



Aetna Better Health® of Illinois
Preferred Drug List
December 2020

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

Pharmacy Program

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

Filling a Prescription

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

There is no cost for covered drugs.

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

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

Generic Drugs

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

Specialty Drugs

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

Pharmacy Benefit Exclusions

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

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

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

Legend

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

Aetna Better Health of Illinois Formulary Guide

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		Coverage Requirements and Limits
lowercase italics = Generic drugs	Drug Tier	AL = Age Restrictions
UPPERCASE BOLD = Brand name drugs	Non – Preferred = Non – Preferred	OTC = OTC Medications
	Preferred = Preferred	PA = Prior Authorization Applies
		QL = Quantity Limits
		ST = Step Therapy Applies
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*5-Ht4 Receptor Agonists*** - Drugs For The Stomach		
<i>*5-Ht4 Receptor Agonists*** - Drugs For The Stomach</i>		
MOTEGRITY	Non – Preferred	
*Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb*** - Drugs For The Heart		
<i>*Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb*** - Drugs For The Heart</i>		
NEXLIZET	Non – Preferred	
*Adenosine Receptor Antagonist*** - Drugs For The Nervous System		
<i>*Adenosine Receptor Antagonist*** - Drugs For The Nervous System</i>		
NOURIANZ	Non – Preferred	
*Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors*** - Drugs For The Heart		
<i>*Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors*** - Drugs For The Heart</i>		
NEXLETOL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexiant - Drugs For The Nervous System		
*Adhd Agent - Selective Alpha Adrenergic Agonists*** - Drugs For Attention Deficit Disorder		
<i>clonidine hcl er</i>	Preferred	QL (120 day per 1 day); AL (Min 6 Years)
<i>guanfacine hcl er</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
INTUNIV	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
*Adhd Agent - Selective Norepinephrine Reuptake Inhibitor*** - Drugs For Attention Deficit Disorder		
<i>atomoxetine hcl</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
STRATTERA	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
*Amphetamine Mixtures*** - Drugs For Attention Deficit Disorder		
<i>amphetamine-dextroamphet er capsule extended release 24 hour 10 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphet er capsule extended release 24 hour 15 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphet er capsule extended release 24 hour 20 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphet er capsule extended release 24 hour 25 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphet er capsule extended release 24 hour 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
MYDAYIS	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
*Amphetamines*** - Drugs For Attention Deficit Disorder		
<i>amphetamine er</i>	Non – Preferred	AL (Min 6 Years)
<i>amphetamine sulfate</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 10 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 15 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 5 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate oral solution</i>	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate oral tablet</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>methamphetamine hcl</i>	Non – Preferred	QL (5 EA per 1 day); AL (Min 6 Years)
ADZENYS ER	Non – Preferred	AL (Min 6 Years)
ADZENYS XR-ODT	Non – Preferred	AL (Min 6 Years)
DESOXYN	Non – Preferred	QL (5 EA per 1 day); AL (Min 6 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
DYANAVEL XR	Non – Preferred	AL (Min 6 Years)
EVEKEO	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
EVEKEO ODT	Non – Preferred	AL (Min 6 Years)
PROCENTRA	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
VYVANSE	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 10 MG ORAL	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 15 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 2.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 20 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 5 MG ORAL	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 7.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>*Stimulants - Misc.*** - Drugs For Attention Deficit Disorder</i>		
<i>armodafinil tablet 150 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>armodafinil tablet 200 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 250 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 50 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
<i>dexmethylphenidate hcl</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>dexmethylphenidate hcl er</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (cd)</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 10 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 20 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 40 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 60 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (xr)</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er tablet extended release 10 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er tablet extended release 18 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er tablet extended release 20 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er tablet extended release 27 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

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

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METHYLIN	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
NUVIGIL TABLET 150 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 200 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 250 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
PROVIGIL	Non – Preferred	AL (Min 17 Years)
QUILLICHEW ER	Non – Preferred	AL (Min 6 Years)
QUILLIVANT XR	Non – Preferred	AL (Min 6 Years)
RELEXXII	Non – Preferred	AL (Min 6 Years)
RITALIN	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
*Agents For Narcotic Withdrawal*** - Drugs For Addiction		
*Agents For Narcotic Withdrawal*** - Drugs For Addiction		
LUCEMYRA	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Agents For Opioid Withdrawal*** - Drugs For Addiction		
<i>*Agents For Opioid Withdrawal*** - Drugs For Addiction</i>		
LUCEMYRA	Preferred	
Amebicides - Drugs For Infections		
<i>*Amebicides*** - Drugs For Parasites</i>		
SOLOSEC	Non – Preferred	
Aminoglycosides - Drugs For Infections		
<i>*Aminoglycosides*** - Antibiotics</i>		
<i>amikacin sulfate</i>	Preferred	
<i>gentamicin in saline</i>	Preferred	
<i>gentamicin sulfate</i>	Preferred	
<i>neomycin sulfate</i>	Preferred	
<i>paromomycin sulfate</i>	Preferred	
<i>tobramycin nebulization solution 300 mg/4ml inhalation</i>	Non – Preferred	
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Non – Preferred	QL (10 ML per 1 day)
<i>tobramycin sulfate</i>	Preferred	
ARIKAYCE	Non – Preferred	
BETHKIS	Non – Preferred	
KITABIS PAK	Preferred	QL (10 ML per 1 day)
TOBI	Non – Preferred	QL (10 ML per 1 day)
TOBI PODHALER	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Aminomethylcyclines*** - Drugs For Infections		
<i>*Aminomethylcyclines*** - Drugs For Infections</i>		
NUZYRA	Non – Preferred	
Analgesics - Anti-Inflammatory - Drugs For Pain And Fever		
<i>*Antirheumatic - Janus Kinase (Jak) Inhibitors*** - Arthritis And Pain Drugs</i>		
OLUMIANT	Non – Preferred	
RINVOQ	Non – Preferred	
XELJANZ	Preferred	PA
XELJANZ XR	Preferred	PA
<i>*Antirheumatic Antimetabolites*** - Arthritis And Pain Drugs</i>		
OTREXUP	Non – Preferred	
RASUVO	Non – Preferred	
<i>*Anti-Tnf-Alpha - Monoclonal Antibodies*** - Arthritis And Pain Drugs</i>		
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS	Preferred	PA; QL (2 SYRINGE per 180 days)
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (3 SYRINGE per 180 days)
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS	Preferred	PA
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (6 EA per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (3 EA per 180 days)
HUMIRA PEN-PS/UV/ADOL HS START PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (6 EA per 28 days)
HUMIRA PEN-PS/UV/ADOL HS START PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS	Preferred	PA; QL (3 EA per 180 days)
HUMIRA PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 10 MG/0.2ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 20 MG/0.4ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS	Preferred	PA
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
SIMPONI	Non – Preferred	
SIMPONI ARIA	Non – Preferred	
<i>*Anti-Tnf-Alpha - Monoclonal Antibodies*** - Arthritis And Pain Drugs</i>		
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS	Preferred	PA; QL (2 SYRINGE per 180 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (3 SYRINGE per 180 days)
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS	Preferred	PA
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (3 EA per 180 days)
HUMIRA PEN-PS/UV/ADOL HS START PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (6 EA per 28 days)
HUMIRA PEN-PS/UV/ADOL HS START PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS	Preferred	PA; QL (3 EA per 180 days)
HUMIRA PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 10 MG/0.2ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 20 MG/0.4ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS	Preferred	PA
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS	Preferred	PA; QL (2 EA per 28 days)
SIMPONI	Non – Preferred	
SIMPONI ARIA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Cyclooxygenase 2 (Cox-2) Inhibitors*** - Arthritis And Pain Drugs		
<i>celecoxib</i>	Preferred	QL (1 EA per 1 day)
CELEBREX	Non – Preferred	QL (1 EA per 1 day)
*Gold Compounds*** - Arthritis And Pain Drugs		
RIDAURA	Non – Preferred	
*Interleukin-1 Blockers*** - Arthritis And Pain Drugs		
ARCALYST	Non – Preferred	
*Interleukin-1 Receptor Antagonist (Il-1Ra)*** - Arthritis And Pain Drugs		
KINERET	Non – Preferred	
*Interleukin-1Beta Blockers*** - Arthritis And Pain Drugs		
ILARIS	Non – Preferred	
*Interleukin-6 Receptor Inhibitors*** - Arthritis And Pain Drugs		
ACTEMRA	Non – Preferred	
ACTEMRA ACTPEN	Non – Preferred	
KEVZARA	Non – Preferred	
*Nonsteroidal Anti-Inflammatory Agent Combinations*** - Arthritis And Pain Drugs		
<i>diclofenac-misoprostol</i>	Non – Preferred	
<i>naproxen-esomeprazole</i>	Non – Preferred	
ARTHROTEC	Non – Preferred	
DUEXIS	Non – Preferred	
VIMOVO	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Nonsteroidal Anti-Inflammatory Agents (Nsaids)*** - Arthritis And Pain Drugs		
<i>diclofenac potassium</i>	Preferred	
<i>diclofenac sodium</i>	Preferred	
<i>diclofenac sodium er</i>	Preferred	
<i>ec-naproxen</i>	Preferred	
<i>etodolac</i>	Preferred	
<i>etodolac er</i>	Preferred	
<i>fenoprofen calcium</i>	Non – Preferred	
<i>flurbiprofen</i>	Preferred	
<i>ibuprofen oral suspension</i>	Non – Preferred	
<i>ibuprofen oral tablet</i>	Preferred	
<i>indomethacin</i>	Preferred	
<i>indomethacin er</i>	Preferred	
<i>ketoprofen</i>	Preferred	
<i>ketoprofen er</i>	Non – Preferred	
<i>ketorolac tromethamine nasal</i>	Non – Preferred	
<i>ketorolac tromethamine oral</i>	Preferred	QL (20 EA per 30 days)
<i>meclofenamate sodium</i>	Non – Preferred	
<i>mefenamic acid</i>	Non – Preferred	
<i>meloxicam</i>	Preferred	QL (1 EA per 1 day)
<i>nabumetone</i>	Preferred	QL (4 EA per 1 day)
<i>naproxen</i>	Preferred	
<i>naproxen dr</i>	Preferred	
<i>naproxen sodium</i>	Preferred	
<i>naproxen sodium er</i>	Non – Preferred	
<i>oxaprozin</i>	Non – Preferred	
<i>piroxicam</i>	Non – Preferred	
<i>sulindac</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tolmetin sodium</i>	Non – Preferred	
DAYPRO	Non – Preferred	
FELDENE	Non – Preferred	
IBU	Preferred	
IBUPAK	Non – Preferred	
INDOCIN	Non – Preferred	
MOBIC	Non – Preferred	QL (1 EA per 1 day)
NALFON	Non – Preferred	
NAPRELAN	Non – Preferred	
QMIIZ ODT	Non – Preferred	
RELAFEN DS	Non – Preferred	
SPRIX	Non – Preferred	
TIVORBEX	Non – Preferred	
VIVLODEX	Non – Preferred	
ZIPSOR	Non – Preferred	
ZORVOLEX	Non – Preferred	
<i>*Pyrimidine Synthesis Inhibitors*** - Arthritis And Pain Drugs</i>		
<i>leflunomide</i>	Preferred	QL (1 EA per 1 day)
ARAVA	Non – Preferred	QL (1 EA per 1 day)
<i>*Selective Costimulation Modulators*** - Arthritis And Pain Drugs</i>		
ORENCIA	Non – Preferred	
ORENCIA CLICKJECT	Non – Preferred	
<i>*Soluble Tumor Necrosis Factor Receptor Agents*** - Arthritis And Pain Drugs</i>		
ENBREL MINI	Preferred	PA; QL (4 PEN per 28 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SOLUTION PREFILLED SYRINGE 25 MG/0.5ML SUBCUTANEOUS	Preferred	PA; QL (2.04 ML per 28 days)
ENBREL SOLUTION PREFILLED SYRINGE 50 MG/ML SUBCUTANEOUS	Preferred	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	Preferred	PA
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED	Preferred	PA
ENBREL SURECLICK	Preferred	PA; QL (4 ML per 28 days)
Analgesics - Nonnarcotic - Drugs For Pain And Fever		
*Analgesics-Sedatives*** - Arthritis And Pain Drugs		
<i>butalbital-acetaminophen oral capsule</i>	Non – Preferred	
<i>butalbital-acetaminophen tablet 50-300 mg oral</i>	Preferred	
<i>butalbital-acetaminophen tablet 50-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine capsule 50-300-40 mg oral</i>	Preferred	
<i>butalbital-apap-caffeine capsule 50-325-40 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine oral tablet</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-aspirin-caffeine oral capsule</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-aspirin-caffeine oral tablet</i>	Preferred	
BUPAP	Preferred	
ESGIC ORAL CAPSULE	Preferred	QL (6 EA per 1 day)
ESGIC ORAL TABLET	Non – Preferred	QL (6 EA per 1 day)
FIORICET	Non – Preferred	
FIORINAL	Non – Preferred	QL (6 EA per 1 day)
VANATOL LQ	Non – Preferred	
VANATOL S	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VTOL LQ	Non – Preferred	
ZEBUTAL	Preferred	QL (6 EA per 1 day)
*Salicylates*** - Arthritis And Pain Drugs		
<i>diflunisal</i>	Preferred	
<i>salsalate</i>	Preferred	
Analgesics - Opioid - Drugs For Pain And Fever		
*Codeine Combinations*** - Arthritis And Pain Drugs		
<i>acetaminophen-codeine #2</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>acetaminophen-codeine #3</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>acetaminophen-codeine #4</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>acetaminophen-codeine oral solution</i>	Preferred	QL (20 ML per 1 day); AL (Min 18 Years)
<i>acetaminophen-codeine oral tablet</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>butalbital-apap-caff-cod capsule 50-300-40-30 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>butalbital-apap-caff-cod capsule 50-325-40-30 mg oral</i>	Non – Preferred	AL (Min 18 Years)
<i>butalbital-asa-caff-codeine</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
ASCOMP-CODEINE	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
FIORINAL/CODEINE #3	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocodone bitartrate er</i>	Non – Preferred	
<i>hydromorphone hcl er</i>	Non – Preferred	
<i>hydromorphone hcl oral liquid</i>	Preferred	
<i>hydromorphone hcl rectal</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 4 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 8 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>levorphanol tartrate</i>	Non – Preferred	
<i>meperidine hcl</i>	Non – Preferred	
<i>methadone hcl oral concentrate</i>	Non – Preferred	QL (3 ML per 1 day)
<i>methadone hcl oral tablet soluble</i>	Non – Preferred	
<i>methadone hcl solution 10 mg/5ml oral</i>	Non – Preferred	QL (15 ML per 1 day)
<i>methadone hcl solution 5 mg/5ml oral</i>	Non – Preferred	QL (30 ML per 1 day)
<i>methadone hcl tablet 10 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>methadone hcl tablet 5 mg oral</i>	Non – Preferred	QL (6 EA per 1 day)
<i>morphine sulfate (concentrate)</i>	Preferred	QL (4.5 ML per 1 day)
<i>morphine sulfate er beads</i>	Non – Preferred	
<i>morphine sulfate er oral capsule extended release 24 hour</i>	Non – Preferred	
<i>morphine sulfate er tablet extended release 100 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 15 mg oral</i>	Preferred	PA; QL (6 EA per 1 day)
<i>morphine sulfate er tablet extended release 200 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 30 mg oral</i>	Preferred	PA
<i>morphine sulfate er tablet extended release 60 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate solution 10 mg/5ml oral</i>	Preferred	QL (45 ML per 1 day)
<i>morphine sulfate solution 20 mg/5ml oral</i>	Preferred	QL (500 ML per 23 days)

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

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURAGESIC-100	Non – Preferred	
DURAGESIC-12	Non – Preferred	
DURAGESIC-25	Non – Preferred	
DURAGESIC-50	Non – Preferred	
DURAGESIC-75	Non – Preferred	
FENTORA	Non – Preferred	
HYSINGLA ER	Non – Preferred	
KADIAN	Non – Preferred	
METHADONE HCL INTENSOL	Non – Preferred	QL (3 ML per 1 day)
METHADOSE ORAL CONCENTRATE	Non – Preferred	QL (3 ML per 1 day)
METHADOSE ORAL TABLET SOLUBLE	Non – Preferred	
METHADOSE SUGAR-FREE	Non – Preferred	QL (3 ML per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 100 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 15 MG ORAL	Non – Preferred	PA; QL (6 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 200 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 30 MG ORAL	Non – Preferred	PA
MS CONTIN TABLET EXTENDED RELEASE 60 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
NUCYNTA	Non – Preferred	
NUCYNTA ER	Non – Preferred	
OXAYDO TABLET 5 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
OXAYDO TABLET 7.5 MG ORAL	Non – Preferred	
OXYCONTIN	Non – Preferred	
ROXICODONE	Non – Preferred	QL (4 EA per 1 day)
ULTRAM	Non – Preferred	QL (8 EA per 1 day); AL (Min 18 Years)
XTAMPZA ER	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZOHYDRO ER	Non – Preferred	
*Opioid Combinations*** - Arthritis And Pain Drugs		
<i>benzhydrocodone-acetaminophen</i>	Non – Preferred	
<i>nalocet</i>	Non – Preferred	
<i>oxycodone-acetaminophen</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone-aspirin</i>	Non – Preferred	QL (4 EA per 1 day)
APADAZ	Non – Preferred	
ENDOCET	Preferred	QL (4 EA per 1 day)
PERCOCET	Non – Preferred	QL (4 EA per 1 day)
PRIMLEV	Non – Preferred	
PROLATE	Non – Preferred	
*Opioid Partial Agonists*** - Arthritis And Pain Drugs		
<i>buprenorphine</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine hcl tablet sublingual 2 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl tablet sublingual 8 mg sublingual</i>	Preferred	QL (2 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film</i>	Preferred	
<i>buprenorphine hcl-naloxone hcl tablet sublingual 2-0.5 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl tablet sublingual 8-2 mg sublingual</i>	Preferred	QL (2 EA per 1 day)
<i>butorphanol tartrate</i>	Non – Preferred	QL (2.5 ML per 30 days)
<i>pentazocine-naloxone hcl</i>	Non – Preferred	QL (4 EA per 1 day)
BELBUCA	Non – Preferred	
BUNAVAIL	Preferred	
BUTRANS	Non – Preferred	QL (4 EA per 28 days)
PROBUPHINE IMPLANT KIT	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUBLOCADE	Preferred	
SUBOXONE	Preferred	
ZUBSOLV	Preferred	
*Tramadol Combinations*** - Arthritis And Pain Drugs		
<i>tramadol-acetaminophen</i>	Non – Preferred	AL (Min 18 Years)
ULTRACET	Non – Preferred	AL (Min 18 Years)
Androgens-Anabolic - Hormones		
*Androgens*** - Drugs For Men		
<i>testosterone cypionate</i>	Preferred	QL (10 ML per 90 days)
<i>testosterone enanthate</i>	Preferred	QL (5 ML per 60 days)
<i>testosterone gel 1.62 % transdermal</i>	Preferred	
<i>testosterone gel 10 mg/lact (2%) transdermal</i>	Preferred	QL (120 GM per 30 days)
<i>testosterone gel 12.5 mg/lact (1%) transdermal</i>	Preferred	QL (300 GM per 30 days)
<i>testosterone gel 20.25 mg/lact (1.62%) transdermal</i>	Preferred	
<i>testosterone gel 25 mg/2.5gm (1%) transdermal</i>	Preferred	
<i>testosterone gel 40.5 mg/2.5gm (1.62%) transdermal</i>	Preferred	
<i>testosterone gel 50 mg/5gm (1%) transdermal</i>	Preferred	
<i>testosterone transdermal solution</i>	Preferred	
Anorectal Agents - Rectal Preparations		
*Intrarectal Steroids*** - Rectal Preparations		
<i>hydrocortisone</i>	Preferred	
CORTENEMA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTIFOAM	Non – Preferred	
UCERIS	Non – Preferred	
*Nitrate Vasodilating Agents*** - Rectal Preparations		
RECTIV	Non – Preferred	
*Rectal Anesthetic/Steroids*** - Rectal Preparations		
<i>lidocaine-hydrocort (perianal)</i>	Non – Preferred	
<i>lidocaine-hydrocortisone ace</i>	Non – Preferred	
ANA-LEX	Non – Preferred	
PROCTOFOAM HC	Non – Preferred	
*Rectal Steroids*** - Rectal Preparations		
<i>hydrocortisone (perianal)</i>	Preferred	
ANUSOL-HC	Non – Preferred	
PROCTO-MED HC	Preferred	
PROCTOZONE-HC	Preferred	
Anthelmintics - Drugs For Infections		
*Anthelmintics*** - Drugs For Parasites		
<i>albendazole</i>	Non – Preferred	
<i>benznidazole</i>	Non – Preferred	
<i>ivermectin</i>	Non – Preferred	
<i>praziquantel</i>	Preferred	
ALBENZA	Non – Preferred	
BILTRICIDE	Non – Preferred	
EMVERM	Non – Preferred	
STROMEKTOL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antianginal Agents - Drugs For The Heart		
*Antianginals-Other*** - Drugs For Angina		
<i>ranolazine er</i>	Non – Preferred	
RANEXA	Non – Preferred	
*Nitrates*** - Drugs For Angina		
<i>isosorbide dinitrate</i>	Preferred	
<i>isosorbide mononitrate</i>	Preferred	
<i>isosorbide mononitrate er tablet extended release 24 hour 120 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>isosorbide mononitrate er tablet extended release 24 hour 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>isosorbide mononitrate er tablet extended release 24 hour 60 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>nitroglycerin sublingual</i>	Preferred	
<i>nitroglycerin transdermal</i>	Preferred	
<i>nitroglycerin translingual</i>	Non – Preferred	
DILATRATE-SR	Preferred	
GONITRO	Non – Preferred	
ISORDIL TITRADOSE	Non – Preferred	
MINITRAN	Preferred	
NITRO-BID	Preferred	
NITRO-DUR	Non – Preferred	
NITROLINGUAL	Non – Preferred	
NITROMIST	Non – Preferred	
NITROSTAT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antianxiety Agents - Drugs For The Nervous System		
*Antianxiety Agents - Misc.*** - Drugs For Anxiety		
<i>bupirone hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>bupirone hcl tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>bupirone hcl tablet 30 mg oral</i>	Preferred	
<i>bupirone hcl tablet 5 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>bupirone hcl tablet 7.5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>hydroxyzine hcl oral syrup</i>	Preferred	
<i>hydroxyzine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>hydroxyzine pamoate</i>	Preferred	QL (4 EA per 1 day)
<i>meprobamate</i>	Non – Preferred	
VISTARIL	Non – Preferred	QL (4 EA per 1 day)
*Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>alprazolam er</i>	Non – Preferred	QL (2 EA per 1 day)
<i>alprazolam oral tablet dispersible</i>	Non – Preferred	
<i>alprazolam tablet 0.25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>alprazolam tablet 0.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>alprazolam tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>alprazolam tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>alprazolam xr</i>	Non – Preferred	QL (2 EA per 1 day)
<i>chlordiazepoxide hcl capsule 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlordiazepoxide hcl capsule 25 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>chlordiazepoxide hcl capsule 5 mg oral</i>	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clorazepate dipotassium tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>clorazepate dipotassium tablet 3.75 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>clorazepate dipotassium tablet 7.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diazepam oral concentrate</i>	Preferred	QL (10 ML per 1 day)
<i>diazepam oral solution</i>	Preferred	QL (10 ML per 1 day)
<i>diazepam oral tablet</i>	Preferred	QL (4 EA per 1 day)
<i>lorazepam oral concentrate</i>	Preferred	QL (2 ML per 1 day)
<i>lorazepam tablet 0.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>lorazepam tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lorazepam tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>oxazepam</i>	Preferred	QL (4 EA per 1 day)
ALPRAZOLAM INTENSOL	Preferred	
ATIVAN TABLET 0.5 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
ATIVAN TABLET 1 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
ATIVAN TABLET 2 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
DIAZEPAM INTENSOL	Preferred	QL (10 ML per 1 day)
LORAZEPAM INTENSOL	Preferred	QL (2 ML per 1 day)
TRANXENE-T	Non – Preferred	QL (3 EA per 1 day)
XANAX TABLET 0.25 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
XANAX TABLET 0.5 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
XANAX TABLET 1 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
XANAX TABLET 2 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
XANAX XR	Non – Preferred	QL (2 EA per 1 day)
Antiarrhythmics - Drugs For The Heart		
*Antiarrhythmics Type I-A*** - Drugs For Abnormal Heart Rhythms		
<i>disopyramide phosphate</i>	Preferred	
<i>quinidine gluconate er</i>	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>quinidine sulfate</i>	Preferred	
NORPACE	Non – Preferred	
NORPACE CR	Preferred	
*Antiarrhythmics Type I-B*** - Drugs For Abnormal Heart Rhythms		
<i>mexiletine hcl</i>	Preferred	
*Antiarrhythmics Type I-C*** - Drugs For Abnormal Heart Rhythms		
<i>flecainide acetate</i>	Preferred	
<i>propafenone hcl</i>	Preferred	
<i>propafenone hcl er</i>	Non – Preferred	
RYTHMOL SR	Non – Preferred	
*Antiarrhythmics Type Iii*** - Drugs For Abnormal Heart Rhythms		
<i>amiodarone hcl</i>	Preferred	
<i>dofetilide</i>	Preferred	
MULTAQ	Non – Preferred	QL (2 EA per 1 day)
PACERONE	Preferred	
TIKOSYN	Non – Preferred	
Antiasthmatic And Bronchodilator Agents - Drugs For The Lungs		
*5-Lipoxygenase Inhibitors*** - Drugs For Asthma/Copd		
<i>zileuton er</i>	Non – Preferred	
ZYFLO	Non – Preferred	
*Adrenergic Combinations*** - Drugs For Asthma/Copd		
<i>budesonide-formoterol fumarate</i>	Non – Preferred	QL (10.2 GM per 30 days)
<i>fluticasone-salmeterol aerosol powder breath activated 100-50 mcg/dose inhalation</i>	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone-salmeterol aerosol powder breath activated 113-14 mcg/act inhalation</i>	Non – Preferred	QL (1 EA per 30 days)
<i>fluticasone-salmeterol aerosol powder breath activated 232-14 mcg/act inhalation</i>	Non – Preferred	QL (1 EA per 30 days)
<i>fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/dose inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 500-50 mcg/dose inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 55-14 mcg/act inhalation</i>	Non – Preferred	QL (1 EA per 30 days)
<i>ipratropium-albuterol</i>	Preferred	QL (18 ML per 1 day)
ADVAIR DISKUS	Non – Preferred	QL (2 EA per 1 day)
ADVAIR HFA	Non – Preferred	
AIRDUO DIGIHALER	Non – Preferred	
AIRDUO RESPICLICK 113/14	Non – Preferred	QL (1 EA per 30 days)
AIRDUO RESPICLICK 232/14	Non – Preferred	QL (1 EA per 30 days)
AIRDUO RESPICLICK 55/14	Non – Preferred	QL (1 EA per 30 days)
ANORO ELLIPTA	Non – Preferred	QL (60 GM per 30 days)
BEVESPI AEROSPHERE	Preferred	
BREO ELLIPTA	Non – Preferred	QL (60 GM per 30 days)
BREZTRI AEROSPHERE	Non – Preferred	
COMBIVENT RESPIMAT	Non – Preferred	QL (8 GM per 28 days)
DUAKLIR PRESSAIR	Non – Preferred	
DULERA AEROSOL 100-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 200-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 50-5 MCG/ACT INHALATION	Preferred	
STIOLTO RESPIMAT	Non – Preferred	QL (1 CANISTER per 28 days)
SYMBICORT	Preferred	QL (10.2 GM per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH INHALATION	Non – Preferred	QL (2 EA per 1 day)
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/INH INHALATION	Non – Preferred	
UTIBRON NEOHALER	Non – Preferred	
WIXELA INHUB	Preferred	QL (2 EA per 1 day)
*Anti-Ige Monoclonal Antibodies*** - Drugs For Asthma/Copd		
XOLAIR	Non – Preferred	
*Anti-Inflammatory Agents*** - Drugs For Asthma/Copd		
<i>cromolyn sodium</i>	Preferred	
*Beta Adrenergics*** - Drugs For Asthma/Copd		
<i>albuterol sulfate er</i>	Non – Preferred	
<i>albuterol sulfate hfa</i>	Preferred	QL (36 GM per 30 days)
<i>albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083% inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	Preferred	QL (2 ML per 1 day)
<i>albuterol sulfate nebulization solution 0.63 mg/3ml inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 1.25 mg/3ml inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 2.5 mg/0.5ml inhalation</i>	Preferred	QL (2 EA per 1 day)
<i>albuterol sulfate oral syrup</i>	Preferred	
<i>albuterol sulfate oral tablet</i>	Non – Preferred	
<i>levalbuterol hcl</i>	Preferred	
<i>levalbuterol tartrate</i>	Preferred	QL (30 GM per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>terbutaline sulfate</i>	Preferred	
ARCAPTA NEOHALER	Non – Preferred	QL (1 EA per 30 days)
BROVANA	Non – Preferred	
PERFOROMIST	Non – Preferred	
PROAIR DIGIHALER	Non – Preferred	
PROAIR HFA	Preferred	QL (36 GM per 30 days)
PROAIR RESPICLICK	Non – Preferred	
PROVENTIL HFA	Preferred	QL (36 GM per 30 days)
SEREVENT DISKUS	Preferred	QL (2 EA per 1 day)
STRIVERDI RESPIMAT	Non – Preferred	QL (4 GM per 28 days)
VENTOLIN HFA	Preferred	QL (36 GM per 30 days)
XOPENEX	Non – Preferred	
XOPENEX CONCENTRATE	Non – Preferred	
XOPENEX HFA	Preferred	QL (30 GM per 30 days)
<i>*Bronchodilators - Anticholinergics*** - Drugs For Asthma/Copd</i>		
<i>ipratropium bromide</i>	Preferred	
ATROVENT HFA	Preferred	QL (26 GM per 30 days)
INCRUSE ELLIPTA	Non – Preferred	
LONHALA MAGNAIR REFILL KIT	Non – Preferred	
LONHALA MAGNAIR STARTER KIT	Non – Preferred	
SEEBRI NEOHALER	Non – Preferred	
SPIRIVA HANDIHALER	Preferred	
SPIRIVA RESPIMAT AEROSOL SOLUTION 1.25 MCG/ACT INHALATION	Preferred	AL (Min 6 Years and Max 17 Years)
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5 MCG/ACT INHALATION	Non – Preferred	
TUDORZA PRESSAIR	Non – Preferred	
YUPELRI	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Leukotriene Receptor Antagonists*** - Drugs For Asthma/Copd		
<i>montelukast sodium</i>	Preferred	QL (1 EA per 1 day)
<i>zafirlukast</i>	Preferred	QL (2 EA per 1 day)
ACCOLATE	Non – Preferred	QL (2 EA per 1 day)
SINGULAIR	Non – Preferred	QL (1 EA per 1 day)
*Selective Phosphodiesterase 4 (Pde4) Inhibitors*** - Drugs For Asthma/Copd		
DALIRESP	Non – Preferred	
*Steroid Inhalants*** - Drugs For Asthma/Copd		
<i>budesonide</i>	Non – Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
ALVESCO	Non – Preferred	
ARMONAIR DIGIHALER	Non – Preferred	
ARNUITY ELLIPTA	Non – Preferred	
ASMANEX (120 METERED DOSES)	Preferred	
ASMANEX (14 METERED DOSES)	Preferred	
ASMANEX (30 METERED DOSES)	Preferred	
ASMANEX (60 METERED DOSES)	Preferred	
ASMANEX HFA	Non – Preferred	
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 100 MCG/BLIST INHALATION	Preferred	QL (2 EA per 1 day)
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 250 MCG/BLIST INHALATION	Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 50 MCG/BLIST INHALATION	Preferred	QL (60 EA Max Qty Per Fill Retail)
FLOVENT HFA AEROSOL 110 MCG/ACT INHALATION	Preferred	QL (0.4 GM per 1 day)
FLOVENT HFA AEROSOL 220 MCG/ACT INHALATION	Preferred	QL (0.4 GM per 1 day)
FLOVENT HFA AEROSOL 44 MCG/ACT INHALATION	Preferred	QL (0.3334 GM per 1 day)
PULMICORT	Non – Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
PULMICORT FLEXHALER	Non – Preferred	
QVAR REDHALER AEROSOL BREATH ACTIVATED 40 MCG/ACT INHALATION	Non – Preferred	QL (0.3533 GM per 1 day)
QVAR REDHALER AEROSOL BREATH ACTIVATED 80 MCG/ACT INHALATION	Non – Preferred	
<i>*Xanthines*** - Drugs For Asthma/Copd</i>		
<i>theophylline</i>	Preferred	
<i>theophylline er</i>	Preferred	
THEO-24	Preferred	
*Anti-Cataplectic Combinations*** - Drugs For The Nervous System		
<i>*Anti-Cataplectic Combinations*** - Drugs For The Nervous System</i>		
XYWAV	Non – Preferred	
Anticoagulants - Drugs For The Blood		
<i>*Coumarin Anticoagulants*** - Drugs To Prevent Blood Clots</i>		
<i>warfarin sodium</i>	Preferred	

Coverage Requirements and Limits

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Drug Tier

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Preferred = Preferred

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANTOVEN	Preferred	
<i>*Direct Factor Xa Inhibitors*** - Drugs To Prevent Blood Clots</i>		
ELIQUIS	Preferred	PA; QL (2 EA per 1 day)
ELIQUIS DVT/PE STARTER PACK	Preferred	PA; QL (2 EA per 1 day)
SAVAYSA	Non – Preferred	
XARELTO STARTER PACK	Preferred	PA; QL (51 EA per 30 days)
XARELTO TABLET 10 MG ORAL	Preferred	PA
XARELTO TABLET 15 MG ORAL	Preferred	PA; QL (1 EA per 1 day)
XARELTO TABLET 2.5 MG ORAL	Preferred	PA
XARELTO TABLET 20 MG ORAL	Preferred	PA
<i>*Heparins And Heparinoid-Like Agents*** - Drugs To Prevent Blood Clots</i>		
<i>heparin sodium (porcine)</i>	Preferred	
<i>heparin sodium (porcine) pf</i>	Preferred	
<i>*Low Molecular Weight Heparins*** - Drugs To Prevent Blood Clots</i>		
<i>enoxaparin sodium</i>	Preferred	
FRAGMIN	Preferred	
LOVENOX	Non – Preferred	
<i>*Synthetic Heparinoid-Like Agents*** - Drugs To Prevent Blood Clots</i>		
<i>fondaparinux sodium</i>	Preferred	
ARIXTRA	Non – Preferred	
<i>*Thrombin Inhibitors - Selective Direct & Reversible*** - Drugs To Prevent Blood Clots</i>		
PRADAXA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anticonvulsants - Drugs For The Nervous System		
*Ampa Glutamate Receptor Antagonists*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
FYCOMPA	Non – Preferred	
*Anticonvulsants - Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>clobazam</i>	Non – Preferred	
<i>clonazepam oral tablet</i>	Preferred	
<i>clonazepam oral tablet dispersible</i>	Non – Preferred	
<i>diazepam</i>	Preferred	QL (2 EA Max Qty Per Fill Retail)
DIASTAT ACUDIAL	Preferred	QL (2 EA Max Qty Per Fill Retail)
DIASTAT PEDIATRIC	Preferred	QL (2 EA Max Qty Per Fill Retail)
KLONOPIN	Non – Preferred	
NAYZILAM	Non – Preferred	
ONFI	Non – Preferred	
SYMPAZAN	Non – Preferred	
VALTOCO 10 MG DOSE	Non – Preferred	
VALTOCO 15 MG DOSE	Non – Preferred	
VALTOCO 20 MG DOSE	Non – Preferred	
VALTOCO 5 MG DOSE	Non – Preferred	
*Anticonvulsants - Misc.*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>carbamazepine</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbamazepine er oral capsule extended release 12 hour</i>	Non – Preferred	QL (4 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 100 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 400 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>gabapentin oral capsule</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin oral solution</i>	Preferred	
<i>gabapentin tablet 600 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin tablet 800 mg oral</i>	Preferred	QL (4.5 EA per 1 day)
<i>lamotrigine er</i>	Non – Preferred	
<i>lamotrigine oral kit</i>	Non – Preferred	
<i>lamotrigine oral tablet dispersible</i>	Non – Preferred	
<i>lamotrigine starter kit-blue</i>	Non – Preferred	
<i>lamotrigine starter kit-green</i>	Non – Preferred	
<i>lamotrigine starter kit-orange</i>	Non – Preferred	
<i>lamotrigine tablet 100 mg oral</i>	Preferred	
<i>lamotrigine tablet 150 mg oral</i>	Preferred	
<i>lamotrigine tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lamotrigine tablet 25 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lamotrigine tablet chewable 25 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lamotrigine tablet chewable 5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>levetiracetam er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>levetiracetam er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>levetiracetam oral solution</i>	Preferred	
<i>levetiracetam tablet 1000 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>levetiracetam tablet 250 mg oral</i>	Preferred	QL (4 EA per 1 day)

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

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX SPRINKLE	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 100 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX TABLET 25 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 50 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TRILEPTAL	Non – Preferred	
TROKENDI XR	Non – Preferred	
VIMPAT	Non – Preferred	
*Carbamates*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>felbamate</i>	Non – Preferred	
FELBATOL	Non – Preferred	
XCOPRI	Non – Preferred	
XCOPRI (250 MG DAILY DOSE)	Non – Preferred	
XCOPRI (350 MG DAILY DOSE)	Non – Preferred	
*Gaba Modulators*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>tiagabine hcl tablet 12 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>tiagabine hcl tablet 16 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>tiagabine hcl tablet 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>tiagabine hcl tablet 4 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>vigabatrin</i>	Non – Preferred	
GABITRIL TABLET 12 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
GABITRIL TABLET 16 MG ORAL	Non – Preferred	QL (3 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GABITRIL TABLET 2 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
GABITRIL TABLET 4 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
SABRIL	Non – Preferred	
VIGADRONE	Non – Preferred	
*Hydantoins*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>phenytoin</i>	Preferred	
<i>phenytoin sodium extended</i>	Preferred	
DILANTIN	Non – Preferred	
DILANTIN INFATABS	Non – Preferred	
PEGANONE	Non – Preferred	
PHENYTEK	Non – Preferred	
PHENYTOIN INFATABS	Preferred	
*Succinimides*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>ethosuximide</i>	Preferred	
CELONTIN	Non – Preferred	
ZARONTIN	Non – Preferred	
*Valproic Acid*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>divalproex sodium</i>	Preferred	
<i>divalproex sodium er</i>	Preferred	
<i>valproic acid</i>	Preferred	
DEPAKOTE	Non – Preferred	
DEPAKOTE ER	Non – Preferred	
DEPAKOTE SPRINKLES	Non – Preferred	

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Modified Cyclics*** - Drugs For Depression		
<i>nefazodone hcl</i>	Non – Preferred	
<i>trazodone hcl</i>	Preferred	
TRINTELLIX	Non – Preferred	
VIIBRYD	Non – Preferred	
VIIBRYD STARTER PACK	Non – Preferred	
*Monoamine Oxidase Inhibitors (Maois)*** - Drugs For Depression		
<i>phenelzine sulfate</i>	Preferred	
<i>tranylcypromine sulfate</i>	Preferred	
EMSAM	Non – Preferred	
MARPLAN	Non – Preferred	
NARDIL	Non – Preferred	
*Selective Serotonin Reuptake Inhibitors (Ssrís)*** - Drugs For Depression		
<i>citalopram hydrobromide oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>citalopram hydrobromide tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>citalopram hydrobromide tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>citalopram hydrobromide tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>escitalopram oxalate oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>escitalopram oxalate oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>fluoxetine hcl capsule 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fluoxetine hcl capsule 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluoxetine hcl capsule 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluoxetine hcl oral capsule delayed release</i>	Non – Preferred	
<i>fluoxetine hcl oral solution</i>	Preferred	QL (150 ML per 30 days)
<i>fluoxetine hcl oral tablet</i>	Preferred	

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Serotonin-Norepinephrine Reuptake Inhibitors (Snris)*** - Drugs For Depression		
<i>desvenlafaxine er</i>	Non – Preferred	
<i>desvenlafaxine succinate er</i>	Non – Preferred	
<i>duloxetine hcl capsule delayed release particles 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 40 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 60 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>venlafaxine hcl</i>	Preferred	
<i>venlafaxine hcl er oral capsule extended release 24 hour</i>	Preferred	QL (1 EA per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour</i>	Non – Preferred	
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 60 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DRIZALMA SPRINKLE	Non – Preferred	
EFFEXOR XR	Non – Preferred	QL (1 EA per 1 day)
FETZIMA	Non – Preferred	
FETZIMA TITRATION	Non – Preferred	
PRISTIQ	Non – Preferred	
*Tricyclic Agents*** - Drugs For Depression		
<i>amitriptyline hcl</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amoxapine</i>	Non – Preferred	
<i>clomipramine hcl</i>	Preferred	
<i>desipramine hcl tablet 10 mg oral</i>	Preferred	
<i>desipramine hcl tablet 100 mg oral</i>	Preferred	
<i>desipramine hcl tablet 150 mg oral</i>	Preferred	
<i>desipramine hcl tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>desipramine hcl tablet 50 mg oral</i>	Preferred	
<i>desipramine hcl tablet 75 mg oral</i>	Preferred	
<i>doxepin hcl</i>	Preferred	
<i>imipramine hcl</i>	Preferred	
<i>imipramine pamoate</i>	Non – Preferred	
<i>nortriptyline hcl</i>	Preferred	
<i>protriptyline hcl</i>	Preferred	
<i>trimipramine maleate</i>	Non – Preferred	
ANAFRANIL	Non – Preferred	
NORPRAMIN TABLET 10 MG ORAL	Non – Preferred	
NORPRAMIN TABLET 25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
PAMELOR	Non – Preferred	
Antidiabetics - Hormones		
*Alpha-Glucosidase Inhibitors*** - Drugs For Diabetes		
<i>acarbose</i>	Preferred	QL (3 EA per 1 day)
<i>miglitol</i>	Preferred	
GLYSET	Non – Preferred	
PRECOSE	Non – Preferred	QL (3 EA per 1 day)
*Antidiabetic - Amylin Analogs*** - Drugs For Diabetes		
SYMLINPEN 120	Non – Preferred	
SYMLINPEN 60	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Biguanides*** - Drugs For Diabetes		
<i>metformin hcl er (mod)</i>	Preferred	
<i>metformin hcl er (osm)</i>	Preferred	
<i>metformin hcl er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>metformin hcl er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>metformin hcl oral solution</i>	Non – Preferred	
<i>metformin hcl oral tablet</i>	Preferred	
FORTAMET	Non – Preferred	
GLUMETZA	Non – Preferred	
RIOMET	Non – Preferred	
RIOMET ER	Non – Preferred	
*Diabetic Other*** - Drugs For Diabetes		
<i>diazoxide</i>	Preferred	
BAQSIMI ONE PACK	Non – Preferred	
BAQSIMI TWO PACK	Non – Preferred	
GLUCAGEN HYPOKIT	Preferred	
GLUCAGON EMERGENCY INJECTION KIT	Preferred	QL (1 EA Max Qty Per Fill Retail)
GLUCAGON EMERGENCY INJECTION SOLUTION RECONSTITUTED	Preferred	
GVOKE HYPOPEN 1-PACK	Non – Preferred	
GVOKE HYPOPEN 2-PACK	Non – Preferred	
GVOKE PFS	Non – Preferred	
PROGLYCEM	Preferred	
*Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors*** - Drugs For Diabetes		
<i>alogliptin benzoate</i>	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUVIA	Preferred	QL (1 EA per 1 day)
NESINA	Non – Preferred	QL (1 EA per 1 day)
ONGLYZA	Non – Preferred	
TRADJENTA	Preferred	QL (1 EA per 1 day)
<i>*Dipeptidyl Peptidase-4 Inhibitor-Biguanide Combinations*** - Drugs For Diabetes</i>		
<i>alogliptin-metformin hcl</i>	Non – Preferred	
JANUMET	Non – Preferred	QL (2 EA per 1 day)
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ORAL	Non – Preferred	
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
JENTADUETO	Non – Preferred	
JENTADUETO XR	Non – Preferred	
KAZANO	Non – Preferred	
KOMBIGLYZE XR	Non – Preferred	
<i>*Dopamine Receptor Agonists - Ergot Derivatives*** - Drugs For Diabetes</i>		
CYCLOSET	Non – Preferred	
<i>*Dpp-4 Inhibitor-Thiazolidinedione Combinations*** - Drugs For Diabetes</i>		
<i>alogliptin-pioglitazone tablet 12.5-15 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>alogliptin-pioglitazone tablet 12.5-30 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>alogliptin-pioglitazone tablet 12.5-45 mg oral</i>	Non – Preferred	
<i>alogliptin-pioglitazone tablet 25-15 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>alogliptin-pioglitazone tablet 25-30 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>alogliptin-pioglitazone tablet 25-45 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
OSENI TABLET 12.5-15 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
OSENI TABLET 12.5-30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
OSENI TABLET 12.5-45 MG ORAL	Non – Preferred	
OSENI TABLET 25-15 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
OSENI TABLET 25-30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
OSENI TABLET 25-45 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
<i>*Human Insulin*** - Drugs For Diabetes</i>		
<i>insulin asp prot & asp flexpen</i>	Non – Preferred	
<i>insulin aspart</i>	Non – Preferred	
<i>insulin aspart flexpen</i>	Non – Preferred	
<i>insulin aspart penfill</i>	Non – Preferred	
<i>insulin aspart prot & aspart</i>	Non – Preferred	
<i>insulin lispro</i>	Preferred	
<i>insulin lispro (1 unit dial)</i>	Preferred	
<i>insulin lispro junior kwikpen</i>	Preferred	QL (1 ML per 1 day)
<i>insulin lispro prot & lispro</i>	Preferred	
ADMELOG	Non – Preferred	
ADMELOG SOLOSTAR	Non – Preferred	
AFREZZA	Non – Preferred	
APIDRA	Non – Preferred	
APIDRA SOLOSTAR	Non – Preferred	
BASAGLAR KWIKPEN	Non – Preferred	
FIASP	Non – Preferred	
FIASP FLEXTOUCH	Non – Preferred	
FIASP PENFILL	Non – Preferred	
HUMALOG	Preferred	

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

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NOVOLIN R FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN R RELION	Non – Preferred	OTC
NOVOLOG	Non – Preferred	
NOVOLOG FLEXPEN	Non – Preferred	
NOVOLOG MIX 70/30	Non – Preferred	
NOVOLOG MIX 70/30 FLEXPEN	Non – Preferred	
NOVOLOG PENFILL	Non – Preferred	
SEMGLEE	Non – Preferred	
TOUJEO MAX SOLOSTAR	Non – Preferred	
TOUJEO SOLOSTAR	Non – Preferred	
TRESIBA	Non – Preferred	
TRESIBA FLEXTOUCH	Non – Preferred	
<i>*Incretin Mimetic Agents (Glp-1 Receptor Agonists)*** - Drugs For Diabetes</i>		
ADLYXIN	Non – Preferred	
ADLYXIN STARTER PACK	Non – Preferred	
BYDUREON	Non – Preferred	
BYDUREON BCISE	Non – Preferred	
BYETTA 10 MCG PEN	Preferred	QL (1 VIAL per 30 days)
BYETTA 5 MCG PEN	Preferred	QL (1.2 ML per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE)	Non – Preferred	QL (0.05 ML per 1 day)
OZEMPIC (1 MG/DOSE)	Non – Preferred	QL (0.11 ML per 1 day)
RYBELSUS	Non – Preferred	
TRULICITY	Non – Preferred	
VICTOZA	Preferred	QL (0.6 ML per 1 day)
<i>*Meglitinide Analogues*** - Drugs For Diabetes</i>		
<i>nateglinide</i>	Preferred	QL (3 EA per 1 day)
<i>repaglinide tablet 0.5 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>repaglinide tablet 1 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>repaglinide tablet 2 mg oral</i>	Non – Preferred	QL (8 EA per 1 day)
STARLIX	Non – Preferred	QL (3 EA per 1 day)
*Progesterone Receptor Antagonists*** - Drugs For Diabetes		
KORLYM	Non – Preferred	
*Sodium-Glucose Co-Transporter 2 (SglT2) Inhibitors*** - Drugs For Diabetes		
FARXIGA	Non – Preferred	
INVOKANA	Preferred	
JARDIANCE	Preferred	QL (1 EA per 1 day)
STEGLATRO	Non – Preferred	
*Sulfonylurea-Biguanide Combinations*** - Drugs For Diabetes		
<i>glipizide-metformin hcl tablet 2.5-250 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide-metformin hcl tablet 2.5-500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide-metformin hcl tablet 5-500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>glyburide-metformin tablet 1.25-250 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glyburide-metformin tablet 2.5-500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glyburide-metformin tablet 5-500 mg oral</i>	Preferred	QL (4 EA per 1 day)
*Sulfonylureas*** - Drugs For Diabetes		
<i>glimepiride tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glimepiride tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glimepiride tablet 4 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide</i>	Preferred	
<i>glipizide er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glipizide er tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide</i>	Preferred	
<i>glyburide micronized tablet 1.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide micronized tablet 3 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide micronized tablet 6 mg oral</i>	Preferred	
<i>tolbutamide</i>	Preferred	
AMARYL TABLET 1 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
AMARYL TABLET 2 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
AMARYL TABLET 4 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
GLUCOTROL	Non – Preferred	
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 2.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
GLYNASE TABLET 1.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
GLYNASE TABLET 3 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
GLYNASE TABLET 6 MG ORAL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Sulfonylurea-Thiazolidinedione Combinations*** - Drugs For Diabetes		
<i>pioglitazone hcl-glimepiride</i>	Non – Preferred	
DUETACT	Non – Preferred	
*Thiazolidinedione-Biguanide Combinations*** - Drugs For Diabetes		
<i>pioglitazone hcl-metformin hcl</i>	Non – Preferred	
ACTOPLUS MET	Non – Preferred	
*Thiazolidinediones*** - Drugs For Diabetes		
<i>pioglitazone hcl</i>	Preferred	QL (1 EA per 1 day)
ACTOS	Non – Preferred	QL (1 EA per 1 day)
AVANDIA	Preferred	QL (1 EA per 1 day)
Antidotes - Drugs For Overdose Or Poisoning		
*Antidotes - Chelating Agents*** - Drugs For Overdose Or Poisoning		
<i>deferasirox</i>	Non – Preferred	
<i>deferasirox granules</i>	Non – Preferred	
<i>deferiprone</i>	Non – Preferred	
CHEMET	Preferred	
EXJADE	Non – Preferred	
FERRIPROX	Non – Preferred	
FERRIPROX TWICE-A-DAY	Non – Preferred	
JADENU	Non – Preferred	
JADENU SPRINKLE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Opioid Antagonists*** - Drugs For Overdose Or Poisoning		
<i>naloxone hcl injection solution</i>	Preferred	
<i>naloxone hcl injection solution cartridge</i>	Preferred	
<i>naloxone hcl injection solution prefilled syringe</i>	Preferred	QL (4 ML Max Qty Per Fill Retail)
<i>naltrexone hcl</i>	Preferred	
NARCAN	Preferred	QL (2 EA Max Qty Per Fill Retail)
VIVITROL	Preferred	
Antiemetics - Drugs For The Stomach		
*5-Ht3 Receptor Antagonists*** - Drugs For Vomiting And Nausea		
<i>granisetron hcl</i>	Non – Preferred	QL (8 EA per 28 days)
<i>ondansetron</i>	Preferred	QL (3 EA per 1 day)
<i>ondansetron hcl oral solution</i>	Preferred	QL (50 ML Max Qty Per Fill Retail)
<i>ondansetron hcl oral tablet</i>	Preferred	QL (3 EA per 1 day)
ANZEMET	Non – Preferred	
SANCUSO	Non – Preferred	
ZOFRAN	Non – Preferred	QL (3 EA per 1 day)
ZUPLENZ	Non – Preferred	
*Antiemetic Combinations*** - Drugs For Vomiting And Nausea		
<i>doxylamine-pyridoxine</i>	Non – Preferred	
AKYNZEO	Non – Preferred	
BONJESTA	Non – Preferred	
DICLEGIS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antiemetics - Anticholinergic*** - Drugs For Vomiting And Nausea		
<i>meclizine hcl</i>	Preferred	
<i>scopolamine</i>	Preferred	
<i>trimethobenzamide hcl</i>	Non – Preferred	
TIGAN	Non – Preferred	
TRANSDERM-SCOP (1.5 MG)	Preferred	
*Antiemetics - Miscellaneous*** - Drugs For Vomiting And Nausea		
<i>dronabinol</i>	Non – Preferred	
MARINOL	Non – Preferred	
*Substance P/Neurokinin 1 (Nk1) Receptor Antagonists*** - Drugs For Vomiting And Nausea		
<i>aprepitant</i>	Preferred	QL (3 EA per 30 days)
EMEND ORAL CAPSULE	Non – Preferred	QL (3 EA per 30 days)
EMEND ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
EMEND TRI-PACK	Non – Preferred	QL (3 EA per 30 days)
VARUBI (180 MG DOSE)	Non – Preferred	
Antifungals - Drugs For Infections		
*Antifungal - Glucan Synthesis Inhibitors (Echinocandins)*** - Drugs For Fungus		
<i>micafungin sodium</i>	Preferred	
*Antifungals*** - Drugs For Fungus		
<i>flucytosine</i>	Non – Preferred	
<i>griseofulvin microsize</i>	Preferred	
<i>griseofulvin ultramicrosize</i>	Preferred	
<i>nystatin</i>	Preferred	QL (6 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>terbinafine hcl</i>	Preferred	QL (1 EA per 1 day)
ANCOBON	Non – Preferred	
*Imidazoles*** - Drugs For Fungus		
<i>ketoconazole</i>	Preferred	QL (1 EA per 1 day)
*Triazoles*** - Drugs For Fungus		
<i>fluconazole in sodium chloride</i>	Preferred	
<i>fluconazole oral suspension reconstituted</i>	Preferred	
<i>fluconazole tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluconazole tablet 150 mg oral</i>	Preferred	QL (2 EA Max Qty Per Fill Retail)
<i>fluconazole tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluconazole tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>itraconazole oral capsule</i>	Non – Preferred	QL (4 EA per 1 day)
<i>itraconazole oral solution</i>	Non – Preferred	
<i>posaconazole</i>	Non – Preferred	
<i>tolsura</i>	Non – Preferred	
<i>voriconazole</i>	Non – Preferred	
CRESEMBA	Non – Preferred	
DIFLUCAN ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
DIFLUCAN TABLET 100 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DIFLUCAN TABLET 150 MG ORAL	Non – Preferred	QL (2 EA Max Qty Per Fill Retail)
DIFLUCAN TABLET 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DIFLUCAN TABLET 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NOXAFIL	Non – Preferred	
SPORANOX ORAL CAPSULE	Non – Preferred	QL (4 EA per 1 day)
SPORANOX ORAL SOLUTION	Non – Preferred	
SPORANOX PULSEPAK	Non – Preferred	QL (4 EA per 1 day)
VFEND	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antihemophilic Products - Monoclonal Antibodies*** - Drugs For The Blood		
<i>*Antihemophilic Products - Monoclonal Antibodies*** - Drugs For The Blood</i>		
HEMLIBRA	Preferred	PA
Antihistamines - Drugs For The Lungs		
<i>*Antihistamines - Alkylamines*** - Drugs For Allergies</i>		
<i>aller-chlor</i>	Preferred	OTC
<i>allergy</i>	Preferred	OTC
<i>allergy relief</i>	Preferred	OTC
<i>chlorpheniramine maleate</i>	Preferred	
WAL-FINATE	Preferred	OTC
Antihyperlipidemics - Drugs For The Heart		
<i>*Antihyperlipidemics - Misc.*** - Drugs For Cholesterol</i>		
<i>omega-3-acid ethyl esters</i>	Non – Preferred	QL (4 EA per 1 day)
LOVAZA	Non – Preferred	QL (4 EA per 1 day)
VASCEPA	Non – Preferred	
*Bile Acid Sequestrants*** - Drugs For Cholesterol		
<i>cholestyramine</i>	Preferred	
<i>cholestyramine light</i>	Preferred	
<i>colesevelam hcl</i>	Non – Preferred	
<i>colestipol hcl</i>	Non – Preferred	
COLESTID	Non – Preferred	

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COLESTID FLAVORED	Non – Preferred	
PREVALITE	Preferred	
QUESTRAN	Non – Preferred	
QUESTRAN LIGHT	Non – Preferred	
WELCHOL	Non – Preferred	
*Fibric Acid Derivatives*** - Drugs For Cholesterol		
<i>fenofibrate</i>	Preferred	
<i>fenofibrate micronized</i>	Preferred	
<i>fenofibric acid</i>	Preferred	
<i>gemfibrozil</i>	Preferred	QL (2 EA per 1 day)
ANTARA	Non – Preferred	
FENOGLIDE	Non – Preferred	
FIBRICOR	Non – Preferred	
LIPOFEN	Non – Preferred	
LOPID	Non – Preferred	QL (2 EA per 1 day)
TRICOR	Non – Preferred	
TRILIPIX	Non – Preferred	
*Hmg Coa Reductase Inhibitors*** - Drugs For Cholesterol		
<i>atorvastatin calcium</i>	Preferred	QL (1 EA per 1 day)
<i>fluvastatin sodium</i>	Non – Preferred	QL (1 EA per 1 day)
<i>fluvastatin sodium er</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>pravastatin sodium</i>	Preferred	QL (1 EA per 1 day)
<i>rosuvastatin calcium</i>	Preferred	QL (1 EA per 1 day)
<i>simvastatin</i>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALTOPREV	Non – Preferred	
CRESTOR	Non – Preferred	QL (1 EA per 1 day)
EZALLOR SPRINKLE	Non – Preferred	
LESCOL XL	Non – Preferred	QL (1 EA per 1 day)
LIPITOR	Non – Preferred	QL (1 EA per 1 day)
LIVALO	Non – Preferred	
PRAVACHOL	Non – Preferred	QL (1 EA per 1 day)
ZOCOR	Non – Preferred	QL (1 EA per 1 day)
ZYPITAMAG	Non – Preferred	
<i>*Intest Cholest Absorp Inhib-Hmg Coa Reductase Inhib Comb*** - Drugs For Cholesterol</i>		
<i>ezetimibe-simvastatin</i>	Non – Preferred	
VYTORIN	Non – Preferred	
<i>*Intestinal Cholesterol Absorption Inhibitors*** - Drugs For Cholesterol</i>		
<i>ezetimibe</i>	Preferred	QL (1 EA per 1 day)
ZETIA	Non – Preferred	QL (1 EA per 1 day)
<i>*Microsomal Triglyceride Transfer Protein Inhibitors*** - Drugs For Cholesterol</i>		
JUXTAPID	Non – Preferred	
<i>*Nicotinic Acid Derivatives*** - Drugs For Cholesterol</i>		
<i>niacin er (antihyperlipidemic)</i>	Non – Preferred	
NIASPAN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihypertensives - Drugs For The Heart		
*Ace Inhibitor & Calcium Channel Blocker Combinations*** - Drugs For High Blood Pressure		
<i>amlodipine besy-benazepril hcl</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril-verapamil hcl er</i>	Preferred	
LOTREL	Non – Preferred	QL (1 EA per 1 day)
TARKA	Non – Preferred	
*Ace Inhibitors & Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure		
<i>benazepril-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<i>captopril-hydrochlorothiazide</i>	Preferred	QL (2 EA per 1 day)
<i>enalapril-hydrochlorothiazide tablet 10-25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>enalapril-hydrochlorothiazide tablet 5-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fosinopril sodium-hctz</i>	Preferred	
<i>lisinopril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lisinopril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lisinopril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>quinapril-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
ACCURETIC	Non – Preferred	QL (1 EA per 1 day)
LOTENSIN HCT	Non – Preferred	QL (1 EA per 1 day)
VASERETIC	Non – Preferred	QL (2 EA per 1 day)
ZESTORETIC TABLET 10-12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZESTORETIC TABLET 20-12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZESTORETIC TABLET 20-25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
*Ace Inhibitors*** - Drugs For High Blood Pressure		
<i>benazepril hcl</i>	Preferred	QL (2 EA per 1 day)
<i>captopril</i>	Preferred	QL (3 EA per 1 day)
<i>enalapril maleate</i>	Preferred	QL (2 EA per 1 day)
<i>fosinopril sodium</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril</i>	Preferred	QL (2 EA per 1 day)
<i>moexipril hcl</i>	Preferred	
<i>perindopril erbumine tablet 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>perindopril erbumine tablet 4 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>perindopril erbumine tablet 8 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>quinapril hcl</i>	Preferred	QL (2 EA per 1 day)
<i>ramipril</i>	Preferred	QL (2 EA per 1 day)
<i>trandolapril tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril tablet 4 mg oral</i>	Preferred	QL (2 EA per 1 day)
ACCUPRIL	Non – Preferred	QL (2 EA per 1 day)
ALTACE	Non – Preferred	QL (2 EA per 1 day)
EPANED	Non – Preferred	
LOTENSIN	Non – Preferred	QL (2 EA per 1 day)
PRINIVIL	Non – Preferred	QL (2 EA per 1 day)
QBRELIS	Non – Preferred	
VASOTEC	Non – Preferred	QL (2 EA per 1 day)
ZESTRIL	Non – Preferred	QL (2 EA per 1 day)
*Adrenolytics-Central & Thiazide/Thiazide-Like Comb*** - Drugs For High Blood Pressure		
<i>methyldopa-hydrochlorothiazide</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Agents For Pheochromocytoma*** - Drugs For High Blood Pressure		
<i>metyrosine</i>	Preferred	
<i>phenoxybenzamine hcl</i>	Non – Preferred	
DEMSER	Preferred	
*Angiotensin li Receptor Antag & Ca Channel Blocker Comb*** - Drugs For High Blood Pressure		
<i>amlodipine besylate-valsartan</i>	Non – Preferred	QL (1 EA per 1 day)
<i>amlodipine-olmesartan</i>	Non – Preferred	
<i>telmisartan-amlodipine</i>	Non – Preferred	
AZOR	Non – Preferred	
EXFORGE	Non – Preferred	QL (1 EA per 1 day)
*Angiotensin li Receptor Antag & Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure		
<i>candesartan cilexetil-hctz</i>	Non – Preferred	QL (1 EA per 1 day)
<i>irbesartan-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium-hctz</i>	Preferred	QL (1 EA per 1 day)
<i>olmesartan medoxomil-hctz</i>	Non – Preferred	
<i>telmisartan-hctz</i>	Non – Preferred	
<i>valsartan-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
ATACAND HCT	Non – Preferred	QL (1 EA per 1 day)
AVALIDE	Non – Preferred	QL (1 EA per 1 day)
BENICAR HCT	Non – Preferred	
DIOVAN HCT	Non – Preferred	QL (1 EA per 1 day)
EDARBYCLOR	Non – Preferred	
HYZAAR	Non – Preferred	QL (1 EA per 1 day)
MICARDIS HCT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Angiotensin II Receptor Antagonists*** - Drugs For High Blood Pressure		
<i>candesartan cilexetil</i>	Non – Preferred	QL (1 EA per 1 day)
<i>irbesartan</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium tablet 100 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>losartan potassium tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>olmesartan medoxomil</i>	Non – Preferred	
<i>telmisartan</i>	Non – Preferred	
<i>valsartan</i>	Preferred	QL (1 EA per 1 day)
ATACAND	Non – Preferred	QL (1 EA per 1 day)
AVAPRO	Non – Preferred	QL (1 EA per 1 day)
BENICAR	Non – Preferred	
COZAAR TABLET 100 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
COZAAR TABLET 25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
COZAAR TABLET 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DIOVAN	Non – Preferred	QL (1 EA per 1 day)
EDARBI	Non – Preferred	
MICARDIS	Non – Preferred	
*Angiotensin II Receptor Ant-Ca Channel Blocker-Thiazides*** - Drugs For High Blood Pressure		
<i>amlodipine-valsartan-hctz</i>	Non – Preferred	
<i>olmesartan-amlodipine-hctz</i>	Non – Preferred	
EXFORGE HCT	Non – Preferred	
TRIBENZOR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antiadrenergics - Centrally Acting*** - Drugs For High Blood Pressure		
<i>clonidine</i>	Preferred	
<i>clonidine hcl</i>	Preferred	
<i>guanfacine hcl tablet 1 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>guanfacine hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>methyl dopa</i>	Preferred	
CATAPRES	Non – Preferred	
CATAPRES-TTS-1	Non – Preferred	
CATAPRES-TTS-2	Non – Preferred	
CATAPRES-TTS-3	Non – Preferred	
*Antiadrenergics - Peripherally Acting*** - Drugs For High Blood Pressure		
<i>doxazosin mesylate tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 4 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 8 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>prazosin hcl</i>	Preferred	QL (4 EA per 1 day)
<i>terazosin hcl capsule 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>terazosin hcl capsule 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>terazosin hcl capsule 2 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>terazosin hcl capsule 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
CARDURA TABLET 1 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 2 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 4 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
MINIPRESS	Non – Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antihypertensives - Misc.*** - Drugs For High Blood Pressure		
VECAMYL	Non – Preferred	
*Beta Blocker & Diuretic Combinations*** - Drugs For High Blood Pressure		
<i>atenolol-chlorthalidone</i>	Preferred	
<i>bisoprolol-hydrochlorothiazide</i>	Preferred	
<i>metoprolol-hydrochlorothiazide</i>	Preferred	
<i>propranolol-hctz</i>	Preferred	
TENORETIC 100	Non – Preferred	
TENORETIC 50	Non – Preferred	
ZIAC	Non – Preferred	
*Direct Renin Inhibitors & Thiazide/Thiazide-Like Comb*** - Drugs For High Blood Pressure		
TEKTURNA HCT	Non – Preferred	
*Direct Renin Inhibitors*** - Drugs For High Blood Pressure		
<i>aliskiren fumarate</i>	Non – Preferred	
TEKTURNA	Non – Preferred	
*Selective Aldosterone Receptor Antagonists (Saras)*** - Drugs For High Blood Pressure		
<i>eplerenone</i>	Non – Preferred	
INSPRA	Non – Preferred	
*Vasodilators*** - Drugs For High Blood Pressure		
<i>hydralazine hcl</i>	Preferred	
<i>minoxidil</i>	Preferred	

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

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>meropenem</i>	Preferred	
<i>meropenem-sodium chloride</i>	Preferred	
*Leprostotics*** - Antibiotics		
<i>dapsone</i>	Preferred	
*Lincosamides*** - Antibiotics		
<i>clindamycin hcl</i>	Preferred	
<i>clindamycin palmitate hcl</i>	Preferred	
<i>clindamycin phosphate</i>	Preferred	
<i>clindamycin phosphate in d5w</i>	Preferred	
<i>clindamycin phosphate in nacl</i>	Preferred	
CLEOCIN	Non – Preferred	
*Oxazolidinones*** - Antibiotics		
<i>linezolid</i>	Non – Preferred	
SIVEXTRO	Non – Preferred	
ZYVOX	Non – Preferred	
*Urinary Antiseptic-Antispasmodic &/Or Analgesics*** - Drugs For Infections		
<i>urin ds</i>	Non – Preferred	
HYOPHEN	Non – Preferred	
PHOSPHASAL	Non – Preferred	
URIMAR-T	Non – Preferred	
UROGESIC-BLUE	Non – Preferred	
USTELL	Non – Preferred	

Coverage Requirements and Limits

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

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pyridostigmine bromide er</i>	Preferred	
FIRDAPSE	Non – Preferred	
MESTINON	Non – Preferred	
RUZURGI	Non – Preferred	
*Antimyasthenic/Cholinergic Agents*** - Drugs For Nerves And Muscles		
<i>guanidine hcl</i>	Non – Preferred	
<i>pyridostigmine bromide</i>	Preferred	
<i>pyridostigmine bromide er</i>	Preferred	
FIRDAPSE	Non – Preferred	
MESTINON	Non – Preferred	
RUZURGI	Non – Preferred	
Antimyasthenic/Cholinergic Agents - Drugs For Nerves And Muscles		
<i>guanidine hcl</i>	Non – Preferred	
<i>pyridostigmine bromide</i>	Preferred	
<i>pyridostigmine bromide er</i>	Preferred	
FIRDAPSE	Non – Preferred	
MESTINON	Non – Preferred	
RUZURGI	Non – Preferred	
Antimycobacterial Agents - Drugs For Infections		
*Antimycobacterial Agents*** - Antibiotics		
<i>cycloserine</i>	Preferred	
<i>ethambutol hcl</i>	Preferred	
<i>isoniazid</i>	Preferred	
<i>pretomanid</i>	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pyrazinamide</i>	Preferred	
<i>rifabutin</i>	Preferred	
<i>rifampin</i>	Preferred	
MYAMBUTOL	Non – Preferred	
MYCOBUTIN	Non – Preferred	
PASER	Non – Preferred	
PRIFTIN	Non – Preferred	
SIRTURO	Non – Preferred	
TRECTOR	Preferred	
*Antineoplastic - Bcl-2 Inhibitors*** - Drugs For Cancer		
<i>*Antineoplastic - Bcl-2 Inhibitors*** - Drugs For Cancer</i>		
VENCLEXTA	Non – Preferred	
VENCLEXTA STARTING PACK	Non – Preferred	
*Antineoplastic - Fgfr Kinase Inhibitors*** - Drugs For Cancer		
<i>*Antineoplastic - Fgfr Kinase Inhibitors*** - Drugs For Cancer</i>		
BALVERSA	Non – Preferred	
PEMAZYRE	Non – Preferred	
*Antineoplastic - Methyltransferase Inhibitors*** - Drugs For Cancer		
<i>*Antineoplastic - Methyltransferase Inhibitors*** - Drugs For Cancer</i>		
TAZVERIK	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antineoplastic - Tropomyosin Receptor Kinase Inhibitors*** - Drugs For Cancer		
<i>*Antineoplastic - Tropomyosin Receptor Kinase Inhibitors*** - Drugs For Cancer</i>		
ROZLYTREK	Non – Preferred	
VITRAKVI	Non – Preferred	
*Antineoplastic - Xpo1 Inhibitors*** - Drugs For Cancer		
<i>*Antineoplastic - Xpo1 Inhibitors*** - Drugs For Cancer</i>		
XPOVIO (100 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (60 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (60 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (80 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (80 MG TWICE WEEKLY)	Non – Preferred	
*Antineoplastic Or Premalignant Lesion Agent - Comb*** - Drugs For The Skin		
<i>*Antineoplastic Or Premalignant Lesion Agent - Comb*** - Drugs For The Skin</i>		
ORMECA	Non – Preferred	

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antimetabolites*** - Drugs For Cancer		
<i>capecitabine tablet 150 mg oral</i>	Non – Preferred	QL (140 EA per 21 days)
<i>capecitabine tablet 500 mg oral</i>	Non – Preferred	QL (154 EA per 21 days)
<i>mercaptopurine</i>	Preferred	
<i>methotrexate</i>	Preferred	
<i>methotrexate sodium (pf)</i>	Preferred	
<i>methotrexate sodium oral</i>	Preferred	
<i>methotrexate sodium solution 250 mg/10ml injection</i>	Preferred	QL (10 VIAL per 28 days)
<i>methotrexate sodium solution 50 mg/2ml injection</i>	Preferred	QL (4 VIAL per 28 days)
ONUREG	Non – Preferred	
PURIXAN	Non – Preferred	
TABLOID	Preferred	
TREXALL	Preferred	
XATMEP	Non – Preferred	
XELODA TABLET 150 MG ORAL	Non – Preferred	QL (140 EA per 21 days)
XELODA TABLET 500 MG ORAL	Non – Preferred	QL (154 EA per 21 days)
*Antineoplastic - Braf Kinase Inhibitors*** - Drugs For Cancer		
BRAFTOVI	Non – Preferred	
TAFINLAR	Non – Preferred	
ZELBORAF	Non – Preferred	
*Antineoplastic - Hedgehog Pathway Inhibitors*** - Drugs For Cancer		
DAURISMO	Non – Preferred	
ERIVEDGE	Preferred	
ODOMZO	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antineoplastic - Histone Deacetylase Inhibitors*** - Drugs For Cancer		
FARYDAK	Non – Preferred	
ZOLINZA	Non – Preferred	
*Antineoplastic - Immunomodulators*** - Drugs For Cancer		
POMALYST	Non – Preferred	
*Antineoplastic - Mek Inhibitors*** - Drugs For Cancer		
COTELLIC	Non – Preferred	
KOSELUGO	Non – Preferred	
MEKINIST	Non – Preferred	
MEKTOVI	Non – Preferred	
*Antineoplastic - Mtor Kinase Inhibitors*** - Drugs For Cancer		
<i>everolimus</i>	Non – Preferred	QL (1 EA per 1 day)
AFINITOR	Non – Preferred	QL (1 EA per 1 day)
AFINITOR DISPERZ	Non – Preferred	
*Antineoplastic - Multikinase Inhibitors*** - Drugs For Cancer		
NEXAVAR	Preferred	QL (4 EA per 1 day)
RYDAPT	Non – Preferred	
STIVARGA	Non – Preferred	
SUTENT CAPSULE 12.5 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 25 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 37.5 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 50 MG ORAL	Preferred	QL (28 EA per 42 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antineoplastic - Proteasome Inhibitors*** - Drugs For Cancer		
NINLARO	Non – Preferred	
*Antineoplastic - Tyrosine Kinase Inhibitors*** - Drugs For Cancer		
<i>erlotinib hcl</i>	Preferred	QL (1 EA per 1 day)
<i>imatinib mesylate tablet 100 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>imatinib mesylate tablet 400 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
ALECENSA	Non – Preferred	
ALUNBRIG	Non – Preferred	
AYVAKIT	Non – Preferred	
BOSULIF	Non – Preferred	
BRUKINSA	Non – Preferred	
CABOMETYX	Non – Preferred	QL (1 EA per 1 day)
CALQUENCE	Non – Preferred	
CAPRELSA	Preferred	
COMETRIQ (100 MG DAILY DOSE)	Non – Preferred	
COMETRIQ (140 MG DAILY DOSE)	Non – Preferred	
COMETRIQ (60 MG DAILY DOSE)	Non – Preferred	
GAVRETO	Non – Preferred	
GILOTRIF	Non – Preferred	
GLEEVEC TABLET 100 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
GLEEVEC TABLET 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ICLUSIG	Non – Preferred	
IMBRUVICA CAPSULE 140 MG ORAL	Non – Preferred	
IMBRUVICA CAPSULE 70 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
IMBRUVICA TABLET 140 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
IMBRUVICA TABLET 280 MG ORAL	Non – Preferred	
IMBRUVICA TABLET 420 MG ORAL	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMBRUVICA TABLET 560 MG ORAL	Non – Preferred	
INLYTA	Non – Preferred	
IRESSA	Preferred	
LENVIMA (10 MG DAILY DOSE)	Non – Preferred	
LENVIMA (12 MG DAILY DOSE)	Non – Preferred	
LENVIMA (14 MG DAILY DOSE)	Non – Preferred	
LENVIMA (18 MG DAILY DOSE)	Non – Preferred	
LENVIMA (20 MG DAILY DOSE)	Non – Preferred	
LENVIMA (24 MG DAILY DOSE)	Non – Preferred	
LENVIMA (4 MG DAILY DOSE)	Non – Preferred	
LENVIMA (8 MG DAILY DOSE)	Non – Preferred	
LORBRENA	Non – Preferred	
NERLYNX	Non – Preferred	
QINLOCK	Non – Preferred	
RETEVMO	Non – Preferred	
SPRYCEL	Non – Preferred	QL (1 EA per 1 day)
TABRECTA	Non – Preferred	
TAGRISO	Non – Preferred	
TARCEVA	Non – Preferred	QL (1 EA per 1 day)
TASIGNA	Non – Preferred	QL (4 EA per 1 day)
TUKYSA	Non – Preferred	
TURALIO	Non – Preferred	
TYKERB	Non – Preferred	QL (6 EA per 1 day)
VIZIMPRO	Non – Preferred	
VOTRIENT	Preferred	QL (4 EA per 1 day)
XALKORI	Non – Preferred	
XOSPATA	Non – Preferred	
ZYKADIA	Non – Preferred	

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Folic Acid Antagonists Rescue Agents*** - Drugs For Cancer		
<i>leucovorin calcium</i>	Preferred	
*Imidazotetrazines*** - Drugs For Cancer		
<i>temozolomide</i>	Preferred	
TEMODAR	Non – Preferred	
*Janus Associated Kinase (Jak) Inhibitors*** - Drugs For Cancer		
INREBIC	Non – Preferred	
JAKAFI	Preferred	
*Mitotic Inhibitors*** - Drugs For Cancer		
<i>etoposide</i>	Preferred	
*Nitrogen Mustards*** - Drugs For Cancer		
<i>cyclophosphamide</i>	Preferred	
<i>melphalan</i>	Preferred	
ALKERAN	Non – Preferred	
LEUKERAN	Preferred	
*Nitrosoureas*** - Drugs For Cancer		
GLEOSTINE	Preferred	
*Progestins-Antineoplastic*** - Drugs For Cancer		
<i>megestrol acetate</i>	Preferred	
*Retinoids*** - Drugs For Cancer		
<i>tretinoin</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Selective Retinoid X Receptor Agonists*** - Drugs For Cancer		
<i>bexarotene</i>	Preferred	
TARGRETIN	Non – Preferred	
*Topoisomerase I Inhibitors*** - Drugs For Cancer		
HYCAMTIN	Preferred	
*Urinary Tract Protective Agents*** - Drugs For Cancer		
MESNEX	Preferred	
Antiparkinson Agents - Drugs For The Nervous System		
*Antiparkinson Anticholinergics*** - Drugs For Parkinson		
<i>benztropine mesylate</i>	Preferred	
<i>trihexyphenidyl hcl</i>	Preferred	
*Antiparkinson Dopaminergics*** - Drugs For Parkinson		
<i>amantadine hcl</i>	Preferred	
<i>bromocriptine mesylate</i>	Preferred	
GOCOVRI	Non – Preferred	
INBRIJA	Non – Preferred	
OSMOLEX ER	Non – Preferred	
PARLODEL	Non – Preferred	
*Antiparkinson Monoamine Oxidase Inhibitors*** - Drugs For Parkinson		
<i>rasagiline mesylate</i>	Non – Preferred	
<i>selegiline hcl</i>	Preferred	
AZILECT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XADAGO	Non – Preferred	
ZELAPAR	Non – Preferred	
*Central/Peripheral Comt Inhibitors*** - Drugs For Parkinson		
<i>tolcapone</i>	Non – Preferred	
TASMAR	Non – Preferred	
*Decarboxylase Inhibitors*** - Drugs For Parkinson		
<i>carbidopa</i>	Preferred	
LODOSYN	Non – Preferred	
*Levodopa Combinations*** - Drugs For Parkinson		
<i>carbidopa-levodopa er</i>	Preferred	
<i>carbidopa-levodopa oral tablet</i>	Preferred	
<i>carbidopa-levodopa oral tablet dispersible</i>	Non – Preferred	
<i>carbidopa-levodopa-entacapone</i>	Non – Preferred	QL (9 EA per 1 day)
RYTARY	Non – Preferred	
SINEMET	Non – Preferred	
STALEVO 100	Non – Preferred	QL (9 EA per 1 day)
STALEVO 125	Non – Preferred	QL (9 EA per 1 day)
STALEVO 150	Non – Preferred	QL (9 EA per 1 day)
STALEVO 200	Non – Preferred	QL (9 EA per 1 day)
STALEVO 50	Non – Preferred	QL (9 EA per 1 day)
STALEVO 75	Non – Preferred	QL (9 EA per 1 day)
*Nonergoline Dopamine Receptor Agonists*** - Drugs For Parkinson		
<i>pramipexole dihydrochloride</i>	Preferred	
<i>pramipexole dihydrochloride er</i>	Non – Preferred	
<i>ropinirole hcl</i>	Preferred	QL (3 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ropinirole hcl er tablet extended release 24 hour 12 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 4 mg oral</i>	Non – Preferred	
<i>ropinirole hcl er tablet extended release 24 hour 6 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 8 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
APOKYN	Non – Preferred	
KYNMOBI	Non – Preferred	
MIRAPEX ER	Non – Preferred	
NEUPRO	Non – Preferred	
*Peripheral Comt Inhibitors*** - Drugs For Parkinson		
<i>entacapone</i>	Preferred	QL (4 EA per 1 day)
COMTAN	Non – Preferred	QL (4 EA per 1 day)
ONGENTYS	Non – Preferred	
Antipsychotics/Antimanic Agents - Drugs For The Nervous System		
*Antimanic Agents*** - Drugs For Severe Mental Disorders		
<i>lithium</i>	Preferred	QL (40 ML per 1 day)
<i>lithium carbonate capsule 150 mg oral</i>	Preferred	QL (16 EA per 1 day)
<i>lithium carbonate capsule 300 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>lithium carbonate capsule 600 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>lithium carbonate er tablet extended release 300 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>lithium carbonate er tablet extended release 450 mg oral</i>	Preferred	QL (6 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lithium carbonate oral tablet</i>	Preferred	QL (8 EA per 1 day)
LITHOBID	Non – Preferred	QL (8 EA per 1 day)
*Antipsychotics - Misc.*** - Drugs For Severe Mental Disorders		
<i>ziprasidone hcl</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>ziprasidone mesylate</i>	Non – Preferred	AL (Min 8 Years)
CAPLYTA	Non – Preferred	AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL	Non – Preferred	AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL	Non – Preferred	QL (8 EA per 1 day); AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL	Non – Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
GEODON CAPSULE 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
GEODON CAPSULE 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
GEODON CAPSULE 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
GEODON CAPSULE 60 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
GEODON CAPSULE 80 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
GEODON INTRAMUSCULAR	Non – Preferred	AL (Min 8 Years)
LATUDA TABLET 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 60 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LATUDA TABLET 80 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
NUPLAZID	Non – Preferred	AL (Min 8 Years)
VRAYLAR ORAL CAPSULE	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
VRAYLAR ORAL CAPSULE THERAPY PACK	Non – Preferred	QL (7 EA per 1 day); AL (Min 8 Years)
*Benzisoxazoles*** - Drugs For Severe Mental Disorders		
<i>paliperidone er tablet extended release 24 hour 1.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>paliperidone er tablet extended release 24 hour 3 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>paliperidone er tablet extended release 24 hour 6 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>paliperidone er tablet extended release 24 hour 9 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>risperidone oral solution</i>	Non – Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
<i>risperidone tablet 0.25 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 0.5 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 1 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 2 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 3 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 4 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet dispersible 0.25 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 0.5 mg oral</i>	Non – Preferred	AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>risperidone tablet dispersible 1 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 2 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 3 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet dispersible 4 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 1 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 10 MG ORAL	Non – Preferred	AL (Min 8 Years)
FANAPT TABLET 12 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 2 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 4 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 6 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TITRATION PACK	Non – Preferred	QL (1 PACK per 90 days); AL (Min 8 Years)
INVEGA SUSTENNA	Preferred	PA; AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 1.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
INVEGA TRINZA	Preferred	PA; AL (Min 8 Years)
PERSERIS	Non – Preferred	AL (Min 8 Years)
RISPERDAL CONSTA	Non – Preferred	AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RISPERDAL ORAL SOLUTION	Non – Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 0.5 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 1 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 2 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 3 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 4 MG ORAL	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>*Butyrophenones*** - Drugs For Severe Mental Disorders</i>		
<i>haloperidol lactate</i>	Preferred	QL (50 ML per 1 day)
<i>haloperidol tablet 0.5 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>haloperidol tablet 1 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 10 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 2 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 20 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>haloperidol tablet 5 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>*Dibenzodiazepines*** - Drugs For Severe Mental Disorders</i>		
<i>clozapine tablet 100 mg oral</i>	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 200 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 25 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clozapine tablet 50 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 100 mg oral</i>	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 12.5 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>clozapine tablet dispersible 150 mg oral</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 200 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 25 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 100 MG ORAL	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 200 MG ORAL	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 25 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 50 MG ORAL	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
VERSACLOZ	Non – Preferred	AL (Min 8 Years)
<i>*Dibenzo-Oxepino Pyrroles*** - Drugs For Severe Mental Disorders</i>		
SAPHRIS	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SECUADO	Non – Preferred	AL (Min 8 Years)
<i>*Dibenzothiazepines*** - Drugs For Severe Mental Disorders</i>		
<i>quetiapine fumarate er tablet extended release 24 hour 150 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 200 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>*Dibenzoxazepines*** - Drugs For Severe Mental Disorders</i>		
<i>loxapine succinate capsule 10 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 25 mg oral</i>	Preferred	QL (10 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 5 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 50 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
ADASUVE	Non – Preferred	AL (Min 8 Years)
<i>*Dihydroindolones*** - Drugs For Severe Mental Disorders</i>		
<i>molindone hcl</i>	Non – Preferred	
<i>*Phenothiazines*** - Drugs For Severe Mental Disorders</i>		
<i>chlorpromazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>chlorpromazine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>fluphenazine hcl oral concentrate</i>	Preferred	QL (8 ML per 1 day)
<i>fluphenazine hcl oral elixir</i>	Preferred	QL (80 ML per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluphenazine hcl tablet 1 mg oral</i>	Preferred	
<i>fluphenazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>fluphenazine hcl tablet 2.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>fluphenazine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>perphenazine tablet 16 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>perphenazine tablet 2 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>perphenazine tablet 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>perphenazine tablet 8 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>prochlorperazine</i>	Preferred	QL (2 EA per 1 day)
<i>prochlorperazine maleate tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>prochlorperazine maleate tablet 5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>thioridazine hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>thioridazine hcl tablet 100 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>thioridazine hcl tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>thioridazine hcl tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>trifluoperazine hcl tablet 1 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
COMPRO	Preferred	QL (2 EA per 1 day)
*Quinolinone Derivatives*** - Drugs For Severe Mental Disorders		
<i>aripiprazole oral solution</i>	Non – Preferred	AL (Min 8 Years)
<i>aripiprazole oral tablet</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>aripiprazole oral tablet dispersible</i>	Non – Preferred	AL (Min 8 Years)
ABILIFY	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE	Preferred	PA; QL (1 SYRINGE per 28 days); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	Preferred	PA; QL (1 VIAL per 28 days); AL (Min 8 Years)
ABILIFY MYCITE	Non – Preferred	AL (Min 8 Years)
ARISTADA INITIO	Preferred	PA; QL (1 SYRINGE per 365 days); AL (Min 8 Years)
ARISTADA PREFILLED SYRINGE 1064 MG/3.9ML INTRAMUSCULAR	Preferred	PA; QL (1 SYRINGE per 56 days); AL (Min 8 Years)
ARISTADA PREFILLED SYRINGE 441 MG/1.6ML INTRAMUSCULAR	Preferred	PA; QL (1 SYRINGE per 28 days); AL (Min 8 Years)
ARISTADA PREFILLED SYRINGE 662 MG/2.4ML INTRAMUSCULAR	Preferred	PA; QL (2.4 ML per 28 days); AL (Min 8 Years)
ARISTADA PREFILLED SYRINGE 882 MG/3.2ML INTRAMUSCULAR	Preferred	PA; QL (3.2 ML per 28 days); AL (Min 8 Years)
REXULTI	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>*Thienbenzodiazepines*** - Drugs For Severe Mental Disorders</i>		
<i>olanzapine intramuscular</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>olanzapine oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA INTRAMUSCULAR	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
ZYPREXA RELPREVV	Non – Preferred	AL (Min 8 Years)
ZYPREXA TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZYPREXA TABLET 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZYPREXA TABLET 2.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZYPREXA TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA TABLET 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZYPREXA TABLET 7.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYPREXA ZYDIS	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>*Thioxanthenes*** - Drugs For Severe Mental Disorders</i>		
<i>thiothixene</i>	Preferred	QL (6 EA per 1 day)
*Antiretrovirals - Cd4-Directed Post-Attachment Inhibitor*** - Drugs For Infections		
<i>*Antiretrovirals - Cd4-Directed Post-Attachment Inhibitor*** - Drugs For Infections</i>		
TROGARZO	Preferred	PA
*Antiretrovirals - Gp120-Directed Attachment Inhibitor*** - Drugs For Infections		
<i>*Antiretrovirals - Gp120-Directed Attachment Inhibitor*** - Drugs For Infections</i>		
<i>rukobia</i>	Non – Preferred	
*Antiretrovirals Adjuvants*** - Drugs That Alter Metabolism		
<i>*Antiretrovirals Adjuvants*** - Drugs That Alter Metabolism</i>		
TYBOST	Non – Preferred	
*Antisense Oligonucleotide (Aso) Inhibitor Agents*** - Hormones		
<i>*Antisense Oligonucleotide (Aso) Inhibitor Agents*** - Hormones</i>		
TEGSEDI	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antivirals - Drugs For Infections		
*Antiretroviral Combinations*** - Drugs For Viral Infections		
<i>abacavir sulfate-lamivudine</i>	Preferred	QL (1 EA per 1 day)
<i>abacavir-lamivudine-zidovudine</i>	Preferred	QL (2 EA per 1 day)
<i>efavirenz-lamivudine-tenofovir</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lamivudine-zidovudine</i>	Preferred	QL (2 EA per 1 day)
<i>lopinavir-ritonavir</i>	Preferred	QL (10 ML per 1 day)
ATRIPLA	Preferred	QL (1 EA per 1 day)
BIKTARVY	Preferred	QL (1 EA per 1 day)
CIMDUO	Non – Preferred	QL (1 EA per 1 day)
COMBIVIR	Non – Preferred	QL (2 EA per 1 day)
COMPLERA	Preferred	QL (1 EA per 1 day)
DELSTRIGO	Preferred	QL (1 EA per 1 day)
DESCOVY	Preferred	QL (1 EA per 1 day)
DOVATO	Preferred	QL (1 EA per 1 day)
EPZICOM	Non – Preferred	QL (1 EA per 1 day)
EVOTAZ	Non – Preferred	
GENVOYA	Preferred	QL (1 EA per 1 day)
JULUCA	Non – Preferred	
KALETRA ORAL SOLUTION	Non – Preferred	QL (10 ML per 1 day)
KALETRA ORAL TABLET	Preferred	QL (4 EA per 1 day)
ODEFSEY	Preferred	QL (1 EA per 1 day)
PREZCOBIX	Non – Preferred	
STRIBILD	Non – Preferred	
SYMFI	Preferred	QL (1 EA per 1 day)
SYMFI LO	Preferred	QL (1 EA per 1 day)
SYMTUZA	Non – Preferred	
TEMIXYS	Non – Preferred	QL (1 EA per 1 day)

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TRIUMEQ	Preferred	QL (1 EA per 1 day)
TRIZIVIR	Non – Preferred	QL (2 EA per 1 day)
TRUVADA	Preferred	QL (1 EA per 1 day)
*Antiretrovirals - Ccr5 Antagonists (Entry Inhibitor)*** - Drugs For Viral Infections		
SELZENTRY	Non – Preferred	
*Antiretrovirals - Fusion Inhibitors*** - Drugs For Viral Infections		
FUZEON	Non – Preferred	QL (2 EA per 1 day)
*Antiretrovirals - Integrase Inhibitors*** - Drugs For Viral Infections		
ISENTRESS HD	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL PACKET	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET CHEWABLE	Preferred	QL (6 EA per 1 day)
TIVICAY	Preferred	QL (2 EA per 1 day)
TIVICAY PD	Preferred	
*Antiretrovirals - Protease Inhibitors*** - Drugs For Viral Infections		
<i>atazanavir sulfate capsule 150 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>atazanavir sulfate capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>atazanavir sulfate capsule 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fosamprenavir calcium</i>	Preferred	QL (4 EA per 1 day)
<i>ritonavir</i>	Preferred	QL (12 EA per 1 day)
APTIVUS ORAL CAPSULE	Preferred	QL (4 EA per 1 day)
APTIVUS ORAL SOLUTION	Preferred	QL (10 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CRIXIVAN CAPSULE 200 MG ORAL	Preferred	QL (12 EA per 1 day)
CRIXIVAN CAPSULE 400 MG ORAL	Preferred	QL (6 EA per 1 day)
INVIRASE	Preferred	QL (4 EA per 1 day)
LEXIVA ORAL SUSPENSION	Preferred	QL (56 ML per 1 day)
LEXIVA ORAL TABLET	Preferred	QL (4 EA per 1 day)
NORVIR ORAL PACKET	Preferred	
NORVIR ORAL SOLUTION	Preferred	QL (15 ML per 1 day)
NORVIR ORAL TABLET	Preferred	QL (12 EA per 1 day)
PREZISTA ORAL SUSPENSION	Preferred	QL (8 ML per 1 day)
PREZISTA TABLET 150 MG ORAL	Preferred	QL (3 EA per 1 day)
PREZISTA TABLET 600 MG ORAL	Preferred	QL (2 EA per 1 day)
PREZISTA TABLET 75 MG ORAL	Preferred	QL (1 EA per 1 day)
PREZISTA TABLET 800 MG ORAL	Preferred	QL (1 EA per 1 day)
REYATAZ CAPSULE 150 MG ORAL	Preferred	QL (1 EA per 1 day)
REYATAZ CAPSULE 200 MG ORAL	Preferred	QL (2 EA per 1 day)
REYATAZ CAPSULE 300 MG ORAL	Preferred	QL (1 EA per 1 day)
REYATAZ ORAL PACKET	Preferred	QL (6 EA per 1 day)
VIRACEPT TABLET 250 MG ORAL	Preferred	QL (10 EA per 1 day)
VIRACEPT TABLET 625 MG ORAL	Preferred	QL (4 EA per 1 day)
*Antiretrovirals - Rti-Non-Nucleoside Analogues*** - Drugs For Viral Infections		
<i>efavirenz capsule 200 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>efavirenz capsule 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>efavirenz oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>nevirapine er</i>	Preferred	QL (1 EA per 1 day)
<i>nevirapine oral suspension</i>	Preferred	QL (40 ML per 1 day)
<i>nevirapine oral tablet</i>	Preferred	QL (2 EA per 1 day)
EDURANT	Preferred	QL (1 EA per 1 day)
INTELENCE TABLET 100 MG ORAL	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTELENCE TABLET 200 MG ORAL	Preferred	QL (2 EA per 1 day)
INTELENCE TABLET 25 MG ORAL	Preferred	QL (4 EA per 1 day)
PIFELTRO	Non – Preferred	
SUSTIVA CAPSULE 200 MG ORAL	Preferred	QL (1 EA per 1 day)
SUSTIVA CAPSULE 50 MG ORAL	Preferred	QL (2 EA per 1 day)
SUSTIVA ORAL TABLET	Preferred	QL (1 EA per 1 day)
VIRAMUNE	Preferred	QL (40 ML per 1 day)
VIRAMUNE XR	Non – Preferred	QL (1 EA per 1 day)
*Antiretrovirals - Rti-Nucleoside Analogues-Purines*** - Drugs For Viral Infections		
<i>abacavir sulfate oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>abacavir sulfate oral tablet</i>	Preferred	QL (2 EA per 1 day)
<i>didanosine</i>	Preferred	QL (1 EA per 1 day)
ZIAGEN ORAL SOLUTION	Preferred	QL (30 ML per 1 day)
ZIAGEN ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
*Antiretrovirals - Rti-Nucleoside Analogues-Pyrimidines*** - Drugs For Viral Infections		
<i>emtricitabine</i>	Preferred	QL (1 EA per 1 day)
<i>lamivudine oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>lamivudine tablet 150 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lamivudine tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL CAPSULE	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL SOLUTION	Preferred	QL (24 ML per 1 day)
EPIVIR ORAL SOLUTION	Non – Preferred	QL (30 ML per 1 day)
EPIVIR TABLET 150 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
EPIVIR TABLET 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antiretrovirals - Rti-Nucleoside Analogues-Thymidines*** - Drugs For Viral Infections		
<i>stavudine capsule 15 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>stavudine capsule 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>stavudine capsule 30 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>stavudine capsule 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>zidovudine oral capsule</i>	Preferred	QL (2 EA per 1 day)
<i>zidovudine oral syrup</i>	Preferred	QL (60 ML per 1 day)
<i>zidovudine oral tablet</i>	Preferred	QL (2 EA per 1 day)
RETROVIR ORAL CAPSULE	Non – Preferred	QL (2 EA per 1 day)
RETROVIR ORAL SYRUP	Non – Preferred	QL (60 ML per 1 day)
*Antiretrovirals - Rti-Nucleotide Analogues*** - Drugs For Viral Infections		
<i>tenofovir disoproxil fumarate</i>	Preferred	QL (1 EA per 1 day)
VIREAD ORAL POWDER	Preferred	QL (8 GM per 1 day)
VIREAD ORAL TABLET	Preferred	QL (1 EA per 1 day)
*Cmv Agents*** - Drugs For Viral Infections		
<i>valganciclovir hcl oral solution reconstituted</i>	Non – Preferred	
<i>valganciclovir hcl oral tablet</i>	Preferred	QL (2 EA per 1 day)
PREVYMIS	Non – Preferred	
VALCYTE ORAL SOLUTION RECONSTITUTED	Non – Preferred	
VALCYTE ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
*Hepatitis B Agents*** - Drugs For Viral Infections		
<i>adefovir dipivoxil</i>	Non – Preferred	
<i>entecavir</i>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lamivudine</i>	Non – Preferred	QL (1 EA per 1 day)
BARACLUDE ORAL SOLUTION	Non – Preferred	
BARACLUDE ORAL TABLET	Non – Preferred	QL (1 EA per 1 day)
EPIVIR HBV ORAL SOLUTION	Non – Preferred	QL (300 ML per 30 days)
EPIVIR HBV ORAL TABLET	Non – Preferred	QL (1 EA per 1 day)
HEPSERA	Non – Preferred	
VEMLIDY	Non – Preferred	QL (1 EA per 1 day)
<i>*Hepatitis C Agents*** - Drugs For Viral Infections</i>		
<i>ribavirin</i>	Preferred	
PEGASYS SOLUTION 180 MCG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (2 UNIT per 28 days)
PEGASYS SOLUTION 180 MCG/ML SUBCUTANEOUS	Non – Preferred	QL (4 UNIT per 28 days)
PEGINTRON	Preferred	PA; QL (4 UNIT per 28 days)
SOVALDI	Non – Preferred	
<i>*Herpes Agents - Purine Analogues*** - Drugs For Viral Infections</i>		
<i>acyclovir oral capsule</i>	Preferred	QL (50 EA per 30 days)
<i>acyclovir oral suspension</i>	Preferred	QL (400 ML per 30 days)
<i>acyclovir oral tablet</i>	Preferred	QL (2 EA per 1 day)
<i>valacyclovir hcl tablet 1 gm oral</i>	Preferred	QL (30 EA per 30 days)
<i>valacyclovir hcl tablet 500 mg oral</i>	Preferred	QL (2 EA per 1 day)
SITAVIG	Non – Preferred	
VALTREX TABLET 1 GM ORAL	Non – Preferred	QL (30 EA per 30 days)
VALTREX TABLET 500 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ZOVIRAX	Non – Preferred	QL (400 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Herpes Agents - Thymidine Analogues*** - Drugs For Viral Infections		
<i>famciclovir</i>	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
*Influenza Agents*** - Drugs For Viral Infections		
<i>rimantadine hcl</i>	Non – Preferred	QL (14 EA Max Qty Per Fill Retail)
*Neuraminidase Inhibitors*** - Drugs For Viral Infections		
<i>oseltamivir phosphate oral capsule</i>	Preferred	QL (10 EA per 30 days)
<i>oseltamivir phosphate oral suspension reconstituted</i>	Preferred	QL (180 ML Max Qty Per Fill Retail)
RELENZA DISKHALER	Preferred	QL (20 EA Max Qty Per Fill Retail)
TAMIFLU ORAL CAPSULE	Non – Preferred	QL (10 EA per 30 days)
TAMIFLU ORAL SUSPENSION RECONSTITUTED	Non – Preferred	QL (180 ML Max Qty Per Fill Retail)
*Rsv Agents - Nucleoside Analogues*** - Drugs For Viral Infections		
<i>ribavirin</i>	Preferred	
VIRAZOLE	Non – Preferred	
Assorted Classes - Vitamins And Minerals		
*Antileptotics*** - Vitamins And Minerals		
THALOMID	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*B-Lymphocyte Stimulator (Blys)- Specific Inhibitors*** - Vitamins And Minerals		
BENLYSTA	Non – Preferred	
*Chelating Agents*** - Vitamins And Minerals		
<i>penicillamine oral capsule</i>	Preferred	
<i>penicillamine oral tablet</i>	Preferred	QL (8 EA per 1 day)
<i>trientine hcl</i>	Preferred	
CLOVIQUE	Preferred	
CUPRIMINE	Non – Preferred	
DEPEN TITRATABS	Preferred	QL (8 EA per 1 day)
SYPRINE	Non – Preferred	
*Cyclosporine Analogs*** - Vitamins And Minerals		
<i>cyclosporine</i>	Preferred	
<i>cyclosporine modified</i>	Preferred	
GENGRAF	Preferred	
NEORAL	Non – Preferred	
SANDIMMUNE ORAL CAPSULE	Non – Preferred	
SANDIMMUNE ORAL SOLUTION	Preferred	
*Immunomodulators For Myelodysplastic Syndromes*** - Vitamins And Minerals		
REVLIMID	Non – Preferred	QL (1 EA per 1 day)
*Inosine Monophosphate Dehydrogenase Inhibitors*** - Vitamins And Minerals		
<i>mycophenolate mofetil</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mycophenolate sodium tablet delayed release 180 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>mycophenolate sodium tablet delayed release 360 mg oral</i>	Preferred	QL (4 EA per 1 day)
CELLCEPT	Non – Preferred	
MYFORTIC TABLET DELAYED RELEASE 180 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
MYFORTIC TABLET DELAYED RELEASE 360 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
<i>*Macrolide Immunosuppressants*** - Vitamins And Minerals</i>		
<i>everolimus</i>	Non – Preferred	
<i>sirolimus</i>	Preferred	
<i>tacrolimus</i>	Preferred	
ASTAGRAF XL	Non – Preferred	
ENVARBUS XR	Non – Preferred	
PROGRAF	Non – Preferred	
RAPAMUNE	Non – Preferred	
ZORTRESS	Non – Preferred	
<i>*Potassium Removing Resins*** - Vitamins And Minerals</i>		
<i>sodium polystyrene sulfonate</i>	Preferred	
KIONEX	Preferred	
LOKELMA	Non – Preferred	
SPS	Preferred	
VELTASSA	Non – Preferred	
<i>*Purine Analogs*** - Vitamins And Minerals</i>		
<i>azathioprine</i>	Preferred	
AZASAN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMURAN	Non – Preferred	
*Atopic Dermatitis - Monoclonal Antibodies*** - Drugs For The Skin		
<i>*Atopic Dermatitis - Monoclonal Antibodies*** - Drugs For The Skin</i>		
DUPIXENT SOLUTION PREFILLED SYRINGE 200 MG/1.14ML SUBCUTANEOUS	Preferred	PA
DUPIXENT SOLUTION PREFILLED SYRINGE 300 MG/2ML SUBCUTANEOUS	Non – Preferred	
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR	Non – Preferred	
Beta Blockers - Drugs For The Heart		
<i>*Alpha-Beta Blockers*** - Drugs For High Blood Pressure</i>		
<i>carvedilol</i>	Preferred	QL (2 EA per 1 day)
<i>carvedilol phosphate er</i>	Non – Preferred	
<i>labetalol hcl</i>	Preferred	
COREG	Non – Preferred	QL (2 EA per 1 day)
COREG CR	Non – Preferred	
*Beta Blockers Cardio-Selective*** - Drugs For High Blood Pressure		
<i>acebutolol hcl</i>	Preferred	
<i>atenolol</i>	Preferred	
<i>betaxolol hcl</i>	Preferred	
<i>bisoprolol fumarate tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>bisoprolol fumarate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 100 mg oral</i>	Preferred	QL (1.5 EA per 1 day)

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metoprolol succinate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 50 mg oral</i>	Preferred	QL (1.5 EA per 1 day)
<i>metoprolol tartrate</i>	Preferred	
BYSTOLIC	Non – Preferred	
FIRST - METOPROLOL	Non – Preferred	
FIRST-ATENOLOL	Non – Preferred	
KAPSPARGO SPRINKLE	Non – Preferred	
LOPRESSOR	Non – Preferred	
TENORMIN	Non – Preferred	
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
<i>*Beta Blockers Non-Selective*** - Drugs For High Blood Pressure</i>		
<i>nadolol</i>	Preferred	QL (2 EA per 1 day)
<i>pindolol</i>	Preferred	
<i>propranolol hcl</i>	Preferred	
<i>propranolol hcl er</i>	Preferred	QL (1 EA per 1 day)
<i>sotalol hcl</i>	Preferred	
<i>sotalol hcl (af)</i>	Non – Preferred	
<i>timolol maleate</i>	Preferred	
BETAPACE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETAPACE AF	Non – Preferred	
CORGARD	Non – Preferred	QL (2 EA per 1 day)
HEMANGEOL	Preferred	PA; AL (Max 1 Years)
INDERAL LA	Non – Preferred	QL (1 EA per 1 day)
INDERAL XL	Non – Preferred	
INNOPRAN XL	Non – Preferred	
SORINE	Preferred	
SOTYLIZE	Non – Preferred	
*Bile Acid Synthesis Disorder Agents*** - Drugs For The Stomach		
<i>*Bile Acid Synthesis Disorder Agents*** - Drugs For The Stomach</i>		
CHOLBAM	Non – Preferred	
*Calcitonin Gene-Related Peptide (Cgrp) Receptor Antag*** - Drugs For The Nervous System		
<i>*Calcitonin Gene-Related Peptide (Cgrp) Receptor Antag*** - Drugs For The Nervous System</i>		
AIMOVIG	Preferred	PA
AJOVY	Non – Preferred	
EMGALITY	Non – Preferred	PA
EMGALITY (300 MG DOSE)	Non – Preferred	
VYEPTI	Non – Preferred	

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

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>verapamil hcl</i>	Preferred	QL (4 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 360 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er oral tablet extended release</i>	Preferred	QL (2 EA per 1 day)
CALAN SR	Non – Preferred	QL (2 EA per 1 day)
CARDIZEM	Non – Preferred	QL (4 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	
CARDIZEM LA	Non – Preferred	
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Preferred	QL (1 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Preferred	QL (3 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Preferred	QL (2 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Preferred	QL (1 EA per 1 day)
KATERZIA	Non – Preferred	
MATZIM LA	Preferred	
NORVASC TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
NORVASC TABLET 2.5 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NORVASC TABLET 5 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NYMALIZE	Non – Preferred	
PROCARDIA	Non – Preferred	
PROCARDIA XL	Non – Preferred	QL (1 EA per 1 day)
SULAR	Non – Preferred	
TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Preferred	QL (1 EA per 1 day)
TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Preferred	QL (3 EA per 1 day)
TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Preferred	QL (2 EA per 1 day)
TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Preferred	QL (1 EA per 1 day)
TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Preferred	QL (3 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Preferred	QL (2 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL	Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cardiotonics - Drugs For The Heart		
<i>*Cardiac Glycosides*** - Drugs For The Heart</i>		
<i>digoxin</i>	Preferred	
DIGITEK	Preferred	
DIGOX	Preferred	
Cardiovascular Agents - Misc. - Drugs For The Heart		
<i>*Calcium Channel Blocker & Hmg Coa Reductase Inhibit Comb*** - Drugs For Cholesterol</i>		
<i>amlodipine-atorvastatin</i>	Non – Preferred	QL (1 EA per 1 day)
CADUET	Non – Preferred	QL (1 EA per 1 day)
<i>*Nitrate & Vasodilator Combinations*** - Drugs For High Blood Pressure</i>		
BIDIL	Preferred	
<i>*Prostaglandin Vasodilators*** - Drugs For High Blood Pressure</i>		
<i>epoprostenol sodium</i>	Preferred	PA
<i>treprostinil</i>	Non – Preferred	
FLOLAN	Preferred	PA
ORENITRAM	Non – Preferred	
REMODULIN	Non – Preferred	
TYVASO	Non – Preferred	
TYVASO REFILL	Non – Preferred	
TYVASO STARTER	Non – Preferred	
VELETRI	Non – Preferred	PA
VENTAVIS	Non – Preferred	

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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Selective Cgmp Phosphodiesterase Type 5 Inhibitors*** - Drugs For High Blood Pressure		
<i>tadalafil</i>	Non – Preferred	
CIALIS	Non – Preferred	
*Cephalosporin Combinations*** - Drugs For Infections		
*Cephalosporin Combinations*** - Drugs For Infections		
AVYCAZ	Preferred	
Cephalosporins - Drugs For Infections		
*Cephalosporins - 1St Generation*** - Antibiotics		
<i>cefadroxil</i>	Preferred	
<i>cefazolin sodium</i>	Preferred	
<i>cefazolin sodium-dextrose</i>	Preferred	
<i>cephalexin</i>	Preferred	
KEFLEX	Non – Preferred	
*Cephalosporins - 2Nd Generation*** - Antibiotics		
<i>cefaclor capsule 250 mg oral</i>	Preferred	
<i>cefaclor capsule 500 mg oral</i>	Preferred	QL (14 EA Max Qty Per Fill Retail)
<i>cefaclor er</i>	Non – Preferred	
<i>cefaclor oral suspension reconstituted</i>	Preferred	
<i>cefoxitin sodium</i>	Preferred	
<i>cefoxitin sodium-dextrose</i>	Preferred	
<i>cefprozil oral suspension reconstituted</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefprozil tablet 250 mg oral</i>	Non – Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>cefprozil tablet 500 mg oral</i>	Non – Preferred	
<i>cefuroxime axetil</i>	Preferred	
*Cephalosporins - 3Rd Generation*** - Antibiotics		
<i>cefdinir</i>	Preferred	
<i>cefixime oral capsule</i>	Preferred	QL (1 EA Max Qty Per Fill Retail)
<i>cefixime oral suspension reconstituted</i>	Non – Preferred	
<i>cefpodoxime proxetil</i>	Non – Preferred	
<i>ceftazidime</i>	Preferred	
<i>ceftazidime and dextrose</i>	Preferred	
<i>ceftriaxone sodium</i>	Preferred	
<i>ceftriaxone sodium in dextrose</i>	Preferred	
<i>ceftriaxone sodium-dextrose</i>	Preferred	
SUPRAX ORAL CAPSULE	Preferred	QL (1 EA Max Qty Per Fill Retail)
SUPRAX ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
SUPRAX ORAL TABLET CHEWABLE	Non – Preferred	
TAZICEF	Preferred	
*Cephalosporins - 4Th Generation*** - Antibiotics		
<i>cefepime hcl</i>	Preferred	
<i>cefepime-dextrose</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Cgrp Receptor Antagonists - Monocolonal Antibodies*** - Drugs For The Nervous System		
<i>*Cgrp Receptor Antagonists - Monocolonal Antibodies*** - Drugs For The Nervous System</i>		
AIMOVIG	Preferred	PA
AJOVY	Non – Preferred	
EMGALITY	Non – Preferred	PA
EMGALITY (300 MG DOSE)	Non – Preferred	
VYEPTI	Non – Preferred	
*Cic Agents - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For The Stomach		
<i>*Cic Agents - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For The Stomach</i>		
TRULANCE	Non – Preferred	
Contraceptives - Drugs For Women		
<i>*Biphasic Contraceptives - Oral*** - Birth Control Pills</i>		
<i>desogestrel-ethinyl estradiol</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>viorele</i>	Preferred	AL (Min 10 Years and Max 55 Years)
AZURETTE	Preferred	AL (Min 10 Years and Max 55 Years)
BEKYREE	Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KARIVA	Preferred	AL (Min 10 Years and Max 55 Years)
LO LOESTRIN FE	Preferred	AL (Min 10 Years and Max 55 Years)
MIRCETTE	Preferred	AL (Min 10 Years and Max 55 Years)
PIMTREA	Preferred	AL (Min 10 Years and Max 55 Years)
SIMLIYA	Preferred	AL (Min 10 Years and Max 55 Years)
VOLNEA	Preferred	AL (Min 10 Years and Max 55 Years)
*Combination Contraceptives - Oral*** - Birth Control Pills		
<i>alyacen 1/35</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>briellyn</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>drospiren-eth estrad-levomefol</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>drospirenone-ethinyl estradiol</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>ethynodiol diac-eth estradiol</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>levonorgestrel-ethinyl estrad</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>marlissa</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>norethin ace-eth estrad-fe</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>norethindrone acet-ethinyl est</i>	Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin-eth estradiol-fe</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>norgestimate-eth estradiol</i>	Preferred	AL (Min 10 Years and Max 55 Years)
AFIRMELLE	Preferred	AL (Min 10 Years and Max 55 Years)
ALTAVERA	Preferred	AL (Min 10 Years and Max 55 Years)
APRI	Preferred	AL (Min 10 Years and Max 55 Years)
AUBRA	Preferred	AL (Min 10 Years and Max 55 Years)
AUBRA EQ	Preferred	AL (Min 10 Years and Max 55 Years)
AUROVELA 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
AUROVELA 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
AUROVELA 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
AUROVELA FE 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
AUROVELA FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
AVIANE	Preferred	AL (Min 10 Years and Max 55 Years)
AYUNA	Preferred	AL (Min 10 Years and Max 55 Years)
BALCOLTRA	Preferred	AL (Min 10 Years and Max 55 Years)
BALZIVA	Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BEYAZ	Preferred	AL (Min 10 Years and Max 55 Years)
BLISOVI 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
BLISOVI FE 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
BLISOVI FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
CHARLOTTE 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
CHATEAL	Preferred	AL (Min 10 Years and Max 55 Years)
CHATEAL EQ	Preferred	AL (Min 10 Years and Max 55 Years)
CRYSSELLE-28	Preferred	AL (Min 10 Years and Max 55 Years)
CYCLAFEM 1/35	Preferred	AL (Min 10 Years and Max 55 Years)
CYRED	Preferred	AL (Min 10 Years and Max 55 Years)
CYRED EQ	Preferred	AL (Min 10 Years and Max 55 Years)
DASETTA 1/35	Preferred	AL (Min 10 Years and Max 55 Years)
ELINEST	Preferred	AL (Min 10 Years and Max 55 Years)
EMOQUETTE	Preferred	AL (Min 10 Years and Max 55 Years)
ENSKYCE	Preferred	AL (Min 10 Years and Max 55 Years)
ESTARYLLA	Preferred	AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FALESSA	Preferred	AL (Min 10 Years and Max 55 Years)
FALMINA	Preferred	AL (Min 10 Years and Max 55 Years)
FEMYNOR	Preferred	AL (Min 10 Years and Max 55 Years)
GENERESS FE	Preferred	AL (Min 10 Years and Max 55 Years)
GIANVI	Preferred	AL (Min 10 Years and Max 55 Years)
HAILEY 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
HAILEY 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
HAILEY FE 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
HAILEY FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
ISIBLOOM	Preferred	AL (Min 10 Years and Max 55 Years)
JASMIEL	Preferred	AL (Min 10 Years and Max 55 Years)
JULEBER	Preferred	AL (Min 10 Years and Max 55 Years)
JUNEL 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
JUNEL 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
JUNEL FE 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
JUNEL FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JUNEL FE 24	Preferred	AL (Min 10 Years and Max 55 Years)
KAITLIB FE	Preferred	AL (Min 10 Years and Max 55 Years)
KALLIGA	Preferred	AL (Min 10 Years and Max 55 Years)
KELNOR 1/35	Preferred	AL (Min 10 Years and Max 55 Years)
KELNOR 1/50	Preferred	AL (Min 10 Years and Max 55 Years)
KURVELO	Preferred	AL (Min 10 Years and Max 55 Years)
LARIN 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
LARIN 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
LARIN 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
LARIN FE 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
LARIN FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
LARISSIA	Preferred	AL (Min 10 Years and Max 55 Years)
LAYOLIS FE	Preferred	AL (Min 10 Years and Max 55 Years)
LESSINA	Preferred	AL (Min 10 Years and Max 55 Years)
LEVORA 0.15/30 (28)	Preferred	AL (Min 10 Years and Max 55 Years)
LILLOW	Preferred	AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOESTRIN 1.5/30 (21)	Preferred	AL (Min 10 Years and Max 55 Years)
LOESTRIN 1/20 (21)	Preferred	AL (Min 10 Years and Max 55 Years)
LOESTRIN FE 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
LOESTRIN FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
LORYNA	Preferred	AL (Min 10 Years and Max 55 Years)
LOW-OGESTREL	Preferred	AL (Min 10 Years and Max 55 Years)
LO-ZUMANDIMINE	Preferred	AL (Min 10 Years and Max 55 Years)
LUTERA	Preferred	AL (Min 10 Years and Max 55 Years)
MELODETTA 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
MIBELAS 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
MICROGESTIN 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
MICROGESTIN 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
MICROGESTIN FE 1.5/30	Preferred	AL (Min 10 Years and Max 55 Years)
MICROGESTIN FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
MILI	Preferred	AL (Min 10 Years and Max 55 Years)
MINASTRIN 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONO-LINYAH	Preferred	AL (Min 10 Years and Max 55 Years)
NECON 0.5/35 (28)	Preferred	AL (Min 10 Years and Max 55 Years)
NIKKI	Preferred	AL (Min 10 Years and Max 55 Years)
NORTREL 0.5/35 (28)	Preferred	AL (Min 10 Years and Max 55 Years)
NORTREL 1/35 (21)	Preferred	AL (Min 10 Years and Max 55 Years)
NORTREL 1/35 (28)	Preferred	AL (Min 10 Years and Max 55 Years)
OCELLA	Preferred	AL (Min 10 Years and Max 55 Years)
ORSYTHIA	Preferred	AL (Min 10 Years and Max 55 Years)
PHILITH	Preferred	AL (Min 10 Years and Max 55 Years)
PIRMELLA 1/35	Preferred	AL (Min 10 Years and Max 55 Years)
PORTIA-28	Preferred	AL (Min 10 Years and Max 55 Years)
PREVIFEM	Preferred	AL (Min 10 Years and Max 55 Years)
RECLIPSEN	Preferred	AL (Min 10 Years and Max 55 Years)
SAFYRAL	Preferred	AL (Min 10 Years and Max 55 Years)
SPRINTEC 28	Preferred	AL (Min 10 Years and Max 55 Years)
SRONYX	Preferred	AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYEDA	Preferred	AL (Min 10 Years and Max 55 Years)
TARINA 24 FE	Preferred	AL (Min 10 Years and Max 55 Years)
TARINA FE 1/20	Preferred	AL (Min 10 Years and Max 55 Years)
TARINA FE 1/20 EQ	Preferred	AL (Min 10 Years and Max 55 Years)
TAYTULLA	Preferred	AL (Min 10 Years and Max 55 Years)
TYDEMY	Preferred	AL (Min 10 Years and Max 55 Years)
VIENVA	Preferred	AL (Min 10 Years and Max 55 Years)
VYFEMLA	Preferred	AL (Min 10 Years and Max 55 Years)
VYLIBRA	Preferred	AL (Min 10 Years and Max 55 Years)
WERA	Preferred	AL (Min 10 Years and Max 55 Years)
WYMZYA FE	Preferred	AL (Min 10 Years and Max 55 Years)
YASMIN 28	Preferred	AL (Min 10 Years and Max 55 Years)
YAZ	Preferred	AL (Min 10 Years and Max 55 Years)
ZARAH	Preferred	AL (Min 10 Years and Max 55 Years)
ZOVIA 1/35E (28)	Preferred	AL (Min 10 Years and Max 55 Years)
ZUMANDIMINE	Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Combination Contraceptives - Transdermal*** - Birth Control Pills		
XULANE	Preferred	QL (3 EA per 28 days); AL (Min 10 Years and Max 55 Years)
*Combination Contraceptives - Vaginal*** - Birth Control Pills		
<i>etonogestrel-ethinyl estradiol</i>	Preferred	QL (1 EA per 28 days); AL (Min 10 Years and Max 55 Years)
ANNOVERA	Preferred	AL (Min 10 Years and Max 55 Years)
ELURYNG	Preferred	QL (1 EA per 28 days); AL (Min 10 Years and Max 55 Years)
NUVARING	Preferred	QL (1 EA per 28 days); AL (Min 10 Years and Max 55 Years)
*Continuous Contraceptives - Oral*** - Birth Control Pills		
<i>levonorgestrel-ethinyl estrad</i>	Preferred	AL (Min 10 Years and Max 55 Years)
AMETHYST	Preferred	AL (Min 10 Years and Max 55 Years)
*Emergency Contraceptives*** - Birth Control Pills		
<i>levonorgestrel</i>	Preferred	OTC
AFTERA	Preferred	OTC
ECONTRA EZ	Preferred	OTC
ECONTRA ONE-STEP	Preferred	OTC
ELLA	Preferred	AL (Min 10 Years and Max 55 Years)
MY CHOICE	Preferred	OTC
MY WAY	Preferred	OTC
NEW DAY	Preferred	OTC

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPCICON ONE-STEP	Preferred	OTC
OPTION 2	Preferred	OTC
PLAN B ONE-STEP	Preferred	OTC
TAKE ACTION	Preferred	OTC
*Extended-Cycle Contraceptives - Oral*** - Birth Control Pills		
<i>levonorgest-eth est & eth est</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>levonorgest-eth estrad 91-day tablet 0.1-0.02 & 0.01 mg oral</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>levonorgest-eth estrad 91-day tablet 0.15-0.03 & 0.01 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
<i>levonorgest-eth estrad 91-day tablet 0.15-0.03 mg oral</i>	Preferred	AL (Min 10 Years and Max 55 Years)
AMETHIA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
AMETHIA LO	Preferred	AL (Min 10 Years and Max 55 Years)
ASHLYNA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
CAMRESE	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
CAMRESE LO	Preferred	AL (Min 10 Years and Max 55 Years)
DAYSEE	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
FAYOSIM	Preferred	AL (Min 10 Years and Max 55 Years)
INTROVALE	Preferred	AL (Min 10 Years and Max 55 Years)
JAIMIESS	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JOLESSA	Preferred	AL (Min 10 Years and Max 55 Years)
LOJAIMIESS	Preferred	AL (Min 10 Years and Max 55 Years)
LOSEASONIQUE	Preferred	AL (Min 10 Years and Max 55 Years)
QUARTETTE	Preferred	AL (Min 10 Years and Max 55 Years)
RIVELSA	Preferred	AL (Min 10 Years and Max 55 Years)
SEASONIQUE	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
SETLAKIN	Preferred	AL (Min 10 Years and Max 55 Years)
SIMPESSE	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
*Four Phase Contraceptives - Oral*** - Birth Control Pills		
NATAZIA	Preferred	AL (Min 10 Years and Max 55 Years)
*Progestin Contraceptives - Injectable*** - Birth Control Pills		
<i>medroxyprogesterone acetate intramuscular suspension</i>	Preferred	QL (1 VIAL per 84 days); AL (Min 10 Years and Max 55 Years)
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe</i>	Preferred	AL (Min 10 Years and Max 55 Years)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION	Preferred	QL (1 VIAL per 84 days); AL (Min 10 Years and Max 55 Years)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	Preferred	AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPO-SUBQ PROVERA 104	Preferred	AL (Min 10 Years and Max 55 Years)
<i>*Progestin Contraceptives - Oral*** - Birth Control Pills</i>		
<i>norethindrone</i>	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
CAMILA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
DEBLITANE	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
ERRIN	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
HEATHER	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
INCASSIA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
JENCYCLA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
LYZA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
NORA-BE	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
NORLYDA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
ORTHO MICRONOR	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
SHAROBEL	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
SLYND	Preferred	AL (Min 10 Years and Max 55 Years)
TULANA	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Triphasic Contraceptives - Oral*** - Birth Control Pills		
<i>alyacen 7/7/7</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>levonorg-eth estrad triphasic</i>	Preferred	AL (Min 10 Years and Max 55 Years)
<i>norgestim-eth estrad triphasic</i>	Preferred	AL (Min 10 Years and Max 55 Years)
ARANELLE	Preferred	AL (Min 10 Years and Max 55 Years)
CAZIAN	Preferred	AL (Min 10 Years and Max 55 Years)
CYCLAFEM 7/7/7	Preferred	AL (Min 10 Years and Max 55 Years)
DASETTA 7/7/7	Preferred	AL (Min 10 Years and Max 55 Years)
ENPRESSE-28	Preferred	AL (Min 10 Years and Max 55 Years)
ESTROSTEP FE	Preferred	AL (Min 10 Years and Max 55 Years)
LEENA	Preferred	AL (Min 10 Years and Max 55 Years)
LEVONEST	Preferred	AL (Min 10 Years and Max 55 Years)
NORTREL 7/7/7	Preferred	AL (Min 10 Years and Max 55 Years)
PIRMELLA 7/7/7	Preferred	AL (Min 10 Years and Max 55 Years)
TILIA FE	Preferred	AL (Min 10 Years and Max 55 Years)
TRI FEMYNOR	Preferred	AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRI-ESTARYLLA	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-LEGEST FE	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-LINYAH	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-LO-ESTARYLLA	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-LO-MARZIA	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-LO-MILI	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-LO-SPRINTEC	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-MILI	Preferred	AL (Min 10 Years and Max 55 Years)
TRINESSA (28)	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-PREVIFEM	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-SPRINTEC	Preferred	AL (Min 10 Years and Max 55 Years)
TRIVORA (28)	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-VYLIBRA	Preferred	AL (Min 10 Years and Max 55 Years)
TRI-VYLIBRA LO	Preferred	AL (Min 10 Years and Max 55 Years)
VELIVET	Preferred	AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Corticosteroids - Hormones		
*Glucocorticosteroids*** - Drugs For Inflammation		
<i>budesonide</i>	Non – Preferred	
<i>budesonide er</i>	Non – Preferred	
<i>cortisone acetate</i>	Non – Preferred	
<i>dexamethasone</i>	Preferred	
<i>dexamethasone sodium phosphate</i>	Preferred	
<i>hydrocortisone</i>	Preferred	
<i>methylprednisolone oral tablet</i>	Preferred	
<i>methylprednisolone oral tablet therapy pack</i>	Preferred	QL (21 EA Max Qty Per Fill Retail)
<i>prednisolone</i>	Preferred	
<i>prednisolone sodium phosphate oral tablet dispersible</i>	Non – Preferred	
<i>prednisolone sodium phosphate solution 10 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 15 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 20 mg/5ml oral</i>	Preferred	QL (150 ML Max Qty Per Fill Retail)
<i>prednisolone sodium phosphate solution 25 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 6.7 (5 base) mg/5ml oral</i>	Preferred	
<i>prednisone oral solution</i>	Preferred	
<i>prednisone oral tablet</i>	Preferred	
<i>prednisone tablet therapy pack 10 mg (21) oral</i>	Preferred	
<i>prednisone tablet therapy pack 10 mg (48) oral</i>	Preferred	QL (48 EA Max Qty Per Fill Retail)

Coverage Requirements and Limits

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

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Cyclin-Dependent Kinases (Cdk) Inhibitors*** - Drugs For Cancer		
<i>*Cyclin-Dependent Kinases (Cdk) Inhibitors*** - Drugs For Cancer</i>		
IBRANCE	Non – Preferred	QL (1 EA per 1 day)
KISQALI (200 MG DOSE)	Non – Preferred	
KISQALI (400 MG DOSE)	Non – Preferred	
KISQALI (600 MG DOSE)	Non – Preferred	
VERZENIO	Non – Preferred	QL (2 EA per 1 day)
*Cystic Fibrosis Agent - Combinations*** - Drugs For The Lungs		
<i>*Cystic Fibrosis Agent - Combinations*** - Drugs For The Lungs</i>		
ORKAMBI	Non – Preferred	
SYMDEKO	Non – Preferred	
TRIKAFTA	Non – Preferred	
Dermatologicals - Drugs For The Skin		
<i>*Acne Antibiotics*** - Drugs For The Skin</i>		
<i>clindamycin phosphate external foam</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>clindamycin phosphate external gel</i>	Non – Preferred	QL (1 GM per 1 day); AL (Min 10 Years and Max 20 Years)
<i>clindamycin phosphate external lotion</i>	Non – Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
<i>clindamycin phosphate external solution</i>	Preferred	QL (2 ML per 1 day); AL (Min 10 Years and Max 20 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clindamycin phosphate external swab</i>	Preferred	QL (2 EA per 1 day); AL (Min 10 Years and Max 20 Years)
<i>dapsone</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>ery</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 10 Years and Max 20 Years)
<i>erythromycin external gel</i>	Non – Preferred	QL (1 GM per 1 day); AL (Min 10 Years and Max 20 Years)
<i>erythromycin solution 2 % external</i>	Preferred	QL (2 ML per 1 day); AL (Min 10 Years and Max 20 Years)
<i>erythromycin solution 2 % external</i>	Preferred	QL (2 ML per 1 day)
<i>sulfacetamide sodium (acne)</i>	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years and Max 20 Years)
ACZONE	Non – Preferred	AL (Min 10 Years and Max 20 Years)
AMZEEQ	Non – Preferred	AL (Min 10 Years and Max 20 Years)
CLEOCIN-T	Non – Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
CLINDACIN ETZ	Preferred	QL (2 EA per 1 day); AL (Min 10 Years and Max 20 Years)
CLINDACIN-P	Preferred	QL (2 EA per 1 day); AL (Min 10 Years and Max 20 Years)
CLINDAGEL	Non – Preferred	QL (1 ML per 1 day); AL (Min 10 Years and Max 20 Years)
ERYGEL	Non – Preferred	QL (1 GM per 1 day); AL (Min 10 Years and Max 20 Years)
EVOCLIN	Non – Preferred	AL (Min 10 Years and Max 20 Years)
KLARON	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years and Max 20 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Acne Combinations*** - Drugs For The Skin		
<i>adapalene-benzoyl peroxide</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>benzoyl peroxide-erythromycin</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>bp 10-1</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>bp cleansing wash</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>clindamycin phos-benzoyl perox</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>clindamycin-tretinoin</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>sss 10-5</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>sulfacetamide-sulfur in urea</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ACANYA	Non – Preferred	AL (Min 10 Years and Max 20 Years)
BENZACLIN	Non – Preferred	AL (Min 10 Years and Max 20 Years)
BENZACLIN WITH PUMP	Non – Preferred	AL (Min 10 Years and Max 20 Years)
BENZAMYCIN	Non – Preferred	
CLINDACIN ETZ	Non – Preferred	AL (Min 10 Years and Max 20 Years)
CLINDACIN PAC	Non – Preferred	AL (Min 10 Years and Max 20 Years)
EPIDUO	Non – Preferred	AL (Min 10 Years and Max 20 Years)

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EPIDUO FORTE	Non – Preferred	AL (Min 10 Years and Max 20 Years)
NEUAC	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ONEXTON	Non – Preferred	AL (Min 10 Years and Max 20 Years)
SUMADAN	Non – Preferred	AL (Min 10 Years and Max 20 Years)
SUMADAN WASH	Non – Preferred	AL (Min 10 Years and Max 20 Years)
SUMADAN XLT	Non – Preferred	AL (Min 10 Years and Max 20 Years)
SUMAXIN	Non – Preferred	AL (Min 10 Years and Max 20 Years)
SUMAXIN CP	Non – Preferred	AL (Min 10 Years and Max 20 Years)
SUMAXIN WASH	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ZIANA	Non – Preferred	AL (Min 10 Years and Max 20 Years)
*Acne Products*** - Drugs For The Skin		
<i>adapalene external cream</i>	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
<i>adapalene external solution</i>	Non – Preferred	
<i>adapalene gel 0.1 % external (rx)</i>	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
<i>adapalene gel 0.3 % external</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>isotretinoin capsule 10 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 20 mg oral</i>	Non – Preferred	AL (Min 12 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>isotretinoin capsule 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
<i>isotretinoin capsule 40 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>tretinoin external cream</i>	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
<i>tretinoin gel 0.01 % external</i>	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
<i>tretinoin gel 0.025 % external</i>	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
<i>tretinoin gel 0.05 % external</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere pump</i>	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ABSORICA CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 25 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
ABSORICA CAPSULE 35 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA LD	Non – Preferred	AL (Min 10 Years and Max 20 Years)
AKLIEF	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ALTRENO	Non – Preferred	AL (Min 10 Years and Max 20 Years)
AMNESTEEM	Non – Preferred	AL (Min 12 Years)

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ARAZLO	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ATRALIN	Non – Preferred	AL (Min 10 Years and Max 20 Years)
AVITA EXTERNAL CREAM	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
AVITA EXTERNAL GEL	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
AZELEX	Non – Preferred	AL (Min 10 Years and Max 20 Years)
CLARAVIS CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
CLARAVIS CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
DIFFERIN EXTERNAL CREAM	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
DIFFERIN EXTERNAL GEL	Non – Preferred	AL (Min 10 Years and Max 20 Years)
DIFFERIN EXTERNAL LOTION	Non – Preferred	AL (Min 10 Years and Max 20 Years)
FABIOR	Non – Preferred	AL (Min 10 Years and Max 20 Years)
MYORISAN CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
MYORISAN CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
MYORISAN CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
MYORISAN CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RETIN-A EXTERNAL CREAM	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
RETIN-A EXTERNAL GEL	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
RETIN-A MICRO	Non – Preferred	AL (Min 10 Years and Max 20 Years)
RETIN-A MICRO PUMP	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ZENATANE CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
ZENATANE CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
<i>*Agents For External Genital And Perianal Warts*** - Drugs For The Skin</i>		
VEREGEN	Non – Preferred	
<i>*Antibiotic Steroid Combinations - Topical*** - Drugs For The Skin</i>		
CORTISPORIN EXTERNAL CREAM	Non – Preferred	
CORTISPORIN EXTERNAL OINTMENT	Preferred	
NEO-SYNALAR	Non – Preferred	
<i>*Antibiotics - Topical*** - Drugs For The Skin</i>		
<i>gentamicin sulfate</i>	Preferred	
<i>mupirocin</i>	Non – Preferred	QL (110 GM per 30 days); AL (Max 20 Years)
<i>mupirocin calcium</i>	Non – Preferred	AL (Max 20 Years)
CENTANY	Non – Preferred	QL (110 GM per 30 days); AL (Max 20 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CENTANY AT	Non – Preferred	
XEPI	Non – Preferred	
*Antifungals - Topical Combinations*** - Drugs For The Skin		
<i>clotrimazole-betamethasone external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>clotrimazole-betamethasone external lotion</i>	Non – Preferred	
<i>miconazole-zinc oxide-petrolat</i>	Non – Preferred	
<i>nystatin-triamcinolone</i>	Non – Preferred	
ECONASIL	Non – Preferred	
VUSION	Non – Preferred	
ZOLPAK	Non – Preferred	
*Antifungals - Topical*** - Drugs For The Skin		
<i>ciclopirox external gel</i>	Non – Preferred	
<i>ciclopirox external shampoo</i>	Non – Preferred	QL (120 ML per 30 days)
<i>ciclopirox external solution</i>	Non – Preferred	QL (6.6 ML per 30 days)
<i>ciclopirox olamine external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>ciclopirox olamine external suspension</i>	Non – Preferred	QL (30 ML per 30 days)
<i>ciclopirox treatment</i>	Non – Preferred	
<i>naftifine hcl</i>	Non – Preferred	
<i>nystatin external cream</i>	Preferred	QL (60 GM per 30 days)
<i>nystatin external ointment</i>	Preferred	QL (60 GM per 30 days)
<i>nystatin external powder</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
CICLODAN	Non – Preferred	QL (6.6 ML per 30 days)
LOPROX EXTERNAL CREAM	Non – Preferred	QL (60 GM per 30 days)
LOPROX EXTERNAL KIT	Non – Preferred	
LOPROX EXTERNAL SHAMPOO	Non – Preferred	QL (120 ML per 30 days)
LOPROX EXTERNAL SUSPENSION	Non – Preferred	QL (30 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MENTAX	Non – Preferred	QL (30 GM per 30 days)
NAFTIN	Non – Preferred	
NYAMYC	Preferred	QL (60 GM Max Qty Per Fill Retail)
NYSTOP	Preferred	QL (60 GM Max Qty Per Fill Retail)
*Anti-Inflammatory Agents - Topical*** - Drugs For The Skin		
<i>diclofenac epolamine</i>	Non – Preferred	
<i>diclofenac sodium external gel</i>	Non – Preferred	QL (200 GM per 30 days)
<i>diclofenac sodium external solution</i>	Non – Preferred	QL (10 ML per 1 day)
FLECTOR	Non – Preferred	
LICART	Non – Preferred	
PENNSAID	Non – Preferred	
VOLTAREN	Non – Preferred	QL (200 GM per 30 days)
*Anti-Inflammatory Combinations - Topical*** - Drugs For The Skin		
DICLOFEX DC	Non – Preferred	
DICLOTREX	Non – Preferred	
*Antineoplastic Alkylating Agents - Topical*** - Drugs For The Skin		
VALCHLOR	Non – Preferred	
*Antineoplastic Antimetabolites - Topical*** - Drugs For The Skin		
<i>fluorouracil</i>	Non – Preferred	
CARAC	Non – Preferred	
EFUDEX	Non – Preferred	
TOLAK	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Antineoplastic Or Premalignant Lesions - Topical Misc.*** - Drugs For The Skin		
PICATO	Non – Preferred	
*Antineoplastic Or Premalignant Lesions - Topical Nsaid's*** - Drugs For The Skin		
<i>diclofenac sodium</i>	Non – Preferred	
*Antineoplastic Retinoids - Topical*** - Drugs For The Skin		
PANRETIN	Preferred	
*Antipruritics - Topical*** - Drugs For The Skin		
<i>doxepin hcl</i>	Non – Preferred	
PRUDOXIN	Non – Preferred	
ZONALON	Non – Preferred	
*Antipsoriatics - Systemic*** - Drugs For The Skin		
<i>acitretin</i>	Non – Preferred	
<i>methoxsalen rapid</i>	Non – Preferred	
COSENTYX	Non – Preferred	
COSENTYX (300 MG DOSE)	Non – Preferred	
COSENTYX SENSOREADY (300 MG)	Non – Preferred	
COSENTYX SENSOREADY PEN	Non – Preferred	
ILUMYA	Non – Preferred	
OXSORALEN ULTRA	Non – Preferred	
SILIQ	Non – Preferred	
SKYRIZI (150 MG DOSE)	Non – Preferred	
SORIATANE	Non – Preferred	
STELARA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TALTZ	Non – Preferred	
TREMFYA	Non – Preferred	
*Antipsoriatics*** - Drugs For The Skin		
<i>calcipotriene external cream</i>	Preferred	QL (4 GM per 1 day)
<i>calcipotriene external ointment</i>	Preferred	QL (4 GM per 1 day)
<i>calcipotriene external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>calcitriol</i>	Non – Preferred	
<i>tazarotene</i>	Non – Preferred	QL (3 GM per 1 day)
DOVONEX	Non – Preferred	QL (4 GM per 1 day)
SORILUX	Non – Preferred	
TAZORAC CREAM 0.05 % EXTERNAL	Non – Preferred	
TAZORAC CREAM 0.1 % EXTERNAL	Non – Preferred	QL (3 GM per 1 day)
TAZORAC EXTERNAL GEL	Non – Preferred	
VECTICAL	Non – Preferred	
*Antiseborrheic Products*** - Drugs For The Skin		
<i>selenium sulfide external lotion</i>	Preferred	
<i>selenium sulfide external shampoo</i>	Non – Preferred	
<i>sulfacetamide sodium</i>	Non – Preferred	
OVACE PLUS	Non – Preferred	
*Antiviral Topical Combinations*** - Drugs For The Skin		
XERESE	Non – Preferred	
*Antivirals - Topical*** - Drugs For The Skin		
<i>acyclovir external cream</i>	Non – Preferred	
<i>acyclovir external ointment</i>	Non – Preferred	QL (15 GM per 30 days)
DENAVIR	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZOVIRAX EXTERNAL CREAM	Non – Preferred	
ZOVIRAX EXTERNAL OINTMENT	Non – Preferred	QL (15 GM per 30 days)
*Astringents*** - Drugs For The Skin		
XERAC AC	Non – Preferred	
*Burn Products*** - Drugs For The Skin		
<i>mafenide acetate</i>	Preferred	
<i>silver sulfadiazine</i>	Preferred	
SILVADENE	Non – Preferred	
SSD	Preferred	
SULFAMYLON EXTERNAL CREAM	Preferred	
SULFAMYLON EXTERNAL PACKET	Non – Preferred	
*Cauterizing Agent Combinations*** - Drugs For The Skin		
<i>grafco silver nit applicator</i>	Non – Preferred	
ARZOL SILVER NIT APPLICATORS	Non – Preferred	
*Cauterizing Agents*** - Drugs For The Skin		
<i>silver nitrate</i>	Non – Preferred	
*Corticosteroids - Topical*** - Drugs For The Skin		
<i>alclometasone dipropionate</i>	Preferred	QL (60 GM per 30 days)
<i>amcinonide</i>	Non – Preferred	
<i>betamethasone dipropionate aug external cream</i>	Non – Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>betamethasone dipropionate aug external gel</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate aug external lotion</i>	Non – Preferred	QL (60 ML per 30 days)
<i>betamethasone dipropionate aug external ointment</i>	Non – Preferred	QL (60 GM per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>betamethasone dipropionate external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate external lotion</i>	Non – Preferred	QL (120 ML per 30 days)
<i>betamethasone dipropionate external ointment</i>	Non – Preferred	QL (2 GM per 1 day)
<i>betamethasone valerate external cream</i>	Preferred	QL (60 GM per 30 days)
<i>betamethasone valerate external foam</i>	Non – Preferred	
<i>betamethasone valerate external lotion</i>	Preferred	QL (120 ML per 30 days)
<i>betamethasone valerate external ointment</i>	Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>clobetasol prop emollient base</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate e</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate emulsion</i>	Non – Preferred	
<i>clobetasol propionate external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external foam</i>	Non – Preferred	
<i>clobetasol propionate external gel</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external liquid</i>	Non – Preferred	
<i>clobetasol propionate external lotion</i>	Non – Preferred	
<i>clobetasol propionate external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external shampoo</i>	Non – Preferred	
<i>clobetasol propionate external solution</i>	Preferred	QL (50 ML per 30 days)
<i>clocortolone pivalate</i>	Non – Preferred	
<i>desonide external cream</i>	Preferred	
<i>desonide external lotion</i>	Non – Preferred	
<i>desonide external ointment</i>	Preferred	
<i>desoximetasone</i>	Non – Preferred	
<i>diflorasone diacetate</i>	Preferred	QL (60 GM per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluocinolone acetonide body</i>	Preferred	
<i>fluocinolone acetonide cream 0.01 % external</i>	Preferred	
<i>fluocinolone acetonide cream 0.025 % external</i>	Preferred	QL (2 GM per 1 day)
<i>fluocinolone acetonide external ointment</i>	Preferred	QL (2 GM per 1 day)
<i>fluocinolone acetonide external solution</i>	Preferred	
<i>fluocinolone acetonide scalp</i>	Preferred	
<i>fluocinonide cream 0.05 % external</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide cream 0.1 % external</i>	Preferred	
<i>fluocinonide emulsified base</i>	Preferred	QL (60 GM per 30 days)
<i>fluocinonide external gel</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>flurandrenolide</i>	Non – Preferred	
<i>fluticasone propionate external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluticasone propionate external lotion</i>	Non – Preferred	
<i>fluticasone propionate external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>halcinonide</i>	Non – Preferred	
<i>halobetasol propionate external cream</i>	Preferred	QL (50 GM per 30 days)
<i>halobetasol propionate external foam</i>	Non – Preferred	
<i>halobetasol propionate external ointment</i>	Preferred	QL (50 GM per 30 days)
<i>hydrocortisone butyr lipo base</i>	Non – Preferred	
<i>hydrocortisone butyrate</i>	Non – Preferred	
<i>hydrocortisone cream 1 % external (rx)</i>	Preferred	QL (454 GM Max Qty Per Fill Retail)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone cream 2.5 % external</i>	Preferred	QL (90 0 per 30 days)
<i>hydrocortisone external lotion</i>	Preferred	QL (120 ML per 30 days)
<i>hydrocortisone external ointment</i>	Preferred	QL (90 GM per 30 days)
<i>hydrocortisone valerate</i>	Preferred	
<i>mometasone furoate external cream</i>	Preferred	QL (45 GM per 30 days)
<i>mometasone furoate external ointment</i>	Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>mometasone furoate external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>prednicarbate</i>	Non – Preferred	
<i>psorcon</i>	Non – Preferred	QL (60 GM per 30 days)
<i>triamcinolone acetonide external aerosol solution</i>	Non – Preferred	
<i>triamcinolone acetonide external cream</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide external lotion</i>	Preferred	QL (120 ML per 30 days)
<i>triamcinolone acetonide ointment 0.025 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide ointment 0.05 % external</i>	Non – Preferred	
<i>triamcinolone acetonide ointment 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.5 % external</i>	Preferred	QL (90 GM per 30 days)
APEXICON E	Non – Preferred	
BESER	Non – Preferred	
BRYHALI	Non – Preferred	
CAPEX	Non – Preferred	
CLOBEX	Non – Preferred	
CLOBEX SPRAY	Non – Preferred	
CLODAN	Non – Preferred	
CLODERM	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORDRAN	Non – Preferred	
CUTIVATE	Non – Preferred	
DERMA-SMOOTHIE/FS BODY	Non – Preferred	
DERMA-SMOOTHIE/FS SCALP	Non – Preferred	
DESONATE	Non – Preferred	
DIPROLENE	Non – Preferred	QL (60 GM per 30 days)
HALOG	Non – Preferred	
KENALOG	Non – Preferred	
LEXETTE	Non – Preferred	
LOCOID	Non – Preferred	
LOCOID LIPOCREAM	Non – Preferred	
LUXIQ	Non – Preferred	
OLUX	Non – Preferred	
OLUX-E	Non – Preferred	
PANDEL	Non – Preferred	
SERNIVO	Non – Preferred	
SYNALAR EXTERNAL CREAM	Non – Preferred	QL (2 GM per 1 day)
SYNALAR EXTERNAL OINTMENT	Non – Preferred	QL (2 GM per 1 day)
SYNALAR EXTERNAL SOLUTION	Non – Preferred	
TASOPROL	Non – Preferred	
TEMOVATE	Non – Preferred	QL (60 GM Max Qty Per Fill Retail)
TEXACORT	Non – Preferred	
TOPICORT	Non – Preferred	
TOPICORT SPRAY	Non – Preferred	
TOVET	Non – Preferred	
TRIANEX	Non – Preferred	
ULTRAVATE	Non – Preferred	
VANOS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Emollient/Keratolytic Agents*** - Drugs For The Skin		
<i>urea cream 39 % external</i>	Preferred	
<i>urea cream 40 % external</i>	Preferred	QL (85 GM per 30 days)
<i>urea external lotion</i>	Preferred	QL (236.3 GM per 30 days)
*Emollient/Keratolytic Combinations*** - Drugs For The Skin		
<i>urea hydrating</i>	Non – Preferred	
*Emollients*** - Drugs For The Skin		
<i>ammonium lactate external cream</i>	Non – Preferred	
<i>ammonium lactate external lotion</i>	Preferred	
*Enzymes - Topical*** - Drugs For The Skin		
SANTYL	Non – Preferred	
*Eyelid Cleansers & Lubricants*** - Drugs For The Skin		
HYPOCYN	Non – Preferred	
*Imidazole-Related Antifungals - Topical*** - Drugs For The Skin		
<i>clotrimazole external cream</i>	Preferred	QL (60 GM per 30 days)
<i>clotrimazole external solution</i>	Non – Preferred	QL (30 ML per 30 days)
<i>econazole nitrate</i>	Preferred	QL (30 GM per 30 days)
<i>ketoconazole external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>ketoconazole external foam</i>	Non – Preferred	
<i>ketoconazole external shampoo</i>	Preferred	QL (120 ML Max Qty Per Fill Retail)
<i>luliconazole</i>	Non – Preferred	
<i>oxiconazole nitrate</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ERTACZO	Non – Preferred	
EXELDERM	Non – Preferred	
EXTINA	Non – Preferred	
JUBLIA	Non – Preferred	
KETODAN	Non – Preferred	
LUZU	Non – Preferred	
OXISTAT	Non – Preferred	
*Immunomodulators Imidazoquinolinamines - Topical*** - Drugs For The Skin		
<i>imiquimod</i>	Non – Preferred	QL (12 PACKET per 30 days); AL (Min 10 Years)
<i>imiquimod pump</i>	Non – Preferred	AL (Min 10 Years)
ALDARA	Non – Preferred	QL (12 PACKET per 30 days); AL (Min 10 Years)
ZYCLARA	Non – Preferred	AL (Min 10 Years)
ZYCLARA PUMP	Non – Preferred	AL (Min 10 Years)
*Keratolytic And/Or Antimitotic Combinations*** - Drugs For The Skin		
<i>bensal hp</i>	Non – Preferred	
*Keratolytic/Antimitotic Agents*** - Drugs For The Skin		
<i>podocon</i>	Non – Preferred	
<i>podofilox</i>	Preferred	
<i>salicylic acid external foam</i>	Non – Preferred	
<i>salicylic acid external gel</i>	Preferred	
<i>salicylic acid wart remover</i>	Preferred	
CONDYLOX	Preferred	
SALEX	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Local Anesthetics - Topical*** - Drugs For The Skin		
<i>lidocaine external ointment</i>	Preferred	QL (50 GM per 30 days)
<i>lidocaine external patch</i>	Non – Preferred	QL (3 EA per 1 day)
<i>lidocaine hcl</i>	Preferred	
<i>lidocaine hcl urethral/mucosal external gel</i>	Preferred	QL (30 ML Max Qty Per Fill Retail)
<i>lidocaine hcl urethral/mucosal external prefilled syringe</i>	Preferred	
GLYDO	Preferred	
LIDODERM	Non – Preferred	QL (3 EA per 1 day)
LYDEXA	Non – Preferred	
QUTENZA	Non – Preferred	
QUTENZA (2 PATCH)	Non – Preferred	
ZTLIDO	Non – Preferred	
*Macrolide Immunosuppressants - Topical*** - Drugs For The Skin		
<i>pimecrolimus</i>	Preferred	PA
<i>tacrolimus</i>	Preferred	PA
ELIDEL	Preferred	PA
PROTOPIC	Preferred	PA
*Misc. Dermatological Products*** - Drugs For The Skin		
HYLATOPIC PLUS	Non – Preferred	
NUVAIL	Non – Preferred	
TETRIX	Non – Preferred	
*Misc. Topical*** - Drugs For The Skin		
QBREXZA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Photodynamic Therapy Agents - Topical*** - Drugs For The Skin		
AMELUZ	Non – Preferred	
LEVULAN KERASTICK	Preferred	
*Rosacea Agents*** - Drugs For The Skin		
<i>azelaic acid</i>	Non – Preferred	
<i>doxycycline</i>	Non – Preferred	
<i>metronidazole</i>	Preferred	
FINACEA	Non – Preferred	
METROCREAM	Non – Preferred	
METROGEL	Non – Preferred	
MIRVASO	Non – Preferred	
NORITATE	Non – Preferred	
ORACEA	Non – Preferred	
RHOFADE	Non – Preferred	
ROSADAN EXTERNAL CREAM	Preferred	
ROSADAN EXTERNAL GEL	Preferred	
ROSADAN EXTERNAL KIT	Non – Preferred	
SOOLANTRA	Non – Preferred	
ZILXI	Non – Preferred	
*Scabicide Combinations*** - Drugs For The Skin		
<i>gnp lice treatment</i>	Preferred	OTC; QL (240 ML per 30 days)
<i>hm lice killing max st</i>	Preferred	OTC; QL (240 ML per 30 days)
<i>lice killing</i>	Preferred	OTC; QL (240 ML per 30 days)
<i>lice killing maximum strength</i>	Preferred	OTC; QL (240 ML per 30 days)
<i>sm lice killing max strength</i>	Preferred	OTC; QL (240 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Scabicides & Pediculicides*** - Drugs For The Skin		
<i>gnp lice treatment</i>	Preferred	OTC; QL (118 ML per 30 days)
<i>hm lice treatment</i>	Preferred	OTC; QL (118 ML per 30 days)
<i>lice treatment</i>	Preferred	OTC
<i>lindane</i>	Non – Preferred	
<i>malathion</i>	Non – Preferred	
<i>permethrin</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>sm lice treatment</i>	Preferred	OTC
<i>spinosad</i>	Non – Preferred	
CROTAN	Non – Preferred	
ELIMITE	Non – Preferred	QL (60 GM Max Qty Per Fill Retail)
NATROBA	Preferred	
OVIDE	Non – Preferred	
SKLICE	Non – Preferred	
*Skin Cleansers*** - Drugs For The Skin		
HYCLODEX	Non – Preferred	
*Steroid-Local Anesthetic Combinations*** - Drugs For The Skin		
EPIFOAM	Non – Preferred	
*Topical Anesthetic Combinations*** - Drugs For The Skin		
<i>lidocaine-prilocaine</i>	Non – Preferred	
APRIZIO PAK II	Non – Preferred	
EMPRICAINE-II	Non – Preferred	

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NUVAKAAN-II	Non – Preferred	
PLIAGLIS	Non – Preferred	
PRIZOPAK II	Non – Preferred	
PRIZOTRAL-II	Non – Preferred	
SYNERA	Non – Preferred	
<i>*Topical Selective Retinoid X Receptor Agonists*** - Drugs For The Skin</i>		
TARGRETIN	Preferred	
<i>*Topical Steroid Combinations*** - Drugs For The Skin</i>		
<i>calcipotriene-betameth diprop</i>	Non – Preferred	
BESER	Non – Preferred	
CLODAN	Non – Preferred	
DUOBRII	Non – Preferred	
ENSTILAR	Non – Preferred	
FLUOPAR	Non – Preferred	
SYNALAR (CREAM)	Non – Preferred	
SYNALAR (OINTMENT)	Non – Preferred	
SYNALAR TS	Non – Preferred	
TACLONEX	Non – Preferred	
<i>*Wound Care - Growth Factor Agents*** - Drugs For The Skin</i>		
REGRANEX	Non – Preferred	
<i>*Wound Care Combinations*** - Drugs For The Skin</i>		
<i>bpc</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diagnostic Products		
*Diagnostic Tests***		
<i>blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>cvs glucose meter test strips</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>diatrue plus test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>easy plus ii glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>easy talk blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>easy trak blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>easy trak ii glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>element compact test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>eq blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>ge100 blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>ght test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>glucose meter test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>gnp easy touch glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>goodsense blood glucose</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>kroger blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>kroger premium glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>kroger test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>liberty test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>meijer blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>meijer essential glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>meijer premium glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>one drop test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>pharmacist choice no coding</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>premium blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>pro voice v8/v9 glucose</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>tgt blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>true focus blood glucose strip</i>	Non – Preferred	OTC; QL (5 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>verasens blood glucose test</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK AVIVA PLUS	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK COMPACT PLUS	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK GUIDE	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK SMARTVIEW	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCUTREND GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
ADVANCE INTUITION TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ADVANCE MICRO-DRAW TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ADVOCATE REDI-CODE	Non – Preferred	OTC; QL (5 EA per 1 day)
ADVOCATE REDI-CODE+ TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ADVOCATE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
AGAMATRIX AMP TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
AGAMATRIX JAZZ TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
AGAMATRIX KEYNOTE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
AGAMATRIX PRESTO TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ASSURE 3 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ASSURE 4 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ASSURE II	Non – Preferred	OTC; QL (5 EA per 1 day)
ASSURE II CHECK	Non – Preferred	OTC; QL (5 EA per 1 day)
ASSURE PLATINUM	Non – Preferred	OTC; QL (5 EA per 1 day)
ASSURE PRISM MULTI TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ASSURE PRO TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
BIOSCANNER GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CAREONE BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CARESENS N GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CARETOUCH TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CLEVER CHEK AUTO-CODE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CLEVER CHEK AUTO-CODE VOICE	Non – Preferred	OTC; QL (5 EA per 1 day)
CLEVER CHEK TEST	Non – Preferred	OTC; QL (5 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE AUTO-CODE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CLEVER CHOICE MICRO TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CLEVER CHOICE NO CODING	Non – Preferred	OTC; QL (5 EA per 1 day)
CLEVER CHOICE TALK SYSTEM	Non – Preferred	OTC; QL (5 EA per 1 day)
CONTOUR NEXT TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CONTOUR TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
COOL BLOOD GLUCOSE TEST STRIPS	Non – Preferred	OTC; QL (5 EA per 1 day)
CVS ADVANCED GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
D-CARE BLOOD GLUCOSE	Non – Preferred	QL (5 EA per 1 day)
DIATHRIVE BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
DIATHRIVE GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
DIATHRIVE+ GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
DUO-CARE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EASY STEP TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EASY TOUCH TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EASYGLUCO	Non – Preferred	OTC; QL (5 EA per 1 day)
EASYGLUCO PLUS	Non – Preferred	OTC; QL (5 EA per 1 day)
EASYMAX 15 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EASYMAX TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EASYPRO BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EASYPRO PLUS	Non – Preferred	OTC; QL (5 EA per 1 day)
ELEMENT TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EMBRACE BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EMBRACE EVO BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EMBRACE PRO GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EMBRACE TALK GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EVENCARE + BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EVENCARE BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EVENCARE G2 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVENCARE G3 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EVENCARE MINI GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EVENCARE PROVIEW GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EVOLUTION AUTOCODE	Non – Preferred	OTC; QL (5 EA per 1 day)
EXACTECH R-S-G TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EXACTECH TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EZ SMART BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
EZ SMART PLUS GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FIFTY50 GLUCOSE TEST 2.0	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA D15G BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA D20 BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA D40/G31 BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA G20 BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA G30/PREM V10 GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA GD20 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA GD50 BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA GTEL BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA TN'G/TN'G VOICE	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA V10 BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA V12 BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA V20 BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA V30A BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORACARE GD40 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORACARE PREMIUM V10 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORACARE TEST N GO TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORTISCARE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FREESTYLE INSULINX TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FREESTYLE LITE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)

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FREESTYLE PRECISION NEO TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FREESTYLE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GENULTIMATE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCO PERFECT 3 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCOCARD 01 SENSOR PLUS	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCOCARD EXPRESSION TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCOCARD SHINE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCOCARD VITAL TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCOCARD X-SENSOR	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCOCOM TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GLUCONAVII BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GOJJI BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
GOJJI BLOOD TEST STRIP/LANCETS	Non – Preferred	OTC; QL (5 EA per 1 day)
HARMONY BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
HW EMBRACE PRO GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
HW EMBRACE TALK GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
IGLUCOSE TEST STRIPS	Non – Preferred	OTC; QL (5 EA per 1 day)
IN TOUCH BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
INFINITY BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
INFINITY VOICE	Non – Preferred	OTC; QL (5 EA per 1 day)
KROGER HEALTHPRO GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
LIBERTY NEXT GENERATION TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
MEIJER TRUETEST TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
MEIJER TRUETRACK TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
MICRODOT TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
MM EASY TOUCH GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
MYGLUCOHEALTH TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
NEUTEK 2TEK TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
NOVA MAX GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONETOUCH ULTRA	Preferred	OTC; QL (5 EA per 1 day)
ONETOUCH VERIO	Preferred	OTC; QL (5 EA per 1 day)
OPTIUM TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
OPTIUMEZ TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
PHARMACIST CHOICE AUTOCODE	Non – Preferred	OTC; QL (5 EA per 1 day)
POCKETCHEM EZ TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
PRECISION PCX	Non – Preferred	OTC; QL (5 EA per 1 day)
PRECISION PCX PLUS TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
PRECISION POINT OF CARE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
PRECISION QID TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
PRECISION SOF-TACT TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
PRECISION XTRA BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
PRODIGY NO CODING BLOOD GLUC	Non – Preferred	OTC; QL (5 EA per 1 day)
PTS PANELS GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
QUICKTEK TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
QUINTET AC BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
QUINTET BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
RA TRUETEST TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
REFUAH PLUS BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
RELION BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
RELION CONFIRM/MICRO TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
RELION PREMIER TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
RELION PRIME TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
RELION ULTIMA TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
REXALL BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
RIGHTEST GS100 BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
RIGHTEST GS300 BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
RIGHTEST GS550 BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
SMART SENSE PREMIUM TEST	Non – Preferred	OTC; QL (5 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMART SENSE VALUE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SMARTTEST BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SOLUS V2 TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SUPREME TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SURE EDGE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SURECHEK BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SURE-TEST EASYPLUS MINI TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
TELCARE BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
TRUETEST TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
TRUETRACK TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ULTIMA TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ULTRATRAK PRO TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ULTRATRAK ULTIMATE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
UNISTRIP1 GENERIC	Non – Preferred	OTC; QL (5 EA per 1 day)
VIVAGUARD INO TEST STRIPS	Non – Preferred	OTC; QL (5 EA per 1 day)
VOCAL POINT BLOOD GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
Digestive Aids - Drugs For The Stomach		
<i>*Digestive Enzymes*** - Drugs For The Stomach</i>		
CREON	Preferred	
PANCREAZE	Preferred	
PERTZYE	Non – Preferred	
VIOKACE	Non – Preferred	
ZENPEP	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Direct-Acting P2y12 Inhibitors*** - Drugs For The Blood		
<i>*Direct-Acting P2y12 Inhibitors*** - Drugs For The Blood</i>		
BRILINTA	Preferred	QL (2 EA per 1 day)
Diuretics - Drugs For The Heart		
<i>*Carbonic Anhydrase Inhibitors*** - Drugs For High Blood Pressure</i>		
<i>acetazolamide</i>	Preferred	
<i>acetazolamide er</i>	Preferred	
<i>methazolamide</i>	Preferred	
KEVEYIS	Non – Preferred	
*Diuretic Combinations*** - Drugs For High Blood Pressure		
<i>amiloride-hydrochlorothiazide</i>	Preferred	
<i>spironolactone-hctz</i>	Preferred	
<i>triamterene-hctz</i>	Preferred	
ALDACTAZIDE	Non – Preferred	
DYAZIDE	Non – Preferred	
MAXZIDE	Non – Preferred	
MAXZIDE-25	Non – Preferred	
*Loop Diuretics*** - Drugs For High Blood Pressure		
<i>bumetanide</i>	Preferred	
<i>ethacrynic acid</i>	Preferred	
<i>furosemide</i>	Preferred	
<i>toremide</i>	Preferred	
BUMEX	Non – Preferred	
EDECIN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LASIX	Non – Preferred	
*Potassium Sparing Diuretics*** - Drugs For High Blood Pressure		
<i>amiloride hcl</i>	Preferred	
<i>spironolactone</i>	Preferred	
<i>triamterene</i>	Preferred	
ALDACTONE	Non – Preferred	
CAROSPIR	Non – Preferred	
*Thiazides And Thiazide-Like Diuretics*** - Drugs For High Blood Pressure		
<i>chlorthalidone</i>	Preferred	
<i>hydrochlorothiazide</i>	Preferred	
<i>indapamide</i>	Preferred	
<i>metolazone</i>	Preferred	
DIURIL	Preferred	
*Dopamine And Norepinephrine Reuptake Inhibitors (Dnris)*** - Drugs For The Nervous System		
*Dopamine And Norepinephrine Reuptake Inhibitors (Dnris)*** - Drugs For The Nervous System		
SUNOSI	Non – Preferred	AL (Min 6 Years)
Endocrine And Metabolic Agents - Misc. - Hormones		
*Abortifacient - Progesterone Receptor Antagonists*** - Drugs For Women		
<i>mifepristone</i>	Non – Preferred	
MIFEPREX	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Bisphosphonates*** - Drugs For Menopause And Bone Loss</i>		
<i>alendronate sodium oral solution</i>	Preferred	QL (10.8 ML per 1 day)
<i>alendronate sodium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>alendronate sodium tablet 35 mg oral</i>	Preferred	QL (4 EA per 28 days)
<i>alendronate sodium tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>alendronate sodium tablet 70 mg oral</i>	Preferred	QL (4 EA per 28 days)
<i>ibandronate sodium</i>	Non – Preferred	QL (1 EA per 30 days)
<i>risedronate sodium</i>	Non – Preferred	
ACTONEL	Non – Preferred	
AELVIA	Non – Preferred	
BINOSTO	Non – Preferred	
BONIVA	Non – Preferred	QL (1 EA per 30 days)
FOSAMAX	Non – Preferred	QL (4 EA per 28 days)
FOSAMAX PLUS D	Non – Preferred	
<i>*Calcimimetic Agents*** - Drugs For Menopause And Bone Loss</i>		
<i>cinacalcet hcl</i>	Non – Preferred	
SENSIPAR	Non – Preferred	
<i>*Calcitonins*** - Drugs For Menopause And Bone Loss</i>		
<i>calcitonin (salmon)</i>	Preferred	QL (3.7 ML per 30 days)
<i>*Carnitine Replenisher - Agents*** - Drugs For Menopause And Bone Loss</i>		
<i>levocarnitine</i>	Non – Preferred	
<i>levocarnitine sf</i>	Non – Preferred	
CARNITOR	Non – Preferred	
CARNITOR SF	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Dopamine Receptor Agonists*** - Drugs For Women</i>		
<i>cabergoline</i>	Preferred	QL (16 EA per 30 days)
<i>*Fabry Disease - Agents*** - Drugs For Menopause And Bone Loss</i>		
GALAFOLD	Non – Preferred	
<i>*Gnrh/Lhrh Antagonists*** - Drugs For Women</i>		
ORLISSA	Preferred	PA
<i>*Growth Hormone Releasing Hormones (Ghrh)*** - Drugs For Growth</i>		
EGRIFTA SV	Non – Preferred	
<i>*Growth Hormones*** - Drugs For Growth</i>		
GENOTROPIN	Preferred	PA
GENOTROPIN MINIQUICK	Preferred	PA
HUMATROPE	Non – Preferred	
NORDITROPIN FLEXPRO	Non – Preferred	
NUTROPIN AQ NUSPIN 10	Non – Preferred	
NUTROPIN AQ NUSPIN 20	Non – Preferred	
NUTROPIN AQ NUSPIN 5	Non – Preferred	
OMNITROPE	Non – Preferred	
SAIZEN	Non – Preferred	
SAIZENPREP	Non – Preferred	
SEROSTIM	Non – Preferred	
ZOMACTON (FOR ZOMA-JET 10)	Non – Preferred	
ZOMACTON SOLUTION RECONSTITUTED 10 MG SUBCUTANEOUS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZOMACTON SOLUTION RECONSTITUTED 5 MG SUBCUTANEOUS	Non – Preferred	PA
ZORBTIVE	Non – Preferred	
*Hereditary Tyrosinemia Type 1 (Ht-1) Treatment - Agents*** - Drugs For Menopause And Bone Loss		
<i>nitisinone</i>	Preferred	
NITYR	Non – Preferred	
ORFADIN ORAL CAPSULE	Preferred	
ORFADIN ORAL SUSPENSION	Non – Preferred	
*Homocystinuria Treatment - Agents*** - Drugs For Menopause And Bone Loss		
CYSTADANE	Non – Preferred	
*Hyperammonemia Treatment - Agents*** - Drugs For Menopause And Bone Loss		
CARBAGLU	Non – Preferred	
*Hyperparathyroid Treatment - Vitamin D Analogs*** - Drugs For Menopause And Bone Loss		
<i>calcitriol</i>	Preferred	
<i>doxercalciferol</i>	Preferred	
<i>paricalcitol</i>	Non – Preferred	QL (1 EA per 1 day)
RAYALDEE	Non – Preferred	
ROCALTROL	Non – Preferred	
ZEMPLAR	Non – Preferred	QL (1 EA per 1 day)
*Insulin-Like Growth Factors (Somatomedins)*** - Hormones		
INCRELEX	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Lhrh/Gnrh Agonist Analog Pituitary Suppressants*** - Drugs For Women		
SYNAREL	Non – Preferred	
*Phenylketonuria Treatment - Agents*** - Drugs For Menopause And Bone Loss		
<i>sapropterin dihydrochloride</i>	Non – Preferred	
KUVAN	Non – Preferred	
*Selective Estrogen Receptor Modulators (Serms)*** - Drugs For Menopause And Bone Loss		
<i>raloxifene hcl</i>	Non – Preferred	
EVISTA	Non – Preferred	
OSPHENA	Non – Preferred	
*Selective Vasopressin V2-Receptor Antagonists*** - Hormones		
<i>tolvaptan</i>	Non – Preferred	
JYNARQUE	Non – Preferred	
SAMSCA	Non – Preferred	
*Somatostatic Agents*** - Drugs For Growth		
<i>octreotide acetate</i>	Non – Preferred	
BYNFEZIA PEN	Non – Preferred	
SANDOSTATIN	Non – Preferred	
SANDOSTATIN LAR DEPOT	Non – Preferred	
SIGNIFOR	Non – Preferred	
SIGNIFOR LAR	Non – Preferred	
SOMATULINE DEPOT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Urea Cycle Disorder - Agents*** - Drugs For Menopause And Bone Loss		
<i>sodium phenylbutyrate</i>	Non – Preferred	
BUPHENYL	Non – Preferred	
RAVICTI	Non – Preferred	
*Vasopressin*** - Hormones		
<i>desmopressin ace spray refrig</i>	Preferred	QL (5 ML per 30 days)
<i>desmopressin acetate</i>	Preferred	QL (3 EA per 1 day)
<i>desmopressin acetate spray</i>	Preferred	QL (5 ML per 30 days)
DDAVP NASAL	Non – Preferred	QL (5 ML per 30 days)
DDAVP ORAL	Non – Preferred	QL (3 EA per 1 day)
DDAVP RHINAL TUBE	Non – Preferred	
NOCDURNA	Non – Preferred	
STIMATE	Preferred	
*Erythroid Maturation Agents*** - Drugs For The Blood		
*Erythroid Maturation Agents*** - Drugs For The Blood		
REBLOZYL	Non – Preferred	
*Estrogen-Progestin-Gnrh Antagonist*** - Hormones		
*Estrogen-Progestin-Gnrh Antagonist*** - Hormones		
ORIAHNN	Non – Preferred	
Estrogens - Hormones		
*Estrogen & Progestin*** - Drugs For Women		
<i>estradiol-norethindrone acet</i>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone-eth estradiol</i>	Non – Preferred	QL (1 EA per 1 day)
ACTIVELLA	Non – Preferred	QL (1 EA per 1 day)
AMABELZ	Preferred	QL (1 EA per 1 day)
ANGELIQ	Non – Preferred	
BIJUVA	Non – Preferred	
CLIMARA PRO	Non – Preferred	
COMBIPATCH	Preferred	QL (8 PATCH per 28 days)
FEMHRT LOW DOSE	Non – Preferred	QL (1 EA per 1 day)
FYAVOLV	Non – Preferred	QL (1 EA per 1 day)
JINTELI	Non – Preferred	QL (1 EA per 1 day)
MIMVEY	Preferred	QL (1 EA per 1 day)
PREFEST	Non – Preferred	
PREMPHASE	Preferred	QL (1 EA per 1 day)
PREMPRO	Preferred	QL (1 EA per 1 day)
*Estrogens*** - Drugs For Women		
<i>estradiol oral</i>	Preferred	
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch weekly 0.025 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>estradiol patch weekly 0.05 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.06 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.075 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.1 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol valerate</i>	Preferred	
ALORA PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
ALORA PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
ALORA PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
ALORA PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
CLIMARA PATCH WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	
CLIMARA PATCH WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.06 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
DELESTROGEN	Preferred	
DEPO-ESTRADIOL	Preferred	
DIVIGEL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DOTTI PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Preferred	QL (8 PATCH per 28 days)
DOTTI PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Preferred	QL (8 PATCH per 28 days)
DOTTI PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
DOTTI PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
DOTTI PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
ELESTRIN	Non – Preferred	
ESTRACE	Non – Preferred	
EVAMIST	Non – Preferred	
MENEST	Preferred	
MENOSTAR	Non – Preferred	
MINIVELLE PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
PREMARIN	Preferred	QL (1 EA per 1 day)
VIVELLE-DOT PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
VIVELLE-DOT PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
VIVELLE-DOT PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIVELLE-DOT PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
VIVELLE-DOT PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
*Estrogen-Selective Estrogen Receptor Modulator Comb*** - Hormones		
<i>*Estrogen-Selective Estrogen Receptor Modulator Comb*** - Hormones</i>		
DUAVEE	Non – Preferred	
*Farnesoid X Receptor (Fxr) Agonists*** - Drugs For The Liver		
<i>*Farnesoid X Receptor (Fxr) Agonists*** - Drugs For The Liver</i>		
OCALIVA	Non – Preferred	
Fluoroquinolones - Drugs For Infections		
<i>*Fluoroquinolones*** - Antibiotics</i>		
<i>ciprofloxacin hcl tablet 100 mg oral</i>	Preferred	QL (30 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 250 mg oral</i>	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 500 mg oral</i>	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 750 mg oral</i>	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin in d5w</i>	Preferred	
<i>levofloxacin in d5w</i>	Preferred	
<i>levofloxacin intravenous</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levofloxacin oral solution</i>	Preferred	QL (280 ML Max Qty Per Fill Retail); AL (Min 16 Years)
<i>levofloxacin oral tablet</i>	Preferred	QL (14 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>moxifloxacin hcl</i>	Non – Preferred	AL (Min 16 Years)
<i>ofloxacin</i>	Non – Preferred	AL (Min 16 Years)
BAXDELA	Non – Preferred	AL (Min 16 Years)
CIPRO ORAL SUSPENSION RECONSTITUTED	Non – Preferred	AL (Min 16 Years)
CIPRO ORAL TABLET	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
Gastrointestinal Agents - Misc. - Drugs For The Stomach		
*Gallstone Solubilizing Agents*** - Drugs For The Stomach		
<i>ursodiol oral capsule</i>	Preferred	
<i>ursodiol oral tablet</i>	Non – Preferred	
ACTIGALL	Non – Preferred	
CHENODAL	Non – Preferred	
URSO 250	Non – Preferred	
URSO FORTE	Non – Preferred	
*Gastrointestinal Antiallergy Agents*** - Drugs For The Stomach		
<i>cromolyn sodium</i>	Preferred	
GASTROCROM	Non – Preferred	
*Gastrointestinal Chloride Channel Activators*** - Drugs For Irritable Bowel Syndrome		
AMITIZA	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Gastrointestinal Stimulants*** - Drugs For The Stomach		
<i>metoclopramide hcl oral solution</i>	Preferred	
<i>metoclopramide hcl oral tablet</i>	Preferred	
<i>metoclopramide hcl oral tablet dispersible</i>	Non – Preferred	
REGLAN	Non – Preferred	
*Glucagon-Like Peptide-2 (Glp-2) Analogues*** - Drugs For The Stomach		
GATTEX	Non – Preferred	
*Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For Irritable Bowel Syndrome		
LINZESS	Non – Preferred	QL (1 EA per 1 day)
*Ibs Agent - Selective 5-Ht3 Receptor Antagonists*** - Drugs For Irritable Bowel Syndrome		
<i>alosetron hcl</i>	Non – Preferred	
LOTRONEX	Non – Preferred	
*Inflammatory Bowel Agents*** - Drugs For Inflammatory Bowel Disease		
<i>balsalazide disodium</i>	Preferred	
<i>mesalamine er</i>	Non – Preferred	QL (4 EA per 1 day)
<i>mesalamine oral capsule delayed release</i>	Non – Preferred	QL (6 EA per 1 day)
<i>mesalamine rectal enema</i>	Preferred	
<i>mesalamine rectal suppository</i>	Preferred	QL (42 EA per 30 days)
<i>mesalamine tablet delayed release 1.2 gm oral</i>	Non – Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits

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Drug Tier

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Preferred = Preferred

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mesalamine tablet delayed release 800 mg oral</i>	Non – Preferred	QL (6 EA per 1 day)
<i>mesalamine-cleanser</i>	Non – Preferred	
<i>sulfasalazine</i>	Preferred	
APRISO	Non – Preferred	QL (4 EA per 1 day)
ASACOL HD	Non – Preferred	QL (6 EA per 1 day)
AZULFIDINE	Non – Preferred	
AZULFIDINE EN-TABS	Non – Preferred	
CANASA	Non – Preferred	QL (42 EA per 30 days)
COLAZAL	Non – Preferred	
DELZICOL	Non – Preferred	QL (6 EA per 1 day)
DIPENTUM	Non – Preferred	
LIALDA	Non – Preferred	QL (4 EA per 1 day)
PENTASA	Preferred	
ROWASA	Non – Preferred	
SFROWASA	Preferred	
<i>*Intestinal Acidifiers*** - Drugs For The Stomach</i>		
<i>enulose</i>	Preferred	AL (Max 20 Years)
<i>generlac</i>	Preferred	AL (Max 20 Years)
<i>lactulose encephalopathy solution 10 gm/15ml oral</i>	Preferred	AL (Max 20 Years)
<i>lactulose encephalopathy solution 10 gm/15ml oral</i>	Preferred	
<i>*Peripheral Opioid Receptor Antagonists*** - Drugs For The Stomach</i>		
ENTEREG	Non – Preferred	
MOVANTIK	Non – Preferred	QL (1 EA per 1 day)
RELISTOR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPROIC	Non – Preferred	QL (1 EA per 1 day)
<i>*Phosphate Binder Agents*** - Drugs For The Stomach</i>		
<i>calcium acetate</i>	Preferred	
<i>calcium acetate (phos binder)</i>	Preferred	
<i>lanthanum carbonate</i>	Preferred	
<i>sevelamer carbonate oral packet</i>	Non – Preferred	
<i>sevelamer carbonate oral tablet</i>	Preferred	
<i>sevelamer hcl</i>	Preferred	
AURYXIA	Non – Preferred	QL (12 EA per 1 day)
FOSRENOL ORAL PACKET	Preferred	
FOSRENOL ORAL TABLET CHEWABLE	Non – Preferred	
PHOSLYRA	Non – Preferred	
RENAGEL	Non – Preferred	
REVELA	Non – Preferred	
VELPHORO	Non – Preferred	
<i>*Tumor Necrosis Factor Alpha Blockers*** - Drugs For Inflammatory Bowel Disease</i>		
AVSOLA	Non – Preferred	
CIMZIA	Non – Preferred	
CIMZIA PREFILLED	Preferred	PA
CIMZIA STARTER KIT	Preferred	PA
INFLECTRA	Non – Preferred	
REMICADE	Non – Preferred	
RENFLEXIS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Genitourinary Agents - Miscellaneous - Drugs For The Urinary System		
<i>*5-Alpha Reductase Inhibitors*** - Drugs For The Prostate</i>		
<i>dutasteride</i>	Non – Preferred	
<i>finasteride</i>	Preferred	QL (1 EA per 1 day)
AVODART	Non – Preferred	
PROSCAR	Non – Preferred	QL (1 EA per 1 day)
<i>*Alpha 1-Adrenoceptor Antagonists*** - Drugs For The Prostate</i>		
<i>alfuzosin hcl er</i>	Preferred	QL (1 EA per 1 day)
<i>silodosin</i>	Non – Preferred	
<i>tamsulosin hcl</i>	Preferred	QL (2 EA per 1 day)
CARDURA XL	Non – Preferred	
FLOMAX	Non – Preferred	QL (2 EA per 1 day)
RAPAFLO	Non – Preferred	
<i>*Citrates*** - Drugs For Infections</i>		
<i>cytra k crystals</i>	Non – Preferred	
<i>potassium citrate er</i>	Non – Preferred	
<i>potassium citrate-citric acid</i>	Non – Preferred	
<i>sod citrate-citric acid</i>	Preferred	QL (500 ML per 30 days)
<i>tricitrates</i>	Non – Preferred	
ORACIT	Preferred	
TARON-CRYSTALS	Non – Preferred	
UROCIT-K 10	Non – Preferred	
UROCIT-K 15	Non – Preferred	
UROCIT-K 5	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Cystinosis Agents*** - Drugs For The Urinary System		
CYSTAGON	Preferred	
PROCYSBI	Non – Preferred	
*Interstitial Cystitis Agents*** - Drugs For The Urinary System		
ELMIRON	Non – Preferred	
*Phosphates*** - Drugs For Infections		
K-PHOS NO 2	Non – Preferred	
*Prostatic Hypertrophy Agent Combinations*** - Drugs For The Prostate		
<i>dutasteride-tamsulosin hcl</i>	Non – Preferred	
JALYN	Non – Preferred	
*Urinary Analgesics*** - Drugs For Infections		
<i>phenazopyridine hcl</i>	Preferred	
PYRIDIUM	Non – Preferred	
*Urinary Stone Agents*** - Drugs For The Urinary System		
LITHOSTAT	Non – Preferred	
THIOLA	Non – Preferred	
THIOLA EC	Non – Preferred	
*Glycopeptides*** - Drugs For Infections		
*Glycopeptides*** - Drugs For Infections		
<i>vancomycin hcl capsule 125 mg oral</i>	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>vancomycin hcl capsule 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>vancomycin hcl in dextrose</i>	Preferred	
<i>vancomycin hcl in nacl</i>	Preferred	
<i>vancomycin hcl intravenous</i>	Preferred	
<i>vancomycin hcl oral solution reconstituted</i>	Preferred	
FIRVANQ	Non – Preferred	
VANCOGIN	Non – Preferred	QL (8 EA per 1 day)
VANCOGIN HCL	Non – Preferred	QL (4 EA per 1 day)
Gout Agents - Drugs For Pain And Fever		
*Gout Agent Combinations*** - Gout Drugs		
<i>colchicine-probenecid</i>	Preferred	
*Gout Agents*** - Gout Drugs		
<i>allopurinol</i>	Preferred	
<i>colchicine</i>	Non – Preferred	QL (9 EA per 30 days)
<i>febuxostat</i>	Non – Preferred	QL (1 EA per 1 day)
COLCRYS	Non – Preferred	QL (9 EA per 30 days)
GLOPERBA	Non – Preferred	
MITIGARE	Non – Preferred	QL (9 EA per 30 days)
ULORIC	Non – Preferred	QL (1 EA per 1 day)
ZYLOPRIM	Non – Preferred	
*Uricosurics*** - Gout Drugs		
<i>probenecid</i>	Preferred	
Hematological Agents - Misc. - Drugs For The Blood		
*Antihemophilic Products*** - Drugs To Prevent Bleeding		
<i>adynovate</i>	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>obizur</i>	Preferred	PA
<i>rixubis</i>	Preferred	PA
ADVATE	Preferred	PA
AFSTYLA	Preferred	PA
ALPHANATE/VWF COMPLEX/HUMAN	Preferred	PA
ALPHANINE SD	Preferred	PA
ALPROLIX	Preferred	PA
BENEFIX	Preferred	PA
COAGADEX	Preferred	PA
CORIFACT	Preferred	PA
ELOCTATE	Preferred	PA
ESPEROCT	Preferred	PA
FEIBA	Preferred	PA
HEMOFIL M	Preferred	PA
HUMATE-P	Preferred	PA
IDELVION	Preferred	PA
IXINITY	Preferred	PA
JIVI	Preferred	PA
KOATE	Preferred	PA
KOATE-DVI	Preferred	PA
KOGENATE FS	Preferred	PA
KOVALTRY	Preferred	PA
MONONINE	Preferred	PA
NOVOEIGHT	Preferred	PA
NOVOSEVEN RT	Preferred	PA
NUWIQ	Preferred	PA
PROFILNINE	Preferred	PA
REBINYN	Preferred	PA
RECOMBINATE	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRETTEN	Preferred	PA
VONVENDI	Preferred	PA
WILATE	Preferred	PA
XYNTHA	Preferred	PA
XYNTHA SOLOFUSE	Preferred	PA
*Bradykinin B2 Receptor Antagonists*** - Drugs For The Blood		
<i>icatibant acetate</i>	Non – Preferred	
FIRAZYR	Non – Preferred	
*C1 Inhibitors*** - Drugs For The Blood		
HAEGARDA	Non – Preferred	
*Cyclopentyltriazolopyrimidine (Cptp) Derivatives*** - Drugs For The Blood		
BRILINTA	Preferred	QL (2 EA per 1 day)
*Hematorheologic Agents*** - Drugs For The Blood		
<i>pentoxifylline er</i>	Preferred	
*Phosphodiesterase Iii Inhibitors*** - Drugs For The Blood		
<i>cilostazol</i>	Non – Preferred	
*Plasma Kallikrein Inhibitors*** - Drugs For The Blood		
KALBITOR	Non – Preferred	
*Platelet Aggregation Inhibitor Combinations*** - Drugs For The Blood		
<i>aspirin-dipyridamole er</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
YOSPRALA	Non – Preferred	
<i>*Platelet Aggregation Inhibitors*** - Drugs For The Blood</i>		
<i>dipyridamole</i>	Preferred	
<i>*Quinazoline Agents*** - Drugs For The Blood</i>		
<i>anagrelide hcl</i>	Preferred	
AGRYLIN	Non – Preferred	
<i>*Thienopyridine Derivatives*** - Drugs For The Blood</i>		
<i>clopidogrel bisulfate tablet 300 mg oral</i>	Preferred	QL (1 EA per 30 days)
<i>clopidogrel bisulfate tablet 75 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>prasugrel hcl</i>	Non – Preferred	
EFFIENT	Non – Preferred	
PLAVIX	Non – Preferred	QL (1 EA per 1 day)
<i>*Hematopoietic Agents* - Drugs For Nutrition</i>		
<i>*Erythropoiesis-Stimulating Agents (Esas)*** - Drugs For Nutrition</i>		
ARANESP (ALBUMIN FREE)	Non – Preferred	
EPOGEN	Preferred	PA
MIRCERA	Non – Preferred	
PROCRIT	Preferred	PA
RETACRIT	Non – Preferred	
<i>*Erythropoietins*** - Drugs For Nutrition</i>		
ARANESP (ALBUMIN FREE)	Non – Preferred	
EPOGEN	Preferred	PA
MIRCERA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCRIT	Preferred	PA
RETACRIT	Non – Preferred	
<i>*Granulocyte Colony-Stimulating Factors (G-Csf)*** - Drugs For Nutrition</i>		
FULPHILA	Non – Preferred	
GRANIX	Non – Preferred	
NEULASTA	Non – Preferred	
NEULASTA ONPRO	Non – Preferred	
NEUPOGEN	Preferred	
NIVESTYM	Non – Preferred	
UDENYCA	Non – Preferred	
ZARXIO	Non – Preferred	
ZIEXTENZO	Non – Preferred	
<i>*Granulocyte/Macrophage Colony-Stimulating Factor(Gm-Csf)*** - Drugs For Nutrition</i>		
LEUKINE	Preferred	
<i>*Thrombopoietin (Tpo) Receptor Agonists*** - Drugs For Nutrition</i>		
DOPTELET	Non – Preferred	
MULPLETA	Non – Preferred	
NPLATE	Non – Preferred	
PROMACTA ORAL PACKET	Non – Preferred	
PROMACTA TABLET 12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROMACTA TABLET 25 MG ORAL	Non – Preferred	
PROMACTA TABLET 50 MG ORAL	Non – Preferred	
PROMACTA TABLET 75 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Hepatitis C Agent - Combinations*** - Drugs For Infections		
<i>*Hepatitis C Agent - Combinations*** - Drugs For Infections</i>		
<i>ledipasvir-sofosbuvir</i>	Non – Preferred	
<i>sofosbuvir-velpatasvir</i>	Preferred	PA
EPCLUSA	Non – Preferred	PA
HARVONI	Non – Preferred	
MAVYRET	Preferred	PA
VIEKIRA PAK	Non – Preferred	
VOSEVI	Non – Preferred	
ZEPATIER	Non – Preferred	
*Histamine H3-Receptor Antagonist/Inverse Agonists*** - Drugs For The Nervous System		
<i>*Histamine H3-Receptor Antagonist/Inverse Agonists*** - Drugs For The Nervous System</i>		
WAKIX	Non – Preferred	AL (Min 6 Years)
Hypnotics - Drugs For The Nervous System		
<i>*Barbiturate Hypnotics*** - Drugs For Insomnia</i>		
<i>phenobarbital</i>	Preferred	
<i>*Benzodiazepine Hypnotics*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
<i>estazolam</i>	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>flurazepam hcl</i>	Non – Preferred	
<i>midazolam hcl</i>	Non – Preferred	
<i>temazepam capsule 15 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 22.5 mg oral</i>	Preferred	
<i>temazepam capsule 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 7.5 mg oral</i>	Preferred	
<i>triazolam</i>	Preferred	QL (1 EA per 1 day)
HALCION	Non – Preferred	QL (1 EA per 1 day)
RESTORIL CAPSULE 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
RESTORIL CAPSULE 22.5 MG ORAL	Non – Preferred	
RESTORIL CAPSULE 30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
RESTORIL CAPSULE 7.5 MG ORAL	Non – Preferred	
<i>*Hypnotics - Tricyclic Agents*** - Drugs For Insomnia</i>		
<i>doxepin hcl</i>	Non – Preferred	
SILENOR	Non – Preferred	
<i>*Non-Benzodiazepine - Gaba-Receptor Modulators*** - Drugs For Insomnia</i>		
<i>eszopiclone</i>	Non – Preferred	
<i>zaleplon</i>	Non – Preferred	
<i>zolpidem tartrate er</i>	Non – Preferred	
<i>zolpidem tartrate oral</i>	Preferred	QL (1 EA per 1 day)
<i>zolpidem tartrate sublingual</i>	Non – Preferred	
AMBIEN	Non – Preferred	QL (1 EA per 1 day)
AMBIEN CR	Non – Preferred	
EDLUAR	Non – Preferred	
INTERMEZZO	Non – Preferred	
LUNESTA	Non – Preferred	
ZOLPIMIST	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Selective Melatonin Receptor Agonists*** - Drugs For Insomnia</i>		
<i>ramelteon</i>	Non – Preferred	QL (1 EA per 1 day)
HETLIOZ	Non – Preferred	
ROZEREM	Non – Preferred	QL (1 EA per 1 day)
<i>*Ibs Agent - 5-Ht4 Receptor Partial Agonists*** - Drugs For The Stomach</i>		
<i>*Ibs Agent - 5-Ht4 Receptor Partial Agonists*** - Drugs For The Stomach</i>		
ZELNORM	Non – Preferred	
<i>*Ibs Agent - Mu-Opioid Receptor Agonists*** - Drugs For The Stomach</i>		
<i>*Ibs Agent - Mu-Opioid Receptor Agonists*** - Drugs For The Stomach</i>		
VIBERZI	Non – Preferred	
<i>*Insulin-Incretin Mimetic Combinations*** - Hormones</i>		
<i>*Insulin-Incretin Mimetic Combinations*** - Hormones</i>		
SOLQUA	Non – Preferred	
XULTOPHY	Non – Preferred	
<i>*Integrin Receptor Antagonists*** - Drugs For The Stomach</i>		
<i>*Integrin Receptor Antagonists*** - Drugs For The Stomach</i>		
ENTYVIO	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Interleukin Antagonists*** - Drugs For The Stomach		
<i>*Interleukin Antagonists*** - Drugs For The Stomach</i>		
STELARA	Non – Preferred	
*Interleukin-5 Antagonists (Igg1 Kappa)*** - Drugs For The Lungs		
<i>*Interleukin-5 Antagonists (Igg1 Kappa)*** - Drugs For The Lungs</i>		
FASENRA	Non – Preferred	
FASENRA PEN	Non – Preferred	
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR	Non – Preferred	
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	Non – Preferred	
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED	Preferred	PA
*Interleukin-5 Antagonists (Igg4 Kappa)*** - Drugs For The Lungs		
<i>*Interleukin-5 Antagonists (Igg4 Kappa)*** - Drugs For The Lungs</i>		
CINQAIR	Non – Preferred	
*Isocitrate Dehydrogenase-1 (Idh1) Inhibitors*** - Drugs For Cancer		
<i>*Isocitrate Dehydrogenase-1 (Idh1) Inhibitors*** - Drugs For Cancer</i>		
TIBSOVO	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Isocitrate Dehydrogenase-2 (Idh2) Inhibitors*** - Drugs For Cancer		
<i>*Isocitrate Dehydrogenase-2 (Idh2) Inhibitors*** - Drugs For Cancer</i>		
IDHIFA	Non – Preferred	
*Lymphocyte Function-Associated Antigen-1 (Lfa-1) Antag*** - Drugs For The Eye		
<i>*Lymphocyte Function-Associated Antigen-1 (Lfa-1) Antag*** - Drugs For The Eye</i>		
XIIDRA	Non – Preferred	
Macrolides - Drugs For Infections		
<i>*Azithromycin*** - Antibiotics</i>		
<i>azithromycin oral packet</i>	Preferred	
<i>azithromycin oral suspension reconstituted</i>	Preferred	QL (30 ML Max Qty Per Fill Retail)
<i>azithromycin tablet 250 mg oral</i>	Preferred	QL (6 EA Max Qty Per Fill Retail)
<i>azithromycin tablet 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>azithromycin tablet 600 mg oral</i>	Preferred	QL (8 EA per 28 days)
ZITHROMAX ORAL PACKET	Preferred	
ZITHROMAX ORAL SUSPENSION RECONSTITUTED	Non – Preferred	QL (30 ML Max Qty Per Fill Retail)
ZITHROMAX TABLET 250 MG ORAL	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)
ZITHROMAX TABLET 500 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
ZITHROMAX TRI-PAK	Non – Preferred	QL (4 EA per 1 day)
ZITHROMAX Z-PAK	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Clarithromycin*** - Antibiotics		
<i>clarithromycin er</i>	Preferred	QL (14 EA Max Qty Per Fill Retail)
<i>clarithromycin oral suspension reconstituted</i>	Preferred	QL (150 ML Max Qty Per Fill Retail)
<i>clarithromycin oral tablet</i>	Preferred	QL (28 EA Max Qty Per Fill Retail)
*Erythromycins*** - Antibiotics		
<i>erythromycin</i>	Preferred	
<i>erythromycin base</i>	Preferred	
<i>erythromycin ethylsuccinate</i>	Preferred	
E.E.S. 400	Preferred	
E.E.S. GRANULES	Preferred	
ERYPED 200	Preferred	
ERYPED 400	Preferred	
ERY-TAB	Preferred	
ERYTHROCIN STEARATE	Preferred	
*Fidaxomicin*** - Antibiotics		
DIFICID	Non – Preferred	
Medical Devices - Medical Supplies And Durable Medical Equipment		
*Glucose Monitoring Test Supplies*** - Medical Supplies And Durable Medical Equipment		
<i>blood glucose monitor system</i>	Non – Preferred	OTC
<i>blood glucose system pak</i>	Non – Preferred	OTC
<i>diatruue plus blood glucose</i>	Non – Preferred	OTC
<i>easy plus ii glucose system</i>	Non – Preferred	OTC
<i>easy talk blood glucose system</i>	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>easy trak blood glucose system</i>	Non – Preferred	OTC
<i>easy trak ii blood glucose sys</i>	Non – Preferred	OTC
<i>element compact glucose system</i>	Non – Preferred	OTC
<i>element compact v glucose sys</i>	Non – Preferred	OTC
<i>ge100 blood glucose system</i>	Non – Preferred	OTC
<i>ght blood glucose monitor</i>	Non – Preferred	OTC
<i>goodsense blood glucose</i>	Non – Preferred	OTC
<i>groger blood glucose</i>	Non – Preferred	OTC
<i>groger premium blood glucose</i>	Non – Preferred	OTC
<i>ldr blood glucose truetest</i>	Non – Preferred	OTC
<i>liberty blood glucose meter</i>	Non – Preferred	OTC
<i>meijer blood glucose</i>	Non – Preferred	OTC
<i>meijer essential blood glucose</i>	Non – Preferred	OTC
<i>meijer premium blood glucose</i>	Non – Preferred	OTC
<i>one drop blood glucose monitor</i>	Non – Preferred	OTC
<i>pro voice v8 glucose system</i>	Non – Preferred	OTC
<i>pro voice v9 glucose system</i>	Non – Preferred	OTC
<i>ra blood glucose monitor</i>	Non – Preferred	OTC
<i>tgt blood glucose monitoring</i>	Non – Preferred	OTC
<i>verasens blood glucose meter</i>	Non – Preferred	OTC
<i>verasens blood glucose system</i>	Non – Preferred	OTC
ACCU-CHEK AVIVA	Non – Preferred	OTC
ACCU-CHEK AVIVA CONNECT	Non – Preferred	OTC
ACCU-CHEK AVIVA PLUS	Non – Preferred	OTC
ACCU-CHEK COMPACT PLUS CARE	Non – Preferred	OTC
ACCU-CHEK GUIDE	Non – Preferred	OTC
ACCU-CHEK GUIDE ME	Non – Preferred	OTC
ACCU-CHEK NANO SMARTVIEW	Non – Preferred	OTC
ADVANCE INTUITION METER	Non – Preferred	OTC

Coverage Requirements and Limits

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Drug Tier

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Preferred = Preferred

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVANCE INTUITION MONITOR	Non – Preferred	OTC
ADVANCE MICRO-DRAW METER	Non – Preferred	OTC
ADVOCATE BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
ADVOCATE BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
ADVOCATE REDI-CODE	Non – Preferred	OTC
ADVOCATE REDI-CODE+	Non – Preferred	OTC
ADVOCATE REDI-CODE+ TALKING	Non – Preferred	OTC
AGAMATRIX AMP	Non – Preferred	OTC
AGAMATRIX JAZZ WIRELESS 2	Non – Preferred	OTC
AGAMATRIX PRESTO	Non – Preferred	OTC
AGAMATRIX PRESTO PRO METER	Non – Preferred	OTC
ASSURE 3 METER	Non – Preferred	OTC
ASSURE 4 METER	Non – Preferred	OTC
ASSURE PLATINUM METER	Non – Preferred	OTC
ASSURE PRISM MULTI METER	Non – Preferred	OTC
ASSURE PRO BLOOD GLUCOSE METER	Non – Preferred	OTC
BD LATITUDE DIABETES	Non – Preferred	OTC
BD LATITUDE DIABETES SYSTEM	Non – Preferred	OTC
BD LOGIC BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
BIOTEL CARE BLOOD GLUCOSE SYST	Non – Preferred	OTC
CAREONE BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
CARESENS N GLUCOSE SYSTEM	Non – Preferred	OTC
CARESENS N VOICE SYSTEM	Non – Preferred	OTC
CARETOUCH MONITOR SYSTEM	Non – Preferred	OTC
CHOICE DM DIABETES RISK TEST	Non – Preferred	OTC
CLEVER CHEK AUTO-CODE SYSTEM	Non – Preferred	OTC
CLEVER CHEK AUTO-CODE VOICE	Non – Preferred	OTC
CLEVER CHEK SYSTEM	Non – Preferred	OTC
CLEVER CHOICE AUTO-CODE SYSTEM	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE MICRO SYSTEM	Non – Preferred	OTC
CLEVER CHOICE MINI SYSTEM	Non – Preferred	OTC
CLEVER CHOICE TALK SYSTEM	Non – Preferred	OTC
CONTOUR MONITOR	Non – Preferred	OTC
CONTOUR NEXT EZ	Non – Preferred	OTC
CONTOUR NEXT LINK	Non – Preferred	OTC
CONTOUR NEXT MONITOR	Non – Preferred	OTC
CONTOUR NEXT ONE	Non – Preferred	OTC
COOL MONITOR	Non – Preferred	OTC
COOL MONITOR KIT	Non – Preferred	OTC
CVS BLOOD GLUCOSE METER	Non – Preferred	OTC
D-CARE GLUCOMETER	Non – Preferred	
DEXCOM G4 PLAT PED RCV/SHARE	Non – Preferred	PA
DEXCOM G4 PLAT PED RECEIVER	Non – Preferred	PA
DEXCOM G4 PLATINUM RCV/SHARE	Non – Preferred	PA
DEXCOM G4 PLATINUM RECEIVER	Non – Preferred	PA
DEXCOM G4 PLATINUM TRANSMITTER	Non – Preferred	PA
DEXCOM G4 SENSOR	Non – Preferred	PA
DEXCOM G5 MOB/G4 PLAT SENSOR	Non – Preferred	PA
DEXCOM G5 MOBILE RECEIVER	Non – Preferred	PA
DEXCOM G5 MOBILE TRANSMITTER	Non – Preferred	PA
DEXCOM G5 RECEIVER KIT	Non – Preferred	PA
DEXCOM G6 RECEIVER	Preferred	PA
DEXCOM G6 SENSOR	Preferred	PA
DEXCOM G6 TRANSMITTER	Preferred	PA
DIATHRIVE BLOOD GLUCOSE METER	Non – Preferred	OTC
DIATHRIVE+ GLUCOSE MONITOR	Non – Preferred	OTC
EASY STEP GLUCOSE MONITOR	Non – Preferred	OTC
EASY TOUCH GLUCOSE SYSTEM	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASYGLUCO	Non – Preferred	OTC
EASYMAX NG BLOOD GLUCOSE	Non – Preferred	OTC
EASYMAX V BLOOD GLUCOSE	Non – Preferred	OTC
EASYPRO BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
EASYPRO PLUS	Non – Preferred	OTC
ELEMENT AUTOCODE SYSTEM	Non – Preferred	OTC
ELEMENT PLUS	Non – Preferred	OTC
EMBRACE BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
EMBRACE EVO GLUCOSE MONITORING	Non – Preferred	OTC
EMBRACE PRO GLUCOSE METER	Non – Preferred	OTC
EMBRACE TALK BLOOD GLUCOSE	Non – Preferred	OTC
EMBRACE TALK MONITORING SYSTEM	Non – Preferred	OTC
ENLITE GLUCOSE SENSOR	Non – Preferred	PA
EVENCARE G2 MONITOR	Non – Preferred	OTC
EVENCARE G3 MONITOR	Non – Preferred	OTC
EVENCARE GLUCOSE MONITORING	Non – Preferred	OTC
EVENCARE MINI MONITOR	Non – Preferred	OTC
EVERSENSE SENSOR/HOLDER	Non – Preferred	PA
EVERSENSE SMART TRANSMITTER	Non – Preferred	PA
EVOLUTION AUTOCODE	Non – Preferred	OTC
EZ SMART MONITORING SYSTEM	Non – Preferred	OTC
EZ SMART PLUS MONITORING SYS	Non – Preferred	OTC
FIFTY50 GLUCOSE METER 2.0	Non – Preferred	OTC
FORA G20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA G30A BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GD20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GD50 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GTEL BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA PREMIUM V10 BLE SYSTEM	Non – Preferred	OTC

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FORA TEST N' GO MONITOR	Non – Preferred	OTC
FORA TN'G VOICE	Non – Preferred	OTC
FORA V10 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA V10/V12/D10/D20 TEST	Non – Preferred	OTC
FORA V12 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA V20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA V30A BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORACARE GD40 MONITOR	Non – Preferred	OTC
FORACARE PREMIUM V10	Non – Preferred	OTC
FORACARE TEST N GO MONITOR	Non – Preferred	OTC
FORTISCARE GLUCOSE SYSTEM	Non – Preferred	OTC
FORTISCARE T1 GLUCOSE SYSTEM	Non – Preferred	OTC
FREESTYLE FLASH SYSTEM	Non – Preferred	OTC
FREESTYLE FREEDOM	Non – Preferred	OTC
FREESTYLE FREEDOM LITE	Non – Preferred	OTC
FREESTYLE INSULINX SYSTEM	Non – Preferred	OTC
FREESTYLE LIBRE 14 DAY READER	Non – Preferred	PA
FREESTYLE LIBRE 14 DAY SENSOR	Non – Preferred	PA
FREESTYLE LIBRE 2 READER SYSTM	Non – Preferred	PA
FREESTYLE LIBRE 2 SENSOR SYSTM	Non – Preferred	PA
FREESTYLE LIBRE READER	Non – Preferred	PA
FREESTYLE LIBRE SENSOR SYSTEM	Non – Preferred	PA
FREESTYLE LITE	Non – Preferred	OTC
FREESTYLE PRECISION NEO SYSTEM	Non – Preferred	OTC
FREESTYLE SIDEKICK II	Non – Preferred	OTC
FREESTYLE SYSTEM	Non – Preferred	OTC
GLUCO PERFECT 3 METER	Non – Preferred	OTC
GLUCOCARD 01 BLOOD GLUCOSE	Non – Preferred	OTC
GLUCOCARD 01-MINI GLUCOSE	Non – Preferred	OTC

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GLUCOCARD EXPRESSION MONITOR	Non – Preferred	OTC
GLUCOCARD SHINE	Non – Preferred	OTC
GLUCOCARD SHINE CONNEX	Non – Preferred	OTC
GLUCOCARD SHINE EXPRESS	Non – Preferred	OTC
GLUCOCARD SHINE XL	Non – Preferred	OTC
GLUCOCARD VITAL MONITOR	Non – Preferred	OTC
GLUCOCARD X-METER	Non – Preferred	OTC
GLUCOCOM BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
GLUCOCOM MONITOR	Non – Preferred	OTC
GLUCONAVII BLOOD GLUCOSE SYS	Non – Preferred	OTC
GNP EASY TOUCH GLUCOSE METER	Non – Preferred	OTC
GUARDIAN CONNECT TRANSMITTER	Non – Preferred	PA
GUARDIAN LINK 3 TRANSMITTER	Non – Preferred	PA
GUARDIAN REAL-TIME REPLACE PED	Non – Preferred	PA
GUARDIAN SENSOR (3)	Non – Preferred	PA
HM EMBRACE TALK SYSTEM	Non – Preferred	OTC
HW EMBRACE PRO GLUCOSE METER	Non – Preferred	OTC
HW EMBRACE TALK BLOOD GLUCOSE	Non – Preferred	OTC
IBG STAR BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
IGLUCOSE MONITORING SYSTEM	Non – Preferred	OTC
IN TOUCH	Non – Preferred	OTC
INFINITY BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
INFINITY VOICE	Non – Preferred	OTC
KROGER HEALTHPRO GLUC MON SYS	Non – Preferred	OTC
LIBERTY NXT GENERATION MONITOR	Non – Preferred	OTC
MEIJER TRUE2GO BLOOD GLUCOSE	Non – Preferred	OTC
MEIJER TRUERESULT GLUCOSE SYS	Non – Preferred	OTC
MEIJER TRUETRACK GLUCOSE SYS	Non – Preferred	OTC
MICRODOT BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED GUARDIAN SENSOR 3	Non – Preferred	PA
MM EASY TOUCH GLUCOSE METER	Non – Preferred	OTC
MYGLUCOHEALTH BLOOD GLUCOSE	Non – Preferred	OTC
NOVA MAX BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
ONETOUCH ULTRA 2	Preferred	OTC
ONETOUCH ULTRA MINI	Preferred	OTC
ONETOUCH VERIO	Preferred	OTC
ONETOUCH VERIO FLEX SYSTEM	Preferred	OTC
ONETOUCH VERIO IQ SYSTEM	Preferred	OTC
ONETOUCH VERIO REFLECT	Preferred	OTC
OPTIUM BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
OPTIUM GLUCOSE MONITOR SYSTEM	Non – Preferred	OTC
PHARMACIST CHOICE AUTOCODE SYS	Non – Preferred	OTC
PHARMACIST CHOICE MINI SYSTEM	Non – Preferred	OTC
POCKETCHEM EZ SYSTEM	Non – Preferred	OTC
PRECISION LINK	Non – Preferred	OTC
PRECISION QID MONITOR	Non – Preferred	OTC
PRECISION SOF-TACT MONITOR	Non – Preferred	OTC
PRECISION XTRA	Non – Preferred	OTC
PRECISION XTRA MONITOR	Non – Preferred	OTC
PRODIGY AUTOCODE BLOOD GLUCOSE	Non – Preferred	OTC
PRODIGY NO CODING BLOOD GLUC	Non – Preferred	OTC
PRODIGY POCKET BLOOD GLUCOSE	Non – Preferred	OTC
PRODIGY VOICE BLOOD GLUCOSE	Non – Preferred	OTC
QUICKTEK	Non – Preferred	OTC
QUICKTEK/METER	Non – Preferred	OTC
QUINTET AC BLOOD GLUCOSE	Non – Preferred	OTC
QUINTET BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
RA TRUE2GO BLOOD GLUCOSE	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RA TRUERESULT BLOOD GLUCOSE	Non – Preferred	OTC
REFUAH PLUS MONITORING SYSTEM	Non – Preferred	OTC
RELION ALL-IN-ONE	Non – Preferred	OTC
RELION CONFIRM GLUCOSE MONITOR	Non – Preferred	OTC
RELION MICRO	Non – Preferred	OTC
RELION PREMIER BLU MONITOR	Non – Preferred	OTC
RELION PREMIER CLASSIC	Non – Preferred	OTC
RELION PREMIER COMPACT SYSTEM	Non – Preferred	OTC
RELION PREMIER VOICE MONITOR	Non – Preferred	OTC
RELION PRIME MONITOR	Non – Preferred	OTC
RELION ULTIMA GLUCOSE SYSTEM	Non – Preferred	OTC
REXALL BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
RIGHTEST GM100 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GM300 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GM550 BLOOD GLUCOSE	Non – Preferred	OTC
SMART SENSE PREMIUM SYSTEM	Non – Preferred	OTC
SMART SENSE VALUE GLUCOSE SYS	Non – Preferred	OTC
SMARTEST EJECT	Non – Preferred	OTC
SMARTEST EJECT STARTER	Non – Preferred	OTC
SMARTEST PERSONA STARTER	Non – Preferred	OTC
SMARTEST PRONTO STARTER	Non – Preferred	OTC
SMARTEST PROTEGE	Non – Preferred	OTC
SMARTEST PROTEGE STARTER	Non – Preferred	OTC
SOLUS V2 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
SURE EDGE GLUCOSE MONITOR	Non – Preferred	OTC
SURECHEK BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
SURE-TEST EASYPLUS MINI METER	Non – Preferred	OTC
TELCARE BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
TRUE FOCUS BLOOD GLUCOSE METER	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE METRIX AIR GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX GO GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX METER	Non – Preferred	OTC
TRUERESULT BLOOD GLUCOSE	Non – Preferred	OTC
TRUETRACK BLOOD GLUCOSE	Non – Preferred	OTC
TRUETRACK SMART SYSTEM	Non – Preferred	OTC
ULTIMA	Non – Preferred	OTC
ULTRA TRAK PRO BLOOD GLUCOSE	Non – Preferred	OTC
ULTRATRAK ACTIVE	Non – Preferred	OTC
ULTRATRAK PRO	Non – Preferred	OTC
ULTRATRAK ULTIMATE MONITOR	Non – Preferred	OTC
VIVAGUARD INO GLUCOSE METER	Non – Preferred	OTC
VOCAL POINT BLOOD GLUCOSE SYS	Non – Preferred	OTC
WAVESENSE AMP	Non – Preferred	OTC
<i>*Insulin Administration Supplies*** - Medical Supplies And Durable Medical Equipment</i>		
OMNIPOD 5 PACK	Preferred	PA
OMNIPOD DASH 5 PACK PODS	Preferred	PA
OMNIPOD STARTER	Preferred	PA
V-GO 20	Non – Preferred	PA
V-GO 30	Non – Preferred	PA
V-GO 40	Non – Preferred	PA
Migraine Products - Drugs For The Nervous System		
<i>*Ergot Combinations*** - Drugs For Migraine Headaches</i>		
CAFERGOT	Non – Preferred	
MIGERGOT	Preferred	

Coverage Requirements and Limits

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

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sumatriptan succinate subcutaneous solution</i>	Preferred	QL (4 VIAL per 28 days)
<i>sumatriptan succinate subcutaneous solution prefilled syringe</i>	Preferred	QL (4 VIAL per 30 days)
<i>zolmitriptan</i>	Non – Preferred	
AMERGE	Non – Preferred	
FROVA	Non – Preferred	
IMITREX NASAL	Non – Preferred	QL (6 EA per 30 days)
IMITREX ORAL	Non – Preferred	QL (9 EA per 30 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 4 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 ML per 28 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 6 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 VIAL per 30 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 4 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 EA per 28 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 6 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 VIAL per 30 days)
IMITREX SUBCUTANEOUS	Non – Preferred	QL (4 VIAL per 28 days)
MAXALT	Non – Preferred	QL (9 EA per 30 days)
MAXALT-MLT	Non – Preferred	QL (9 EA per 30 days)
ONZETRA XSAIL	Non – Preferred	
RELPAX	Non – Preferred	
TOSYMRA	Non – Preferred	
ZEMBRACE SYMTOUCH	Non – Preferred	
ZOMIG	Non – Preferred	
ZOMIG ZMT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Monobactams*** - Drugs For Infections		
<i>*Monobactams*** - Drugs For Infections</i>		
<i>aztreonam</i>	Preferred	
CAYSTON	Non – Preferred	
Mouth/Throat/Dental Agents - Drugs For The Mouth And Throat		
<i>*Anesthetics Topical Oral*** - Drugs For The Mouth And Throat</i>		
<i>lidocaine hcl</i>	Preferred	
<i>lidocaine viscous hcl</i>	Preferred	
*Anti-Infectives - Throat*** - Drugs For The Mouth And Throat		
<i>clotrimazole</i>	Preferred	
<i>nystatin</i>	Preferred	QL (120 ML Max Qty Per Fill Retail)
ORAVIG	Non – Preferred	
*Antiseptics - Mouth/Throat*** - Drugs For The Mouth And Throat		
<i>chlorhexidine gluconate</i>	Preferred	
PAROEX	Preferred	
*Dental Products - Combinations*** - Drugs For The Mouth And Throat		
<i>sodium fluoride 5000 sensitive</i>	Non – Preferred	
*Dry Mouth Agents And Artificial Saliva*** - Drugs For The Mouth And Throat		
AQUORAL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Fluoride Dental Products*** - Drugs For The Mouth And Throat		
<i>sf</i>	Non – Preferred	
<i>sf 5000 plus</i>	Non – Preferred	
<i>sodium fluoride</i>	Non – Preferred	
<i>sodium fluoride 5000 ppm</i>	Non – Preferred	
DENTA 5000 PLUS	Non – Preferred	
DENTAGEL	Non – Preferred	
*Protectants - Mouth/Throat*** - Drugs For The Mouth And Throat		
GELX	Non – Preferred	
*Saliva Stimulants*** - Drugs For The Mouth And Throat		
<i>cevimeline hcl</i>	Non – Preferred	
<i>pilocarpine hcl</i>	Preferred	
EVOXAC	Non – Preferred	
SALAGEN	Non – Preferred	
*Steroids - Mouth/Throat*** - Drugs For The Mouth And Throat		
<i>triamcinolone acetonide</i>	Preferred	
ORALONE	Preferred	
*Multiple Sclerosis Agents - Antimetabolites*** - Drugs For The Nervous System		
*Multiple Sclerosis Agents - Antimetabolites*** - Drugs For The Nervous System		
MAVENCLAD (10 TABS)	Non – Preferred	
MAVENCLAD (4 TABS)	Non – Preferred	
MAVENCLAD (5 TABS)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVENCLAD (6 TABS)	Non – Preferred	
MAVENCLAD (7 TABS)	Non – Preferred	
MAVENCLAD (8 TABS)	Non – Preferred	
MAVENCLAD (9 TABS)	Non – Preferred	
Multivitamins - Drugs For Nutrition		
*Prenatal Mv & Min WIFe-Fa*** - Drugs For Nutrition		
<i>c-nate dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>completenate</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>pnv tabs 29-1</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>pnv-omega</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>pnv-select</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>prenatal</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>prenatal vitamin plus low iron</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>preplus</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>pretab</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>relnate dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>se-natal 19</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>trinatal rx 1</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>tri-tabs dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>virt-c dha</i>	Non – Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>virt-nate dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>virt-pn plus</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>vol-plus</i>	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
<i>vp-pnv-dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL B-CALM	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL BLOOM	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL RX	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CONCEPT DHA	Non – Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
CONCEPT OB	Non – Preferred	QL (90 EA per 100 days); AL (Min 10 Years and Max 55 Years)
ELITE-OB	Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBRACE HR	Non – Preferred	AL (Min 10 Years and Max 55 Years)
FOLIVANE-OB	Non – Preferred	QL (90 EA per 100 days); AL (Min 10 Years and Max 55 Years)
NESTABS	Non – Preferred	AL (Min 10 Years and Max 55 Years)
NESTABS DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
NIVA-PLUS	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
OB COMPLETE	Preferred	AL (Min 10 Years and Max 55 Years)
OB COMPLETE ONE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
OB COMPLETE PETITE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
OB COMPLETE PREMIER	Non – Preferred	AL (Min 10 Years and Max 55 Years)
OB COMPLETE/DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE ELITE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATRIX	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
PRIMACARE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PROVIDA OB	Non – Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
SELECT-OB	Non – Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TARON-C DHA	Non – Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
TRICARE	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
TRICARE PRENATAL DHA ONE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VINATE DHA RF	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL GUMMIES	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL-NANO	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL-OB	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
ZATEAN-PN PLUS	Non – Preferred	AL (Min 10 Years and Max 55 Years)
*Prenatal Mv & Min WIFe-Fa-Ca-Omega 3 Fish Oil*** - Drugs For Nutrition		
<i>complete natal dha</i>	Non – Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
*Prenatal Mv & Min WIFe-Fa-Dha*** - Drugs For Nutrition		
<i>pnv-dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>pnv-dha+docusate</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>prenaissance</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prenaisance plus</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>tristart dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>virt-pn dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>westgel dha</i>	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL 90 DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL ASSURE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL BLOOM DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
CITRANATAL HARMONY	Non – Preferred	AL (Min 10 Years and Max 55 Years)
NESTABS ONE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE ENHANCE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE ESSENTIAL	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE MINI	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE PIXIE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE RESTORE	Non – Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECT-OB+DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
TARON-PREX	Non – Preferred	AL (Min 10 Years and Max 55 Years)
TRISTART ONE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL FE+	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL ULTRA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL-OB+DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL-ONE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
ZATEAN-PN DHA	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>*Prenatal Mv & Minerals WIFa*** - Drugs For Nutrition</i>		
PRENATE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
<i>*Prenatal Vitamins*** - Drugs For Nutrition</i>		
PREMESISRX	Non – Preferred	AL (Min 10 Years and Max 55 Years)
PRENATE AM	Non – Preferred	AL (Min 10 Years and Max 55 Years)
VITAFOL STRIPS	Non – Preferred	AL (Min 10 Years and Max 55 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Musculoskeletal Therapy Agents - Drugs For Muscles, Ligaments, Tendons, And Bones		
*Central Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>baclofen</i>	Preferred	QL (4 EA per 1 day)
<i>carisoprodol tablet 250 mg oral</i>	Non – Preferred	
<i>carisoprodol tablet 350 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>chlorzoxazone</i>	Preferred	
<i>cyclobenzaprine hcl er</i>	Non – Preferred	
<i>cyclobenzaprine hcl tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>cyclobenzaprine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>cyclobenzaprine hcl tablet 7.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>metaxalone</i>	Non – Preferred	
<i>methocarbamol</i>	Preferred	QL (4 EA per 1 day)
<i>orphenadrine citrate er</i>	Preferred	QL (2 EA per 1 day)
<i>tizanidine hcl oral capsule</i>	Non – Preferred	
<i>tizanidine hcl tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>tizanidine hcl tablet 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
AMRIX	Non – Preferred	
FEXMID	Non – Preferred	QL (4 EA per 1 day)
LORZONE	Preferred	
ROBAXIN-750	Non – Preferred	QL (4 EA per 1 day)
SKELAXIN	Non – Preferred	
SOMA TABLET 250 MG ORAL	Non – Preferred	
SOMA TABLET 350 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
ZANAFLEX ORAL CAPSULE	Non – Preferred	
ZANAFLEX ORAL TABLET	Non – Preferred	QL (6 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Direct Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>dantrolene sodium</i>	Preferred	QL (4 EA per 1 day)
DANTRIUM	Non – Preferred	QL (4 EA per 1 day)
*Muscle Relaxant Combinations*** - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>carisoprodol-aspirin-codeine</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>norgesic forte</i>	Non – Preferred	
Nasal Agents - Systemic And Topical - Drugs For The Nose		
*Antihistamine-Steroid*** - Allergy		
<i>azelastine-fluticasone</i>	Non – Preferred	
DYMISTA	Non – Preferred	
*Nasal Anticholinergics*** - Allergy		
<i>ipratropium bromide solution 0.03 % nasal</i>	Non – Preferred	
<i>ipratropium bromide solution 0.06 % nasal</i>	Non – Preferred	QL (15 ML per 30 days)
*Nasal Antihistamines*** - Allergy		
<i>azelastine hcl solution 0.1 % nasal</i>	Preferred	QL (30 ML per 30 days)
<i>azelastine hcl solution 0.15 % nasal</i>	Preferred	
<i>azelastine hcl solution 137 mcg/spray nasal</i>	Preferred	QL (30 ML per 30 days)
<i>olopatadine hcl</i>	Preferred	
PATANASE	Non – Preferred	
*Nasal Steroids*** - Allergy		
<i>flunisolide</i>	Preferred	QL (1.6667 ML per 1 day)
<i>fluticasone propionate</i>	Preferred	QL (16 GM Max Qty Per Fill Retail)
<i>mometasone furoate</i>	Non – Preferred	QL (1.1333 GM per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BECONASE AQ	Non – Preferred	
NASONEX	Non – Preferred	QL (1.1333 GM per 1 day)
OMNARIS	Non – Preferred	
QNASL	Non – Preferred	
QNASL CHILDRENS	Non – Preferred	
SINUVA	Non – Preferred	
XHANCE	Non – Preferred	
ZETONNA	Non – Preferred	
*Neprilysin Inhib (Arni)-Angiotensin li Recept Antag Comb*** - Drugs For The Heart		
<i>*Neprilysin Inhib (Arni)-Angiotensin li Recept Antag Comb*** - Drugs For The Heart</i>		
ENTRESTO	Non – Preferred	QL (2 EA per 1 day)
*Neurogenic Orthostatic Hypotension (Noh) - Agents*** - Drugs For The Heart		
<i>*Neurogenic Orthostatic Hypotension (Noh) - Agents*** - Drugs For The Heart</i>		
NORTHERA	Non – Preferred	
Neuromuscular Agents - Drugs For Nerves And Muscles		
<i>*Benzathiazoles*** - Drugs For Nerves And Muscles</i>		
<i>riluzole</i>	Preferred	
RILUTEK	Non – Preferred	
TIGLUTIK	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*N-Methyl-D-Aspartic Acid (Nmda) Receptor Antagonists*** - Drugs For The Nervous System		
<i>*N-Methyl-D-Aspartic Acid (Nmda) Receptor Antagonists*** - Drugs For The Nervous System</i>		
SPRAVATO (56 MG DOSE)	Non – Preferred	
SPRAVATO (84 MG DOSE)	Non – Preferred	
Ophthalmic Agents - Drugs For The Eye		
<i>*Alpha Adrenergic Agonist & Carbonic Anhydrase Inhib Comb*** - Drugs For Glaucoma</i>		
SIMBRINZA	Non – Preferred	
*Artificial Tear Inserts*** - Drugs For The Eye		
LACRISERT	Preferred	
*Beta-Blockers - Ophthalmic Combinations*** - Drugs For Glaucoma		
<i>dorzolamide hcl-timolol mal</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>dorzolamide hcl-timolol mal pf</i>	Non – Preferred	
COMBIGAN	Non – Preferred	QL (10 ML per 30 days)
COSOPT	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
COSOPT PF	Non – Preferred	
*Beta-Blockers - Ophthalmic*** - Drugs For Glaucoma		
<i>betaxolol hcl</i>	Preferred	QL (10 ML per 30 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carteolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>levobunolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>timolol maleate gel forming solution 0.25 % ophthalmic</i>	Preferred	QL (5 ML per 30 days)
<i>timolol maleate gel forming solution 0.5 % ophthalmic</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>timolol maleate solution 0.25 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>timolol maleate solution 0.5 % (daily) ophthalmic</i>	Preferred	
<i>timolol maleate solution 0.5 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
BETOPTIC-S	Non – Preferred	
ISTALOL	Non – Preferred	
TIMOPTIC	Non – Preferred	QL (10 ML per 30 days)
TIMOPTIC OCUDOSE	Non – Preferred	
TIMOPTIC-XE GEL FORMING SOLUTION 0.25 % OPHTHALMIC	Non – Preferred	QL (5 ML per 30 days)
TIMOPTIC-XE GEL FORMING SOLUTION 0.5 % OPHTHALMIC	Non – Preferred	QL (5 ML Max Qty Per Fill Retail)
*Cycloplegic Mydriatic Combinations*** - Drugs For The Eye		
CYCLOMYDRIL	Preferred	
*Cycloplegic Mydriatics*** - Drugs For The Eye		
<i>atropine sulfate ophthalmic ointment</i>	Preferred	QL (3.5 GM per 30 days)
<i>atropine sulfate ophthalmic solution</i>	Preferred	QL (5 ML per 30 days)
<i>cyclopentolate hcl solution 0.5 % ophthalmic</i>	Preferred	
<i>cyclopentolate hcl solution 1 % ophthalmic</i>	Preferred	QL (6 ML per 30 days)
<i>cyclopentolate hcl solution 2 % ophthalmic</i>	Preferred	QL (5 ML per 30 days)
<i>phenylephrine hcl</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tropicamide</i>	Preferred	QL (15 ML Max Qty Per Fill Retail)
CYCLOGYL SOLUTION 0.5 % OPTHALMIC	Non – Preferred	
CYCLOGYL SOLUTION 1 % OPTHALMIC	Non – Preferred	QL (6 ML per 30 days)
CYCLOGYL SOLUTION 2 % OPTHALMIC	Non – Preferred	QL (5 ML per 30 days)
ISOPTO ATROPINE	Non – Preferred	QL (5 ML per 30 days)
MYDRIACYL	Non – Preferred	QL (15 ML Max Qty Per Fill Retail)
*Miotics - Cholinesterase Inhibitors*** - Drugs For Glaucoma		
PHOSPHOLINE IODIDE	Preferred	
*Miotics - Direct Acting*** - Drugs For Glaucoma		
<i>pilocarpine hcl</i>	Preferred	QL (15 ML per 30 days)
ISOPTO CARPINE	Non – Preferred	QL (15 ML per 30 days)
*Ophthalmic Antiallergic*** - Drugs For Itchy Eye		
<i>azelastine hcl</i>	Preferred	QL (6 ML Max Qty Per Fill Retail)
<i>cromolyn sodium</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>epinastine hcl</i>	Non – Preferred	
<i>olopatadine hcl solution 0.1 % ophthalmic (rx)</i>	Non – Preferred	QL (5 ML per 30 days)
<i>olopatadine hcl solution 0.2 % ophthalmic (rx)</i>	Non – Preferred	
ALOCRIAL	Non – Preferred	
ALOMIDE	Non – Preferred	
BEPREVE	Non – Preferred	
LASTACAFT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PATADAY	Non – Preferred	
PAZEO	Preferred	
ZERVIAE	Non – Preferred	
*Ophthalmic Antibiotics*** - Anti-Infective/Anti-Inflammatories		
<i>bacitracin</i>	Preferred	
<i>ciprofloxacin hcl</i>	Preferred	QL (5 ML per 30 days)
<i>erythromycin</i>	Preferred	
<i>gatifloxacin</i>	Non – Preferred	
<i>gentamicin sulfate</i>	Preferred	QL (5 ML per 30 days)
<i>levofloxacin</i>	Preferred	QL (5 ML per 30 days)
<i>moxifloxacin hcl</i>	Non – Preferred	
<i>moxifloxacin hcl (2x day)</i>	Non – Preferred	
<i>ofloxacin</i>	Preferred	QL (5 ML per 30 days)
<i>tobramycin</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
AZASITE	Non – Preferred	
BESIVANCE	Non – Preferred	
CILOXAN OPHTHALMIC OINTMENT	Preferred	QL (3.5 GM per 30 days)
CILOXAN OPHTHALMIC SOLUTION	Non – Preferred	QL (5 ML per 30 days)
GENTAK	Preferred	
MOXEZA	Non – Preferred	
OCUFLOX	Non – Preferred	QL (5 ML per 30 days)
TOBREX OPHTHALMIC OINTMENT	Preferred	QL (3.5 GM per 30 days)
TOBREX OPHTHALMIC SOLUTION	Non – Preferred	QL (5 ML Max Qty Per Fill Retail)
VIGAMOX	Non – Preferred	
ZYMAXID	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Ophthalmic Antifungal*** - Drugs For The Eye		
NATACYN	Preferred	QL (15 ML per 30 days)
*Ophthalmic Anti-Infective Combinations*** - Anti-Infective/Anti-Inflammatories		
<i>ak-poly-bac</i>	Preferred	
<i>bacitracin-polymyxin b</i>	Preferred	
<i>neomycin-bacitracin zn-polymyx</i>	Preferred	QL (7 GM per 30 days)
<i>neomycin-polymyxin-gramicidin</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>polymyxin b-trimethoprim</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
NEO-POLYCIN	Preferred	QL (7 GM per 30 days)
POLYCIN	Preferred	
POLYTRIM	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
*Ophthalmic Antiseptics*** - Anti-Infective/Anti-Inflammatories		
BETADINE OPHTHALMIC PREP	Non – Preferred	
*Ophthalmic Antivirals*** - Anti-Infective/Anti-Inflammatories		
<i>trifluridine</i>	Preferred	QL (7.5 ML Max Qty Per Fill Retail)
ZIRGAN	Preferred	
*Ophthalmic Carbonic Anhydrase Inhibitors*** - Drugs For Glaucoma		
<i>dorzolamide hcl</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
AZOPT	Non – Preferred	QL (10 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUSOPT	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
*Ophthalmic Diagnostic Products*** - Drugs For The Eye		
GLOSTRIPS	Non – Preferred	
*Ophthalmic Immunomodulators*** - Anti-Infective/Anti-Inflammatories		
CEQUA	Non – Preferred	
RESTASIS	Non – Preferred	
RESTASIS MULTIDOSE	Non – Preferred	
*Ophthalmic Local Anesthetics*** - Drugs For The Eye		
<i>proparacaine hcl</i>	Non – Preferred	
<i>tetracaine hcl</i>	Non – Preferred	
AKTEN	Non – Preferred	
ALCAINE	Non – Preferred	
*Ophthalmic Nonsteroidal Anti-Inflammatory Agents*** - Anti-Infective/Anti-Inflammatories		
<i>bromfenac sodium (once-daily)</i>	Non – Preferred	
<i>diclofenac sodium</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>flurbiprofen sodium</i>	Preferred	QL (5 ML per 25 days)
<i>ketorolac tromethamine solution 0.4 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>ketorolac tromethamine solution 0.5 % ophthalmic</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
ACULAR	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
ACULAR LS	Non – Preferred	QL (10 ML per 30 days)
BROMSITE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ILEVRO	Non – Preferred	
NEVANAC	Non – Preferred	
PROLENSA	Non – Preferred	
*Ophthalmic Selective Alpha Adrenergic Agonists*** - Drugs For Glaucoma		
<i>apraclonidine hcl</i>	Non – Preferred	
<i>brimonidine tartrate solution 0.15 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.2 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
ALPHAGAN P	Preferred	
IOPIDINE	Non – Preferred	
*Ophthalmic Steroid Combinations*** - Anti-Infective/Anti-Inflammatories		
<i>bacitra-neomycin-polymyxin-hc</i>	Preferred	
<i>neomycin-polymyxin-dexameth ophthalmic ointment</i>	Preferred	
<i>neomycin-polymyxin-dexameth ophthalmic suspension</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>neomycin-polymyxin-hc</i>	Preferred	QL (7.5 ML per 30 days)
<i>sulfacetamide-prednisolone</i>	Non – Preferred	QL (5 ML per 30 days)
<i>tobramycin-dexamethasone</i>	Preferred	QL (10 ML per 30 days)
BLEPHAMIDE	Non – Preferred	
BLEPHAMIDE S.O.P.	Non – Preferred	
MAXITROL OPHTHALMIC OINTMENT	Non – Preferred	
MAXITROL OPHTHALMIC SUSPENSION	Non – Preferred	QL (5 ML Max Qty Per Fill Retail)
NEO-POLYCIN HC	Preferred	
PRED-G	Non – Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRED-G S.O.P.	Non – Preferred	
TOBRADEX OPHTHALMIC OINTMENT	Non – Preferred	
TOBRADEX OPHTHALMIC SUSPENSION	Non – Preferred	QL (10 ML per 30 days)
TOBRADEX ST	Non – Preferred	
ZYLET	Non – Preferred	
*Ophthalmic Steroids*** - Anti-Infective/Anti-Inflammatories		
<i>dexamethasone sodium phosphate</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>fluorometholone</i>	Preferred	QL (10 ML per 30 days)
<i>loteprednol etabonate</i>	Preferred	
<i>prednisolone acetate</i>	Preferred	QL (10 ML per 30 days)
<i>prednisolone sodium phosphate</i>	Preferred	QL (10 ML per 30 days)
ALREX	Preferred	
DEXTENZA	Non – Preferred	
DUREZOL	Non – Preferred	
FLAREX	Preferred	
FML	Preferred	QL (3.5 GM per 30 days)
FML FORTE	Preferred	
FML LIQUIFILM	Non – Preferred	QL (10 ML per 30 days)
INVELTYS	Non – Preferred	
LOTEMAX	Non – Preferred	
LOTEMAX SM	Non – Preferred	
MAXIDEX	Preferred	
PRED FORTE	Non – Preferred	QL (10 ML per 30 days)
PRED MILD	Preferred	QL (10 ML per 30 days)
*Ophthalmic Sulfonamides*** - Anti-Infective/Anti-Inflammatories		
<i>sulfacetamide sodium ophthalmic ointment</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sulfacetamide sodium ophthalmic solution</i>	Preferred	QL (15 ML Max Qty Per Fill Retail)
BLEPH-10	Non – Preferred	QL (15 ML Max Qty Per Fill Retail)
*Ophthalmics - Cystinosis Agents** - Drugs For The Eye		
CYSTADROPS	Non – Preferred	
CYSTARAN	Non – Preferred	
*Prostaglandins - Ophthalmic*** - Drugs For Glaucoma		
<i>bimatoprost</i>	Non – Preferred	
<i>latanoprost</i>	Preferred	QL (2.5 ML per 25 days)
<i>travoprost (bak free)</i>	Non – Preferred	
LUMIGAN	Non – Preferred	
TRAVATAN Z	Non – Preferred	
VYZULTA	Non – Preferred	
XALATAN	Non – Preferred	QL (2.5 ML per 25 days)
XELPROS	Non – Preferred	
ZIOPTAN	Non – Preferred	
*Ophthalmic Kinase Inhibitors - Combinations*** - Drugs For The Eye		
*Ophthalmic Kinase Inhibitors - Combinations*** - Drugs For The Eye		
ROCKLATAN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Ophthalmic Nerve Growth Factors*** - Drugs For The Eye		
<i>*Ophthalmic Nerve Growth Factors*** - Drugs For The Eye</i>		
OXERVATE	Non – Preferred	
*Ophthalmic Rho Kinase Inhibitors*** - Drugs For The Eye		
<i>*Ophthalmic Rho Kinase Inhibitors*** - Drugs For The Eye</i>		
RHOPRESSA	Non – Preferred	
*Orexin Receptor Antagonists*** - Drugs For The Nervous System		
<i>*Orexin Receptor Antagonists*** - Drugs For The Nervous System</i>		
BELSOMRA	Non – Preferred	
DAYVIGO	Non – Preferred	
Otic Agents - Drugs For The Ear		
<i>*Otic Agents - Miscellaneous*** - Wax Removal</i>		
<i>acetic acid</i>	Preferred	
*Otic Anti-Infectives*** - Antibiotics		
<i>ciprofloxacin hcl</i>	Non – Preferred	QL (28 EA per 30 days)
<i>ofloxacin</i>	Preferred	QL (15 ML per 30 days)
*Otic Steroid-Anti-Infective Combinations*** - Anti-Infective/Anti-Inflammatories		
<i>ciprofloxacin-dexamethasone</i>	Preferred	QL (7.5 ML per 30 days)
<i>ciprofloxacin-fluocinolone pf</i>	Non – Preferred	
<i>neomycin-polymyxin-hc</i>	Preferred	QL (10 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CIPRO HC	Non – Preferred	
CIPRODEX	Preferred	QL (7.5 ML per 30 days)
CORTISPORIN-TC	Non – Preferred	
OTOVEL	Non – Preferred	
*Otic Steroids*** - Anti-Infective/Anti-Inflammatories		
<i>fluocinolone acetonide</i>	Non – Preferred	
<i>hydrocortisone-acetic acid</i>	Non – Preferred	
DERMOTIC	Non – Preferred	
FLAC	Non – Preferred	
*Oxaborole-Related Antifungals - Topical*** - Drugs For The Skin		
*Oxaborole-Related Antifungals - Topical*** - Drugs For The Skin		
KERYDIN	Non – Preferred	
Oxytocics - Hormones		
*Oxytocics*** - Drugs For Women		
<i>methylergonovine maleate</i>	Preferred	
METHERGINE	Preferred	
*Pa Endonuclease Inhibitors*** - Drugs For Infections		
*Pa Endonuclease Inhibitors*** - Drugs For Infections		
XOFLUZA (40 MG DOSE)	Non – Preferred	
XOFLUZA (80 MG DOSE)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Passive Immunizing Agents - Biological Agents		
*Antiviral Monoclonal Antibodies*** - Biological Agents		
SYNAGIS	Preferred	QL (1 VIAL per 26 days)
*Pcsk9 Inhibitors*** - Drugs For The Heart		
*Pcsk9 Inhibitors*** - Drugs For The Heart		
PRALUENT	Non – Preferred	
REPATHA	Non – Preferred	
REPATHA PUSHTRONEX SYSTEM	Non – Preferred	
REPATHA SURECLICK	Non – Preferred	
Penicillins - Drugs For Infections		
*Aminopenicillins*** - Antibiotics		
<i>amoxicillin</i>	Preferred	
<i>ampicillin</i>	Preferred	
<i>ampicillin sodium</i>	Preferred	
*Natural Penicillins*** - Antibiotics		
<i>penicillin g pot in dextrose</i>	Preferred	
<i>penicillin g potassium</i>	Preferred	
<i>penicillin g procaine</i>	Preferred	
<i>penicillin g sodium</i>	Preferred	
<i>penicillin v potassium</i>	Preferred	
BICILLIN L-A	Preferred	
PFIZERPEN	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Penicillin Combinations*** - Antibiotics		
<i>amoxicillin-pot clavulanate er</i>	Non – Preferred	QL (28 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate oral suspension reconstituted</i>	Preferred	
<i>amoxicillin-pot clavulanate oral tablet chewable</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 250-125 mg oral</i>	Preferred	QL (30 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 500-125 mg oral</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 875-125 mg oral</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>ampicillin-sulbactam sodium</i>	Preferred	
<i>piperacillin sod-tazobactam so</i>	Preferred	
AUGMENTIN	Preferred	
BICILLIN C-R	Preferred	
BICILLIN C-R 900/300	Preferred	
ZOSYN	Preferred	
*Penicillinase-Resistant Penicillins*** - Antibiotics		
<i>dicloxacillin sodium</i>	Preferred	
*Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors*** - Drugs For Cancer		
*Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors*** - Drugs For Cancer		
COPIKTRA	Non – Preferred	
PIQRAY (200 MG DAILY DOSE)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PIQRAY (250 MG DAILY DOSE)	Non – Preferred	
PIQRAY (300 MG DAILY DOSE)	Non – Preferred	
ZYDELIG	Non – Preferred	
*Phosphodiesterase 4 (Pde4) Inhibitors - Topical*** - Drugs For The Skin		
<i>*Phosphodiesterase 4 (Pde4) Inhibitors - Topical*** - Drugs For The Skin</i>		
EUCRISA	Preferred	PA
*Phosphodiesterase 4 (Pde4) Inhibitors*** - Drugs For Pain And Fever		
<i>*Phosphodiesterase 4 (Pde4) Inhibitors*** - Drugs For Pain And Fever</i>		
OTEZLA	Non – Preferred	
*Plasma Kallikrein Inhibitors - Monoclonal Antibodies*** - Drugs For The Heart		
<i>*Plasma Kallikrein Inhibitors - Monoclonal Antibodies*** - Drugs For The Heart</i>		
TAKHZYRO	Non – Preferred	
*Pleuromutilins*** - Drugs For Infections		
<i>*Pleuromutilins*** - Drugs For Infections</i>		
XENLETA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Poly (Adp-Ribose) Polymerase (Parp) Inhibitors** - Drugs For Cancer		
<i>*Poly (Adp-Ribose) Polymerase (Parp) Inhibitors** - Drugs For Cancer</i>		
LYNPARZA	Non – Preferred	QL (4 EA per 1 day)
RUBRACA	Non – Preferred	
TALZENNA	Non – Preferred	
ZEJULA	Non – Preferred	
*Poly (Adp-Ribose) Polymerase (Parp) Inhibitors*** - Drugs For Cancer		
<i>*Poly (Adp-Ribose) Polymerase (Parp) Inhibitors*** - Drugs For Cancer</i>		
LYNPARZA	Non – Preferred	QL (4 EA per 1 day)
RUBRACA	Non – Preferred	
TALZENNA	Non – Preferred	
ZEJULA	Non – Preferred	
*Postherpetic Neuralgia (Phn) Combination Agents*** - Drugs For The Nervous System		
<i>*Postherpetic Neuralgia (Phn) Combination Agents*** - Drugs For The Nervous System</i>		
GABAPAL	Non – Preferred	
LIDOTIN	Non – Preferred	
LIPRITIN	Non – Preferred	
LIPRITIN II	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENTICAN	Non – Preferred	
PRILOPENTIN	Non – Preferred	
*Postherpetic Neuralgia (Phn)/Neuropathic Pain Agents*** - Drugs For The Nervous System		
<i>*Postherpetic Neuralgia (Phn)/Neuropathic Pain Agents*** - Drugs For The Nervous System</i>		
GRALISE	Non – Preferred	
LYRICA CR	Non – Preferred	
*Postherpetic Neuralgia(Phn)/Neuropathic Pain Comb Agents*** - Drugs For The Nervous System		
<i>*Postherpetic Neuralgia(Phn)/Neuropathic Pain Comb Agents*** - Drugs For The Nervous System</i>		
GABAPAL	Non – Preferred	
LIDOTIN	Non – Preferred	
LIPRITIN	Non – Preferred	
LIPRITIN II	Non – Preferred	
PENTICAN	Non – Preferred	
PRILOPENTIN	Non – Preferred	
*Potassium Removing Agents*** - Drugs For Nutrition		
<i>*Potassium Removing Agents*** - Drugs For Nutrition</i>		
<i>sodium polystyrene sulfonate</i>	Preferred	
KIONEX	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOKELMA	Non – Preferred	
SPS	Preferred	
VELTASSA	Non – Preferred	
*Prenatal Mv & Minerals W/Fa Without Iron*** - Drugs For Nutrition		
<i>*Prenatal Mv & Minerals W/Fa Without Iron*** - Drugs For Nutrition</i>		
PRENATE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
Progestins - Hormones		
<i>*Progestins*** - Drugs For Women</i>		
<i>hydroxyprogesterone caproate</i>	Non – Preferred	PA
<i>medroxyprogesterone acetate</i>	Preferred	
<i>megestrol acetate</i>	Non – Preferred	
<i>norethindrone acetate</i>	Non – Preferred	
<i>progesterone</i>	Preferred	
<i>progesterone micronized</i>	Preferred	QL (2 EA per 1 day)
AYGESTIN	Non – Preferred	
MAKENA	Preferred	PA
PROMETRIUM	Non – Preferred	QL (2 EA per 1 day)
PROVERA	Non – Preferred	
*Protease-Activated Receptor-1 (Par-1) Antagonists*** - Drugs For The Blood		
<i>*Protease-Activated Receptor-1 (Par-1) Antagonists*** - Drugs For The Blood</i>		
ZONTIVITY	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Psychotherapeutic And Neurological Agents - Misc. - Drugs For The Nervous System		
*Alcohol Deterrents*** - Drugs For The Nervous System		
<i>acamprosate calcium</i>	Preferred	
<i>disulfiram</i>	Preferred	QL (1 EA per 1 day)
ANTABUSE	Preferred	QL (1 EA per 1 day)
*Anti-Cataplectic Agents*** - Drugs For Sleep Disorder		
XYREM	Non – Preferred	
*Benzodiazepines & Tricyclic Agents*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>chlordiazepoxide-amitriptyline</i>	Preferred	
*Cholinomimetics - Ache Inhibitors*** - Drugs For Alzheimer's Disease		
<i>donepezil hcl oral tablet dispersible</i>	Preferred	QL (1 EA per 1 day)
<i>donepezil hcl tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>donepezil hcl tablet 23 mg oral</i>	Preferred	
<i>donepezil hcl tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>galantamine hydrobromide er</i>	Non – Preferred	
<i>galantamine hydrobromide oral solution</i>	Non – Preferred	QL (2 ML per 1 day)
<i>galantamine hydrobromide oral tablet</i>	Non – Preferred	
<i>rivastigmine</i>	Non – Preferred	
<i>rivastigmine tartrate</i>	Non – Preferred	
ARICEPT TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ARICEPT TABLET 23 MG ORAL	Non – Preferred	
ARICEPT TABLET 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EXELON	Non – Preferred	
RAZADYNE ER	Non – Preferred	
<i>*Fibromyalgia Agent - Snris*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i>		
SAVELLA	Non – Preferred	
SAVELLA TITRATION PACK	Non – Preferred	QL (55 EA per 90 days)
<i>*Movement Disorder Drug Therapy*** - Drugs For The Nervous System</i>		
<i>tetrabenazine</i>	Non – Preferred	
AUSTEDO	Non – Preferred	
INGREZZA	Non – Preferred	
XENAZINE	Non – Preferred	
<i>*Ms Agents - Pyrimidine Synthesis Inhibitors*** - Drugs For Multiple Sclerosis</i>		
AUBAGIO	Non – Preferred	QL (1 EA per 1 day)
<i>*Multiple Sclerosis Agents - Interferons*** - Drugs For Multiple Sclerosis</i>		
AVONEX PEN	Non – Preferred	QL (1 KIT per 28 days)
AVONEX PREFILLED	Non – Preferred	QL (1 SYRINGE per 28 days)
BETASERON	Preferred	QL (15 VIAL per 30 days)
EXTAVIA	Non – Preferred	QL (15 VIAL per 30 days)
PLEGRIDY	Non – Preferred	
PLEGRIDY STARTER PACK	Non – Preferred	
REBIF	Preferred	QL (12 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS	Preferred	
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS	Preferred	QL (12 ML per 30 days)
REBIF REBIDOSE TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
REBIF TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
<i>*Multiple Sclerosis Agents - Monoclonal Antibodies*** - Drugs For Multiple Sclerosis</i>		
KESIMPTA	Non – Preferred	
LEMTRADA	Non – Preferred	
OCREVUS	Non – Preferred	
TYSABRI	Non – Preferred	
<i>*Multiple Sclerosis Agents - Nrf2 Pathway Activators*** - Drugs For Multiple Sclerosis</i>		
<i>dimethyl fumarate</i>	Non – Preferred	PA; QL (2 EA per 1 day)
<i>dimethyl fumarate starter pack</i>	Non – Preferred	PA; QL (60 EA per 90 days)
BAFIERTAM	Non – Preferred	
TECFIDERA ORAL	Preferred	PA; QL (60 EA per 90 days)
TECFIDERA ORAL CAPSULE DELAYED RELEASE	Preferred	PA; QL (2 EA per 1 day)
VUMERITY	Non – Preferred	
<i>*Multiple Sclerosis Agents - Potassium Channel Blockers*** - Drugs For Multiple Sclerosis</i>		
<i>dalfampridine er</i>	Non – Preferred	
AMPYRA	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Multiple Sclerosis Agents*** - Drugs For Multiple Sclerosis		
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	Non – Preferred	QL (1 ML per 1 day)
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	Non – Preferred	QL (12 SYRINGE per 30 days)
COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Preferred	QL (1 ML per 1 day)
COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Non – Preferred	QL (12 SYRINGE per 30 days)
GLATOPA SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Non – Preferred	QL (1 ML per 1 day)
GLATOPA SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Non – Preferred	QL (12 SYRINGE per 30 days)
*N-Methyl-D-Aspartate (Nmda) Receptor Antagonists*** - Drugs For Alzheimer's Disease		
<i>memantine hcl er</i>	Non – Preferred	
<i>memantine hcl oral solution</i>	Non – Preferred	
<i>memantine hcl tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>memantine hcl tablet 28 x 5 mg & 21 x 10 mg oral</i>	Non – Preferred	
<i>memantine hcl tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
NAMENDA	Non – Preferred	QL (2 EA per 1 day)
NAMENDA TITRATION PAK	Non – Preferred	
NAMENDA XR	Non – Preferred	
NAMENDA XR TITRATION PACK	Non – Preferred	
*Phenothiazines & Tricyclic Agents*** - Drugs For Depression		
<i>perphenazine-amitriptyline</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Postherpetic Neuralgia (Phn) Agents*** - Drugs For Seizures /Personality Disorder/Nerve Pain		
GRALISE	Non – Preferred	
LYRICA CR	Non – Preferred	
*Premenstrual Dysphoric Disorder (Pmdd) Agents - SsrIs*** - Drugs For Depression		
<i>fluoxetine hcl (pmdd)</i>	Non – Preferred	
SARAFEM	Non – Preferred	
*Pseudobulbar Affect Agent Combinations*** - Drugs For Severe Mental Disorders		
NUDEXTA	Non – Preferred	
*Psychotherapeutic And Neurological Agents - Misc.*** - Drugs For Severe Mental Disorders		
<i>ergoloid mesylates</i>	Preferred	
<i>pimozide</i>	Preferred	
*Restless Leg Syndrome (RLs) Agents*** - Drugs For The Nervous System		
HORIZANT	Non – Preferred	
*Smoking Deterrents*** - Drugs For Depression		
<i>bupropion hcl er (smoking det)</i>	Preferred	QL (2 EA per 1 day)
<i>gnp nicotine mini</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	OTC
<i>gnp nicotine polacrilex</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>hm nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>hm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>hm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	OTC
<i>hm nicotine polacrilex</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine mini</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine patch 24 hour 14 mg/24hr transdermal (otc)</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine patch 24 hour 21 mg/24hr transdermal (otc)</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine patch 24 hour 7 mg/24hr transdermal (otc)</i>	Preferred	OTC
<i>nicotine polacrilex</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine step 1</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine step 2</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine step 3</i>	Preferred	OTC
<i>nicotine transdermal kit</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	OTC
<i>sm nicotine polacrilex</i>	Preferred	OTC; QL (200 EA per 30 days)
CHANTIX	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHANTIX CONTINUING MONTH PAK	Preferred	
CHANTIX STARTING MONTH PAK	Preferred	
NICOTROL	Preferred	QL (3 INHALER per 30 days)
NICOTROL NS	Preferred	QL (120 ML per 30 days)
*Sphingosine 1-Phosphate (S1p) Receptor Modulators*** - Drugs For Multiple Sclerosis		
GILENYA	Non – Preferred	QL (1 EA per 1 day)
MAYZENT	Non – Preferred	
ZEPOSIA	Non – Preferred	
ZEPOSIA 7-DAY STARTER PACK	Non – Preferred	
ZEPOSIA STARTER KIT	Non – Preferred	
*Thienbenzodiazepines & Ssrís*** - Drugs For Severe Mental Disorders		
<i>olanzapine-fluoxetine hcl</i>	Non – Preferred	QL (1 EA per 1 day)
SYMBYAX	Non – Preferred	QL (1 EA per 1 day)
*Vasomotor Symptom Agents - Ssrís*** - Drugs For The Nervous System		
<i>paroxetine mesylate</i>	Non – Preferred	
BRISDELLE	Non – Preferred	
*Pulmonary Fibrosis Agents - Kinase Inhibitors*** - Drugs For Cancer		
*Pulmonary Fibrosis Agents - Kinase Inhibitors*** - Drugs For Cancer		
OFEV	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Pulmonary Fibrosis Agents*** - Drugs For The Lungs		
<i>*Pulmonary Fibrosis Agents*** - Drugs For The Lungs</i>		
ESBRIET	Non – Preferred	
*Pulmonary Hypertension - Prostacyclin Receptor Agonist*** - Drugs For The Heart		
<i>*Pulmonary Hypertension - Prostacyclin Receptor Agonist*** - Drugs For The Heart</i>		
UPTRAVI	Non – Preferred	
Respiratory Agents - Misc. - Drugs For The Lungs		
<i>*Cftr Potentiators*** - Drugs For Cystic Fibrosis</i>		
KALYDECO	Non – Preferred	
<i>*Hydrolytic Enzymes*** - Drugs For The Lungs</i>		
PULMOZYME	Preferred	QL (5 ML per 1 day)
*Selective Serotonin Agonists 5-Ht(1F)*** - Drugs For The Nervous System		
<i>*Selective Serotonin Agonists 5-Ht(1F)*** - Drugs For The Nervous System</i>		
REYVOW	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Serotonin Modulators*** - Drugs For The Nervous System		
<i>*Serotonin Modulators*** - Drugs For The Nervous System</i>		
<i>nefazodone hcl</i>	Non – Preferred	
<i>trazodone hcl</i>	Preferred	
TRINTELLIX	Non – Preferred	
VIIBRYD	Non – Preferred	
VIIBRYD STARTER PACK	Non – Preferred	
*SglT2 Inhibitor - Dpp-4 Inhibitor - Biguanide Comb*** - Hormones		
<i>*SglT2 Inhibitor - Dpp-4 Inhibitor - Biguanide Comb*** - Hormones</i>		
TRIJARDY XR	Non – Preferred	
*SglT2 Inhibitor - Dpp-4 Inhibitor Combinations*** - Hormones		
<i>*SglT2 Inhibitor - Dpp-4 Inhibitor Combinations*** - Hormones</i>		
GLYXAMBI	Non – Preferred	
QTERN	Non – Preferred	
STEGLUJAN	Non – Preferred	
*Sinus Node Inhibitors** - Drugs For The Heart		
<i>*Sinus Node Inhibitors** - Drugs For The Heart</i>		
CORLANOR ORAL SOLUTION	Non – Preferred	
CORLANOR ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Sodium-Glucose Co-Transporter 2 Inhibitor-Biguanide Comb*** - Hormones		
<i>*Sodium-Glucose Co-Transporter 2 Inhibitor-Biguanide Comb*** - Hormones</i>		
INVOKAMET	Non – Preferred	
INVOKAMET XR	Non – Preferred	
SEGLUROMET	Non – Preferred	
SYNJARDY	Non – Preferred	
SYNJARDY XR	Non – Preferred	
XIGDUO XR	Non – Preferred	
*Spleen Tyrosine Kinase (Syk) Inhibitors*** - Drugs For The Blood		
<i>*Spleen Tyrosine Kinase (Syk) Inhibitors*** - Drugs For The Blood</i>		
TAVALISSE	Non – Preferred	
*Steroids - Mouth/Throat/Dental*** - Drugs For The Mouth And Throat		
<i>*Steroids - Mouth/Throat/Dental*** - Drugs For The Mouth And Throat</i>		
<i>triamcinolone acetonide</i>	Preferred	
ORALONE	Preferred	
Sulfonamides - Drugs For Infections		
<i>*Sulfonamides*** - Antibiotics</i>		
<i>sulfadiazine</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Tetracyclines - Drugs For Infections		
<i>*Tetracyclines*** - Antibiotics</i>		
<i>demeclocycline hcl</i>	Preferred	
<i>doxycycline hyclate intravenous</i>	Preferred	
<i>doxycycline hyclate oral capsule</i>	Preferred	
<i>doxycycline hyclate oral tablet</i>	Preferred	
<i>doxycycline hyclate oral tablet delayed release</i>	Non – Preferred	
<i>doxycycline monohydrate</i>	Preferred	
<i>minocycline hcl</i>	Preferred	
<i>minocycline hcl er</i>	Non – Preferred	
<i>tetracycline hcl</i>	Preferred	
DORYX	Non – Preferred	
DORYX MPC	Non – Preferred	
DOXY 100	Preferred	
MINOLIRA	Non – Preferred	
MORGIDOX COMBINATION	Non – Preferred	
MORGIDOX ORAL	Preferred	
SOLODYN	Non – Preferred	
VIBRAMYCIN ORAL CAPSULE	Non – Preferred	
VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
VIBRAMYCIN ORAL SYRUP	Preferred	
XIMINO	Non – Preferred	
Thyroid Agents - Hormones		
<i>*Antithyroid Agents*** - Drugs For Thyroid</i>		
<i>methimazole</i>	Preferred	
<i>propylthiouracil</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAPAZOLE	Non – Preferred	
*Thyroid Hormones*** - Drugs For Thyroid		
<i>levothyroxine sodium</i>	Preferred	QL (1 EA per 1 day)
<i>liothyronine sodium tablet 25 mcg oral</i>	Preferred	QL (2 EA per 1 day)
<i>liothyronine sodium tablet 5 mcg oral</i>	Preferred	QL (4 EA per 1 day)
<i>liothyronine sodium tablet 50 mcg oral</i>	Preferred	QL (2 EA per 1 day)
<i>np thyroid</i>	Preferred	QL (1 EA per 1 day)
ARMOUR THYROID	Preferred	QL (1 EA per 1 day)
CYTOMEL TABLET 25 MCG ORAL	Non – Preferred	QL (2 EA per 1 day)
CYTOMEL TABLET 5 MCG ORAL	Non – Preferred	QL (4 EA per 1 day)
CYTOMEL TABLET 50 MCG ORAL	Non – Preferred	QL (2 EA per 1 day)
EUTHYROX	Preferred	QL (1 EA per 1 day)
LEVO-T	Preferred	QL (1 EA per 1 day)
LEVOXYL	Preferred	QL (1 EA per 1 day)
SYNTHROID	Non – Preferred	QL (1 EA per 1 day)
TIROSINT	Non – Preferred	
TIROSINT-SOL	Non – Preferred	
UNITHROID	Preferred	QL (1 EA per 1 day)
Toxoids - Biological Agents		
*Toxoid Combinations*** - Vaccines		
<i>diphtheria-tetanus toxoids dt</i>	Preferred	
INFANRIX	Preferred	
*Transthyretin Stabilizers*** - Hormones		
*Transthyretin Stabilizers*** - Hormones		
VYNDAMAX	Non – Preferred	
VYNDAQEL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Tryptophan Hydroxylase Inhibitors*** - Drugs For The Stomach		
<i>*Tryptophan Hydroxylase Inhibitors*** - Drugs For The Stomach</i>		
XERMELO	Non – Preferred	
Ulcer Drugs - Drugs For The Stomach		
<i>*Anticholinergic Combinations*** - Drugs For Stomach Cramps</i>		
<i>belladonna alkaloids-opium</i>	Preferred	
<i>chlordiazepoxide-clidinium</i>	Non – Preferred	
LIBRAX	Non – Preferred	
<i>*Antispasmodics*** - Drugs For Stomach Cramps</i>		
<i>dicyclomine hcl</i>	Preferred	
<i>*Belladonna Alkaloids*** - Drugs For Stomach Cramps</i>		
<i>ed-spaz</i>	Preferred	
<i>hyoscyamine sulfate</i>	Preferred	
<i>oscimin</i>	Preferred	
<i>oscimin sr</i>	Preferred	
ANASPAZ	Non – Preferred	
LEVSIN	Non – Preferred	
LEVSIN/SL	Non – Preferred	
NULEV	Preferred	
<i>*H-2 Antagonists*** - Drugs For Ulcers And Stomach Acid</i>		
<i>cimetidine</i>	Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cimetidine hcl</i>	Preferred	QL (27 ML per 1 day)
<i>famotidine oral suspension reconstituted</i>	Preferred	
<i>famotidine tablet 20 mg oral (rx)</i>	Preferred	
<i>famotidine tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>nizatidine capsule 150 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>nizatidine capsule 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>nizatidine oral solution</i>	Preferred	
PEPCID TABLET 20 MG ORAL	Non – Preferred	
PEPCID TABLET 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
*Misc. Anti-Ulcer*** - Drugs For Ulcers And Stomach Acid		
<i>sucralfate</i>	Preferred	
CARAFATE ORAL SUSPENSION	Preferred	
CARAFATE ORAL TABLET	Non – Preferred	
*Proton Pump Inhibitor-Antacid Combinations*** - Drugs For Ulcers And Stomach Acid		
<i>omeprazole-sodium bicarbonate</i>	Non – Preferred	
ZEGERID	Non – Preferred	
*Proton Pump Inhibitors*** - Drugs For Ulcers And Stomach Acid		
<i>esomeprazole magnesium capsule delayed release 20 mg oral (rx)</i>	Non – Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium capsule delayed release 40 mg oral</i>	Non – Preferred	
<i>esomeprazole magnesium oral packet</i>	Non – Preferred	
<i>lansoprazole capsule delayed release 15 mg oral (rx)</i>	Non – Preferred	
<i>lansoprazole capsule delayed release 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lansoprazole oral tablet delayed release dispersible</i>	Non – Preferred	AL (Max 10 Years)
<i>omeprazole</i>	Preferred	QL (2 EA per 1 day)
<i>pantoprazole sodium oral packet</i>	Non – Preferred	
<i>pantoprazole sodium tablet delayed release 20 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>pantoprazole sodium tablet delayed release 40 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>rabeprazole sodium</i>	Non – Preferred	
ACIPHEX	Non – Preferred	
ACIPHEX SPRINKLE	Non – Preferred	
DEXILANT	Non – Preferred	AL (Max 20 Years)
NEXIUM CAPSULE DELAYED RELEASE 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NEXIUM CAPSULE DELAYED RELEASE 40 MG ORAL	Non – Preferred	
NEXIUM ORAL PACKET	Non – Preferred	
PREVACID CAPSULE DELAYED RELEASE 15 MG ORAL	Non – Preferred	
PREVACID CAPSULE DELAYED RELEASE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
PREVACID SOLUTAB	Non – Preferred	AL (Max 10 Years)
PRILOSEC	Non – Preferred	
PROTONIX ORAL PACKET	Non – Preferred	
PROTONIX TABLET DELAYED RELEASE 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROTONIX TABLET DELAYED RELEASE 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
<i>*Quaternary Anticholinergics*** - Drugs For Stomach Cramps</i>		
<i>glycopyrrolate</i>	Preferred	
<i>methscopolamine bromide</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>propantheline bromide</i>	Preferred	
CUVPOSA	Non – Preferred	
GLYCATE	Non – Preferred	
*Ulcer Anti-Infective W/ Bismuth Combinations*** - Drugs For Ulcers And Stomach Acid		
HELIDAC THERAPY	Non – Preferred	
PYLERA	Non – Preferred	
*Ulcer Anti-Infective W/ Proton Pump Inhibitors*** - Drugs For Ulcers And Stomach Acid		
<i>amoxicill-clarithro-lansopraz</i>	Non – Preferred	
OMECLAMOX-PAK	Non – Preferred	
TALICIA	Non – Preferred	
*Ulcer Drugs - Prostaglandins*** - Drugs For Ulcers And Stomach Acid		
<i>misoprostol</i>	Preferred	
CYTOTEC	Non – Preferred	
Urinary Anti-Infectives - Drugs For The Urinary System		
*Urinary Anti-Infectives*** - Drugs For Infections		
<i>fosfomycin tromethamine</i>	Preferred	
<i>methenamine hippurate</i>	Preferred	
<i>methenamine mandelate</i>	Preferred	
<i>nitrofurantoin</i>	Preferred	
<i>nitrofurantoin macrocrystal</i>	Preferred	
<i>nitrofurantoin monohyd macro</i>	Preferred	
HIPREX	Non – Preferred	
MACROBID	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACRODANTIN	Non – Preferred	
MONUROL	Preferred	
Urinary Antispasmodics - Drugs For The Urinary System		
*Beta-3 Adrenergic Agonists*** - Drugs For The Bladder		
MYRBETRIQ	Non – Preferred	
*Urinary Antispasmodic - Antimuscarinic (Anticholinergic)*** - Drugs For The Bladder		
<i>darifenacin hydrobromide er</i>	Non – Preferred	
<i>oxybutynin chloride er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride oral syrup</i>	Preferred	QL (20 ML per 1 day)
<i>oxybutynin chloride oral tablet</i>	Preferred	QL (4 EA per 1 day)
<i>solifenacin succinate</i>	Preferred	QL (1 EA per 1 day)
<i>tolterodine tartrate</i>	Non – Preferred	
<i>tolterodine tartrate er</i>	Non – Preferred	
<i>tropium chloride</i>	Non – Preferred	
<i>tropium chloride er</i>	Non – Preferred	QL (1 EA per 1 day)
DETROL	Non – Preferred	
DETROL LA	Non – Preferred	
DITROPAN XL	Non – Preferred	QL (1 EA per 1 day)
ENABLEX	Non – Preferred	
GELNIQUE	Non – Preferred	
OXYTROL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOVIAZ	Non – Preferred	
VESICARE	Non – Preferred	QL (1 EA per 1 day)
*Urinary Antispasmodic - Antimuscarinics (Antichol)*** (New) - Drugs For The Bladder		
<i>darifenacin hydrobromide er</i>	Non – Preferred	
<i>oxybutynin chloride er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride oral syrup</i>	Preferred	QL (20 ML per 1 day)
<i>oxybutynin chloride oral tablet</i>	Preferred	QL (4 EA per 1 day)
<i>solifenacin succinate</i>	Preferred	QL (1 EA per 1 day)
<i>tolterodine tartrate</i>	Non – Preferred	
<i>tolterodine tartrate er</i>	Non – Preferred	
<i>tropium chloride</i>	Non – Preferred	
<i>tropium chloride er</i>	Non – Preferred	QL (1 EA per 1 day)
DETROL	Non – Preferred	
DETROL LA	Non – Preferred	
DITROPAN XL	Non – Preferred	QL (1 EA per 1 day)
ENABLEX	Non – Preferred	
GELNIQUE	Non – Preferred	
OXYTROL	Non – Preferred	
TOVIAZ	Non – Preferred	
VESICARE	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Urinary Antispasmodics - Beta-3 Adrenergic Agonists*** - Drugs For The Bladder		
MYRBETRIQ	Non – Preferred	
*Urinary Antispasmodics - Cholinergic Agonists*** - Drugs For The Bladder		
<i>bethanechol chloride</i>	Preferred	
*Urinary Antispasmodics - Cholinergic Agonists*** (New) - Drugs For The Bladder		
<i>bethanechol chloride</i>	Preferred	
*Urinary Antispasmodics - Direct Muscle Relaxants*** - Drugs For The Bladder		
<i>flavoxate hcl</i>	Non – Preferred	QL (8 EA per 1 day)
*Urinary Antispasmodics - Direct Muscle Relaxants*** (New) - Drugs For The Bladder		
<i>flavoxate hcl</i>	Non – Preferred	QL (8 EA per 1 day)
Vaginal Products - Drugs For Women		
*Imidazole-Related Antifungals*** - Drugs For Infections		
<i>miconazole 3</i>	Preferred	QL (3 EA Max Qty Per Fill Retail)
<i>terconazole vaginal cream</i>	Preferred	
<i>terconazole vaginal suppository</i>	Preferred	QL (3 EA Max Qty Per Fill Retail)
GYNAZOLE-1	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*Miscellaneous Vaginal Combinations*** - Drugs For Infections		
TRIMO-SAN	Non – Preferred	
*Miscellaneous Vaginal Products*** - Drugs For Women		
INTRAROSA	Non – Preferred	
*Vaginal Anti-Infectives*** - Drugs For Infections		
<i>clindamycin phosphate</i>	Preferred	
<i>metronidazole</i>	Preferred	
CLEOCIN VAGINAL CREAM	Non – Preferred	
CLEOCIN VAGINAL SUPPOSITORY	Preferred	
CLINDESSE	Non – Preferred	
NUVESSA	Non – Preferred	
VANDAZOLE	Preferred	
*Vaginal Estrogens*** - Drugs For Women		
<i>estradiol vaginal cream</i>	Preferred	
<i>estradiol vaginal tablet</i>	Non – Preferred	QL (8 EA per 28 days)
ESTRACE	Non – Preferred	
ESTRING	Non – Preferred	QL (1 EA per 90 days)
FEMRING	Non – Preferred	
IMVEXXY MAINTENANCE PACK	Non – Preferred	
IMVEXXY STARTER PACK	Non – Preferred	
PREMARIN	Preferred	QL (60 GM per 30 days)
VAGIFEM	Non – Preferred	QL (8 EA per 28 days)
YUVAFEM	Non – Preferred	QL (8 EA per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>*Vaginal Progestins*** - Drugs For Women</i>		
CRINONE	Non – Preferred	
ENDOMETRIN	Preferred	
<i>*Vasopressors* - Drugs For The Heart</i>		
<i>*Anaphylaxis Therapy Agents*** - Drugs For Serious Allergic Reaction</i>		
<i>epinephrine solution auto-injector 0.15 mg/0.15ml injection</i>	Preferred	QL (4 UNIT per 365 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml injection</i>	Preferred	QL (4 EA per 365 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml injection</i>	Preferred	QL (4 UNIT per 365 days)
EPIPEN 2-PAK	Non – Preferred	QL (4 UNIT per 365 days)
EPIPEN JR 2-PAK	Non – Preferred	QL (4 EA per 365 days)
SYMJEPI	Non – Preferred	
<i>*Vasopressors*** - Drugs For Serious Allergic Reaction</i>		
<i>midodrine hcl</i>	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs

UPPERCASE BOLD = Brand name drugs

Drug Tier

Non – Preferred = Non – Preferred

Preferred = Preferred

AL = Age Restrictions

OTC = OTC Medications

PA = Prior Authorization Applies

QL = Quantity Limits

ST = Step Therapy Applies

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WEEKLY)	75	ZETIA	63	ZYLET	220
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WEEKLY)	75	ZIAC	69	ZYMAXID	216
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