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**. 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.**

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

Table of Contents

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs

Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

Coverage Requirements and Limits
AL = Age Restrictions
OTC = OTC Medications
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**		
****5-Ht4 Receptor Agonists*** - Drugs For The Stomach***		
MOTEGRITY	Non – Preferred	
Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb - Drugs For The Heart**		
****Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb*** - Drugs For The Heart***		
NEXLIZET	Non – Preferred	
Adenosine Receptor Antagonist - Drugs For The Nervous System**		
****Adenosine Receptor Antagonist*** - Drugs For The Nervous System***		
NOURIANZ	Non – Preferred	
Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors - Drugs For The Heart**		
****Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors*** - Drugs For The Heart***		
NEXLETOL	Non – 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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
amphetamine-dextroamphet er capsule extended release 24 hour 5 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 10 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 12.5 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 15 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 20 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 30 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 5 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 7.5 mg oral	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)

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

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**		
amphetamine er	Non – Preferred	AL (Min 6 Years)
amphetamine sulfate	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate er capsule extended release 24 hour 10 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate er capsule extended release 24 hour 15 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate er capsule extended release 24 hour 5 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate oral solution	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate oral tablet	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
methamphetamine hcl	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)

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

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)
Stimulants - Misc. - Drugs For Attention Deficit Disorder***		
armodafinil tablet 150 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methylphenidate hcl er tablet extended release 36 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er tablet extended release 54 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er tablet extended release 72 mg oral	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl oral solution	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
methylphenidate hcl oral tablet	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl oral tablet chewable	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
modafinil	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
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

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	

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Aminomethylcyclines - Drugs For Infections**		
****Aminomethylcyclines*** - Drugs For Infections***		
NUZYRA	Non – Preferred	
***Analgesics - Anti-Inflammatory* - Drugs For Pain And Fever**		
****Antirheumatic - Janus Kinase (Jak) Inhibitors*** - Arthritis And Pain Drugs***		
OLUMIANT	Non – Preferred	
RINVOQ	Non – Preferred	
XELJANZ	Preferred	PA
XELJANZ XR	Preferred	PA
****Antirheumatic Antimetabolites*** - Arthritis And Pain Drugs***		
OTREXUP	Non – Preferred	
RASUVO	Non – Preferred	
****Anti-Tnf-Alpha - Monoclonal Antibodies*** - Arthritis And Pain Drugs***		
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)

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

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	
****Anti-Tnf-Alpha - Monoclonoal Antibodies*** - Arthritis And Pain Drugs***		
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS	Preferred	PA; QL (2 SYRINGE per 180 days)

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

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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cyclooxygenase 2 (Cox-2) Inhibitors - Arthritis And Pain Drugs***		
celecoxib	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***		
diclofenac-misoprostol	Non – Preferred	
naproxen-esomeprazole	Non – Preferred	
ARTHROTEC	Non – Preferred	
DUEXIS	Non – Preferred	
VIMOVO	Non – 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tolmetin sodium	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	
Pyrimidine Synthesis Inhibitors - Arthritis And Pain Drugs***		
leflunomide	Preferred	QL (1 EA per 1 day)
ARAVA	Non – Preferred	QL (1 EA per 1 day)
Selective Costimulation Modulators - Arthritis And Pain Drugs***		
ORENCIA	Non – Preferred	
ORENCIA CLICKJECT	Non – Preferred	
Soluble Tumor Necrosis Factor Receptor Agents - Arthritis And Pain Drugs***		
ENBREL MINI	Preferred	PA; QL (4 PEN per 28 days)

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

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***		
butalbital-acetaminophen oral capsule	Non – Preferred	
butalbital-acetaminophen tablet 50-300 mg oral	Preferred	
butalbital-acetaminophen tablet 50-325 mg oral	Preferred	QL (6 EA per 1 day)
butalbital-apap-caffeine capsule 50-300-40 mg oral	Preferred	
butalbital-apap-caffeine capsule 50-325-40 mg oral	Preferred	QL (6 EA per 1 day)
butalbital-apap-caffeine oral tablet	Preferred	QL (6 EA per 1 day)
butalbital-aspirin-caffeine oral capsule	Preferred	QL (6 EA per 1 day)
butalbital-aspirin-caffeine oral tablet	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	

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

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***		
diflunisal	Preferred	
salsalate	Preferred	
***Analgesics - Opioid* - Drugs For Pain And Fever**		
Codeine Combinations - Arthritis And Pain Drugs***		
acetaminophen-codeine #2	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
acetaminophen-codeine #3	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
acetaminophen-codeine #4	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
acetaminophen-codeine oral solution	Preferred	QL (20 ML per 1 day); AL (Min 18 Years)
acetaminophen-codeine oral tablet	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
butalbital-apap-caff-cod capsule 50-300-40-30 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
butalbital-apap-caff-cod capsule 50-325-40-30 mg oral	Non – Preferred	AL (Min 18 Years)
butalbital-asa-caff-codeine	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)

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

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
morphine sulfate suppository 10 mg rectal	Preferred	QL (4 EA per 1 day)
morphine sulfate suppository 20 mg rectal	Preferred	QL (4 EA per 1 day)
morphine sulfate suppository 30 mg rectal	Preferred	QL (3 EA per 1 day)
morphine sulfate suppository 5 mg rectal	Preferred	QL (4 EA per 1 day)
morphine sulfate tablet 15 mg oral	Preferred	QL (4 EA per 1 day)
morphine sulfate tablet 30 mg oral	Preferred	QL (3 EA per 1 day)
oxycodone hcl er	Non – Preferred	
oxycodone hcl oral capsule	Preferred	QL (4 EA per 1 day)
oxycodone hcl oral concentrate	Preferred	QL (6 ML per 1 day)
oxycodone hcl oral solution	Preferred	QL (60 ML per 1 day)
oxycodone hcl tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
oxycodone hcl tablet 15 mg oral	Preferred	QL (4 EA per 1 day)
oxycodone hcl tablet 20 mg oral	Preferred	QL (3 EA per 1 day)
oxycodone hcl tablet 30 mg oral	Preferred	QL (4 EA per 1 day)
oxycodone hcl tablet 5 mg oral	Preferred	QL (4 EA per 1 day)
oxymorphone hcl	Non – Preferred	
oxymorphone hcl er	Non – Preferred	QL (2 EA per 1 day)
tramadol hcl er	Non – Preferred	AL (Min 18 Years)
tramadol hcl er (biphasic)	Non – Preferred	AL (Min 18 Years)
tramadol hcl tablet 100 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
tramadol hcl tablet 50 mg oral	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
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

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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZOHYDRO ER	Non – Preferred	
Opioid Combinations - Arthritis And Pain Drugs**		
benzhydrocodone-acetaminophen	Non – Preferred	
nalocet	Non – Preferred	
oxycodone-acetaminophen	Preferred	QL (4 EA per 1 day)
oxycodone-aspirin	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**		
buprenorphine	Non – Preferred	QL (4 EA per 28 days)
buprenorphine hcl tablet sublingual 2 mg sublingual	Preferred	QL (3 EA per 1 day)
buprenorphine hcl tablet sublingual 8 mg sublingual	Preferred	QL (2 EA per 1 day)
buprenorphine hcl-naloxone hcl sublingual film	Preferred	
buprenorphine hcl-naloxone hcl tablet sublingual 2-0.5 mg sublingual	Preferred	QL (3 EA per 1 day)
buprenorphine hcl-naloxone hcl tablet sublingual 8-2 mg sublingual	Preferred	QL (2 EA per 1 day)
butorphanol tartrate	Non – Preferred	QL (2.5 ML per 30 days)
pentazocine-naloxone hcl	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	

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

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

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***		
lidocaine-hydrocort (perianal)	Non – Preferred	
lidocaine-hydrocortisone ace	Non – Preferred	
ANA-LEX	Non – Preferred	
PROCTOFOAM HC	Non – Preferred	
Rectal Steroids - Rectal Preparations***		
hydrocortisone (perianal)	Preferred	
ANUSOL-HC	Non – Preferred	
PROCTO-MED HC	Preferred	
PROCTOZONE-HC	Preferred	
Anthelmintics - Drugs For Infections***		
Anthelmintics - Drugs For Parasites***		
albendazole	Non – Preferred	
benznidazole	Non – Preferred	
ivermectin	Non – Preferred	
praziquantel	Preferred	
ALBENZA	Non – Preferred	
BILTRICIDE	Non – Preferred	
EMVERM	Non – Preferred	
STROMECTOL	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antianginal Agents* - Drugs For The Heart**		
****Antianginals-Other*** - Drugs For Angina***		
ranolazine er	Non – Preferred	
RANEXA	Non – Preferred	
****Nitrates*** - Drugs For Angina***		
isosorbide dinitrate	Preferred	
isosorbide mononitrate	Preferred	
isosorbide mononitrate er tablet extended release 24 hour 120 mg oral	Preferred	QL (2 EA per 1 day)
isosorbide mononitrate er tablet extended release 24 hour 30 mg oral	Preferred	QL (1 EA per 1 day)
isosorbide mononitrate er tablet extended release 24 hour 60 mg oral	Preferred	QL (1 EA per 1 day)
nitroglycerin sublingual	Preferred	
nitroglycerin transdermal	Preferred	
nitroglycerin translingual	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	

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clorazepate dipotassium tablet 15 mg oral	Preferred	QL (3 EA per 1 day)
clorazepate dipotassium tablet 3.75 mg oral	Preferred	QL (2 EA per 1 day)
clorazepate dipotassium tablet 7.5 mg oral	Preferred	QL (3 EA per 1 day)
diazepam oral concentrate	Preferred	QL (10 ML per 1 day)
diazepam oral solution	Preferred	QL (10 ML per 1 day)
diazepam oral tablet	Preferred	QL (4 EA per 1 day)
lorazepam oral concentrate	Preferred	QL (2 ML per 1 day)
lorazepam tablet 0.5 mg oral	Preferred	QL (4 EA per 1 day)
lorazepam tablet 1 mg oral	Preferred	QL (6 EA per 1 day)
lorazepam tablet 2 mg oral	Preferred	QL (5 EA per 1 day)
oxazepam	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***		
disopyramide phosphate	Preferred	
quinidine gluconate er	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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluticasone-salmeterol aerosol powder breath activated 113-14 mcg/act inhalation	Non – Preferred	QL (1 EA per 30 days)
fluticasone-salmeterol aerosol powder breath activated 232-14 mcg/act inhalation	Non – Preferred	QL (1 EA per 30 days)
fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/dose inhalation	Non – Preferred	QL (2 EA per 1 day)
fluticasone-salmeterol aerosol powder breath activated 500-50 mcg/dose inhalation	Non – Preferred	QL (2 EA per 1 day)
fluticasone-salmeterol aerosol powder breath activated 55-14 mcg/act inhalation	Non – Preferred	QL (1 EA per 30 days)
ipratropium-albuterol	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)

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

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**		
cromolyn sodium	Preferred	
Beta Adrenergics - Drugs For Asthma/Copd**		
albuterol sulfate er	Non – Preferred	
albuterol sulfate hfa	Preferred	QL (36 GM per 30 days)
albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083% inhalation	Preferred	QL (12 ML per 1 day)
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	Preferred	QL (2 ML per 1 day)
albuterol sulfate nebulization solution 0.63 mg/3ml inhalation	Preferred	QL (12 ML per 1 day)
albuterol sulfate nebulization solution 1.25 mg/3ml inhalation	Preferred	QL (12 ML per 1 day)
albuterol sulfate nebulization solution 2.5 mg/0.5ml inhalation	Preferred	QL (2 EA per 1 day)
albuterol sulfate oral syrup	Preferred	
albuterol sulfate oral tablet	Non – Preferred	
levalbuterol hcl	Preferred	
levalbuterol tartrate	Preferred	QL (30 GM per 30 days)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
terbutaline sulfate	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)
Bronchodilators - Anticholinergics - Drugs For Asthma/Copd**		
ipratropium bromide	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
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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Leukotriene Receptor Antagonists - Drugs For Asthma/Copd***		
montelukast sodium	Preferred	QL (1 EA per 1 day)
zafirlukast	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***		
budesonide	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

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

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 REDIHALER AEROSOL BREATH ACTIVATED 40 MCG/ACT INHALATION	Non – Preferred	QL (0.3533 GM per 1 day)
QVAR REDIHALER AEROSOL BREATH ACTIVATED 80 MCG/ACT INHALATION	Non – Preferred	
Xanthines - Drugs For Asthma/Copd**		
theophylline	Preferred	
theophylline er	Preferred	
THEO-24	Preferred	
Anti-Cataplectic Combinations - Drugs For The Nervous System**		
Anti-Cataplectic Combinations - Drugs For The Nervous System**		
XYWAV	Non – Preferred	
***Anticoagulants* - Drugs For The Blood**		
Coumarin Anticoagulants - Drugs To Prevent Blood Clots**		
warfarin sodium	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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANTOVEN	Preferred	
Direct Factor Xa Inhibitors - Drugs To Prevent Blood Clots***		
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
Heparins And Heparinoid-Like Agents - Drugs To Prevent Blood Clots***		
heparin sodium (porcine)	Preferred	
heparin sodium (porcine) pf	Preferred	
Low Molecular Weight Heparins - Drugs To Prevent Blood Clots***		
enoxaparin sodium	Preferred	
FRAGMIN	Preferred	
LOVENOX	Non – Preferred	
Synthetic Heparinoid-Like Agents - Drugs To Prevent Blood Clots***		
fondaparinux sodium	Preferred	
ARIXTRA	Non – Preferred	
Thrombin Inhibitors - Selective Direct & Reversible - Drugs To Prevent Blood Clots***		
PRADAXA	Non – 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

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***		
clobazam	Non – Preferred	
clonazepam oral tablet	Preferred	
clonazepam oral tablet dispersible	Non – Preferred	
diazepam	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***		
carbamazepine	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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levetiracetam tablet 500 mg oral	Preferred	QL (6 EA per 1 day)
levetiracetam tablet 750 mg oral	Preferred	QL (4 EA per 1 day)
oxcarbazepine	Preferred	
pregabalin	Preferred	
primidone	Preferred	
topiramate er	Non – Preferred	
topiramate oral capsule sprinkle	Preferred	QL (4 EA per 1 day)
topiramate tablet 100 mg oral	Preferred	QL (4 EA per 1 day)
topiramate tablet 200 mg oral	Preferred	QL (2 EA per 1 day)
topiramate tablet 25 mg oral	Preferred	QL (4 EA per 1 day)
topiramate tablet 50 mg oral	Preferred	QL (4 EA per 1 day)
zonisamide	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	

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

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)

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

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**		
felbamate	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**		
tiagabine hcl tablet 12 mg oral	Non – Preferred	QL (4 EA per 1 day)
tiagabine hcl tablet 16 mg oral	Non – Preferred	QL (3 EA per 1 day)
tiagabine hcl tablet 2 mg oral	Non – Preferred	QL (1 EA per 1 day)
tiagabine hcl tablet 4 mg oral	Non – Preferred	QL (4 EA per 1 day)
vigabatrin	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)

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

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**		
phenytoin	Preferred	
phenytoin sodium extended	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**		
ethosuximide	Preferred	
CELONTIN	Non – Preferred	
ZARONTIN	Non – Preferred	
Valproic Acid - Drugs For Seizures /Personality Disorder/Nerve Pain**		
divalproex sodium	Preferred	
divalproex sodium er	Preferred	
valproic acid	Preferred	
DEPAKOTE	Non – Preferred	
DEPAKOTE ER	Non – Preferred	
DEPAKOTE SPRINKLES	Non – 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

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluvoxamine maleate er	Non – Preferred	
fluvoxamine maleate tablet 100 mg oral	Preferred	QL (3 EA per 1 day)
fluvoxamine maleate tablet 25 mg oral	Preferred	QL (1 EA per 1 day)
fluvoxamine maleate tablet 50 mg oral	Preferred	QL (1 EA per 1 day)
paroxetine hcl er	Non – Preferred	
paroxetine hcl tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
paroxetine hcl tablet 20 mg oral	Preferred	QL (1 EA per 1 day)
paroxetine hcl tablet 30 mg oral	Preferred	QL (2 EA per 1 day)
paroxetine hcl tablet 40 mg oral	Preferred	QL (1.5 EA per 1 day)
sertraline hcl oral concentrate	Preferred	QL (120 ML per 30 days)
sertraline hcl oral tablet	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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Serotonin-Norepinephrine Reuptake Inhibitors (Snris) - Drugs For Depression***		
desvenlafaxine er	Non – Preferred	
desvenlafaxine succinate er	Non – Preferred	
duloxetine hcl capsule delayed release particles 20 mg oral	Preferred	QL (1 EA per 1 day)
duloxetine hcl capsule delayed release particles 30 mg oral	Preferred	QL (1 EA per 1 day)
duloxetine hcl capsule delayed release particles 40 mg oral	Preferred	QL (1 EA per 1 day)
duloxetine hcl capsule delayed release particles 60 mg oral	Preferred	QL (2 EA per 1 day)
venlafaxine hcl	Preferred	
venlafaxine hcl er oral capsule extended release 24 hour	Preferred	QL (1 EA per 1 day)
venlafaxine hcl er oral tablet extended release 24 hour	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***		
amitriptyline hcl	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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
amoxapine	Non – Preferred	
clomipramine hcl	Preferred	
desipramine hcl tablet 10 mg oral	Preferred	
desipramine hcl tablet 100 mg oral	Preferred	
desipramine hcl tablet 150 mg oral	Preferred	
desipramine hcl tablet 25 mg oral	Preferred	QL (2 EA per 1 day)
desipramine hcl tablet 50 mg oral	Preferred	
desipramine hcl tablet 75 mg oral	Preferred	
doxepin hcl	Preferred	
imipramine hcl	Preferred	
imipramine pamoate	Non – Preferred	
nortriptyline hcl	Preferred	
protriptyline hcl	Preferred	
trimipramine maleate	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***		
acarbose	Preferred	QL (3 EA per 1 day)
miglitol	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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Biguanides - Drugs For Diabetes**		
metformin hcl er (mod)	Preferred	
metformin hcl er (osm)	Preferred	
metformin hcl er tablet extended release 24 hour 500 mg oral	Preferred	QL (4 EA per 1 day)
metformin hcl er tablet extended release 24 hour 750 mg oral	Preferred	QL (2 EA per 1 day)
metformin hcl oral solution	Non – Preferred	
metformin hcl oral tablet	Preferred	
FORTAMET	Non – Preferred	
GLUMETZA	Non – Preferred	
RIOMET	Non – Preferred	
RIOMET ER	Non – Preferred	
Diabetic Other - Drugs For Diabetes**		
diazoxide	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**		
alogliptin benzoate	Non – Preferred	QL (1 EA per 1 day)

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

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)
Dipeptidyl Peptidase-4 Inhibitor-Biguanide Combinations - Drugs For Diabetes**		
alogliptin-metformin hcl	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	
Dopamine Receptor Agonists - Ergot Derivatives - Drugs For Diabetes**		
CYCLOSET	Non – Preferred	
Dpp-4 Inhibitor-Thiazolidinedione Combinations - Drugs For Diabetes**		
alogliptin-pioglitazone tablet 12.5-15 mg oral	Non – Preferred	QL (1 EA per 1 day)
alogliptin-pioglitazone tablet 12.5-30 mg oral	Non – Preferred	QL (1 EA per 1 day)
alogliptin-pioglitazone tablet 12.5-45 mg oral	Non – Preferred	
alogliptin-pioglitazone tablet 25-15 mg oral	Non – Preferred	QL (1 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
alogliptin-pioglitazone tablet 25-30 mg oral	Non – Preferred	QL (1 EA per 1 day)
alogliptin-pioglitazone tablet 25-45 mg oral	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)
Human Insulin - Drugs For Diabetes***		
insulin asp prot & asp flexpen	Non – Preferred	
insulin aspart	Non – Preferred	
insulin aspart flexpen	Non – Preferred	
insulin aspart penfill	Non – Preferred	
insulin aspart prot & aspart	Non – Preferred	
insulin lispro	Preferred	
insulin lispro (1 unit dial)	Preferred	
insulin lispro junior kwikpen	Preferred	QL (1 ML per 1 day)
insulin lispro prot & lispro	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	

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
Incretin Mimetic Agents (Glp-1 Receptor Agonists) - Drugs For Diabetes***		
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)
Meglitinide Analogues - Drugs For Diabetes***		
nateglinide	Preferred	QL (3 EA per 1 day)
repaglinide tablet 0.5 mg oral	Non – Preferred	QL (4 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
repaglinide tablet 1 mg oral	Non – Preferred	QL (4 EA per 1 day)
repaglinide tablet 2 mg oral	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**		
glipizide-metformin hcl tablet 2.5-250 mg oral	Preferred	QL (2 EA per 1 day)
glipizide-metformin hcl tablet 2.5-500 mg oral	Preferred	QL (2 EA per 1 day)
glipizide-metformin hcl tablet 5-500 mg oral	Preferred	QL (4 EA per 1 day)
glyburide-metformin tablet 1.25-250 mg oral	Preferred	QL (2 EA per 1 day)
glyburide-metformin tablet 2.5-500 mg oral	Preferred	QL (2 EA per 1 day)
glyburide-metformin tablet 5-500 mg oral	Preferred	QL (4 EA per 1 day)
Sulfonylureas - Drugs For Diabetes**		
glimepiride tablet 1 mg oral	Preferred	QL (1 EA per 1 day)
glimepiride tablet 2 mg oral	Preferred	QL (1 EA per 1 day)
glimepiride tablet 4 mg oral	Preferred	QL (2 EA per 1 day)
glipizide	Preferred	
glipizide er tablet extended release 24 hour 10 mg oral	Preferred	QL (2 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
glipizide er tablet extended release 24 hour 2.5 mg oral	Preferred	QL (1 EA per 1 day)
glipizide er tablet extended release 24 hour 5 mg oral	Preferred	QL (1 EA per 1 day)
glipizide xl tablet extended release 24 hour 10 mg oral	Preferred	QL (2 EA per 1 day)
glipizide xl tablet extended release 24 hour 2.5 mg oral	Preferred	QL (1 EA per 1 day)
glipizide xl tablet extended release 24 hour 5 mg oral	Preferred	QL (1 EA per 1 day)
glyburide	Preferred	
glyburide micronized tablet 1.5 mg oral	Preferred	QL (1 EA per 1 day)
glyburide micronized tablet 3 mg oral	Preferred	QL (1 EA per 1 day)
glyburide micronized tablet 6 mg oral	Preferred	
tolbutamide	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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sulfonylurea-Thiazolidinedione Combinations - Drugs For Diabetes***		
pioglitazone hcl-glimepiride	Non – Preferred	
DUETACT	Non – Preferred	
Thiazolidinedione-Biguanide Combinations - Drugs For Diabetes***		
pioglitazone hcl-metformin hcl	Non – Preferred	
ACTOPLUS MET	Non – Preferred	
Thiazolidinediones - Drugs For Diabetes***		
pioglitazone hcl	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***		
deferasirox	Non – Preferred	
deferasirox granules	Non – Preferred	
deferiprone	Non – Preferred	
CHEMET	Preferred	
EXJADE	Non – Preferred	
FERRIPROX	Non – Preferred	
FERRIPROX TWICE-A-DAY	Non – Preferred	
JADENU	Non – Preferred	
JADENU SPRINKLE	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Opioid Antagonists - Drugs For Overdose Or Poisoning**		
naloxone hcl injection solution	Preferred	
naloxone hcl injection solution cartridge	Preferred	
naloxone hcl injection solution prefilled syringe	Preferred	QL (4 ML Max Qty Per Fill Retail)
naltrexone hcl	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**		
granisetron hcl	Non – Preferred	QL (8 EA per 28 days)
ondansetron	Preferred	QL (3 EA per 1 day)
ondansetron hcl oral solution	Preferred	QL (50 ML Max Qty Per Fill Retail)
ondansetron hcl oral tablet	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**		
doxylamine-pyridoxine	Non – Preferred	
AKYNZEO	Non – Preferred	
BONJESTA	Non – Preferred	
DICLEGIS	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiemetics - Anticholinergic - Drugs For Vomiting And Nausea***		
meclizine hcl	Preferred	
scopolamine	Preferred	
trimethobenzamide hcl	Non – Preferred	
TIGAN	Non – Preferred	
TRANSDERM-SCOP (1.5 MG)	Preferred	
Antiemetics - Miscellaneous - Drugs For Vomiting And Nausea***		
dronabinol	Non – Preferred	
MARINOL	Non – Preferred	
Substance P/Neurokinin 1 (Nk1) Receptor Antagonists - Drugs For Vomiting And Nausea***		
aprepitant	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***		
micafungin sodium	Preferred	
Antifungals - Drugs For Fungus***		
flucytosine	Non – Preferred	
griseofulvin microsize	Preferred	
griseofulvin ultramicrosize	Preferred	
nystatin	Preferred	QL (6 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
terbinafine hcl	Preferred	QL (1 EA per 1 day)
ANCOBON	Non – Preferred	
Imidazoles - Drugs For Fungus**		
ketoconazole	Preferred	QL (1 EA per 1 day)
Triazoles - Drugs For Fungus**		
fluconazole in sodium chloride	Preferred	
fluconazole oral suspension reconstituted	Preferred	
fluconazole tablet 100 mg oral	Preferred	QL (2 EA per 1 day)
fluconazole tablet 150 mg oral	Preferred	QL (2 EA Max Qty Per Fill Retail)
fluconazole tablet 200 mg oral	Preferred	QL (2 EA per 1 day)
fluconazole tablet 50 mg oral	Preferred	QL (2 EA per 1 day)
itraconazole oral capsule	Non – Preferred	QL (4 EA per 1 day)
itraconazole oral solution	Non – Preferred	
posaconazole	Non – Preferred	
tolsura	Non – Preferred	
voriconazole	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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihemophilic Products - Monoclonal Antibodies - Drugs For The Blood**		
****Antihemophilic Products - Monoclonal Antibodies*** - Drugs For The Blood***		
HEMLIBRA	Preferred	PA
***Antihistamines* - Drugs For The Lungs**		
****Antihistamines - Alkylamines*** - Drugs For Allergies***		
aller-chlor	Preferred	OTC
allergy	Preferred	OTC
allergy relief	Preferred	OTC
chlorpheniramine maleate	Preferred	
WAL-FINATE	Preferred	OTC
***Antihyperlipidemics* - Drugs For The Heart**		
****Antihyperlipidemics - Misc.*** - Drugs For Cholesterol***		
omega-3-acid ethyl esters	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***		
cholestyramine	Preferred	
cholestyramine light	Preferred	
colesevelam hcl	Non – Preferred	
colestipol hcl	Non – Preferred	
COLESTID	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COLESTID FLAVORED	Non – Preferred	
PREVALITE	Preferred	
QUESTRAN	Non – Preferred	
QUESTRAN LIGHT	Non – Preferred	
WELCHOL	Non – Preferred	
Fibric Acid Derivatives - Drugs For Cholesterol**		
fenofibrate	Preferred	
fenofibrate micronized	Preferred	
fenofibric acid	Preferred	
gemfibrozil	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**		
atorvastatin calcium	Preferred	QL (1 EA per 1 day)
fluvastatin sodium	Non – Preferred	QL (1 EA per 1 day)
fluvastatin sodium er	Non – Preferred	QL (1 EA per 1 day)
lovastatin tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
lovastatin tablet 20 mg oral	Preferred	QL (1 EA per 1 day)
lovastatin tablet 40 mg oral	Preferred	QL (2 EA per 1 day)
pravastatin sodium	Preferred	QL (1 EA per 1 day)
rosuvastatin calcium	Preferred	QL (1 EA per 1 day)
simvastatin	Preferred	QL (1 EA per 1 day)

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

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	
Intest Cholest Absorp Inhib-Hmg Coa Reductase Inhib Comb - Drugs For Cholesterol**		
ezetimibe-simvastatin	Non – Preferred	
VYTORIN	Non – Preferred	
Intestinal Cholesterol Absorption Inhibitors - Drugs For Cholesterol**		
ezetimibe	Preferred	QL (1 EA per 1 day)
ZETIA	Non – Preferred	QL (1 EA per 1 day)
Microsomal Triglyceride Transfer Protein Inhibitors - Drugs For Cholesterol**		
JUXTAPID	Non – Preferred	
Nicotinic Acid Derivatives - Drugs For Cholesterol**		
niacin er (antihyperlipidemic)	Non – Preferred	
NIASPAN	Non – 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

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***		
amlodipine besy-benazepril hcl	Preferred	QL (1 EA per 1 day)
trandolapril-verapamil hcl er	Preferred	
LOTREL	Non – Preferred	QL (1 EA per 1 day)
TARKA	Non – Preferred	
****Ace Inhibitors & Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure***		
benazepril-hydrochlorothiazide	Preferred	QL (1 EA per 1 day)
captopril-hydrochlorothiazide	Preferred	QL (2 EA per 1 day)
enalapril-hydrochlorothiazide tablet 10-25 mg oral	Preferred	QL (2 EA per 1 day)
enalapril-hydrochlorothiazide tablet 5-12.5 mg oral	Preferred	QL (1 EA per 1 day)
fosinopril sodium-hctz	Preferred	
lisinopril-hydrochlorothiazide tablet 10-12.5 mg oral	Preferred	QL (1 EA per 1 day)
lisinopril-hydrochlorothiazide tablet 20-12.5 mg oral	Preferred	QL (1 EA per 1 day)
lisinopril-hydrochlorothiazide tablet 20-25 mg oral	Preferred	QL (2 EA per 1 day)
quinapril-hydrochlorothiazide	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
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

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**		
benazepril hcl	Preferred	QL (2 EA per 1 day)
captopril	Preferred	QL (3 EA per 1 day)
enalapril maleate	Preferred	QL (2 EA per 1 day)
fosinopril sodium	Preferred	QL (2 EA per 1 day)
lisinopril	Preferred	QL (2 EA per 1 day)
moexipril hcl	Preferred	
perindopril erbumine tablet 2 mg oral	Non – Preferred	QL (1 EA per 1 day)
perindopril erbumine tablet 4 mg oral	Non – Preferred	QL (1 EA per 1 day)
perindopril erbumine tablet 8 mg oral	Non – Preferred	QL (2 EA per 1 day)
quinapril hcl	Preferred	QL (2 EA per 1 day)
ramipril	Preferred	QL (2 EA per 1 day)
trandolapril tablet 1 mg oral	Preferred	QL (1 EA per 1 day)
trandolapril tablet 2 mg oral	Preferred	QL (1 EA per 1 day)
trandolapril tablet 4 mg oral	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**		
methyldopa-hydrochlorothiazide	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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Angiotensin Ii Receptor Antagonists - Drugs For High Blood Pressure***		
candesartan cilexetil	Non – Preferred	QL (1 EA per 1 day)
irbesartan	Preferred	QL (1 EA per 1 day)
losartan potassium tablet 100 mg oral	Preferred	QL (1 EA per 1 day)
losartan potassium tablet 25 mg oral	Preferred	QL (2 EA per 1 day)
losartan potassium tablet 50 mg oral	Preferred	QL (2 EA per 1 day)
olmesartan medoxomil	Non – Preferred	
telmisartan	Non – Preferred	
valsartan	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***		
amlodipine-valsartan-hctz	Non – Preferred	
olmesartan-amlodipine-hctz	Non – Preferred	
EXFORGE HCT	Non – Preferred	
TRIBENZOR	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiadrenergics - Centrally Acting - Drugs For High Blood Pressure***		
clonidine	Preferred	
clonidine hcl	Preferred	
guanfacine hcl tablet 1 mg oral	Preferred	QL (8 EA per 1 day)
guanfacine hcl tablet 2 mg oral	Preferred	QL (4 EA per 1 day)
methyldopa	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***		
doxazosin mesylate tablet 1 mg oral	Preferred	QL (1 EA per 1 day)
doxazosin mesylate tablet 2 mg oral	Preferred	QL (1 EA per 1 day)
doxazosin mesylate tablet 4 mg oral	Preferred	QL (1 EA per 1 day)
doxazosin mesylate tablet 8 mg oral	Preferred	QL (2 EA per 1 day)
prazosin hcl	Preferred	QL (4 EA per 1 day)
terazosin hcl capsule 1 mg oral	Preferred	QL (1 EA per 1 day)
terazosin hcl capsule 10 mg oral	Preferred	QL (2 EA per 1 day)
terazosin hcl capsule 2 mg oral	Preferred	QL (2 EA per 1 day)
terazosin hcl capsule 5 mg oral	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
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

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***		
atenolol-chlorthalidone	Preferred	
bisoprolol-hydrochlorothiazide	Preferred	
metoprolol-hydrochlorothiazide	Preferred	
propranolol-hctz	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***		
aliskiren fumarate	Non – Preferred	
TEKTURNA	Non – Preferred	
Selective Aldosterone Receptor Antagonists (Saras) - Drugs For High Blood Pressure***		
eplerenone	Non – Preferred	
INSPRA	Non – Preferred	
Vasodilators - Drugs For High Blood Pressure***		
hydralazine hcl	Preferred	
minoxidil	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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antimalarials* - Drugs For Infections**		
****Antimalarial Combinations*** - Drugs For Parasites***		
atovaquone-proguanil hcl tablet 250-100 mg oral	Preferred	QL (12 EA Max Qty Per Fill Retail)
atovaquone-proguanil hcl tablet 62.5-25 mg oral	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***		
chloroquine phosphate	Preferred	
hydroxychloroquine sulfate	Preferred	
mefloquine hcl	Preferred	
primaquine phosphate	Preferred	QL (28 EA Max Qty Per Fill Retail)
pyrimethamine	Non – Preferred	
quinine sulfate	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***		
guanidine hcl	Non – Preferred	
pyridostigmine bromide	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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Tropomyosin Receptor Kinase Inhibitors - Drugs For Cancer**		
****Antineoplastic - Tropomyosin Receptor Kinase Inhibitors*** - Drugs For Cancer***		
ROZLYTREK	Non – Preferred	
VITRAKVI	Non – Preferred	
Antineoplastic - Xpo1 Inhibitors - Drugs For Cancer**		
****Antineoplastic - Xpo1 Inhibitors*** - Drugs For Cancer***		
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**		
****Antineoplastic Or Premalignant Lesion Agent - Comb*** - Drugs For The Skin***		
ORMECA	Non – 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antimetabolites - Drugs For Cancer**		
capecitabine tablet 150 mg oral	Non – Preferred	QL (140 EA per 21 days)
capecitabine tablet 500 mg oral	Non – Preferred	QL (154 EA per 21 days)
mercaptopurine	Preferred	
methotrexate	Preferred	
methotrexate sodium (pf)	Preferred	
methotrexate sodium oral	Preferred	
methotrexate sodium solution 250 mg/10ml injection	Preferred	QL (10 VIAL per 28 days)
methotrexate sodium solution 50 mg/2ml injection	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	

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

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***		
everolimus	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
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

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***		
erlotinib hcl	Preferred	QL (1 EA per 1 day)
imatinib mesylate tablet 100 mg oral	Non – Preferred	QL (3 EA per 1 day)
imatinib mesylate tablet 400 mg oral	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
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

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	
TAGRISSO	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	

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

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***		
hydroxyurea	Preferred	
HYDREA	Non – Preferred	
MATULANE	Preferred	
Aromatase Inhibitors - Drugs For Cancer***		
anastrozole	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
exemestane	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
letrozole	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	

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Selective Retinoid X Receptor Agonists - Drugs For Cancer**		
bexarotene	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**		
benztropine mesylate	Preferred	
trihexyphenidyl hcl	Preferred	
Antiparkinson Dopaminergics - Drugs For Parkinson**		
amantadine hcl	Preferred	
bromocriptine mesylate	Preferred	
GOCOVRI	Non – Preferred	
INBRIJA	Non – Preferred	
OSMOLEX ER	Non – Preferred	
PARLODEL	Non – Preferred	
Antiparkinson Monoamine Oxidase Inhibitors - Drugs For Parkinson**		
rasagiline mesylate	Non – Preferred	
selegiline hcl	Preferred	
AZILECT	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XADAGO	Non – Preferred	
ZELAPAR	Non – Preferred	
Central/Peripheral Comt Inhibitors - Drugs For Parkinson**		
tolcapone	Non – Preferred	
TASMAR	Non – Preferred	
Decarboxylase Inhibitors - Drugs For Parkinson**		
carbidopa	Preferred	
LODOSYN	Non – Preferred	
Levodopa Combinations - Drugs For Parkinson**		
carbidopa-levodopa er	Preferred	
carbidopa-levodopa oral tablet	Preferred	
carbidopa-levodopa oral tablet dispersible	Non – Preferred	
carbidopa-levodopa-entacapone	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**		
pramipexole dihydrochloride	Preferred	
pramipexole dihydrochloride er	Non – Preferred	
ropinirole hcl	Preferred	QL (3 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ropinirole hcl er tablet extended release 24 hour 12 mg oral	Non – Preferred	QL (2 EA per 1 day)
ropinirole hcl er tablet extended release 24 hour 2 mg oral	Non – Preferred	QL (1 EA per 1 day)
ropinirole hcl er tablet extended release 24 hour 4 mg oral	Non – Preferred	
ropinirole hcl er tablet extended release 24 hour 6 mg oral	Non – Preferred	QL (1 EA per 1 day)
ropinirole hcl er tablet extended release 24 hour 8 mg oral	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**		
entacapone	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**		
lithium	Preferred	QL (40 ML per 1 day)
lithium carbonate capsule 150 mg oral	Preferred	QL (16 EA per 1 day)
lithium carbonate capsule 300 mg oral	Preferred	QL (8 EA per 1 day)
lithium carbonate capsule 600 mg oral	Preferred	QL (4 EA per 1 day)
lithium carbonate er tablet extended release 300 mg oral	Preferred	QL (8 EA per 1 day)
lithium carbonate er tablet extended release 450 mg oral	Preferred	QL (6 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lithium carbonate oral tablet	Preferred	QL (8 EA per 1 day)
LITHOBID	Non – Preferred	QL (8 EA per 1 day)
Antipsychotics - Misc. - Drugs For Severe Mental Disorders***		
ziprasidone hcl	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
ziprasidone mesylate	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)

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

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**		
paliperidone er tablet extended release 24 hour 1.5 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
paliperidone er tablet extended release 24 hour 3 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
paliperidone er tablet extended release 24 hour 6 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
paliperidone er tablet extended release 24 hour 9 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
risperidone oral solution	Non – Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
risperidone tablet 0.25 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 0.5 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 1 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 2 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 3 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
risperidone tablet 4 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
risperidone tablet dispersible 0.25 mg oral	Non – Preferred	AL (Min 8 Years)
risperidone tablet dispersible 0.5 mg oral	Non – Preferred	AL (Min 8 Years)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
risperidone tablet dispersible 1 mg oral	Non – Preferred	AL (Min 8 Years)
risperidone tablet dispersible 2 mg oral	Non – Preferred	AL (Min 8 Years)
risperidone tablet dispersible 3 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
risperidone tablet dispersible 4 mg oral	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)

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

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)
Butyrophenones - Drugs For Severe Mental Disorders**		
haloperidol lactate	Preferred	QL (50 ML per 1 day)
haloperidol tablet 0.5 mg oral	Preferred	QL (5 EA per 1 day)
haloperidol tablet 1 mg oral	Preferred	QL (10 EA per 1 day)
haloperidol tablet 10 mg oral	Preferred	QL (10 EA per 1 day)
haloperidol tablet 2 mg oral	Preferred	QL (10 EA per 1 day)
haloperidol tablet 20 mg oral	Preferred	QL (5 EA per 1 day)
haloperidol tablet 5 mg oral	Preferred	QL (5 EA per 1 day)
Dibenzodiazepines - Drugs For Severe Mental Disorders**		
clozapine tablet 100 mg oral	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
clozapine tablet 200 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
clozapine tablet 200 mg oral	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
clozapine tablet 25 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
quetiapine fumarate er tablet extended release 24 hour 300 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate er tablet extended release 24 hour 400 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate er tablet extended release 24 hour 50 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 100 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 200 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 25 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 25 mg oral	Preferred	QL (3 EA per 1 day)
quetiapine fumarate tablet 300 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 400 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 50 mg oral	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)

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

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)
Dibenzoxazepines - Drugs For Severe Mental Disorders**		
loxapine succinate capsule 10 mg oral	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
loxapine succinate capsule 25 mg oral	Preferred	QL (10 EA per 1 day); AL (Min 8 Years)
loxapine succinate capsule 5 mg oral	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
loxapine succinate capsule 50 mg oral	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
ADASUVE	Non – Preferred	AL (Min 8 Years)
Dihydroindolones - Drugs For Severe Mental Disorders**		
molindone hcl	Non – Preferred	
Phenothiazines - Drugs For Severe Mental Disorders**		
chlorpromazine hcl tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
chlorpromazine hcl tablet 100 mg oral	Preferred	QL (4 EA per 1 day)
chlorpromazine hcl tablet 200 mg oral	Preferred	QL (5 EA per 1 day)
chlorpromazine hcl tablet 25 mg oral	Preferred	QL (4 EA per 1 day)
chlorpromazine hcl tablet 50 mg oral	Preferred	QL (4 EA per 1 day)
fluphenazine hcl oral concentrate	Preferred	QL (8 ML per 1 day)
fluphenazine hcl oral elixir	Preferred	QL (80 ML per 1 day)

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

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

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

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)
Thienbenzodiazepines - Drugs For Severe Mental Disorders***		
olanzapine intramuscular	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
olanzapine oral	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)

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antivirals* - Drugs For Infections**		
****Antiretroviral Combinations*** - Drugs For Viral Infections***		
abacavir sulfate-lamivudine	Preferred	QL (1 EA per 1 day)
abacavir-lamivudine-zidovudine	Preferred	QL (2 EA per 1 day)
efavirenz-lamivudine-tenofovir	Non – Preferred	QL (1 EA per 1 day)
lamivudine-zidovudine	Preferred	QL (2 EA per 1 day)
lopinavir-ritonavir	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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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***		
atazanavir sulfate capsule 150 mg oral	Preferred	QL (1 EA per 1 day)
atazanavir sulfate capsule 200 mg oral	Preferred	QL (2 EA per 1 day)
atazanavir sulfate capsule 300 mg oral	Preferred	QL (1 EA per 1 day)
fosamprenavir calcium	Preferred	QL (4 EA per 1 day)
ritonavir	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)

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

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***		
efavirenz capsule 200 mg oral	Preferred	QL (1 EA per 1 day)
efavirenz capsule 50 mg oral	Preferred	QL (2 EA per 1 day)
efavirenz oral tablet	Preferred	QL (1 EA per 1 day)
nevirapine er	Preferred	QL (1 EA per 1 day)
nevirapine oral suspension	Preferred	QL (40 ML per 1 day)
nevirapine oral tablet	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)

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

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***		
abacavir sulfate oral solution	Preferred	QL (30 ML per 1 day)
abacavir sulfate oral tablet	Preferred	QL (2 EA per 1 day)
didanosine	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***		
emtricitabine	Preferred	QL (1 EA per 1 day)
lamivudine oral solution	Preferred	QL (30 ML per 1 day)
lamivudine tablet 150 mg oral	Preferred	QL (2 EA per 1 day)
lamivudine tablet 300 mg oral	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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretrovirals - Rti-Nucleoside Analogues-Thymidines - Drugs For Viral Infections***		
stavudine capsule 15 mg oral	Preferred	QL (1 EA per 1 day)
stavudine capsule 20 mg oral	Preferred	QL (1 EA per 1 day)
stavudine capsule 30 mg oral	Preferred	QL (2 EA per 1 day)
stavudine capsule 40 mg oral	Preferred	QL (2 EA per 1 day)
zidovudine oral capsule	Preferred	QL (2 EA per 1 day)
zidovudine oral syrup	Preferred	QL (60 ML per 1 day)
zidovudine oral tablet	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***		
tenofovir disoproxil fumarate	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***		
valganciclovir hcl oral solution reconstituted	Non – Preferred	
valganciclovir hcl oral tablet	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***		
adefovir dipivoxil	Non – Preferred	
entecavir	Preferred	QL (1 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lamivudine	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)
Hepatitis C Agents - Drugs For Viral Infections***		
ribavirin	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	
Herpes Agents - Purine Analogues - Drugs For Viral Infections***		
acyclovir oral capsule	Preferred	QL (50 EA per 30 days)
acyclovir oral suspension	Preferred	QL (400 ML per 30 days)
acyclovir oral tablet	Preferred	QL (2 EA per 1 day)
valacyclovir hcl tablet 1 gm oral	Preferred	QL (30 EA per 30 days)
valacyclovir hcl tablet 500 mg oral	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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Herpes Agents - Thymidine Analogues - Drugs For Viral Infections***		
famciclovir	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
Influenza Agents - Drugs For Viral Infections***		
rimantadine hcl	Non – Preferred	QL (14 EA Max Qty Per Fill Retail)
Neuraminidase Inhibitors - Drugs For Viral Infections***		
oseltamivir phosphate oral capsule	Preferred	QL (10 EA per 30 days)
oseltamivir phosphate oral suspension reconstituted	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***		
ribavirin	Preferred	
VIRAZOLE	Non – Preferred	
***Assorted Classes* - Vitamins And Minerals**		
Antileprotics - Vitamins And Minerals***		
THALOMID	Non – 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

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***		
penicillamine oral capsule	Preferred	
penicillamine oral tablet	Preferred	QL (8 EA per 1 day)
trientine hcl	Preferred	
CLOVIQUE	Preferred	
CUPRIMINE	Non – Preferred	
DEPEN TITRATABS	Preferred	QL (8 EA per 1 day)
SYPRINE	Non – Preferred	
Cyclosporine Analogs - Vitamins And Minerals***		
cyclosporine	Preferred	
cyclosporine modified	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***		
mycophenolate mofetil	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMURAN	Non – Preferred	
Atopic Dermatitis - Monoclonal Antibodies - Drugs For The Skin**		
****Atopic Dermatitis - Monoclonal Antibodies*** - Drugs For The Skin***		
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**		
****Alpha-Beta Blockers*** - Drugs For High Blood Pressure***		
carvedilol	Preferred	QL (2 EA per 1 day)
carvedilol phosphate er	Non – Preferred	
labetalol hcl	Preferred	
COREG	Non – Preferred	QL (2 EA per 1 day)
COREG CR	Non – Preferred	
****Beta Blockers Cardio-Selective*** - Drugs For High Blood Pressure***		
acebutolol hcl	Preferred	
atenolol	Preferred	
betaxolol hcl	Preferred	
bisoprolol fumarate tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
bisoprolol fumarate tablet 5 mg oral	Preferred	QL (1 EA per 1 day)
metoprolol succinate er tablet extended release 24 hour 100 mg oral	Preferred	QL (1.5 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
metoprolol succinate er tablet extended release 24 hour 200 mg oral	Preferred	QL (2 EA per 1 day)
metoprolol succinate er tablet extended release 24 hour 25 mg oral	Preferred	QL (1 EA per 1 day)
metoprolol succinate er tablet extended release 24 hour 50 mg oral	Preferred	QL (1.5 EA per 1 day)
metoprolol tartrate	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)
Beta Blockers Non-Selective - Drugs For High Blood Pressure**		
nadolol	Preferred	QL (2 EA per 1 day)
pindolol	Preferred	
propranolol hcl	Preferred	
propranolol hcl er	Preferred	QL (1 EA per 1 day)
sotalol hcl	Preferred	
sotalol hcl (af)	Non – Preferred	
timolol maleate	Preferred	
BETAPACE	Non – 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

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**		
****Bile Acid Synthesis Disorder Agents*** - Drugs For The Stomach***		
CHOLBAM	Non – Preferred	
Calcitonin Gene-Related Peptide (Cgrp) Receptor Antag - Drugs For The Nervous System**		
****Calcitonin Gene-Related Peptide (Cgrp) Receptor Antag*** - Drugs For The Nervous System***		
AIMOVIG	Preferred	PA
AJOVY	Non – Preferred	
EMGALITY	Non – Preferred	PA
EMGALITY (300 MG DOSE)	Non – Preferred	
VYEPTI	Non – 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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
verapamil hcl	Preferred	QL (4 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 100 mg oral	Preferred	QL (2 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 120 mg oral	Preferred	QL (1 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 180 mg oral	Preferred	QL (1 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 200 mg oral	Preferred	QL (2 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 240 mg oral	Preferred	QL (2 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 300 mg oral	Preferred	QL (1 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 360 mg oral	Preferred	QL (1 EA per 1 day)
verapamil hcl er oral tablet extended release	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)

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

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)

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

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)

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

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

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

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***		
ambrisentan	Non – Preferred	PA; QL (1 EA per 1 day)
bosentan	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***		
sildenafil citrate intravenous	Non – Preferred	
sildenafil citrate oral suspension reconstituted	Non – Preferred	PA
sildenafil citrate oral tablet	Preferred	PA; QL (3 EA per 1 day)
tadalafil (pah)	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)

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cefprozil tablet 250 mg oral	Non – Preferred	QL (20 EA Max Qty Per Fill Retail)
cefprozil tablet 500 mg oral	Non – Preferred	
cefuroxime axetil	Preferred	
Cephalosporins - 3Rd Generation - Antibiotics**		
cefdinir	Preferred	
cefixime oral capsule	Preferred	QL (1 EA Max Qty Per Fill Retail)
cefixime oral suspension reconstituted	Non – Preferred	
cefpodoxime proxetil	Non – Preferred	
ceftazidime	Preferred	
ceftazidime and dextrose	Preferred	
ceftriaxone sodium	Preferred	
ceftriaxone sodium in dextrose	Preferred	
ceftriaxone sodium-dextrose	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**		
cefepime hcl	Preferred	
cefepime-dextrose	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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cgrp Receptor Antagonists - Monocolonal Antibodies - Drugs For The Nervous System**		
****Cgrp Receptor Antagonists - Monocolonal Antibodies*** - Drugs For The Nervous System***		
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**		
****Cic Agents - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For The Stomach***		
TRULANCE	Non – Preferred	
***Contraceptives* - Drugs For Women**		
****Biphasic Contraceptives - Oral*** - Birth Control Pills***		
desogestrel-ethinyl estradiol	Preferred	AL (Min 10 Years and Max 55 Years)
viorele	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)

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

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***		
alyacen 1/35	Preferred	AL (Min 10 Years and Max 55 Years)
briellyn	Preferred	AL (Min 10 Years and Max 55 Years)
drospiren-eth estrad-levomefol	Preferred	AL (Min 10 Years and Max 55 Years)
drospirenone-ethinyl estradiol	Preferred	AL (Min 10 Years and Max 55 Years)
ethynodiol diac-eth estradiol	Preferred	AL (Min 10 Years and Max 55 Years)
levonorgestrel-ethinyl estrad	Preferred	AL (Min 10 Years and Max 55 Years)
marlissa	Preferred	AL (Min 10 Years and Max 55 Years)
norethin ace-eth estrad-fe	Preferred	AL (Min 10 Years and Max 55 Years)
norethindrone acet-ethinyl est	Preferred	AL (Min 10 Years and Max 55 Years)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethin-eth estradiol-fe	Preferred	AL (Min 10 Years and Max 55 Years)
norgestimate-eth estradiol	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)

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

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)
CRYSELLE-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
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

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)

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

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
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

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)

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

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
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

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)

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

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***		
etonogestrel-ethinyl estradiol	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***		
levonorgestrel-ethinyl estrad	Preferred	AL (Min 10 Years and Max 55 Years)
AMETHYST	Preferred	AL (Min 10 Years and Max 55 Years)
Emergency Contraceptives - Birth Control Pills***		
levonorgestrel	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
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

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***		
levonorgest-eth est & eth est	Preferred	AL (Min 10 Years and Max 55 Years)
levonorgest-eth estrad 91-day tablet 0.1-0.02 & 0.01 mg oral	Preferred	AL (Min 10 Years and Max 55 Years)
levonorgest-eth estrad 91-day tablet 0.15-0.03 &0.01 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 10 Years and Max 55 Years)
levonorgest-eth estrad 91-day tablet 0.15-0.03 mg oral	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
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

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***		
medroxyprogesterone acetate intramuscular suspension	Preferred	QL (1 VIAL per 84 days); AL (Min 10 Years and Max 55 Years)
medroxyprogesterone acetate intramuscular suspension prefilled syringe	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
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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPO-SUBQ PROVERA 104	Preferred	AL (Min 10 Years and Max 55 Years)
Progestin Contraceptives - Oral - Birth Control Pills***		
norethindrone	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
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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Triphasic Contraceptives - Oral - Birth Control Pills***		
alyacen 7/7/7	Preferred	AL (Min 10 Years and Max 55 Years)
levonorg-eth estrad triphasic	Preferred	AL (Min 10 Years and Max 55 Years)
norgestim-eth estrad triphasic	Preferred	AL (Min 10 Years and Max 55 Years)
ARANELLE	Preferred	AL (Min 10 Years and Max 55 Years)
CAZIANT	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
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

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
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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
prednisone tablet therapy pack 5 mg (21) oral	Preferred	
prednisone tablet therapy pack 5 mg (48) oral	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	
Mineralocorticoids - Drugs For Inflammation**		
fludrocortisone acetate	Preferred	
Cortisol Synthesis Inhibitors - Hormones**		
Cortisol Synthesis Inhibitors - Hormones**		
ISTURISA	Non – 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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clindamycin phosphate external swab	Preferred	QL (2 EA per 1 day); AL (Min 10 Years and Max 20 Years)
dapsone	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ery	Non – Preferred	QL (2 EA per 1 day); AL (Min 10 Years and Max 20 Years)
erythromycin external gel	Non – Preferred	QL (1 GM per 1 day); AL (Min 10 Years and Max 20 Years)
erythromycin solution 2 % external	Preferred	QL (2 ML per 1 day); AL (Min 10 Years and Max 20 Years)
erythromycin solution 2 % external	Preferred	QL (2 ML per 1 day)
sulfacetamide sodium (acne)	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
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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Acne Combinations - Drugs For The Skin***		
adapalene-benzoyl peroxide	Non – Preferred	AL (Min 10 Years and Max 20 Years)
benzoyl peroxide-erythromycin	Non – Preferred	AL (Min 10 Years and Max 20 Years)
bp 10-1	Non – Preferred	AL (Min 10 Years and Max 20 Years)
bp cleansing wash	Non – Preferred	AL (Min 10 Years and Max 20 Years)
clindamycin phos-benzoyl perox	Non – Preferred	AL (Min 10 Years and Max 20 Years)
clindamycin-tretinoin	Non – Preferred	AL (Min 10 Years and Max 20 Years)
sss 10-5	Non – Preferred	AL (Min 10 Years and Max 20 Years)
sulfacetamide sodium-sulfur	Non – Preferred	AL (Min 10 Years and Max 20 Years)
sulfacetamide-sulfur in urea	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
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

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**		
adapalene external cream	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
adapalene external solution	Non – Preferred	
adapalene gel 0.1 % external (rx)	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
adapalene gel 0.3 % external	Non – Preferred	AL (Min 10 Years and Max 20 Years)
isotretinoin capsule 10 mg oral	Non – Preferred	AL (Min 12 Years)
isotretinoin capsule 20 mg oral	Non – Preferred	AL (Min 12 Years)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
isotretinoin capsule 30 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
isotretinoin capsule 40 mg oral	Non – Preferred	AL (Min 12 Years)
tretinoin external cream	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years and Max 20 Years)
tretinoin gel 0.01 % external	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
tretinoin gel 0.025 % external	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years and Max 20 Years)
tretinoin gel 0.05 % external	Non – Preferred	AL (Min 10 Years and Max 20 Years)
tretinoin microsphere	Non – Preferred	AL (Min 10 Years and Max 20 Years)
tretinoin microsphere pump	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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)

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

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)
Agents For External Genital And Perianal Warts - Drugs For The Skin***		
VEREGEN	Non – Preferred	
Antibiotic Steroid Combinations - Topical - Drugs For The Skin***		
CORTISPORIN EXTERNAL CREAM	Non – Preferred	
CORTISPORIN EXTERNAL OINTMENT	Preferred	
NEO-SYNALAR	Non – Preferred	
Antibiotics - Topical - Drugs For The Skin***		
gentamicin sulfate	Preferred	
mupirocin	Non – Preferred	QL (110 GM per 30 days); AL (Max 20 Years)
mupirocin calcium	Non – Preferred	AL (Max 20 Years)
CENTANY	Non – Preferred	QL (110 GM per 30 days); AL (Max 20 Years)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CENTANY AT	Non – Preferred	
XEPI	Non – Preferred	
Antifungals - Topical Combinations - Drugs For The Skin**		
clotrimazole-betamethasone external cream	Non – Preferred	QL (60 GM per 30 days)
clotrimazole-betamethasone external lotion	Non – Preferred	
miconazole-zinc oxide-petrolat	Non – Preferred	
nystatin-triamcinolone	Non – Preferred	
ECONASIL	Non – Preferred	
VUSION	Non – Preferred	
ZOLPAK	Non – Preferred	
Antifungals - Topical - Drugs For The Skin**		
ciclopirox external gel	Non – Preferred	
ciclopirox external shampoo	Non – Preferred	QL (120 ML per 30 days)
ciclopirox external solution	Non – Preferred	QL (6.6 ML per 30 days)
ciclopirox olamine external cream	Non – Preferred	QL (60 GM per 30 days)
ciclopirox olamine external suspension	Non – Preferred	QL (30 ML per 30 days)
ciclopirox treatment	Non – Preferred	
naftifine hcl	Non – Preferred	
nystatin external cream	Preferred	QL (60 GM per 30 days)
nystatin external ointment	Preferred	QL (60 GM per 30 days)
nystatin external powder	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)

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

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**		
diclofenac epolamine	Non – Preferred	
diclofenac sodium external gel	Non – Preferred	QL (200 GM per 30 days)
diclofenac sodium external solution	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**		
fluorouracil	Non – Preferred	
CARAC	Non – Preferred	
EFUDEX	Non – Preferred	
TOLAK	Non – 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

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***		
diclofenac sodium	Non – Preferred	
Antineoplastic Retinoids - Topical - Drugs For The Skin***		
PANRETIN	Preferred	
Antipruritics - Topical - Drugs For The Skin***		
doxepin hcl	Non – Preferred	
PRUDOXIN	Non – Preferred	
ZONALON	Non – Preferred	
Antipsoriatics - Systemic - Drugs For The Skin***		
acitretin	Non – Preferred	
methoxsalen rapid	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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TALTZ	Non – Preferred	
TREMFYA	Non – Preferred	
Antipsoriatics - Drugs For The Skin**		
calcipotriene external cream	Preferred	QL (4 GM per 1 day)
calcipotriene external ointment	Preferred	QL (4 GM per 1 day)
calcipotriene external solution	Preferred	QL (60 ML Max Qty Per Fill Retail)
calcitriol	Non – Preferred	
tazarotene	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**		
selenium sulfide external lotion	Preferred	
selenium sulfide external shampoo	Non – Preferred	
sulfacetamide sodium	Non – Preferred	
OVACE PLUS	Non – Preferred	
Antiviral Topical Combinations - Drugs For The Skin**		
XERESE	Non – Preferred	
Antivirals - Topical - Drugs For The Skin**		
acyclovir external cream	Non – Preferred	
acyclovir external ointment	Non – Preferred	QL (15 GM per 30 days)
DENAVIR	Non – 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

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**		
mafenide acetate	Preferred	
silver sulfadiazine	Preferred	
SILVADENE	Non – Preferred	
SSD	Preferred	
SULFAMYLON EXTERNAL CREAM	Preferred	
SULFAMYLON EXTERNAL PACKET	Non – Preferred	
Cauterizing Agent Combinations - Drugs For The Skin**		
grafco silver nit applicator	Non – Preferred	
ARZOL SILVER NIT APPLICATORS	Non – Preferred	
Cauterizing Agents - Drugs For The Skin**		
silver nitrate	Non – Preferred	
Corticosteroids - Topical - Drugs For The Skin**		
alclometasone dipropionate	Preferred	QL (60 GM per 30 days)
amcinonide	Non – Preferred	
betamethasone dipropionate aug external cream	Non – Preferred	QL (45 GM Max Qty Per Fill Retail)
betamethasone dipropionate aug external gel	Non – Preferred	QL (60 GM per 30 days)
betamethasone dipropionate aug external lotion	Non – Preferred	QL (60 ML per 30 days)
betamethasone dipropionate aug external ointment	Non – Preferred	QL (60 GM per 30 days)

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

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

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrocortisone cream 2.5 % external	Preferred	QL (90 0 per 30 days)
hydrocortisone external lotion	Preferred	QL (120 ML per 30 days)
hydrocortisone external ointment	Preferred	QL (90 GM per 30 days)
hydrocortisone valerate	Preferred	
mometasone furoate external cream	Preferred	QL (45 GM per 30 days)
mometasone furoate external ointment	Preferred	QL (45 GM Max Qty Per Fill Retail)
mometasone furoate external solution	Preferred	QL (60 ML Max Qty Per Fill Retail)
prednicarbate	Non – Preferred	
psorcon	Non – Preferred	QL (60 GM per 30 days)
triamcinolone acetonide external aerosol solution	Non – Preferred	
triamcinolone acetonide external cream	Preferred	QL (90 GM per 30 days)
triamcinolone acetonide external lotion	Preferred	QL (120 ML per 30 days)
triamcinolone acetonide ointment 0.025 % external	Preferred	QL (90 GM per 30 days)
triamcinolone acetonide ointment 0.05 % external	Non – Preferred	
triamcinolone acetonide ointment 0.1 % external	Preferred	
triamcinolone acetonide ointment 0.5 % external	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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORDRAN	Non – Preferred	
CUTIVATE	Non – Preferred	
DERMA-SMOOTHE/FS BODY	Non – Preferred	
DERMA-SMOOTHE/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	

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

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

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**		
imiquimod	Non – Preferred	QL (12 PACKET per 30 days); AL (Min 10 Years)
imiquimod pump	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**		
bensal hp	Non – Preferred	
Keratolytic/Antimitotic Agents - Drugs For The Skin**		
podocon	Non – Preferred	
podofilox	Preferred	
salicylic acid external foam	Non – Preferred	
salicylic acid external gel	Preferred	
salicylic acid wart remover	Preferred	
CONDYLOX	Preferred	
SALEX	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Local Anesthetics - Topical - Drugs For The Skin**		
lidocaine external ointment	Preferred	QL (50 GM per 30 days)
lidocaine external patch	Non – Preferred	QL (3 EA per 1 day)
lidocaine hcl	Preferred	
lidocaine hcl urethral/mucosal external gel	Preferred	QL (30 ML Max Qty Per Fill Retail)
lidocaine hcl urethral/mucosal external prefilled syringe	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**		
pimecrolimus	Preferred	PA
tacrolimus	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	

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

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***		
azelaic acid	Non – Preferred	
doxycycline	Non – Preferred	
metronidazole	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***		
gnp lice treatment	Preferred	OTC; QL (240 ML per 30 days)
hm lice killing max st	Preferred	OTC; QL (240 ML per 30 days)
lice killing	Preferred	OTC; QL (240 ML per 30 days)
lice killing maximum strength	Preferred	OTC; QL (240 ML per 30 days)
sm lice killing max strength	Preferred	OTC; QL (240 ML per 30 days)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Scabicides & Pediculicides - Drugs For The Skin**		
gnp lice treatment	Preferred	OTC; QL (118 ML per 30 days)
hm lice treatment	Preferred	OTC; QL (118 ML per 30 days)
lice treatment	Preferred	OTC
lindane	Non – Preferred	
malathion	Non – Preferred	
permethrin	Preferred	QL (60 GM Max Qty Per Fill Retail)
sm lice treatment	Preferred	OTC
spinosad	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**		
lidocaine-prilocaine	Non – Preferred	
APRIZIO PAK II	Non – Preferred	
EMPRICAINE-II	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUVAKAAN-II	Non – Preferred	
PLIAGLIS	Non – Preferred	
PRIZOPAK II	Non – Preferred	
PRIZOTRAL-II	Non – Preferred	
SYNERA	Non – Preferred	
Topical Selective Retinoid X Receptor Agonists - Drugs For The Skin**		
TARGRETIN	Preferred	
Topical Steroid Combinations - Drugs For The Skin**		
calcipotriene-betameth diprop	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	
Wound Care - Growth Factor Agents - Drugs For The Skin**		
REGRANEX	Non – Preferred	
Wound Care Combinations - Drugs For The Skin**		
bpco	Non – 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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
verasens blood glucose test	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)

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

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)

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

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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)

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

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
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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMART SENSE VALUE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SMARTEST 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**		
****Digestive Enzymes*** - Drugs For The Stomach***		
CREON	Preferred	
PANCREAZE	Preferred	
PERTZYE	Non – Preferred	
VIOKACE	Non – Preferred	
ZENPEP	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LASIX	Non – Preferred	
Potassium Sparing Diuretics - Drugs For High Blood Pressure**		
amiloride hcl	Preferred	
spironolactone	Preferred	
triamterene	Preferred	
ALDACTONE	Non – Preferred	
CAROSPIR	Non – Preferred	
Thiazides And Thiazide-Like Diuretics - Drugs For High Blood Pressure**		
chlorthalidone	Preferred	
hydrochlorothiazide	Preferred	
indapamide	Preferred	
metolazone	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**		
mifepristone	Non – Preferred	
MIFEPREX	Non – 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dopamine Receptor Agonists - Drugs For Women***		
cabergoline	Preferred	QL (16 EA per 30 days)
Fabry Disease - Agents - Drugs For Menopause And Bone Loss***		
GALAFOLD	Non – Preferred	
Gnrh/Lhrh Antagonists - Drugs For Women***		
ORILISSA	Preferred	PA
Growth Hormone Releasing Hormones (Ghrh) - Drugs For Growth***		
EGRIFTA SV	Non – Preferred	
Growth Hormones - Drugs For Growth***		
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	

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

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***		
nitisinone	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***		
calcitriol	Preferred	
doxercalciferol	Preferred	
paricalcitol	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	

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

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***		
sapropterin dihydrochloride	Non – Preferred	
KUVAN	Non – Preferred	
Selective Estrogen Receptor Modulators (Serms) - Drugs For Menopause And Bone Loss***		
raloxifene hcl	Non – Preferred	
EVISTA	Non – Preferred	
OSPHENA	Non – Preferred	
Selective Vasopressin V2-Receptor Antagonists - Hormones***		
tolvaptan	Non – Preferred	
JYNARQUE	Non – Preferred	
SAMSCA	Non – Preferred	
Somatostatic Agents - Drugs For Growth***		
octreotide acetate	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	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Urea Cycle Disorder - Agents - Drugs For Menopause And Bone Loss***		
sodium phenylbutyrate	Non – Preferred	
BUPHENYL	Non – Preferred	
RAVICTI	Non – Preferred	
Vasopressin - Hormones***		
desmopressin ace spray refrig	Preferred	QL (5 ML per 30 days)
desmopressin acetate	Preferred	QL (3 EA per 1 day)
desmopressin acetate spray	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***		
estradiol-norethindrone acet	Preferred	QL (1 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone-eth estradiol	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**		
estradiol oral	Preferred	
estradiol patch twice weekly 0.025 mg/24hr transdermal	Preferred	QL (8 PATCH per 28 days)
estradiol patch twice weekly 0.0375 mg/24hr transdermal	Preferred	QL (8 PATCH per 28 days)
estradiol patch twice weekly 0.05 mg/24hr transdermal	Preferred	QL (8 EA per 28 days)
estradiol patch twice weekly 0.075 mg/24hr transdermal	Preferred	QL (8 EA per 28 days)
estradiol patch twice weekly 0.1 mg/24hr transdermal	Preferred	QL (8 EA per 28 days)
estradiol patch weekly 0.025 mg/24hr transdermal	Preferred	
estradiol patch weekly 0.0375 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
estradiol patch weekly 0.05 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol patch weekly 0.06 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol patch weekly 0.075 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol patch weekly 0.1 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol valerate	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	

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

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)

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

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**		
****Estrogen-Selective Estrogen Receptor Modulator Comb*** - Hormones***		
DUAVEE	Non – Preferred	
Farnesoid X Receptor (Fxr) Agonists - Drugs For The Liver**		
****Farnesoid X Receptor (Fxr) Agonists*** - Drugs For The Liver***		
OCALIVA	Non – Preferred	
***Fluoroquinolones* - Drugs For Infections**		
****Fluoroquinolones*** - Antibiotics***		
ciprofloxacin hcl tablet 100 mg oral	Preferred	QL (30 EA Max Qty Per Fill Retail); AL (Min 16 Years)
ciprofloxacin hcl tablet 250 mg oral	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
ciprofloxacin hcl tablet 500 mg oral	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
ciprofloxacin hcl tablet 750 mg oral	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
ciprofloxacin in d5w	Preferred	
levofloxacin in d5w	Preferred	
levofloxacin intravenous	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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gastrointestinal Stimulants - Drugs For The Stomach***		
metoclopramide hcl oral solution	Preferred	
metoclopramide hcl oral tablet	Preferred	
metoclopramide hcl oral tablet dispersible	Non – Preferred	
REGLAN	Non – Preferred	
Glucagon-Like Peptide-2 (Glp-2) Analogs - 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***		
alosetron hcl	Non – Preferred	
LOTRONEX	Non – Preferred	
Inflammatory Bowel Agents - Drugs For Inflammatory Bowel Disease***		
balsalazide disodium	Preferred	
mesalamine er	Non – Preferred	QL (4 EA per 1 day)
mesalamine oral capsule delayed release	Non – Preferred	QL (6 EA per 1 day)
mesalamine rectal enema	Preferred	
mesalamine rectal suppository	Preferred	QL (42 EA per 30 days)
mesalamine tablet delayed release 1.2 gm oral	Non – Preferred	QL (4 EA per 1 day)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
mesalamine tablet delayed release 800 mg oral	Non – Preferred	QL (6 EA per 1 day)
mesalamine-cleanser	Non – Preferred	
sulfasalazine	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	
Intestinal Acidifiers - Drugs For The Stomach**		
enulose	Preferred	AL (Max 20 Years)
generlac	Preferred	AL (Max 20 Years)
lactulose encephalopathy solution 10 gm/15ml oral	Preferred	AL (Max 20 Years)
lactulose encephalopathy solution 10 gm/15ml oral	Preferred	
Peripheral Opioid Receptor Antagonists - Drugs For The Stomach**		
ENTEREG	Non – Preferred	
MOVANTIK	Non – Preferred	QL (1 EA per 1 day)
RELISTOR	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPROIC	Non – Preferred	QL (1 EA per 1 day)
Phosphate Binder Agents - Drugs For The Stomach***		
calcium acetate	Preferred	
calcium acetate (phos binder)	Preferred	
lanthanum carbonate	Preferred	
sevelamer carbonate oral packet	Non – Preferred	
sevelamer carbonate oral tablet	Preferred	
sevelamer hcl	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	
RENVELA	Non – Preferred	
VELPHORO	Non – Preferred	
Tumor Necrosis Factor Alpha Blockers - Drugs For Inflammatory Bowel Disease***		
AVSOLA	Non – Preferred	
CIMZIA	Non – Preferred	
CIMZIA PREFILLED	Preferred	PA
CIMZIA STARTER KIT	Preferred	PA
INFLECTRA	Non – Preferred	
REMICADE	Non – Preferred	
RENFLEXIS	Non – 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

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

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**		
dutasteride-tamsulosin hcl	Non – Preferred	
JALYN	Non – Preferred	
Urinary Analgesics - Drugs For Infections**		
phenazopyridine hcl	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**		
vancomycin hcl capsule 125 mg oral	Preferred	QL (4 EA per 1 day)

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
obizur	Preferred	PA
rixubis	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

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

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**		
icatibant acetate	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**		
pentoxifylline er	Preferred	
Phosphodiesterase Iii Inhibitors - Drugs For The Blood**		
cilostazol	Non – Preferred	
Plasma Kallikrein Inhibitors - Drugs For The Blood**		
KALBITOR	Non – Preferred	
Platelet Aggregation Inhibitor Combinations - Drugs For The Blood**		
aspirin-dipyridamole er	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCRIT	Preferred	PA
RETACRIT	Non – Preferred	
Granulocyte Colony-Stimulating Factors (G-Csf) - Drugs For Nutrition***		
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	
Granulocyte/Macrophage Colony-Stimulating Factor(Gm-Csf) - Drugs For Nutrition***		
LEUKINE	Preferred	
Thrombopoietin (Tpo) Receptor Agonists - Drugs For Nutrition***		
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
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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
flurazepam hcl	Non – Preferred	
midazolam hcl	Non – Preferred	
temazepam capsule 15 mg oral	Preferred	QL (1 EA per 1 day)
temazepam capsule 22.5 mg oral	Preferred	
temazepam capsule 30 mg oral	Preferred	QL (1 EA per 1 day)
temazepam capsule 7.5 mg oral	Preferred	
triazolam	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	
Hypnotics - Tricyclic Agents - Drugs For Insomnia**		
doxepin hcl	Non – Preferred	
SILENOR	Non – Preferred	
Non-Benzodiazepine - Gaba-Receptor Modulators - Drugs For Insomnia**		
eszopiclone	Non – Preferred	
zaleplon	Non – Preferred	
zolpidem tartrate er	Non – Preferred	
zolpidem tartrate oral	Preferred	QL (1 EA per 1 day)
zolpidem tartrate sublingual	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	

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Interleukin Antagonists - Drugs For The Stomach**		
****Interleukin Antagonists*** - Drugs For The Stomach***		
STELARA	Non – Preferred	
Interleukin-5 Antagonists (Igg1 Kappa) - Drugs For The Lungs**		
****Interleukin-5 Antagonists (Igg1 Kappa)*** - Drugs For The Lungs***		
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**		
****Interleukin-5 Antagonists (Igg4 Kappa)*** - Drugs For The Lungs***		
CINQAIR	Non – Preferred	
Isocitrate Dehydrogenase-1 (Idh1) Inhibitors - Drugs For Cancer**		
****Isocitrate Dehydrogenase-1 (Idh1) Inhibitors*** - Drugs For Cancer***		
TIBSOVO	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Isocitrate Dehydrogenase-2 (Idh2) Inhibitors - Drugs For Cancer**		
****Isocitrate Dehydrogenase-2 (Idh2) Inhibitors*** - Drugs For Cancer***		
IDHIFA	Non – Preferred	
Lymphocyte Function-Associated Antigen-1 (Lfa-1) Antag - Drugs For The Eye**		
****Lymphocyte Function-Associated Antigen-1 (Lfa-1) Antag*** - Drugs For The Eye***		
XIIDRA	Non – Preferred	
***Macrolides* - Drugs For Infections**		
****Azithromycin*** - Antibiotics***		
azithromycin oral packet	Preferred	
azithromycin oral suspension reconstituted	Preferred	QL (30 ML Max Qty Per Fill Retail)
azithromycin tablet 250 mg oral	Preferred	QL (6 EA Max Qty Per Fill Retail)
azithromycin tablet 500 mg oral	Preferred	QL (4 EA per 1 day)
azithromycin tablet 600 mg oral	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
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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Clarithromycin - Antibiotics**		
clarithromycin er	Preferred	QL (14 EA Max Qty Per Fill Retail)
clarithromycin oral suspension reconstituted	Preferred	QL (150 ML Max Qty Per Fill Retail)
clarithromycin oral tablet	Preferred	QL (28 EA Max Qty Per Fill Retail)
Erythromycins - Antibiotics**		
erythromycin	Preferred	
erythromycin base	Preferred	
erythromycin ethylsuccinate	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**		
blood glucose monitor system	Non – Preferred	OTC
blood glucose system pak	Non – Preferred	OTC
diatrue plus blood glucose	Non – Preferred	OTC
easy plus ii glucose system	Non – Preferred	OTC
easy talk blood glucose system	Non – Preferred	OTC

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
easy trak blood glucose system	Non – Preferred	OTC
easy trak ii blood glucose sys	Non – Preferred	OTC
element compact glucose system	Non – Preferred	OTC
element compact v glucose sys	Non – Preferred	OTC
ge100 blood glucose system	Non – Preferred	OTC
ght blood glucose monitor	Non – Preferred	OTC
goodsense blood glucose	Non – Preferred	OTC
kroger blood glucose	Non – Preferred	OTC
kroger premium blood glucose	Non – Preferred	OTC
ldr blood glucose truetest	Non – Preferred	OTC
liberty blood glucose meter	Non – Preferred	OTC
meijer blood glucose	Non – Preferred	OTC
meijer essential blood glucose	Non – Preferred	OTC
meijer premium blood glucose	Non – Preferred	OTC
one drop blood glucose monitor	Non – Preferred	OTC
pro voice v8 glucose system	Non – Preferred	OTC
pro voice v9 glucose system	Non – Preferred	OTC
ra blood glucose monitor	Non – Preferred	OTC
tgt blood glucose monitoring	Non – Preferred	OTC
verasens blood glucose meter	Non – Preferred	OTC
verasens blood glucose system	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
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

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

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

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

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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

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

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

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

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

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

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
Insulin Administration Supplies - Medical Supplies And Durable Medical Equipment***		
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**		
Ergot Combinations - Drugs For Migraine Headaches***		
CAFERGOT	Non – Preferred	
MIGERGOT	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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sumatriptan succinate subcutaneous solution	Preferred	QL (4 VIAL per 28 days)
sumatriptan succinate subcutaneous solution prefilled syringe	Preferred	QL (4 VIAL per 30 days)
zolmitriptan	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	

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluoride Dental Products - Drugs For The Mouth And Throat**		
sf	Non – Preferred	
sf 5000 plus	Non – Preferred	
sodium fluoride	Non – Preferred	
sodium fluoride 5000 ppm	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**		
cevimeline hcl	Non – Preferred	
pilocarpine hcl	Preferred	
EVOXAC	Non – Preferred	
SALAGEN	Non – Preferred	
Steroids - Mouth/Throat - Drugs For The Mouth And Throat**		
triamcinolone acetonide	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	

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

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 W/Fe-Fa*** - Drugs For Nutrition***		
c-nate dha	Non – Preferred	AL (Min 10 Years and Max 55 Years)
completenate	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
pnv tabs 29-1	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
pnv-omega	Non – Preferred	AL (Min 10 Years and Max 55 Years)
pnv-select	Non – Preferred	AL (Min 10 Years and Max 55 Years)
prenatal	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
prenatal vitamin plus low iron	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
preplus	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
pretab	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
relnate dha	Non – Preferred	AL (Min 10 Years and Max 55 Years)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
se-natal 19	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
trinatal rx 1	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
tri-tabs dha	Non – Preferred	AL (Min 10 Years and Max 55 Years)
virt-c dha	Non – Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
virt-nate dha	Non – Preferred	AL (Min 10 Years and Max 55 Years)
virt-pn plus	Non – Preferred	AL (Min 10 Years and Max 55 Years)
vol-plus	Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
vp-pnv-dha	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)

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

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)

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

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 W/Fe-Fa-Ca-Omega 3 Fish Oil*** - Drugs For Nutrition***		
complete natal dha	Non – Preferred	QL (100 EA per 90 days); AL (Min 10 Years and Max 55 Years)
****Prenatal Mv & Min W/Fe-Fa-Dha*** - Drugs For Nutrition***		
pnv-dha	Non – Preferred	AL (Min 10 Years and Max 55 Years)
pnv-dha+docusate	Non – Preferred	AL (Min 10 Years and Max 55 Years)
prenaissance	Non – Preferred	AL (Min 10 Years and Max 55 Years)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
prenaissance plus	Non – Preferred	AL (Min 10 Years and Max 55 Years)
tristart dha	Non – Preferred	AL (Min 10 Years and Max 55 Years)
virt-pn dha	Non – Preferred	AL (Min 10 Years and Max 55 Years)
westgel dha	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)

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

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)
Prenatal Mv & Minerals W/Fa - Drugs For Nutrition***		
PRENATE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
Prenatal Vitamins - Drugs For Nutrition***		
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)

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

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***		
baclofen	Preferred	QL (4 EA per 1 day)
carisoprodol tablet 250 mg oral	Non – Preferred	
carisoprodol tablet 350 mg oral	Non – Preferred	QL (3 EA per 1 day)
chlorzoxazone	Preferred	
cyclobenzaprine hcl er	Non – Preferred	
cyclobenzaprine hcl tablet 10 mg oral	Preferred	QL (3 EA per 1 day)
cyclobenzaprine hcl tablet 5 mg oral	Preferred	QL (3 EA per 1 day)
cyclobenzaprine hcl tablet 7.5 mg oral	Preferred	QL (4 EA per 1 day)
metaxalone	Non – Preferred	
methocarbamol	Preferred	QL (4 EA per 1 day)
orphenadrine citrate er	Preferred	QL (2 EA per 1 day)
tizanidine hcl oral capsule	Non – Preferred	
tizanidine hcl tablet 2 mg oral	Preferred	QL (3 EA per 1 day)
tizanidine hcl tablet 4 mg oral	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)

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

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

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

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 Ii Recept Antag Comb - Drugs For The Heart**		
****Neprilysin Inhib (Arni)-Angiotensin Ii Recept Antag Comb*** - Drugs For The Heart***		
ENTRESTO	Non – Preferred	QL (2 EA per 1 day)
Neurogenic Orthostatic Hypotension (Noh) - Agents - Drugs For The Heart**		
****Neurogenic Orthostatic Hypotension (Noh) - Agents*** - Drugs For The Heart***		
NORTHERA	Non – Preferred	
***Neuromuscular Agents* - Drugs For Nerves And Muscles**		
****Benzathiazoles*** - Drugs For Nerves And Muscles***		
riluzole	Preferred	
RILUTEK	Non – Preferred	
TIGLUTIK	Non – 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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
carteolol hcl	Preferred	QL (10 ML per 30 days)
levobunolol hcl	Preferred	QL (10 ML per 30 days)
timolol maleate gel forming solution 0.25 % ophthalmic	Preferred	QL (5 ML per 30 days)
timolol maleate gel forming solution 0.5 % ophthalmic	Preferred	QL (5 ML Max Qty Per Fill Retail)
timolol maleate solution 0.25 % ophthalmic	Preferred	QL (10 ML per 30 days)
timolol maleate solution 0.5 % (daily) ophthalmic	Preferred	
timolol maleate solution 0.5 % ophthalmic	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***		
atropine sulfate ophthalmic ointment	Preferred	QL (3.5 GM per 30 days)
atropine sulfate ophthalmic solution	Preferred	QL (5 ML per 30 days)
cyclopentolate hcl solution 0.5 % ophthalmic	Preferred	
cyclopentolate hcl solution 1 % ophthalmic	Preferred	QL (6 ML per 30 days)
cyclopentolate hcl solution 2 % ophthalmic	Preferred	QL (5 ML per 30 days)
phenylephrine hcl	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tropicamide	Preferred	QL (15 ML Max Qty Per Fill Retail)
CYCLOGYL SOLUTION 0.5 % OPHTHALMIC	Non – Preferred	
CYCLOGYL SOLUTION 1 % OPHTHALMIC	Non – Preferred	QL (6 ML per 30 days)
CYCLOGYL SOLUTION 2 % OPHTHALMIC	Non – Preferred	QL (5 ML per 30 days)
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**		
pilocarpine hcl	Preferred	QL (15 ML per 30 days)
ISOPTO CARPINE	Non – Preferred	QL (15 ML per 30 days)
Ophthalmic Antiallergic - Drugs For Itchy Eye**		
azelastine hcl	Preferred	QL (6 ML Max Qty Per Fill Retail)
cromolyn sodium	Preferred	QL (10 ML Max Qty Per Fill Retail)
epinastine hcl	Non – Preferred	
olopatadine hcl solution 0.1 % ophthalmic (rx)	Non – Preferred	QL (5 ML per 30 days)
olopatadine hcl solution 0.2 % ophthalmic (rx)	Non – Preferred	
ALOCRIL	Non – Preferred	
ALOMIDE	Non – Preferred	
BEPREVE	Non – Preferred	
LASTACAFT	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PATADAY	Non – Preferred	
PAZEO	Preferred	
ZERVIATE	Non – Preferred	
Ophthalmic Antibiotics - Anti-Infective/Anti-Inflammatories**		
bacitracin	Preferred	
ciprofloxacin hcl	Preferred	QL (5 ML per 30 days)
erythromycin	Preferred	
gatifloxacin	Non – Preferred	
gentamicin sulfate	Preferred	QL (5 ML per 30 days)
levofloxacin	Preferred	QL (5 ML per 30 days)
moxifloxacin hcl	Non – Preferred	
moxifloxacin hcl (2x day)	Non – Preferred	
ofloxacin	Preferred	QL (5 ML per 30 days)
tobramycin	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	

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

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***		
ak-poly-bac	Preferred	
bacitracin-polymyxin b	Preferred	
neomycin-bacitracin zn-polymyx	Preferred	QL (7 GM per 30 days)
neomycin-polymyxin-gramicidin	Preferred	QL (10 ML Max Qty Per Fill Retail)
polymyxin b-trimethoprim	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***		
trifluridine	Preferred	QL (7.5 ML Max Qty Per Fill Retail)
ZIRGAN	Preferred	
Ophthalmic Carbonic Anhydrase Inhibitors - Drugs For Glaucoma***		
dorzolamide hcl	Preferred	QL (10 ML Max Qty Per Fill Retail)
AZOPT	Non – Preferred	QL (10 ML per 30 days)

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

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***		
proparacaine hcl	Non – Preferred	
tetracaine hcl	Non – Preferred	
AKTEN	Non – Preferred	
ALCAINE	Non – Preferred	
Ophthalmic Nonsteroidal Anti-Inflammatory Agents - Anti-Infective/Anti-Inflammatories***		
bromfenac sodium (once-daily)	Non – Preferred	
diclofenac sodium	Preferred	QL (5 ML Max Qty Per Fill Retail)
flurbiprofen sodium	Preferred	QL (5 ML per 25 days)
ketorolac tromethamine solution 0.4 % ophthalmic	Preferred	QL (10 ML per 30 days)
ketorolac tromethamine solution 0.5 % ophthalmic	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	

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

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***		
apraclonidine hcl	Non – Preferred	
brimonidine tartrate solution 0.15 % ophthalmic	Preferred	
brimonidine tartrate solution 0.2 % ophthalmic	Preferred	QL (10 ML per 30 days)
ALPHAGAN P	Preferred	
IOPIDINE	Non – Preferred	
Ophthalmic Steroid Combinations - Anti-Infective/Anti-Inflammatories***		
bacitra-neomycin-polymyxin-hc	Preferred	
neomycin-polymyxin-dexameth ophthalmic ointment	Preferred	
neomycin-polymyxin-dexameth ophthalmic suspension	Preferred	QL (5 ML Max Qty Per Fill Retail)
neomycin-polymyxin-hc	Preferred	QL (7.5 ML per 30 days)
sulfacetamide-prednisolone	Non – Preferred	QL (5 ML per 30 days)
tobramycin-dexamethasone	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
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

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**		
dexamethasone sodium phosphate	Preferred	QL (5 ML Max Qty Per Fill Retail)
fluorometholone	Preferred	QL (10 ML per 30 days)
loteprednol etabonate	Preferred	
prednisolone acetate	Preferred	QL (10 ML per 30 days)
prednisolone sodium phosphate	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**		
sulfacetamide sodium ophthalmic ointment	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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sulfacetamide sodium ophthalmic solution	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**		
bimatoprost	Non – Preferred	
latanoprost	Preferred	QL (2.5 ML per 25 days)
travoprost (bak free)	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	

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

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

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

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**		
fluocinolone acetonide	Non – Preferred	
hydrocortisone-acetic acid	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**		
methylergonovine maleate	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	

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

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***		
amoxicillin	Preferred	
ampicillin	Preferred	
ampicillin sodium	Preferred	
****Natural Penicillins*** - Antibiotics***		
penicillin g pot in dextrose	Preferred	
penicillin g potassium	Preferred	
penicillin g procaine	Preferred	
penicillin g sodium	Preferred	
penicillin v potassium	Preferred	
BICILLIN L-A	Preferred	
PFIZERPEN	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

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

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

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**		
****Phosphodiesterase 4 (Pde4) Inhibitors - Topical*** - Drugs For The Skin***		
EUCRISA	Preferred	PA
Phosphodiesterase 4 (Pde4) Inhibitors - Drugs For Pain And Fever**		
****Phosphodiesterase 4 (Pde4) Inhibitors*** - Drugs For Pain And Fever***		
OTEZLA	Non – Preferred	
Plasma Kallikrein Inhibitors - Monoclonal Antibodies - Drugs For The Heart**		
****Plasma Kallikrein Inhibitors - Monoclonal Antibodies*** - Drugs For The Heart***		
TAKHZYRO	Non – Preferred	
Pleuromutilins - Drugs For Infections**		
****Pleuromutilins*** - Drugs For Infections***		
XENLETA	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Poly (Adp-Ribose) Polymerase (Parp) Inhibitors** - Drugs For Cancer**		
****Poly (Adp-Ribose) Polymerase (Parp) Inhibitors** - Drugs For Cancer***		
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**		
****Poly (Adp-Ribose) Polymerase (Parp) Inhibitors*** - Drugs For Cancer***		
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**		
****Postherpetic Neuralgia (Phn) Combination Agents*** - Drugs For The Nervous System***		
GABAPAL	Non – Preferred	
LIDOTIN	Non – Preferred	
LIPRITIN	Non – Preferred	
LIPRITIN II	Non – 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

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**		
****Postherpetic Neuralgia (Phn)/Neuropathic Pain Agents*** - Drugs For The Nervous System***		
GRALISE	Non – Preferred	
LYRICA CR	Non – Preferred	
Postherpetic Neuralgia(Phn)/Neuropathic Pain Comb Agents - Drugs For The Nervous System**		
****Postherpetic Neuralgia(Phn)/Neuropathic Pain Comb Agents*** - Drugs For The Nervous System***		
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**		
****Potassium Removing Agents*** - Drugs For Nutrition***		
sodium polystyrene sulfonate	Preferred	
KIONEX	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

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**		
****Prenatal Mv & Minerals W/Fa Without Iron*** - Drugs For Nutrition***		
PRENATE	Non – Preferred	AL (Min 10 Years and Max 55 Years)
***Progestins* - Hormones**		
****Progestins*** - Drugs For Women***		
hydroxyprogesterone caproate	Non – Preferred	PA
medroxyprogesterone acetate	Preferred	
megestrol acetate	Non – Preferred	
norethindrone acetate	Non – Preferred	
progesterone	Preferred	
progesterone micronized	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**		
****Protease-Activated Receptor-1 (Par-1) Antagonists*** - Drugs For The Blood***		
ZONTIVITY	Non – 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

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***		
acamprosate calcium	Preferred	
disulfiram	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***		
chlordiazepoxide-amitriptyline	Preferred	
****Cholinomimetics - Ache Inhibitors*** - Drugs For Alzheimer's Disease***		
donepezil hcl oral tablet dispersible	Preferred	QL (1 EA per 1 day)
donepezil hcl tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
donepezil hcl tablet 23 mg oral	Preferred	
donepezil hcl tablet 5 mg oral	Preferred	QL (1 EA per 1 day)
galantamine hydrobromide er	Non – Preferred	
galantamine hydrobromide oral solution	Non – Preferred	QL (2 ML per 1 day)
galantamine hydrobromide oral tablet	Non – Preferred	
rivastigmine	Non – Preferred	
rivastigmine tartrate	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)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EXELON	Non – Preferred	
RAZADYNE ER	Non – Preferred	
Fibromyalgia Agent - Snris - Drugs For Seizures /Personality Disorder/Nerve Pain***		
SAVELLA	Non – Preferred	
SAVELLA TITRATION PACK	Non – Preferred	QL (55 EA per 90 days)
Movement Disorder Drug Therapy - Drugs For The Nervous System***		
tetrabenazine	Non – Preferred	
AUSTEDO	Non – Preferred	
INGREZZA	Non – Preferred	
XENAZINE	Non – Preferred	
Ms Agents - Pyrimidine Synthesis Inhibitors - Drugs For Multiple Sclerosis***		
AUBAGIO	Non – Preferred	QL (1 EA per 1 day)
Multiple Sclerosis Agents - Interferons - Drugs For Multiple Sclerosis***		
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)

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

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)
Multiple Sclerosis Agents - Monoclonal Antibodies - Drugs For Multiple Sclerosis***		
KESIMPTA	Non – Preferred	
LEMTRADA	Non – Preferred	
OCREVUS	Non – Preferred	
TYSABRI	Non – Preferred	
Multiple Sclerosis Agents - Nrf2 Pathway Activators - Drugs For Multiple Sclerosis***		
dimethyl fumarate	Non – Preferred	PA; QL (2 EA per 1 day)
dimethyl fumarate starter pack	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	
Multiple Sclerosis Agents - Potassium Channel Blockers - Drugs For Multiple Sclerosis***		
dalfampridine er	Non – Preferred	
AMPYRA	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Multiple Sclerosis Agents - Drugs For Multiple Sclerosis***		
glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous	Non – Preferred	QL (1 ML per 1 day)
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	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***		
memantine hcl er	Non – Preferred	
memantine hcl oral solution	Non – Preferred	
memantine hcl tablet 10 mg oral	Preferred	QL (2 EA per 1 day)
memantine hcl tablet 28 x 5 mg & 21 x 10 mg oral	Non – Preferred	
memantine hcl tablet 5 mg oral	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***		
perphenazine-amitriptyline	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

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***		
fluoxetine hcl (pmdd)	Non – Preferred	
SARAFEM	Non – Preferred	
Pseudobulbar Affect Agent Combinations - Drugs For Severe Mental Disorders***		
NUEDEXTA	Non – Preferred	
Psychotherapeutic And Neurological Agents - Misc. - Drugs For Severe Mental Disorders***		
ergoloid mesylates	Preferred	
pimozide	Preferred	
Restless Leg Syndrome (Rls) Agents - Drugs For The Nervous System***		
HORIZANT	Non – Preferred	
Smoking Deterrents - Drugs For Depression***		
bupropion hcl er (smoking det)	Preferred	QL (2 EA per 1 day)
gnp nicotine mini	Preferred	OTC; QL (200 EA per 30 days)
gnp nicotine patch 24 hour 14 mg/24hr transdermal	Preferred	OTC; QL (1 EA per 1 day)

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

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

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 & Ssris - Drugs For Severe Mental Disorders***		
olanzapine-fluoxetine hcl	Non – Preferred	QL (1 EA per 1 day)
SYMBYAX	Non – Preferred	QL (1 EA per 1 day)
Vasomotor Symptom Agents - Ssris - Drugs For The Nervous System***		
paroxetine mesylate	Non – Preferred	
BRISDELLE	Non – Preferred	
Pulmonary Fibrosis Agents - Kinase Inhibitors - Drugs For Cancer**		
Pulmonary Fibrosis Agents - Kinase Inhibitors - Drugs For Cancer***		
OFEV	Non – 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Serotonin Modulators - Drugs For The Nervous System**		
****Serotonin Modulators*** - Drugs For The Nervous System***		
nefazodone hcl	Non – Preferred	
trazodone hcl	Preferred	
TRINTELLIX	Non – Preferred	
VIIBRYD	Non – Preferred	
VIIBRYD STARTER PACK	Non – Preferred	
Sglt2 Inhibitor - Dpp-4 Inhibitor - Biguanide Comb - Hormones**		
****Sglt2 Inhibitor - Dpp-4 Inhibitor - Biguanide Comb*** - Hormones***		
TRIJARDY XR	Non – Preferred	
Sglt2 Inhibitor - Dpp-4 Inhibitor Combinations - Hormones**		
****Sglt2 Inhibitor - Dpp-4 Inhibitor Combinations*** - Hormones***		
GLYXAMBI	Non – Preferred	
QTERN	Non – Preferred	
STEGLUJAN	Non – Preferred	
***Sinus Node Inhibitors** - Drugs For The Heart**		
****Sinus Node Inhibitors** - Drugs For The Heart***		
CORLANOR ORAL SOLUTION	Non – Preferred	
CORLANOR ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Tetracyclines* - Drugs For Infections**		
****Tetracyclines*** - Antibiotics***		
demeclocycline hcl	Preferred	
doxycycline hyclate intravenous	Preferred	
doxycycline hyclate oral capsule	Preferred	
doxycycline hyclate oral tablet	Preferred	
doxycycline hyclate oral tablet delayed release	Non – Preferred	
doxycycline monohydrate	Preferred	
minocycline hcl	Preferred	
minocycline hcl er	Non – Preferred	
tetracycline hcl	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**		
****Antithyroid Agents*** - Drugs For Thyroid***		
methimazole	Preferred	
propylthiouracil	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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAPAZOLE	Non – Preferred	
Thyroid Hormones - Drugs For Thyroid***		
levothyroxine sodium	Preferred	QL (1 EA per 1 day)
liothyronine sodium tablet 25 mcg oral	Preferred	QL (2 EA per 1 day)
liothyronine sodium tablet 5 mcg oral	Preferred	QL (4 EA per 1 day)
liothyronine sodium tablet 50 mcg oral	Preferred	QL (2 EA per 1 day)
np thyroid	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***		
diphtheria-tetanus toxoids dt	Preferred	
INFANRIX	Preferred	
Transthyretin Stabilizers - Hormones**		
Transthyretin Stabilizers - Hormones***		
VYNDAMAX	Non – Preferred	
VYNDAQEL	Non – 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

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

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lansoprazole oral tablet delayed release dispersible	Non – Preferred	AL (Max 10 Years)
omeprazole	Preferred	QL (2 EA per 1 day)
pantoprazole sodium oral packet	Non – Preferred	
pantoprazole sodium tablet delayed release 20 mg oral	Non – Preferred	QL (1 EA per 1 day)
pantoprazole sodium tablet delayed release 40 mg oral	Non – Preferred	QL (2 EA per 1 day)
rabeprazole sodium	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)
Quaternary Anticholinergics - Drugs For Stomach Cramps***		
glycopyrrolate	Preferred	
methscopolamine bromide	Non – 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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
propantheline bromide	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***		
amoxicill-clarithro-lansopraz	Non – Preferred	
OMECLAMOX-PAK	Non – Preferred	
TALICIA	Non – Preferred	
Ulcer Drugs - Prostaglandins - Drugs For Ulcers And Stomach Acid***		
misoprostol	Preferred	
CYTOTEC	Non – Preferred	
***Urinary Anti-Infectives* - Drugs For The Urinary System**		
Urinary Anti-Infectives - Drugs For Infections***		
fosfomycin tromethamine	Preferred	
methenamine hippurate	Preferred	
methenamine mandelate	Preferred	
nitrofurantoin	Preferred	
nitrofurantoin macrocrystal	Preferred	
nitrofurantoin monohyd macro	Preferred	
HIPREX	Non – Preferred	
MACROBID	Non – 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

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***		
darifenacin hydrobromide er	Non – Preferred	
oxybutynin chloride er tablet extended release 24 hour 10 mg oral	Preferred	QL (1 EA per 1 day)
oxybutynin chloride er tablet extended release 24 hour 15 mg oral	Preferred	QL (2 EA per 1 day)
oxybutynin chloride er tablet extended release 24 hour 5 mg oral	Preferred	QL (1 EA per 1 day)
oxybutynin chloride oral syrup	Preferred	QL (20 ML per 1 day)
oxybutynin chloride oral tablet	Preferred	QL (4 EA per 1 day)
solifenacin succinate	Preferred	QL (1 EA per 1 day)
tolterodine tartrate	Non – Preferred	
tolterodine tartrate er	Non – Preferred	
trospium chloride	Non – Preferred	
trospium chloride er	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	

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

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***		
darifenacin hydrobromide er	Non – Preferred	
oxybutynin chloride er tablet extended release 24 hour 10 mg oral	Preferred	QL (1 EA per 1 day)
oxybutynin chloride er tablet extended release 24 hour 15 mg oral	Preferred	QL (2 EA per 1 day)
oxybutynin chloride er tablet extended release 24 hour 5 mg oral	Preferred	QL (1 EA per 1 day)
oxybutynin chloride oral syrup	Preferred	QL (20 ML per 1 day)
oxybutynin chloride oral tablet	Preferred	QL (4 EA per 1 day)
solifenacin succinate	Preferred	QL (1 EA per 1 day)
tolterodine tartrate	Non – Preferred	
tolterodine tartrate er	Non – Preferred	
trospium chloride	Non – Preferred	
trospium chloride er	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)

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

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***		
bethanechol chloride	Preferred	
Urinary Antispasmodics - Cholinergic Agonists (New) - Drugs For The Bladder***		
bethanechol chloride	Preferred	
Urinary Antispasmodics - Direct Muscle Relaxants - Drugs For The Bladder***		
flavoxate hcl	Non – Preferred	QL (8 EA per 1 day)
Urinary Antispasmodics - Direct Muscle Relaxants (New) - Drugs For The Bladder***		
flavoxate hcl	Non – Preferred	QL (8 EA per 1 day)
***Vaginal Products* - Drugs For Women**		
Imidazole-Related Antifungals - Drugs For Infections***		
miconazole 3	Preferred	QL (3 EA Max Qty Per Fill Retail)
terconazole vaginal cream	Preferred	
terconazole vaginal suppository	Preferred	QL (3 EA Max Qty Per Fill Retail)
GYNAZOLE-1	Non – 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

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***		
clindamycin phosphate	Preferred	
metronidazole	Preferred	
CLEOCIN VAGINAL CREAM	Non – Preferred	
CLEOCIN VAGINAL SUPPOSITORY	Preferred	
CLINDESSE	Non – Preferred	
NUVESSA	Non – Preferred	
VANDAZOLE	Preferred	
Vaginal Estrogens - Drugs For Women***		
estradiol vaginal cream	Preferred	
estradiol vaginal tablet	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)

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

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

Index of Drugs