a 14 day course every 365 days
ceftriaxone sodium 10gm	1	QL (0.5 vials every day); Initial limit allows up to a 14 day course every 365 days
cefuroxime axetil	1	
cephalexin	1	
tazicef	1	
ERYTHROMYCINS/MACROLIDES		
azithromycin	1	
clarithromycin	1	
DIFICID	2	PA
e.e.s. 400	1	
erythromycin base	1	
erythromycin ethylsuccinate	1	
fidaxomicin	1	PA
FLUOROQUINOLONES		
BAXDELA	3	
CIPRO	3	
ciprofloxacin hcl	1	
levofloxacin soln 25mg/ml	1	
levofloxacin soln 25mg/ml	1	QL (40 mL every day); Initial limit allows up to a 14 day course every 365 days
levofloxacin tabs	1	
moxifloxacin hcl	1	
ofloxacin	1	
HEPATITIS B		
adefovir dipivoxil	4	
BARACLUDE	4	PA, QL (630 mL every 30 days)
entecavir	4	PA, QL (30 tabs every 30 days)
lamivudine (hbv)	1	
HEPATITIS C		
MAVYRET PACK	2	PA, QL (140 packets every 28 days)
MAVYRET TABS	2	PA, QL (84 tabs every 28 days)

Drug Name	Drug Tier	Requirements/Limits
PEGASYS	4	PA
ribavirin (hepatitis c)	1	
SOVALDI PACK 150MG	5	ST, PA, QL (28 pellets every 28 days)
SOVALDI PACK 200MG	5	ST, PA, QL (56 pellets every 28 days)
SOVALDI TABS 200MG	5	ST, PA, QL (56 tabs every 28 days)
SOVALDI TABS 400MG	5	ST, PA, QL (28 tabs every 28 days)
MISCELLANEOUS		
atovaquone	1	
aztreonam	1	
clindamycin hcl	1	
clindamycin palmitate hydrochloride	1	
dapsone	1	
ertapenem sodium	1	QL (2 vials every day); Initial limit allows up to a 14 day course every 365 days
lincomycin hcl	1	
linezolid	1	
meropenem 1gm	1	QL (6 vials every day); Initial limit allows up to a 14 day course every 365 days
meropenem 500mg	1	QL (12 vials every day); Initial limit allows up to a 14 day course every 365 days
methenamine hippurate	1	
metronidazole	1	
nitazoxanide	1	QL (20 tabs every 30 days)
nitrofurantoin	1	
nitrofurantoin macrocrystal	1	
nitrofurantoin monohyd macro	1	
pentamidine isethionate	1	
polymyxin b sulfate	1	
pyrimethamine	3	PA
sulfamethoxazole-trimethoprim	1	
trimethoprim	1	
vancomycin hcl caps	1	QL (80 caps every 10 days)
vancomycin hcl solr 1gm	1	QL (2 vials every day); Initial limit allows up to a 14 day course every 365 days
vancomycin hcl solr 5gm, 10gm	1	QL (0.3 bottles every day); Initial limit allows up to a 14 day course every 365 days

Drug Name	Drug Tier	Requirements/Limits
vancomycin hcl solr 500mg, 750mg	1	QL (4 vials every day); Initial limit allows up to a 14 day course every 365 days
PENICILLINS		
amoxicillin	1	
amoxicillin & pot clavulanate	1	
ampicillin	1	
ampicillin sodium	1	
dicloxacillin sodium	1	
penicillin g potassium	1	
penicillin g sodium	1	
penicillin v potassium	1	
pfizerpen	1	
piperacillin sodium-tazobactam sodium	1	
TETRACYCLINES		
avidoxy	1	
demeclocycline hcl	1	
doxy 100	1	
doxycycline (monohydrate)	1	
doxycycline hyclate	1	
minocycline hcl	1	
tetracycline hcl	1	QL (120 caps every 30 days)
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
busulfan	1	
carmustine	1	
cyclophosphamide caps	1	
cyclophosphamide solr	4	
dacarbazine	1	
GLIADEL WAFER	2	
ifosfamide	1	
LEUKERAN	2	
lomustine	1	
MATULANE	2	
melphalan hcl	1	
TEMODAR	4	PA
temozolomide	4	PA
ANTIBIOTICS		
adriamycin	1	
bleomycin sulfate	1	
daunorubicin hcl	1	
doxorubicin hcl	1	
doxorubicin hcl liposomal	1	

Drug Name	Drug Tier	Requirements/Limits
idarubicin hcl	1	
mitomycin	1	
mitoxantrone hcl	4	
ANTIMETABOLITES		
azacitidine	4	PA
capecitabine	4	PA
cladribine	1	
clofarabine	1	
cytarabine	1	
decitabine	4	PA
fludarabine phosphate	1	
fluorouracil	1	
gemcitabine hcl	4	
mercaptopurine	1	
methotrexate sodium	1	
NIPENT	2	
pemetrexed disodium	4	
TABLOID	2	
ANTINEOPLASTIC, BCL-2 INHIBITORS		
VENCLEXTA 10MG, 50MG	4	PA, QL (120 tabs every 30 days)
VENCLEXTA 100MG	4	PA, QL (180 tabs every 30 days)
VENCLEXTA STARTING PACK	4	PA, QL (1 pack every 28 days)
BIOLOGIC RESPONSE MODIFIERS		
ERBITUX	4	PA
ERIVEDGE	4	PA, QL (30 caps every 30 days)
KADCYLA	4	PA
KEYTRUDA	4	PA
lenalidomide 2.5mg, 5mg, 10mg, 15mg	4	PA, QL (28 caps every 28 days)
lenalidomide 20mg, 25mg	4	PA, QL (21 caps every 28 days)
PADCEV 20MG	5	PA, QL (21 vials every 28 days)
PADCEV 30MG	5	PA, QL (15 vials every 28 days)
pomalidomide	4	PA, QL (21 caps every 28 days)
THALOMID 50MG	5	PA, QL (28 caps every 28 days)
THALOMID 100MG	5	PA, QL (112 caps every 28 days)

Drug Name	Drug Tier	Requirements/Limits
TICE BCG	2	
BIOSIMILARS		
GAZYVA	4	PA
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate 250mg	4	PA, QL (120 tabs every 30 days)
abiraterone acetate 500mg	4	PA, QL (60 tabs every 30 days)
anastrozole	1	$0 copay for women ages 35 and older for the primary prevention of breast cancer
bicalutamide	1	
ELIGARD	4	PA
ERLEADA 60MG	4	PA, QL (120 tabs every 30 days)
ERLEADA 240MG	4	PA, QL (30 tabs every 30 days)
exemestane	1	$0 copay for women ages 35 and older for the primary prevention of breast cancer
fulvestrant	4	PA
letrozole	1	
leuprolide acetate	4	PA
LYSODREN	2	
megestrol acetate	1	
nilutamide	1	
NUBEQA	4	PA, QL (120 tabs every 30 days)
tamoxifen citrate	1	$0 copay for women ages 35 and older for the primary prevention of breast cancer
toremifene citrate	1	
XTANDI CAPS	4	PA, QL (120 caps every 30 days)
XTANDI TABS 40MG	4	PA, QL (120 tabs every 30 days)
XTANDI TABS 80MG	4	PA, QL (60 tabs every 30 days)
YONSA	4	PA, QL (120 tabs every 30 days)
KINASE INHIBITORS		
ALECENSA	4	PA, QL (240 caps every 30 days)
BRAFTOVI	4	PA, QL (180 caps every 30 days)

Drug Name	Drug Tier	Requirements/Limits
BRUKINSA CAPS	4	PA, QL (120 caps every 30 days)
BRUKINSA TABS	4	PA, QL (60 tabs every 30 days)
CABOMETYX	4	PA, QL (30 tabs every 30 days)
CALQUENCE	5	PA, QL (60 tabs every 30 days)
CAPRELSA 100MG	4	PA, QL (60 tabs every 30 days)
CAPRELSA 300MG	4	PA, QL (30 tabs every 30 days)
COMETRIQ	4	PA, QL (1 kit every 28 days)
dasatinib 20mg	4	PA, QL (90 tabs every 30 days)
dasatinib 50mg, 70mg, 80mg, 100mg, 140mg	4	PA, QL (30 tabs every 30 days)
erlotinib hcl 25mg	4	PA, QL (60 tabs every 30 days)
erlotinib hcl 100mg, 150mg	4	PA, QL (30 tabs every 30 days)
everolimus tabs	4	PA, QL (30 tabs every 30 days)
everolimus tbso 2mg, 5mg	4	PA, QL (60 tabs every 30 days)
everolimus tbso 3mg	4	PA, QL (90 tabs every 30 days)
IBTROZI	5	PA, QL (90 caps every 30 days)
imatinib mesylate 100mg	4	PA, QL (120 tabs every 30 days)
imatinib mesylate 400mg	4	PA, QL (60 tabs every 30 days)
IMBRUVICA CAPS 70MG	5	PA, QL (30 caps every 30 days)
IMBRUVICA CAPS 140MG	5	PA, QL (90 caps every 30 days)
IMBRUVICA SUSP	5	PA, QL (216 ml every 36 days)
IMBRUVICA TABS	5	PA, QL (30 tabs every 30 days)
INLYTA 1MG	4	PA, QL (240 tabs every 30 days)
INLYTA 5MG	4	PA, QL (120 tabs every 30 days)
ITOVEBI 3MG	5	PA, QL (60 tabs every 30 days)

Drug Name	Drug Tier	Requirements/Limits
ITOVEBI 9MG	5	PA, QL (30 tabs every 30 days)
JAKAFI	4	PA, QL (60 tabs every 30 days)
KISQALI 200MG	4	PA, QL (21 tabs every 28 days); 200 mg dose
KISQALI 200MG	4	PA, QL (42 tabs every 28 days); 400 mg dose
KISQALI 200MG	4	PA, QL (63 tabs every 28 days); 600 mg dose
lapatinib ditosylate	4	PA, QL (180 tabs every 30 days)
LENVIMA 4 MG DAILY DOSE	5	PA, QL (30 caps every 30 days)
LENVIMA 8 MG DAILY DOSE	5	PA, QL (60 caps every 30 days)
LENVIMA 10 MG DAILY DOSE	5	PA, QL (30 caps every 30 days)
LENVIMA 12MG DAILY DOSE	5	PA, QL (90 caps every 30 days)
LENVIMA 14 MG DAILY DOSE	5	PA, QL (60 caps every 30 days)
LENVIMA 18 MG DAILY DOSE	5	PA, QL (90 caps every 30 days)
LENVIMA 20 MG DAILY DOSE	5	PA, QL (60 caps every 30 days)
LENVIMA 24 MG DAILY DOSE	5	PA, QL (90 caps every 30 days)
LORBRENA 25MG	5	PA, QL (90 tabs every 30 days)
LORBRENA 100MG	5	PA, QL (30 tabs every 30 days)
MEKINIST SOLR	4	PA, QL (12 bottles every 28 days)
MEKINIST TABS 2MG	4	PA, QL (30 tabs every 30 days)
MEKINIST TABS .5MG	4	PA, QL (90 tabs every 30 days)
MEKTOVI	4	PA, QL (180 tabs every 30 days)
nilotinib hcl	4	PA, QL (120 caps every 30 days)
pazopanib hcl	4	PA, QL (120 tabs every 30 days)
RYDAPT	5	PA, QL (224 caps every 28 days)
SCEMBLIX 20MG	4	PA, QL (60 tabs every 30 days)

Drug Name	Drug Tier	Requirements/Limits
SCEMBLIX 40MG	4	PA, QL (240 tabs every 30 days)
SCEMBLIX 100MG	4	PA, QL (120 tabs every 30 days)
sorafenib tosylate	4	PA, QL (120 tabs every 30 days)
STIVARGA	4	PA, QL (84 tabs every 28 days)
sunitinib malate	4	PA, QL (30 caps every 30 days)
TAFINLAR CAPS	4	PA, QL (120 caps every 30 days)
TAFINLAR TBSO	4	PA, QL (4 bottles every 28 days)
TAGRISSO	5	PA, QL (30 tabs every 30 days)
TRUQAP	5	PA, QL (64 tabs every 28 days)
TUKYSA	5	PA, QL (120 tabs every 30 days)
VERZENIO	4	PA, QL (56 tabs every 28 days)
VITRAKVI CAPS 25MG	5	PA, QL (180 caps every 30 days)
VITRAKVI CAPS 100MG	5	PA, QL (60 caps every 30 days)
VITRAKVI SOLN	5	PA, QL (300 mL every 30 days)
XALKORI CAPS	4	PA, QL (120 caps every 30 days)
XALKORI CPSP 20MG, 50MG	4	PA, QL (120 pellets every 30 days)
XALKORI CPSP 150MG	4	PA, QL (180 pellets every 30 days)
ZYDELIG	4	PA, QL (60 tabs every 30 days)
ZYKADIA	4	PA, QL (90 tabs every 30 days)
MISCELLANEOUS		
arsenic trioxide	1	
bexarotene	4	PA
hydroxyurea	1	
IDHIFA	4	PA, QL (30 tabs every 30 days)
LYNPARZA	4	PA, QL (120 tabs every 30 days)

Drug Name	Drug Tier	Requirements/Limits
ODOMZO	4	PA, QL (30 caps every 30 days)
ONCASPAR	4	PA
PHOTOFRIN	2	
POLIVY	5	PA
tretinoin (chemotherapy)	1	
VISTOGARD	4	QL (20 packets every 5 days)
ZEJULA	4	PA, QL (30 tabs every 30 days)
ZOLINZA	4	PA, QL (120 caps every 30 days)
MITOTIC INHIBITORS		
docetaxel	1	
paclitaxel	1	
vinblastine sulfate	1	
vincristine sulfate	1	
vinorelbine tartrate	1	
PLATINUM-BASED AGENTS		
carboplatin	1	
cisplatin	1	
oxaliplatin	4	
PROTECTIVE AGENTS		
dexrazoxane hcl	1	
leucovorin calcium	1	
mesna	1	
TOPOISOMERASE INHIBITORS		
etoposide	1	
irinotecan hcl 40mg/2ml, 100mg/5ml, 500mg/25ml	4	
irinotecan hcl 300mg/15ml	1	
topotecan hcl	1	
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
amlodipine besylate-benazepril hcl	1	
benazepril & hydrochlorothiazide	1	
enalapril maleate & hydrochlorothiazide	1	
fosinopril sodium & hydrochlorothiazide	1	
lisinopril & hydrochlorothiazide	1	
quinapril-hydrochlorothiazide	1	
trandolapril-verapamil hcl	1	
ACE INHIBITORS		
benazepril hcl	1	
captopril	1	
enalapril maleate	1	

Drug Name	Drug Tier	Requirements/Limits
fosinopril sodium	1	
lisinopril	1	
moexipril hcl	1	
perindopril erbumine	1	
quinapril hcl	1	
ramipril	1	
trandolapril	1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
eplerenone	1	
KERENDIA	3	PA
spironolactone	1	
ALPHA BLOCKERS		
prazosin hcl	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
amlodipine besylate-valsartan	1	
candesartan cilexetil-hydrochlorothiazide	1	
irbesartan-hydrochlorothiazide	1	
losartan potassium & hydrochlorothiazide	1	
olmesartan medoxomil-amlodipine-hydrochlorothiazide	1	
olmesartan medoxomil-hydrochlorothiazide	1	
telmisartan-hydrochlorothiazide	1	
valsartan-hydrochlorothiazide	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil	1	
irbesartan	1	
losartan potassium	1	
olmesartan medoxomil	1	
telmisartan	1	
valsartan	1	
ANTIARRHYTHMICS		
amiodarone hcl	1	
disopyramide phosphate	1	
dofetilide	1	
flecainide acetate	1	
lidocaine hcl (cardiac)	1	
MULTAQ	2	PA
NORPACE CR	2	
pacerone	1	
procainamide hcl	1	
propafenone hcl	1	
sotalol hcl	1	
sotalol hcl (afib/afl)	1	

Drug Name	Drug Tier	Requirements/Limits
ANTILIPEMICS, ACL INHIBITORS/COMBINATIONS		
NEXLETOL	3	PA
ANTILIPEMICS, BILE ACID RESINS		
cholestyramine	1	
cholestyramine light	1	
colesevelam hcl	1	
colestipol hcl	1	
prevalite	1	
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR		
ezetimibe	1	
ANTILIPEMICS, FIBRATES		
choline fenofibrate	1	
fenofibrate	1	
fenofibrate micronized	1	
gemfibrozil	1	
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS		
atorvastatin calcium 10mg, 20mg	1	$0 copay for members age 40 through 75
atorvastatin calcium 40mg, 80mg	1	Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
fluvastatin sodium	1	$0 copay for members age 40 through 75
lovastatin	1	$0 copay for members age 40 through 75
pitavastatin calcium	1	$0 copay for members age 40 through 75
pravastatin sodium	1	$0 copay for members age 40 through 75
rosuvastatin calcium 5mg, 10mg	1	$0 copay for members age 40 through 75
rosuvastatin calcium 20mg, 40mg	1	Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
simvastatin 5mg, 10mg, 20mg, 40mg	1	$0 copay for members age 40 through 75

Drug Name	Drug Tier	Requirements/Limits
simvastatin 80mg	1	ST; PA**; Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS		
ezetimibe-simvastatin	1	
ANTILIPEMICS, MISCELLANEOUS		
niacin (antihyperlipidemic)	1	
ANTILIPEMICS, OMEGA-3 FATTY ACIDS		
omega-3-acid ethyl esters	1	
VASCEPA	1	
ANTILIPEMICS, PCSK9 INHIBITORS		
REPATHA	2	QL (3 syringes every 28 days)
REPATHA SURECLICK	2	QL (3 pens every 28 days)
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol & chlorthalidone	1	
bisoprolol & hydrochlorothiazide	1	
metoprolol & hydrochlorothiazide	1	
BETA-BLOCKERS		
acebutolol hcl	1	
atenolol	1	
betaxolol hcl	1	
bisoprolol fumarate	1	
carvedilol	1	
carvedilol phosphate	1	
labetalol hcl	1	
metoprolol succinate	1	
metoprolol tartrate	1	
nadolol	1	
nebivolol hcl	1	
pindolol	1	
propranolol hcl	1	
timolol maleate	1	
CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS		
amlodipine besylate-atorvastatin calcium	1	
CALCIUM CHANNEL BLOCKERS		
amlodipine besylate	1	
cartia xt	1	
dilt-xr	1	
diltiazem hcl	1	

Drug Name	Drug Tier	Requirements/Limits
diltiazem hcl coated beads	1	
diltiazem hcl extended release beads	1	
felodipine	1	
isradipine	1	
matzim la	1	
nicardipine hcl	1	
nifedipine	1	
nimodipine	1	
nisoldipine	1	
verapamil hcl	1	
DIGITALIS GLYCOSIDES		
digoxin	1	
DIRECT RENIN INHIBITORS/COMBINATIONS		
aliskiren fumarate	1	
DIURETICS		
acetazolamide	1	
amiloride & hydrochlorothiazide	1	
amiloride hcl	1	
bumetanide	1	
chlorthalidone	1	
ethacrynic acid	3	
furosemide	1	
hydrochlorothiazide	1	
indapamide	1	
mannitol	1	
methazolamide	1	
metolazone	1	
spironolactone & hydrochlorothiazide	1	
torsemide	1	
triamterene	1	
triamterene & hydrochlorothiazide	1	
HEART FAILURE		
CORLANOR	2	
ENTRESTO	3	
isosorbide dinitrate-hydralazine hcl	1	
ivabradine hcl	1	
sacubitril-valsartan	1	
MISCELLANEOUS		
clonidine	1	
clonidine hcl	1	
guanfacine hcl	1	
hydralazine hcl	1	
methyldopa	1	

Drug Name	Drug Tier	Requirements/Limits
midodrine hcl	1	
minoxidil	1	
phenoxybenzamine hcl	4	PA, QL (360 caps every 30 days)
ranolazine	1	ST; PA**
NITRATES		
isosorbide dinitrate	1	
isosorbide mononitrate	1	
nitro-bid	1	
NITRO-DUR	2	
nitroglycerin	1	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS	4	PA, QL (90 tabs every 30 days)
ambrisentan	4	PA, QL (30 tabs every 30 days)
bosentan tabs	4	PA, QL (60 tabs every 30 days)
bosentan tbso	4	PA, QL (112 tabs every 28 days)
OPSUMIT	4	PA, QL (30 tabs every 30 days)
sildenafil citrate (pulmonary hypertension) soln	4	PA, QL (90 vials every 30 days)
sildenafil citrate (pulmonary hypertension) tabs	4	PA, QL (360 tabs every 30 days)
tadalafil (pulmonary hypertension)	4	PA, QL (60 tabs every 30 days)
treprostinil	4	PA
UPTRAVI SOLR	4	PA, QL (60 vials every 30 days)
UPTRAVI TABS 200MCG	4	PA, QL (140 tabs every 28 days)
UPTRAVI TABS 400MCG, 600MCG, 800MCG, 1000MCG, 1200MCG, 1400MCG, 1600MCG	4	PA, QL (60 tabs every 30 days)
UPTRAVI TITRATION PACK	4	PA, QL (1 pack every 28 days)
CENTRAL NERVOUS SYSTEM		
ALCOHOL DETERRENTS		
acamprosate calcium	1	
disulfiram	1	
AMYOTROPHIC LATERAL SCLEROSIS (ALS)		
riluzole	1	
ANTIANXIETY		
alprazolam	1	QL (150 tabs every 30 days)

Drug Name	Drug Tier	Requirements/Limits
ALPRAZOLAM INTENSOL	2	QL (300 mL every 30 days)
buspirone hcl	1	
chlordiazepoxide hcl	1	QL (360 caps every 30 days)
clomipramine hcl	1	
fluvoxamine maleate	1	
lorazepam conc	1	QL (150 mL every 30 days)
lorazepam tabs	1	QL (150 tabs every 30 days)
meprobamate	1	
oxazepam	1	QL (120 caps every 30 days)
ANTIDEMENTIA		
donepezil hydrochloride	1	
galantamine hydrobromide	1	
memantine hcl	1	
rivastigmine	1	
rivastigmine tartrate	1	
ANTIDEPRESSANTS		
amitriptyline hcl	1	
amoxapine	1	
bupropion hcl	1	
citalopram hydrobromide	1	
desipramine hcl	1	
desvenlafaxine succinate	1	(generic of Pristiq)
doxepin hcl	1	
duloxetine hcl	1	
EMSAM	3	PA
escitalopram oxalate	1	
FETZIMA	3	
FETZIMA TITRATION PACK	3	
fluoxetine hcl caps; cpdr; soln	1	
fluoxetine hcl tabs	1	(generic Sarafem not covered)
imipramine hcl	1	
imipramine pamoate	1	
MARPLAN	3	
mirtazapine	1	
nefazodone hcl	1	
nortriptyline hcl	1	
paroxetine hcl	1	
phenelzine sulfate	1	
protriptyline hcl	1	
sertraline hcl	1	
SPRAVATO 56MG DOSE	4	PA
SPRAVATO 84MG DOSE	4	PA

Drug Name	Drug Tier	Requirements/Limits
tranylcypromine sulfate	1	
trazodone hcl	1	
trimipramine maleate	1	
TRINTELLIX	3	
venlafaxine hcl	1	
vilazodone hcl	1	
ANTIPARKINSONIAN AGENTS		
amantadine hcl	1	
APOKYN	5	ST, PA, QL (20 cartridges every 30 days)
benztropine mesylate	1	
bromocriptine mesylate	1	
carbidopa	1	
carbidopa-levodopa	1	
carbidopa-levodopa-entacapone	1	
entacapone	1	
INBRIJA	4	PA, QL (300 caps every 30 days)
NEUPRO	2	
ONGENTYS	3	PA
pramipexole dihydrochloride	1	
rasagiline mesylate	1	
ropinirole hydrochloride	1	
selegiline hcl	1	
trihexyphenidyl hcl	1	
ANTIPSYCHOTICS		
aripiprazole	1	
ARISTADA	2	
ARISTADA INITIO	2	
asenapine maleate	1	
chlorpromazine hcl	1	
clozapine	1	
COBENFY	3	
COBENFY STARTER PACK	3	
ERZOFRI	2	
fluphenazine decanoate	1	
fluphenazine hcl	1	
haloperidol	1	
haloperidol decanoate	1	
haloperidol lactate	1	
INVEGA HAFYERA	2	
INVEGA SUSTENNA	2	
INVEGA TRINZA	2	

Drug Name	Drug Tier	Requirements/Limits
loxapine succinate	1	
lurasidone hcl	1	
olanzapine	1	
paliperidone	1	
perphenazine	1	
quetiapine fumarate	1	
risperidone	1	
RYKINDO	2	
thioridazine hcl	1	
thiothixene	1	
trifluoperazine hcl	1	
VRAYLAR	2	
ziprasidone hcl	1	
ANTISEIZURE AGENTS		
carbamazepine	1	
clobazam	1	
clonazepam	1	
clorazepate dipotassium	1	QL (180 tabs every 30 days)
diazepam soln 5mg/5ml	1	QL (1200 mL every 30 days)
diazepam soln 5mg/ml	1	
diazepam tabs	1	QL (120 tabs every 30 days)
diazepam intensol	1	QL (240 mL every 30 days)
DILANTIN	3	
divalproex sodium	1	
ethosuximide	1	
felbamate	1	
fosphenytoin sodium	1	
gabapentin	1	
lacosamide	1	
lamotrigine	1	
levetiracetam	1	
levetiracetam in sodium chloride	1	
methsuximide	1	
NAYZILAM	2	QL (10 units every 30 days)
oxcarbazepine	1	
perampanel	1	
phenobarbital	1	
phenytoin	1	
phenytoin infatabs	1	
phenytoin sodium	1	
phenytoin sodium extended	1	
pregabalin	1	
primidone	1	

Drug Name	Drug Tier	Requirements/Limits
rufinamide	1	
tiagabine hcl	1	
topiramate	1	
valproate sodium	1	
valproic acid	1	
vigabatrin pack	4	PA, QL (180 packets every 30 days)
vigabatrin tabs	4	PA, QL (180 tabs every 30 days)
XCOPRI	2	
zonisamide	1	
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
amphetamine 3.1mg, 6.3mg, 9.4mg	1	QL (60 tabs every 30 days)
amphetamine 12.5mg, 15.7mg, 18.8mg	1	QL (30 tabs every 30 days)
amphetamine-dextroamphetamine cp24	1	QL (30 caps every 30 days)
amphetamine-dextroamphetamine cp24	1	QL (90 caps every 30 days)
amphetamine-dextroamphetamine tabs	1	QL (30 tabs every 30 days)
amphetamine-dextroamphetamine tabs	1	QL (60 tabs every 30 days)
amphetamine-dextroamphetamine tabs	1	QL (90 tabs every 30 days)
atomoxetine hcl	1	
AZSTARYS	2	QL (30 caps every 30 days)
dexmethylphenidate hcl cp24 5mg, 10mg, 15mg, 20mg	1	QL (60 caps every 30 days)
dexmethylphenidate hcl cp24 25mg, 30mg, 35mg, 40mg	1	QL (30 caps every 30 days)
dexmethylphenidate hcl tabs 2.5mg, 5mg	1	QL (120 tabs every 30 days)
dexmethylphenidate hcl tabs 10mg	1	QL (60 tabs every 30 days)
dextroamphetamine sulfate cp24 5mg, 10mg	1	QL (120 caps every 30 days)
dextroamphetamine sulfate cp24 15mg	1	QL (60 caps every 30 days)
dextroamphetamine sulfate soln	1	QL (1,200 mL every 30 days)
dextroamphetamine sulfate tabs 5mg, 10mg	1	QL (120 tabs every 30 days)
dextroamphetamine sulfate tabs 15mg, 20mg	1	QL (60 tabs every 30 days)
dextroamphetamine sulfate tabs 30mg	1	QL (30 tabs every 30 days)
guanfacine hcl (adhd)	1	
lisdexamfetamine dimesylate caps 10mg, 20mg, 30mg	1	QL (60 caps every 30 days)
lisdexamfetamine dimesylate caps 40mg, 50mg, 60mg, 70mg	1	QL (30 caps every 30 days)
lisdexamfetamine dimesylate chew 10mg, 20mg, 30mg	1	QL (60 chew tabs every 30 days)
lisdexamfetamine dimesylate chew 40mg, 50mg, 60mg	1	QL (30 chew tabs every 30 days)
methamphetamine hcl	1	QL (150 tabs every 30 days)
methylphenidate hcl chew	1	QL (180 chew tabs every 30 days)

Drug Name	Drug Tier	Requirements/Limits
methylphenidate hcl cp24 20mg, 30mg	1	QL (60 caps every 30 days)
methylphenidate hcl cp24 40mg, 60mg	1	QL (30 caps every 30 days)
methylphenidate hcl cpcr 10mg, 20mg, 30mg	1	QL (60 caps every 30 days)
methylphenidate hcl cpcr 40mg, 50mg, 60mg	1	QL (30 caps every 30 days)
methylphenidate hcl soln 5mg/5ml	1	QL (1800 mL every 30 days)
methylphenidate hcl soln 10mg/5ml	1	QL (900 mL every 30 days)
methylphenidate hcl tabs 5mg, 10mg	1	QL (180 tabs every 30 days)
methylphenidate hcl tabs 20mg	1	QL (90 tabs every 30 days)
methylphenidate hcl tbcr 10mg, 20mg	1	QL (90 tabs every 30 days)
methylphenidate hcl tbcr 18mg, 27mg, 36mg	1	QL (60 tabs every 30 days)
methylphenidate hcl tbcr 54mg	1	QL (30 tabs every 30 days)
zenzedi	1	QL (120 tabs every 30 days)
FIBROMYALGIA		
milnacipran hcl	1	ST; PA**
HYPNOTICS		
BELSOMRA	2	
cvs sleep-aid nighttime	1	OTC
DAYVIGO	2	PA, QL (30 tabs every 30 days)
doxepin hcl (sleep)	1	
estazolam	3	QL (15 tabs every 30 days)
eszopiclone	1	QL (15 tabs every 30 days)
ramelteon	1	QL (15 tabs every 30 days)
tasimelteon	4	PA, QL (30 caps every 30 days)
temazepam	1	QL (15 caps every 30 days)
triazolam	3	QL (10 tabs every 30 days)
zaleplon	1	QL (15 caps every 30 days)
zolpidem tartrate	1	QL (15 tabs every 30 days)
MIGRAINE - ERGOTAMINE DERIVATIVES		
dihydroergotamine mesylate	1	
ERGOMAR	3	
ergotamine w/ caffeine	3	
MIGRAINE - MISCELLANEOUS		
QULIPTA	2	ST, QL (30 tabs every 30 days); PA**
UBRELVY	2	ST, QL (16 tabs every 30 days); PA**
MIGRAINE - MONOCLONAL ANTIBODIES		
AIMOVIG	2	ST, QL (1 injection every 30 days); PA**

Drug Name	Drug Tier	Requirements/Limits
EMGALITY SOAJ	2	ST, QL (1 injection every 30 days); PA**; Loading dose of 2 injections in 30 days allowed for initial fill
EMGALITY SOSY 100MG/ML	2	ST, QL (3 injections every 30 days); PA**
EMGALITY SOSY 120MG/ML	2	ST, QL (1 injection every 30 days); PA**; Loading dose of 2 injections in 30 days allowed for initial fill
MIGRAINE - TRIPTANS AND COMBINATIONS		
almotriptan malate	1	QL (12 tabs every 30 days)
eletriptan hydrobromide	1	QL (12 tabs every 30 days)
naratriptan hcl	1	QL (12 tabs every 30 days)
rizatriptan benzoate	1	QL (18 tabs every 30 days)
sumatriptan 5mg/act	1	QL (24 sprays every 30 days)
sumatriptan 20mg/act	1	QL (12 sprays every 30 days)
sumatriptan succinate soaj	1	QL (12 units every 30 days)
sumatriptan succinate soln	1	QL (12 vials every 30 days)
sumatriptan succinate tabs	1	QL (12 tabs every 30 days)
sumatriptan-naproxen sodium	3	ST, QL (9 tabs every 30 days); PA**
zolmitriptan soln	1	QL (12 sprays every 30 days)
zolmitriptan tabs; tbdp	1	QL (12 tabs every 30 days)
MISCELLANEOUS		
EVRYSDI SOLR	5	PA, QL (2 bottles every 24 days)
EVRYSDI TABS	5	PA, QL (30 tabs every 30 days)
MOOD STABILIZERS		
lithium	1	
lithium carbonate	1	
MOVEMENT DISORDERS		
AUSTEDO 6MG	4	PA, QL (60 tabs every 30 days)
AUSTEDO 9MG, 12MG	4	PA, QL (120 tabs every 30 days)
tetrabenazine 12.5mg	4	PA, QL (120 tabs every 30 days)
tetrabenazine 25mg	4	PA, QL (60 tabs every 30 days)
MULTIPLE SCLEROSIS AGENTS		
BETASERON	4	PA, QL (14 injections every 28 days)

Drug Name	Drug Tier	Requirements/Limits
dalfampridine	4	PA, QL (60 tabs every 30 days)
dimethyl fumarate cdpk	4	PA, QL (1 kit every 30 days)
dimethyl fumarate cpdr 120mg	4	PA, QL (14 caps every 28 days)
dimethyl fumarate cpdr 240mg	4	PA, QL (60 caps every 30 days)
fingolimod hcl	4	PA, QL (30 caps every 30 days)
glatiramer acetate	1	PA, QL (12 syringes every 28 days)
glatopa	1	PA, QL (30 injections every 30 days)
KESIMPTA	4	PA, QL (1 pen every 28 days)
teriflunomide	4	PA, QL (30 tabs every 30 days)
TYRUKO	4	PA, QL (15 mL every 28 days)
TYSABRI	4	PA, QL (15 mL every 28 days)
MUSCULOSKELETAL THERAPY AGENTS		
baclofen	1	
carisoprodol	1	
chlorzoxazone	1	
cyclobenzaprine hcl	1	
dantrolene sodium	1	
metaxalone	1	
methocarbamol	1	
norgesic	3	
orphenadrine citrate	1	
tizanidine hcl	1	
MYASTHENIA GRAVIS		
pyridostigmine bromide	1	
NARCOLEPSY/CATAPLEXY		
armodafinil 50mg	1	PA, QL (60 tabs every 30 days)
armodafinil 150mg, 200mg, 250mg	1	PA, QL (30 tabs every 30 days)
modafinil	1	PA, QL (60 tabs every 30 days)
sodium oxybate 500mg/ml	1	PA, QL (540mL every 30 days); ANDA Generics
sodium oxybate 500mg/ml	4	PA, QL (540mL every 30 days); HIKMA AG
SUNOSI	2	PA, QL (30 tabs every 30 days)

Drug Name	Drug Tier	Requirements/Limits
XYWAV	4	PA, QL (540 ml every 30 days)
OPIOID AGONIST/ANTAGONIST		
buprenorphine hcl-naloxone hcl dihydrate film	1	
buprenorphine hcl-naloxone hcl dihydrate subl	0	$0 copay
ZUBSOLV	2	
OPIOID ANTAGONIST		
naloxone hcl liqd	1	OTC
naloxone hcl soct; soln; sosy	1	
naltrexone hcl	0	$0 copay
OPIOID PARTIAL AGONISTS		
buprenorphine hcl	0	$0 copay
PSYCHOTHERAPEUTIC-MISC		
chlordiazepoxide-amitriptyline	3	
lofexidine hcl	1	
NUEDEXTA	2	PA
perphenazine-amitriptyline	3	
pimozide	1	
SMOKING DETERRENTS		
bupropion hcl (smoking deterrent)	0	$0 limited to 2 treatment cycles/year
goodsense nicotine polacr	0	OTC; $0 limited to 2 treatment cycles/year
nicotine	0	OTC; $0 limited to 2 treatment cycles/year
nicotine polacrilex	0	OTC; $0 limited to 2 treatment cycles/year
nicotine step 3	0	OTC; $0 limited to 2 treatment cycles/year
nicotine transdermal syst	0	OTC; $0 limited to 2 treatment cycles/year
NICOTROL INHALER	0	QL (max 168 days every year); $0 limited to 2 treatment cycles/year
NICOTROL NS	0	QL (max 168 days every year); $0 limited to 2 treatment cycles/year
varenicline tartrate	0	$0 limited to 2 treatment cycles/year
ENDOCRINE AND METABOLIC		
ACROMEGALY		
octreotide acetate soln 50mcg/ml, 100mcg/ml, 500mcg/ml	4	PA, QL (90 ml every 30 days)
octreotide acetate soln 200mcg/ml	4	PA, QL (225 ml every 30 days)

Drug Name	Drug Tier	Requirements/Limits
octreotide acetate soln 1000mcg/ml	4	PA, QL (45 ml every 30 days)
octreotide acetate sosy	4	PA, QL (90 ml every 30 days)
SOMATULINE DEPOT	4	PA, QL (1 injection every 28 days)
SOMAVERT	4	PA, QL (30 vials every 30 days)
ANDROGENS		
testosterone	1	PA
testosterone cypionate	1	PA
testosterone enanthate	1	PA
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose	1	
miglitol	1	
ANTIDIABETICS, BIGUANIDE		
metformin hcl tabs 500mg, 1000mg	1	
metformin hcl tabs 850mg	1	$0 copay for members age 35-70 for prevention of diabetes
metformin hcl tb24	1	
ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS		
glipizide-metformin hcl	1	
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR COMBINATIONS		
alogliptin-metformin hcl	1	ST; PA**
sitagliptin phosphate-metformin hcl	1	ST; PA**
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
alogliptin benzoate	1	ST; PA**
sitagliptin phosphate	1	ST; PA**
ANTIDIABETICS, INCRETIN MIMETIC AGENTS		
liraglutide	1	ST, QL (3 pens every 30 days); PA**
MOUNJARO	2	ST, QL (4 pens every 28 days); PA**
OZEMPIC SOPN	2	ST, QL (3 mL every 28 days); PA**
OZEMPIC TABS	2	ST, QL (30 tabs every 30 days); PA**
TRULICITY	2	ST, QL (4 pens every 28 days); PA**
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
SOLIQUA 100/33	2	ST; PA**
XULTOPHY 100/3.6	2	ST; PA**
ANTIDIABETICS, INSULIN		
BASAGLAR KWIKPEN	2	
FIASP	2	

Drug Name	Drug Tier	Requirements/Limits
FIASP FLEXTOUCH	2	
FIASP PENFILL	2	
FIASP PUMPCART	2	
HUMULIN 70/30	3	OTC
HUMULIN 70/30 KWIKPEN	3	OTC
HUMULIN N	3	OTC
HUMULIN N KWIKPEN	3	OTC
HUMULIN R	3	OTC
HUMULIN R U-500 KWIKPEN	2	
INSULIN GLARGINE-YFGN	2	
NOVOLIN 70/30	2	OTC; RELION not covered
NOVOLIN 70/30 FLEXPEN	2	OTC; RELION not covered
NOVOLIN N	2	OTC; RELION not covered
NOVOLIN N FLEXPEN	2	OTC; RELION not covered
NOVOLIN R	2	OTC; RELION not covered
NOVOLIN R FLEXPEN	2	OTC; RELION not covered
NOVOLOG	2	
NOVOLOG FLEXPEN	2	
NOVOLOG MIX 70/30	2	
NOVOLOG MIX 70/30 PREFILL	2	
NOVOLOG PENFILL	2	
TRESIBA	2	
TRESIBA FLEXTOUCH	2	
ANTIDIABETICS, INSULIN SENSITIZER		
pioglitazone hcl	1	
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
pioglitazone hcl-metformin hcl	1	
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
pioglitazone hcl-glimepiride	1	
ANTIDIABETICS, MEGLITINIDE		
nateglinide	1	
repaglinide	1	
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS		
SYNJARDY	2	ST; PA**
SYNJARDY XR	2	ST; PA**
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS		
GLYXAMBI	2	ST; PA**
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS		
JARDIANCE	2	ST; PA**; Indicated for Diabetes and Heart Failure

Drug Name	Drug Tier	Requirements/Limits
ANTIDIABETICS, SULFONYLUREA		
glimepiride	1	
glipizide	1	
CALCIUM RECEPTOR AGONISTS		
cinacalcet hcl 30mg, 60mg	4	PA, QL (60 tabs every 30 days)
cinacalcet hcl 90mg	4	PA, QL (120 tabs every 30 days)
CALCIUM REGULATORS, BISPHOSPHONATES		
alendronate sodium	1	
FOSAMAX PLUS D	3	
ibandronate sodium	1	
pamidronate disodium	1	
risedronate sodium	1	
zoledronic acid	4	PA
CALCIUM REGULATORS, MISCELLANEOUS		
calcitonin (salmon)	1	
OSPOMYV	4	PA, QL (1 syringe (60 mg) every 180 days)
STOBOCLO	4	PA, QL (1 syringe (60 mg) every 180 days)
CALCIUM REGULATORS, PARATHYROID HORMONES		
TYMLOS	4	PA, QL (1 pen every 30 days)
CENTRAL PRECOCIOUS PUBERTY		
LUPRON DEPOT-PED (1-MONTH	4	PA
LUPRON DEPOT-PED (3-MONTH	4	PA
LUPRON DEPOT-PED (6-MONTH	4	PA
SUPPRELIN LA	4	PA
TRIPTODUR	4	PA
CHELATING AGENTS		
CHEMET	3	
deferiprone	4	PA
FERRIPROX	4	PA
FERRIPROX TWICE-A-DAY	4	PA
penicillamine	4	
CONTRACEPTIVES		
altavera	0	
alyacen 1/35	0	
alyacen 7/7/7	0	
amethyst	0	
ANNOVERA	0	QL (1 every 300 days)
apri	0	
aranelle	0	

Drug Name	Drug Tier	Requirements/Limits
ashlyna	0	
AVERI	0	
aviane	0	
azurette	0	
camila	0	
camrese	0	
CAYA	0	QL (1 every 300 days)
chateal eq	0	
CONDOMS	0	QL (12 condoms every 30 days), OTC
dasetta 1/35	0	
dasetta 7/7/7	0	
delyla	0	
DEPO-SUBQ PROVERA 104	0	QL (4 inj every 300 days)
drospirenone-ethinyl estradiol	0	
drospirenone-ethinyl estradiol-levomefolate calcium	0	
DUREX REALFEEL NON-LATEX	0	QL (12 condoms every 30 days), OTC
elinest	0	
ELLA	0	
enskyce	0	
errin	0	
etonogestrel-ethinyl estradiol	0	QL (13 every 300 days)
falmina	0	
FC2 FEMALE CONDOM	0	QL (12 condoms every 30 days), OTC
FEMCAP	0	QL (1 every 300 days)
FEMLYV	0	
galbriela	0	
gemmily	0	
heather	0	
introvale	0	
jolessa	0	
junel 1.5/30	0	
junel 1/20	0	
junel fe 1.5/30	0	
junel fe 1/20	0	
junel fe 24	0	
kariva	0	
kelnor 1/35	0	
kurvelo	0	
KYLEENA	0	QL (1 every 300 days)
larin 1.5/30	0	
lessina	0	

Drug Name	Drug Tier	Requirements/Limits
levonest	0	
levonorgestrel & eth estradiol	0	
levonorgestrel-ethinyl estradiol (91-day)	0	
levonorgestrel-ethinyl estradiol-iron	0	
LILETTA	0	QL (1 every 300 days)
LO LOESTRIN FE	0	
loryna	0	
low-ogestrel	0	
marlissa	0	
medroxyprogesterone acetate (contraceptive)	0	QL (4 inj every 300 days)
microgestin 1.5/30	0	
MIRENA	0	QL (1 every 300 days)
MIUDELLA COPPER INTRAUTER	0	QL (1 unit every 300 days)
mono-linyah	0	
NATAZIA	0	
necon 0.5/35-28	0	
NEXPLANON	0	QL (1 every 300 days)
NEXTSTELLIS	0	
nikki	0	
nora-be	0	
norethin acet & estrad-fe	0	
norethindrone (contraceptive)	0	
norethindrone acet & eth estra	0	
norgestimate-ethinyl estradiol	0	
norgestimate-ethinyl estradiol (triphasic)	0	
nortrel 0.5/35 (28)	0	
nortrel 1/35	0	
nortrel 7/7/7	0	
nylia 1/35	0	
OMNIFLEX DIAPHRAGM	0	QL (1 every 300 days)
OPILL	0	OTC
PARAGARD INTRAUTERINE COP	0	QL (1 unit every 300 days)
portia-28	0	
reclipsen	0	
rivelsa	0	
SKYLA	0	QL (1 every 300 days)
SLYND	0	
sprintec 28	0	
syeda	0	
take action	0	OTC
tilia fe	0	
tri-linyah	0	
tri-sprintec	0	

Drug Name	Drug Tier	Requirements/Limits
TRUSTEX WITH NONOXYNOL-9/	0	QL (12 condoms every 30 days), OTC
TRUSTEX/RIA NON-LUBRICATE	0	QL (12 condoms every 30 days), OTC
TWIRLA	0	
TYBLUME	0	
valtya 1/50	0	
velivet	0	
viorele	0	
vyfemla	0	
wera	0	
WIDE-SEAL SILICONE DIAPHR	0	QL (1 every 300 days)
xelria fe	0	
xulane	0	
zovia 1/35	0	
DIABETIC SUPPLIES		
ACCU-CHEK AVIVA	2	OTC
ACCU-CHEK AVIVA PLUS KIT	2	OTC
ACCU-CHEK AVIVA PLUS STRP	2	QL (150 Test Strips every 30 days), OTC
ACCU-CHEK COMPACT BLUE CO	2	OTC
ACCU-CHEK COMPACT PLUS CL	2	OTC
ACCU-CHEK FASTCLIX LANCET	2	OTC
ACCU-CHEK GUIDE KIT	2	OTC
ACCU-CHEK GUIDE STRP	2	QL (150 Test Strips every 30 days), OTC
ACCU-CHEK GUIDE CONTROL L	2	OTC
ACCU-CHEK GUIDE ME	2	OTC
ACCU-CHEK GUIDE TEST STRI	2	QL (150 Test Strips every 30 days), OTC
ACCU-CHEK NANO SMARTVIEW	2	OTC
ACCU-CHEK SMARTVIEW CONTR	2	OTC
ACCU-CHEK SMARTVIEW STRIP	2	QL (150 Test Strips every 30 days), OTC
ACCU-CHEK SOFTCLIX LANCET	2	OTC
ALCOHOL PREP PADS	2	OTC
BD VEO INSULIN SYRINGE UL	2	OTC
CAREFINE PEN NEEDLES 32GX	2	OTC
CHEMSTRIP 2 GP STRIPS	3	OTC
CHEMSTRIP 5 OB	3	OTC
CHEMSTRIP 7	3	OTC
CHEMSTRIP 9 STRIPS	3	OTC
CHEMSTRIP 10 MD	3	OTC
CHEMSTRIP -10 WITH SG	3	OTC

Drug Name	Drug Tier	Requirements/Limits
CHEMSTRIP UGK	3	OTC
CHEMSTRIP-K	3	OTC
CVS KETONE CARE	3	OTC
DEXCOM G6 RECEIVER	2	
DEXCOM G6 SENSOR	2	QL (3 sensors every 30 days)
DEXCOM G6 TRANSMITTER	2	
DEXCOM G7 15 DAY SENSOR	2	QL (2 sensors every 30 days)
DEXCOM G7 RECEIVER	2	
DEXCOM G7 SENSOR	2	QL (3 sensors every 30 days)
DIASCREEN 1B	3	OTC
DIASCREEN 1G	3	OTC
DIASCREEN 1K	3	OTC
DIASCREEN 2GK	3	OTC
DIASCREEN 2GP	3	OTC
DIASCREEN 3	3	OTC
DIASCREEN 4NL	3	OTC
DIASCREEN 4OBL	3	OTC
DIASCREEN 4PH	3	OTC
DIASCREEN 5	3	OTC
DIASCREEN 6	3	OTC
DIASCREEN 7	3	OTC
DIASCREEN 8	3	OTC
DIASCREEN 9	3	OTC
DIASCREEN 10	3	OTC
DIASCREEN LIQUID URINE CO	3	OTC
DIASTIX	3	OTC
KETONE	3	OTC
KETONE TEST STRIPS	3	OTC
NOVOFINE PEN NEEDLE 32G X	2	OTC
OMNIPOD 5 DEXCOM G7G6 INT	2	
OMNIPOD 5 DEXCOM G7G6 POD	2	
OMNIPOD 5 G7 INTRO KIT (G	2	
OMNIPOD 5 G7 PODS (GEN 5)	2	
OMNIPOD CLASSIC PDM START	2	
OMNIPOD CLASSIC PODS (GEN	2	
OMNIPOD DASH INTRO KIT (G	2	
OMNIPOD DASH PDM KIT (GEN	2	
OMNIPOD DASH PODS (GEN 4)	2	
TWIIST REFILL KIT	2	
TWIIST REFILL KIT/INFUSIO	2	
TWIIST STARTER KIT	2	
ULTILET SHARPS CONTAINER	2	OTC

Drug Name	Drug Tier	Requirements/Limits
ENDOMETRIOSIS		
danazol	1	
ORILISSA	2	
SYNAREL	5	PA
GLUCOCORTICOIDS		
deflazacort susp	4	PA, QL (52 mL every 30 days)
deflazacort tabs 6mg	4	PA, QL (60 tabs every 30 days)
deflazacort tabs 18mg, 30mg, 36mg	4	PA, QL (30 tabs every 30 days)
DEPO-MEDROL	3	
dexamethasone	1	
DEXAMETHASONE INTENSOL	2	
dexamethasone sodium phosphate	1	
fludrocortisone acetate	1	
hydrocortisone	1	
hydrocortisone sod succinate	1	
MEDROL	2	
methylprednisolone	1	
methylprednisolone acetate	1	
methylprednisolone sod succ	1	
prednisolone	1	
prednisolone sodium phosphate	1	
prednisone	1	
PREDNISONE INTENSOL	2	
SOLU-CORTEF	3	
SOLU-MEDROL	3	
GLUCOSE ELEVATING AGENTS		
glucagon	1	
GVOKE HYPOPEN 1-PACK	2	
GVOKE KIT	2	
GVOKE PFS	2	
INSTA-GLUCOSE	2	OTC
HEREDITARY TYROSINEMIA TYPE 1 AGENTS		
nitisinone	4	PA
ORFADIN	4	PA
HUMAN GROWTH HORMONES		
NORDIPEN 5 INJECTION DEVI	2	
NORDIPEN DELIVERY SYSTEM	2	OTC
NORDITROPIN FLEXPRO	4	PA

Drug Name	Drug Tier	Requirements/Limits
LYSOSOMAL STORAGE DISORDERS - GAUCHER DISEASE		
CERDELGA	4	PA, QL (56 caps every 28 days)
MENOPAUSAL SYMPTOM AGENTS		
BIJUVA	3	
CLIMARA PRO	2	
DEPO-ESTRADIOL	3	
DUAVEE	2	
ELESTRIN	3	
estradiol	1	
estradiol & norethindrone acetate	1	
estradiol vaginal	1	
estradiol valerate	1	
estrogens, conjugated	1	
EVAMIST	3	
IMVEXXY MAINTENANCE PACK	2	
IMVEXXY STARTER PACK	2	
jinteli	1	
mimvey	1	
norethindrone acetate-ethinyl estradiol	1	
PREMARIN	3	
yuvafem	1	
MISCELLANEOUS		
betaine	4	PA
cabergoline	1	
CHORIONIC GONADOTROPIN	4	PA
CORTROPHIN GEL	4	PA, QL (35 mL every 21 days)
CORTROPHIN PRSY	4	PA, QL (28 syringes every 28 days)
CYSTAGON	4	PA
INCRELEX	4	PA
INTRAROSA	3	
MYALEPT	4	PA, QL (30 vials every 30 days)
OSPHENA	3	
raloxifene hcl	1	$0 copay for women ages 35 and older for the primary prevention of breast cancer
sapropterin dihydrochloride	4	PA
SIGNIFOR	5	PA, QL (60 ampules every 30 days)
tolvaptan (hyponatremia)	4	PA

Drug Name	Drug Tier	Requirements/Limits
PHOSPHATE BINDER AGENTS		
calcium acetate (phosphate binder)	1	
lanthanum carbonate	1	
sevelamer carbonate	1	
VELPHORO	3	ST; PA**
POTASSIUM-REMOVING AGENTS		
sps	1	
PROGESTINS		
CRINONE	2	
medroxyprogesterone acetate	1	
megestrol acetate	1	
megestrol acetate (appetite)	1	
norethindrone acetate	1	
progesterone	1	
THYROID AGENTS		
levothyroxine sodium	1	
levoxyl	1	
liothyronine sodium	1	
methimazole	1	
propylthiouracil	1	
SYNTHROID	2	
unithroid	1	
UREA CYCLE DISORDER		
carglumic acid	4	PA
PHEBURANE	4	PA, QL (672g every 30 days)
sodium phenylbutyrate powd	4	PA, QL (798g every 30 days)
sodium phenylbutyrate tabs	4	PA, QL (1200 tabs every 30 days)
VASOPRESSINS		
desmopressin acetate	1	
desmopressin acetate spray	1	
desmopressin acetate spray refrigerated	1	
VITAMIN D ANALOGS		
calcitriol	1	
doxercalciferol	1	
paricalcitol	1	
GASTROINTESTINAL		
ANTICHOLINERGICS		
atropine sulfate	1	
dicyclomine hcl	1	
glycopyrrolate	1	
methscopolamine bromide	1	

Drug Name	Drug Tier	Requirements/Limits
ANTIDIARRHEALS		
diphenoxylate w/ atropine	1	
loperamide hcl	1	
MOTOFEN	3	
ANTIEMETICS		
AKYNZEO	3	QL (2 caps every 28 days)
aprepitant caps 40mg	1	QL (3 caps every 180 days)
aprepitant caps 80mg	1	QL (4 caps every 28 days)
aprepitant caps 125mg	1	QL (2 caps every 28 days)
aprepitant cppk	1	QL (2 packs every 28 days)
compro	1	
dronabinol	1	QL (60 caps every 30 days)
granisetron hcl	1	
meclizine hcl	1	
metoclopramide hcl	1	
ondansetron	1	
ondansetron hcl	1	
prochlorperazine	1	
prochlorperazine maleate	1	
promethazine hcl	1	
promethegan	1	
SANCUSO	2	
scopolamine	1	
trimethobenzamide hcl	1	
VARUBI	2	
H2-RECEPTOR ANTAGONISTS		
cimetidine	1	
famotidine	1	
famotidine in nacl	1	
nizatidine	1	
ranitidine hcl	1	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium	1	
budesonide	1	
CORTIFOAM	2	
DIPENTUM	3	
hydrocortisone (intrarectal)	1	
mesalamine	1	
mesalamine w/ cleanser	1	
sulfasalazine	1	
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS	2	
lubiprostone	1	

Drug Name	Drug Tier	Requirements/Limits
IRRITABLE BOWEL SYNDROME WITH DIARRHEA		
alosetron hcl	1	PA
VIBERZI	2	PA
LAXATIVES		
CLENPIQ	0	$0 copay for members age 45 through 75, Tier 2 for all others
enulose	1	
gavilyte-c	1	
gavilyte-g	1	
lactulose	1	
peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid	0	$0 copay for members age 45 through 75, otherwise not covered
peg 3350-kcl-sod bicarb-sod chloride-sod sulfate	1	
peg 3350-potassium chloride-sod bicarbonate-sod chloride	1	
PEG-PREP	0	$0 copay for members age 45 through 75, otherwise not covered
PLENVU	0	$0 copay for members age 45 through 75, otherwise not covered
polyethylene glycol 3350	1	OTC
sodium sulfate-potassium sulfate-magnesium sulfate	0	$0 copay for members age 45 through 75, otherwise not covered
SUFLAVE	0	$0 copay for members age 45 through 75, otherwise not covered
SUTAB	0	$0 copay for members age 45 through 75, otherwise not covered
MISCELLANEOUS		
cromolyn sodium (mastocytosis)	1	
IQIRVO	4	PA, QL (30 tabs every 30 days)
misoprostol	1	
MOVANTIK	2	
SUCRAID	3	PA, QL (354 mL every 30 days)
sucralfate	1	
ursodiol	1	
VOWST	5	PA, QL (12 caps every 30 days)

Drug Name	Drug Tier	Requirements/Limits
PANCREATIC ENZYMES		
CREON	2	PA
VIOKACE	2	PA
ZENPEP	2	PA
PROTON PUMP INHIBITORS		
esomeprazole magnesium cpdr	1	
esomeprazole magnesium pack	1	Covered for age less than 1 year only
lansoprazole	1	
omeprazole	1	
omeprazole-sodium bicarbonate	3	
pantoprazole sodium	1	
rabeprazole sodium	1	
RECTAL, CORTICOSTEROIDS		
hydrocortisone (rectal)	1	
proctozone-hc	1	
ULCER THERAPY COMBINATIONS		
amoxicillin-clarithromycin w/ lansoprazole	1	
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
alfuzosin hcl	1	
CARDURA XL	3	
doxazosin mesylate	1	
dutasteride	1	
dutasteride-tamsulosin hcl	1	
finasteride	1	
silodosin	1	
tadalafil	1	PA, QL (30 tabs every 30 days)
tamsulosin hcl	1	
terazosin hcl	1	
CONTRACEPTIVES		
ENCARE	0	OTC
OPTIONS GYNOL II VAGINAL	0	OTC
PHEXX	0	
PHEXXI	0	
TODAY SPONGE	0	OTC
VCF VAGINAL CONTRACEPTIVE	0	OTC
ERECTILE DYSFUNCTION		
avanafil	1	QL (6 tabs every 30 days)
MISCELLANEOUS		
bethanechol chloride	1	
ELMIRON	3	

Drug Name	Drug Tier	Requirements/Limits
eq urinary pain relief	1	OTC
potassium citrate (alkalinizer)	1	
URINARY ANTISPASMODICS		
darifenacin hydrobromide	1	
fesoterodine fumarate	1	
mirabegron	1	
oxybutynin chloride	1	
solifenacin succinate	1	
tolterodine tartrate	1	
trospium chloride	1	
VAGINAL ANTI-INFECTIVES		
CLEOCIN	2	
clindamycin phosphate vaginal	1	
GYNAZOLE-1	3	
metronidazole vaginal	1	
miconazole 3	1	
terconazole vaginal	1	
HEMATOLOGIC		
ANTICOAGULANTS		
dabigatran etexilate mesylate	1	
ELIQUIS	2	
ELIQUIS STARTER PACK	2	
enoxaparin sodium	1	
fondaparinux sodium	1	
FRAGMIN	3	
heparin sodium (porcine)	1	
rivaroxaban	1	
warfarin sodium	1	
XARELTO	2	
XARELTO STARTER PACK	2	
HEMATOPOIETIC GROWTH FACTORS		
ARANESP ALBUMIN FREE	4	PA
FYLNETRA	4	PA, QL (2 syringes every 28 days)
MIRCERA	4	PA
NIVESTYM	4	PA
NYVEPRIA	4	PA, QL (2 syringes every 28 days)
RETACRIT	4	PA
HEMOPHILIA A AGENTS		
HEMLIBRA	5	PA
MISCELLANEOUS		
anagrelide hcl	1	

Drug Name	Drug Tier	Requirements/Limits
cilostazol	1	
pentoxifylline	1	
tranexamic acid	1	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole	1	
clopidogrel bisulfate	1	
dipyridamole	1	
prasugrel hcl	1	
YOSPRALA	3	
SICKLE CELL DISEASE		
DROXIA	2	
THROMBOCYTOPENIA AGENTS		
ALVAIZ 9MG, 54MG	4	PA, QL (60 tabs every 30 days)
ALVAIZ 18MG, 36MG	4	PA, QL (90 tabs every 30 days)
DOPTELET SPRINKLE	4	PA, QL (60 caps every 30 days)
DOPTELET TAB 20MG (10 TABLETS)	4	PA, QL (1 carton every 5 days)
DOPTELET TAB 20MG (15 TABLETS)	4	PA, QL (1 carton every 5 days)
DOPTELET TAB 20MG (30 TABLETS)	4	PA, QL (2 cartons every 30 days)
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS (PHYSICIAN-ADMINISTERED)		
ACTEMRA 80MG/4ML	5	ST, PA, QL (20 vials every 28 days)
ACTEMRA 200MG/10ML	5	ST, PA, QL (8 vials every 28 days)
ACTEMRA 400MG/20ML	5	ST, PA, QL (4 vials every 28 days)
COSENTYX	4	PA, QL (15 mL every 28 days); Preferred agent for Ankylosing Spondylitis, NRAXSPA, and Psoriatic Arthritis
ENTYVIO	5	PA, QL (1 vial every 56 days)
INFLIXIMAB	4	PA, QL (5 vials every 42 days)
SIMPONI ARIA	5	PA, QL (200 mg every 8 weeks)
SKYRIZI	4	PA, QL (6 vials every 56 days)
TREMFYA	4	PA, QL (One time use only)

Drug Name	Drug Tier	Requirements/Limits
AUTOIMMUNE AGENTS (SELF-ADMINISTERED)		
ACTEMRA	5	ST, PA, QL (4 syringes every 28 days)
ACTEMRA ACTPEN	5	ST, PA, QL (4 injections every 28 days)
ADALIMUMAB-ADAZ SOAJ 40MG/0.4ML	4	PA, QL (4 auto-injectors every 28 days)
ADALIMUMAB-ADAZ SOAJ 80MG/0.8ML	4	PA, QL (2 auto-injectors every 28 days)
ADALIMUMAB-ADAZ SOSY 10MG/0.1ML	4	PA, QL (2 syringes every 28 days)
ADALIMUMAB-ADAZ SOSY 20MG/0.2ML, 40MG/0.4ML	4	PA, QL (4 syringes every 28 days)
ADALIMUMAB-FKJP AJKT	4	PA, QL (4 auto-injectors every 28 days)
ADALIMUMAB-FKJP PSKT	4	PA, QL (4 syringes every 28 days)
CIMZIA (1 SYRINGE)	4	PA, QL (4 syringes every 28 days); Preferred agent for NRAXSPA
CIMZIA STARTER KIT	4	PA, QL (One time use only); Preferred agent for NRAXSPA
COSENTYX 75MG/0.5ML, 150MG/ML	4	PA, QL (1 syringe every 28 days); Preferred agent for Ankylosing Spondylitis, Hidradenitis Suppurativa, NRAXSPA, and Psoriatic Arthritis
COSENTYX 150MG/ML	4	PA, QL (300 mg every 28 days); Preferred agent for Ankylosing Spondylitis, Hidradenitis Suppurativa, NRAXSPA, and Psoriatic Arthritis
COSENTYX SENSOREADY PEN 150MG/ML	4	PA, QL (1 pen every 28 days); Preferred agent for Ankylosing Spondylitis, Hidradenitis Suppurativa, NRAXSPA, and Psoriatic Arthritis
COSENTYX SENSOREADY PEN 150MG/ML	4	PA, QL (300 mg every 28 days); Preferred agent for Ankylosing Spondylitis, Hidradenitis Suppurativa, NRAXSPA, and Psoriatic Arthritis

Drug Name	Drug Tier	Requirements/Limits
COSENTYX UNOREADY	4	PA, QL (1 pen every 28 days); Preferred agent for Ankylosing Spondylitis, Hidradenitis Suppurativa, NRAXSPA, and Psoriatic Arthritis
ENBREL SOLN	4	PA, QL (8 vials every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
ENBREL SOSY 25MG/0.5ML	4	PA, QL (8 syringes every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
ENBREL SOSY 50MG/ML	4	PA, QL (4 syringes every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
ENBREL MINI	4	PA, QL (4 cartridges every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
ENBREL SURECLICK	4	PA, QL (4 syringes every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
ENTYVIO PEN	5	PA, QL (2 pens every 28 days)
HYRIMOZ SOAJ	4	PA, QL (4 auto-injectors every 28 days); except NDCs 61314-XXXX-XX
HYRIMOZ SOSY	4	PA, QL (4 syringes every 28 days); except NDCs 61314-XXXX-XX
HYRIMOZ PLAQUE PSORIASIS	4	PA, QL (Starter pack - initial dose only); except NDCs 61314-XXXX-XX
HYRIMOZ SENSOREADY CD/UC/	4	PA, QL (2 auto-injectors every 28 days); except NDCs 61314-XXXX-XX
HYRIMOZ SENSOREADY PENS	4	PA, QL (2 auto-injectors every 28 days); except NDCs 61314-XXXX-XX

Drug Name	Drug Tier	Requirements/Limits
KEVZARA SOAJ	4	PA, QL (2 pens every 28 days); Preferred agent for Rheumatoid Arthritis
KEVZARA SOSY	4	PA, QL (2 syringes every 4 weeks); Preferred agent for Rheumatoid Arthritis
LITFULO	4	PA, QL (28 caps every 28 days); Preferred agent for Alopecia Areata
OLUMIANT	4	PA, QL (30 tabs every 30 days); Preferred agent for Alopecia Areata
OTEZLA TABS	4	PA, QL (60 tabs every 30 days); Preferred agent for Psoriasis and Psoriatic Arthritis
OTEZLA TBPK	4	PA, QL (55 tabs every 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis
OTEZLA XR	4	PA, QL (30 tabs every 30 days); Preferred agent for Psoriasis and Psoriatic Arthritis
OTEZLA/OTEZLA XR 28 DAY T	4	PA, QL (41 tabs every 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis
PYZCHIVA SOAJ 45MG/0.5ML	4	PA, QL (1 pen every 84 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis
PYZCHIVA SOAJ 90MG/ML	4	PA, QL (1 pen every 56 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis
PYZCHIVA SOLN	4	PA, QL (1 vial every 84 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis
PYZCHIVA SOSY 45MG/0.5ML	4	PA, QL (1 syringe every 84 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis
PYZCHIVA SOSY 90MG/ML	4	PA, QL (1 syringe every 56 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis

Drug Name	Drug Tier	Requirements/Limits
RINVOQ 15MG	4	PA, QL (30 tabs every 30 days); Preferred agent for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, NRAXSPA, Psoriatic Arthritis, Rheumatoid Arthritis, and Ulcerative Colitis
RINVOQ 30MG	4	PA, QL (30 tabs every 30 days); Preferred agent for Atopic Dermatitis, Crohn's Disease and Ulcerative Colitis.
RINVOQ 45MG	4	PA, QL (One time use only (for CD/UC diagnosis)); Preferred agent for Crohn's Disease and Ulcerative Colitis.
RINVOQ LQ	4	PA, QL (360 mL every 30 days); Preferred agent for Psoriatic Arthritis
SIMPONI	5	ST, PA, QL (1 injection every 28 days)
SKYRIZI SOCT	4	PA, QL (1 cartridge every 56 days); Preferred Agent for Crohn's Disease and Ulcerative Colitis
SKYRIZI SOSY	4	PA, QL (1 syringe every 12 weeks); Preferred agent for Psoriasis and Psoriatic Arthritis
SKYRIZI PEN	4	PA, QL (1 syringe every 12 weeks); Preferred agent for Psoriasis and Psoriatic Arthritis
TALTZ SOAJ	4	PA, QL (1 injection every 28 days); Preferred agent for Psoriasis
TALTZ SOSY 20MG/0.25ML, 40MG/0.5ML	4	PA, QL (1 syringe every 28 days); Preferred agent for Psoriasis
TALTZ SOSY 80MG/ML	4	PA, QL (1 injection every 28 days); Preferred agent for Psoriasis
tofacitinib citrate soln	4	PA, QL (240 mL every 24 days)

Drug Name	Drug Tier	Requirements/Limits
tofacitinib citrate tabs 5mg	4	PA, QL (60 tabs every 30 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis and Ulcerative Colitis.
tofacitinib citrate tabs 10mg	4	PA, QL (60 tabs every 30 days); Preferred agent for Ulcerative Colitis.
tofacitinib citrate tb24 11mg	4	PA, QL (30 tabs every 30 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis and Ulcerative Colitis.
tofacitinib citrate tb24 22mg	4	PA, QL (30 tabs every 30 days); Preferred agent for Ulcerative Colitis.
TREMFYA SOAJ	4	PA, QL (1 injection every 28 days); Preferred agent for Crohn's Disease and Ulcerative Colitis
TREMFYA SOPN	4	PA, QL (1 injection every 56 days); Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, and Ulcerative Colitis
TREMFYA SOSY 100MG/ML	4	PA, QL (1 injection every 56 days); Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, and Ulcerative Colitis
TREMFYA SOSY 200MG/2ML	4	PA, QL (1 injection every 28 days); Preferred agent for Crohn's Disease and Ulcerative Colitis
TREMFYA PEN	4	PA, QL (1 injection every 56 days); Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, and Ulcerative Colitis
VELSIPITY	4	PA, QL (30 tabs every 30 days); Preferred agent for Ulcerative Colitis
YESINTEK SOLN	4	PA, QL (1 vial every 84 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis

Drug Name	Drug Tier	Requirements/Limits
YESINTEK SOSY 45MG/0.5ML	4	PA, QL (1 syringe every 84 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis
YESINTEK SOSY 90MG/ML	4	PA, QL (1 syringe every 56 days); Preferred agent for Crohn's Disease, Psoriasis, and Ulcerative Colitis
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
hydroxychloroquine sulfate	1	
leflunomide	1	
methotrexate sodium	1	
HEREDITARY ANGIOEDEMA		
icatibant acetate	4	PA, QL (45 syringes every 90 days)
TAKHZYRO	5	PA, QL (2 syringes every 28 days)
IMMUNOGLOBULIN		
CUTAQUIG	4	PA
IMMUNOMODULATORS		
ACTIMMUNE	5	PA
ARCALYST	4	PA, QL (8 vials every 28 days)
IMMUNOSUPPRESSANTS		
azathioprine	1	
cyclosporine	1	
cyclosporine modified (for microemulsion)	1	
ENVARSUS XR	3	
everolimus (immunosuppressant)	1	
gengraf	1	
mycophenolate mofetil	1	
mycophenolate mofetil hcl	1	
mycophenolate sodium	1	
NULOJIX	3	
PROGRAF	3	
SANDIMMUNE	3	
sirolimus	1	
tacrolimus	1	
MISCELLANEOUS		
BEYFORTUS	0	$0 copay for members age 18 and younger, otherwise not covered

Drug Name	Drug Tier	Requirements/Limits
ENFLONSIA	0	$0 copay for members age 18 and younger, otherwise not covered
VACCINES		
ABRYSVO	0	
ACTHIB	0	$0 copay for members age 18 and younger, otherwise not covered
ADACEL	0	
AREXVY	0	$0 copay for members age 19 and older, otherwise not covered
BEXSERO	0	
BOOSTRIX	0	
CAPVAXIVE	0	
COMIRNATY 2025-26	0	
COMIRNATY/5-11Y/2025-26	0	
DAPTACEL	0	$0 copay for members age 18 and younger, otherwise not covered
DENGVAXIA	0	$0 copay for members age 18 and younger, otherwise not covered
ENGERIX-B	0	
FLUAD 2025-2026	0	
FLUMIST NASAL VACCINE 202	0	
GARDASIL 9	0	
HAVRIX	0	
HEPLISAV-B	0	
HIBERIX	0	$0 copay for members age 18 and younger, otherwise not covered
INFANRIX	0	$0 copay for members age 18 and younger, otherwise not covered
IPOL INACTIVATED IPV	0	
JYNNEOS	0	
KINRIX	0	$0 copay for members age 18 and younger, otherwise not covered
M-M-R II	0	
MENQUADFI	0	
MENVEO	0	
MNEXSPIKE COVID-19 VACCIN	0	

Drug Name	Drug Tier	Requirements/Limits
MRESVIA	0	$0 copay for members age 19 and older, otherwise not covered
NUVAXOVID COVID-19 VACCIN	0	
PEDIARIX	0	$0 copay for members age 18 and younger, otherwise not covered
PEDVAXHIB	0	$0 copay for members age 18 and younger, otherwise not covered
PENBRAYA	0	
PENMENVY	0	
PENTACEL	0	$0 copay for members age 18 and younger, otherwise not covered
PNEUMOVAX 23	0	
PREVNAR 20	0	
PRIORIX	0	
PROQUAD	0	$0 copay for members age 18 and younger, otherwise not covered
QUADRACEL	0	$0 copay for members age 18 and younger, otherwise not covered
RECOMBIVAX HB	0	
ROTARIX	0	$0 copay for members age 18 and younger, otherwise not covered
ROTATEQ	0	$0 copay for members age 18 and younger, otherwise not covered
SHINGRIX	0	$0 copay for members age 19 and older, otherwise not covered
SPIKEVAX COVID-19 VACCINE	0	
TENIVAC	0	$0 copay for members age 19 and older, otherwise not covered
TRUMENBA	0	
TWINRIX	0	$0 copay for members age 19 and older, otherwise not covered
VAQTA	0	
VARIVAX	0	
VAXELIS	0	$0 copay for members age 18 and younger, otherwise not covered

Drug Name	Drug Tier	Requirements/Limits
VAXNEUVANCE	0	
NUTRITIONAL/SUPPLEMENTS		
ELECTROLYTES		
EFFER-K	1	
klor-con m15	1	
magnesium sulfate	1	
magnesium sulfate in dextrose	1	
MONOJECT SODIUM CHLORIDE	1	
potassium chloride	1	
potassium chloride microencapsulated crystals er	1	
sodium chloride	1	
sodium fluoride chew 1mg	1	
sodium fluoride chew .25mg, .5mg	0	$0 applies for ages 5 and under, otherwise not covered
sodium fluoride soln	0	$0 applies for ages 5 and under, otherwise not covered
sodium fluoride tabs 1mg	1	
sodium fluoride tabs .5mg	0	$0 applies for ages 5 and under, otherwise not covered
PRENATAL VITAMINS		
elite-ob	1	
pnv-dha	1	
pnv-select	1	
VITAMINS		
cholecalciferol	1	OTC
cyanocobalamin	1	
ergocalciferol	1	
folic acid caps	0	QL (100 caps every 30 days), OTC; $0 copay for members 55 and younger capable of pregnancy, otherwise not covered
folic acid tabs 1mg	1	
folic acid tabs 400mcg, 800mcg	0	QL (100 tabs every 30 days), OTC; $0 copay for members 55 and younger capable of pregnancy, otherwise not covered
ped multivitamins w/fl & iron	1	
pediatric multivitamins w/fl	1	
phytonadione	1	
pyridoxine hcl	1	OTC
tri-vite/fluoride	1	

Drug Name	Drug Tier	Requirements/Limits
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
bacitracin-poly-neomycin-hc	1	
loteprednol etabonate-tobramycin	1	
neomycin-polymy-dexameth	1	
neomycin-polymyxin-hc (ophth)	1	
sulfacetamide sod-prednisolone	1	
TOBRADEX	2	
TOBRADEX ST	2	
tobramycin-dexamethasone	1	
ANTI-INFECTIVES		
AZASITE	2	
bacitracin-polymyxin b (ophth)	1	
BESIVANCE	3	
ciprofloxacin hcl (ophth)	1	
erythromycin (ophth)	1	
gatifloxacin (ophth)	1	
gentamicin sulfate (ophth)	1	
moxifloxacin hcl (ophth)	1	
NATACYN	2	
neomycin-bacitracin zn-polymyxin	1	
neomycin-polymyxin-gramicidin	1	
ofloxacin (ophth)	1	
polymyxin b-trimethoprim	1	
sulfacetamide sodium (ophth)	1	
tobramycin (ophth)	1	
trifluridine	1	
ZIRGAN	3	
ANTI-INFLAMMATORIES		
ACUVAIL	2	
bromfenac sodium (ophth)	1	
dexamethasone sodium phosphate (ophth)	1	
diclofenac sodium (ophth)	1	
difluprednate	1	
flurbiprofen sodium	1	
ILEVRO	2	
ketorolac tromethamine (ophth)	1	
loteprednol etabonate	1	
NEVANAC	2	
prednisolone acetate (ophth)	1	
PREDNISOLONE SODIUM PHOSP	2	
ANTIALLERGICS		
ALOCRIL	3	

Drug Name	Drug Tier	Requirements/Limits
azelastine hcl (ophth)	1	
bepotastine besilate	1	
cromolyn sodium (ophth)	1	
epinastine hcl (ophth)	1	
olopatadine hcl	1	
ZERVIATE	3	
ANTIGLAUCOMA BETA-BLOCKERS		
betaxolol hcl (ophth)	1	
BETOPTIC-S	2	
carteolol hcl (ophth)	1	
levobunolol hcl	1	
timolol maleate (ophth)	1	
ANTIGLAUCOMA COMBINATION AGENTS		
brimonidine tartrate-timolol maleate	1	
dorzolamide hcl-timolol maleate	1	
SIMBRINZA	2	
CARBONIC ANHYDRASE INHIBITORS		
brinzolamide	1	
dorzolamide hcl	1	
DRY EYE DISEASE		
cyclosporine (ophth)	1	
RESTASIS MULTIDOSE	2	
TRYPTYR	2	
MISCELLANEOUS		
atropine sulfate (ophthalmic)	1	
CYSTARAN	5	PA, QL (4 bottles every 28 days)
phenylephrine hcl (mydriatic)	1	
PHOSPHOLINE IODIDE	3	
pilocarpine hcl	1	
proparacaine hcl	1	
tropicamide	1	
PROSTAGLANDINS		
bimatoprost	1	
latanoprost	1	
tafluprost	1	
travoprost	1	
SYMPATHOMIMETICS		
apraclonidine hcl	1	
brimonidine tartrate	1	
IOPIDINE	3	

Drug Name	Drug Tier	Requirements/Limits
RESPIRATORY		
ALPHA-1 ANTITRYPSIN DEFICIENCY AGENTS		
PROLASTIN-C	4	PA
ANAPHYLAXIS TREATMENT AGENTS		
epinephrine (anaphylaxis) .15mg/0.3ml, .3mg/0.3ml	1	QL (4 auto-injectors every 30 days)
epinephrine (anaphylaxis) .15mg/0.15ml	1	QL (4 auto-injectors every 30 days); (generic of Adrenaclick)
EPIPEN 2-PAK	2	QL (4 auto-injectors every 30 days)
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
BEVESPI AEROSPHERE	2	QL (1 package every 30 days)
ipratropium-albuterol	1	QL (6 boxes every 30 days)
STIOLTO RESPIMAT	2	QL (1 package every 30 days)
ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS		
BREZTRI AEROSPHERE	2	QL (1 package every 30 days)
TRELEGY ELLIPTA	2	QL (1 package every 30 days)
ANTICHOLINERGICS		
ipratropium bromide	1	QL (5 boxes every 30 days)
ipratropium bromide (nasal)	1	
SPIRIVA RESPIMAT	2	QL (1 package every 30 days)
tiotropium bromide	1	QL (1 package every 30 days)
ANTIHISTAMINE COMBINATIONS		
azelastine hcl-fluticasone propionate	1	QL (1 package every 30 days)
ANTIHISTAMINES		
azelastine hcl	1	QL (2 bottles every 30 days)
carbinoxamine maleate	1	
clemastine fumarate	1	
cyproheptadine hcl	1	
desloratadine	1	
diphenhydramine hcl	1	
hydroxyzine hcl	1	
hydroxyzine pamoate	1	
levocetirizine dihydrochloride	1	
olopatadine hcl (nasal)	1	QL (1 container every 30 days)
BETA AGONISTS		
albuterol sulfate aers	1	QL (2 inhalers every 30 days)
albuterol sulfate nebu 2.5mg/0.5ml	1	QL (120 vials every 30 days)
albuterol sulfate nebu .083%, .63mg/3ml, 1.25mg/3ml	1	QL (5 boxes every 30 days)
albuterol sulfate syrp	1	

Drug Name	Drug Tier	Requirements/Limits
albuterol sulfate tabs	1	
arformoterol tartrate	1	QL (60 vials every 30 days)
formoterol fumarate	1	QL (60 vials every 30 days)
levalbuterol hcl 1.25mg/0.5ml	1	QL (45 mL every 30 days)
levalbuterol hcl .31mg/3ml, .63mg/3ml, 1.25mg/3ml	1	QL (300 mL every 30 days)
levalbuterol tartrate	1	QL (2 inhalers every 30 days)
SEREVENT DISKUS	2	QL (1 package every 30 days)
STRIVERDI RESPIMAT	2	QL (1 package every 30 days)
terbutaline sulfate	1	
COLD/COUGH		
benzonatate	1	
guaifenesin-codeine	1	QL (60 mL every day), OTC; Subject to initial 7-day limit
hydrocodone bitartrate-homatropine methylbromide soln	1	QL (30 mL every day); Subject to initial 7-day limit
hydrocodone bitartrate-homatropine methylbromide tabs	1	QL (6 tabs every day); Subject to initial 7-day limit
hydrocodone polistirex-chlorpheniramine polistirex	1	QL (10 mL every day); Subject to initial 7-day limit
promethazine & phenylephrine	1	
promethazine w/codeine	1	QL (30 mL every day); Subject to initial 7-day limit
promethazine-dm	1	
pseudoephed-bromphen-dm	1	
TUXARIN ER	3	QL (2 tabs every day); Subject to initial 7-day limit
CYSTIC FIBROSIS		
CAYSTON	4	PA, QL (84 vials every 28 days)
KALYDECO PACK	4	PA, QL (56 packets every 28 days)
KALYDECO TABS	4	PA, QL (56 tabs every 28 days); carton consists of 56 tablets
ORKAMBI PACK	4	PA, QL (56 packets every 28 days)
ORKAMBI TABS	4	PA, QL (112 tabs every 28 days)
SYMDEKO	4	PA, QL (56 tabs every 28 days)
tobramycin 300mg/4ml	4	PA, QL (224 mL every 28 days)
tobramycin 300mg/5ml	4	PA, QL (280 mL every 28 days)

Drug Name	Drug Tier	Requirements/Limits
TRIKAFTA TBPK	4	PA, QL (84 tabs every 28 days)
TRIKAFTA THPK	4	PA, QL (56 packets every 28 days)
LEUKOTRIENE MODIFIERS		
zileuton	3	
LEUKOTRIENE RECEPTOR ANTAGONISTS		
montelukast sodium	1	
zafirlukast	1	
MAST CELL STABILIZERS		
cromolyn sodium	1	QL (2 boxes every 30 days)
MISCELLANEOUS		
acetylcysteine	1	
roflumilast	1	PA
sodium chloride (inhalant)	1	
NASAL STEROIDS		
flunisolide (nasal)	1	QL (3 containers every 30 days)
fluticasone propionate (nasal)	1	QL (1 container every 30 days)
mometasone furoate (nasal)	1	QL (2 packages every 30 days)
OMNARIS	3	QL (1 package every 30 days)
triamcinolone acetonide (nasal)	1	QL (1 package every 30 days), OTC
PULMONARY FIBROSIS AGENTS		
nintedanib esylate	4	PA, QL (60 caps every 30 days)
pirfenidone caps	4	PA, QL (270 caps every 30 days)
pirfenidone tabs 267mg	4	PA, QL (270 tabs every 30 days)
pirfenidone tabs 801mg	4	PA, QL (90 tabs every 30 days)
RESPIRATORY THERAPY SUPPLIES		
AEROCHAMBER PLUS FLOW VU	2	
CLEVER CHOICE ANTI-STATIC	2	OTC
FLEXICHAMBER CHILD MASK/S	2	
PEDIATRIC PANDA MASK	2	OTC
SEVERE ASTHMA AGENTS		
DUPIXENT 200MG/1.14ML	4	PA, QL (2 pens every 28 days); Indicated for Asthma and Atopic Dermatitis

Drug Name	Drug Tier	Requirements/Limits
DUPIXENT 300MG/2ML	4	PA, QL (4 pens every 28 days); Indicated for Asthma and Atopic Dermatitis
FASENRA PEN	4	PA, QL (1 auto-injector every 28 days)
NUCALA SOAJ	4	PA, QL (3 autoinjectors every 28 days)
NUCALA SOSY 40MG/0.4ML	4	PA, QL (1 syringe every 28 days)
NUCALA SOSY 100MG/ML	4	PA, QL (3 syringes every 28 days)
STEROID INHALANTS		
ALVESCO 80MCG/ACT	3	QL (3 packages every 30 days)
ALVESCO 160MCG/ACT	3	QL (2 packages every 30 days)
ASMANEX HFA	2	QL (1 package every 30 days)
budesonide (inhalation) 1mg/2ml	1	QL (1 box every 30 days)
budesonide (inhalation) .5mg/2ml	1	QL (2 boxes every 30 days)
budesonide (inhalation) .25mg/2ml	1	QL (3 boxes every 30 days)
fluticasone furoate (inhalation)	1	QL (1 package every 30 days)
STEROID/BETA-AGONIST COMBINATIONS		
AIRSUPRA	2	QL (3 packages every 30 days)
BREO ELLIPTA	2	QL (1 package every 30 days)
breyna	1	QL (3 packages every 30 days)
budesonide-formoterol fumarate dihydrate	1	QL (3 packages every 30 days)
fluticasone-salmeterol	1	QL (1 package every 30 days)
XANTHINES		
theophylline	1	
TOPICAL		
DERMATOLOGY, ACNE		
adapalene	1	PA, QL (45g every 28 days); PA applies for members age 35 and older
adapalene-benzoyl peroxide	1	
benzoyl peroxide-erythromycin	1	QL (47g every 30 days)
clindamycin phosphate (topical) foam; swab	1	
clindamycin phosphate (topical) gel	1	QL (75g every 30 days)
clindamycin phosphate (topical) lotn; soln	1	QL (60 mL every 30 days)
clindamycin phosphate-benzoyl peroxide	1	QL (50g every 30 days)
clindamycin phosphate-benzoyl peroxide (refrigerate)	1	QL (45g every 30 days)

Drug Name	Drug Tier	Requirements/Limits
ery	1	
erythromycin (acne aid) gel	1	QL (60g every 30 days)
erythromycin (acne aid) soln	1	QL (60 mL every 30 days)
isotretinoin	1	PA
sulfacetamide sodium (acne)	1	
tretinoin	1	PA; PA applies for members age 35 and older
tretinoin microsphere	1	PA; PA applies for members age 35 and older
DERMATOLOGY, ACTINIC KERATOSIS		
diclofenac sodium (actinic keratoses)	3	
fluorouracil (topical)	1	
imiquimod	1	
DERMATOLOGY, ANTIBIOTICS		
antiseptic products, misc.	1	OTC
gentamicin sulfate (topical)	1	
mupirocin	1	QL (30g every 30 days)
silver sulfadiazine	1	
ssd	1	
SULFAMYLON	3	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox gel	1	QL (120g every 30 days)
ciclopirox sham	1	QL (120 mL every 30 days)
ciclopirox soln	1	
ciclopirox olamine crea	1	QL (120g every 30 days)
ciclopirox olamine susp	1	QL (120 mL every 30 days)
clotrimazole (topical) crea	1	QL (120g every 30 days)
clotrimazole (topical) soln	1	QL (120 mL every 30 days)
clotrimazole w/ betamethasone crea	1	QL (60g every 30 days)
clotrimazole w/ betamethasone lotn	1	QL (60 mL every 30 days)
econazole nitrate	1	QL (60g every 30 days)
ERTACZO	3	QL (60g every 30 days)
JUBLIA	3	PA, QL (4 mL every 28 days)
ketoconazole (topical)	1	QL (120g every 30 days)
luliconazole	3	QL (60g every 30 days)
naftifine hcl	1	QL (60g every 30 days)
nystatin (topical)	1	QL (120g every 30 days)
nystatin-triamcinolone	1	QL (60g every 30 days)
nystop	1	QL (120g every 30 days)
oxiconazole nitrate	1	QL (60g every 30 days)
sulconazole nitrate crea	1	QL (60g every 30 days)
sulconazole nitrate soln	1	QL (60 mL every 30 days)

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGY, ANTIPRURITIC		
doxepin hcl (antipruritic)	3	
DERMATOLOGY, ANTIPSORIATICS		
acitretin	1	
calcipotriene	1	ST, QL (60 mL every 30 days); PA**
calcipotriene-betamethasone dipropionate	3	ST, QL (60g every 30 days); PA**
calcitriol (topical)	3	ST, QL (100g every 30 days); PA**
methoxsalen rapid	1	
tazarotene	1	PA
ZORYVE	2	
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical)	1	QL (120 mL every 30 days)
selenium sulfide	1	
DERMATOLOGY, ATOPIC DERMATITIS		
DUPIXENT 200MG/1.14ML	4	PA, QL (2 syringes every 28 days); Indicated for Asthma and Atopic Dermatitis
DUPIXENT 300MG/2ML	4	PA, QL (4 syringes every 28 days); Indicated for Asthma and Atopic Dermatitis
EBGLYSS SOAJ	4	PA, QL (2 pens every 28 days)
EBGLYSS SOSY	4	PA, QL (2 syringes every 28 days)
EUCRISA	2	ST, QL (60g every 30 days); PA**
pimecrolimus	3	ST; PA**
tacrolimus (topical)	3	ST; PA**
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort	1	QL (120g every 30 days)
alclometasone dipropionate	1	QL (120g every 30 days)
amcinonide	1	QL (120g every 30 days)
betamethasone dipropionate (topical) crea	1	QL (120g every 30 days)
betamethasone dipropionate (topical) lotn	1	QL (120 mL every 30 days)
betamethasone dipropionate augmented crea; gel; oint	1	QL (120g every 30 days)
betamethasone dipropionate augmented lotn	1	QL (120 mL every 30 days)
betamethasone valerate crea; foam; oint	1	QL (120g every 30 days)
betamethasone valerate lotn	1	QL (120 mL every 30 days)
BRYHALI	2	QL (120 mL every 30 days)
clobetasol propionate crea; foam; gel; oint	1	QL (120g every 30 days)
clobetasol propionate liqd; lotn; sham; soln	1	QL (120 mL every 30 days)

Drug Name	Drug Tier	Requirements/Limits
clobetasol propionate emo	1	QL (120g every 30 days)
clocortolone pivalate	3	QL (120g every 30 days)
desonide crea; oint	1	QL (120g every 30 days)
desonide lotn	1	QL (120 mL every 30 days)
desoximetasone crea; gel; oint	1	QL (120g every 30 days)
desoximetasone liqd	3	QL (120 mL every 30 days)
diflorasone diacetate	3	QL (120g every 30 days)
fluocinolone acetonide crea; oint	1	QL (120g every 30 days)
fluocinolone acetonide oil; soln	1	QL (120 mL every 30 days)
fluocinonide crea; gel; oint	1	QL (120g every 30 days)
fluocinonide soln	1	QL (120 mL every 30 days)
fluticasone propionate crea; oint	1	QL (120g every 30 days)
fluticasone propionate lotn	1	QL (120 mL every 30 days)
halobetasol propionate	1	QL (120g every 30 days)
hydrocortisone (topical) crea; oint	1	QL (120g every 30 days)
hydrocortisone (topical) lotn	1	QL (120 mL every 30 days)
hydrocortisone butyrate crea; oint	1	QL (120g every 30 days)
hydrocortisone butyrate soln	1	QL (120 mL every 30 days)
hydrocortisone valerate	1	QL (120g every 30 days)
mometasone furoate crea; oint	1	QL (120g every 30 days)
mometasone furoate soln	1	QL (120 mL every 30 days)
triamcinolone acetonide (topical) crea; oint	1	QL (120g every 30 days)
triamcinolone acetonide (topical) lotn	1	QL (120 mL every 30 days)
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine oint	1	QL (50g every 30 days)
lidocaine ptch	1	PA, QL (90 patches every 30 days)
lidocaine hcl prsy	1	QL (60 mL every 30 days)
lidocaine hcl soln	1	QL (50 mL every 30 days)
lidocaine pain relief pat	1	QL (30 patches every 30 days), OTC
lidocaine-prilocaine	1	QL (30g every 30 days)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
acyclovir topical	3	
bexarotene (topical)	4	PA
lactic acid (ammonium lactate)	1	
nitroglycerin (intra-anal)	1	
penciclovir	1	
podofilox	1	
DERMATOLOGY, ROSACEA		
azelaic acid	1	
brimonidine tartrate (topical)	1	PA
FINACEA	2	

Drug Name	Drug Tier	Requirements/Limits
ivermectin (rosacea)	1	PA
metronidazole (topical) crea; gel	1	QL (60g every 30 days)
metronidazole (topical) lotn	1	QL (60 mL every 30 days)
DERMATOLOGY, SCABICIDES AND PEDICULICIDES		
crotan	1	
cvs ivermectin lice treat	1	OTC
malathion	1	
permethrin	1	
sb lice treatment	1	OTC
spinosad	1	
DERMATOLOGY, WOUND CARE AGENTS		
sodium chloride (gu irrigant)	1	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl	1	
chlorhexidine gluconate (mouth-throat)	1	
clotrimazole	1	QL (90 lozenges every 30 days)
lidocaine hcl (mouth-throat)	1	
nystatin (mouth-throat)	1	
oralone dental paste	1	
ORAVIG	3	QL (14 tabs every 30 days)
periogard	1	
pilocarpine hcl (oral)	1	
triamcinolone acetonide (mouth)	1	
OTIC		
acetic acid (otic)	1	
ciprofloxacin hcl (otic)	1	
ciprofloxacin-dexamethasone	1	
ciprofloxacin-fluocinolone acetonide	3	
CORTISPORIN-TC	3	
fluocinolone acetonide (otic)	1	
hydrocortisone w/acetic acid	1	
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