# Aetna Better Health® of California
Formulary Guide

**December 2021**

Notice: The formulary is subject to change and all previous versions of the formulary are no longer in effect.

An electronic version of the formulary is posted on the Aetna Better Health of California website.

For members at: **www.aetnabetterhealth.com/california/members/pharmacy**
For providers at: **www.aetnabetterhealth.com/california/providers/pharmacy**

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## Definitions

**Brand name drug** means a drug that is marketed under a proprietary, trademark-protected name. Abrand name drug is listed in this formulary in all CAPITAL letters.

**Coinsurance** means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

**Copayment** means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

**Deductible** means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

**Drug Tier** means a group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.

**Exception request** means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

**Exigent circumstances** means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

**Formulary** or **prescription drug list** means the list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.

**Generic drug** means a drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.

**Medically Necessary** means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

**Non-formulary drug** means a prescription drug that is not listed on this formulary.

**Out-of-pocket costs** means your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

**Prescribing provider** means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

**Prescription** means an oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.

**Prescription drug** means a drug that by law requires a prescription.

**Prior authorization** means a decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

**Step therapy** means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

**What is the Aetna Better Health of California Formulary (List of Drugs)?**
This is a drug list created by Aetna Better Health of California called the Drug Formulary.The plan will cover drugs on this list. Some drugs may have coverage rules. If the rules for that drug are met, the plan will cover the drug.

There is a committee called the Pharmacy and Therapeutics Committee made up of doctors and pharmacists from Aetna Better Health of California and the medical community. They meet every three months to review this list of drugs and any new drugs that have come out.

**Can the Plan's drug list change?**
The plan may add or remove drugs on the list. Utilizing members and their providerswill be notified at least 30 days before a drug is removed from the formulary. All changes to the formulary will be posted on the plan's website at:
**www.aetnabetterhealth.com/california/members/pharmacy.**

The formulary can change throughout the year. Some reasons why they can change include:

- New drugs are approved.
- Existing drugs are removed from the market.
- Prescription drugs may become available over the counter (without a prescription).Over-the-counter drugs are not generally covered in a formulary.
- Brand-name drugs lose patent protection and generic versions become available. When this happens, the generic drug will be covered in place of the brand-name drug. The brand-name drug is likely to become non-formulary or covered at a higher cost. See the "what are generic drugs?" section above for more information.

**How do I use the Plan's Formulary?**
A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the brand or generic name of the drug in the alphabetical index. If a generic equivalent for a brand name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

- A drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs
- The generic name for a brand name drug is included after the brand name in parentheses and all bold and lowercase italicized letters. (For example: COREG (*carvedilol*))

- If a generic equivalent for a brand name drug is both available and covered, the generic drug will be listed separately from the brand name drug in all bold and lowercase italicized letters; and (For example: *carvedilol*)
- If a generic drug is marketed under a proprietary, trademark-protected brand name,the brand name after the generic name in parentheses and regular typeface with first letter of each word capitalized. (For example: *desogestrel-ethinyl estradiol* (Azurette)).
- Inclusion of a prescription drug on the formulary does not guarantee that your provider will prescribe the drug for a particular medical condition.

- **Column #1: Prescription Drug Name**: lists the covered drug. Brand drugs are in all CAPITAL letters (e.g., DRUG). Generics are inlower case letters (e.g., drug). Different dosage forms or strengths are identified.

- **Column #2: Drug Tier**: Indicates that the drug is covered without cost sharing, unless it is carved out to state. In this case, it just means that the pharmacy will process it differently when you present your prescription to them.

- **Column #3: Coverage Requirements and Limits**: tells you if drug has a need for prior authorization or other restrictions

Drugs are also grouped by drug class. If you know what class your drug is in, please look for that class name in the table of contents. Then look under that page for your drug.

**What are generic drugs?**
The plan covers both brand and generic drugs. Generic drugs cost less and are approved by the Food and Drug Administration (FDA). Generic drugs are proven to be just as safe and effective as brand-name drugs. They contain the same active ingredients in the same amounts as the brand-name drugs and work the same way. So they have the same risks and benefits as brand-name drugs. However, they typically cost less.

**What if my drug is not on the drug list?**
In certain cases, you or your prescriber can request a medical exception to the prior authorization, step therapy or quantity limits requirement or for a drug that's not covered on your plan. Coverage determinations will be made within 72 hours of receiving non-urgent requests. You can ask for your request to be expedited. Expedited coverage decisions are made within 24 hours. We will then contact you and your doctor with our decision. All medically necessary outpatient prescription drugs will be covered.

Medical exceptions which are approved for non-urgent requests will cover the duration of the prescription, including refills. Approved medical exceptions for exigent circumstances will provide coverage for the duration of the exigency. If your request is denied you have the right to file an appeal using the process described in the notification letter.

If a determination is not made for a prior authorization or step therapy exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed approved and we may not deny the request thereafter.

In accordance with state law, members who have previously received approval from us for coverage of medications for their medical conditions will continue to have those medications covered, for as long as the prescriber continues prescribing them, as long as the drug is appropriately prescribed and is considered safe and effective for treating the member's medical condition.

**How do I get a mail order prescription?**
If you take medicine for an ongoing health condition, you can have them mailed to your home. Aetna Better Health works with a company called CVS Caremark, to give you this service which is available at no cost to you.

If you choose this option, your medicine comes right to your home. You can set up your refills. You can ask the pharmacists questions. Here are some other features of home delivery:

- Pharmacists check each order for safety.
- You can order refills by mail, by phone, online, or you can sign up for automatic refills.
- You can talk with pharmacists by phone.

It's easy to start using mail service.
Choose ONE of the following three ways to use mail service for a medicine that you take on an ongoing basis:

- Call the CVS toll-free number at **1-855-271-6603 (TTY: 711)** (24 hours a day, 7 days a week). They will let you know which of your medicines can be filled through CVS mail service pharmacy. CVS will then contact your doctor for a prescription and mail the medicine to you. When you call, be sure to have:
    - Your Plan member ID card
    - Your doctor's first and last name and phone number
    - Your payment information and mailing address

- Go to our member portal to register or login. Once you enter the member portal, go to Tasks and then Pharmacy Services. Click on the CVS link to go to**Caremark.com**. Click on start "mail service" to print off the mail order form. You can contact CVS at **1-855-271-6603**. Be sure to have your member ID card handy when you register for the first time.
- Fill out and send a mail service order form. If you already have a prescription, you can send it to CVS Caremark with a completed mail service order form. If you don't have an order form, you can download it. You can also request one by calling Member Services at **1-855-772-9076 (TTY: 711)**.

  Have the following information with you when you complete the form:
  - Your Plan member ID card
  - Your complete mailing address, including ZIP code
  - Your doctor's first and last name and phone number
  - A list of your allergies and other health conditions
  - Your original prescription from your doctor

**Where can I get a specialty drug?**
CVS Specialty Pharmacy is the preferred specialty pharmacy for Aetna Better Health of California members. A specialty pharmacy fills drugs and has other services to help you. The Specialty Drug Program has special services for you:

- You can talk to a pharmacist 24 hours a day, 7 days a week
- Counseling about your drug and disease
- Coordination of care with you and your doctor
- Delivery of specialty drugs to your home or doctor's office
- You can drop off your prescription and pick up your drug at any CVSPharmacy (including those inside Target stores)
- You can call CVS Specialty Pharmacy at **1-800-237-2767**; TTY/TDD: **1-800-863-5488**. CVS Specialty Pharmacy will help you with filling your specialty drug.

View the **specialty drug list** available through CVS Specialty Pharmacy.

**Are Over-The-Counter (OTC) drugs covered?**
The plan will cover OTC drugs on the formulary. Some OTC drugs may have coverage rules. If the rules for that OTC drug are met, the plan will cover the OTC drug. Like other drugs, OTC drugs need a prescription from a doctor if they are to be covered by the plan.

**Are certain injectable drugs given by my doctor or provider in a clinic covered?**
These types of drugs are covered under the medical benefit instead of the pharmacy benefit. For the most part, this drug formulary is made up of drugs you get from a pharmacy and give to yourself. If your provider needs to administer a drug in the clinic such as an injectable, they have instructions on how to bill Aetna Better Health of California.

**How do I find a network pharmacy?**
You can find a pharmacy in two ways:

- **Online**: Log onto our website at **www.aetnabetterhealth.com/california/find-provider**.

- **By phone**: Call Member Services at **1-855-772-9076 (TTY: 711)**. They'll be glad tohelp you find a network pharmacy near you.

Always remember to fill your prescription at a network pharmacy. Your prescriptions won't be covered at other pharmacies.

**Are there medication copays?**
Refer to member handbook for copay information.

**What are some types of coverage rules?**

- **Prior Approval (PA)**: This means your doctor will need to get approval from the plan first before the drug can be filled at the pharmacy. If it is not approved, the plan will not cover the drug.

- **Quantity Level Limits (QLL)**: This means there is a limit on the amount of drug the plan will cover. For example, the plan provides 60 pills in 30 days for some drugs.

- **Step Therapy (ST)**: This means you may need to try certain drugs first to treat your condition. After the first drug is tried, the plan will then cover the other drug for that same condition. For example, Drug A and Drug B may treat your condition. The plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, then Drug B will be covered.

- **Simple Intravenous Solutions**: Simple intravenous solutions are typically used forhydration therapy. Included are commercially available (non-compounded) solutions such as Normal Saline, Dextrose (up to 10% in Water) and Lactated

Ringer's Solution; commercially prepared solutions of potassium chloride in suchsolutions are also included in this definition. Simple intravenous solutions should be billed using the product's National Drug Code (NDC) number.

- **Parenteral Nutrition Solutions (TPN or Hyperalimentation)**: (Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that typically are suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin &/or mineral supplements and trace elements.)
  - Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when I.V. therapy with the same drug was started before discharge. There is a maximum of 10 days' supply per dispensing within the 10-day period.
  - Adjuncts to parenteral nutrition are other drugs which are physically mixedinto a parenteral nutrition solution at any time prior to administration. Bill for these products as part of the parenteral nutrition billing.

***Note**: Non-compounded products must be billed using the product's NDC number.Compounded solutions must be billed as a compound claim.

- **Separately Administered Intravenous Lipids**:
  - Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when I.V. therapy with the same product was startedbefore discharge. There is a maximum of 10 days supply per dispensing within this 10-day period.
  - Intravenous lipid solutions or suspensions that are administered separatelyfrom parenteral nutrition solutions (that is, are not physically mixed into theparenteral nutrition solution container) should be billed using the product'sNDC number.

- **Enteral Products**:
  - Products on the Medi-Cal List of Enteral Nutrition products are covered upon medical prior authorization and medical necessity review. These products are listed here: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Aetna Better Health provides or arranges for medically necessary covered enteral products, and to ensure that these are provided in an amount no lessthan what is offered to beneficiaries under Medi-Cal Fee-For-Service, according to the Medi-Cal policy listed here:

**http://files.medi-cal.ca.gov/pubsdoco/publications/masters-**

**mtp/part2/enteral_a04p00.doc**

**What if my drug is not on the plan's Formulary?**
If your medicine is not on the preferred drug list, there are some things you can do.

- Ask your provider for a similar drug that *is* on the list.
- Ask your provider to seek "prior authorization" (pre-approval) from Aetna Better Health of California to cover this medicine.

**How can my doctor or provider request a prior authorization or exception if the plan does not cover my drug?**
They can do this in three ways:

1. Your provider may fax a completed pharmacy prior authorization or step therapy exception form to **1-844-823-5478** and include all necessary information.
2. They can also submit the request over the phone by calling **1-855-772-9076**.
3. They can submit an Electronic Prior Authorization (ePA)

**What if I have questions about how Aetna Better Health of California covers drugs?**
Learn about your pharmacy benefits:

Whether it's pain medication after an injury or medication to manage a health condition, getting the prescription drugs you need is an important part of your health care. We want to make it as easy for you as possible. If you have any questions, please call Member Services at **1-855-772-9076 (TTY: 711)**. Have a list of your prescriptions ready when you call. Ask us to look up your medicines to see if they're on the list.

## LEGEND

*lowercase italics* - Generic drugs **UPPERCASE BOLD** -Brand name drugs

**Coverage Requirements and Limits**
AL - Age Restrictions OTC - OTC Medications PA - Prior Authorization may apply
QL - Quantity Limits ST - Step Therapy may apply

**Drug Tier**
Covered - Covered Medications Not Covered -Not Covered Medications

## Definiciones

**Autorización previa** quiere decir una decisión por parte de su aseguradora respecto de si un beneficio de atención médica es médicamente necesario para usted. Si un medicamento con receta está sujeto a una autorización previa en este formulario, su proveedor autorizado a emitir recetas debe solicitar la aprobación de su aseguradora para cubrir el medicamento antes de que usted pueda obtener la receta. Su aseguradora debe concederle una solicitud de autorización previa cuando es médicamente necesario que usted tome el medicamento.

**Circunstancias urgentes** se refiere a cuando sufre de una afección médica que puede poner en grave peligro su vida, su salud o su capacidad para recuperar la función máxima, o cuando se está sometiendo a un tratamiento en curso que incluye un medicamento que no está en el formulario.

**Copago** quiere decir un monto fijo en dólares que paga por un beneficio de atención médica cubierto después de haber pagado el deducible, si se aplica un deducible al beneficio de atención médica.

**Coseguro** se refiere a un porcentaje del costo de un beneficio de atención médica cubierto que paga después de haber pagado el deducible, si se aplica un deducible al beneficio de atención médica.

**Costos que paga de su bolsillo** quiere decir los gastos a su cargo por los beneficios de atención médica que su seguro de salud no reembolsa. Los costos que paga de su bolsillo incluyen deducibles, copagos y coseguros por los beneficios de atención médica cubiertos, más todos los costos por los beneficios de atención médica que no están cubiertos.

**Deducible** quiere decir el monto que paga por los beneficios de atención médica cubiertos que están sujetos al deducible antes de que su aseguradora de salud comience a pagar. Si la póliza de su seguro de salud tiene un deducible, puede tener uno solo o varios separados para los beneficios médicos y los beneficios de medicamentos con receta. Después de pagar el deducible, por lo general solo paga un copago o coseguro por los beneficios de atención médica cubiertos. Su compañía de seguros paga el resto.

**Formulario** o **lista de medicamentos con receta** quiere decir la lista de medicamentos que su póliza de seguro de salud cubre conforme al beneficio de medicamentos con receta de la póliza.

**Médicamente necesarios** quiere decir que los beneficios de atención médica necesarios para diagnosticar, tratar o prevenir una afección médica o sus síntomas, y que cumplen los estándares aceptados de la medicina. Por lo general, el seguro de salud no cubre los beneficios de atención médica que no son médicamente necesarios.

**Medicamento con receta** implica un medicamento que, por ley, requiere una receta.

**Medicamento de marca** quiere decir un medicamento que se comercializa bajo un nombre registrado y protegido por una marca comercial. Los medicamentos de marca enumerados en este formulario aparecen en MAYÚSCULA.

**Medicamento genérico** se refiere a un medicamento que es igual a su medicamento de marca equivalente en cuanto a la dosificación, la concentración, el efecto, la forma de tomarlo, la calidad, la seguridad y el uso previsto. Los medicamentos genéricos enumerados en este formulario aparecen en minúscula y cursiva.

**Medicamento que no está en el formulario** implica un medicamento con receta que no figura en este formulario.

**Nivel del medicamento** se refiere a un grupo de medicamentos con receta que forma parte de un nivel de costo compartido específico en su póliza de seguro de salud. El nivel del medicamento en el que se ubica un medicamento con receta determina la parte del costo del medicamento que le corresponde a usted.

**Proveedor autorizado a emitir recetas** quiere decir un proveedor de atención médica que puede emitir una receta para un medicamento para diagnosticar, tratar o prevenir una afección médica.

**Receta** se refiere a una orden verbal, escrita o electrónica de un proveedor autorizado a emitir recetas que autoriza a un individuo específico a obtener un medicamento con receta.

**Solicitud de excepción** quiere decir una solicitud de cobertura de un medicamento que no está en el formulario. Si usted, su representante o el proveedor de atención médica autorizado a emitir recetas envían una solicitud de cobertura de un medicamento no está en el formulario, su aseguradora deberá cubrir dicho medicamento cuando se considere médicamente necesario que lo tome.

**Tratamiento escalonado** quiere decir una secuencia específica en la que se deben probar medicamentos con receta para una afección médica particular. Si un medicamento está sujeto al tratamiento escalonado en este formulario, es posible que tenga que probar uno o más medicamentos para que la póliza de seguro de salud cubra ese medicamento para su afección médica. Si el proveedor autorizado a emitir recetas envía una solicitud de excepción a los requisitos del tratamiento escalonado, su aseguradora tendrá que conceder la solicitud cuando se considere médicamente necesario que tome el medicamento.

**¿En qué consiste el formulario de Aetna Better Health of California (Lista de medicamentos)?**
Se trata de una lista de medicamentos que creó Aetna Better Health of California denominada Formulario de medicamentos. El plan cubrirá los medicamentos de esta lista. Algunos medicamentos pueden tener normas de cobertura. Si se cumplen las normas para ese medicamento, el plan lo cubrirá.

Hay un comité denominado Comité de Farmacia y Terapéutica que está formado por médicos y farmacéuticos de Aetna Better Health of California y la comunidad médica. Se reúnen cada tres meses para revisar esta lista de medicamentos y cualquier medicamento nuevo que haya salido.

**¿Es posible que la lista de medicamentos del plan cambie?**
El plan puede incorporar o eliminar medicamentos de la lista. Se les informará a los miembros que la utilizan y a sus proveedores al menos 30 días antes de eliminar un medicamento del formulario. Todos los cambios en el formulario se publicarán en el sitio web del plan en: **www.aetnabetterhealth.com/california/members/pharmacy.**

El formulario puede cambiar durante el año. Estas son algunas de las razones por las que puede cambiar:

- Se aprueban nuevos medicamentos.
- Medicamentos existentes se retiran del mercado.
- Los medicamentos con receta pueden pasar a ser de venta libre (no se necesita receta). Por lo general, el formulario no cubre los medicamentos de venta libre.
- Medicamentos de marca pierden la protección de patente y surgen versiones genéricas. Cuando esto sucede, se cubrirá el medicamento genérico en vez del medicamento de marca. Es posible que el medicamento de marca deje de estar incluido en el formulario o esté cubierto a un costo más elevado. Consulte la sección anterior denominada “¿Qué son los medicamentos genéricos?” para obtener más información.

**¿Cómo utilizo el formulario del plan?**
Es posible encontrar un medicamento con receta al buscar la categoría y la clase terapéutica a la que pertenece el medicamento, o la marca o el nombre genérico del medicamento en el índice alfabético. Si no hay un equivalente genérico para el medicamento de marca disponible en el mercado o si no está cubierto, el medicamento no figurará en la lista por separado bajo su nombre genérico.

- Los medicamentos figuran alfabéticamente por marca y nombre

genérico en la categoría y clase terapéutica a la que pertenecen.

- El nombre genérico de un medicamento de marca se incluye después de la marca entre paréntesis, en negrita, minúscula y cursiva. (Por ejemplo: COREG (*carvedilol*)).
- Si hay un equivalente genérico de un medicamento de marca disponible y cubierto, el medicamento genérico figurará en la lista separado del medicamento de marca en negrita, minúscula y cursiva. (Por ejemplo: *carvedilol*).
- Si el medicamento genérico se comercializa bajo un nombre registrado y protegido por una marca comercial, la marca aparecerá después del nombre genérico entre paréntesis y con tipografía regular, con la primera letra de cada palabra en mayúscula. (Por ejemplo: *desogestrel-ethinyl estradiol* (Azurette)).
- El hecho de que un medicamento con receta esté incluido en el formulario no le garantiza que su proveedor le vaya a recetar el medicamento para una afección médica particular.

- **Columna n.º 1: Nombre del medicamento con receta:** enumera los medicamentos cubiertos. Los medicamentos de marca aparecen en MAYÚSCULA (por ejemplo, MEDICAMENTO). Los medicamentos genéricos aparecen en minúscula (por ejemplo, medicamento). Se identifican las diferentes formas de dosificación y concentraciones.

- **Columna n.º 2: Nivel del medicamento**: indica que el medicamento está cubierto sin costo compartido, a menos que el servicio esté excluido del estado. En ese caso, solo quiere decir que la farmacia lo procesará de manera diferente cuando usted presente la receta.

- **Columna n.º 3: Requisitos y límites de cobertura**: indican si se necesita una autorización previa para el medicamento o si hay otras restricciones.

Los medicamentos también se agrupan por clase. Si sabe en qué clase se ubica su medicamento, busque el nombre de la clase en el índice. Luego, busque su medicamento en esa página.

**¿Qué son los medicamentos genéricos?**
El plan cubre tanto los medicamentos de marca como los genéricos. Los medicamentos genéricos cuestan menos y están aprobados por la Administración de Drogas y Alimentos (FDA). Se ha comprobado que los medicamentos genéricos son tan seguros y eficaces como los medicamentos de marca. Tienen los mismos ingredientes activos y las mismas cantidades que los medicamentos de marca, y funcionan de la misma manera, por lo que

tienen los mismos riesgos y beneficios que los medicamentos de marca. Sin embargo, suelen costar menos.

**¿Qué sucede si mi medicamento no está incluido en la lista de medicamentos?**
En algunos casos, usted o la persona autorizada a emitir recetas pueden solicitar una excepción médica para la autorización previa, el tratamiento escalonado o los límites de cantidad, o para un medicamento que su plan no cubre. Las determinaciones de cobertura se tomarán dentro de las 72 horas después de recibir las solicitudes no urgentes. Puede solicitar que se acelere su solicitud. Las decisiones de cobertura aceleradas se toman dentro de las 24 horas. Luego, nos comunicaremos con usted y con su médico para informarles nuestra decisión. Se cubrirán todos los medicamentos con receta para pacientes externos que sean médicamente necesarios.

Las excepciones médicas aprobadas para solicitudes no urgentes brindarán cobertura mientras dure la receta, incluidos los resurtidos. Las excepciones médicas aprobadas para circunstancias urgentes brindarán cobertura mientras dure la urgencia. Si le deniegan su solicitud, tiene derecho a presentar una apelación mediante el proceso que se detalla en la carta de notificación.

Si no se toma una determinación para una solicitud de excepción de una autorización previa o un tratamiento escalonado dentro de las 72 horas después de recibir una solicitud no urgente y las 24 horas después de recibir una solicitud basada en circunstancias urgentes, la solicitud se considera aprobada y es posible que no podamos denegarla posteriormente.

De acuerdo con las leyes estatales, los miembros que hayan recibido nuestra aprobación previa para la cobertura de los medicamentos para sus afecciones médicas, seguirán teniendo cobertura de esos medicamentos, durante el tiempo que la persona autorizada a emitir recetas continúe recetándolos de manera adecuada y siempre que se consideren seguros y eficaces para tratar la afección médica de los miembros.

**¿Cómo obtengo una receta de pedido por correo?**
Si toma medicamentos para una afección médica existente, puede pedir que se los envíen por correo a su hogar. Aetna Better Health trabaja con una empresa llamada CVS Caremark, que le ofrece este servicio sin costo alguno para usted.

Si elige esta opción, recibirá el medicamento directamente en su hogar. Puede programar sus resurtidos. Puede hacerles preguntas a los farmacéuticos. Estas son algunas de las características de la entrega a domicilio:

- Los farmacéuticos controlan cada pedido para su seguridad.
- Puede pedir resurtidos por correo, por teléfono o en línea, o puede inscribirse

para recibir resurtidos automáticos.
- Puede hablar con los farmacéuticos por teléfono.

Es fácil comenzar a usar el servicio por correo.
Elija UNO de los siguientes tres modos para usar el servicio por correo para un medicamento que toma de forma permanente:

- Llame al número gratuito de CVS al **1-855-271-6603 (TTY: 711)** (durante las 24 horas, los 7 días de la semana). Allí le informarán cuáles de sus medicamentos pueden surtirse a través de la farmacia de servicio por correo CVS. Luego, CVS se comunicará con su médico para solicitarle una receta y le enviará el medicamento por correo. Cuando llame, asegúrese de tener lo siguiente:
  - Su identificación de miembro del Plan
  - El nombre, apellido y número de teléfono de su médico
  - Su información de pago y dirección de correo postal
- Visite nuestro portal para miembros para registrarse o iniciar sesión. Una vez que ingrese al portal para miembros, diríjase a Tasks (Tareas) y, luego, a Pharmacy Services (Servicios de farmacia). Haga clic en el enlace de CVS para dirigirse a **Caremark.com**. Haga clic en comenzar a usar el "servicio por correo" para imprimir el formulario de pedido por correo. Puede comunicarse con CVS llamando al **1-855-271-6603**. Asegúrese de tener a mano su tarjeta de identificación de miembro cuando se registre por primera vez.
- Complete y envíe un formulario del servicio de pedido por correo. Si ya tiene una receta, puede enviársela a CVS Caremark junto con un formulario del servicio de pedido por correo completo. Si no tiene un formulario de pedido, puede descargarlo. También puede solicitar uno si llama al Departamento de Servicios para Miembros al **1-855-772-9076 (TTY: 711)**.

Cuando complete el formulario, tenga a mano la siguiente información:
- Su identificación de miembro del Plan
- Su dirección de correo postal completa, incluido el código postal
- El nombre, apellido y número de teléfono de su médico
- Una lista de las alergias y otras afecciones médicas que padece
- La receta original que le entregó su médico

**¿Dónde puedo obtener medicamentos especializados?**
CVS Specialty Pharmacy es la farmacia de especialidad preferida de los miembros de Aetna Better Health of California. Las farmacias de especialidad le surten

medicamentos y le proporcionan otros servicios para ayudarlo. El Programa de Medicamentos Especializados cuenta con los siguientes servicios especiales para usted:

- Posibilidad de hablar con un farmacéutico durante las 24 horas, los 7 días de la semana
- Asesoramiento sobre su medicamento y su enfermedad
- Coordinación de su atención con usted y su médico
- Entrega de medicamentos especializados en su hogar o en el consultorio de su médico
- Posibilidad de dejar la receta y recoger el medicamento en cualquier CVS Pharmacy (incluidas las que están dentro de tiendas Target)
- Posibilidad de llamar a CVS Specialty Pharmacy al **1-800-237-2767**; TTY/TDD: **1-800-863-5488**. CVS Specialty Pharmacy lo ayudará a obtener su medicamento especializado.

Consulte la **lista de medicamentos especializados** disponible a través de CVS Specialty Pharmacy.

**¿Están cubiertos los medicamentos de venta libre (OTC)?**
El plan cubrirá los medicamentos OTC del formulario. Algunos medicamentos OTC pueden tener normas de cobertura. Si se cumplen las normas para ese medicamento OTC, el plan lo cubrirá. Al igual que con otros medicamentos, los medicamentos OTC necesitan la receta de un médico si se espera que el plan los cubra.

**¿Están cubiertos determinados medicamentos inyectables que el médico o proveedor me administran en una clínica?**
Este tipo de medicamentos están cubiertos por el beneficio médico, en vez del beneficio de farmacia. Por lo general, este formulario de medicamentos está compuesto por medicamentos que obtiene de una farmacia y se autoadministra. Si el proveedor tiene que administrarle un medicamento en la clínica como un inyectable, tiene las instrucciones a seguir para facturarle a Aetna Better Health of California.

**¿Cómo encuentro una farmacia de la red?**
Puede encontrar una farmacia de dos maneras:

- **En línea:** regístrese en nuestro sitio web en **www.aetnabetterhealth.com/california/find-provider**.

- **Por teléfono:** llame al Departamento de Servicios para Miembros al **1-855-**

**772-9076 (TTY: 711)**. Con gusto le ayudarán a encontrar una farmacia de la red que esté cerca de usted.

Recuerde siempre obtener sus medicamentos con receta en una farmacia de la red. Otras farmacias no cubrirán sus medicamentos con receta.

**¿Los medicamentos tienen copagos?**
Consulte el manual para miembros para obtener información sobre los copagos.

**¿Cuáles son algunos de los tipos de normas de cobertura?**

- **Autorización previa (PA)**: esto significa que su médico deberá obtener primero la aprobación del plan antes de que usted pueda obtener el medicamento en la farmacia. Si no se aprueba, el medicamento no estará cubierto por el plan.

- **Límites de nivel de cantidad (QLL)**: esto quiere decir que hay un límite en cuanto a la cantidad del medicamento que estará cubierta por el plan. Por ejemplo, el plan ofrece 60 píldoras en 30 días para ciertos medicamentos.

- **Tratamiento escalonado (ST)**: esto significa que es posible que necesite probar primero determinados medicamentos para tratar su afección. Después de probar el primer medicamento, el plan cubrirá el siguiente para esa misma afección. Por ejemplo, el medicamento A y el medicamento B pueden tratar su afección. Es posible que el plan no cubra el medicamento B a menos que usted pruebe primero el medicamento A. Si el medicamento A no funciona para usted, entonces se cubrirá el medicamento B.

- **Solución intravenosa estándar**: esta solución se suele usar para el tratamiento de hidratación. Las soluciones que están incluidas son aquellas comerciales (no compuestas), como el suero fisiológico, la dextrosa (de hasta al 10%) y la solución láctica de Ringer. Las soluciones comerciales que se preparan con cloruro de potasio en esas soluciones también están incluidas en la definición. La solución intravenosa estándar se debe facturar con el número del Código Nacional de Medicamentos (NDC) del producto.

- **Solución de la nutrición parenteral (TPN o hiperalimentación)**: (la solución de la nutrición parenteral es un producto de nutrición que se administra por vía intravenosa o intraarterial. Por lo general, suele ser una suspensión o solución de aminoácidos o proteínas, dextrosa, lípidos, electrolitos, suplementos de vitaminas o minerales, y oligoelementos).
  - Se restringe la provisión dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos cuando el tratamiento

intravenoso con el mismo medicamento comenzó antes del alta. Hay un máximo de 10 días de suministro por provisión dentro del periodo de 10 días.
- Los coadyuvantes de la nutrición parenteral son otros medicamentos que se mezclan físicamente en una solución de nutrición parenteral en cualquier momento previo a ser administrados. La factura para estos productos es parte de las facturas de la nutrición parenteral.

***Nota**: los productos no compuestos se deben facturar con el número del NDC del producto. Las soluciones compuestas se deben facturar como una reclamación compuesta.

- **Lípidos intravenosos administrados por separado**:
  - Se restringe la provisión dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos cuando el tratamiento intravenoso con el mismo producto comenzó antes del alta. Hay un máximo de 10 días de suministro por provisión dentro de este periodo de 10 días.
  - Las soluciones o suspensiones de lípidos intravenosas que se administren separadas de las soluciones de nutrición parenteral (es decir, que no se mezclen en el envase de la solución de nutrición parenteral) se deben facturar con el número del NDC del producto.

- **Productos de nutrición enteral**:
  - Los productos de la lista de productos de nutrición enteral de Medi-Cal están cubiertos si se obtiene una autorización médica previa y una revisión médicamente necesaria. Estos productos se detallan aquí: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Aetna Better Health proporciona o coordina los productos de nutrición enteral cubiertos que son médicamente necesarios y se asegura de que no se administre menos cantidad de la que se les ofrece a los beneficiarios de Medi-Cal de pago por servicio, de acuerdo con la política de Medi-Cal que se detalla aquí: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**¿Qué sucede si mi medicamento no está incluido en el formulario del plan?**
Si su medicamento no se encuentra en nuestra Lista de medicamentos preferidos, hay varias cosas que puede hacer.
- Solicitarle a su proveedor un medicamento similar que *figure* en la lista.
- Solicitarle a su proveedor que le pida a Aetna Better Health of California

que cubra este medicamento a través de una “autorización previa” (aprobación previa).

**¿Cómo puede hacer mi médico o proveedor para solicitar una autorización previa o excepción si el medicamento no está cubierto por el plan?**
Pueden hacer esto de tres maneras:

1. Su proveedor puede enviar por fax el formulario completo de excepción de una autorización previa de la farmacia o de un tratamiento escalonado al **1-844-823-5478** e incluir toda la información necesaria.
2. Además, pueden enviar la solicitud por teléfono si llaman al **1-855-772-9076**.
3. Pueden enviar una autorización previa electrónica (ePA).

**¿Qué sucede si tengo preguntas sobre la manera en que Aetna Better Health of California cubre los medicamentos?**
Obtenga más información sobre sus beneficios de farmacia:

Ya sea un analgésico para una lesión o un medicamento para controlar una afección médica, obtener los medicamentos con receta que necesita es una parte importante de su atención médica. Queremos facilitárselo tanto como podamos. Si tiene alguna pregunta, llame al Departamento de Servicios para Miembros al **1-855-772-9076 (TTY: 711)**. Tenga la lista de sus medicamentos con receta a mano cuando llame. Solicítenos que busquemos sus medicamentos para ver si figuran en la lista.

## LEYENDA

*cursiva minúscula* - Medicamentos genéricos
**NEGRITA MAYÚSCULA** -Medicamentos de marca

**Requisitos y límites de cobertura**
AL - Restricciones de edad OTC - Medicamentos de venta libre
PA - Es posible que se necesite una autorización previa
QL - Límites de cantidad ST - Es posible que se necesite un tratamiento escalonado

**Nivel del medicamento**
Cubierto - Medicamentos cubiertos No cubierto -Medicamentos que no están cubiertos

## 定義

**品牌藥**是指以專有商標保護名稱銷售的藥物。本處方藥一覽表中的品牌藥均以大寫字母列示。

**共同保險**是指如果自付扣除金適用於醫療保健福利，則在您支付自付扣除金後，您應支付的承保醫療保健福利費用的百分比。

**定額手續費**是指如果自付扣除金適用於醫療保健福利，則在您支付自付扣除金後，您應為承保醫療保健福利支付的固定金額。

**自付扣除金**是指在您的醫療保險公司開始支付前，您為需支付自付扣除金的承保醫療保健福利支付的金額。如果您的健康保險保單設有自付扣除金，則醫療福利和處方藥福利可能為一項自付扣除金，也可能是多項單獨的自付扣除金。支付自付扣除金後，您通常只需為承保的醫療保健福利支付定額手續費或共同保險。其餘的則由保險公司支付。

**藥物等級**是指與您的健康保險保單中的特定分攤費用等級對應的一組處方藥。處方藥所處的藥物等級決定了您需為藥物支付的費用比例。

**例外處理請求**是指就非處方藥一覽表藥物提出的承保請求。如果您、您的指定人或開具處方的醫療服務提供者就非處方藥一覽表藥物提交了承保請求，那麼僅當您使用該藥物具有醫療必需性時，您的保險公司才必須承保該非處方藥一覽表藥物。

**緊急情況**是指您的病情可能嚴重危及生命、健康或恢復最佳身體機能的能力，或者您目前正在接受非處方藥一覽表藥物的治療。

**處方藥一覽表**或**處方藥清單**是指您的健康保險保單中的處方藥福利所承保的藥物清單。

**普通藥**是指在劑量、規格、療效、服用方式、品質、安全性和預期用途等方面與其品牌藥相同的藥物。本處方藥一覽表中的普通藥均以斜體小寫字母列示。

**具有醫療必需性**是指診斷、治療或預防疾病或其症狀所需以及符合公認醫學標準的醫療保健福利。健康保險通常不承保不具有醫療必需性的醫療保健福利。

**非處方藥一覽表藥物**是指未列入本處方藥一覽表的處方藥。

**自付費用**是指您的健康保險不予報銷的醫療保健福利費用。自付費用包括承保的醫療保健福利的自付扣除金、定額手續費和共同保險，加上未承保的醫療保健福利的所有費用。

**處方提供者**是指能夠開具藥物處方以診斷、治療或預防某種醫療疾病的醫療服務提供者。

**處方**是指處方提供者授權將處方藥提供給特定個人的口頭、書面或電子醫囑。

**處方藥**是指法律規定需要處方的藥物。

**事先授權**是指您的健康保險公司確定某項醫療保健福利對您而言具有醫療必需性。如果本處方藥一覽表中的處方藥需要獲得事先授權，那麼您的處方提供者必須請求您的健康保險公司批准，之後您才能配取處方藥。如果您使用某種藥物具有醫療必需性，您的健康保險公司必須批准事先授權請求。

**階段療法**是指必須依照特定順序試用針對特定醫療狀況的處方藥。如果本處方藥一覽表中的某種藥物需要採用階段療法，則您可能需要嘗試一種或多種其他藥物，之後您的健康保險保單才能為您的疾病承保這種藥物。如果您的處方提供者提交了一份關於階段療法要求的例外請求，那麼僅在您使用該藥物具有醫療必需性時，您的健康保險公司才必須批准該請求。

### 什麼是 Aetna Better Health of California 處方藥一覽表（藥物清單）？

這是一份由 Aetna Better Health of California 擬定的藥物清單，稱為「處方藥一覽表」。本計劃將承保這份清單中的藥物。有些藥物可能有承保規則。如果符合該藥物的相關規則，則本計劃將承保該藥物。

我們有一個名為「藥物和治療委員會」的委員會，由來自 Aetna Better Health of California 和醫學界的醫生和藥劑師組成。該委員會每三個月召開一次會議，目的是審核這份藥物清單以及任何已推出的新藥。

### 本計劃的藥物清單是否會變更？

本計劃可能會在清單上增加或刪除藥物。如果某藥物從處方藥一覽表中刪除，則使用該藥物的會員及其提供者將至少提前 30 天收到通知。所有對處方藥一覽表的修改將公佈在本計劃的網站上：**www.aetnabetterhealth.com/california/members/pharmacy。**

處方藥一覽表在一年當中都有可能發生變更。一些變更原因包括：

- 新藥獲得批准。
- 現有藥物退出市場。
- 處方藥可以在櫃檯買到（不需要處方）。處方藥一覽表中一般不承保非處方藥。
- 品牌藥失去專利保護和普通藥上市。在此情況下，普通藥將取代品牌藥進入承保範圍。品牌藥可能會變成非處方藥一覽表藥物或承保費用更高。請參見「什麼是普通藥？」部分瞭解更多資訊。

### 如何使用本計劃的處方藥一覽表？

在按字母順序排列的索引中，您可以依照藥物所屬的治療類別和等級，或者品牌藥或普通藥的名稱查找處方藥。如果市面上沒有與某品牌藥等效的普通藥，或普通藥無法承保，那麼該藥物將不會使用其普通藥名稱單獨列出。

- 藥物在所屬的治療類別和等級中按其品牌藥名和普通藥名的字母順序列出。
- 品牌藥的後面使用括號附加了其普通藥，普通藥名使用斜體小寫字母並加粗。（例如：COREG (***carvedilol***)）
- 如果某品牌藥的等效普通藥既在市面上有售又在承保範圍內，則該普通藥

將以加粗的斜體小寫字母與該品牌藥分開列出；（例如：*carvedilol*）
- 如果普通藥以專有商標保護的品牌藥名銷售，則品牌藥名放在普通藥後面的括號內，使用常規字體且每個單詞的首字母大寫。（例如：*desogestrel-ethinyl estradiol* (Azurette)）。
- 即使某種處方藥包含在處方藥一覽表中，您的處方提供者也不一定會為特定醫療狀況開立該藥物。

- **欄 1：處方藥名稱**：承保藥物清單。品牌藥全部使用大寫字母（如 DRUG）。普通藥使用小寫字母（如 drug）。區分不同的劑型或規格。

- **欄 2：藥物等級**：表明該藥物獲得承保且無費用分攤，由州管理的情況除外。這種情況僅表示，您在向藥房出示處方時，他們會採取不同的處理方式。

- **欄 3：承保要求和限制**：說明藥物是否需要事先授權或存在其他限制

藥物還按照藥物等級分組。如果您清楚藥物所屬的等級，請在目錄中查找該等級名稱。然後，在此頁面下查找所需的藥物。

## 什麼是普通藥？

我們計劃同時承保品牌藥和普通藥。普通藥均已獲美國食品藥物管理局 (FDA) 批准。事實證明，普通藥與品牌藥一樣安全有效。它們含有與品牌藥等量的相同活性成分，且藥效也相同。所以它們的風險和優勢與品牌藥一樣。不過，它們的成本往往更低。

## 若我的藥物不在處方藥一覽表上，該怎麼辦？

在某些情況下，您或您的處方提供者可以就以下各項提出醫療例外請求：事先授權、階段療法或數量限制要求，或者不在您計劃承保範圍內的藥物。承保範圍決定將在收到非緊急請求後的 72 小時內做出。您可以申請加急處理您的請求。快速承保範圍決定在 24 小時內做出。之後，我們會將決定通知給您和您的醫生。所有具有醫療必需性的門診處方藥都將包含在承保範圍內。

針對非緊急請求批准的醫療例外將在處方期間承保，包括重新配藥。針對緊急情況批准的醫療例外將在緊急情況期間承保。如果您的請求被拒，您有權透過通知函中所述的程序提出上訴。

如果在收到非緊急請求後 72 小時內，以及收到在緊急情況下提出的請求後 24 小時內，我們未就事先授權或階段療法例外處理請求做出決定，則該請求被視為已獲批准，且之後我們不得否認該請求。

根據州法律規定，以前獲得我們批准為其醫療狀況提供藥物承保的會員，只要該類藥物開具適當且被視為能安全有效地治療會員的病症，我們就將在處方提供者繼續開立這些藥物期間繼續承保藥物。

## 我如何郵購處方藥？

如果您因長期病症而使用藥物，可以要求將藥物郵寄到您家中。Aetna Better Health 與 CVS Caremark 公司合作，免費為您提供這項服務。

如果您選擇該方案，則您的藥物會直接送到您家。您可以預約重新配藥。您可以向藥劑師諮詢問題。以下是送貨上門服務的其他特點：

- 藥劑師會檢查每份訂單，以確保安全。
- 您可透過郵購、電話、上網重配藥物，或進行註冊以自動重配藥物。
- 您可以透過電話與藥劑師交談。

使用郵購服務很簡單。
從以下三種方式中選擇一種，對您長期使用的藥物使用郵購服務：

- 請撥打 CVS 的免費電話 **1-855-271-6603（聽障專線：711）**（每週 7 天，每天 24 小時提供服務）。他們將告訴您可以透過 CVS 郵購服務藥房配取哪些藥物。然後，CVS 將就處方事宜聯絡您的醫生並將藥物郵寄給您。在致電時，請務必提供：
  - 您的計劃會員 ID 卡
  - 您的醫生的姓名和電話號碼
  - 您的付款資訊和郵寄地址
- 請瀏覽我們的會員入口網站進行註冊或登入。進入會員入口網站後，前往 Tasks（任務），然後選擇 Pharmacy Services（藥房服務）。點擊 CVS 連結即可前往 **Caremark.com**。點擊開始「郵購服務」列印郵購訂單。您可致電 CVS：
  **1-855-271-6603**。請務必在首次註冊時準備好您的會員 ID 卡。
- 填寫並發送郵購服務訂單。如果您已有處方，則可以將其連同填好的郵購服務訂單一起發送給 CVS Caremark。如果您沒有訂單，則可以下載。您也可以致電會員服務部索要一份：**1-855-772-9076（聽障專線：711）**。

  填寫表格時，請提供以下資訊：
  - 您的計劃會員 ID 卡
  - 您的完整郵寄地址，包括郵遞區號
  - 您的醫生的姓名和電話號碼
  - 您的過敏症和其他病症清單
  - 您的醫生開具的原始處方

## 我在哪裡可以獲得特殊級藥物？

CVS 特殊藥房是 Aetna Better Health of California 會員首選的特殊藥房。特殊藥房可為您提供配藥和其他服務。特殊級藥物項目可為您提供特殊服務：

- 您可以隨時聯絡藥劑師

- 諮詢您的藥物和疾病
- 與您和您的醫生協調護理事宜
- 將特殊級藥物送到您家或醫生的辦公室
- 您可以持處方前往任意 CVS 藥房（包括 Target 商店內的藥房）取藥
- 您可以致電 CVS 特殊藥房：**1-800-237-2767**；聽障專線/語障專線：**1-800-863-5488**。CVS 特殊藥房將幫您配取特殊級藥物。

您可透過 CVS 特殊藥房查看**特殊級藥物清單**。

**是否承保非處方 (OTC) 藥物？**
本計劃將承保處方藥一覽表中的 OTC 藥物。有些 OTC 藥物可能有承保規則。如果符合該 OTC 藥物的規則，則本計劃將承保該 OTC 藥物。與其他藥物一樣，如果 OTC 藥物要獲得本計劃的承保，則需要醫生開處方。

**我的醫生或診所提供者開立的某些注射藥物是否在承保範圍內？**
這些類型的藥物由醫療福利承保，而非藥房福利。在大多數情況下，本處方藥一覽表由您從藥房購買並自己服用的藥物組成。如果您的提供者需要在診所內為您給藥（如注射型藥物），那麼他們會有如何給 Aetna Better Health of California 開具賬單的說明。

**我如何找到網絡內藥房？**
您可以透過兩種方式找到藥房：

- **線上**：登入我們的網站：**www.aetnabetterhealth.com/california/find-provider**。
- **撥打電話**：請致電會員服務部：**1-855-772-9076（聽障專線：711）**。他們將很樂意幫助您在附近尋找網絡內藥房。

請務必在網絡內藥房配取處方藥。您在其他藥房配取處方藥無法獲得承保。

**是否有藥物定額手續費？**
請參閱會員手冊，瞭解有關定額手續費的資訊。

**有哪些類型的承保規則？**

- **事先批准 (PA)**：這表示，您的醫生需要先獲得本計劃的批准，然後您才能在藥房配藥。如果未取得批准，本計劃將不會承保該藥物。
- **數量水平限制 (QLL)**：這意味著本計劃承保的藥物數量是有限制的。例如，本計劃在 30 天內僅為某些藥物提供 60 粒藥丸。

- **階段療法 (ST)**：這意味著您可能需要先嘗試某些藥物來治療您的病症。在您嘗試了第一種藥物後，本計劃將承保治療同一病症的另一種藥物。例如，藥物 A 和藥物 B 都可以治療您的病症。本計劃可能不承保藥物 B，除非您先嘗試藥物 A。若藥物 A 對您不起效，則藥物 B 將獲得承保。

- **簡單的靜脈注射溶液**：簡單的靜脈注射溶液通常用於水合療法。包括市售（非複合）溶液，如生理鹽水、葡萄糖（含水量最多 10%）和乳酸林格氏液；此類溶液中的商用氯化鉀溶液也包含在本定義中。簡單的靜脈注射溶液應使用產品的國家藥品編碼 (NDC) 開具賬單。

- **腸外營養液（TPN 或靜脈輸入營養液）**：（腸外營養液是指透過靜脈或動脈內給藥的營養品，通常是氨基酸或蛋白質、葡萄糖、脂質、電解質、維生素和/或礦物質補充劑和微量元素的懸浮液或溶液。）
  - 如果患者在出院前開始使用相同藥物進行靜脈注射治療，則限制在其從急性護理醫院出院後 10 天內配藥。在 10 天的期限內，每次配藥最多提供 10 天的份量。
  - 腸外營養液的輔助性藥物是指在給藥前任何時候物理混合到腸外營養溶液中的其他藥物。對這些藥物的收費將納入腸外營養液的賬單中。

  ***註**：非複合藥物必須使用藥物的 NDC 號開具賬單。複合溶液必須作為複合物賠付開具賬單。

- **單獨使用的靜脈注射用脂質**：
  - 如果患者在出院前開始使用相同產品進行靜脈注射治療，則限制在其從急性護理醫院出院後 10 天內配藥。在 10 天的期限內，每次配藥最多提供 10 天的份量。
  - 如果靜脈注射用脂質溶液或懸浮液與腸外營養液分開使用（即，沒有物理混合到腸外營養液容器中），則應使用產品的 NDC 號開具賬單。

- **腸內產品**：
  - Medi-Cal 腸內營養產品清單上的產品可在獲得醫療事先授權並經過醫療必需性審核後承保。這些產品列於此處：
    **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Aetna Better Health 提供或安排具有醫療必需性的承保腸內產品，並確保提供的產品數量不低於按服務收費的 Medi-Cal 下向受益人提供的數量（根據以下 Medi-Cal 保單所列）：
    **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**若我的藥物不在本計劃的處方藥一覽表上，該怎麼辦？**
如果您的藥物不在首選藥物清單上，您可以採取以下措施。

- 向您的提供者索要清單*上*的類似藥物。
- 請您的提供者向 Aetna Better Health of California 尋求「事先授權」（預先批准）以承保該藥物。

**如果本計劃不承保我的藥物，我的醫生或提供者如何請求事先授權或例外處理？**
他們可以透過三種方式來請求：

1. 您的提供者可將填妥的藥房事先授權或階段療法例外處理申請表傳真至 **1-844-823-5478**，並附上所有必要資訊。
2. 另外，他們也可致電 **1-855-772-9076** 提交請求。
3. 他們還可以提交電子版事先授權 (ePA)。

**如果我對 Aetna Better Health of California 承保藥物的方式存有疑問，該怎麼做？**
瞭解您的藥房福利：

無論是受傷後的止痛藥，還是控制病情的藥物，獲得您需要的處方藥是您醫療保健的重要組成部分。我們希望盡可能為您提供方便。如果您有任何疑問，請致電客戶服務部：**1-855-772-9076（聽障專線：711）**。致電時，請準備好您的處方藥清單。要求我們查詢您的藥物，看看它們是否列在清單中。

## 圖例

*斜體小寫字母* — 普通藥　　**粗體大寫字母** — 品牌藥

**承保要求和限制**
AL — 年齡限制　OTC — OTC 藥物　　PA — 可能適用事先授權
QL — 數量限制　　ST — 可能適用階段療法

**藥物等級**
承保 — 承保藥物　　不承保 — 不承保藥物

## 定义

**品牌药**是指以专有商标保护名称销售的药物。本处方药一览表中的品牌药均以大写字母列示。

**共同保险**是指您在支付自付扣除金后，支付承保的医疗保健福利费用的百分比，前提是医疗保健福利适用自付扣除金。

**定额手续费**是指您在支付自付扣除金后，为承保的医疗保健福利支付的固定美元金额，前提是医疗保健福利适用自付扣除金。

**自付扣除金**是指在您的医疗保险公司开始支付前，您为承保的、需支付自付扣除金的医疗保健福利支付的金额。如果您的健康保险保单有自付扣除金，则医疗保健福利和处方药福利可能有一个自付扣除金或多个单独的自付扣除金。支付自付扣除金后，您通常只需为承保的医疗保健福利支付定额手续费或共同保险。其余的则由保险公司支付。

**药物等级**是指与您的健康保险保单中的特定分摊费用等级对应的一组处方药。处方药所处的药物等级决定了您需为药物支付的费用比例。

**例外处理请求**是指就非处方药一览表药物提出的承保请求。如果您、您的指定人或开具处方的医疗服务提供者就非处方药一览表药物提交了承保请求，那么当您服用该药物具有医疗必要性时，您的保险公司才必须承保该非处方药一览表药物。

**紧急情况**是指您的病情可能严重危及生命、健康或恢复最佳身体机能的能力，或者您目前正在接受非处方药一览表药物治疗的情况。

**处方药一览表**或**处方药清单**是指您的健康保险保单中的处方药福利所承保的药物清单。

**普通药**是指在剂量、规格、疗效、服用方式、质量、安全性和适应症等方面与等效品牌药相同的药物。本处方药一览表中的普通药均以斜体小写字母列示。

**具有医疗必要性**是指诊断、治疗或预防病情或其症状所需的医疗保健福利以及满足公认医学标准的医疗保健福利。健康保险通常不承保不具有医疗必要性的医疗保健福利。

**非处方药一览表药物**是指未列入本处方药一览表的处方药。

**自付费用**是指您的健康保险无法报销的医疗保健福利费用。自付费用包括承保的医疗保健福利的自付扣除金、定额手续费和共同保险，加上未承保的医疗保健福利的所有费用。

**处方提供者**是指能够开具药物处方以诊断、治疗或预防某种医疗状况的医疗服务提供者。

**处方**是指处方提供者授权将处方药提供给特定个人的口头、书面或电子医嘱。

**处方药**是指法律规定需要处方的药物。

**事先授权**是指您的健康保险公司确定医疗保健福利对您而言具有医疗必要性。如果本处方药一览表中的处方药需要获得事先授权，那么您的处方提供者必须请求您的健康保险公司批准，之后才能为您配取处方药。如果服用药物具有医疗必要性，您的健康保险公司必须批准事先授权请求。

**阶段疗法**是指治疗特定医疗状况的处方药必须以特定顺序服用。如果本处方药一览表中的某种药物需要采用阶段疗法，则您可能需要尝试一种或多种其他药物，之后您的健康保险保单才能为您的病情承保这种药物。如果您的处方提供者提交了一份关于阶段疗法要求的例外请求，那么当您服用该药物具有医疗必要性时，您的健康保险公司才必须批准该请求。

**什么是 Aetna Better Health of California 处方药一览表（药物清单）？**

这是一份由 Aetna Better Health of California 拟定的药物清单，称为“处方药一览表”。本计划将承保这份清单中的药物。有些药物可能有承保规则。如果符合该药物的规则，则本计划将承保该药物。

有一个称为“药事和治疗委员会”的委员会，其成员由来自 Aetna Better Health of California 和医学界的医生和药剂师组成。该委员会每三个月召开一次会议，目的是审核这份药物清单以及任何已经诞生的新药。

**本计划的药物清单是否会变更？**

本计划可能会在清单上增加或删除药物。如果某药物从处方药一览表中删除，则使用该药物的会员及其提供者将至少提前 30 天收到通知。所有对处方药一览表的修改将公布在本计划的网站上：**www.aetnabetterhealth.com/california/members/pharmacy。**

处方药一览表在一年当中都有可能发生变更。一些变更原因包括：

- 新药获得批准。
- 现有药物退出市场。
- 处方药可以在柜台买到（不需要处方）。处方药一览表中一般不承保非处方药。
- 品牌药失去专利保护，而普通药可以买到。在此情况下，普通药将取代品牌药进入承保范围。品牌药可能会变成非处方药一览表药物或承保费用更高。请参见“什么是普通药？”部分了解更多信息。

**如何使用本计划的处方药一览表？**

在字母顺序索引中，您可以按照药物所属的治疗类别和等级，或者品牌名或普通药名查找处方药。如果市面上没有与某品牌药等效的普通药，或普通药无法承保，那么该药物将不会按其普通药名单独列出。

- 药物在所属的治疗类别和等级中按品牌名和普通药名的字母顺序列出。
- 品牌药的后面使用括号附加了其普通药，药名使用斜体小写字母并加粗。（例如：COREG (***carvedilol***)）
- 如果某品牌药的等效普通药既在市面上有售又在承保范围内，则该普通药将以加粗的斜体小写字母与该品牌药分开列出；（例如：***carvedilol***）
- 如果普通药以专有商标保护的品牌名销售，则品牌名放在普通药后面的括号内，使用常规字体且每个单词的首字母大写。（例如：***desogestrel-ethinyl***

*estradiol* (Azurette)）。
- 即使处方药包含在处方药一览表中，您的处方提供者也不一定会为特定医疗状况开立该药物。

- **栏 1：处方药名称**：承保药物清单。品牌药全部使用大写字母（如 DRUG）。普通药使用小写字母（如 drug）。确定不同的剂型或规格。

- **栏 2：药物等级**：表明该药物在无费用分摊的情况下承保，除非由州管理。这种情况仅表示，您在向药房出示处方时，他们会采用不同的处理方式。

- **栏 3：承保要求和限制**：说明药物是否需要事先授权或存在其他限制

药物还按照药物等级分组。如果您清楚药物所属的等级，请在目录中查找该等级名称。然后，在此页面下查找所需的药物。

**什么是普通药？**
该计划同时承保品牌药和普通药。普通药成本更低，并且经过美国食品药物管理局 (FDA) 批准。事实证明，普通药与品牌药一样安全有效。它们含有与品牌药等量等质的活性成分，且药效也相同。所以它们的风险和优势与品牌药一样。不过，它们的成本往往更低。

**若我的药物不在处方药一览表上，该怎么办？**
在某些情况下，您或您的处方提供者可以就以下各项提出医疗例外请求：事先授权、阶段疗法或数量限制要求，或者不在您计划承保范围内的药物。承保范围决定将在收到非紧急请求后的 72 小时内做出。您可以申请加急处理您的请求。快速承保范围决定在 24 小时内做出。之后，我们会将决定通知给您和您的医生。所有具有医疗必要性的门诊处方药都将包含在承保范围内。

针对非紧急请求批准的医疗例外将对处方期间承保，包括重新配药。针对紧急情况批准的医疗例外将对紧急情况期间承保。如果您的请求被拒，您有权通过通知函中所述的程序提出上诉。

如果在收到非紧急请求后 72 小时内，以及收到在紧急情况下提出的请求后 24 小时内，未就事先授权或阶段疗法例外处理请求做出决定，则该请求被视为已获批准，且之后我们不得否认该请求。

根据州法律规定，对于以前获得我们批准为其病症提供药物承保的会员，只要药物开立适当并被视为能安全有效地治疗会员的病症，我们就将在处方开具者继续开立这些药物期间继续为其承保。

**我如何邮购处方药？**
如果您因长期病症而使用药物，可以要求将药物邮寄到您家中。Aetna Better Health 与 CVS Caremark 公司合作，免费为您提供这项服务。

如果您选择该方案，则您的药物会直接送到您家。您可以预约重新配药。您可以向药剂师咨询问题。以下是送货上门服务的其他特点：

- 药剂师会检查每份订单，以确保安全。
- 您可通过邮购、电话、上网重配药物，或登记自动重配药物。
- 您可以通过电话与药剂师交谈。

使用邮寄服务很简单。
从以下三种方式中选择一种，对您长期使用的药物使用邮寄服务：

- 请拨打 CVS 的免费电话 **1-855-271-6603（听障专线：711）**（每周 7 天，每天 24 小时提供服务）。他们将告诉您可以通过 CVS 邮寄服务药房配取哪些药物。然后，CVS 将联系您的医生以获取处方并将药物邮寄给您。在致电时，请务必提供：
  - 您的计划会员 ID 卡
  - 医生的姓名和电话号码
  - 您的付款信息和邮寄地址
- 请访问我们的会员门户网站进行注册或登录。进入会员门户网站后，前往 Tasks（任务），然后选择 Pharmacy Services（药房服务）。点击 CVS 链接即可前往 **Caremark.com**。点击“开始‘邮寄服务’”列印邮购单。您可致电 CVS：**1-855-271-6603**。请务必在首次注册时准备好您的会员 ID 卡。
- 填写并发送邮寄服务订单。如果您已有处方，则可以将其连同填好的邮寄服务订单一起发送给 CVS Caremark。如果您没有订单，则可以下载。您也可以致电会员服务部索要一份：**1-855-772-9076（听障专线：711）**。

  填写表格时，请提供以下信息：
  - 您的计划会员 ID 卡
  - 您的完整邮寄地址，包括邮政编码
  - 医生的姓名和电话号码
  - 您的过敏症和其他病症清单
  - 您的医生开具的原始处方

**我在哪里可以获得特殊级药物？**
CVS 特殊药房是 Aetna Better Health of California 会员首选的特殊药房。特殊药房可为您提供配药和其他服务。特殊级药物项目可为您提供特殊服务：

- 您可以随时联系药剂师
- 咨询您的药物和疾病
- 与您和您的医生协调护理事宜
- 将特殊级药物送到您家或医生的办公室
- 您可以持处方前往任意 CVS 药房（包括 Target 商店内的药房）取药

- 您可以致电 CVS 特殊药房：**1-800-237-2767**；听障专线/语障专线：**1-800-863-5488**。CVS 特殊药房将帮您配取特殊级药物。

您可通过 CVS 特殊药房查看**特殊级药物清单**。

**是否承保非处方药？**
本计划将承保处方药一览表中的非处方药。有些 OTC 可能有承保规则。如果符合该 OTC 药物的规则，则本计划将承保该 OTC 药物。与其他药物一样，如果 OTC 药物要获得本计划的承保，则需要医生开处方。

**我的医生或诊所提供者开立的某些注射药物是否在承保范围内？**
这些类型的药物由医疗福利承保，而非药房福利。在很大程度上，本处方药一览表由您从药房购买并自己服用的药物组成。如果您的提供者需要在诊所内给药（如注射药物），那么他们应说明如何给 Aetna Better Health of California 开具账单。

**我如何找到网络内药房？**
您可以通过两种方式找到药房：

- **线上**：登录我们的网站：**www.aetnabetterhealth.com/california/find-provider**。
- **拨打电话**：请致电会员服务部：**1-855-772-9076（听障专线：711）**。他们将很乐意帮助您在附近找到网络内药房。

请务必在网络内药房配取处方药。您在其他药房配取处方药将无法获得承保。

**是否有药物定额手续费？**
请参阅会员手册，了解有关定额手续费的信息。

**有哪些类型的承保规则？**

- **事先批准 (PA)**：这表示，您的医生需要先获得本计划的批准，然后才能在药房配药。如果未取得批准，本计划将不会承保该药物。
- **数量水平限制 (QLL)**：这意味着本计划承保的药物数量是有限制的。例如，本计划在 30 天内仅为某些药物提供 60 粒药丸。
- **阶段疗法 (ST)**：这意味着您可能需要先尝试某些药物来治疗您的病情。在您尝试了第一种药物后，本计划将承保治疗同一病症的另一种药物。例如，药物 A 和药物 B 都可以治疗您的病情。本计划可能不承保药物 B，除非您先尝试药物 A。若药物 A 对您不起效，则药物 B 将在承保范围内。

- **简单的静脉注射溶液**：简单的静脉注射溶液通常用于水化疗法。包括市售（非复合）溶液，如生理盐水、葡萄糖（含水量最多 10%）和乳酸林格氏液；此类溶液中的商用氯化钾溶液也包含在本定义中。简单的静脉注射溶液应使用产品的国家药品编码 (NDC) 号开具账单。

- **肠外营养液（TPN 或静脉输入营养液）**：（肠外营养液是指静脉或动脉内给药的营养品，通常是氨基酸或蛋白质、葡萄糖、脂质、电解质、维生素和/或矿物质补充剂和微量元素的悬浮液或溶液。）
  - 如果患者在出院前开始使用相同药物进行静脉注射治疗，则限制在其从急性护理医院出院后 10 天内配药。在 10 天的期限内，每次配药最多提供 10 天的份量。
  - 肠外营养液的辅助性药物是指在给药前任何时候物理混合到肠外营养溶液中的其他药物。这些产品的账单作为肠外营养液账单的一部分。

***注**：非复合产品必须使用产品的 NDC 号开具账单。复合溶液必须作为复合溶液索赔开具账单。

- **单独使用的静脉注射用脂质**：
  - 如果患者在出院前开始使用相同产品进行静脉注射治疗，则限制在其从急性护理医院出院后 10 天内配药。在 10 天的期限内，每次配药最多提供 10 天的份量。
  - 如果静脉注射用脂质溶液或悬浮液与肠外营养液分开使用（即，没有物理混合到肠外营养液容器中），则应使用产品的 NDC 号开具账单。

- **肠内产品**：
  - Medi-Cal 肠内营养产品清单上的产品可在获得医疗事先授权并经过医疗必要性审核后承保。这些产品列于此处：
    **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Aetna Better Health 根据下列 Medi-Cal 保单提供或安排具有医疗必要性的承保肠内产品，并确保提供的产品数量不低于按服务收费的 Medi-Cal 下向受益人提供的数量：
    **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**若我的药物不在本计划的处方药一览表上，该怎么办？**
如果您的药物不在首选药物清单上，您可以采取以下措施。
- 向您的提供者索要清单上的类似药物。
- 请您的提供者向 Aetna Better Health of California 寻求“事先授权”（预先批准）以承保该药物。

**如果本计划不承保我的药物，我的医生或提供者如何请求事先授权或例外？**

他们可以通过三种方式来请求：

1. 您的提供者可将填妥的药房事先授权或阶段疗法例外处理申请表传真至 **1-844-823-5478**，并附上所有必要信息。
2. 另外，他们也可致电 **1-855-772-9076** 提交请求。
3. 他们还可以提交电子版事先授权 (ePA)。

**如果我对 Aetna Better Health of California 承保药物的方式存有疑问，该怎么做？**
了解您的药房福利：

无论是受伤后的止痛药，还是控制病情的药物，获得您需要的处方药是您医疗保健的重要组成部分。我们希望尽可能为您提供方便。如果您有任何疑问，请致电客户服务部：**1-855-772-9076（听障专线：711）**。致电时，请准备好您的处方药清单。让我们查询您的药物，看看它们是否列在清单中。

## 图例

*斜体小写字母* — 普通药　　**粗体大写字母** — 品牌药

**承保要求和限制**
AL — 年龄限制　OTC — OTC 药物　　PA — 可能适用事先授权
QL — 数量限制　　ST — 可能适用阶段疗法

**药物等级**
承保 — 承保药物　　不承保 — 不承保药物

## Định nghĩa

**Bậc thuốc** nghĩa là nhóm các loại thuốc kê toa đáp ứng một bậc chia sẻ chi phí cụ thể trong hợp đồng bảo hiểm y tế của quý vị. Bậc thuốc mà thuốc kê toa là một phần trong đó sẽ xác định phần chi phí thuốc quý vị phải trả.

**Cần thiết về mặt y tế** nghĩa là các quyền lợi chăm sóc sức khỏe là cần thiết để chẩn đoán, điều trị, hoặc phòng ngừa một bệnh lý hoặc các triệu chứng của nó và quyền lợi đó đáp ứng các tiêu chuẩn về thuốc được chấp nhận. Bảo hiểm y tế thường không bao trả cho các quyền lợi chăm sóc sức khỏe không cần thiết về mặt y tế.

**Chi phí tiền túi** nghĩa là chi phí cho các quyền lợi chăm sóc sức khỏe của quý vị không được bảo hiểm y tế của quý vị bồi hoàn. Chi phí tiền túi bao gồm các khoản khấu trừ, đồng thanh toán, và đồng bảo hiểm cho các quyền lợi chăm sóc sức khỏe được bao trả, cộng với tất cả các chi phí cho các quyền lợi chăm sóc sức khỏe không được bao trả.

**Cho phép trước** nghĩa là hãng bảo hiểm y tế của quý vị quyết định rằng quyền lợi chăm sóc sức khỏe là cần thiết cho quý vị về mặt y tế. Nếu, trong danh mục này, thuốc kê toa phải có sự cho phép trước, nhà cung cấp kê toa của quý vị phải yêu cầu hãng bảo hiểm y tế của quý vị chấp thuận bao trả cho thuốc trước khi quý vị mua toa thuốc của mình. Hãng bảo hiểm y tế của quý vị phải chấp thuận yêu cầu cho phép trước nếu thuốc là cần thiết về mặt y tế đối với quý vị.

**Danh mục thuốc** hoặc **danh sách thuốc kê toa** có nghĩa là danh sách thuốc được bao trả bởi hợp đồng bảo hiểm y tế của quý vị theo quyền lợi thuốc kê toa của hợp đồng này.

**Đồng bảo hiểm** nghĩa là tỷ lệ phần trăm chi phí của một quyền lợi chăm sóc sức khỏe được bao trả mà quý vị thanh toán sau khi quý vị đã trả khoản khấu trừ, nếu quyền lợi chăm sóc sức khỏe này có áp dụng khoản khấu trừ.

**Đồng thanh toán** nghĩa là số tiền cố định tính bằng đồng đô la mà quý vị trả cho một quyền lợi chăm sóc sức khỏe được bao trả sau khi quý vị đã thanh toán khoản khấu trừ, nếu quyền lợi chăm sóc sức khỏe này có áp dụng khoản khấu trừ.

**Khoản khấu trừ** nghĩa là số tiền quý vị thanh toán cho các quyền lợi chăm sóc sức khỏe được bao trả mà chịu khấu trừ trước khi hãng bảo hiểm y tế bắt đầu chi trả. Nếu hợp đồng bảo hiểm y tế của quý vị quy định về một khoản khấu trừ thì nó có thể có một khoản khấu trừ hoặc các khoản khấu trừ riêng biệt áp dụng cho các quyền lợi y tế và các quyền lợi thuốc kê toa. Sau khi quý vị thanh toán khoản khấu trừ, quý vị thường sẽ thanh toán một khoản đồng thanh toán hoặc đồng bảo hiểm cho các quyền lợi chăm sóc sức khỏe được bao trả. Hãng bảo hiểm của quý vị sẽ thanh toán phần còn lại.

**Nhà cung cấp kê toa** nghĩa là nhà cung cấp dịch vụ chăm sóc sức khỏe có thể kê toa thuốc để chẩn đoán, điều trị, hoặc phòng ngừa một bệnh lý.

**Thuốc chính hiệu** nghĩa là thuốc được bán trên thị trường dưới tên độc quyền, được bảo hộ

nhãn hiệu. Trong danh mục này, thuốc chính hiệu được liệt kê dưới dạng tất cả chữ IN HOA.

**Thuốc gốc** nghĩa là thuốc giống như thuốc chính hiệu, tương đương về liều lượng, hoạt lực, hiệu quả, cách dùng, chất lượng, độ an toàn, và mục đích sử dụng. Trong danh mục này, thuốc gốc được liệt kê dưới dạng chữ thường in nghiêng.

**Thuốc kê toa** nghĩa là thuốc mà luật pháp bắt buộc phải kê toa.

**Thuốc không thuộc danh mục** nghĩa là thuốc kê toa không được liệt kê trong danh mục này.

**Toa thuốc** nghĩa là đơn bằng miệng, văn bản hoặc điện tử của nhà cung cấp kê toa cho phép cung cấp thuốc kê toa cho một cá nhân cụ thể.

**Trị liệu theo bước** nghĩa là một bước cụ thể trong đó phải thử thuốc kê toa cho một bệnh lý cụ thể. Nếu, trong danh mục này, một loại thuốc phải tuân thủ trị liệu theo bước, quý vị có thể phải thử một hoặc nhiều loại thuốc khác trước khi hợp đồng bảo hiểm y tế của quý vị bao trả thuốc đó cho bệnh lý của quý vị. Nếu nhà cung cấp kê toa của quý vị gửi yêu cầu xin ngoại lệ đối với yêu cầu trị liệu theo bước, hãng bảo hiểm y tế của quý vị phải chấp nhận yêu cầu đó khi thuốc là cần thiết về mặt y tế đối với quý vị.

**Trường hợp khẩn cấp** có nghĩa là khi quý vị đang gặp phải một tình trạng bệnh lý có thể ảnh hưởng nghiêm trọng đến tính mạng, sức khỏe của quý vị, hoặc khả năng quý vị phục hồi tối đa chức năng, hoặc khi quý vị đang trải qua một đợt điều trị bằng thuốc không thuộc danh mục.

**Yêu cầu ngoại lệ** có nghĩa là yêu cầu bao trả cho thuốc không thuộc danh mục. Nếu quý vị, người được chỉ định của quý vị, hoặc nhà cung cấp dịch vụ chăm sóc sức khỏe kê toa của quý vị gửi yêu cầu bao trả cho thuốc không thuộc danh mục, hãng bảo hiểm của quý vị phải bao trả cho thuốc không thuộc danh mục đó khi nó cần thiết về mặt y tế đối với quý vị.

**Danh mục thuốc (Danh sách thuốc) của Aetna Better Health of California là gì?**
Đây là danh sách thuốc lập bởi Aetna Better Health of California được gọi là Danh mục thuốc. Chương trình sẽ bao trả cho các loại thuốc có tên trong danh sách này. Một số loại thuốc có thể có những quy tắc bảo hiểm. Nếu đáp ứng những quy tắc của thuốc đó, chương trình sẽ bao trả cho thuốc.

Có một ủy ban mang tên Ủy ban Dược phẩm và Trị liệu gồm các bác sĩ và dược sĩ đến từ Aetna Better Health of California cũng như cộng đồng y khoa. Họ gặp gỡ cứ ba tháng một lần để xem lại danh sách thuốc này và bất kỳ loại thuốc mới nào xuất hiện.

**Danh sách thuốc của Chương trình có thể thay đổi không?**
Chương trình có thể thêm hoặc bớt thuốc trên danh sách. Những hội viên đang sử dụng và nhà cung cấp của họ sẽ được thông báo trước ít nhất 30 ngày trước khi thuốc bị loại ra khỏi danh mục thuốc. Mọi thay đổi về danh mục thuốc sẽ được đăng trên trang web của chương trình tại địa chỉ: **www.aetnabetterhealth.com/california/members/pharmacy.**

Danh mục thuốc có thể thay đổi trong suốt cả năm. Một số lý do giải thích tại sao danh mục có thể thay đổi:

- Các thuốc mới được phê duyệt.
- Các thuốc hiện hành bị loại khỏi thị trường.
- Thuốc kê toa có thể trở thành thuốc không cần kê toa (không cần kê toa). Thông thường, trong một danh mục thuốc, thuốc không cần kê toa sẽ không được bao trả.
- Thuốc chính hiệu mất bảo vệ bằng sáng chế và phiên bản thuốc gốc trở lên khả dụng. Khi điều này xảy ra, thuốc gốc sẽ được bao trả thay cho thuốc chính hiệu. Thuốc chính hiệu có khả năng trở thành thuốc không thuộc danh mục hoặc được bao trả ở mức chi phí cao hơn. Xem phần “thuốc gốc là gì?” ở trên để biết thêm thông tin.

**Cách sử dụng Danh mục thuốc của Chương trình?**
Có thể tìm thấy thuốc kê toa bằng cách tra cứu danh mục trị liệu và phân loại của thuốc hoặc tên thuốc gốc hoặc tên thuốc chính hiệu theo thứ tự bảng chữ cái. Nếu trên thị trường không có thuốc gốc tương đương với thuốc chính hiệu hoặc thuốc gốc tương đương không được bao trả, thuốc này sẽ không được liệt kê riêng biệt theo tên gốc của thuốc.

- Một loại thuốc được liệt kê theo thứ tự chữ cái theo tên chính hiệu hoặc tên gốc trong danh mục trị liệu và phân loại của thuốc.
- Tên gốc cho một loại thuốc chính hiệu được liệt kê sau tên chính hiệu trong ngoặc đơn và dưới dạng chữ in nghiêng viết thường và đậm nét. (Ví dụ: COREG (*carvedilol*)).

- Nếu thuốc gốc tương đương cho một loại thuốc chính hiệu có sẵn và được bao trả, thuốc gốc sẽ được liệt kê riêng biệt với thuốc chính hiệu dưới dạng chữ in nghiêng thường và đậm nét; và (Ví dụ: *carvedilol*).
- Nếu thuốc gốc được bán ra thị trường dưới tên chính hiệu độc quyền, được bảo hộ nhãn hiệu, tên chính hiệu sau tên gốc trong ngoặc đơn và kiểu chữ thường có chữ đầu tiên của mỗi từ được viết hoa. (Ví dụ: *desogestrel-ethinyl estradiol* (Azurette)).
- Thuốc kê toa có tên trên danh mục thuốc không đảm bảo rằng bác sĩ kê toa của quý vị sẽ kê toa thuốc đó cho một bệnh lý cụ thể.

- **Cột số 1: Tên Thuốc Kê toa**: liệt kê thuốc được bao trả. Thuốc chính hiệu được viết toàn bộ bằng chữ IN HOA (ví dụ: DRUG). Thuốc gốc được viết bằng chữ thường (ví dụ: drug). Người ta xác định kiểu liều hoặc hoạt lực khác nhau.

- **Cột số 2: Bậc thuốc**: Cho biết thuốc được bao trả mà không phải chia sẻ chi phí, trừ khi bị cắt bớt. Trong trường hợp này, điều này có nghĩa là nhà thuốc sẽ xử lý khác đi khi quý vị xuất trình đơn thuốc cho họ.

- **Cột số 3: Yêu cầu bao trả và Giới hạn**: cho quý vị biết thuốc có cần phải cho phép trước hoặc có giới hạn khác không.

Thuốc cũng được phân nhóm theo loại thuốc. Nếu quý vị biết thuốc thuộc loại nào, vui lòng tìm tên loại thuốc trong phần mục lục. Sau đó tìm thuốc ở trang đó.

**Thuốc gốc là gì?**
Chương trình bao trả cho cả thuốc chính hiệu lẫn thuốc gốc. Thuốc gốc có mức chi phí thấp hơn và được Cơ quan Quản lý Thực phẩm và Dược Phẩm (FDA) chấp thuận. Thuốc gốc được chứng minh là cũng an toàn và hiệu quả như thuốc chính hiệu. Chúng chứa cùng thành phần hoạt tính với cùng lượng như thuốc chính hiệu và có tác dụng theo cách tương tự. Do đó, chúng có cùng rủi ro và lợi ích như thuốc chính hiệu. Tuy nhiên, thường thì chi phí của chúng thấp hơn.

**Thuốc của tôi không có trên danh sách thuốc thì sao?**
Trong một số trường hợp, quý vị hoặc bác sĩ kê toa của quý vị có thể yêu cầu một ngoại lệ về mặt y tế đối với sự cho phép trước, trị liệu theo bước hoặc yêu cầu hạn chế số lượng hoặc yêu cầu thuốc mà không được chương trình của quý vị bao trả. Người ta sẽ xác định việc bao trả trong vòng 72 giờ sau khi nhận được yêu cầu không khẩn cấp. Quý vị có thể đề nghị xử lý cấp tốc yêu cầu của mình. Quyết định bao trả cấp tốc sẽ được xử lý trong vòng 24 giờ. Sau đó chúng tôi sẽ liên hệ với quý vị và bác sĩ của quý vị để cho biết quyết định của chúng tôi. Tất cả các loại thuốc kê toa ngoại trú cần thiết về mặt y tế đều sẽ được bao trả.

Mọi ngoại lệ về mặt y tế được chấp thuận cho yêu cầu không khẩn cấp sẽ có hiệu lực trong khoảng thời gian kê toa, gồm cả mua lại thuốc. Các ngoại lệ về mặt y tế được chấp thuận cho các trường hợp khẩn cấp sẽ có hiệu lực trong khoảng thời gian khẩn cấp. Nếu yêu cầu của quý vị bị từ chối, quý vị có quyền kháng cáo thông qua quy trình được hướng dẫn trong thư thông báo.

Nếu quyết định về yêu cầu ngoại lệ đối với sự cho phép trước hoặc trị liệu theo bước không được đưa ra trong vòng 72 giờ kể từ khi nhận được yêu cầu không khẩn cấp và 24 giờ kể từ khi nhận được yêu cầu dựa trên trường hợp khẩn cấp thì yêu cầu được coi là đã được chấp thuận và sau đó chúng tôi không được từ chối yêu cầu.

Theo luật của tiểu bang, những hội viên trước đó đã được chúng tôi chấp thuận bao trả cho thuốc cho bệnh lý của họ, thì sẽ tiếp tục được bao trả cho thuốc đó, chừng nào bác sĩ kê toa tiếp tục kê thuốc đó, chừng nào thuốc đó còn được kê một cách thích hợp và được coi là an toàn và hiệu quả trong việc điều trị bệnh lý của hội viên.

**Tôi nhận thuốc kê toa qua đường bưu điện như thế nào?**
Nếu quý vị dùng thuốc cho một bệnh trạng hiện thời, quý vị có thể nhận thuốc tại nhà được gửi đến qua đường bưu điện. Aetna Better Health hợp tác với một công ty có tên là CVS Caremark, để cung cấp cho quý vị dịch vụ này mà không tính phí quý vị.

Nếu quý vị chọn cách này thì thuốc của quý vị sẽ được gửi thẳng đến nhà quý vị. Quý vị có thể thu xếp việc mua lại thuốc của mình. Quý vị có thể đặt câu hỏi cho dược sĩ. Dưới đây là một số đặc điểm khác của dịch vụ giao thuốc đến tận nhà:

- Dược sĩ kiểm tra mỗi đơn thuốc để bảo đảm sự an toàn.
- Quý vị có thể đặt mua tiếp thuốc qua đường bưu điện, qua điện thoại, trực tuyến hoặc quý vị có thể đăng ký để được tự động mua tiếp thuốc.
- Quý vị có thể nói chuyện với dược sĩ qua điện thoại.

Thật dễ để bắt đầu sử dụng dịch vụ gửi thuốc qua đường bưu điện.
Chọn MỘT trong ba cách sau để sử dụng dịch vụ qua đường bưu điện đối với thuốc quý vị dùng liên tục:

- Goi đến số miễn cước **1-855-271-6603 (TTY: 711)** (24 giờ/ngày, 7 ngày/tuần). Họ sẽ cho quý vị biết loại thuốc nào của quý vị có thể được mua tiếp thông qua dịch vụ gửi thuốc qua đường bưu điện CVS. CVS sau đó sẽ liên hệ với bác sĩ của quý vị để lấy đơn thuốc và gửi thuốc qua bưu điện cho quý vị. Khi gọi điện, quý vị đảm bảo chuẩn bị sẵn:
    - Thẻ ID hội viên Chương trình của mình
    - Số điện thoại, họ và tên của bác sĩ của quý vị
    - Thông tin thanh toán và địa chỉ gửi thư của quý vị

- Truy cập cổng thông tin hội viên để đăng ký hoặc đăng nhập. Ngay sau khi quý vị đăng nhập vào cổng thông tin hội viên, hãy đến phần Tác vụ và sau đó là Dịch vụ Nhà thuốc. Nhấn vào đường dẫn CVS để chuyển tới **Caremark.com**. Nhấn vào bắt đầu "dịch vụ qua bưu điện" để in mẫu yêu cầu qua đường bưu điện. Quý vị có thể liên hệ với CVS theo số **1-855-271-6603**. Đảm bảo rằng quý vị đã chuẩn bị sẵn thẻ ID hội viên khi lần đầu đăng ký.
- Điền thông tin và gửi mẫu yêu cầu dịch vụ qua đường bưu điện. Nếu quý vị đã có đơn thuốc, quý vị có thể gửi đến CVS Caremark cùng với mẫu yêu cầu dịch vụ qua đường bưu điện đã điền thông tin. Nếu quý vị không có mẫu yêu cầu, quý vị có thể tải xuống. Quý vị cũng có thể gọi đến Dịch vụ Hội viên theo số **1-855-772-9076 (TTY: 711)** để yêu cầu mẫu.

  Chuẩn bị thông tin sau khi quý vị điền vào mẫu:
  - Thẻ ID hội viên Chương trình của mình
  - Địa chỉ gửi thư đầy đủ của quý vị, gồm cả mã ZIP
  - Số điện thoại, họ và tên của bác sĩ của quý vị
  - Danh sách các dị ứng và các tình trạng sức khỏe khác
  - Đơn thuốc gốc do bác sĩ của quý vị kê

**Tôi có thể mua thuốc biệt dược ở đâu?**
CVS Specialty Pharmacy là nhà thuốc biệt dược dành cho các hội viên của Aetna Better Health of California. Nhà thuốc biệt dược có các loại thuốc và các dịch vụ khác để giúp quý vị. Chương trình Thuốc Biệt dược có các dịch vụ đặc biệt dành cho quý vị:

- Quý vị có thể trao đổi với dược sĩ 24 giờ/ngày, 7 ngày/tuần
- Tham vấn về thuốc và bệnh của quý vị
- Điều phối chăm sóc với quý vị và bác sĩ của quý vị
- Giao thuốc biệt dược đến nhà quý vị hoặc phòng khám bác sĩ
- Quý vị có thể để trình đơn thuốc và nhận thuốc của mình tại bất kỳ nhà thuốc CVS Pharmacy nào (gồm cả những nhà thuốc bên trong các cửa hàng Target)
- Quý vị có thể gọi cho CVS Specialty Pharmacy theo số **1-800-237-2767**; TTY/TDD:
  **1-800-863-5488**. CVS Specialty Pharmacy sẽ giúp quý vị mua thuốc biệt dược của mình.

Xem **danh sách thuốc biệt dược** có sẵn tại CVS Specialty Pharmacy.

**Thuốc không cần kê toa (OTC) có được bao trả không?**
Chương trình sẽ bao trả cho thuốc OTC có trên danh mục thuốc. Một số loại thuốc OTC có thể có quy tắc về bao trả. Nếu đáp ứng những quy tắc của thuốc OTC đó, chương trình sẽ bao trả cho thuốc OTC. Giống như các loại thuốc khác, thuốc OTC cần đơn thuốc của bác sĩ để được chương trình bao trả.

**Một số loại thuốc tiêm được bác sĩ hoặc nhà cung cấp của tôi cho dùng tại phòng khám thì có được bao trả không?**
Những loại thuốc này được bao trả theo quyền lợi y tế thay vì quyền lợi nhà thuốc. Thông thường, danh mục thuốc này bao gồm các loại thuốc quý vị mua từ nhà thuốc và tự dùng. Nếu nhà cung cấp của quý vị cần cho quý vị dùng thuốc này tại phòng khám, chẳng hạn như một loại thuốc tiêm thì họ có hướng dẫn về cách gửi hóa đơn cho Aetna Better Health of California.

**Làm thế nào để tôi tìm được nhà thuốc trong mạng lưới?**
Quý vị có thể tìm thấy nhà thuốc theo hai cách:

- **Trực tuyến**: Đăng nhập vào trang web tại địa chỉ **www.aetnabetterhealth.com/california/find-provider**.

- **Qua điện thoại**: Gọi cho Dịch vụ Hội viên theo số **1-855-772-9076 (TTY: 711)**. Họ sẽ sẵn lòng giúp quý vị tìm nhà thuốc trong mạng lưới gần quý vị.

Luôn nhớ mua thuốc kê toa tại nhà thuốc trong mạng lưới. Thuốc kê toa của quý vị sẽ không được bao trả nếu mua tại các nhà thuốc khác.

**Tôi có phải đồng trả thuốc không?**
Tham khảo sổ tay hội viên để biết thông tin về đồng trả.

**Một số loại quy tắc bao trả là gì?**

- **Chấp thuận trước (PA)**: Điều này có nghĩa là bác sĩ của quý vị sẽ cần xin chấp thuận trước từ chương trình trước khi có thể mua thuốc tại nhà thuốc. Nếu không được chấp thuận, chương trình sẽ không bao trả cho thuốc đó.

- **Hạn mức số lượng (QLL)**: Điều này có nghĩa là có hạn mức về lượng thuốc mà chương trình sẽ bao trả. Ví dụ: chương trình cung cấp 60 viên trong 30 ngày cho một số loại thuốc.

- **Trị liệu theo bước (ST)**: Điều này có nghĩa là quý vị cần thử một số loại thuốc trước để điều trị bệnh lý của mình. Sau khi đã thử thuốc đầu tiên,

chương trình sau đó sẽ bao trả cho thuốc khác cho cùng bệnh lý. Ví dụ: Thuốc A và Thuốc B có thể điều trị bệnh lý của quý vị. Chương trình có thể không bao trả cho Thuốc B trừ khi quý vị thử Thuốc A trước. Nếu Thuốc A không có hiệu quả với quý vị, thì Thuốc B sẽ được bao trả.

- **Dung dịch truyền tĩnh mạch đơn giản**: Các dung dịch truyền tĩnh mạch đơn giản thường được sử dụng làm liệu pháp bù nước. Bao gồm các dung dịch có sẵn về mặt thương mại (không hợp chất), chẳng hạn như Dung dịch muối Thông thường, Dextrose (tối đa 10% Nước) và Lactated Ringer's Solution; các dung dịch kali clorua được pha chế thương mại trong các dung dịch đó cũng thuộc định nghĩa này. Các dung dịch truyền tĩnh mạch đơn giản phải được lập hóa đơn sử dụng số Mã Thuốc Quốc gia (NDC) của sản phẩm.

- **Dung dịch Dinh dưỡng Ngoài đường tiêu hóa (TPN hay Hyperalimentation)**: (Dung dịch dinh dưỡng ngoài đường tiêu hóa là các sản phẩm dinh dưỡng trong tĩnh mạch hoặc trong động mạch thường là hỗn dịch hoặc dung dịch axit amin, dextrose, lipid, chất điện giải, vitamin &/hoặc bổ sung khoáng chất và nguyên tố vi lượng.)
  - Chỉ được phân phát trong vòng 10 ngày sau khi xuất viện khỏi bệnh viện chăm sóc cấp tính, khi liệu pháp I.V. với cùng loại thuốc được bắt đầu trước khi xuất viện. Phân phát đủ cho tối đa 10 ngày trong thời hạn 10 ngày.
  - Bổ sung cho dinh dưỡng ngoài đường tiêu hóa là các thuốc khác được pha vào dung dịch dinh dưỡng ngoài đường tiêu hóa vào bất kỳ thời điểm nào trước khi cho dùng. Hóa đơn cho những sản phẩm này là một phần của hóa đơn dinh dưỡng ngoài đường tiêu hóa.

  ***Lưu ý**: Các sản phẩm không hợp chất phải được lập hóa đơn sử dụng số NDC của sản phẩm. Các dung dịch hợp chất phải được lập hóa đơn dưới dạng yêu cầu về hợp chất.

- **Lipid qua đường tĩnh mạch riêng biệt**:
  - Chỉ được phân phát trong vòng 10 ngày sau khi xuất viện khỏi bệnh viện chăm sóc cấp tính, khi liệu pháp I.V. với cùng loại sản phẩm được bắt đầu trước khi xuất viện. Phân phát đủ cho tối đa 10 ngày trong thời hạn 10 ngày.
  - Dung dịch hoặc hỗn dịch lipid qua tĩnh mạch được cho dùng riêng biệt với dung dịch dinh dưỡng ngoài đường tiêu hóa (tức là, không pha vào lọ dung dịch dinh dưỡng ngoài đường tiêu hóa) phải được lập hóa đơn sử dụng số NDC của sản phẩm.

- **Sản phẩm qua đường ruột**:
  - Các sản phẩm trên Danh sách sản phẩm Dinh dưỡng qua đường ruột của Medi-Cal được bao trả khi có sự cho phép trước và khi có sự xem xét về tính cần thiết về mặt y tế. Những sản phẩm này được liệt kê tại đây: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Aetna Better Health cung cấp hoặc thu xếp các sản phẩm qua đường ruột được bao trả cần thiết về mặt y tế, và đảm bảo rằng những sản phẩm này được cung cấp với số lượng không thấp hơn số lượng được cung cấp cho những người thụ hưởng theo Dịch vụ tính phí của Medi-Cal, theo chính sách Medi-Cal được liệt kê ở đây: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**Thuốc của tôi không có trên Danh mục thuốc của chương trình thì sao?**
Nếu thuốc của quý vị không có trong danh sách thuốc được ưu tiên, quý vị có thể thực hiện một số việc.

- Đề nghị nhà cung cấp của quý vị kê thuốc tương tự *như* trên danh sách.
- Đề nghị nhà cung cấp của quý vị xin "cho phép trước" (chấp thuận trước) từ Aetna Better Health of California để bao trả cho thuốc này.

**Bác sĩ hoặc nhà cung cấp của tôi có thể yêu cầu cho phép trước hoặc ngoại lệ bằng cách nào nếu chương trình không bao trả cho thuốc của tôi?**
Họ có thể làm điều này theo ba cách:

1. Nhà cung cấp của quý vị có thể gửi fax mẫu xin ngoại lệ đối với trị liệu theo bước hoặc cho phép trước hoàn chỉnh đến **1-844-823-5478** và kèm mọi thông tin cần thiết.
2. Họ cũng có thể gửi yêu cầu qua điện thoại bằng cách gọi đến số **1-855-772-9076**.
3. Họ có thể gửi Cho Phép Trước Điện Tử (ePA).

**Nếu tôi có thắc mắc về cách Aetna Better Health of California bao trả cho thuốc thì sao?**
Tìm hiểu về các quyền lợi nhà thuốc của quý vị:

Dù là thuốc giảm đau sau chấn thương hoặc thuốc để kiểm soát tình trạng bệnh, việc mua thuốc kê toa quý vị cần là một phần quan trọng trong chăm sóc sức khỏe của quý vị. Chúng tôi muốn việc này dễ dàng nhất với quý vị. Nếu quý vị có thắc mắc gì, vui lòng gọi cho Dịch vụ Hội viên theo số **1-855-772-9076 (TTY: 711)**. Chuẩn bị sẵn

danh sách đơn thuốc khi quý vị gọi. Nhờ chúng tôi tra cứu thuốc của quý vị để xem thuốc đó có trên danh sách không.

## GHI CHÚ

*chữ thường in nghiêng* - Thuốc gốc **CHỮ IN HOA ĐẬM** -Thuốc chính hiệu

**Yêu cầu bao trả và Giới hạn**

AL - Giới hạn độ tuổi OTC - Thuốc OTC PA - Có thể áp dụng cho phép trước
QL - Giới hạn số lượng ST - Có thể áp dụng trị liệu theo bước

**Bậc thuốc**

Được bao trả - Thuốc được bao trả Không được bao trả -Thuốc không được bao trả

## Mga Depinisyon

Ang **may brand name na gamot** ay nangangahulugan sa isang gamot na mina-market sa ilalim ng isang pangalan na may nagmamay-ari at protektado ng trademark. Nakalista ang may brand name na gamot sa formulary na ito nang nakasulat sa MALALAKING letra lahat.

Ang **coinsurance** ay nangangahulugan sa porsiyento ng halaga ng sakop na benepisyo sa pangangalagang pangkalusugan na babayaran mo pagkatapos mong bayaran ang deductible, kung mayroong deductible sa benepisyo sa pangangalagang pangkalusugan.

Ang **copayment** ay nangangahulugan sa hindi nagbabagong halaga ng dolyar na babayaran mo para sa isang sakop na benepisyo sa pangangalagang pangkalusugan pagkatapos mong bayaran ang deductible, kung mayroong deductible sa benepisyo sa pangangalagang pangkalusugan.

Ang **deductible** ay nangangahulugan sa halagang babayaran mo para sa mga sakop na benepisyo sa pangangalagang pangkalusugan na sumasailalim sa deductible bago magsimulang magbayad ang iyong insurer sa kalusugan. Kung may deductible ang policy ng iyong insurance sa kalusugan, maaari itong magkaroon ng alinman sa isang deductible o hiwalay na mga deductible para sa mga pangmedikal na benepisyo at mga benepisyo sa inireresetang gamot. Pagkatapos mong bayaran ang iyong deductible, kadalasan ay babayaran mo lang ang isang copayment o coinsurance para sa mga sakop na benepisyo sa pangangalagang pangkalusugan. Babayaran ng kumpanya ng iyong insurance ang natitira.

Ang **tier ng gamot** ay nangangahulugan sa grupo ng mga inireresetang gamot na katumbas ng isang tinukoy tier ng pagbabahagi sa halaga sa policy ng iyong insurance sa kalusugan. Ang tier ng gamot kung saan inilalagay ang isang inireresetang gamot ay tinutukoy ang bahagi mo sa halaga para sa gamot.

Ang **exception request** ay nangangahulugan sa isang request sa pag-cover ng gamot na wala sa formulary. Kung ikaw, ang iyong itinalaga, o ang iyong tagaresetang provider ng pangangalagang pangkalusugan ay magsusumite ng isang request sa pag-cover ng gamot na walang sa formulary, dapat i-cover ng iyong insurer ang gamot na wala sa formulary kapag ito ay medikal na kinakailangan para mainom mo ang gamot.

Ang **exigent na mga pangyayari** ay nangangahulugan sa kapag nakakaranas ka ng medikal na kondisyon na posibleng lubhang mailagay sa panganib ang iyong buhay, kalusugan, o kakayahang makabalik sa maximum na paggana, o kapag ikaw ay sumasailalim sa isang kasalukuyang haba ng paggamot gamit ang isang gamot na wala sa formulary.

Ang **formulary** o **listahan ng inireresetang gamot** ay nangangahulugan sa listahan ng mga gamot na covered ng policy ng iyong insurance sa kalusugan sa ilalim ng benepisyo sa inireresetang gamot ng policy.

Ang **generic na gamot** ay nangangahulugan sa isang gamot na katumbas ng may brand name na gamot nito sa dosis, lakas, epekto, paano ito iniinom, kalidad, kaligtasan at nilalayong paggamit nito. Nakalista ang generic na gamot sa formulary na ito nang nakasulat sa naka-italic na maliliit na letra.

Ang **medikal na kinakailangan** ay nangangahulugan sa mga benepisyo sa pangangalagang pangkalusugan na kinakailangan para i-diagnose, gamutin, o iwasan ang isang medikal na kondisyon o ang mga sintomas nito at na nakakatugon sa mga tinatanggap na pamantayan sa medisina. Kadalasan ay hindi kino-cover ng insurance sa kalusugan ang mga benepisyo sa pangangalagang pangkalusugan na hindi medikal na kinakailangan.

Ang **gamot na wala sa formulary** ay nangangahulugan sa inireresetang gamot na hindi nakalista sa formulary na ito.

Ang **mga gastos na babayaran mula sa sariling bulsa** ay nangangahulugan sa mga gastos mo para sa mga benepisyo sa pangangalagang pangkalusugan na hindi babayaran ng iyong insurance sa kalusugan. Kasama sa mga gastos na babayaran mula sa sariling bulsa ang mga deductible, copayment, at coninsurance para sa mga covered na benepisyo sa pangangalagang pangkalusugan, at ang lahat ng gastos para sa mga benepisyo sa pangangalagang pangkalusugan na hindi covered.

Ang **tagaresetang provider** ay nangangahulugan sa provider ng pangangalagan pangkalusugan na maaaring sumulat ng reseta para sa isang gamot para i-diagnose, gamutin, o iwasan ang isang medikal na kondisyon.

Ang **reseta ay nangangahulugan** sa isang berbal, nakasulat, o elektronikong order mula sa isang tagaresetang provider na nagbibigay ng awtorisasyon sa isang inireresetang gamot na ibigay sa partikular na indibiduwal.

Ang **gamot na wala sa formulary** ay nangangahulugan sa isang gamot na nangangailangan ng reseta ayon sa batas.

Ang **paunang pahintulot** ay nangangahulugan sa isang desisyon ng iyong insurer sa kalusugan na medikal na kinakailangan para sa iyo ang isang benepisyo sa pangangalagang pangkalusugan. Kung sumasailalim ang isang inireresetang gamot sa paunang pahintulot sa formulary na ito, dapat humingi ng pag-apruba ang iyong tagaresetang provider mula sa iyong insurer sa kalusugan para ma-cover ang gamot bago mo papunan ng gamot ang iyong reseta. Dapat payagan ng iyong insurer sa kalusugan ang isang request para sa paunang pahintulot kapag ito ay medikal na kinakailangan para mainom mo ang gamot.

Ang **step therapy** ay nangangahulugan sa partikular na sequence na dapat subukan ang mga inireresetang gamot para sa isang partikular na medikal na kondisyon. Kung ang isang gamot ay sumasailalim sa step therapy sa formulary na ito,

maaaring kailangan mong subukan ang isa o higit pa sa mga gamot bago i-cover ng policy ng iyong insurance sa kalusugan ang gamot na iyon para sa iyong medikal na kondisyon. Kung magsusumite ng request ang iyong tagaresetang provider para sa isang exception sa kinakailangang step therapy, dapat payagan ng iyong insurer sa kalusugan ang request kapag ito ay medikal na kinakailangan para mainom mo ang gamot.

**Ano ang Formulary ng Aetna Better Health of California (Listahan ng mga Gamot)?**
Ito ay listahan ng gamot na ginawa ng Aetna Better Health of Califiornia na tinatawag na Formulary ng Gamot. Iko-cover ng plano ang mga gamot na nasa listahang ito. Ang ilang gamot ay posibleng may mga panuntunan tungkol sa coverage. Kung natutugunan ng gamot na iyon ang mga panuntunan, iko-cover ng plano ang gamot.

May komite na tinatawag na Pharmacy and Therapeutics Committee na binubuo ng mga doktor at parmasya mula sa Aetna Better Health of California at ng medikal na komunidad. Nagpupulong sila kada tatlong buwan para suriin ang listahan ng mga gamot na ito at ang anumang mga bagong gamot na lumabas.

**Maaari bang magbago ang listahan ng gamot ng Plano?**
Posibleng magdagdag o mag-alis ang planong mga gamot sa listhan. Aabisuhan ang mga gumagamit na miyembro at ang kanilang mga provider nang hindi bababa sa 30 araw bago alisin ang gamot sa formulary. Ang lahat ng pagbabago sa formulary ay ipo-post sa website ng plano sa: **www.aetnabetterhealth.com/california/members/pharmacy.**

Maaaring magbago ang formulary sa buong taon. Kasama sa ilang dahilan kung bakit maaaring magbago ito:

- Inaprubahan ang mga bagong gamot.
- Inalis sa merkado ang mga dati nang gamot.
- Posibleng makuha ang mga inireresetang gamot nang over the counter (walang reseta). Ang mga over-the-counter na gamot ay hindi karaniwang covered sa isang formulary.
- Nawalan ng proteksyon sa patent ang mga may brand name na gamot at nagkaroon ng mga generic na bersyon. Kapag nangyari ito, iko-cover ang generic na gamot kapalit ng may brand name na gamot. Ang may brand name na gamot ay posibleng maging hindi kasama sa formulary o i-cover sa mas mataas na halaga. Tingnan ang seksyong “ano ang mga generic na gamot?” sa itaas para sa higit pang impormasyon.

**Paao ko gagamitin ang Formulary ng Plano?**
Maaaring mahanap ang inireresetang gamot sa pamamagitan ng paghahanap sa

kategorya at uri ng gamot kung saan ito napapabilang o ang brand o generic name ng gamot sa nakaalpabetong index. Kung hindi available sa merkado ang generic na katumbas para sa isang may brand name na gamot o hindi ito covered, hindi hiwalay na ililista ang gamot nang ayon sa generic name nito.

- Nakalista nang nakaalpabeto ang isang gamot ayon sa brand nito at sa mga generic name na nasa kategorya at uri ng gamot kung saan ito napapabilang.
- Ang generic name para sa isang may brand name na gamot ay isinasama pagkatapos ng brand name sa loob ng parenthesis at nakasulat sa naka-bold at maliliit na naka-italicize na letra. (Halimbawa: COREG (*carvedilol*)).
- Kung ang generic na katumbas para sa isang may brand name para sa isang may brand name na gamot ay parehong available at covered, hiwalay na ililista ang generic na gamot sa may brand name na gamot nang nakasulat sa naka-bold at maliliit na naka-italicize na letra, at (Halimbawa: *carvedilol*).
- Kung mina-market ang isang generic na gamot sa ilalim ng isang brand name na may nagmamay-ari at protektado ng trademark, ang brand name pagkatapos ng generic name na nasa loob ng parenthesis at regular na typeface kung saan ang unang letra ng bawat salita ay nakasulat sa malaking letra. (Halimbawa: *desogestrel-ethinyl estradiol* (Azurette)).
- Ang pagsasama ng isang inireresetang gamot sa formulary ay hindi ginagarantiya na irereseta ng iyong provider ang gamot para sa isang partikular na medikal na kondisyon.

- **Hanay #1: Pangalan ng Inireresetang Gamot**: inililista ang covered na gamot. Ang mga may brand na gamot ay nakasulat sa MALALAKING letra lahat (halimbawa: GAMOT). Ang mga generic ay nakasulat sa maliliit na letra (halimbawa: gamot). Tinutukoy ang iba't ibang anyo o lakas ng dosis.

- **Hanay #2: Tier ng Gamot**: Isinasaad na covered ang gamot nang walang pagbabahagi sa gastos, maliban na lang kung ito ay hindi isinama sa state. Sa kasong ito, ibig sabihin lang nito na ipoproseso ito ng parmasya sa ibang paraan kapag ibinigay mo sa kanila ang iyong reseta.

- **Hanay #3: Mga Kinakailangan at Limitasyon sa Coverage**: sinasabi sa iyo kung kailangan ng gamot ng paunang pahintulot o ng iba pang mga paghihigpit

Ginugrupo rin ang mga gamot nang ayon sa uri ng gamot. Kung alam mo kung sa

anong uri napapabilang ang iyong gamot, pakihanap ang pangalan ng uri sa talaan ng mga nilalaman. Pagkatapos, hanapin ang iyong gamot sa page na iyon.

**Ano ang mga generic na gamot?**
Kino-cover ng plano ang parehong mga brand at mga generic na gamot. Mas mura ang mga generic na gamot at aprubado ang mga ito ng Food and Drug Administration (FDA). Napatunayan ang mga generic na gamot bilang kasing ligtas at kasing bisa ng mga may brand name na gamot. Ang mga ito ay mayroong parehong mga aktibong sangkap na may parehong dami katulad ng sa mga may brand name na gamot at gumagana ito sa parehong paraan. Kaya ang mga ito ay may parehong mga panganib at benepisyo katulad ng sa mga may brand name na gamot. Gayunpaman, karaniwan ang mga ito ay mas mura.

**Paano kung wala sa listahan ng gamot ang aking gamot?**
Sa ilang mga pangyayari, ikaw o ang iyong tagareseta ay maaaring humiling ng isang medikal na exception sa paunang pahintulot, step therapy o kinakailangan tungkol sa mga limitasyon sa dami o para sa isang gamot na hindi covered sa iyong plano. Gagawa ng mga pagpapasya tungkol sa coverage sa loob ng 72 oras pagkatapos matanggap ang mga hindi apurahang request. Maaari mong hilingin na pabilisin ang iyong request. Ang mga pinabilis na desisyon tungkol sa coverage ay ginagawa sa loob ng 24 na oras. Pagkatapos, makikipag-ugnayan kami sa iyo at sa iyong doktor tungkol sa aming desisyon. Iko-cover ang lahat ng medikal na kinakailangang mga pang-outpatient na inireresetang gamot.

Iko-cover ng mga medikal na exception na inaprubahan para sa mga hindi apurahang request ang tagal ng gamot, kasama ang mga pag-refill. Ang mga inaprubahang medikal na exception para sa mga pangyayari na nangangailangan ng agarang aksyon ay magbibigay ng coverage para sa haba ng pangyayari na nangangailangan ng agarang aksyon. Kung tatanggihan ang iyong request, may karapatan kang magsampa ng apela gamit ang prosesong inilarawan sa sulat na abiso.

Kung hindi gagawa ng pagpapasya para sa paunang pahintulot o request para sa step therapy exception sa loob ng 72 oras pagkatapos matanggap ang request na hindi apurahan at 24 na oras pagkatapos matanggap ang request batay sa isang pangyayari na nangangailangan ng agarang aksyon, itinuturing na inaprubahan ang request at hindi namin maaaring tanggaihan ang request pagkatapos noon.

Ayon sa batas ng estado, ang mga miyembrong nakatanggap ng pag-apruba dati mula sa amin para sa coverage ng mga gamot para sa kanilang mga medikal na kondisyon ay patuloy na iko-cover ang mga gamot na iyon, basta't patuloy na irereseta ag mga ito ng tagareseta, basta't ang gamot ay inireseta nang naaangkop at itinuturing na ligtas at mabisa para gamutin ang medikal na kondisyon ng miyembro.

**Paano ako makakatanggap ng gamot na in-order sa koreo?**
Kung umiinom ka ng gamot para sa kasalukuyang kondisyon sa kalusugan, maaari mong hilingin na ipadala ito sa iyong bahay sa pamamagitan ng koreo. Nakikipagtulungan ang Aetna Better Health sa isang kumpanyang tinatawag na CVS Caremark, para ibigay sa iyo ang serbisyong ito na makukuha mo nang wala kang babayaran.

Kung pipiliin mo ang opsyong ito, ihahatid sa iyong bahay ang gamot mo. Maaari mong i-set up ang iyong mga refill. Maaari kang magtanong sa mga parmasiyotiko. Narito ang ilang iba pang feature ng paghahatid sa bahay:

- Tinitingnan ng mga parmasiyotiko ang bawat order para sa kaligtasan.
- Maaari kang mag-order ng mga refill sa koreo, telepono, online o puwede kang mag-sign up para sa mga awtomatikong pag-refill.
- Maaari mong kausapin sa telepono ang mga parmasiyotiko.

Madaling magsimulang gumamit ng serbisyo ng koreo.
Pumili ng ISA sa mga sumusunod na tatlong paraan para gumamit ng serbisyo ng koreo para isang gamot na patuloy mong iniinom:

- Tawagan ang numero ng CVS sa **1-855-271-6603 (TTY: 711)** nang walang bayad (24 na oras sa isang araw, 7 araw sa isang linggo). Ipapaalam sa iyo nito kung alin sa iyong mga gamot ang maaaring mapunan sa pamamagitan ng parmasya ng CVS na mayroong serbisyo ng koreo. Pagkatapos, makikipag-ugnayan kami sa iyong doktor para sa isang reseta at ipapadala sa iyo ang gamot sa pamamagitan ng koreo. Kapag tumawag ka, tiyaking ihanda mo ang:
  - Ang iyong member ID card sa Plano
  - Ang pangalan at apelyido at numero ng telepono ng iyong doktor
  - Ang iyong impormasyon sa pagbabayad at address para sa koreo

- Pumunta sa aming portal ng miyembro para mag-register o mag-log in. Kapag nakapasok ka na sa portal ng miyembro, pumuna sa Tasks (Mga Gawain) at pagkatapos ay sa Pharmacy Services (Mga Serbisyo ng Parmasya). I-click sa link ng CVS para pumunta sa **Caremark.com**. I-click sa simulan ang "mail service (serbisyo ng koreo)" para i-print ang form para sa pag-order sa koreo. Maaari kang makipag-ugnayan sa CVS sa **1-855-271-6603**. Tiyaking ihanda ang iyong ID card ng miyembro kapag nag-register ka sa unang pagkakataon.
- Punan at ipadala ang form para sa pag-order sa pamamagitan ng serbisyo ng koreo. Kung mayroon ka nang reseta, puwede mo itong

ipadala sa CVS Caremark kasama ng nakumpletong form para sa pag-order sa pamamagitan ng serbisyo ng koreo. Kung wala kang form para sa order, mada-download mo ito. Maaari ka ring humingi nito sa pamamagitan ng pagtawag sa Member Services sa **1-855-772-9076 (TTY: 711)**.

Ihanda ang mga sumusunod na impormasyon kapag kinumpleto mo ang form:

- Ang iyong member ID card sa Plano
- Ang kumpleto mong address para sa koreo, kasama ang ZIP code
- Ang pangalan at apelyido at numero ng telepono ng iyong doktor
- Listahan ng iyong mga alerhiya at iba pang mga kondisyon sa kalusugan
- Ang orihinal na reseta mula sa iyong doktor

**Saan ako makakakuha ng gamot para sa kumplikadong kondisyon (specialty drug)?**
Ang CVS Specialty Pharmacy ay ang pinipiling specialty na parmasya para sa mga miyembro ng Aetna Better Health of California: Pinupunan ng isang specialty pharmacy ang mga gamot at mayroon itong iba pang mga serbisyo para tulungan ka. Ang Specialty Drug Progam ay may mga espesyal na serbisyo para sa iyo:

- Maaari kang makipag-usap sa isang parmasiyotiko nang 24 na oras sa isang araw, 7 araw sa isang linggo
- Pagpapayo tungkol sa iyong gamot at sakit
- Pag-uugnay ng pangangalaga kasama ka at ang iyong doktor
- Paghahatid ng mga specialty drug sa iyong bahay o sa opisina ng doktor
- Maaari mong i-drop off ang iyong reseta at kunin ang iyong gamot sa kahit saang CVS Pharmacy (kasama ang mga nasa loob ng mga tindahan ng Target)
- Maaari mong tawagan ang CVS Specialty Pharmacy sa **1-800-237-2767**; TTY/TDD: **1-800-863- 5488**. Tutulungan ka ng CVS Specialty Pharmacy sa pagpupuno ng iyong specialty drug.

Tingnan ang **listahan ng** s**pecialty** na makukuha sa CVS Specialty Pharmacy.

**Covered ba ang mga Over-The-Counter (OTC) na gamot?**
Iko-cover ng plano ang mga OTC gamot na nasa formulary na ito. Ang ilang OTC na gamot ay posibleng may mga panuntunan tungkol sa coverage. Kung natutugunan ng OTC na gamot na iyon ang mga panuntunan, iko-cover ng plano ang OTC na gamot.

Tulad ng iba pang mga gamot, ang mga OTC na gamot ay kailangan ng reseta mula sa isang doktor kung iko-cover ito ng plano.

**Covered ba ang ilang injectable na gamot na ibinibigay ng aking doktor o provider sa isang klinika?**
Ang ganitong mga uri ng mga gamot ay covered sa ilalim ng pangmedikal na benepisyo sa halip na benepisyo sa parmasya. Para sa karamihan ng bahagi, ang formulary ng gamotn a ito ay binubuo ng mga gamot na nakukuha mo mula sa isang parmasya at ibinibigay sa sarili mo. Kung kailangang magbigay ng iyong provider ng isang gamot sa klinika, tulad ng isang injectable, may mga instruksiyon ang mga ito kung paano sisingilin ang Aetna Better Health of California.

**Paano ako maghahanap ng parmasya na nasa network?**
Makakahanap ka ng parmasya sa dalawang paraan:

- **Online**: Mag-log in sa aming website sa **www.aetnabetterhealth.com/california/find-provider**.

- **Sa telepono:** Tawagan ang Member Services sa **1-855-772-9076 (TTY: 711)**. Ikalulugod nilang tulungan kang maghanap ng parmasyang nasa network na malapit sa iyo.

Palaging tandaan na papunan ng gamot ang iyong reseta sa isang parmasya na nasa network. Hindi iko-over sa ibang parmasya ang iyong mga reseta.

**May mga copay ba sa gamot?**
Tingnan ang handbook ng miyembro para sa impormasyon ng copay.

**Ano ang ilang uri ng mga panuntunan sa coverage?**

- **Paunang Pag-apruba (Prior Approval, PA):** Ibig sabihin nito hihingi muna ng pag-apruba ang iyong doktor mula sa plano bago papunan ang gamot sa parmasya. Kung hindi ito aaprubahan, hindi iko-cover ng plano ang gamot.
- **Mga Limitasyon sa Level ng Dami (Quantity Level Limits, QLL)**: Ibig sabihin nito may limitasyon sa dami ng gamot na iko-cover ng plano. Halimbawa, magbibigay ang plano ng 60 gamot sa loob ng 30 araw para sa ilang gamot.
- **Step Therapy (ST)**: Ibig sabihin nito maaaring kailanganin mong subukan muna ag ilang gamot bago gamutin ang iyong kondisyon. Pagkatapos masubukan ang unang gamot, iko-cover ng plano ang iba pang gamot para sa parehong kondisyon. Halimbawa, posibleng

magamot ng Gamot A at Gamot B ang iyong kondisyon. Posibleng hindi ma-cover ng plano ang Gamot B maliban na lang kung susubukan mo muna ang Gamot A. Kung hindi gagana sa iyo ang Gamot A, iko-cover ang Gamot B.

- **Mga Simpleng Solusyon na Ibibigay sa Ugat**: Ang mga simpleng solusyon na ibibigay sa ugat ay karaniwang ginagamit para sa hydration therapy. Kasama ang mga mabibili (hindi compounded) na mga solusyon tulad ng Normal Saline, Dextrose (hanggang 10% sa Tubig) at Lactated Ringer's Solution; kasama rin sa depinsiyong ito ang mga solusyon ng potassium chloride na komersyal na hinahanda sa mga nasabing solusyon. Ang mga simpleng solusyon na ibibigay sa ugat ay dapat singilin gamit ang numero ng National Drug Code (NDC) ng produkto.

- **Mga Parenteral (Ibibigay sa Ugat) na Mga Solusyon ng Nutrisyon (TPN o Hyperalimentation)**: (Ang mga parenteral na solusyon ng nutrisyon ay mga nutrisyonal na produkto na ibibigay sa ugat o intra-arterially na karaniwang mga suspension o mga solusyon ng mga amino acid o protina, dextrose, lipids, electrolytes, bitamina &/o mga mineral na suplemento at mga trace element.)
  - Pinaghihigpitan sa pagbibigay sa loob ng 10 araw kasunod ng inpatient na paglabas mula sa isang ospital para sa panandaliang pangangalaga para sa malubhang kondisyon, kapag sinimulan ang I.V. therapy gamit ang parehong gamot bago ang paglabas. May maximum na 10 araw na supply bawat pagbibigay sa loob ng 10 araw na panahon.
  - Karagdagan sa parenteral na nutrisyon ay iba pang mga gamot na aktwal na hinahalo sa parenteral na solusyon ng nutrisyon anumang oras bago ang pagbibigay nito. Bayarin para sa mga produktong ito bilang bahagi ng pagsingil sa parenteral na nutrisyon.

  ***Tandaan**: Ang mga non-compounded na produkto ay dapat singilin gamit ang numero ng NDC ng produkto. Dapat singilin ang mga compounded na solusyon bilang compound claim.

- **Mga Intravenous Lipid na Hiwalay na Ibinibigay:**
  - Pinaghihigpitan sa pagbibigay sa loob ng 10 araw kasunod ng inpatient na paglabas mula sa isang ospital para sa panandaliang pangangalaga para sa malubhang kondisyon, kapag sinimulan ang I.V. therapy gamit ang parehong produkto bago ang paglabas. May maximum na 10 araw na supply bawat pagbibigay sa loob ng 10 araw na panahong ito.

  - Ang intravenous na mga solusyon o suspension ng lipid na ibinibigay nang hiwalay sa mga parenteral na solusyon ng nutrisyon (iyon ay, hindi aktwal na hinahalo sa lalagyan ng parenteral na solusyon ng nutrisyon) ay dapat singilin gamit ang numero ng NDC ng produkto.

- **Mga Enteral (Idinadaan sa Bituka) na Produkto**:
  - Covered ang mga produkto na nasa Listahan ng mga produktong Enteral na Nutrisyon ng Medi-Cal kapag may paunang pahintulot ng doktor at kapag sinuri ang medikal na pangangailangan. Nakalista dito ang mga produktong ito: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Ang Aetna Better Health ay nagbibigay o nag-aasikaso para sa mga covered na enteral na produkto na medikal na kinakailangan, at para matiyak na ibinibigay ang mga ito sa dami na mas kaunti sa ibinibigay sa mga benepisyaryo sa ilalim ng Fee-For-Service (May Bayad na Serbisyo) ng Medi-Cal, ayon sa patakaran ng Medi-Cal na nakalista rito: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**Paano kung wala ang aking gamot sa Formulary ng plano?**
Kung wala ang iyong gamot sa listahan ng pinipiling gamot, may ilang bagay na magagawa ka.

- Tanungin ang iyong provider para sa parehong gamot na *nasa* listahan.
- Hilingin sa iyong provier na humingi ng “paunang pahintulot” (paunang pag-apruba) mula sa Aetna Better Health of California para ma-cover ang gamot na ito.

**Paano hihingi ang aking doktor o provider ng paunang pahintulot o exception kung hindi kino-cover ng plano ang aking gamot?**
Magagawa nila ito sa tatlong paraan:

1. Maaaring i-fax ng iyong provider ang nakumpletong paunang pahintulot ng parmasya o exception form para sa step therapy sa **1-844-823-5478** at kasama ang lahat ng kinakailangang impormasyon.
2. Maaari rin silang magsumite ng request sa telepono sa pamamagitan ng pagtawag sa **1-855-772-9076**.
3. Maaari silang magsumite ng isa.g Elektronikong Paunang Pahintulot

(Electronic Prior Authorization, ePA),

**Paano kung mayroon akong mga tanong tungkol sa kung paano kino-cover ng Aetna Better Health of California ang mga gamot?**
Alamin ang tungkol sa iyong mga benepisyo sa parmasya:

Ito man ay gamot para sa pananakit pagkatpos mapinsala o gamot para mapamahalaan ang isang kondisyon sa kalusugan, ang makakuha ng mga inireresetang gamot na kailangan mo ay mahalagang bahagi ng iyong pangangalagang pangkalusugan. Gusto namin itong padaliin para sa iyo hangga't maaari. Kung mayroon kang anumang mga tanong, pakitawagan ang Member Services sa **1-855-772-9076 (TTY: 711)**. Ihanda ang listahan ng iyong mga gamot sa iyong pagtawag. Hilingin sa aming hanapin ang iyong mga gamot para malaman kung nasa listahan ito.

**LEYENDA**

*naka-italic na maliliit na letra* - Mga generic na gamot
**NAKA-BOLD NA MALALAKING LETRA** -May brand name na gamot

**Mga Kinakailangan at Limitasyon sa Coverage**
AL - Mga Paghihigpit sa Edad OTC - Mga OTC na Gamot
PA - May gagamiting Paunang Pahintulot
QL - Mga Limitasyon sa Dami ST - Gagamit ng Step Therapy

**Tier ng Gamot**
Covered - Mga Covered na Gamot Hindi Covered -Hindi Covered na Mga Gamot

## Определения

**Фирменный препарат** означает лекарство, которое реализуется под патентованным наименованием, защищенным товарным знаком. Фирменные препараты в настоящем формуляре приводятся ЗАГЛАВНЫМИ буквами.

**Сострахование** означает процент стоимости покрываемой медицинской услуги, который вы оплачиваете после выплаты франшизы, если в отношении медицинской услуги действует франшиза.

**Доплата** означает фиксированную сумму в долларах США, которую вы оплачиваете за покрываемую медицинскую услугу после выплаты франшизы, если в отношении медицинской услуги действует франшиза.

**Франшиза** означает сумму, которую вы платите за покрываемые медицинские услуги, в отношении которых действует франшиза, до того, как начнет платить ваша медицинская страховая компания. Если в вашем медицинском страховом полисе предусмотрена франшиза, то может подразумеваться единая франшиза или отдельные франшизы для медицинских услуг и рецептурных препаратов. Обычно после выплаты франшизы вы только вносите доплату или выплачиваете сумму совместного страхования за покрываемые медицинские услуги. Остальные расходы оплачивает ваша страховая компания.

**Уровень медицинского препарата** означает группу рецептурных лекарств, которые соответствуют определенному уровню распределения затрат, предусмотренному в вашем медицинском страховом полисе. Уровень, к которому отнесен рецептурный препарат, определяет размер оплаты, которую вы должны внести за лекарство.

**Запрос на предоставление исключения** означает запрос на покрытие лекарства, не включенного в формуляр. Если вы, назначенное вами лицо или ваш поставщик медицинских услуг, который выписывает лекарство, подает запрос на покрытие лекарства, не включенного в формуляр, ваша страховая компания должна покрыть стоимость лекарства, не включенного в формуляр, если у вас имеются медицинские показания для его приема.

**Неотложные обстоятельства** — наличие у вас заболевания, которое может серьезно угрожать вашей жизни, здоровью или способности сохранять максимальную самостоятельность, или прохождение курса лечения с применением медицинского препарата, не включенного в формуляр, в настоящее время.

**Формуляр** или **список рецептурных препаратов** означает список лекарств, которые покрываются вашим медицинским страховым полисом в соответствии с предусмотренными полисом льготами в отношении рецептурных препаратов.

**Дженерик** означает лекарство, аналогичное патентованному в части дозировки, концентрации, действия, способа приема, качества, безопасности и назначения. Дженерики в настоящем формуляре приводятся строчными буквами и выделяются курсивом.

**Необходимость по медицинским показаниям** означает медицинские услуги, которые необходимо оказать для диагностики, лечения или профилактики заболевания или его симптомов и которые соответствуют принятым медицинским стандартам. Медицинская страховка обычно не предусматривает покрытия медицинских услуг при отсутствии медицинских показаний.

**Лекарство, не включенное в формуляр,** означает рецептурное лекарство, которое не указано в данном формуляре.

**Собственные расходы** означает ваши расходы на медицинские услуги, которые не компенсируются вашим планом медицинского страхования. Собственные расходы включают франшизы, доплаты и суммы сострахования, связанные с покрываемыми медицинскими услугами, а также все расходы на непокрываемые медицинские услуги.

**Поставщик, выписывающий рецептурное лекарство,** означает поставщика медицинских услуг, который может выписать рецепт на лекарство для диагностики, лечения или профилактики заболевания.

**Рецепт** означает устный, письменный или электронный заказ от поставщика, выписывающего рецептурное лекарство, который позволяет предоставить рецептурное лекарство определенному лицу.

**Рецептурный препарат** означает лекарство, на которое по закону необходимо оформить рецепт.

**Предварительное разрешение** означает решение вашей медицинской страховой компании о том, что у вас имеются медицинские показания для получения медицинской услуги. Если рецептурное лекарство, указанное в настоящем формуляре, требует получения предварительного разрешения, ваш поставщик, выписывающий рецептурные препараты, должен запросить разрешение от вашей медицинской страховой компании на покрытие лекарства до того, как выпишет вам рецепт. Ваша медицинская страховая компания должна предоставить запрос на предварительное разрешение при наличии у вас медицинских показаний для приема лекарства.

**Поэтапное лечение** означает особую последовательность, в которой следует принимать рецептурные препараты при лечении определенного заболевания. Если в отношении лекарства, указанного в настоящем формуляре, действуют условия поэтапного лечения, то существует вероятность, что вы должны будете попробовать одно или несколько других лекарств, прежде чем ваша медицинская страховка начнет покрывать данное лекарство. Если ваш поставщик, выписывающий рецептурное лекарство, отправляет запрос на предоставление исключения в отношении поэтапного лечения, ваша медицинская страховая компания должна удовлетворить запрос при наличии у вас медицинских показаний для приема запрошенного лекарства.

**Что такое формуляр (список препаратов) Aetna Better Health of California?**
Список лекарств, составленный Aetna Better Health of California, именуется формуляром лекарственных средств. Медицинские препараты из этого списка покрываются планом. В отношении некоторых лекарств могут действовать определенные правила покрытия. Если правила, действующие в отношении такого лекарства, соблюдены, то план его покроет.

В комитет, который именуется фармацевтическо-терапевтическим комитетом, входят врачи и фармацевты из Aetna Better Health of California, а также представители медицинского сообщества. Комитет собирается каждые три месяца для пересмотра этого списка препаратов и рассмотрения новых лекарств, выпущенных в обращение.

**Может ли список лекарств плана меняться?**
План может добавлять лекарства в список или удалять их из него. Принимающие лекарство участники и их поставщики будут уведомлены по меньшей мере за 30 дней до удаления лекарства из формуляра. Информация обо всех изменениях в формуляре будет размещаться на веб-сайте плана: **www.aetnabetterhealth.com/california/members/pharmacy.**

Формуляр может меняться в течение года. Ниже приводятся некоторые причины внесения изменений:

- Новые препараты были согласованы для применения.
- Существующие препараты были сняты с продажи.
- Рецептурные лекарства становятся безрецептурными (рецепт не требуется). Безрецептурные лекарства обычно не включаются в формуляр.
- Фирменные лекарства утрачивают патентную защиту, и становятся доступными дженерики. Когда это происходит, вместо фирменного препарата будет покрываться дженерик. Фирменное лекарство, скорее всего, будет исключено из формуляра или будет покрываться с более высокой стоимостью. См. дополнительную информацию в разделе «Какие лекарства считаются дженериками?» выше.

**Как пользоваться действующим в плане формуляром?**
Рецептурное лекарство можно найти, выбрав терапевтическую категорию и класс, к которому принадлежит лекарство, или по наименованию фирменного препарата или дженерика в алфавитном указателе. Если дженерик — эквивалент фирменного препарата — отсутствует на рынке или на него не распространяется покрытие, то он не будет отдельно указываться в формуляре.

- Наименование фирменного препарата и дженерика указывается в алфавитном порядке в соответствующей терапевтической категории и классе препаратов.
- Наименование дженерика для фирменного препарата указывается после фирменного наименования в скобках строчными буквами и выделяется жирным шрифтом и курсивом (например: COREG (*carvedilol*)).

- Если дженерик, являющийся аналогом фирменного препарата, имеется в наличии и на него распространяется покрытие, то такой дженерик указывается отдельно от наименования фирменного препарата строчными буквами и выделяется жирным шрифтом и курсивом (например: ***carvedilol***).
- Если дженерик реализуется под фирменным наименованием, защищенным товарным знаком, тогда фирменное наименование указывается после наименования дженерика в скобках базовым шрифтом с первой заглавной буквой каждого слова (например: *desogestrel-ethinyl estradiol* (Azurette)).
- Включение рецептурного лекарства в формуляр не гарантирует, что ваш поставщик будет выписывать это лекарство для лечения определенного заболевания.

- **Столбец № 1: Наименование рецептурного препарата**: указываются лекарства, на которые распространяется покрытие. Фирменные препараты приводятся ПРОПИСНЫМИ буквами (например, «ЛЕКАРСТВО»). Дженерики приводятся строчными буквами (например, «лекарство»). Указываются разные дозировки или концентрации.

- **Столбец № 2: Уровень медицинского препарата:** указывается, что лекарство покрывается без вашего участия в затратах, кроме случаев, когда вопросами, связанными с покрытием расходов на это лекарство, занимается штат. В таком случае это просто означает, что аптека будет иначе обрабатывать предоставленный вами рецепт.

- **Столбец № 3: Требования к покрытию и ограничения**: содержит информацию о необходимости оформления предварительного разрешения в отношении лекарственного препарата или иных ограничениях

Лекарства также объединяются по классам лекарств. Если вы знаете, к какому классу лекарств относится ваше лекарство, выполните поиск наименования данного класса в оглавлении. Затем найдите страницу с информацией о вашем лекарстве.

**Какие лекарства считаются дженериками?**
План покрывает фирменные препараты и дженерики. Дженерики стоят дешевле и утверждены Управлением по санитарному надзору за качеством пищевых продуктов и медикаментов (Food and Drug Administration, FDA). Доказано, что дженерики обладают такой же безопасностью и эффективностью, как и фирменные препараты. Они содержат те же активные вещества в тех же количествах, что и фирменные лекарства, и оказывают такое же действие. В связи с этим риски и преимущества при приеме фирменных препаратов и дженериков одинаковы. При этом дженерики, как правило,

стоят дешевле.

**Что делать, если мое лекарство не указано в списке лекарств?**
В определенных случаях вы или ваш поставщик можете запросить медицинское исключение в отношении предварительного разрешения, поэтапного лечения, количественного ограничения или лекарства, которое не покрывается вашим планом. Решение о покрытии принимается в течение 72 часов с момента получения несрочных запросов. Вы можете обратиться с просьбой ускорить обработку вашего запроса. По ускоренной процедуре решения о покрытии принимаются в течение 24 часов. Мы сообщим вам и вашему врачу свое решение. Покрытие будет предоставлено для всех рецептурных препаратов, принимаемых амбулаторно и необходимых по медицинским показаниям.

Медицинские исключения, которые были одобрены в рамках несрочных запросов, действительны в течение срока действия рецепта, включая период пополнения запаса лекарственных средств. Одобренные медицинские исключения при неотложных обстоятельствах обеспечивают покрытие до тех пор, пока действует неотложное обстоятельство. Если ваш запрос будет отклонен, у вас есть право подать апелляцию. Сведения о процедуре подачи апелляции будут содержаться в отправленном вам уведомлении.

Если решение по запросу об исключении в отношении предварительного разрешения или поэтапного лечения не принимается в течение 72 часов с момента получения несрочного запроса и 24 часов с момента получения запроса на основании неотложных обстоятельств, такой запрос считается одобренным, и мы не сможем отклонить его впоследствии.

В соответствии с законодательством штата участники, которые уже получили одобрение от нас в связи с покрытием необходимых им лекарств, продолжат получать покрытие таких лекарств до тех пор, пока поставщик будет выписывать соответствующие рецепты, и при условии, что рецепт оформляется надлежащим образом и лекарство считается безопасным и эффективным для лечения соответствующего заболевания.

**Как мне заказать рецептурные препараты по почте?**
Если вы регулярно принимаете какое-либо лекарство, его можно заказывать по почте с доставкой на дом. Aetna Better Health сотрудничает с компанией CVS Caremark, которая будет бесплатно предоставлять вам эту услугу.

Если вы выберете данный вариант, ваше лекарство будет доставлено вам домой. Вы можете организовать процесс пополнения запаса лекарственных средств удобным для вас образом. Вы можете задавать вопросы фармацевтам.

Предлагаются и другие дополнительные услуги:

- Фармацевты этой компании проверяют каждый заказ на предмет безопасности.
- Заказы на пополнение запаса лекарственных средств можно подавать по почте, телефону или через интернет. Кроме того, вы можете оформить автоматическое пополнение запаса нужных вам лекарств.
- Вы можете проконсультироваться с фармацевтом по телефону.

Начать пользоваться услугой заказа лекарств по почте очень просто.
Выберите ОДИН из трех описанных ниже способов, чтобы заказать доставку регулярно принимаемых лекарств по почте.

- Позвоните по бесплатному номеру CVS **1-855-271-6603 (TTY: 711)** в любое время суток и в любой день недели. Вам сообщат, какие из лекарств, которые вы принимаете, можно получить по почте через CVS. Представители CVS свяжутся с вашим врачом, чтобы получить рецепт, и отправят вам лекарство по почте. Будьте готовы сообщить следующую информацию во время общения по телефону:
  - Номер идентификационной карты участника плана
  - Имя, фамилию и номер телефона вашего врача
  - Сведения, необходимые для оплаты, и почтовый адрес

- Посетите наш портал для участников, чтобы пройти регистрацию или выполнить вход. После входа на портал для участников перейдите в раздел Tasks («Задачи»), а затем — Pharmacy Services («Услуги аптек»). Нажмите на ссылку CVS, чтобы перейти на сайт **Caremark.com**. Нажмите start mail service («начать обслуживание по почте»), чтобы распечатать бланк заказа лекарств по почте. Вы можете связаться с CVS по телефону **1-855-271-6603**. Для первоначальной регистрации вам потребуется идентификационная карта участника плана.
- Заполните и отправьте бланк заказа лекарств по почте. Если у вас уже есть рецепт, вы можете отправить его в CVS Caremark вместе с заполненным бланком заказа лекарств по почте. Если у вас нет бланка заказа, вы можете загрузить его. Вы также можете запросить бланк, позвонив в отдел обслуживания участников по номеру **1-855-772-9076 (TTY: 711)**.

  Для заполнения бланка подготовьте следующие данные:
  - Номер идентификационной карты участника плана
  - Ваш полный почтовый адрес, включая почтовый индекс
  - Имя, фамилию и номер телефона вашего врача
  - Список ваших аллергий и других заболеваний

- Оригинал рецепта, выданный вам врачом

**Где я могут получить лекарства особой категории?**
CVS Specialty Pharmacy является предпочтительной специализированной аптекой для участников Aetna Better Health of California. Специализированная аптека принимает заказы на лекарства и предлагает другие полезные услуги. В программе предоставления лекарств особой категории для вас предусмотрены специальные услуги:

- Возможность обращения к фармацевту круглосуточно и в любой день недели
- Консультации по поводу вашего лекарства и заболевания
- Координация обслуживания между вами и вашим врачом
- Доставка специализированных лекарственных препаратов на дом или в кабинет врача
- Вы можете предъявить рецепт и забрать свое лекарство в любой аптеке CVS (в том числе в аптеках, действующих при магазинах Target)
- Вы можете позвонить в специализированную аптеку CVS по номеру **1-800-237-2767**; TTY/TDD: **1-800-863-5488**. Специализированная аптека CVS поможет вам получить ваше лекарство особой категории.

Ознакомьтесь со **списком лекарств особой категории,** которые можно приобрести в специализированной аптеке CVS.

**Покрываются ли безрецептурные лекарства (Over-The-Counter, OTC)?**
Покрытие плана распространяется на безрецептурные препараты из формуляра. На некоторые безрецептурные препараты могут распространяться определенные правила покрытия. Если правила, действующие в отношении такого безрецептурного лекарства, соблюдены, то план предоставит необходимое покрытие. Как и другие лекарства, безрецептурные препараты должны быть прописаны врачом, чтобы на них распространялось покрытие.

**Покрываются ли некоторые инъекционные препараты, которые вводит мой врач или поставщик в клинике?**
Такие лекарства покрываются в рамках не фармацевтических, а медицинских льгот. По большей части данный формуляр лекарств составляется из лекарств, которые вы получаете в аптеке и принимаете самостоятельно. Если ваш поставщик должен ввести лекарство в клинике, например инъекционный препарат, у него есть инструкции по выставлению счета на оплату стоимости препарата плану Aetna Better Health of California.

**Как мне найти аптеку, входящую в сеть?**
Вы можете найти аптеку двумя способами:

- **Через интернет:** выполните вход на нашем веб-сайте по ссылке **www.aetnabetterhealth.com/california/find-provider**.

- **По телефону:** позвоните в отдел обслуживания участников по номеру **1-855-772-9076 (TTY: 711)**. Наши сотрудники будут рады помочь вам найти аптеку, входящую в сеть, рядом с вами.

Не забывайте, что лекарства, отпускаемые по рецепту, следует получать в аптеке, которая входит в сеть. Ваши рецептурные лекарства не будут покрываться в других аптеках.

**Предусмотрена ли доплата за лекарства?**
См. информацию о доплате в справочнике участника.

**Какие правила покрытия существуют?**

- **Предварительное разрешение (Prior Approval, PA):** Это означает, что ваш врач должен сначала получить одобрение от плана, и только потом лекарство может быть подготовлено в аптеке. Если лекарство не будет согласовано, план его не покроет.

- **Количественные ограничения (Quantity Level Limits, QLL)**: Это означает, что в отношении количества лекарства, покрываемого планом, действует ограничение. Например, план покрывает 60 таблеток на 30 дней приема для некоторых лекарств.

- **Поэтапное лечение (Step Therapy, ST)**: Это означает, что вам, возможно, придется сначала попробовать другие лекарства для лечения вашего заболевания. После того, как вы попробуете первое лекарство, план покроет другое лекарство для того же заболевания. Например, для лечения вашего заболевания можно использовать лекарство А и лекарство Б. План может не покрывать лекарство Б, пока вы не попробуете лекарство А. Если лекарство А вам не поможет, будет покрываться лекарство Б.

- **Простые растворы для внутривенного введения**: Простые растворы для внутривенного введения обычно используются для восполнения потери жидкости. К ним относятся имеющиеся в продаже (не экстемпоральные) растворы, например изотонический раствор, D-глюкоза (до 10% в воде) и лактированный раствор Рингера; промышленно приготовленные растворы

хлористого калия в таких растворах также относятся к данному определению. Счет за простые растворы для внутривенного введения должен выставляться с использованием номера государственного кода лекарственных средств (National Drug Code, NDC) для соответствующего изделия.

- **Растворы для парентерального питания (полное парентеральное питание или внутривенное питание)**: (растворы для парентерального питания представляют собой питательные препараты, которые вводятся внутривенно или в артерию, например суспензии или растворы аминокислот или белка, D-глюкозы, липидов, электролитов, витаминов и/или минеральных добавок и микроэлементов)
  - Применение ограничивается 10 днями после выписки из стационара больницы скорой неотложной помощи при условии, что внутривенное введение того же лекарства началось до выписки. Максимальный запас может быть рассчитан на 10 дней применения.
  - Вспомогательные средства для парентерального питания представляют собой другие лекарства, которые физически смешиваются с раствором парентерального питания в любое время до введения. Счет за данные средства входит в счет за парентеральное питание.

  ***Примечание:** Счет за неэкстемпоральные средства выставляется по номеру NDC изделия. Счет за экстемпоральные растворы оформляется как запрос экстемпорального препарата.

- **Липиды для самостоятельного внутривенного введения**:
  - Применение ограничивается 10 днями после выписки из стационара больницы неотложной помощи при условии, что внутривенное введение того же средства началось до выписки. Максимальный запас может быть рассчитан на 10 дней применения.
  - Счет за растворы или суспензии липидов для внутривенного введения, которые вводятся отдельно от растворов парентерального питания (т. е. не смешиваются физически в одной емкости с раствором парентерального питания), оформляется по номеру NDC изделия.

- **Средства для энтерального питания**:
  - Товары в списке средств для энтерального питания Medi-Cal покрываются при условии получения предварительного разрешения и подтверждения необходимости по медицинским показаниям. Данные товары перечислены здесь: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**

- Aetna Better Health предоставляет или обеспечивает предоставление необходимых по медицинским показаниям покрываемых средств для энтерального питания в достаточном количестве, которое соответствует предоставляемому для бенефициаров программы Medi-Cal Fee-For-Service на основании действующей политики Medi-Cal: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**Что делать, если мое лекарство не указано в формуляре плана?**
Если ваше лекарство не входит в список предпочтительных препаратов, вы можете предпринять определенные действия.

- Попросите своего поставщика назначить вам аналогичное лекарство, которое *входит* в список.
- Попросите своего поставщика обратиться за предварительным разрешением к представителям плана Aetna Better Health of California, чтобы согласовать покрытие такого лекарства.

**Как мой врач или поставщик может запросить предварительное разрешение или исключение, если план не покрывает мое лекарство?**
Они могут сделать это тремя способами:

1. Ваш поставщик может отправить заполненный бланк запроса предварительного разрешения или запроса о предоставлении исключения в отношении поэтапного лечения по номеру факса **1-844-823-5478**, указав всю необходимую информацию.
2. Запрос можно отправить по телефону **1-855-772-9076**.
3. Можно отправить электронный бланк запроса предварительного разрешения (Electronic Prior Authorization, ePA).

**Что делать, если у меня появились вопросы по поводу того, как Aetna Better Health of California обеспечивает покрытие лекарств?**
Узнайте о положенных вам фармацевтических льготах:

Будь то обезболивающее после травмы или лекарство для лечения хронического заболевания, получение необходимых рецептурных лекарств является важной частью вашего медицинского обслуживания. Мы хотим максимально упростить для вас этот процесс. Если у вас появятся вопросы, позвоните в отдел обслуживания участников по номеру **1-855-772-9076 (TTY: 711)**. Когда будете звонить, имейте под рукой список ваших рецептурных препаратов. Попросите проверить, включены ли ваши лекарства в список.

## УСЛОВНЫЕ ОБОЗНАЧЕНИЯ

*строчные буквы, выделенные курсивом* — Дженерики
**ПРОПИСНЫЕ БУКВЫ ЖИРНЫМ ШРИФТОМ** — Фирменные препараты

**Требования к покрытию и ограничения**

AL — Возрастные ограничения  OTC — Безрецептурные препараты
PA — Может потребоваться предварительное разрешение
QL — Количественные ограничения  ST — Может применяться поэтапное лечение

**Уровень медицинского препарата**

Покрывается — Покрываемые лекарства  Не покрывается — Непокрываемые лекарства

## تعاریف

**دارو با نام تجاری** به معنای دارویی که با نام اختصاصی و با مارک تجاری محافظت شده به بازار عرضه می شود. یک دارو با نام تجاری در این فرمولاری با حروف تمام بزرگ ذکر می‌شود.

**بیمه مشترک** به معنای درصدی از هزینه بیمه تکمیلی تحت پوشش است که پس از پرداخت فرانشیز پرداخت می کنید، اگر کسر هزینه بیمه تکمیلی اعمال شود.

**پرداخت مشترک** این به معنای مقدار ثابتی دلار است که شما برای مزایای خدمات درمانی تحت پوشش پس از پرداخت فرانشیز پرداخت می کنید، اگر کسر هزینه مزایای مراقبت های بهداشتی اعمال شود.

**فرانشیز** به معنای مبلغی است که شما برای بیمه تکمیلی تحت پوشش پرداخت می‌کنید و مشمول کسر هزینه قبل از پرداخت بیمه‌گر بهداشتی شما می شود. اگر بیمه نامه درمانی شما دارای فرانشیز باشد، ممکن است یک کسر یا کسرهای جداگانه برای مزایای پزشکی و مزایای داروهای تجویز شده داشته باشد. بعد از اینکه فرانشیز خود را پرداخت کردید، معمولاً فقط یک پرداخت مشترک یا بیمه مشترک بابت بیمه تکمیلی پرداخت می‌کنید. شرکت بیمه شما باقیمانده را پرداخت می‌کند.

**ردیف دارو** به معنی گروهی از داروهای تجویز شده است که با یک طبقه بندی مشخص تقسیم هزینه در بیمه نامه درمانی شما مطابقت دارد. ردیف دارویی که داروی تجویز شده در آن قرار می‌گیرد، سهم شما را از هزینه دارو تعیین می‌کند.

**درخواست استثنا** به معنی درخواست پوشش دارویی که در فرمولاری نیست. اگر شما، فرد مشخص شده از سمت شما، یا ارائه دهنده خدمات درمانی تجویز کننده شما درخواستی را برای تحت پوشش قرار دادن دارویی که در فرمولاری نیست ارائه دهید، بیمه گر شما درصورتی که از نظر پزشکی مصرف دارو برای شما ضروری باشد، باید داروی غیر موجود در فرمولاری را تحت پوشش پزشکی خود قرار دهد.

**شرایط وخیم** به معنای آن است که شما مبتلا به یک بیماری هستید که ممکن است زندگی، سلامتی یا توانایی بازیابی حداکثر عملکردتان را به طور جدی به خطر انداخته، یا اینکه شما در حال گذراندن دوره درمان فعلی با استفاده از دارویی غیر موجود در فرمولاری هستید.

**فرمولاری** یا **لیست داروهای تجویز شده** به معنای لیستی از داروهایی است که تحت بیمه نامه درمانی شما تحت مزایای داروی تجویز شده بیمه نامه قرار دارد.

**داروی ژنریک** به معنای دارویی است که از نظر دوز، قدرت، اثر، نحوه مصرف، کیفیت، ایمنی، و کاربرد مورد نظر با داروی با نام تجاری‌اش برابر باشد. یک داروی ژنریک در این فرمولاری با حروف کوچک ایتالیک لیست شده است.

**ضرورت پزشکی** به این معناست که بیمه تکمیلی برای تشخیص، معالجه، یا جلوگیری از یک بیماری پزشکی یا علائم آن مورد نیاز است و مطابق با استانداردهای پذیرفته شده پزشکی است. بیمه درمانی معمولاً بیمه تکمیلی که از نظر پزشکی ضروری نیستند، را پوشش نمی‌دهد.

**داروی غیر موجود در فرمولاری** به معنای داروی تجویزی است که در این فرمولاری ذکر نشده است.

**هزینه‌های خرج شده از جیب** به معنای هزینه‌های شما برای بیمه تکمیلی است که توسط بیمه درمانی شما جبران نمی‌شود. هزینه‌های خرج شده از جیب شما عبارتست از فرانشیز، پرداخت مشترک، و بیمه مشترک برای بیمه تکمیلی موارد تحت پوشش، به علاوه تمام هزینه های بیمه تکمیلی است که تحت پوشش نمی‌باشد.

**تجویز کننده** به معنای ارائه دهنده خدمات درمانی است که می‌تواند برای تشخیص، معالجه یا پیشگیری از یک بیماری پزشکی نسخه‌ای برای دارو بنویسد.

**نسخه** به معنای سفارش شفاهی، کتبی، یا الکترونیکی یک تجویز کننده است که اجازه می‌دهد یک داروی تجویز شده برای فرد خاصی تهیه شود.

**داروی تجویز شده** به معنی دارویی است که طبق قانون نیاز به نسخه دارد.

**مجوز قبلی** به معنای تصمیم بیمه گر سلامت شما است که مزایای بیمه تکمیلی برای شما ضرورت پزشکی دارد. اگر داروی تجویز شده در این فرمولاری نیازمند مجوز قبلی باشد، تجویز کننده باید قبل از پیچیدن نسخه توسط شما، از بیمه گرتان برای تحت پوشش قراردادن دارو درخواست تأیید کند. بیمه گر سلامت شما درصورتی که از نظر پزشکی لازم است دارو را مصرف کنید، باید درخواست مجوز قبلی را بپذیرد.

**درمان مرحله‌ای** به معنای توالی خاصی است که در آن باید داروهای تجویز شده برای یک بیماری خاص را امتحان کرد. اگر دارویی در این فرمولاری تحت درمان مرحله‌ای است، ممکن است مجبور شوید یک یا چند داروی دیگر را امتحان کنید قبل از اینکه بیمه نامه شما آن دارو را برای شرایط پزشکی شما پوشش دهد. اگر تجویز کننده شما یک درخواست استثنا برای نیاز یک درمان مرحله‌ای ارائه می‌دهد، بیمه گر شما باید در صورت ضرورت پزشکی شما جهت مصرف این دارو، این درخواست را بپذیرد.

**فرمولاری (لیست داروهای) Aetna Better Health of California چیست؟**
این یک لیست دارویی است که توسط Aetna Better Health of California به نام فرمولاری دارو ایجاد شده است. این طرح داروهای موجود در این لیست را پوشش می‌دهد. بعضی از داروها ممکن است قوانین پوشش داشته باشند. اگر قوانین مربوط به آن دارو رعایت شود، این طرح دارو را پوشش می‌دهد.

کمیته‌ای به نام کمیته داروخانه و درمانی وجود دارد که از پزشکان و داروسازان Aetna Better Health of California و جامعه پزشکی تشکیل شده است. آنها هر سه ماه با هم ملاقات کرده تا این لیست داروها و سایر داروهای جدید را مرور کنند.

**آیا لیست دارویی طرح می‌تواند تغییر کند؟**
این طرح ممکن است داروها را در لیست اضافه یا حذف کند. اعضای استفاده کننده و ارائه‌دهندگان آنها حداقل 30 روز قبل از حذف دارو از فرمولاری، به آنها اطلاع رسانی خواهند شد. تمام تغییرات در فرمولاری در وب سایت طرح به آدرس زیر قرار می گیرد: **www.aetnabetterhealth.com/california/members/pharmacy.**

فرمولاری می‌تواند در طول سال تغییر کند. برخی از دلایلی که چرا آنها می‌توانند تغییر کنند عبارتند از:

- داروهای جدید تأیید می‌شوند .
- داروهای موجود از بازار حذف می‌شوند .
- داروهای تجویزی ممکن است بدون نسخه در دسترس باشند. داروهای بدون نسخه عموماً در فرمولاری قرار ندارند.
- داروهای با نام تجاری که حفاظت حق ثبت اختراع را از دست می‌دهند و نسخه های ژنریک آن در دسترس قرار می گیرد وقتی این اتفاق می‌افتد ، داروی ژنریک به جای دارو با نام تجاری پوشش داده می شود. این داروی با نام تجاری به احتمال زیاد از فرمولاری خارج می‌شود یا با هزینه بیشتری پوشش داده می‌شود . برای اطلاعات بیشتر در بالا به بخش "داروهای ژنریک چیست؟" مراجعه کنید.

**چگونه می‌توانم از فرمولاری یک طرح استفاده کنم؟**
یک داروی تجویز شده ممکن است با جستجوی دسته درمانی و کلاسی که دارو به آن تعلق دارد یا نام تجاری یا نام ژنریک دارو بر اساس فهرست حروف الفبا قرار گرفته باشد. اگر معادل ژنریک دارویی با دارویی با نام تجاری در بازار موجود نباشد یا پوشش داده نشود، دارو با نام ژنریک آن به طور جداگانه لیست نمی‌شود .

- یک دارو بر اساس حروف الفبا با نام تجاری و نام های ژنریک در دسته درمانی و کلاسی که به آن تعلق دارد، ذکر شده است.
- نام ژنریک داروی با نام تجاری، بعد از نام تجاری در داخل پرانتز با حروف تماماً پررنگ و ایتالیک کوچک نوشته شده است. (برای مثال: COREG (*carvedilol*).

- اگر معادل ژنریک داروی با نام تجاری هم در دسترس بوده و هم پوشش داده شود، داروی ژنریک جدا از داروی با نام تجاری با حروف تماماً پررنگ و کوچک ایتالیک ذکر می‌شود؛ و (به عنوان مثال: ***carvedilol***).
- اگر یک داروی ژنریک با یک نام تجاری اختصاصی محافظت شده به بازار عرضه شود، نام تجاری بعد از نام ژنریک داخل پرانتز و حروفچینی معمولی با حرف بزرگ اول هر کلمه نوشته می‌شود . (برای مثال: ***desogestrel-ethinyl estradiol*** (Azurette)).
- درج داروی تجویز شده روی فرمولاری تضمین کننده این نیست که ارائه دهنده شما دارو را برای یک بیماری خاص تجویز می‌کند .

- **ستون #1: نام داروی تجویزی**: داروی تحت پوشش را لیست می‌کند . داروهای تجاری با حروف تماماً بزرگ وجود دارد (به عنوان مثال، DRUG). ژنریک‌ها با حروف کوچک می‌باشند (به عنوان مثال، drug). فرم ها یا مقادیر مختلف دوزها مشخص می‌شود .

- **ستون #2: ردیف دارو**: نشان می دهد که این دارو بدون تقسیم هزینه تحت پوشش قرار گرفته است، مگر اینکه بسته به حالت مستثنی باشد. در این حالت، این فقط به این معنی است که وقتی نسخه خود را به داروخانه ارائه می‌دهید، داروخانه فرآیند آن را متفاوت ادامه می‌دهد .

- **ستون #3: شرایط و محدودیت های پوشش**: به شما می‌گوید که آیا دارو به مجوز قبلی یا محدودیت های دیگر احتیاج دارد .

داروها نیز بر اساس کلاس دارو گروه‌بندی می‌شوند . اگر می دانید داروی شما در چه کلاسی قرار دارد، لطفاً در فهرست مطالب به دنبال آن کلاس بگردید. سپس در همان صفحه به دنبال داروی خود بگردید.

**داروهای ژنریک چیست؟**
این طرح هم داروهای تجاری و هم داروهای ژنریک را شامل می‌شود . داروهای ژنریک هزینه کمتری داشته و توسط سازمان غذا و دارو (FDA) تأیید شده‌اند . ثابت شده است که داروهای ژنریک به همان اندازه داروهای با نام تجاری ایمن و موثر هستند. آنها حاوی همان مواد فعال به همان میزان داروهای با نام تجاری هستند و به همان روش عمل می‌کنند. بنابراین آنها دارای همان ریسک‌ها و مزایایی هستند که داروهای با نام تجاری هستند. با این حال، آنها معمولاً هزینه کمتری دارند.

**اگر داروی من در لیست داروها نباشد چه؟**
در موارد خاص، شما یا تجویز کننده می‌توانید یک استثنا پزشکی در مورد مجوز قبلی، درمان مرحله‌ای یا محدودیت های مقدار مورد نیاز یا دارویی را که تحت طرح شما نیست، درخواست کنید. تعیین تحت پوشش بودن ظرف 72 ساعت پس از دریافت درخواست‌های غیر فوری انجام می‌شود . شما می توانید درخواست خود را تسریع کنید. تصمیمات سریع پوشش، در عرض 24 ساعت گرفته می‌شود . سپس ما با نتیجه تصمیم گیری خود با شما و پزشکتان تماس خواهیم گرفت. تمام داروهای تجویز شده سرپایی پزشکی تحت پوشش قرار می‌گیرند.

موارد استثنایی پزشکی که برای درخواستهای غیر فوری تأیید می شوند، مدت زمان نسخه، از جمله زمان تجدید دارو را پوشش می دهد . استثناهای پزشکی تأیید شده برای شرایط وخیم، پوشش را برای مدت زمان وخامت فراهم می‌کند. اگر درخواست شما رد شود شما حق درخواست تجدیدنظر با استفاده از روشی را دارید که در نامه اطلاع رسانی شرح داده شده است.

اگر طی 72 ساعت پس از دریافت درخواست غیر فوری و 24 ساعت پس از دریافت درخواست بر اساس شرایط وخیم، برای درخواست مجوز قبلی یا درخواست درمان مرحله‌ای تصمیم گیری نشود، درخواست تایید شده تلقی شده و پس از آن ممکن است درخواست را رد نکنیم.

مطابق با قانون ایالت، برای اعضایی که قبلاً از ما تأییدیه‌ای برای پوشش داروها برای شرایط پزشکی خود دریافت کرده اند، تا زمانی که تجویز کننده آنها را تجویز می‌کند، تا زمانی که دارو به طور مناسب تجویز شود و برای درمان وضعیت پزشکی عضو ایمن و موثر تلقی شود، همچنان تحت پوشش این داروها هستند.

**چگونه می‌توانم نسخه سفارش پستی دریافت کنم؟**
اگر برای شرایط پزشکی خاصی که به صورت مداوم دچار آن هستید دارو دریافت می‌کنید، می‌توانید درخواست کنید داروهایتان از طریق پست ارسال شوند. Aetna Better Health با شرکتی به نام CVS Caremark همکاری می‌کند تا این سرویس را به شما ارائه دهد که هیچ هزینه ای هم برای شما ندارد.

اگر این گزینه را انتخاب کنید، داروها را مستقیماً در منزل خود دریافت خواهید کرد. می توانید تجدید دارو را تنظیم کنید. می توانید از داروسازان سوال کنید. در اینجا چند ویژگی مختلف از تحویل دارو در منزل ارائه شده است:

- مسئول داروخانه همه موارد را برای حفظ ایمنی شما بررسی می کند.
- می توانید از طریق نامه، به صورت تلفنی یا آنلاین نسخه را تجدید کنید یا اینکه برای تجدید داروی خودکار، ثبت نام کنید .
- می توانید از طریق تلفن با داروسازها صحبت کنید.

شروع استفاده از سرویس پستی آسان است.
یکی از سه روش زیر را برای استفاده از سرویس پستی برای دارویی که به طور مداوم مصرف می‌کنید انتخاب کنید:

- با شماره تلفن رایگان CVS به شماره **1-855-271-6603 (TTY: 711)** تماس بگیرید (24 ساعت در روز، 7 روز در هفته). آنها به شما اطلاع خواهند داد که کدام یک از داروهای شما از طریقCVS mail service داروخانه پیچیده می‌شود . سپس CVS با پزشک شما برای تهیه نسخه تماس گرفته و دارو را برای شما پست می کند . هنگام تماس، حتماً موارد زیر را داشته باشید:
  - کارت شناسایی طرح عضویت شما
  - نام و نام خانوادگی و شماره تلفن پزشک شما
  - اطلاعات پرداخت و آدرس پستی شما

- برای ثبت نام یا ورود به پورتال اعضا ما بروید. پس از ورود به پورتال اعضا، به "وظایف" و سپس "خدمات داروسازی" بروید. برای رفتن به **Caremark.com** روی لینک CVS کلیک کنید. برای چاپ فرم سفارش پستی بر روی شروع "سرویس پستی" کلیک کنید. می توانید با CVS به شماره تلفن **1-855-271-6603** تماس بگیرید. هنگام ثبت نام برای اولین بار حتماً کارت شناسایی عضویت خود را در دسترس داشته باشید.
- فرم سفارش خدمات پستی را پر کرده و ارسال کنید. اگر در حال حاضر نسخه پزشکی دارید، می توانید آن را به همراه فرم سفارش سرویس پستی تکمیل شده به CVS Caremark ارسال کنید. اگر فرم سفارش ندارید، می توانید آن را دانلود کنید. همچنین می‌توانید با تماس با خدمات اعضاء به شماره **1-855-772-9076 (TTY: 711)** یکی از آنها را درخواست کنید.

هنگام تکمیل فرم، اطلاعات زیر را با خود داشته باشید:

- کارت شناسایی طرح عضویت شما
- آدرس پستی کامل شما، شامل کد پستی
- نام و نام خانوادگی و شماره تلفن پزشک شما
- لیستی از آلرژی‌ها و سایر شرایط سلامتی شما
- نسخه اصلی شما از پزشکتان

**از کجا می توانم یک داروی تخصصی تهیه کنم؟**

CVS Specialty Pharmacy داروخانه تخصصی ارجح برای اعضای Aetna Better Health of California است. یک داروخانه تخصصی داروها را می‌پیچد و خدمات دیگری نیز برای کمک به شما دارد. برنامه داروی تخصصی دارای خدمات ویژه ای برای شماست:

- شما می‌توانید 7 روز هفته و 24 ساعت شبانه روز با داروساز صحبت کنید
- مشاوره در خصوص دارو و بیماری خود
- هماهنگی مراقبت با شما و پزشک
- تحویل داروهای تخصصی به خانه شما یا مطب پزشک
- می توانید نسخه خود را تحویل داده و داروی خود را در هر داروخانه CVS (از جمله داروخانه های داخل فروشگاه‌های Target) تحویل بگیرید.
- می توانید با این شماره تلفن با داروخانه تخصصی CVS تماس بگیرید**1-800-237-2767**؛ TTY/TDD: **1-800-863-5488**. داروخانه تخصصی CVS به شما کمک می کند تا داروی تخصصی خود را بپیچید.

**لیست داروهای تخصصی** موجود از طریق داروخانه تخصصی CVS را مشاهده کنید.

**آیا داروهای بدون نسخه (OTC) تحت پوشش هستند؟**

این طرح داروهای OTC را در فرمولاری پوشش می‌دهد . بعضی از داروهای OTC ممکن است قوانین پوشش داشته باشند. اگر قوانین مربوط به آن داروی OTC رعایت شود، این طرح داروی OTC را پوشش می‌دهد . مانند سایر داروها، داروهای OTC اگر قرار است تحت این طرح قرار بگیرند، به نسخه پزشک نیاز دارند.

**آیا داروهای تزریقی خاصی که توسط پزشک یا ارائه دهنده خدمات پزشکی من در یک کلینیک تجویز می‌شود تحت پوشش هستند؟**
این نوع داروها به جای مزایای داروخانه تحت مزایای پزشکی قرار می‌گیرند. در بیشتر موارد، این فرمولاری دارویی از داروهایی تشکیل شده است که از داروخانه دریافت می‌کنید و به خودتان تحویل می شود. اگر ارائه دهنده خدمات پزشکی شما نیاز به مصرف دارویی در کلینیک مانند داروی تزریقی دارد، دستورالعمل‌هایی در مورد نحوه صدور صورتحساب برای
Aetna Better Health of California دارند.

**چگونه یک داروخانه شبکه پیدا کنم؟**
به دو روش می توانید داروخانه پیدا کنید:

- **آنلاین:** وارد وب سایت ما به این آدرس بشوید **www.aetnabetterhealth.com/california/find-provider**.

- **به صورت تلفنی:** با خدمات اعضا به شماره **1-855-772-9076 (TTY: 711)** تماس بگیرید. آنها خوشحال خواهند شد که به شما کمک کنند یک داروخانه شبکه در نزدیکی خود پیدا کنید.

همیشه به یاد داشته باشید که نسخه خود را در داروخانه شبکه بپیچید. نسخه‌های شما در سایر داروخانه‌ها تحت پوشش نیست.

**آیا دارو پرداخت مشترک هستند؟**
برای اطلاعات مربوط به پرداخت مشترک به کتابچه راهنمای اعضا مراجعه کنید.

**انواع مختلف قوانین پوشش چیست؟**

- **مجوز قبلی (PA):** این بدان معناست که پزشک شما قبل از پیچیدن دارو در داروخانه، ابتدا باید از طرح تأییدیه بگیرد. در صورت عدم تصویب، این طرح دارو را پوشش نمی‌دهد .

- **محدودیت سطح مقدار (QLL):** این بدان معناست که محدودیتی در مقدار دارویی که این طرح پوشش خواهد داد وجود دارد. برای مثال، برای برخی از داروها در این طرح 60 قرص در 30 روز در نظر گرفته شده است.

- **درمان مرحله‌ای (ST):** این بدان معناست که برای درمان بیماری خود ممکن است لازم باشد ابتدا داروهای خاصی را امتحان کنید. پس از آزمایش اولین دارو، این طرح داروی دیگر را برای همان شرایط تحت پوشش قرار خواهد داد. به عنوان مثال، داروی A و داروی B ممکن است بیماری شما را درمان کنند. این طرح ممکن است داروی B را پوشش ندهد، مگر اینکه ابتدا داروی A را امتحان کنید. اگر داروی A به درد شما نخورد، داروی B تحت پوشش قرار می‌گیرد.

- **محلول‌های ساده وریدی:** از محلولهای ساده وریدی معمولاً برای هیدراتاسیون درمانی استفاده می‌شود . از جمله محلول‌های (غیر مرکب) تجاری مانند نرمال سالین، دکستروز (تا 10% در آب) و محلول رینگر لاکتات؛ محلولهای تجاری کلرید پتاسیم که در این محلولها تهیه شده‌اند نیز در این تعریف گنجانده شده اند .

محلول های ساده وریدی باید با استفاده از شماره کد ملی (NDC) دارو محصول صورتحساب شوند.

**راه حل های تغذیه ای تزریقی (TPN یا تغذیه وریدی تام):** (محلول های تغذیه ای تزریقی به صورت تزریق داخل وریدی یا داخل شریانی محصولات غذایی هستند که به طور معمول سوسپانسیون یا محلول‌های اسیدهای آمینه یا پروتئین، دکستروز، لیپیدها، الکترولیت ها، مکمل های ویتامین و/یا مواد معدنی و عناصر کمیاب هستند.)

- محدود به توزیع ظرف 10 روز پس از ترخیص بیماران بستری از بیمارستان مراقبت های حاد، زمانی که I.V. درمانی با همان دارو قبل از ترخیص شروع شده باشد. حداکثر 10 روز عرضه برای هر توزیع، در مدت 10 روزه وجود دارد.
- مواد الحاقی به تغذیه تزریقی داروهای دیگری هستند که هر زمان قبل از تزریق، به صورت فیزیکی در محلول تغذیه ای تزریقی مخلوط می‌شود . صورتحساب این محصولات به عنوان بخشی از صورتحساب تغذیه‌ی تزریقی است.

***توجه:** محصولات غیر کامپاند باید با استفاده از شماره NDC محصول صورتحساب شود. محلولهای کامپاند باید به عنوان صورتحساب کامپاند مطالبه شود.

- **لیپیدهای قابل تزریق وریدی جداگانه تجویز شده:**
  - محدود به توزیع ظرف 10 روز پس از ترخیص بیماران بستری از بیمارستان مراقبت های حاد، زمانی که I.V. درمانی با همان محصول قبل از ترخیص شروع شده باشد. حداکثر 10 روز عرضه برای هر توزیع، در این مدت 10 روزه وجود دارد.
  - محلول‌ها یا سوسپانسیون‌های داخل وریدی لیپیدی که جدا از محلول‌های تغذیه‌ای تزریقی تجویز می شوند (یعنی از نظر فیزیکی در محفظه محلول تغذیه ای ترکیب نشده اند) باید با استفاده از شماره NDC محصول صورتحساب شود.

- **محصولات انترال:**
  - محصولات موجود در لیست Medi-Cal محصولات تغذیه روده‌ای تحت مجوز قبلی پزشکی و بررسی ضرورت پزشکی تحت پوشش قرار می‌گیرند. این محصولات در اینجا ذکر شده است: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Aetna Better Health با توجه به سیاست Medi-Cal که در اینجا ذکر شده است، محصولات انترال تحت پوشش ضرورت پزشکی را فراهم کرده و محصولات آنها را تحت پوشش قرار می دهد و اطمینان حاصل شود که این مبلغ کمتر از مبلغی نیست که در ذیل مزایای خدمات Medi-Cal به ذینفعان ارائه می‌شود :

**http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**اگر داروی من در فرمولاری طرح نباشد چه؟**

اگر داروی شما در لیست داروهای ترجیحی نیست، مواردی وجود دارد که می‌توانید انجام دهید.

- از ارائه‌دهنده خود بخواهید دارویی را تجویز کند که در لیست قرار *دارد* .
- از ارائه دهنده خدمات خود بخواهید برای تهیه این دارو "مجوز قبلی" (پیش تأییدیه) را از Aetna Better Health of California بخواهد.

**اگر این طرح داروی من را پوشش نمی‌دهد، چگونه پزشک یا ارائه دهنده من می‌تواند مجوز قبلی یا استثنا را درخواست کند؟**
آنها می توانند این کار را به سه روش انجام دهند:

1. ارائه دهنده شما ممکن است یک فرم داروخانه مجوز قبلی یا فرم استثناء درمان مرحله‌ای تکمیل شده را به شماره **1-844-823-5478** فکس کرده و کلیه اطلاعات لازم را ضمیمه کند.

2. آنها همچنین می‌توانند از طریق تماس با شماره تلفن **1-855-772-9076** درخواست را ارائه دهند.
3. آنها می‌توانند مجوز قبلی الکترونیکی (ePA) را ارسال کنند.

**اگر در مورد چگونگی پوشش داروهای Aetna Better Health of California سوالی داشته باشم چه کنم؟**
درباره مزایای داروخانه خود بیاموزید:

اینکه داروی ضد درد پس از یک آسیب یا دارویی برای مدیریت یک بیماری باشد، دریافت داروهای تجویز شده مورد نیاز بخش مهمی از مراقبت‌های سلامتی شماست. ما می‌خواهیم آن را تا حد ممکن برای شما آسان کنیم. اگر سوالی داشتید، لطفاً با شماره های خدمات اعضا تماس بگیرید **1-855-772-9076 (TTY: 711)**. هنگام تماس لیستی از نسخه‌های خود آماده کنید. از ما بخواهید که داروهای شما را جستجو کنیم تا ببینیم که آیا در لیست وجود دارد یا خیر.

## علائم واختصارات

حروف کوچک *ایتالیک* - داروی ژنریک **حروف بزرگ پررنگ** -داروها با نام تجاری

**الزامات و محدودیت های پوشش**

AL - محدودیت های سنی OTC - داروهای PA OTC - ممکن است مجوز قبلی اعمال شود
QL - محدودیت مقدار ST - درمان مرحله‌ای ممکن است اعمال شود

**ردیف دارو**

تحت پوشش - داروهای تحت پوشش پوشش داده نشده - داروهایی که تحت پوشش نیست

## Cov ntsiab lus txhais

**Cov nqi yus yuav tau them yus** txhais tau tias yog koj cov nqi siv rau cov txiaj ntsig saib xyuas kev noj qab haus huv uas yuav tsis tau txais kev them rov qab los ntawm koj lub chaw tuav pov hwm kev noj qab haus huv. Cov nqi yus yuav tau them yus suav nrog cov nqi uas yus yuav tau them ua ntej, cov nqi sib koom them, thiab cov kev sib koom tuav pov hwm rau cov txiaj ntsig saib xyuas kev noj qab haus huv uas tau pab them, ntxiv rau txhua tus nqi them rau cov txiaj ntsig saib xyuas kev noj qab haus huv uas tsis rag pab them.

**Daim ntawv qhia tshuaj** los sis **daim npe tshuaj kho mob uas yuav tau muaj ntawv yuav** txhais tau tias yog daim npe cov tshuaj kho mob uas tau pab them los ntawm koj txoj cai tuav pov hwm kev noj qab haus huv nyob rau qhov txiaj ntsig ntawm tshuaj kho mob uas yuav tau muaj ntawv yuav ntawm txoj cai.

**Daim ntawv yuav tshuaj** txhais tau tias yog qhov lus txib los ntawm ncauj, sau ua ntaub ntawv, los sis nyob rau es lev taus niv los ntawm tus kws pab kho mob txib yuav tshuaj uas tso cai muab tshuaj kho mob uas yuav tau muaj ntawv yuav rau tus neeg tshwj xeeb.

**Kauj ruam kho mob** txhais tau tias yog theem tshwj xeeb uas yuav tsum tau sim cov tshuaj kho mob uas yuav tau muaj ntawv yuav los kho tus yam ntxwv mob. Yog tias qhov tshuaj kho mob nce rau khauj ruam kho mob nyob rau hauv daim ntawv qhia tshuaj no, tej zaum koj yuav tsum tau sim ib los sis tshaj ib yam tshuaj kho mob ua ntej koj txoj cai tuav pov hwm kev noj qab haus huv yuav pab them qhov tshuaj kho mob uas siv kho koj tus yam ntxwv mob. Yog tias koj tus kws pab kho mob txib yuav tshuaj xa qhov kev thov zam khauj ruam kho mob uas yuav tsum tau ua, koj lub chaw tuav pov hwm kev noj qab haus huv yuav tsum tau muab kev pom zoo rau qhov kev thov thaum nws yog kev tsim nyog fab kev kho mob rau koj los siv qhov tshuaj kho mob.

**Kev thov zam** txhais tau tias yog qhov thov rau kev pab them qhov tshuaj kho mob tsis muaj nyob rau daim ntawv qhia tshuaj. Yog tias koj, koj tus neeg sawv cev, los sis koj tus kws pab saib xyuas kev noj qab haus huav uas txib yuav tshuaj xa qhov kev thov rau kev pab them qhov tshuaj kho mob uas tsis muaj nyob rau daim ntawv qhia tshuaj, koj lub chaw tuav pov hwm yuav tsum tau pab them qhov tshuaj kho mob uas tsis muaj nyob rau hauv daim ntawv qhia tshuaj thaum uas nws yog kev tsim nyog fab kev kho mob rau koj los siv qhov tshuaj kho mob ntawd.

**Kev Tsim Nyog Fab Kev Kho Mob** txhais tau tias yog cov txiaj ntsig kev saib xyuas kev noj qab haus huv uas yuav tsum tau ua kev ntaus nqi mob, kho, los sis pov thaiv tus yam ntxwv mob los sis nws cov tsos mob thiab raug raws li cov qauv cai ntawm tshuaj kho mob uas tau lees txais. Feem ntau lawm lub chaw tuav pov hwm kev noj qab haus huv yuav tsis pab them cov txiaj ntsig kev saib xyuas kev noj qab haus uas tsis tsim nyog rau fab kev kho mob.

**Kev tso cai ua ntej** txhais tau tias yog qhov kev txiav txim los ntawm koj lub chaw tuav pov hwm kev noj qab haus huv tias qhov txiaj ntsig saib xyuas kev noj qab haus huv yog kev tsim nyog fab kev kho mob rau koj. Yog tias qhov tshuaj kho mob uas yuav tau muaj ntawv yuav nce rau qhov kev tso cai ua ntej nyob rau hauv daim ntawv qhia tshuaj no, koj tus kws pab kho mob txib yuav tshuaj yuav tsum thov kev tso cai los ntawm koj lub chaw tuav pov hwm kev noj qab haus huv txhawm rau pab them qhov tshuaj kho mob ua ntej koj sau koj daim ntawv yuav tshuaj. Koj lub chaw tuav pov hwm kev noj qab haus huv yuav tsum tso cai rau qhov kev thov kev tso cai ua ntej thaum nws yog kev tsim nyog fab kev kho mob rau koj los siv qhov tshuaj.

**Kev tuav pov hwm siv koom** txhais tau tias yog qhov feem pua ntawm tu nqi qhov txiaj ntsig kev saib xyuas kev noj qab haus huv uas tau pab them uas koj them tom qab koj tau them tus nqi uas yus yuav tau them ua ntej, yog tias tus nqi uas yus yuav tau them ua ntej siv tau rau cov txiaj ntsig kev saib xyuas kev noj qab haus huv.

**Theem Tshuaj Kho Mob** txhais tau tias yog cov tshuaj kho mob uas yuav tau muaj ntawv yuav uas raug raws li theem tus nqi sib faib them uas sau tseg rau hauv koj txoj cai tuav pov hwm. Theem tshuaj kho mob uas tau tso qhov tshuaj kho mob uas yuav tau muaj ntawv yuav - yuav txiav txim koj feem tus nqi them rau qhov tshuaj kho mob.

**Tshuaj kho mob muaj npe lag luam** yog qhov tshuaj kho mob uas tau muaj muag raws lub npe tus tswv, lub npe uas raug pov thaiv los ntawm lub cim lag luam. Tshuaj kho mob muaj npe lag luam raug teev npe tseg nyob rau hauv daim ntawv qhia tshuaj no ua cov NIAM NTAWV LOJ tag nrho.

**Tshuaj kho mob raws li ncua dav** txhais tau tias yog qhov tshuaj kho mob uas zoo ib yam nkaus li nws qhov tshuaj kho mob muaj npe lag luam uas muaj qhov ntau, lub zog, feem cuam tshuam, txoj hauv kev noj, qhov siv tau zoo, kev nyab xeeb, thiab lub hom phiaj siv sib luag zos. Tshuaj kho mob raws ncua dav raug teev npe tseg nyob rau hauv daim ntawv qhia tshuaj no uas ua cov niam ntawv me qaij.

**Tshuaj kho mob uas tsis muaj nyob rau hauv daim ntawv qhia tshuaj** txhais tau tias yog qhov tshuaj kho mob uas yuav tau muaj ntawv yuav uas tsis raug teev npe tseg rau hauv daim ntawv qhia tshuaj no.

**Tshuaj kho mob uas yuav tau muaj ntawv yuav** txhais tau tias yog qhov tshuaj kho mob uas cai lij choj teeb tseg kom muaj daim ntawv yuav tshuaj mus yuav.

**Tus kws pab kho mob txib yuav tshuaj** txhais tau tias yog tus kws pab saib xyuas kev noj qab haus huv uas tuaj yeem sau tau daim ntawv yuav tshuaj rau qhov tshuaj siv los ntau nqi, kho, los sis pov thaiv tus yam ntxwv mob.

**Tus nqi sib koom them** txhais tau tias yog qhov nyiaj ruaj khov uas koj them rau qhov txiaj ntsig saib xyuas kev noj qab haus huv tom qab koj tau them tus nqi uas yus yuav tau them ua ntej, yog tias tus nqi uas yus yuav tau them ua ntej siv tau rau qhov txiaj ntsig saib xyuas kev noj qab haus huv.

**Tus nqi uas yus yuav tau them ua ntej** txhais tau tias yog qhov nyiaj koj them rau cov txiaj ntsig saib xyuas kev noj qab haus huv uas tau pab them uas them ua ntej koj lub chaw tuav pov hwv pib them. Yog tias koj txoj cai tuav pov hwm kev noj qab haus huv muaj tus nqi uas yus yuav tau them ua ntej, tej zaum nws yuav muaj ib tus nqi uas yus yuav tau them ua ntej los sis cais cov nqi uas yus yuav tau them ua ntej rau cov txiaj ntsig fab kev kho mob thiab cov txiaj ntsig tshuaj kho mob uas yuav tau muaj ntawv yuav. Tom qab koj them koj tus nqi uas yus yuav tau them ua ntej, feem ntau lawm koj tsuas them tus nqi sib koom them los sis sib koom tuav pov hwm rau cov txiaj ntsig saib xyuas kev noj qab haus huv uas tau pab them lawm xwb. Koj lub tuam txhab tuav pov hwm yuav tau them qhov seem.

**Xwm txheej ceev** txhais tau tias yog thaum uas tab tom ntsib cov tsos mob uas tej zaum yuav tsim kev puas tsuaj loj rau koj txoj sia, kev noj qab haus huv, los sis lub peev rov qab los ua hauj lwm nyob rau qib siab tshaj plaws, los sis thaum koj tab tom raug kho mob uas siv qhov tshuaj kho mob tsis muaj nyob rau hauv daim ntawv qhia tshuaj.

**Aetna Better Health of California Daim Ntawv Qhia Tshuaj (Daim Npe Tshuaj) yog dab tsi?**

Qhov no yog daim npe tshuaj uas tau tsim los ntawm Aetna Better Health of California uas tau ua hu daim Ntawv Qhia Tshuaj. Lub phiaj xwm yuav pab them cov tshuaj kho mob nyob rau hauv daim npe no. Qee cov tshuaj kho mob tej zaum yuav muaj cov kev cai pab them. Yog tias qhov tshuaj kho mob tau muaj raug raws li cov kev cai, lub phiaj xwm yuav pab them qhov tshuaj kho mob.

Muaj tus thawj coj saib xyuas uas tau hu ua tus Thawj Coj Saib Xyuas Khw Muag Tshuaj thiab Kev Kho Mob uas tau tsim ntawm cov kws kho mob thiab cov kws tshuaj los ntawm Aetna Better Health of California thiab fab kev kho mob. Lawv sib ntsib txhua peb lub hlis txhawm rau tshab xyuas daim npe tshuaj no thiab tej cov tshuaj kho mob tshiab uas tawm los.

**Lub Phiaj Xwm daim npe tshuaj puas tuaj yeem hloov pauv tau?**

Tej zaum lub phiaj xwm yuav txhab ntxiv los sis rho tawm tau cov tshuaj kho mob nyob rau hauv daim npe. Kev siv cov tswv cuab thiab lawv cov kws pab kho mob yuav tau txais kev ceeb toom yam tsawg kawg 30 hnub ua ntej qhov tshuaj kho mob raug rho tawm ntawm daim ntawv qhia tshuaj. Txhua cov kev hloov pauv rau daim ntawv qhia tshuaj yuav raug tshaj tawm nyob rau lub phiaj xwm lub vev xaib ntawm: **www.aetnabetterhealth.com/california/members/pharmacy.**

Daim ntawv qhia tshuaj tuaj yeem hloov pauv tau thoob plaws lub xyoo. Qee cov laj thawj tias vim li cas lawv ho hloov pauv tau suav nrog:

- Cov tshuaj kho mob tshiab uas tau txais kev pom zoo.
- Cov tshuaj kho mob uas twb muaj lawm raug rho tawm ntawm lub khw.
- Cov tshuaj kho mob uas yuav tau muaj ntawv yuav tej zaum yuav dhau los muaj muag ntawm chaw muag tshuaj (yam uas tsis muaj ntawv yuav tshuaj). Cov tshuaj kho mob uas tsis siv ntawv yuav tshuaj yuav raws li ncua dav lawm yuav tsis muaj nyob rau hauv daim ntawv qhia tshuaj.
- Cov tshuaj kho mob muaj npe lag luam yuav plam kev pov thaiv ntaub ntawv tso cai tsim khoom tshiab thiab yuav muaj cov phaum raws li ncua dav. Thaum qhov no tshwm sim, cov tshuaj kho mob raws li ncua dav yuav raug pab them hloov qhov tshuaj muaj npe lag luam. Qhov tshuaj kho mob muaj npe lag luam tej zaum yuav dhau mus ua qhov tshuaj kho mob uas tsis muaj nyob rau hauv daim ntawv qhia tshuaj los sis tau pab them tus nqi siab zog. Saib qhov "cov tshuaj kho mob raws ncua dav yog dab tsi?" tshooj saum toj rau kev paub ntxiv.

**Kuv yuav siv lub Phiaj Xwm Daim Ntawv Qhia Tshuaj Li Cas?**
Qhov tshuaj kho mob uas yuav tau muaj ntawv yuav tej zaum tuaj yeem nrhiav tau los ntawm kev nrhiav nyob kev kho mob muab cais ua hom thiab ua pawg seb qhov tshuaj nce rau qhov twg los sis lub npe lag luam los sis lub npe ib txwm siv ntawm qhov tshuaj kho mob nyob rau hauv daim npe teev raws tus niam ntawv. Yog tias qhov tshuaj kho mob raws ncua dav uas muaj qhov sib luag li qhov tshuaj kho mob muaj npe lag luam tsis muaj muag hauv khw los sis tsis raug pab them, qhov tshuaj yuav tsis raug teev tseg uas muab cais raws li nws lub npe raws ncua dav.

- Qhov tshuaj kho mob uas tau teev npe raws li tus niam ntawv los ntawm nws lub npe lag luam thiab lub npe ib txwv siv nyob rau hauv kev siv kho mob muab cais ua hom thiab ua pawg seb nws ce raug pawg twg
- Lub npe raws ncua dav rau qhov tshuaj kho mob uas muaj lub npe lag luam yuav raug suav nrog tom qab lub npe nyob rau hauv lub voos lev thiab txhua tus niam ntawv ua tus me tuab thiab qaij. (Rau piv txwv: COREG (*carvedilol*))
- Yog tias qhov tshuaj kho mob raws ncua dav uas muaj qhov sib luag li qhov tshuaj kho mob muaj npe lag luam ob qho no muaj thiab raug pab them tib si, qhov tshuaj kho mob raws ncua dav yuav raug teev tseg uas muab cais los ntawm qhov tshuaj kho mob muaj npe lag luam uas txhua tus niam ntawv ua tus me tuab thiab qaij; thiab (Rau piv txwv: *carvedilol*)
- Yog tias qhov tshuaj kho mob raws ncua dav tau muaj muag raws li lub npe tus tswv, lub npe lag luam uas raug pov thaiv los ntawm lub cim lag luam, lub npe lag luam tom qab lub npe raws ncua dav nyob rau hauv lub voos lev thiab cov niam ntawv zoo raws li ib txwm uas thawj tus niam ntawv ntawm txhua tej lo lus ua tus loj. (Rau piv txwv: *desogestrel-ethinyl estradiol* (Azurette)).

- Kev xam raws qhov tshuaj uas yuav tau muaj ntawv yuav nyob rau hauv daim ntawv qhia tshuaj yuav lav tsis tau tias koj tus kws pab kho mob yuav txib yuav tau qhov tshuaj rau tus yam ntxwv mob tshwj xeeb.

- **Kem #1: Lub Npe Tshuaj Kho Mob Uas Yuav Tau Muaj Ntawv Yuav**: cov npe tshuaj kho mob uas raug pab them. Cov tshuaj kho mob uas muaj npe lag luam yog cov uas txhua tus niam ntawv ua NIAM NTAWV LOJ (xws li, TSUAJ KHO MOB). Cov tshuaj kho mob raws ncua dav yog cov uas cov niam ntawv ua tus niam me (xws li, tshuaj kho mob). Tau muaj kev qhia txog qhov sib txawv ntawm qhov ntau ntawm qhov tshuaj los sis lub zog.

- **Kem #2: Theem Tshuaj Kho Mob**: Qhia pom tias qhov tshuaj kho mob raug them yam uas tsis muaj tus nqi sib faib them, tshwj tsis yog nws raug txiav tawm. Nyob rau qhov xwm txheej no, nws tsuas txhais tias lub khw muag tshuaj yuav ua kev lis nws sib txawv thaum uas koj muab koj daim ntawv yuav tshuaj rau khw muag tshuaj.

- **Kem #3: Cov Cai thiab Cov Ciam Txwv Txog Kev Pab Them**: qhia koj yog tias qhov tshuaj kho mob yuav tsum tau muaj qhov kev tso cai ua ntej los sis lwm cov kev txwv.

  Cov tshuaj kho mob los kuj tau muab cais ua pawg raws li hom tshuaj kho mob. Yog tias koj paub koj qhov tshuaj kho mob yog hom twg, thov saib lub npe hom ntawd nyob rau lub kem ntawv cov ntsiab lus. Tag ntawd saib nyob rau hauv qab ntawm nplooj ntawd rau koj qhov tshuaj kho mob.

**Cov tshuaj kho mob ncua dav yog dab tsi?**
Lub phiaj xwm pab them rau cov tshuaj kho mob muaj npe lag luam thiab cov tshuaj kho mob raws ncua dav tib si. Cov tshuaj kho mob raws ncua dav muaj tus nqi tsawg heev thiab tau txais kev pom zoo los ntawm Chaw Tswj thiab Pov Thaiv Kab Mob (Food and Drug Administration, FDA). Cov tshuaj kho mob raws ncua dav pom tau tiav muaj kev nyab xeeb thiab kev siv tau zoo ib yam li cov tshuaj kho mob muaj npe lag luam thiab xwb. Cov tshuaj ntawd muaj tib cov feem xyuam xyaw uas ntau tib yam nkaus li cov tshuaj kho mob muaj npe lag luam thiab siv tau zoo tib yam nkaus. Yog li ntawd cov tshuaj ntawd muaj cov kev pheej hmoo thiab cov txiaj ntsig tib yam nkaus li cov tshuaj kho mob muaj npe lag luam. Txawm li cas los, cov tshuaj ntawd feem ntau yeej muaj nqi tsawg dua.

**Yuav ua li cas yog tias kuv qhov tshuaj kho mob tsis nyob hauv daim npe tshuaj?**
Nyob rau qee xwm tsheej, koj los sis koj tus kws txib yuav tshuaj tuaj yeem thov tau qhov kev zam fab kev kho mob rau qhov kev tso cai ua ntej, kauj ruam kho mob los sis cov ciam txwv txog qhov ntau uas yuav tau muaj los sis qhov tshuaj kho mob uas tsis raug pab them nyob rau koj lub phiaj xwm. Cov kev txiav txim txog kev pab them rau yuav raug ua nyob rau

72 xuab moos tom qab tau txais cov kev thov uas tsis yog kev thov maj ceev. Koj tuaj yeem thov koj qhov kev thov ua kev thov maj ceev tau. Cov kev txiav txim txog kev pab them maj ceev yuav tau ua nyob rau 24 xuab moos. Tom qab ntawd peb yuav txuas lus rau koj thiab koj tus kws kho mob txog peb qhov kev txiav txim. Txhua cov tshuaj kho mob uas yuav tau muaj ntawv yuav siv rau cov neeg mob sab nrauv uas muaj kev tsim nyog fab kev kho mob yuav raug pab them.

Cov kev zam fab kev kho mob uas tau txais kev pom zoo rau cov kev thov uas tsis yog kev thov maj ceev yuav suav nrog ncua sij hawm sau daim ntawv yuav tshuaj, suav nrog kev cov kev rov sau dua. Cov kev zam fab kev kho mob uas tau txais kev pom zoo rau cov xwm txheej ceev yuav muab kev pab them rau ncua sij hawm xwm txheej ceev. Yog tias koj qhov kev thov raug tsis kam lees koj muaj cai xa qhov thov kom rov qab txiav txim dua uas siv qhov txheej txheem uas tau piav qhia nyob rau daim ntawv ceeb toom.

Yog tias tsis tau ua kev txiav txim rau qhov kev thov zam kev tso cai ua ntej los sis kauj ruam kho mob nyob rau 72 xuab moos tom qab tau txais qhov kev thov uas tsis yog kev thov maj ceev thiab 24 xuab moos tom qab tau txais qhov kev thov saib raws li xwm txheej ceev, qhov kev thov raug xam tias tau txais kev pom zoo lawm thiab tej zaum peb yuav lees txais qhov kev thov tom qab ntawd.

Saib raws li xeev txoj cai lij choj, cov tswv cuab uas tau txais kev pom zoo tag los los ntawm peb rau kev pab them tshuaj kho lawv tus yam ntxwv mob yuav tau txais kev pab them cov tshuaj kho mob ntawd mus ntxiv, mus ntev li ntev tau uas tus kws txib yuav tshuaj tseem txib yuav cov tshuaj ntawd, mus ntev li ntev tau uas qhov tshuaj kho mob raug txib yuav tseem phim siv thiab tau xam tias muaj kev nyab xeeb thiab muaj kev siv tau zoo rau kev kho tus tswv cuab tus yam ntxwv mob.

**Kuv yuav tau txais qhov kev txib yuav tshuaj uas yuav tau muaj ntawv yuav hauv kev xa ntawv li cas?**

Yog tias koj noj tshuaj kho tus yam ntxwv mob uas tseem mob, koj yuav tau txais kev xa cov tshuaj ntawd rau tom koj tsev. Aetna Better Health ua hauj lwm nrog ib lub tuam txhab uas tau hu ua CVS Caremark, txhawm rau muab cov kev pab cuam no rau koj yam uas tsis xam nqi rau koj them.

Yog tias koj xaiv txoj hauv kev xaiv no, koj cov tshuaj kho mob yuav xa ncaj nraim tuaj rau ntawm koj tsev. Koj tuaj yeem teeb tau koj cov kev rov sau dua. Koj tuaj yeem nug tau cov lus nug ntawm cov kws tshuaj. Ntawm no yog qee tus yam ntxwv ntawm kev xa tuaj ntawm tsev:

- Cov kws tshuaj yuav ntsuam xyuas txhua tej qhov kev txib yuav txhawm rau kev nyab xeeb.

- Koj tuaj yeem rov sau dua kev txib yuav tshuaj tau los ntawm kev xa ntawv, los ntawm xov tooj, hauv oos lais, los sis koj tuaj yeem rau npe tau rau cov kev rov sau dua uas nws sau nws.
- Koj tuaj yeem sib tham tau nrog cov kws tshuaj los ntawm xov tooj.

Nws yooj yim los pib siv kev pab cuam hauv kev xa ntawv.
Xaiv IB ntawm peb txoj hauv kev txuas mus no txhawm rau siv kev pab cuam hauv oos lais rau qhov tshuaj uas koj tab tom siv:

- Hu rau CVS tus nab npawb xov tooj hu dawb ntawm **1-855-271-6603 (TTY: 711)** (24 xuab moos rau ib hnub, 7 hnub rau ib vij). Lawv yuav qhia koj paub tias koj cov tshuaj kho mob twg thiaj tuaj yeem sau tau los ntawm khw muag tshuaj CVS li kev pab cuam hauv kev xa ntawv. Tom qab ntawd CVS yuav txuas lus rau koj tus kws kho mob txog daim ntawv yuav tshuaj thiab kev xa qhov tshuaj kho mob rau koj. Thaum koj hu mus, yuav tsum ntseeg siab tias muaj:
  - Koj Phiaj Xwm daim npav ID tswv cuab.
  - Koj tus kws kho mob lub npe thiab lub xeem thiab tus nab npawb xov tooj.
  - Koj cov ntaub ntawv txog kev them nyiaj thiab chaw nyob xa ntawv.

- Mus rau peb lub vev xaib muab kev nkag mus rau tswv cuab txhawm rau sau npe los sis nkag mus. Thaum koj nkag mus rau hauv lub vev xaib muab kev nkag mus rau tswv cuab, mus rau Cov Hauj Lwm (Tasks) thiab tom qab ntawv mus rau Cov Kev Pab Cuam Khw Muag Tshuaj (Pharmacy Services). Nyem rau CVS txoj kab txuas nkag mus txhawm rau mus rau **Caremark.com**. Nyem rau pib (start) "kev pab cuam hauv kev xav ntawv" txhawm rau luam tawm daim foos txib yuav hauv kev xav ntawv. Koj tuaj yeem hu tau rau CVS ntawm tus xov tooj **1-855-271-6603**. Ua kom ntseeg siab tias muaj koj daim npav ID tswv cuab nrog thaum koj rau npe rau thawj zaug.
- Sau thiab xa koj daim foos txib yuav kev pab cuam hauv kev xa ntawv. Yog tias koj npaj tau daim ntawv yuav tshuaj lawm, koj tuaj yeem muab xa tau rau CVS Caremark nrog rau daim foos txib yuav kev pab cuam hauv kev xa ntawv uas tau ua tiav lawm. Yog tias koj tsis muaj daim foos txib yuav, koj tuaj yeem daus lauj tau daim foos. Koj los kuj tuaj yeem thov tau ib daim los ntawm kev hu rau Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj **1-855-772-9076 (TTY: 711)**.

  Muaj cov ntaub ntawv txuas mus no nrog koj thaum koj ua tiav daim foos:

- Koj Phiaj Xwm daim npav ID tswv cuab.
- Koj li chaw nyob xav ntawv, suav nrog tus khauj ZIP.
- Koj tus kws kho mob lub npe thiab lub xeem thiab tus nab npawb xov tooj.
- Daim npe koj cov kev fab tshuaj thiab lwm cov yam ntxwv mob.
- Koj daim ntawv yuav tshuaj thaum xub thawj los ntawm koj tus kws kho mob.

**Kuv yuav tau txais qhov tshuaj kho mob tshwj xeeb nyob rau qhov twg?**
Lub Khw Muag Tshuaj Tshwj Xeeb CVS yog lub khw muag tshuaj tshwj xeeb rau Aetna Better Health of California cov tswv cuab. Lub khw muag tshuaj tshwj xeeb yuav sau cov tshuaj kho mob thiab muaj lwm cov kev pab cuam los pab koj. Khoos Kas Tshuaj Kho Mob Tshwj Xeeb muaj cov kev pab cuam tshwj xeeb rau koj:

- Koj tuaj yeem sib tham tau nrog tus kws tshuaj 24 xuab moos rau ib hnub, 7 hnub rau ib vij.
- Kev sab laj txog koj li tshuaj kho mob thiab kab mob.
- Kev khiav hauj lwm fab kev saib xyuas mob nrog koj thiab koj tus kws kho mob.
- Kev xa cov tshuaj kho mob tshwj xeeb tuaj ntawm koj lub tsev los sis tus kws kho mob lub chaw ua hauj lwm.
- Koj tuaj yeem xa tau koj daim ntawv yuav tshuaj thiab tau txais tshuaj kho mob ntawm Khw Muag Tshuaj CVS (suav nrog cov uas nyob sab hauv cov khw Target).
- Koj tuaj yeem hu tau rau lub Khw Muag Tshuaj Tshwj Xeeb CVS ntawm tus xov tooj **1-800-237-2767**; TTY/TDD: **1-800-863- 5488**. Khw Muag Tshuaj Tshwj Xeeb CVS yuav pab koj sau koj qhov tshuaj kho mob tshwj xeeb.

Saib daim **npe tshuaj kho mob tshwj xeeb** uas muaj los nawm Khw Muag Tshuaj Tshwj Xeeb CVS.

**Cov tshuaj kho mob ntawm lub Chaw Muag Tshuaj Yuav Tau Yam Tsis Siv Ntawv Yuav (Over-The-Counter, OTC) puas raug pab them?**
Lub phiaj xwm yuav pab them cov tshuaj kho mob OTC uas nyob rau hauv daim ntawv qhia tshuaj. Qee cov tshuaj kho mob OTC tej zaum yuav muaj cov kev cai pab them. Yog tias qhov tshuaj kho mob OTC tau muaj raug raws li cov kev cai, lub phiaj xwm yuav pab them qhov tshuaj kho mob OTC. Zoo ib yam li lwm cov tshuaj kho mob, cov tshuaj kho mob OTC yuav tsum tau muaj daim ntawv yuav los ntawm tus kws kho mob yog tias cov tshuaj ntawd raug pab them los ntawm lub phiaj xwm.

**Qee yam tshuaj txhaj uas kuv tus kws kho mob los sis tus kws pab kho mob tau muab nyob rau hauv lub khw kuaj mob puas raug pab them?**
Cov hom tshuaj kho mob no raug pab them raws li qhov txiaj ntsig fab kev kho mob hloov qhov txiaj ntsig fab khw muag tshuaj. Feem ntau lawm, daim ntawv qhia tshuaj no muaj cov tshuaj kho mob uas koj tau txais los ntawm lub khw muag tshuaj thiab muab rau koj tus kheej. Yog tias koj tus kws pab kho mob xav siv qhov tshuaj kho mob nyob rau hauv lub khw kuaj mob xws li qhov tshuaj txhaj, lawv muaj cov lus qhia txog txoj hauv kev sau nyiaj ntawm Aetna Better Health of California.

**Kuv yuav nrhiav lub nev vawj khw muag tshuaj li cas?**
Koj tuaj yeem nrhiav tau lub khw muag tshuaj nyob rau ob txoj hauv kev:

- **Hauv Oos Lais**: Nkag mus rau peb lub vev xaib ntawm **www.aetnabetterhealth.com/california/find-provider**.
- **Los ntawm xov tooj**: Hu Rau Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj **1-855-772-9076 (TTY: 711)**. Lawv yuav zoo siab los pab koj nrhiav lub nev vawj khw muag tshuaj uas nyob ze koj.

Yuav ntsum nco qab ntsoov los sau koj daim ntawv yuav tshuaj ntawm lub nev vawj khw muag tshuaj. Koj cov ntawv yuav tshuaj yuav tsis raug pab them nyob rau lwm cov khw muag tshuaj.

**Puas muaj cov tshuaj kho mob uas sib koom them?**
Saib phau ntawv qhia siv rau tswv cuab rau kev paub txog nqi sib koom them.

**Cov cai pab them rau qee hom yog dab tsi?**

- **Kev Pom Zoo Ua Ntej (Prior Approval, PA)**: Qhov no txhais tau tias koj tus kws kho mob yuav tsum tau txais kev pom zoo los ntawm lub phiaj xwm ua ntej thiaj tuaj yeem sau tau qhov tshuaj kho mob ntawm lub khw muag tshuaj. Yog tias nws tsis tau txais kev pom zoo, lub phiaj xwm yuav tsis them qhov tshuaj kho mob.

- **Cov Ciam Txwv Txog Qhov Ntau (Quantity Level Limits, QLL)**: Qhov no txhais tau tias muaj ciam txwm txog qhov ntau ntawm tshuaj kho mob uas lub phiaj xwm yuav them. Rau piv txwv, lub phiaj xwm muab 60 ntsiav tshuaj nyob rau 30 hnub rau qee cov tshuaj kho mob.

- **Kauj Ruam Kho Mob (Step Therapy, ST)**: Qhov no txhais tias tej zaum koj yuav tsum tau sim qee cov tshuaj kho mob los kho koj tus yam ntxwv mob ua ntej. Tom qab tau sim thawj qhov tshuaj kho mob, tom qab ntawd lub phiaj xwm yuav pab them rau lwm qhov tshuaj kho mob siv

rau tib tus yam ntxwv mob ntawd. Piv txwv, Tshuaj Kho Mob A thiab Tshuaj Kho Mob B tej zaum yuav kho tau koj tus yam ntxwv mob. Tej zaum lub phiaj xwm yuav tsis pab them qhov Tshuaj Kho Mob B tshwj tsis yog koj sim qhov Tshuaj Kho Mob A ua ntej. Yog tias qhov Tshuaj Kho Mob A kho tsis tau koj, ces qhov Tshuaj Kho Mob B yuav raug pab them.

- **Kob Tshuaj Yaj Nrog Dej Tso Rau Txoj Leeg Ntshav Uas Yooj Yim**: Kob tshuaj yaj nrog dej tso rau txoj leeg ntshav uas yooj yim feem ntau lawm tau siv rau kev kho mob uas tso dej. Suav nrog kob tshuaj yaj nrog dej uas muaj muag (tsis sib tov) xws li Normal Saline, Dextrose (nce txog 10% nyob rau Cov Dej) thiab Lactated Ringer's Solution, kob tshuaj yaj nrog dej phaus tes xiaj khos xiaj (potassium chloride) uas tau npaj muag kob tshuaj yaj nrog dej ntawd kuj tau suav nrog rau cov ntsiab lus no. Kob tshuaj yaj nrog dej tso rau txoj leeg tshav uas yooj yim tsim nyog raug sau nqi uas siv Tus Khauj Tshuaj Kho Mob Hauv Teb Chaws (National Drug Code, NDC) ntawm qhov tshuaj.

- **Kob Tshuaj Yaj Nrog Dej Tam Khoom Noj Tso Rau Txoj Leeg Ntshav (Parenteral Nutrition Solutions) (TPN los sis Kev Muab Khoom Noj Raws Txoj Leeg Ntshav (Hyperalimentation))**: (Kob tshuaj yaj nrog dej tam khoom noj tso rau txoj leeg ntshav yog kev muab cov tshuaj tam khoom noj txhaj rau txoj leeg ntshav los sis tso rau leeg ntshav uas feem ntau lawm yog cov khob tshuaj tsis yaj nrog dej los sis cov kob tshuaj yaj nrog dej ntawm as mis naus as xiv (amino acids) los sis plaus tees (protein), dev xas taus (dextrose), roj, is lev thaus lais (electrolytes), vis tas mees (vitamin) thiab/los sis khoom noj txhab ntxiv thiab cov feem xyuam xyaw tsis daw.)
  - Raug txwv muab nyob rau 10 hnub tom qab tus neeg mob pw tsev kho mob tawm ntawm kev kho mob hnyav ntawm tsev kho mob, thaum kho mob I.V. uas tau pib siv tib hom tshuaj kho mob ua ntej tawm tsev kho mob. Muaj qhov kev muab siab kawg 10 hnub rau kev muab ncua sij hawm nyob rau hauv 10-hnub.
  - Cov txhab ntxiv rau khoom noj tso rau txoj leeg ntshav yog lwm cov tshuaj kho mob uas tov nrog kob tshuaj yaj nrog dej tam khoom noj tso rau txoj leeg ntshav tau txhua sij hawm ua ntej tso. Kev sau nqi ntawm cov khoom no yog ib feem ntawm kev sau nqi qhov koom noj tso rau txoj leeg.

***Cim Tseg**: Cov tshuaj uas tsis sib tov yuav tsum raug sau nqi uas siv qhov tshuaj tus NDC. Cov kob tshuaj yaj nrog dej sib tov yuav tsum raug sau nqi raws li qhov thov tov.

- **Cais Kev Tau Tso Roj Rau Txoj Leeg Ntshav**:
  - Raug txwv muab nyob rau 10 hnub tom qab tus neeg mob pw tsev kho mob tawm ntawm kev kho mob hnyav ntawm tsev kho mob, thaum kho mob I.V. uas tau pib siv tib hom tshuaj ua ntej tawm tsev kho mob. Muaj qhov kev muab siab kawg 10 hnub rau kev muab ncua sij hawm nyob rau hauv 10-hnub no.
  - Cov kob tshuaj yaj nrog dej los sis cov kob tshuaj tsis yaj nrog dej tam roj uas raug tso rau txoj leeg ntshav cais los ntawm cov kob tshuaj yaj nrog dej tam khoom noj tso rau txoj leeg ntshav (uas tov, tsis tov nrog kob tshuaj yaj nrog dej tam khoom noj tso rau txoj leeg ntshav hauv lub taub) tsim nyog raug sau nqi uas siv qhov khoom tus NDC.

- **Cov Khoom Uas Tso Nkag Mus Rau Lub Cev**:
  - Cov Khoom uas nyob rau Medi-Cal Daim Npe Cov Khoom Noj Tso Nkag Mus Rau Lub Cev raug pab them raws li kev tso cai ua ntej fab kev kho mob thiab kev tshab xyuas kev tsim nyog fab kev kho mob. Cov koom no raug teev tseg nyob ntawm no: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**
  - Aetna Better Health muab los sis npaj cov khoom tso mus rau lub cev uas muaj kev tsim nyog fab kev kho mob uas tau pab them, thiab los ua kom ntseeg siab tias cov khoom noj tau muab lawm tsis tsawg tshaj tej yam uas tau muab rau cov neeg tau txais txiaj ntsig raws Medi-Cal Tus Nqi Kev Pab Cuam, saib raws li Medi-Cal txoj cai tau teev tseg ntawm no: **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**Yuav ua li cas yog tias kuv qhov tshuaj kho mob tsis nyob rau hauv lub phiaj xwm daim Ntawv Qhia Tshuaj?**

Yog tias koj qhov tshuaj kho mob tsis nyob rau hauv daim npe tshuaj, muaj qee yam uas koj tuaj yeem ua tau.

- Nug koj tus kws pab kho mob txog qhov tshuaj kho mob uas zoo xws li qhov tshuaj uas *nyob* rau hauv daim npe.
- Thov koj tus kws pab kho mob kom nrhiav "kev tso cai ua ntej" (kev pom zoo ua ntej) los ntawm Aetna Better Health of California txhawm rau pab them qhov tshuaj kho mob no.

**Kuv tus kws kho mob los sis kws pab kho mob yuav thov tau qhov kev tso cai ua**

**ntej los sis kev zam yog tias lub phiaj xwm tsis pab them kuv qhov tshuaj kho mob li cas?**
Lawv tuaj yeem ua tau qhov no nyob rau peb txoj hauv kev:

1. Tej zaum koj tus kws pab kho mob yuav fev tau daim foos kev tso cai ua ntej ntawm khw muag tshuaj los sis daim foos kev zam kauj ruam kho mob rau **1-844-823-5478** thiab suav nrog txhua cov ntaub ntawv tsim nyog.
2. Lawv los kuj tuaj yeem xa tau qhov kev thov los ntawm xov tooj uas hu rau tus xov tooj **1-855-772-9076**.
3. Lawv tuaj yeem xa tau qhov Kev Tso Cai Ua Ntej Hauv Ev Les Tauv Niv (Electronic Prior Authorization, ePA).

**Yuav ua li cas yog tias kuv muaj lus nug txog txoj hauv kev Aetna Better Health of California pab them cov tshuaj kho mob?**
Kawm kom paub txog koj cov txiaj ntsig khw muag tshuaj:

Tsis hais nws yog tshuaj kho qhov mob tom qab raug mob los sis tshuaj kho mob los tswj tus yam ntxwv mob, kev tau txais cov tshuaj kho mob uas yuav tau siv ntawv yuav uas koj xav yog ib feem tseem ceeb ntawm koj qhov kev saib xyuas kev noj qab haus huv. Peb xav ua kom nws yooj yim rau koj npaum li ua tau. Yog tias koj muaj lus nug dab tsi, thov hu rau Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj **1-855-772-9076 (TTY: 711)**. Npaj kom txhij daim npe koj cov ntawv yuav tshuaj thaum koj hu mus. Thov kom peb nrhiav koj cov tshuaj kho mob los saib yog tias cov tshuaj kho mob ntawd muaj nyob rau hauv daim npe.

## KEEB KWM

*niam ntawv me qaij* - Cov tshuaj kho mob raws ncua dav TUS **NIAM NTAWV LOJ TUAB** -Cov tshuaj kho mob muaj npe lag luam

**Cov Cai thiab Cov Ciam Txwv Txog Kev Pab Them**
AL - Cov Kev Txwv Txog Hnub Nyoog OTC - OTC Cov Tshuaj Kho Mob
PA - Kev Pom Zoo Ua Ntej tej zaum yuav siv tau
QL - Cov Ciam Txwv Txog Qhov Ntau ST - Kauj Ruam Kho Mob tej zaum yuav siv tau

**Theem Tshuaj Kho Mob**
Raug Pab Them - Cov Tshuaj Kho Mob Raug Pab Them
Tsis Raug Pab Them -Cov Tshuaj Kho Mob Tsis Raug Pab Them

## التعريفات

**الدواء الذي يحمل علامة تجارية** يعني الدواء يتم تسويقه تحت اسم ملكية محمية بعلامة تجارية. يتم ادراج الدواء الذي يحمل اسم العلامة التجارية في هذا الدليل بالأحرف الكبيرة.

**التأمين المشترك** يعني نسبة مئوية من تكلفة مزايا الرعاية الصحية المغطاة التي تسددها بعد دفعك للخصم، إذا كان الخصم ينطبق على مزايا الرعاية الصحية.

**المشاركة في السداد** تعني مبلغًا ثابتًا بالدولار تسدده مقابل ميزة الرعاية الصحية المغطاة بعد دفعك للخصم، إذا كان الخصم ينطبق على مزايا الرعاية الصحية.

**المبلغ المقتطع** يعني المبلغ الذي تسدده مقابل مزايا الرعاية الصحية المغطاة التي تخضع للخصم قبل أن تبدأ شركة التأمين الصحي الخاصة بك في الدفع. إذا كانت بوليصة التأمين الصحي الخاصة بك تحتوي على خصم، فقد يكون لها خصم واحد أو خصم منفصل للمزايا الطبية ومزايا الأدوية التي تستلزم وصفة طبية. بعد أن تدفع المبلغ المقتطع الخاص بك، فإنك تسدد عادةً فقط دفعة مشتركة أو تأمين مشترك لمزايا الرعاية الصحية المغطاة. وإن شركة التأمين الخاصة بك تسدد الباقي.

**مستويات الأدوية** تعني مجموعة من الأدوية التي تستلزم وصفة طبية والتي تتوافق مع مستوى مشاركة التكلفة المحددة في بوليصة التأمين الصحي الخاصة بك. تحدد مستويات الأدوية التي يتم تصنيف فيها الدواء الموصوف طبيًا حصتك في السداد من تكلفة الدواء.

**طلب الاستثناء** يعني طلب تغطية دواء غير موجود في كتيب الوصفات. إذا قدمت أنت، أو من ينوب عنك، أو مقدم الرعاية الصحية طلبًا لتغطية دواء غير موجود في كتيب الوصفات، يجب على شركة التأمين الخاصة بك تغطية الدواء غير موجود في كتيب الوصفات عندما يكون من الضروري طبياً تناول الدواء.

**الظروف الطارئة** تعني أنك تعاني من حالة صحية قد تعرّض حياتك أو صحتك أو قدرتك على استعادة الحد الأقصى للأداء الوظيفي للخطر، أو تخضع لمسار علاج حاليًا باستخدام دواء غير موجود في كتيب الوصفات.

**كتيب الوصفات** أو **قائمة الأدوية التي تستلزم وصفة طبية** تعني قائمة الأدوية التي تغطيها بوليصة التأمين الصحي الخاصة بك بموجب مزايا الأدوية التي تستلزم وصفة طبية في البوليصة.

**الأدوية الجنيسة** يُقصد بها الأدوية المشابهة لعلامتها التجارية والتي تساوي الدواء من حيث الجرعة والقوة والتأثير وكيفية تناوله والجودة والسلامة والاستخدام المقصود. يتم ادراج الدواء الجنيس في هذا الكتيب بأحرف صغيرة مائلة.

**الضرورة الطبية** تعني مزايا الرعاية الصحية اللازمة لتشخيص حالة طبية أو أعراضها أو علاجها أو الوقاية منها والتي تلبي معايير الطب المقبولة. لا يغطي التأمين الصحي عادةً مزايا الرعاية الصحية غير الضرورية طبيًا.

**الدواء غير موجود في كتيب الوصفات** يُقصد به دواءً موصوفًا بوصفة طبية غير مدرج في هذا الكتيب.

**التكاليف النثرية** تعني نفقاتك على مزايا الرعاية الصحية التي لا يسددها التأمين الصحي الخاص بك. تشمل التكاليف النثرية المبالغ المقتطعة والمشاركة في السداد والتأمين المشترك لمزايا الرعاية الصحية المغطاة، بالإضافة إلى جميع تكاليف مزايا الرعاية الصحية التي لم يتم تغطيتها.

**مقدم الرعاية الذي يصف وصفة طبية** يُقصد به مقدم الرعاية الصحية الذي يمكنه كتابة وصفة طبية لدواء لتشخيص حالة طبية أو علاجها أو الوقاية منها.

**الوصفة الطبية** تعني أمرًا شفهيًا أو كتابيًا أو إلكترونيًا من مقدم الرعاية الذي يصف وصفة طبية يسمح بصرف دواء بوصفة طبية إلى فرد معين.

**الأدوية الموصوفة طبيًا** هي أدوية تتطلب وصفة طبية لصرفها بموجب القانون.

**التصريح المسبق** يعني قرارًا تتخذه شركة التأمين الصحي بأن مزايا الرعاية الصحية ضرورية لك من الناحية الطبية. إذا كان الدواء الموصوف طبيًا خاضعًا لتصريح مسبق في هذا الكتيب، يجب على مقدم الرعاية الذي يصف الوصفات الطبية الخاص بك أن يطلب موافقة من شركة التأمين الصحي الخاصة بك لتغطية الدواء قبل أن تملأ الوصفة الطبية الخاصة بك. يجب أن تمنح شركة التأمين الصحي الخاصة بك طلب تصريح مسبق عندما يكون من الضروري طبيًا تناول الدواء.

**العلاج البديل** يعني تسلسلًا محددًا يجب فيه تجربة الأدوية الموصوفة لحالة طبية معينة. إذا كان الدواء خاضعًا للعلاج البديل في هذا الكتيب، فقد تضطر إلى تجربة دواء آخر أو أكثر قبل أن تغطي بوليصة التأمين الصحي هذا الدواء لحالتك الطبية. إذا قدم مقدم الرعاية الذي يصف الوصفات الطبية الخاص بك طلبًا للحصول على استثناء من متطلبات العلاج البديل، فيجب على شركة التأمين الصحي الخاصة بك الموافقة على الطلب عندما يكون من الضروري طبياً تناول الدواء.

**ما هو كتيب وصفات Aetna Better Health of California (قائمة الأدوية؟**
هذه قائمة الأدوية التي كتبتها Aetna Better Health of California تسمى كتيب وصفات الأدوية. ستغطي الخطة الأدوية في هذه القائمة. قد يكون لبعض الأدوية قواعد للتغطية. إذا تم استيفاء قواعد هذا الدواء، فستغطي الخطة الدواء.

هناك لجنة تسمى لجنة الصيدلة والعلاج، وتتألف من أطباء وصيادلة من Aetna Better Health of California والمجتمع الطبي. يجتمعون كل ثلاثة أشهر لمراجعة قائمة الأدوية هذه وأي أدوية جديدة ظهرت.

**هل يمكن تغيير قائمة الأدوية الخاصة بالخطة؟**
قد تضيف الخطة أو تحذف أدوية من القائمة. سيتم إخطار الأعضاء المنتفعين ومقدمي خدماتهم قبل 30 يومًا على الأقل من حذف الدواء من كتيب الوصفات. سيتم نشر جميع التغييرات التي تم إجراؤها على كتيب الوصفات على موقع الالكتروني الخاص بالخطة على:**www.aetnabetterhealth.com/california/members/pharmacy.**

يمكن أن يتغير كتيب الوصفات على مدار العام. تشمل بعض الأسباب التي تجعلهم قادرين على التغيير:

- تمت الموافقة على الأدوية الجديدة.
- تم إزالة الأدوية الموجودة من السوق.
- قد تصبح الأدوية الموصوفة متاحة بدون وصفة طبية. لا يتم تغطية الأدوية التي لا تستلزم وصفة طبية بشكل عام في كتيب الوصفات.
- تفقد الأدوية التي تحمل اسم العلامة التجارية حماية براءات الاختراع وتصبح الإصدارات من الأدوية الجنيسة متاحة. عندما يحدث هذا، ستتم تغطية الدواء الجنيس بدلاً من الدواء الذي يحمل اسم العلامة التجارية. من المحتمل أن يصبح الدواء الذي يحمل اسم العلامة التجارية غير مسجّل أو مغطى بتكلفة أعلى. اطلع على قسم "ما هي الأدوية الجنيسة؟" أعلاه لمزيد من المعلومات.

**كيف يمكنني استخدام كتيب الوصفات الخاص بالخطة؟**
يمكن تحديد موقع الأدوية الموصوفة طبيًا من خلال البحث عن الفئة العلاجية والفئة التي ينتمي إليها الدواء أو العلامة التجارية أو الاسم الجنيس للدواء في الفهرس الأبجدي. إذا كان الدواء الجنيس مكافئ للدواء الذي يحمل اسم العلامة التجارية غير متوفر في السوق أو لم يتم تغطيته، فلن يتم ادراج الدواء بشكل منفصل باسمه الجنيس.

- يتم ادراج الأدوية وفق الأحرف الأبجدية حسب اسم علامتها التجارية وأسماء الأدوية الجنيسة في فئة العلاج والصنف الذي تنتمي إليها.
- يتم تضمين الاسم الدواء الجنيس مع الدواء الذي يحمل اسم العلامة التجارية بعد اسم العلامة التجارية بين قوسين وجميع الأحرف مطبوعة بخط غامق وصغير مائل. (على سبيل المثال: COREG (*carvedilol)*).

- إذا كان الدواء الجنيس مكافئ للدواء الذي يحمل اسم العلامة التجارية متاحًا ومغطى على حد سواء، فسيتم إدراج الدواء الجنيس بشكل منفصل عن الدواء الذي يحمل اسم العلامة التجارية بالأحرف الغامقة والصغيرة المائلة؛ و (على سبيل المثال: ***carvedilol***).
- إذا تم تسويق الدواء الجنيس تحت اسم علامة تجارية مملوكة ومحمية بعلامة تجارية، فإن الدواء الذي يحمل اسم العلامة التجارية سيدرج بعد اسم الدواء الجنيس بين قوسين وبأحرف عادية مع كتابة الحرف الأول من كل كلمة بأحرف كبيرة. (على سبيل المثال: ***desogestrel-ethinyl estradiol*** (Azurette)).
- لا يضمن ادراج دواء موصوف طبيًا في كتيب الوصفات أن مقدم الرعاية الخاص بك سيصف الدواء لحالة طبية معينة.

- **العامود رقم 1: اسم الدواء الموصوف طبيًا:** يدرج الدواء المغطى. الأدوية التي تحمل العلامات التجارية مكتوبة بأحرف كبيرة (على سبيل المثال، DRUG). الأدوية الجنيسة مكتوبة بأحرف صغيرة (على سبيل المثال، drug). يتم تحديد أشكال الجرعات أو نقاط القوة المختلفة.

- **العامود رقم 2: مستويات الأدوية:** تشير إلى أن الدواء مغطى بدون تقاسم التكاليف، ما لم يتم اقتطاعه على النحو المنصوص عليه. في هذه الحالة، يعني فقط أن الصيدلية ستعالج الأمر بشكل مختلف عندما تقدم الوصفة الطبية الخاصة بك إليهم.

- **العامود رقم 3: متطلبات وحدود التغطية:** تخبرك ما إذا كان الدواء بحاجة إلى تصريح مسبق أو لديها قيود أخرى.

يتم أيضًا تصنيف الأدوية حسب فئة الأدوية. إذا كنت تعرف فئة الدواء الخاص بك، فالرجاء البحث عن اسم الفئة في جدول المحتويات. ثم ابحث تحت تلك الصفحة عن الدواء الخاص بك.

**ما هي الأدوية الجنيسة؟**
تغطي الخطة كلاً من الأدوية التي تحمل اسم العلامة التجارية والأدوية الجنيسة. الأدوية الجنيسة تكلفتها أقل وتمت الموافقة عليها من قبل إدارة الغذاء والدواء (FDA). ثبت أن الأدوية الجنيسة آمنة وفعالة مثل الأدوية التي تحمل أسماء العلامة التجارية. أنها تحتوي على نفس المكونات النشطة بنفس كميات الأدوية التي تحمل اسم العلامة التجارية وتعمل بنفس الطريقة. لذلك لديهم نفس المخاطر والفوائد مثل الأدوية التي تحمل أسماء العلامات التجارية. ومع ذلك، فهي عادة ما تكون أقل تكلفة.

**ماذا لو لم يكن دوائي مدرجًا في قائمة الأدوية؟**
في حالات معينة، يمكنك أنت أو واصف الوصفة الطبية طلب استثناء طبي من التصريح المسبق أو العلاج البديل أو متطلبات حدود الكمية أو لدواء لم يتم تغطيته في خطتك. سيتم اتخاذ قرارات التغطية في غضون 72 ساعة من تلقي الطلبات غير العاجلة. يمكنك طلب الإسراع في طلبك. يتم اتخاذ قرارات التغطية المُعجّلة في غضون 24 ساعة. ثم سنتصل بك وبطبيبك لإبلاغك بقرارنا. سيتم تغطية جميع الأدوية الضرورية طبيًا للمرضى الخارجيين.

ستغطي الاستثناءات الطبية التي تمت الموافقة عليها للطلبات غير العاجلة مدة الوصفة الطبية، بما في ذلك إعادة صرف الأدوية. ستوفر الاستثناءات الطبية المعتمدة لظروف طارئة تغطية طوال مدة الضرورة. إذا تم رفض طلبك، فيحق لك تقديم التماس باستخدام العملية الموضحة في خطاب الإخطار.

إذا لم يتم اتخاذ قرار للحصول على تصريح مسبق أو طلب استثناء للعلاج البديل في غضون 72 ساعة من تلقي طلب غير عاجل و 24 ساعة من تلقي طلب بناءً على ظروف طارئة، يُعتبر الطلب معتمدًا ولا يجوز لنا رفض الطلب بعد ذلك.

وفقًا لقانون الولاية، سيستمر الأعضاء الذين تلقوا موافقة منا مسبقًا لتغطية الأدوية لحالاتهم الطبية في الحصول على تغطية هذه الأدوية، طالما استمر مقدم الرعاية في وصفها، وطالما تم وصف الدواء بشكل مناسب ويعتبر آمن وفعّال في علاج الحالة الطبية للعضو.

**كيف أحصل على وصفة طبية عن طريق البريد؟**
إذا كنت تتناول الدواء لحالة صحية مستمرة، فيمكن إرساله لك بالبريد إلى منزلك. تعمل Aetna Better Health مع شركة اسمها CVS Caremark، يمكنها أن توفر لك هذه الخدمة التي يمكنك الحصول عليها مجاناً.

إذا اخترت الحصول على هذه الخدمة، فسيأتي دواءك إلى بابك مباشرة. ويمكنك تحديد إعادة صرف الأدوية الخاصة بك. يمكنك طرح أسئلة على الصيادلة. فيما يلي بعض الميزات الأخرى للتوصيل إلى المنزل:

- يقوم الصيادلة بفحص كل طلبية من للتأكد من سلامتها.
- يمكنك طلب إعادة صرف الأدوية بالبريد، الهاتف، أو عبر الإنترنت، أو يمكنك التسجيل للحصول على إعادة صرف تلقائية.
- يمكن التحدث إلى الصيادلة عبر الهاتف.

يمكنك بدء استخدام خدمة الطلب عبر البريد بسهولة.
اختر واحدة من الطرق الثلاث التالية لاستخدام خدمة الطلب عبر البريد لدواء تتناوله على أساس مستمر:

- اتصل بـ CVS على الرقم المجاني **1-855-271-6603 (الهاتف النصي: 711)**، (على مدار الساعة وطوال أيام الأسبوع). سيقومون بإعلامك بالأدوية التي يمكنك صرفها من خلال صيدلية خدمة البريد CVS. وبعد ذلك ستتصل CVS بطبيبك من أجل الوصفة وترسل الدواء لك بالبريد. عند الاتصال، تأكد من توفير:
  - بطاقة هوية عضو الخاصة بالخطة
  - الاسم الأول والأخير ورقم الهاتف الخاص بطبيبك
  - معلومات الدفع والعنوان البريدي
- انتقل إلى بوابة الأعضاء لدينا للتسجيل أو تسجيل الدخول. بمجرد دخولك إلى بوابة الأعضاء، انتقل إلى Tasks (المهام) ثم Pharmacy Services (خدمات الصيدلة). انقر فوق رابط CVS للانتقال إلى **Caremark.com**. انقر فوق ابدأ "خدمة البريد" لطباعة نموذج طلب البريد. يمكنك الاتصال بـ CVS على الرقم **1-855-271-6603**. تأكد من توفر بطاقة هوية العضو في متناولك عندما تسجّل للمرة الأولى.
- قم بتعبئة نموذج طلب خدمة البريد وأرسله. إذا كانت لديك وصفة طبية بالفعل، فيمكنك إرسالها إلى CVS Caremark مع نموذج طلب خدمة البريد مكتملاً. إذا لم يكن لديك نموذج طلب، فيمكنك تنزيله. يمكنك أيضًا طلب واحد من خلال الاتصال بخدمات الأعضاء على الرقم **1-855-772-9076 (الهاتف النصي: 711)**.

احرص على توفر المعلومات التالية معك عندما تكمل النموذج:
- بطاقة هوية عضو الخاصة بالخطة
- عنوانك البريدي بالكامل، بما في ذلك الرمز البريدي

- الاسم الأول والأخير ورقم الهاتف الخاص بطبيبك
- قائمة بالحساسية التي لديك والحالات الصحية الأخرى
- الوصفة الطبية الأصلية الخاصة بك من طبيبك

**أين يمكنني الحصول على دواء متخصص؟**
إن CVS Specialty Pharmacy هي الصيدلية المتخصصة المفضلة لأعضاء Aetna Better Health of California. صيدلية متخصصة تصرف الأدوية ولديها خدمات أخرى لمساعدتك. يقدم لك برنامج Specialty Drug Program خدمات خاصة:

- يمكنك التحدث مع الصيدلي على مدار الساعة وطوال أيام الأسبوع
- الاستشارة حول دوائك ومرضك
- تنسيق الرعاية معك ومع طبيبك
- توصيل الأدوية المتخصصة إلى منزلك أو عيادة طبيبك
- يمكنك ترك الوصفة الطبية الخاصة بك وأخذ الأدوية الخاصة بك من أي صيدلية CVS (بما في ذلك تلك الموجودة داخل متاجر Target)
- يمكنك الاتصال بـ CVS Specialty Pharmacy على الرقم **1-800-237-2767**؛ الهاتف النصي / جهاز المخصص لضعاف السمع والكلام: **1-800-863-5488**. سوف تساعدك CVS Specialty Pharmacy في صرف الدواء المتخصص الخاص بك.

عرض **قائمة الأدوية المتخصصة** المتاحة من خلال CVS Specialty Pharmacy.

**هل الأدوية المتاحة بدون وصفة طبية مغطاة؟**
ستغطي الخطة الأدوية المتاحة بدون وصفة طبية المدرجة في كتيب الوصفات. وقد يكون لبعض الأدوية المتاحة بدون وصفة طبية قواعد تغطية. في حالة تلبية القواعد الخاصة بهذا الدواء المتاح بدون وصفة طبية، ستغطي الخطة هذا الدواء. كما هو الحال مع الأدوية الأخرى، تحتاج الأدوية المتاحة بدون وصفة طبية إلى وصفة من طبيب إذا كانت خاضعة لتغطية الخطة.

**هل يتم تغطية بعض أدوية الحقن التي يقدمها طبيبي أو مقدم الرعاية في العيادة؟**
يتم تغطية هذه الأنواع من الأدوية تحت المزايا الطبية بدلاً من مزايا الصيدلية. يحتوي كتيب وصفات الأدوية هذا في الغالب على الأدوية التي تحصل عليها من صيدلية وتعطيها لنفسك. إذا احتاج مقدم الرعاية إلى تقديم الدواء في العيادة مثل الحقن، فلديه تعليمات حول كيفية تقديم فاتورة إلى
Aetna Better Health of California.

**كيف يمكنني العثور على صيدلية تابعة للشبكة؟**
يمكنك إيجاد صيدلية بطريقتين:

- **عبر الإنترنت** قم بتسجيل الدخول إلى موقعنا الإلكتروني **www.aetnabetterhealth.com/california/find-provider**.

- **عبر الهاتف:** اتصل بخدمات الأعضاء على الرقم **1-855-772-9076** (**الهاتف النصي: 711**). سيكونون سعداء لمساعدتك في العثور على صيدلية تابعة للشبكة قريبة منك.

تذكر دومًا صرف وصفتك الطبية من صيدلية تابعة للشبكة. لن تتم تغطية وصفاتك الطبية من أي صيدلية أخرى.

**هل هناك أدوية يتم فيها المشاركة في السداد؟**
الرجوع إلى دليل الأعضاء للحصول على معلومات المشاركة في السداد.

**ما هي بعض أنواع قواعد التغطية؟**

- **الموافقة المسبقة (PA)**: هذا يعني أن طبيبك سيحتاج إلى الحصول على موافقة من الخطة أولاً قبل أن يتم صرف الدواء في الصيدلية. إذا لم تتم الموافقة عليها، فلن تغطي الخطة الدواء.

- **حدود مستوى الكمية (QLL)**: هذا يعني أن هناك حدًا لكمية الدواء التي ستغطيها الخطة. على سبيل المثال، توفر الخطة 60 حبة في 30 يومًا لبعض الأدوية.

- **العلاج البديل (ST)**: هذا يعني أنك قد تحتاج إلى تجربة بعض الأدوية أولاً لعلاج حالتك. بعد تجربة الدواء الأول، ستغطي الخطة بعد ذلك العقار الآخر لنفس الحالة. على سبيل المثال، قد يعالج الدواءان أ و ب حالتك. قد لا تغطي الخطة الدواء ب إلا إذا جربت الدواء أ أولاً. في حال عدم ملائمة الدواء أ بالنسبة لك، سنقوم بتغطية الدواء ب.

- **محاليل وريدية بسيطة:** تُستخدم المحاليل الوريدية البسيطة عادةً في العلاج المائي. تشمل المحاليل المتاحة تجارياً (غير المركبة) مثل المحلول الملحي العادي وسكر العنب (حتى 10٪ في الماء) ومحلول Lactated Ringer؛ محاليل كلوريد البوتاسيوم المحضرة تجاريًا ومثل هذه المحاليل مدرجة أيضا في هذا التعريف. يجب إصدار فاتورة بالمحاليل الوريدية البسيطة باستخدام رقم رمز الدواء الوطني (NDC) الخاص بالمنتج.

- **المحاليل التغذية الوريدية (TPN أو فرط التغذية):** (محاليل التغذية الوريدية هي منتجات غذائية يتم إعطاؤها عن طريق الوريد أو داخل الشرايين والتي تكون عادةً معلقات أو محاليل للأحماض الأمينية أو البروتين أو الدكستروز أو الدهون أو الإلكتروليتات أو الفيتامينات و/أو المكملات المعدنية والعناصر النزرة.)
  - يقتصر على الاستغناء في غضون 10 أيام بعد خروج المرضى الداخليين من مستشفى الرعاية الحاذقة، عندما بدأ العلاج عن طريق الوريد بنفس الدواء قبل الخروج. يوجد حد أقصى للإمداد يبلغ 10 أيام لكل صرف خلال فترة 10 أيام.
  - إضافات التغذية الوريدية هي أدوية أخرى يتم مزجها جسديًا في محلول التغذية الوريدية في أي وقت قبل إعطاء التغذية عبر الوريد. فاتورة لهذه المنتجات هو جزء من فواتير التغذية الوريدية.

***ملاحظة:** يجب إصدار فواتير المنتجات غير المركبة باستخدام رقم رمز الدواء الوطني (NDC) الخاص بالمنتج. يجب إصدار فواتير المحاليل المركبة على أنها مطالبة مركبة.

- **إعطاء الدهون عبر الوريد بشكل منفصل:**
  - يقتصر على الاستغناء في غضون 10 أيام بعد خروج المرضى الداخليين من مستشفى الرعاية الحاذقة، عندما بدأ العلاج عن طريق الوريد بنفس المنتج قبل الخروج. يوجد حد أقصى للإمداد يبلغ 10 أيام لكل صرف خلال فترة العشرة أيام هذه.
  - يجب أن يتم إصدار فاتورة المحاليل الدهنية في الوريد أو المعلقات التي يتم إعطاؤها بشكل منفصل عن محاليل التغذية الوريدية (أي لا يتم خلطها فعليًا في كيس محلول التغذية بالحقن) باستخدام رقم رمز الدواء الوطني (NDC) الخاص بالمنتج.

- **المنتجات المعوية:**
  - تتم تغطية المنتجات الموجودة في قائمة Medi-Cal لمنتجات التغذية المعوية بناءً على تصريح طبي مسبق ومراجعة الضرورة الطبية. هذه المنتجات مدرجة هنا:

**http://files.medi-cal.ca.gov/pubsdoco/publications/masters-tp/part2/enteral_a04p00.doc**

- توفر Aetna Better Health أو ترتب المنتجات المعوية المغطاة الضرورية طبيًا، ولضمان تقديمها بمبلغ لا يقل عن ما يتم تقديمه للمستفيدين بموجب Medi-Cal Fee-For-Service، وفقًا لسياسة Medi-Cal المدرجة هنا:

**http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc**

**ماذا لو لم يكن دوائي موجودًا في كتيب وصفات الخطة؟**

إذا لم يكن دواؤك ضمن قائمة الأدوية المفضلة، فستجد ما يُمكنك القيام به.

- اطلب من مزودك دواء مشابهًا مدرجًا في القائمة.
- اطلب من مقدم الرعاية الخاص بك الحصول على "تصريح مسبق" (موافقة مسبقة) من Aetna Better Health of California لتغطية هذا الدواء.

**كيف يمكن لطبيبي أو مقدم الرعاية طلب تصريح مسبق أو استثناء إذا كانت الخطة لا تغطي دوائي؟**

يمكنهم القيام بذلك بثلاث طرق:

1. قد يقوم مقدم الرعاية الخاص بك بإرسال تصريح مسبق كامل من الصيدلية بالفاكس أو نموذج استثناء للعلاج البديل من رقم **1-844-823-5478** ويتضمن جميع المعلومات الضرورية.
2. يمكنهم أيضًا إرسال الطلب عبر الهاتف عن طريق الاتصال بالرقم **1-855-772-9076**.
3. يمكنهم تقديم تصريح إلكتروني مسبق (ePA).

**ماذا لو كانت لدي أسئلة حول كيفية تغطية Aetna Better Health of California للأدوية؟**

تعرف على مزايا الصيدلية الخاصة بك:

سواء كان الأمر يتعلق بمسكن للألم بعد الإصابة أو دواء لإدارة حالة صحية، فإن الحصول على الأدوية الموصوفة التي تحتاجها هو جزء مهم من رعايتك الصحية. نريد أن نجعل الأمر سهلاً عليك قدر الإمكان. إذا كانت لديك أية أسئلة، فيُرجى الاتصال بخدمات الأعضاء على الرقم **1-855-772-9076 (الهاتف النصي: 711)**. ينبغي أن تكون الوصفات الطبية في متناول يديك عندما تتصل. اطلب منا البحث عن الأدوية الخاصة بك لمعرفة ما إذا كانت مدرجة في القائمة.

**المفاتيح**

خط *مائل صغير* - أدوية جنيسة **الأحرف الكبيرة الغامقة** - أدوية التي تحمل اسم العلامة التجارية

**متطلبات وحدود التغطية**

AL - قيود المطبقة على العمر OTC - الأدوية المتاحة بدون وصفة طبية PA - قد يتم تطبيق الإذن المسبق

QL - حدود الكمية ST - قد يتم تطبيق العلاج البديل

**مستويات الأدوية**

غطاة - أدوية مغطاة غير مغطاة - أدوية غير مغطاة

Nondiscrimination Notice

Discrimination is against the law. Aetna Better Health of California follows Federal civil rights laws. Aetna Better Health of California does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.
Aetna Better Health of California provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
- Information written in other languages

If you need these services, contact Aetna Better Health of California 24 hours a day, 7 days a week by calling **1-855-772-9076**. Or, if you cannot hear or speak well, please call **TTY 711**.

**How to file a grievance**
If you believe that Aetna Better Health of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Aetna Better Health of California. You can file a grievance by phone, in writing, in person, or electronically:
**By phone**: Contact Aetna Better Health of California 24 hours a day, 7 days a week by calling **1-855-772-9076**. Or, if you cannot hear or speak well, please call **TTY 711**.

**In writing**: Fill out a complaint form or write a letter and send it to:
Aetna Better Health of California
10260 Meanley Drive
San Diego, CA 92131

**In person:** Visit your doctor's office or Aetna Better Health of California and say you want to file a grievance.

**Electronically:** Visit Aetna Better Health of California website at
**AetnaBetterHealth.com/California**

**Office of Civil Rights**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

**By phone:** Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

**In writing:** Fill out a complaint form or send a letter to:
**U.S. Department of Health and Human Services**
**200 Independence Avenue, SW**
**Room 509F, HHH Building**
**Washington, D.C. 20201**

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

**Electronically:** Visit the Office for Civil Rights Complaint Portal at
**https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**

## TAGLINES

**English Tagline**

ATTENTION: If you need help in your language call 1-800-385-4101 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-385-4101 (TTY: 711). These services are free of charge.

**الشعار بالعربية (Arabic)**

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-385-4101 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-385-4101 (TTY: 711). هذه الخدمات مجانية.

**Հայերեն պիտակ (Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-385-4101 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-385-4101 (TTY: 711): Այդ ծառայություններն անվճար են:

**ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)**

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-385-4101 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-385-4101 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

**简体中文标语 (Chinese)**

请注意：如果您需要以您的母语提供帮助，请致电 1-800-385-4101 (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如文盲和需要较大字体阅读，也是方便取用的。请致电 1-800-385-4101 (TTY: 711)。这些服务都是免费的。

**مطلب به زبان فارسی (Farsi)**

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-385-4101 (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-385-4101 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

**हिंदी टैगलाइन (Hindi)**
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-385-4101 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-385-4101 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

**Nqe Lus Hmoob Cob (Hmong)**
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-385-4101 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-385-4101 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

**日本語表記 (Japanese)**
注意日本語での対応が必要な場合は 1-800-385-4101 (TTY: 711) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-385-4101 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

**한국어 태그라인 (Korean)**
유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-385-4101 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-385-4101 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

**ແທກໄລພາສາລາວ (Laotian)**
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-385-4101 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-800-385-4101 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

**Mien Tagline (Mien)**
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-385-4101 (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-385-4101 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

**ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)**
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-385-4101 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-800-385-4101 (TTY: 711).
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

**Русский слоган (Russian)**
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-385-4101 (TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-385-4101 (TTY: 711). Такие услуги предоставляются бесплатно.

**Mensaje en español (Spanish)**
ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-385-4101 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-385-4101 (TTY: 711). Estos servicios son gratuitos.

**Tagalog Tagline (Tagalog)**
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-385-4101 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-385-4101 (TTY: 711). Libre ang mga serbisyong ito.

**แท็กไลน์ภาษาไทย (Thai)**
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-385-4101 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่1-800-385-4101 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

**Примітка українською (Ukrainian)**
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-385-4101 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-385-4101 (TTY: 711). Ці послуги безкоштовні.

**Khẩu hiệu tiếng Việt (Vietnamese)**
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-385-4101 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-385-4101 (TTY: 711). Các dịch vụ này đều miễn phí.

**Aetna Better Health of California Formulary Guide**

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**lowercase bold italics** = Generic drugs
**UPPERCASE BOLD** = Brand name drugs

**Drug Tier**
**Covered** = Covered Medications
**Not Covered** = Not Covered Medications

**Coverage Requirements and Limits**
**AL** = Age Restrictions
**OTC** = OTC Medications
**PA** = Prior Authorization May Apply
**QL** = Quantity Limits
**ST** = Step Therapy May Apply

| 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*** | | |
| ***guanfacine hcl er*** | Covered | QL (1 EA per 1 day); AL (Min 6 Years) |
| ****Amphetamine Mixtures*** - Drugs For Attention Deficit Disorder*** | | |
| ***amphetamine-dextroamphet er*** | Covered | PA; QL (1 EA per 1 day) |
| ***amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg*** | Covered | PA; QL (90 EA per 30 days) |
| ***amphetamine-dextroamphetamine oral tablet 30 mg*** | Covered | PA; QL (60 EA per 30 days) |
| ****Amphetamines*** - Drugs For Attention Deficit Disorder*** | | |
| ***dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg*** | Covered | PA; QL (4 EA per 1 day) |
| ***dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg*** | Covered | PA; QL (3 EA per 1 day) |
| ***dextroamphetamine sulfate oral solution*** | Covered | PA; QL (60 ML per 1 day) |
| ***dextroamphetamine sulfate oral tablet*** | Covered | PA; QL (180 EA per 30 days) |
| ****Analeptics*** - Drugs For The Nervous System*** | | |
| ***caffeine anhydrous*** | Covered | |
| ***caffeine citrate*** | Covered | |
| ****Anorexiant Combinations*** - Drugs For The Nervous System*** | | |
| **QSYMIA** (***phentermine-topiramate***) | Covered | PA; QL (1 EA per 1 day); AL (Min 18 Years) |
| ****Anorexiants Non-Amphetamine*** - Drugs For The Nervous System*** | | |
| ***benzphetamine hcl*** | Covered | PA; QL (90 EA per 30 days); AL (Min 12 Years) |
| ***diethylpropion hcl*** | Covered | PA; QL (90 EA per 30 days); AL (Min 17 Years) |
| ***diethylpropion hcl er*** | Covered | PA; QL (1 EA per 1 day); AL (Min 17 Years) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***phendimetrazine tartrate*** | Covered | PA; QL (90 EA per 30 days); AL (Min 17 Years) |
| ***phendimetrazine tartrate er*** | Covered | PA; QL (30 EA per 30 days); AL (Min 17 Years) |
| ***phentermine hcl oral capsule 15 mg*** | Covered | PA; QL (60 EA per 30 days); AL (Min 16 Years) |
| ***phentermine hcl oral capsule 30 mg, 37.5 mg*** | Covered | PA; QL (30 EA per 30 days); AL (Min 16 Years) |
| ***phentermine hcl oral tablet*** | Covered | PA; QL (30 EA per 30 days); AL (Min 16 Years) |
| ****Anti-Obesity Agent Combinations** - Drugs For The Nervous System*** | | |
| **CONTRAVE** (***naltrexone-bupropion hcl***) | Covered | PA; QL (4 EA per 1 day); AL (Min 18 Years) |
| ****Serotonin 2C Receptor Agonists*** - Drugs For The Nervous System*** | | |
| **BELVIQ** (***lorcaserin hcl***) | Covered | PA; QL (2 EA per 1 day); AL (Min 18 Years) |
| **BELVIQ XR** (***lorcaserin hcl***) | Covered | PA; QL (1 EA per 1 day) |
| ****Stimulants - Misc.*** - Drugs For Attention Deficit Disorder*** | | |
| ***armodafinil oral tablet 150 mg, 200 mg, 250 mg*** | Covered | PA; QL (1 EA per 1 day) |
| ***armodafinil oral tablet 50 mg*** | Covered | PA; QL (2 EA per 1 day) |
| ***dexmethylphenidate hcl*** | Covered | PA; QL (2 EA per 1 day) |
| ***dexmethylphenidate hcl er*** | Covered | PA; QL (1 EA per 1 day) |
| ***methylphenidate hcl er (cd)*** | Covered | PA; QL (1 EA per 1 day) |
| ***methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 40 mg, 60 mg*** | Covered | PA; QL (30 EA per 30 days) |
| ***methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg*** | Covered | PA; QL (60 EA per 30 days) |
| ***methylphenidate hcl er oral tablet extended release 10 mg, 20 mg*** | Covered | PA; QL (90 EA per 30 days) |
| ***methylphenidate hcl er oral tablet extended release 18 mg, 27 mg, 54 mg*** | Covered | PA; QL (30 EA per 30 days) |
| ***methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg*** | Covered | PA; QL (1 EA per 1 day) |
| ***methylphenidate hcl er oral tablet extended release 24 hour 36 mg*** | Covered | PA; QL (2 EA per 1 day) |
| ***methylphenidate hcl er oral tablet extended release 36 mg*** | Covered | PA; QL (60 EA per 30 days) |
| ***methylphenidate hcl oral solution 10 mg/5ml*** | Covered | PA; QL (900 mL per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***methylphenidate hcl oral solution 5 mg/5ml*** | Covered | PA; QL (900 ML per 30 days) |
| ***methylphenidate hcl oral tablet*** | Covered | PA; QL (90 EA per 30 days) |
| ***methylphenidate hcl oral tablet chewable 10 mg*** | Covered | PA; QL (6 EA per 1 day) |
| ***methylphenidate hcl oral tablet chewable 2.5 mg, 5 mg*** | Covered | PA; QL (5 EA per 1 day) |
| ***Alternative Medicines* - Vitamins And Minerals** | | |
| ****Alternative Medicine - St's*** - Vitamins And Minerals*** | | |
| ***stevia*** | Covered | OTC |
| ***Aminoglycosides* - Drugs For Infections** | | |
| ****Aminoglycosides*** - Antibiotics*** | | |
| ***gentamicin in saline*** | Covered | PA |
| ***neomycin sulfate*** | Covered | |
| ***paromomycin sulfate*** | Covered | |
| ***tobramycin*** | Covered | PA; QL (280 mL Max Qty Per Fill Retail) |
| **ZEMDRI** (***plazomicin sulfate***) | Covered | PA |
| ***Analgesics - Anti-Inflammatory* - Drugs For Pain And Fever** | | |
| ****Anti-Tnf-Alpha - Monoclonal Antibodies*** - Arthritis And Pain Drugs*** | | |
| **HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS** (***adalimumab***) | Covered | PA; QL (3 EA per 28 days) |
| **HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS** (***adalimumab***) | Covered | PA; QL (6 EA per 28 days) |
| **HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML** (***adalimumab***) | Covered | PA; QL (3 SYRINGES per 180 days) |
| **HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML** (***adalimumab***) | Covered | PA; QL (2 SYRINGES per 180 days) |
| **HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS** (***adalimumab***) | Covered | PA; QL (2 EA per 28 days) |
| **HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML** (***adalimumab***) | Covered | PA; QL (2 SYRINGES per 28 days) |
| **HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS** (***adalimumab***) | Covered | PA; QL (6 EA per 28 days) |
| **HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML** (***adalimumab***) | Covered | PA; QL (3 EA per 180 days) |
| **HUMIRA PEN-PS/UV/ADOL HS START PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS** (***adalimumab***) | Covered | PA; QL (4 EA per 28 days) |

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**Drug Tier**

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**Not Covered** = Not Covered Medications

**Coverage Requirements and Limits**

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML** (***adalimumab***) | Covered | PA; QL (3 EA per 180 days) |
| **HUMIRA PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS** (***adalimumab***) | Covered | PA; QL (2 EA per 28 days) |
| **HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML** (***adalimumab***) | Covered | PA; QL (2 SYRINCES per 28 days) |
| **HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML** (***adalimumab***) | Covered | PA; QL (2 SYRINGES per 28 days) |
| **HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML** (***adalimumab***) | Covered | PA; QL (2 Syringes per 28 days) |
| ****Cyclooxygenase 2 (Cox-2) Inhibitors*** - Arthritis And Pain Drugs*** | | |
| ***celecoxib*** | Covered | ST; QL (30 EA per 30 days) |
| ****Gold Compounds*** - Arthritis And Pain Drugs*** | | |
| **RIDAURA** (***auranofin***) | Covered | |
| ****Nonsteroidal Anti-Inflammatory Agents (Nsaids)*** - Arthritis And Pain Drugs*** | | |
| ***all day pain relief*** | Covered | OTC; QL (60 EA per 30 days) |
| ***all day relief*** | Covered | OTC; QL (60 EA per 30 days) |
| ***childrens ibuprofen*** | Covered | OTC |
| ***childrens ibuprofen 100*** | Covered | OTC |
| ***cvs all day pain relief*** | Covered | OTC; QL (60 EA per 30 days) |
| ***cvs childrens ibuprofen*** | Covered | OTC |
| ***cvs ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***cvs ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***cvs naproxen sodium oral capsule*** | Covered | OTC |
| ***cvs naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |
| ***diclofenac potassium*** | Covered | |
| ***diclofenac sodium*** | Covered | |
| ***diclofenac sodium er*** | Covered | |
| ***dyspel*** | Covered | OTC; QL (120 EA per 30 days) |
| ***eq ibuprofen childrens*** | Covered | OTC |
| ***eq ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***eq ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***eq naproxen sodium oral capsule*** | Covered | OTC |
| ***eq naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***eql childrens ibuprofen*** | Covered | OTC |
| ***eql ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***eql ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***eql naproxen sodium*** | Covered | OTC; QL (60 EA per 30 days) |
| ***etodolac*** | Covered | |
| ***flurbiprofen*** | Covered | |
| ***genpril*** | Covered | OTC; QL (120 EA per 30 days) |
| ***gnp all day pain relief*** | Covered | OTC; QL (60 EA per 30 days) |
| ***gnp childrens ibuprofen*** | Covered | OTC |
| ***gnp ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***gnp ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***gnp naproxen sodium oral capsule*** | Covered | OTC |
| ***gnp naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |
| ***goodsense ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***goodsense ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***goodsense naproxen sodium*** | Covered | OTC; QL (60 EA per 30 days) |
| ***hm ibuprofen childrens*** | Covered | OTC |
| ***hm ibuprofen ib*** | Covered | OTC; QL (120 EA per 30 days) |
| ***hm ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***hm ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***hm naproxen sodium oral capsule*** | Covered | OTC |
| ***hm naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |
| ***hy-vee all day relief*** | Covered | OTC; QL (60 EA per 30 days) |
| ***ibu-200*** | Covered | OTC; QL (120 EA per 30 days) |
| ***ibuprofen childrens*** | Covered | OTC |
| ***ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***ibuprofen oral suspension*** | Covered | |
| ***ibuprofen oral tablet 200 mg*** | Covered | OTC; QL (120 EA per 30 days) |
| ***ibuprofen oral tablet 400 mg, 600 mg, 800 mg*** | Covered | |
| ***indomethacin*** | Covered | |
| ***indomethacin er*** | Covered | |
| ***ketorolac tromethamine*** | Covered | QL (20 Tablets per 30 days); AL (Min 16 Years) |
| ***kls ibuprofen*** | Covered | OTC; QL (120 EA per 30 days) |

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|---|---|---|
| ***kls naproxen sodium*** | Covered | OTC; QL (60 EA per 30 days) |
| ***ks ibuprofen*** | Covered | OTC; QL (180 EA per 30 days) |
| ***meijer ibuprofen*** | Covered | OTC; QL (120 EA per 30 days) |
| ***meloxicam*** | Covered | QL (30 EA per 30 days) |
| ***nabumetone*** | Covered | QL (120 EA per 30 days) |
| ***naproxen dr*** | Covered | |
| ***naproxen oral suspension*** | Covered | ST |
| ***naproxen oral tablet*** | Covered | |
| ***naproxen sodium oral capsule*** | Covered | OTC |
| ***naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |
| ***piroxicam*** | Covered | |
| ***px all day relief*** | Covered | OTC; QL (60 EA per 30 days) |
| ***px childrens profen ib*** | Covered | OTC |
| ***px ibuprofen*** | Covered | OTC; QL (120 EA per 30 days) |
| ***qc childrens ibuprofen*** | Covered | OTC |
| ***qc ibuprofen*** | Covered | OTC; QL (120 EA per 30 days) |
| ***qc ibuprofen ib*** | Covered | OTC; QL (120 EA per 30 days) |
| ***qc naproxen sodium*** | Covered | OTC; QL (60 EA per 30 days) |
| ***ra ibuprofen childrens*** | Covered | OTC |
| ***ra ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***ra ibuprofen oral suspension*** | Covered | OTC |
| ***ra ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***ra naproxen sodium oral capsule*** | Covered | OTC |
| ***ra naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |
| ***sb ibuprofen*** | Covered | OTC; QL (120 EA per 30 days) |
| ***sb naproxen sodium*** | Covered | OTC; QL (60 EA per 30 days) |
| ***sm childrens ibuprofen*** | Covered | OTC |
| ***sm ibuprofen ib*** | Covered | OTC; QL (120 EA per 30 days) |
| ***sm ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***sm ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***sm naproxen sodium oral capsule*** | Covered | OTC |
| ***sm naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |
| ***sulindac*** | Covered | |
| ***tgt childrens ibuprofen*** | Covered | OTC |

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|---|---|---|
| ***tgt ibuprofen childrens*** | Covered | OTC |
| ***tgt ibuprofen oral capsule*** | Covered | OTC; QL (180 EA per 30 days) |
| ***tgt ibuprofen oral tablet*** | Covered | OTC; QL (120 EA per 30 days) |
| ***tgt naproxen sodium oral capsule*** | Covered | OTC |
| ***tgt naproxen sodium oral tablet*** | Covered | OTC; QL (60 EA per 30 days) |
| **ADDAPRIN** (***ibuprofen***) | Covered | OTC; QL (120 EA per 30 days) |
| **ADVIL JUNIOR STRENGTH** (***ibuprofen***) | Covered | OTC |
| ****Pyrimidine Synthesis Inhibitors*** - Arthritis And Pain Drugs*** | | |
| ***leflunomide*** | Covered | QL (30 EA per 30 days) |
| ****Soluble Tumor Necrosis Factor Receptor Agents*** - Arthritis And Pain Drugs*** | | |
| **ENBREL MINI** (***etanercept***) | Covered | PA |
| **ENBREL SUBCUTANEOUS SOLUTION** (***etanercept***) | Covered | PA; QL (3.92 ML per 28 days) |
| **ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML** (***etanercept***) | Covered | PA; QL (2.04 ML per 28 days) |
| **ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML** (***etanercept***) | Covered | PA; QL (4 ML per 28 days) |
| **ENBREL SURECLICK** (***etanercept***) | Covered | PA; QL (4 ML per 28 days) |
| ***Analgesics - Nonnarcotic* - Drugs For Pain And Fever** | | |
| ****Analgesics Other*** - Arthritis And Pain Drugs*** | | |
| ***8 hour pain reliever*** | Covered | OTC; QL (6 EA per 1 day) |
| ***acetaminophen er*** | Covered | OTC; QL (6 EA per 1 day) |
| ***acetaminophen extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***acetaminophen oral liquid*** | Covered | OTC; QL (240 mL per 30 days) |
| ***acetaminophen oral solution*** | Covered | OTC |
| ***acetaminophen oral tablet 325 mg*** | Covered | OTC; QL (300 EA per 30 days) |
| ***acetaminophen oral tablet 500 mg*** | Covered | OTC; QL (240 EA per 30 days) |
| ***acetaminophen oral tablet chewable*** | Covered | OTC |
| ***acetaminophen rectal*** | Covered | OTC |
| ***aminofen*** | Covered | OTC; QL (240 EA per 30 days) |
| ***apra*** | Covered | OTC; QL (240 mL per 30 days) |
| ***arthritis pain relief*** | Covered | OTC; QL (6 EA per 1 day) |
| ***childrens acetaminophen*** | Covered | OTC |
| ***childrens aspirin free*** | Covered | OTC; QL (240 mL per 30 days) |
| ***childrens non-aspirin*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***childrens pain reliever*** | Covered | OTC |
| ***childrens silapap*** | Covered | OTC; QL (240 mL per 30 days) |
| ***childrens tactinal*** | Covered | OTC |
| ***cvs childs non-aspirin*** | Covered | OTC |
| ***cvs fever reducing childrens*** | Covered | OTC |
| ***cvs non-aspirin childrens*** | Covered | OTC |
| ***cvs non-aspirin extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***cvs pain relief extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***ed-apap*** | Covered | OTC; QL (240 mL per 30 days) |
| ***eq acetaminophen*** | Covered | OTC; QL (240 EA per 30 days) |
| ***eq acetaminophen childrens*** | Covered | OTC |
| ***eq childrens pain reliever*** | Covered | OTC |
| ***eq pain reliever*** | Covered | OTC; QL (240 EA per 30 days) |
| ***eq pain reliever junior*** | Covered | OTC |
| ***eql acetaminophen ex st*** | Covered | OTC; QL (240 EA per 30 days) |
| ***fever reducer childrens*** | Covered | OTC |
| ***gnp childrens easy-melts*** | Covered | OTC |
| ***gnp pain relief extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***goodsense pain relief extra st*** | Covered | OTC; QL (240 EA per 30 days) |
| ***hm pain relief extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***kls acetaminophen ex st*** | Covered | OTC; QL (240 EA per 30 days) |
| ***kls rapid release pain*** | Covered | OTC; QL (240 EA per 30 days) |
| ***liquid pain relief*** | Covered | OTC; QL (240 mL per 30 days) |
| ***mapap oral capsule*** | Covered | OTC |
| ***mapap oral liquid*** | Covered | OTC; QL (240 mL per 30 days) |
| ***mapap oral tablet*** | Covered | OTC; QL (240 EA per 30 days) |
| ***mapap oral tablet chewable*** | Covered | OTC |
| ***meijer aspirin free*** | Covered | OTC; QL (240 EA per 30 days) |
| ***meijer jr st aspirin free*** | Covered | OTC |
| ***non-aspirin extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***non-aspirin jr strength*** | Covered | OTC |
| ***nortemp infants*** | Covered | OTC |
| ***pain & fever childrens*** | Covered | OTC |
| ***pain & fever extra strength*** | Covered | OTC; QL (240 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***pain relief extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***pain reliever*** | Covered | OTC; QL (240 EA per 30 days) |
| ***pain reliever extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***pain reliever/fever reducer*** | Covered | OTC |
| ***px pain relief extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***qc non-aspirin extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***qc pain relief extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***ra acetaminophen ex st*** | Covered | OTC; QL (240 EA per 30 days) |
| ***ra acetaminophen rapid melts*** | Covered | OTC |
| ***sb childrens non-aspirin*** | Covered | OTC |
| ***sb non-aspirin*** | Covered | OTC |
| ***sb non-aspirin extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***sb pain reliever ex st*** | Covered | OTC; QL (240 EA per 30 days) |
| ***sm pain relief extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***sm pain reliever*** | Covered | OTC |
| ***sm pain reliever ex st oral capsule*** | Covered | OTC |
| ***sm pain reliever ex st oral tablet*** | Covered | OTC; QL (240 EA per 30 days) |
| ***tactinal extra strength*** | Covered | OTC; QL (240 EA per 30 days) |
| ***tgt acetaminophen ex st*** | Covered | OTC; QL (240 EA per 30 days) |
| **ACEPHEN** (***acetaminophen***) | Covered | OTC |
| **CHILDRENS MEDI-TABS** (***acetaminophen***) | Covered | OTC |
| **CHLORASEPTIC SORE THROAT** (***acetaminophen***) | Covered | OTC; QL (240 mL per 30 days) |
| **FEVERALL ADULTS** (***acetaminophen***) | Covered | OTC |
| **FEVERALL CHILDRENS** (***acetaminophen***) | Covered | OTC |
| **FEVERALL JUNIOR STRENGTH** (***acetaminophen***) | Covered | OTC |
| **LITTLE REMEDIES FOR FEVER** (***acetaminophen***) | Covered | OTC; QL (240 mL per 30 days) |
| **MAPAP ACETAMINOPHEN EXTRA STR** (***acetaminophen***) | Covered | OTC; QL (240 mL per 30 days) |
| **MAPAP CHILDRENS** (***acetaminophen***) | Covered | OTC |
| **MEDI-TABS CHILDRENS** (***acetaminophen***) | Covered | OTC; QL (240 mL per 30 days) |
| **MEDI-TABS JUNIOR STRENGTH** (***acetaminophen***) | Covered | OTC |
| **TRIAMINIC FEVER REDUCER** (***acetaminophen***) | Covered | OTC; QL (240 mL per 30 days) |
| ****Analgesics-Sedatives*** - Arthritis And Pain Drugs*** | | |
| ***butalbital-acetaminophen*** | Covered | QL (180 EA per 30 days) |
| ***butalbital-apap-caffeine*** | Covered | QL (2 EA per 1 day) |

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|---|---|---|
| ***butalbital-aspirin-caffeine*** | Covered | QL (2 EA per 1 day) |
| ****Salicylate Combinations*** - Arthritis And Pain Drugs*** | | |
| ***choline-mag trisalicylate*** | Covered | |
| ****Salicylates*** - Arthritis And Pain Drugs*** | | |
| ***aspirin*** | Covered | OTC |
| ***aspirin 81*** | Covered | OTC |
| ***aspirin adult low dose*** | Covered | OTC |
| ***aspirin adult low strength*** | Covered | OTC |
| ***aspirin childrens*** | Covered | OTC |
| ***aspirin ec*** | Covered | OTC |
| ***aspirin ec low dose*** | Covered | OTC |
| ***aspirin ec low strength*** | Covered | OTC |
| ***aspirin low dose oral tablet chewable*** | Covered | OTC |
| ***aspirin low dose oral tablet delayed release*** | Covered | |
| ***aspirin low strength*** | Covered | OTC |
| ***aspirtab maximum strength*** | Covered | OTC |
| ***childrens aspirin*** | Covered | OTC |
| ***childrens aspirin low strength*** | Covered | OTC |
| ***cvs aspirin*** | Covered | OTC |
| ***cvs aspirin adult low dose*** | Covered | OTC |
| ***cvs aspirin adult low strength*** | Covered | OTC |
| ***cvs aspirin ec*** | Covered | OTC |
| ***cvs aspirin low dose*** | Covered | OTC |
| ***diflunisal*** | Covered | |
| ***ec-81 aspirin*** | Covered | OTC |
| ***eq adult aspirin low strength*** | Covered | OTC |
| ***eq aspirin*** | Covered | OTC |
| ***eq aspirin adult low dose*** | Covered | OTC |
| ***eq aspirin low dose*** | Covered | OTC |
| ***eq childrens aspirin*** | Covered | OTC |
| ***eql aspirin low dose*** | Covered | OTC |
| ***gnp adult aspirin low strength*** | Covered | OTC |
| ***gnp aspirin*** | Covered | OTC |
| ***gnp aspirin low dose*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***goodsense aspirin low dose*** | Covered | OTC |
| ***hm aspirin*** | Covered | OTC |
| ***hm aspirin ec low dose*** | Covered | OTC |
| ***kls aspirin low dose*** | Covered | OTC |
| ***kp aspirin*** | Covered | OTC |
| ***mm aspirin*** | Covered | OTC |
| ***px aspirin*** | Covered | OTC |
| ***px enteric aspirin*** | Covered | OTC |
| ***qc aspirin*** | Covered | OTC |
| ***qc aspirin low dose*** | Covered | OTC |
| ***qc childrens aspirin*** | Covered | OTC |
| ***ra aspirin*** | Covered | OTC |
| ***ra aspirin adult low dose*** | Covered | OTC |
| ***ra aspirin adult low strength*** | Covered | OTC |
| ***ra aspirin childrens*** | Covered | OTC |
| ***ra aspirin ec*** | Covered | OTC |
| ***ra aspirin ec adult low st*** | Covered | OTC |
| ***ra childrens aspirin*** | Covered | OTC |
| ***salsalate*** | Covered | |
| ***sb aspirin*** | Covered | OTC |
| ***sb childrens aspirin*** | Covered | OTC |
| ***sb low dose asa ec*** | Covered | OTC |
| ***sm aspirin*** | Covered | OTC |
| ***sm aspirin adult low strength*** | Covered | OTC |
| ***sm aspirin ec low strength*** | Covered | OTC |
| ***sm childrens aspirin*** | Covered | OTC |
| ***tgt aspirin*** | Covered | OTC |
| ***tgt aspirin low dose*** | Covered | OTC |
| ***tgt childrens aspirin*** | Covered | OTC |
| **ASPIR-LOW** (***aspirin***) | Covered | OTC |
| **BAYER ADVANCED ASPIRIN EX ST** (***aspirin***) | Covered | OTC |
| **BAYER ADVANCED ASPIRIN REG ST** (***aspirin***) | Covered | OTC |
| **BAYER ASPIRIN** (***aspirin***) | Covered | OTC |
| **BAYER ASPIRIN EC LOW DOSE** (***aspirin***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **BAYER ASPIRIN EXTRA STRENGTH** (***aspirin***) | Covered | OTC |
| **BAYER LOW DOSE** (***aspirin***) | Covered | OTC |
| **ECOTRIN LOW STRENGTH** (***aspirin***) | Covered | OTC |
| **MINIPRIN LOW DOSE** (***aspirin***) | Covered | OTC |
| **NORWICH ASPIRIN** (***aspirin***) | Covered | OTC |
| **ST JOSEPH ASPIRIN** (***aspirin***) | Covered | OTC |
| ***Analgesics - Opioid* - Drugs For Pain And Fever** | | |
| ****Codeine Combinations*** - Arthritis And Pain Drugs*** | | |
| ***acetaminophen-codeine #2*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ***acetaminophen-codeine #3*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ***acetaminophen-codeine #4*** | Covered | AL (Min 18 Years) |
| ***acetaminophen-codeine oral solution*** | Covered | QL (2700 ML per 30 days); AL (Min 18 Years) |
| ***acetaminophen-codeine oral tablet*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ***butalbital-apap-caff-cod*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ***butalbital-asa-caff-codeine*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ***butalbital-asa-caff-codeine*** (Ascomp-Codeine) | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ****Hydrocodone Combinations*** - Arthritis And Pain Drugs*** | | |
| ***hydrocodone-acetaminophen oral solution*** | Covered | QL (60 ML per 1 day); AL (Min 18 Years) |
| ***hydrocodone-acetaminophen oral tablet*** | Covered | QL (120 EA per 30 days); AL (Min 18 Years) |
| ***hydrocodone-ibuprofen*** | Covered | QL (120 EA per 30 days); AL (Min 18 Years) |
| **NORCO** (***hydrocodone-acetaminophen***) | Covered | QL (120 EA per 30 days); AL (Min 18 Years) |
| ****Opioid Agonists*** - Arthritis And Pain Drugs*** | | |
| ***codeine sulfate*** | Covered | QL (120 EA per 30 days); AL (Min 18 Years) |
| ***fentanyl*** | Covered | PA; QL (10 EA per 30 days) |
| ***fentanyl citrate*** | Covered | PA; QL (120 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***hydromorphone hcl oral tablet 2 mg, 4 mg*** | Covered | QL (120 EA per 30 days) |
| ***hydromorphone hcl oral tablet 8 mg*** | Covered | QL (2 EA per 1 day) |
| ***hydromorphone hcl rectal*** | Covered | QL (120 EA per 30 days) |
| ***methadone hcl oral concentrate*** | Covered | PA; QL (2 EA per 1 day) |
| ***methadone hcl oral solution 10 mg/5ml*** | Covered | PA; QL (11 ML per 1 day) |
| ***methadone hcl oral solution 5 mg/5ml*** | Covered | PA; QL (22 ML per 1 day) |
| ***methadone hcl oral tablet 10 mg*** | Covered | PA; QL (2 EA per 1 day) |
| ***methadone hcl oral tablet 5 mg*** | Covered | PA; QL (4 EA per 1 day) |
| ***methadone hcl oral tablet soluble*** | Covered | PA; QL (22 EA per 30 days) |
| ***morphine sulfate (concentrate)*** | Covered | QL (4 ML per 1 day) |
| ***morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg*** | Covered | PA; QL (1 EA per 1 day) |
| ***morphine sulfate er oral tablet extended release 15 mg*** | Covered | PA; QL (6 EA per 1 day) |
| ***morphine sulfate er oral tablet extended release 30 mg*** | Covered | PA; QL (3 EA per 1 day) |
| ***morphine sulfate oral solution 10 mg/5ml*** | Covered | QL (1350 ML per 30 days) |
| ***morphine sulfate oral solution 20 mg/5ml*** | Covered | QL (675 ML per 30 days) |
| ***morphine sulfate oral tablet 15 mg*** | Covered | QL (120 EA per 30 days) |
| ***morphine sulfate oral tablet 30 mg*** | Covered | QL (3 EA per 1 day) |
| ***morphine sulfate rectal suppository 10 mg, 20 mg, 5 mg*** | Covered | QL (120 EA per 30 days) |
| ***morphine sulfate rectal suppository 30 mg*** | Covered | QL (3 EA per 1 day) |
| ***oxycodone hcl oral solution*** | Covered | QL (1800 ML per 30 days) |
| ***oxycodone hcl oral tablet 10 mg, 5 mg*** | Covered | QL (120 EA per 30 days) |
| ***oxycodone hcl oral tablet 15 mg*** | Covered | QL (4 EA per 1 day) |
| ***oxycodone hcl oral tablet 20 mg*** | Covered | QL (3 EA per 1 day) |
| ***oxycodone hcl oral tablet 30 mg*** | Covered | QL (2 EA per 1 day) |
| ***oxymorphone hcl er*** | Covered | PA; QL (2 EA per 1 day) |
| ***tramadol hcl oral tablet 100 mg*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ***tramadol hcl oral tablet 50 mg*** | Covered | QL (120 EA per 30 days); AL (Min 18 Years) |
| **EMBEDA** (***morphine-naltrexone***) | Covered | PA; QL (30 EA per 30 days) |
| ***methadone hcl*** (Methadone Hcl Intensol) | Covered | PA; QL (2 ML per 1 day) |
| ****Opioid Combinations*** - Arthritis And Pain Drugs*** | | |
| ***oxycodone-acetaminophen*** | Covered | QL (120 EA per 30 days) |
| ***oxycodone-aspirin*** | Covered | QL (120 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Opioid Partial Agonists*** - Arthritis And Pain Drugs*** | | |
| ***buprenorphine hcl*** | State Carve Out | |
| ***buprenorphine hcl-naloxone hcl*** | State Carve Out | |
| ***butorphanol tartrate*** | Covered | QL (2.5 ML per 30 days) |
| ***pentazocine-naloxone hcl*** | Covered | QL (120 EA per 30 days) |
| **BELBUCA** (***buprenorphine hcl***) | State Carve Out | |
| **BUNAVAIL** (***buprenorphine hcl-naloxone hcl***) | State Carve Out | |
| **BUTRANS** (***buprenorphine***) | State Carve Out | |
| **PROBUPHINE IMPLANT KIT** (***buprenorphine hcl***) | State Carve Out | |
| **SUBLOCADE** (***buprenorphine***) | State Carve Out | |
| **SUBOXONE** (***buprenorphine hcl-naloxone hcl***) | State Carve Out | |
| ***Tramadol Combinations*** - Arthritis And Pain Drugs*** | | |
| ***tramadol-acetaminophen*** | Covered | QL (120 EA per 30 days); AL (Min 18 Years) |
| ***Androgens-Anabolic* - Hormones** | | |
| ***Androgens*** - Drugs For Men*** | | |
| ***danazol*** | Covered | |
| ***testosterone cypionate*** | Covered | PA; QL (10 ML per 90 days) |
| ***testosterone enanthate*** | Covered | PA; QL (5 ML per 60 days) |
| ***testosterone transdermal gel 10 mg/act (2%)*** | Covered | PA; QL (120 GM per 30 days) |
| ***testosterone transdermal gel 12.5 mg/act (1%)*** | Covered | PA; QL (300 GM per 30 days) |
| ***testosterone transdermal gel 20.25 mg/act (1.62%)*** | Covered | PA; QL (5 GM per 1 day) |
| ***testosterone transdermal gel 25 mg/2.5gm (1%)*** | Covered | PA; QL (2.5 GM per 1 day) |
| ***testosterone transdermal gel 50 mg/5gm (1%)*** | Covered | PA; QL (10 GM per 1 day) |
| ***testosterone transdermal solution*** | Covered | PA; QL (6 ML per 1 day) |
| ***Anorectal And Related Products* - Rectal Preparations** | | |
| ***Intrarectal Steroids*** - Rectal Preparations*** | | |
| ***hydrocortisone*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***hydrocortisone*** (Colocort) | Covered | |
| ****Nitrate Vasodilating Agents*** - Rectal Preparations*** | | |
| **RECTIV** (***nitroglycerin***) | Covered | PA |
| ****Rectal Anesthetic Combinations*** - Rectal Preparations*** | | |
| ***eq hemorrhoidal max st*** | Covered | OTC |
| ***eql hemorrhoidal*** | Covered | OTC |
| ***hemorrhoidal*** | Covered | OTC |
| ***hemorrhoidal max st/aloe*** | Covered | OTC |
| ***px hemorrhoidal*** | Covered | OTC |
| ***ra hemorrhoidal*** | Covered | OTC |
| ***tgt hemorrhoidal*** | Covered | OTC |
| ****Rectal Anesthetic/Steroids*** - Rectal Preparations*** | | |
| **PROCTOFOAM HC** (***hydrocortisone ace-pramoxine***) | Covered | |
| ****Rectal Steroids*** - Rectal Preparations*** | | |
| ***hydrocortisone*** | Covered | |
| ***Antacids* - Drugs For The Stomach** | | |
| ****Antacid & Simethicone*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***antacid*** | Covered | OTC |
| ***antacid anti-gas max strength*** | Covered | OTC |
| ***antacid extra strength*** | Covered | OTC |
| ***antacid iii*** | Covered | OTC |
| ***antacid maximum strength*** | Covered | OTC |
| ***antacid plus anti-gas relief*** | Covered | OTC |
| ***antacid/simethicone ds*** | Covered | OTC |
| ***comfort gel antacid anti-gas*** | Covered | OTC |
| ***cvs antacid plus antigas*** | Covered | OTC |
| ***cvs antacid/anti-gas*** | Covered | OTC |
| ***eq antacid maximum strength*** | Covered | OTC |
| ***eql antacid advanced max st*** | Covered | OTC |
| ***fast acting antacid/anti-gas*** | Covered | OTC |
| ***gnp antacid maximum strength*** | Covered | OTC |
| ***hm advanced antacid max st*** | Covered | OTC |
| ***hm antacid anti-gas ex st*** | Covered | OTC |
| ***mag-al plus xs*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***meijer antacid*** | Covered | OTC |
| ***mi-acid maximum strength*** | Covered | OTC |
| ***milantex extra strength*** | Covered | OTC |
| ***mintox maximum strength*** | Covered | OTC |
| ***px antacid maximum strength*** | Covered | OTC |
| ***qc antacid/anti-gas*** | Covered | OTC |
| ***ra antacid/anti-gas max st*** | Covered | OTC |
| ***ra antacid/gas relief max st*** | Covered | OTC |
| ***sm antacid advanced max st*** | Covered | OTC |
| ***sm antacid maximum strength*** | Covered | OTC |
| **ALMACONE DOUBLE STRENGTH** (***alum & mag hydroxide-simeth***) | Covered | OTC |
| **GNP MASANTI MAXIMUM STRENGTH** (***alum & mag hydroxide-simeth***) | Covered | OTC |
| **MAALOX MAX** (***alum & mag hydroxide-simeth***) | Covered | OTC |
| **MAALOX MULTI SYMPTOM MAX ST** (***alum & mag hydroxide-simeth***) | Covered | OTC |
| ****Antacid Combinations*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***gnp foaming antacid*** | Covered | OTC |
| ***sm foaming antacid*** | Covered | OTC |
| **MI-ACID** (***ca carbonate-mag hydroxide***) | Covered | OTC |
| ****Antacids - Bicarbonate*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***sodium bicarbonate oral powder*** | Covered | |
| ***sodium bicarbonate oral tablet*** | Covered | OTC |
| ****Antacids - Calcium Salts*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***childrens pepto*** | Covered | OTC |
| ***ra stomach relief kids*** | Covered | OTC |
| **CHILDRENS SOOTHE** (***calcium carbonate antacid***) | Covered | OTC |
| **MAALOX CHILDRENS** (***calcium carbonate antacid***) | Covered | OTC |
| **TITRALAC** (***calcium carbonate antacid***) | Covered | OTC |
| ****Antacids - Magnesium Salts*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***gnp magnesium oxide*** | Covered | OTC |
| ***hm magnesium*** | Covered | OTC |
| ***magnesium oxide*** | Covered | OTC |
| **MAOX** (***magnesium oxide***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Anthelmintics* - Drugs For Infections** | | |
| ****Anthelmintics*** - Drugs For Parasites*** | | |
| ***albendazole*** | Covered | ST |
| ***ivermectin*** | Covered | |
| ***praziquantel*** | Covered | PA |
| ***reeses pinworm medicine*** | Covered | OTC |
| ***Antianginal Agents* - Drugs For The Heart** | | |
| ****Nitrates*** - Drugs For Angina*** | | |
| ***isosorbide dinitrate*** | Covered | |
| ***isosorbide dinitrate er*** | Covered | |
| ***isosorbide mononitrate*** | Covered | |
| ***isosorbide mononitrate er oral tablet extended release 24 hour 120 mg*** | Covered | QL (60 EA per 30 days) |
| ***isosorbide mononitrate er oral tablet extended release 24 hour 30 mg, 60 mg*** | Covered | QL (30 EA per 30 days) |
| ***nitroglycerin*** | Covered | |
| ***nitroglycerin er*** | Covered | |
| ***nitroglycerin*** (Minitran) | Covered | |
| **NITRO-TIME** (***nitroglycerin***) | Covered | |
| ***Antianxiety Agents* - Drugs For The Nervous System** | | |
| ****Antianxiety Agents - Misc.*** - Drugs For Anxiety*** | | |
| ***buspirone hcl oral tablet 10 mg*** | Covered | QL (180 EA per 30 days); AL (Min 6 Years) |
| ***buspirone hcl oral tablet 15 mg*** | Covered | QL (120 EA per 30 days); AL (Min 6 Years) |
| ***buspirone hcl oral tablet 5 mg*** | Covered | QL (360 EA per 30 days); AL (Min 6 Years) |
| ***buspirone hcl oral tablet 7.5 mg*** | Covered | QL (240 EA per 30 days); AL (Min 6 Years) |
| ***hydroxyzine hcl oral syrup*** | Covered | |
| ***hydroxyzine hcl oral tablet 10 mg, 25 mg*** | Covered | QL (4 EA per 1 day) |
| ***hydroxyzine hcl oral tablet 50 mg*** | Covered | QL (8 EA per 1 day) |
| ***hydroxyzine pamoate*** | Covered | QL (4 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***alprazolam er*** | Covered | QL (2 EA per 1 day); AL (Min 18 Years) |
| ***alprazolam oral tablet 0.25 mg, 0.5 mg*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ***alprazolam oral tablet 1 mg*** | Covered | QL (6 EA per 1 day); AL (Min 18 Years) |
| ***alprazolam oral tablet 2 mg*** | Covered | QL (5 EA per 1 day); AL (Min 18 Years) |
| ***alprazolam xr*** | Covered | QL (2 EA per 1 day); AL (Min 18 Years) |
| ***chlordiazepoxide hcl oral capsule 10 mg, 5 mg*** | Covered | QL (4 EA per 1 day); AL (Min 6 Years) |
| ***chlordiazepoxide hcl oral capsule 25 mg*** | Covered | QL (12 EA per 1 day); AL (Min 6 Years) |
| ***diazepam oral solution*** | Covered | QL (10 ML per 1 day) |
| ***diazepam oral tablet*** | Covered | QL (4 EA per 1 day) |
| ***lorazepam oral concentrate*** | Covered | QL (2 ML per 1 day); AL (Min 12 Years) |
| ***lorazepam oral tablet 0.5 mg*** | Covered | QL (4 EA per 1 day) |
| ***lorazepam oral tablet 1 mg*** | Covered | QL (6 EA per 1 day) |
| ***lorazepam oral tablet 2 mg*** | Covered | QL (5 EA per 1 day) |
| ***oxazepam*** | Covered | QL (4 EA per 1 day); AL (Min 6 Years) |
| ***Antiarrhythmics* - Drugs For The Heart** | | |
| ****Antiarrhythmics Type I-A*** - Drugs For Abnormal Heart Rhythms*** | | |
| ***disopyramide phosphate*** | Covered | |
| ***quinidine sulfate*** | Covered | |
| ****Antiarrhythmics Type I-B*** - Drugs For Abnormal Heart Rhythms*** | | |
| ***mexiletine hcl*** | Covered | |
| ****Antiarrhythmics Type I-C*** - Drugs For Abnormal Heart Rhythms*** | | |
| ***flecainide acetate*** | Covered | |
| ***propafenone hcl*** | Covered | |
| ****Antiarrhythmics Type Iii*** - Drugs For Abnormal Heart Rhythms*** | | |
| ***amiodarone hcl*** | Covered | |
| **MULTAQ** (***dronedarone hcl***) | Covered | PA; QL (2 EA per 1 day) |

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|---|---|---|
| ***amiodarone hcl*** (Pacerone) | Covered | |
| ***Antiasthmatic And Bronchodilator Agents* - Drugs For The Lungs** | | |
| ****Adrenergic Combinations*** - Drugs For Asthma/Copd*** | | |
| ***budesonide-formoterol fumarate*** | Covered | QL (10.2 GM per 30 days) |
| ***fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose*** | Covered | QL (2 EA per 1 day); AL (Min 4 Years and Max 11 Years) |
| ***fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act*** | Covered | QL (1 EA per 30 days) |
| ***ipratropium-albuterol*** | Covered | QL (6 Nebules per 1 day) |
| **BEVESPI AEROSPHERE** (***glycopyrrolate-formoterol***) | Covered | QL (10.7 GM per 30 days) |
| **TRELEGY ELLIPTA** (***fluticasone-umeclidin-vilant***) | Covered | ST; QL (2 EA per 1 day) |
| ****Anti-Ige Monoclonal Antibodies*** - Drugs For Asthma/Copd*** | | |
| **XOLAIR** (***omalizumab***) | Covered | PA |
| ****Anti-Inflammatory Agents*** - Drugs For Asthma/Copd*** | | |
| ***cromolyn sodium*** | Covered | |
| ****Beta Adrenergics*** - Drugs For Asthma/Copd*** | | |
| ***albuterol sulfate hfa*** | Covered | QL (6 Fills per 365 days) |
| ***albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%*** | Covered | QL (360 ML per 30 days) |
| ***albuterol sulfate inhalation nebulization solution 0.63 mg/3ml, 1.25 mg/3ml*** | Covered | ST; QL (12 Nebules per 1 day); AL (Max 18 Years) |
| ***albuterol sulfate oral*** | Covered | |
| ***levalbuterol tartrate*** | Covered | ST; QL (90 GM per 365 days) |
| ***metaproterenol sulfate*** | Covered | |
| **ARCAPTA NEOHALER** (***indacaterol maleate***) | Covered | |
| **STRIVERDI RESPIMAT** (***olodaterol hcl***) | Covered | QL (4 GM per 30 days) |
| **VENTOLIN HFA** (***albuterol sulfate***) | Covered | QL (2 Inhaler per 30 days) |
| ****Bronchodilators - Anticholinergics*** - Drugs For Asthma/Copd*** | | |
| ***ipratropium bromide*** | Covered | |
| **INCRUSE ELLIPTA** (***umeclidinium bromide***) | Covered | QL (30 EA per 30 days) |
| ****Leukotriene Receptor Antagonists*** - Drugs For Asthma/Copd*** | | |
| ***montelukast sodium oral packet*** | Covered | PA; QL (1 EA per 1 day); AL (Min 1 Years and Max 2 Years) |
| ***montelukast sodium oral tablet*** | Covered | QL (30 EA per 30 days) |
| ***montelukast sodium oral tablet chewable*** | Covered | QL (30 EA per 30 days) |

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|---|---|---|
| ***zafirlukast*** | Covered | ST; QL (60 EA per 30 days) |
| ****Steroid Inhalants*** - Drugs For Asthma/Copd*** | | |
| ***budesonide*** | Covered | QL (120 ML per 30 days); AL (Max 5 Years) |
| **ARNUITY ELLIPTA** (***fluticasone furoate***) | Covered | QL (1 EA per 1 day) |
| **FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 220 MCG/ACT** (***fluticasone propionate hfa***) | Covered | QL (12 GM per 30 days); AL (Max 12 Years) |
| **FLOVENT HFA INHALATION AEROSOL 44 MCG/ACT** (***fluticasone propionate hfa***) | Covered | QL (10.6 GM per 30 days); AL (Max 12 Years) |
| **QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT** (***beclomethasone diprop hfa***) | Covered | QL (10.6 GM per 30 days) |
| **QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT** (***beclomethasone diprop hfa***) | Covered | QL (21.2 GM per 30 days) |
| ****Xanthines*** - Drugs For Asthma/Copd*** | | |
| ***theophylline*** | Covered | |
| ***theophylline er*** | Covered | |
| **THEOCHRON** (***theophylline***) | Covered | |
| ***Anticoagulants* - Drugs For The Blood** | | |
| ****Coumarin Anticoagulants*** - Drugs To Prevent Blood Clots*** | | |
| ***warfarin sodium*** | Covered | |
| ***warfarin sodium*** (Jantoven) | Covered | |
| ****Direct Factor Xa Inhibitors*** - Drugs To Prevent Blood Clots*** | | |
| **ELIQUIS** (***apixaban***) | Covered | PA; QL (2 EA per 1 day) |
| **XARELTO** (***rivaroxaban***) | Covered | PA; QL (1 EA per 1 day) |
| **XARELTO STARTER PACK** (***rivaroxaban***) | Covered | PA; QL (51 EA per 30 days) |
| ****Heparins And Heparinoid-Like Agents*** - Drugs To Prevent Blood Clots*** | | |
| ***heparin sodium (porcine)*** | Covered | |
| ***heparin sodium (porcine) pf*** | Covered | |
| ****In Vitro/Lock Anticoagulant Combinations*** - Drugs To Prevent Blood Clots*** | | |
| ***sodium citrate-gentamicin sulf*** | Covered | PA |
| ****Low Molecular Weight Heparins*** - Drugs To Prevent Blood Clots*** | | |
| ***enoxaparin sodium*** | Covered | QL (21 days per 168 days) |

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|---|---|---|
| ***Anticonvulsants* - Drugs For The Nervous System** | | |
| ****Anticonvulsants - Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***clonazepam*** | Covered | |
| ***diazepam*** | Covered | QL (2 EA per 1 Fill) |
| **DIASTAT ACUDIAL** (***diazepam***) | Covered | QL (2 EA per 1 Fill) |
| **DIASTAT PEDIATRIC** (***diazepam***) | Covered | QL (2 EA per 1 Fill) |
| **NAYZILAM** (***midazolam (anticonvulsant)***) | Covered | PA; QL (2 EA per 1 day) |
| **VALTOCO 10 MG DOSE** (***diazepam***) | Covered | QL (2 EA per 30 days) |
| **VALTOCO 15 MG DOSE** (***diazepam***) | Covered | QL (2 EA per 30 days) |
| **VALTOCO 20 MG DOSE** (***diazepam***) | Covered | QL (2 EA per 30 days) |
| **VALTOCO 5 MG DOSE** (***diazepam***) | Covered | QL (2 EA per 30 days) |
| ****Anticonvulsants - Misc.*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***carbamazepine*** | Covered | |
| ***carbamazepine er oral capsule extended release 12 hour*** | Covered | QL (120 EA per 30 days) |
| ***carbamazepine er oral tablet extended release 12 hour 100 mg*** | Covered | QL (300 EA per 30 days); AL (Min 6 Years) |
| ***carbamazepine er oral tablet extended release 12 hour 200 mg*** | Covered | QL (150 EA per 30 days); AL (Min 6 Years) |
| ***carbamazepine er oral tablet extended release 12 hour 400 mg*** | Covered | QL (75 EA per 30 days); AL (Min 6 Years) |
| ***gabapentin*** | Covered | QL (3600 MG per 1 day) |
| ***lamotrigine oral tablet 100 mg, 200 mg*** | Covered | QL (60 EA per 30 days) |
| ***lamotrigine oral tablet 150 mg*** | Covered | QL (90 EA per 30 days) |
| ***lamotrigine oral tablet 25 mg*** | Covered | QL (180 EA per 30 days) |
| ***lamotrigine oral tablet chewable 25 mg*** | Covered | QL (6 EA per 1 day) |
| ***lamotrigine oral tablet chewable 5 mg*** | Covered | QL (8 EA per 1 day) |
| ***levetiracetam er oral tablet extended release 24 hour 500 mg*** | Covered | QL (6 EA per 1 day) |
| ***levetiracetam er oral tablet extended release 24 hour 750 mg*** | Covered | QL (4 EA per 1 day) |
| ***levetiracetam oral solution*** | Covered | |
| ***levetiracetam oral tablet 1000 mg*** | Covered | QL (90 EA per 30 days) |
| ***levetiracetam oral tablet 250 mg*** | Covered | QL (60 EA per 30 days) |
| ***levetiracetam oral tablet 500 mg*** | Covered | QL (180 EA per 30 days) |
| ***levetiracetam oral tablet 750 mg*** | Covered | QL (120 EA per 30 days) |

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**AL** = Age Restrictions
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***oxcarbazepine*** | Covered | |
| ***pregabalin oral capsule 100 mg, 150 mg, 25 mg, 50 mg, 75 mg*** | Covered | PA; QL (3 EA per 1 day) |
| ***pregabalin oral capsule 225 mg, 300 mg*** | Covered | PA; QL (2 EA per 1 day) |
| ***primidone*** | Covered | |
| ***topiramate oral capsule sprinkle*** | Covered | QL (120 EA per 30 days) |
| ***topiramate oral tablet 100 mg*** | Covered | QL (90 EA per 30 days) |
| ***topiramate oral tablet 200 mg*** | Covered | QL (60 EA per 30 days) |
| ***topiramate oral tablet 25 mg, 50 mg*** | Covered | QL (120 EA per 30 days) |
| ***zonisamide*** | Covered | QL (180 EA per 30 days) |
| ***carbamazepine*** (Epitol) | Covered | |
| ****Carbamates*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***felbamate*** | Covered | |
| ****Gaba Modulators*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***tiagabine hcl oral tablet 2 mg*** | Covered | QL (30 EA per 30 days) |
| ***tiagabine hcl oral tablet 4 mg*** | Covered | QL (120 EA per 30 days) |
| ***vigabatrin*** | Covered | |
| **GABITRIL ORAL TABLET 12 MG** (***tiagabine hcl***) | Covered | QL (120 EA per 30 days) |
| **GABITRIL ORAL TABLET 16 MG** (***tiagabine hcl***) | Covered | QL (90 EA per 30 days) |
| ****Hydantoins*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***phenytoin*** | Covered | |
| ***phenytoin sodium extended*** | Covered | |
| **DILANTIN** (***phenytoin sodium extended***) | Covered | |
| ***phenytoin*** (Phenytoin Infatabs) | Covered | |
| ****Succinimides*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***ethosuximide*** | Covered | |
| **CELONTIN** (***methsuximide***) | Covered | |
| ****Valproic Acid*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***divalproex sodium*** | Covered | |
| ***divalproex sodium er*** | Covered | PA |
| ***valproic acid*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Antidepressants* - Drugs For The Nervous System** | | |
| ***Alpha-2 Receptor Antagonists (Tetracyclics)*** - Drugs For Depression*** | | |
| ***mirtazapine oral tablet*** | Covered | QL (30 EA per 30 days) |
| ***mirtazapine oral tablet dispersible*** | Covered | QL (1 EA per 1 day) |
| ***Antidepressants - Misc.*** - Drugs For Depression*** | | |
| ***bupropion hcl*** | Covered | QL (90 EA per 30 days) |
| ***bupropion hcl er (sr)*** | Covered | QL (2 EA per 1 day) |
| ***bupropion hcl er (xl)*** | Covered | QL (1 EA per 1 day) |
| ***maprotiline hcl*** | Covered | |
| ***Monoamine Oxidase Inhibitors (Maois)*** - Drugs For Depression*** | | |
| ***phenelzine sulfate*** | State Carve Out | |
| ***tranylcypromine sulfate*** | State Carve Out | |
| **EMSAM** (***selegiline***) | State Carve Out | |
| **MARPLAN** (***isocarboxazid***) | State Carve Out | |
| ***Selective Serotonin Reuptake Inhibitors (Ssris)*** - Drugs For Depression*** | | |
| ***citalopram hydrobromide oral solution*** | Covered | QL (300 ML per 30 days); AL (Max 12 Years) |
| ***citalopram hydrobromide oral tablet 10 mg, 20 mg*** | Covered | QL (45 EA per 30 days) |
| ***citalopram hydrobromide oral tablet 40 mg*** | Covered | QL (30 EA per 30 days) |
| ***escitalopram oxalate oral solution*** | Covered | QL (300 ML per 30 days); AL (Max 12 Years) |
| ***escitalopram oxalate oral tablet*** | Covered | QL (1 EA per 1 day) |
| ***fluoxetine hcl oral capsule 10 mg*** | Covered | QL (30 EA per 30 days) |
| ***fluoxetine hcl oral capsule 20 mg, 40 mg*** | Covered | QL (60 EA per 30 days) |
| ***fluoxetine hcl oral solution*** | Covered | QL (150 ML per 30 days) |
| ***fluvoxamine maleate oral tablet 100 mg*** | Covered | QL (90 EA per 30 days) |
| ***fluvoxamine maleate oral tablet 25 mg, 50 mg*** | Covered | QL (30 EA per 30 days) |
| ***paroxetine hcl oral tablet 10 mg, 20 mg*** | Covered | QL (30 EA per 30 days) |
| ***paroxetine hcl oral tablet 30 mg*** | Covered | QL (60 EA per 30 days) |
| ***paroxetine hcl oral tablet 40 mg*** | Covered | QL (45 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***sertraline hcl oral concentrate*** | Covered | QL (75 ML per 30 days); AL (Max 12 Years) |
| ***sertraline hcl oral tablet 100 mg*** | Covered | QL (2 EA per 1 day) |
| ***sertraline hcl oral tablet 25 mg, 50 mg*** | Covered | QL (45 EA per 30 days) |
| **LEXAPRO** (***escitalopram oxalate***) | Covered | QL (300 ML per 30 days); AL (Max 12 Years) |
| ****Serotonin Modulators*** - Drugs For Depression*** | | |
| ***trazodone hcl*** | Covered | |
| ****Serotonin-Norepinephrine Reuptake Inhibitors (Snris)*** - Drugs For Depression*** | | |
| ***duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg*** | Covered | QL (2 EA per 1 day) |
| ***duloxetine hcl oral capsule delayed release particles 40 mg*** | Covered | QL (1 EA per 1 day) |
| ***venlafaxine hcl*** | Covered | |
| ***venlafaxine hcl er*** | Covered | QL (30 EA per 30 days) |
| ****Tricyclic Agents*** - Drugs For Depression*** | | |
| ***amitriptyline hcl*** | Covered | |
| ***amoxapine*** | Covered | |
| ***doxepin hcl*** | Covered | |
| ***imipramine hcl*** | Covered | |
| ***nortriptyline hcl oral capsule*** | Covered | |
| ***nortriptyline hcl oral solution*** | Covered | AL (Max 12 Years) |
| ***Antidiabetics* - Hormones** | | |
| ****Alpha-Glucosidase Inhibitors*** - Drugs For Diabetes*** | | |
| ***acarbose*** | Covered | QL (90 EA per 30 days) |
| ****Antidiabetic - Amylin Analogs*** - Drugs For Diabetes*** | | |
| **SYMLINPEN 60** (***pramlintide acetate***) | Covered | PA |
| ****Biguanides*** - Drugs For Diabetes*** | | |
| ***metformin hcl*** | Covered | |
| ***metformin hcl er oral tablet extended release 24 hour 500 mg*** | Covered | QL (120 EA per 30 days) |
| ***metformin hcl er oral tablet extended release 24 hour 750 mg*** | Covered | QL (60 EA per 30 days) |
| ****Diabetic Other - Combinations*** - Drugs For Diabetes*** | | |
| ***cvs glucose*** | Covered | OTC |
| ***glucose*** | Covered | OTC |
| ***gnp glucose*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***hm glucose*** | Covered | OTC |
| ***hy-vee glucose*** | Covered | OTC |
| ***kroger glucose*** | Covered | OTC |
| ***leader glucose*** | Covered | OTC |
| ***longs glucose*** | Covered | OTC |
| ***meijer glucose*** | Covered | OTC |
| ***preferred plus glucose*** | Covered | OTC |
| ***px glucose*** | Covered | OTC |
| ***ra glucose*** | Covered | OTC |
| ***sm glucose*** | Covered | OTC |
| ***tgt glucose*** | Covered | OTC |
| ***up & up glucose*** | Covered | OTC |
| ***value plus glucose*** | Covered | OTC |
| ***walgreens glucose*** | Covered | OTC |
| **DEX4** (***glucose-vitamin c***) | Covered | OTC |
| **DEX4 GLUCOSE** (***glucose-vitamin c***) | Covered | OTC |
| **DEX4 NATURALS** (***glucose-vitamin c***) | Covered | OTC |
| **DEX4 POUCH PACK** (***glucose-vitamin c***) | Covered | OTC |
| **RELION GLUCOSE** (***glucose-vitamin c***) | Covered | OTC |
| **SMART SENSE GLUCOSE** (***glucose-vitamin c***) | Covered | OTC |
| ****Diabetic Other*** - Drugs For Diabetes*** | | |
| ***cvs glucose*** | Covered | OTC |
| ***cvs glucose shot*** | Covered | OTC |
| ***glucagon emergency*** | Covered | QL (1 Unit Max Qty Per Fill Retail) |
| ***glucose*** | Covered | OTC |
| ***gnp glucose*** | Covered | OTC |
| ***gnp quick dissolve glucose*** | Covered | OTC |
| ***leader quick dissolve glucose*** | Covered | OTC |
| ***ra glucose*** | Covered | OTC |
| ***sm glucose*** | Covered | OTC |
| ***value plus glucose*** | Covered | OTC |
| ***walgreens glucose*** | Covered | OTC |
| **BAQSIMI ONE PACK** (***glucagon***) | Covered | QL (2 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **BAQSIMI TWO PACK** (***glucagon***) | Covered | QL (2 EA per 30 days) |
| **BD GLUCOSE** (***dextrose (diabetic use)***) | Covered | OTC |
| **DEX4 QUICK DISSOLVE GLUCOSE** (***dextrose (diabetic use)***) | Covered | OTC |
| **GLUCAGEN HYPOKIT** (***glucagon hcl (rdna)***) | Covered | QL (1 Unit Max Qty Per Fill Retail) |
| **GLUCO BURST** (***dextrose (diabetic use)***) | Covered | OTC |
| **GVOKE HYPOPEN** (***glucagon***) | Covered | QL (2 pens Max Qty Per Fill Retail) |
| **GVOKE PFS** (***glucagon***) | Covered | QL (0.2 ML Max Qty Per Fill Retail) |
| **INSTA-GLUCOSE** (***dextrose (diabetic use)***) | Covered | OTC |
| **RELION GLUCOSE** (***dextrose (diabetic use)***) | Covered | OTC |
| **RELION GLUCOSE DRINK** (***dextrose (diabetic use)***) | Covered | OTC |
| ****Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors*** - Drugs For Diabetes*** | | |
| ***alogliptin benzoate*** | Covered | QL (1 EA per 1 Day) |
| ****Dipeptidyl Peptidase-4 Inhibitor-Biguanide Combinations*** - Drugs For Diabetes*** | | |
| ***alogliptin-metformin hcl*** | Covered | QL (2 EA per 1 Day) |
| ****Dpp-4 Inhibitor-Thiazolidinedione Combinations*** - Drugs For Diabetes*** | | |
| ***alogliptin-pioglitazone*** | Covered | QL (1 EA per 1 Day) |
| ****Human Insulin*** - Drugs For Diabetes*** | | |
| ***insulin glargine-yfgn*** | Covered | |
| ***insulin lispro subcutaneous solution*** | Covered | |
| ***insulin lispro subcutaneous solution pen-injector*** | Covered | AL (Max 18 Years) |
| **ADMELOG** (***insulin lispro***) | Covered | |
| **ADMELOG SOLOSTAR** (***insulin lispro***) | Covered | AL (Max 18 Years) |
| **BASAGLAR KWIKPEN** (***insulin glargine***) | Covered | |
| **HUMALOG** (***insulin lispro***) | Covered | |
| **HUMALOG KWIKPEN** (***insulin lispro***) | Covered | AL (Max 18 Years) |
| **HUMALOG MIX 50/50** (***insulin lispro prot & lispro***) | Covered | |
| **HUMALOG MIX 50/50 KWIKPEN** (***insulin lispro prot & lispro***) | Covered | AL (Max 18 Years) |
| **HUMALOG MIX 75/25** (***insulin lispro prot & lispro***) | Covered | |
| **HUMALOG MIX 75/25 KWIKPEN** (***insulin lispro prot & lispro***) | Covered | AL (Max 18 Years) |
| **HUMULIN 70/30** (***insulin nph isophane & regular***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **HUMULIN 70/30 KWIKPEN** (***insulin nph isophane & regular***) | Covered | OTC; AL (Max 18 Years) |
| **HUMULIN N** (***insulin nph human (isophane)***) | Covered | OTC |
| **HUMULIN N KWIKPEN** (***insulin nph human (isophane)***) | Covered | OTC; AL (Max 18 Years) |
| **HUMULIN R** (***insulin regular human***) | Covered | OTC |
| **HUMULIN R U-500 (CONCENTRATED)** (***insulin regular human***) | Covered | |
| **HUMULIN R U-500 KWIKPEN** (***insulin regular human***) | Covered | AL (Max 18 Years) |
| **NOVOLIN 70/30** (***insulin nph isophane & regular***) | Covered | OTC |
| **NOVOLIN 70/30 RELION** (***insulin nph isophane & regular***) | Covered | OTC |
| **NOVOLIN N** (***insulin nph human (isophane)***) | Covered | OTC |
| **NOVOLIN N RELION** (***insulin nph human (isophane)***) | Covered | OTC |
| **NOVOLIN R** (***insulin regular human***) | Covered | OTC |
| **NOVOLIN R FLEXPEN** (***insulin regular human***) | Covered | OTC |
| **NOVOLIN R RELION** (***insulin regular human***) | Covered | OTC |
| **NOVOLOG MIX 70/30** (***insulin aspart prot & aspart***) | Covered | |
| **NOVOLOG MIX 70/30 FLEXPEN** (***insulin aspart prot & aspart***) | Covered | AL (Max 18 Years) |
| ****Incretin Mimetic Agents (Glp-1 Receptor Agonists)*** - Drugs For Diabetes*** | | |
| **OZEMPIC (0.25 OR 0.5 MG/DOSE)** (***semaglutide***) | Covered | ST; QL (0.05 ML per 1 day) |
| **OZEMPIC (1 MG/DOSE)** (***semaglutide***) | Covered | ST; QL (0.1071 ML per 1 day) |
| **TRULICITY** (***dulaglutide***) | Covered | ST |
| ****Meglitinide Analogues*** - Drugs For Diabetes*** | | |
| ***nateglinide*** | Covered | QL (3 EA per 1 day) |
| ***repaglinide oral tablet 0.5 mg, 1 mg*** | Covered | QL (120 EA per 30 days) |
| ***repaglinide oral tablet 2 mg*** | Covered | QL (240 EA per 30 days) |
| ****Meglitinide-Biguanide Combinations*** - Drugs For Diabetes*** | | |
| ***repaglinide-metformin hcl*** | Covered | |
| ****Sodium-Glucose Co-Transporter 2 (Sglt2) Inhibitors*** - Drugs For Diabetes*** | | |
| **JARDIANCE** (***empagliflozin***) | Covered | PA; QL (1 EA per 1 day) |
| **STEGLATRO** (***ertugliflozin l-pyroglutamicac***) | Covered | ST; QL (1 EA per 1 day) |
| ****Sodium-Glucose Co-Transporter 2 Inhibitor-Biguanide Comb*** - Drugs For Diabetes*** | | |
| **SEGLUROMET** (***ertugliflozin-metformin hcl***) | Covered | ST; QL (2 EA per 1 day) |
| ****Sulfonylurea-Biguanide Combinations*** - Drugs For Diabetes*** | | |
| ***glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg*** | Covered | QL (2 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***glipizide-metformin hcl oral tablet 5-500 mg*** | Covered | QL (4 EA per 1 day) |
| ***glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg*** | Covered | QL (60 EA per 30 days) |
| ***glyburide-metformin oral tablet 5-500 mg*** | Covered | QL (120 EA per 30 days) |
| ****Sulfonylureas*** - Drugs For Diabetes*** | | |
| ***glimepiride oral tablet 1 mg, 2 mg*** | Covered | QL (30 EA per 30 days) |
| ***glimepiride oral tablet 4 mg*** | Covered | QL (60 EA per 30 days) |
| ***glipizide*** | Covered | |
| ***glipizide er oral tablet extended release 24 hour 10 mg*** | Covered | QL (2 EA per 1 day) |
| ***glipizide er oral tablet extended release 24 hour 2.5 mg, 5 mg*** | Covered | QL (1 EA per 1 day) |
| ***glipizide xl oral tablet extended release 24 hour 10 mg*** | Covered | QL (60 EA per 30 days) |
| ***glipizide xl oral tablet extended release 24 hour 2.5 mg, 5 mg*** | Covered | QL (1 EA per 1 day) |
| ***glyburide*** | Covered | |
| ***glyburide micronized oral tablet 1.5 mg, 3 mg*** | Covered | QL (30 EA per 30 days) |
| ***glyburide micronized oral tablet 6 mg*** | Covered | QL (60 EA per 30 days) |
| ****Thiazolidinediones*** - Drugs For Diabetes*** | | |
| ***pioglitazone hcl*** | Covered | QL (1 EA per 1 day) |
| **AVANDIA** (***rosiglitazone maleate***) | Covered | ST; QL (30 EA per 30 days) |
| ***Antidiarrheal/Probiotic Agents* - Drugs For The Stomach** | | |
| ****Antiperistaltic Agents*** - Drugs For Diarrhea*** | | |
| ***anti-diarrheal*** | Covered | OTC |
| ***cvs anti-diarrheal*** | Covered | OTC |
| ***diphenoxylate-atropine*** | Covered | |
| ***eq anti-diarrheal*** | Covered | OTC |
| ***gnp anti-diarrheal*** | Covered | OTC |
| ***hm loperamide hcl*** | Covered | OTC |
| ***loperamide hcl*** | Covered | |
| ***ra anti-diarrheal*** | Covered | OTC |
| ***sm anti-diarrheal*** | Covered | OTC |
| ***tgt loperamide hcl*** | Covered | OTC |
| ***Antidotes And Specific Antagonists* - Drugs For Overdose Or Poisoning** | | |
| ****Antidotes - Chelating Agents*** - Drugs For Overdose Or Poisoning*** | | |
| **CHEMET** (***succimer***) | Covered | |

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|---|---|---|
| ***Opioid Antagonists*** - Drugs For Overdose Or Poisoning*** | | |
| ***naloxone hcl*** | State Carve Out | |
| ***naltrexone hcl*** | State Carve Out | |
| **EVZIO** (***naloxone hcl***) | State Carve Out | |
| **NARCAN** (***naloxone hcl***) | State Carve Out | |
| **VIVITROL** (***naltrexone***) | State Carve Out | |
| ***Antiemetics* - Drugs For The Stomach** | | |
| ***5-Ht3 Receptor Antagonists*** - Drugs For Vomiting And Nausea*** | | |
| ***granisetron hcl*** | Covered | ST; QL (8 EA per 30 days) |
| ***ondansetron*** | Covered | QL (90 EA per 30 days) |
| ***ondansetron hcl oral tablet 24 mg*** | Covered | QL (30 EA per 30 days) |
| ***ondansetron hcl oral tablet 4 mg, 8 mg*** | Covered | QL (3 EA per 1 day) |
| ***Antiemetics - Anticholinergic*** - Drugs For Vomiting And Nausea*** | | |
| ***cvs motion sickness ii*** | Covered | OTC |
| ***cvs motion sickness relief*** | Covered | OTC |
| ***eq motion sickness relief*** | Covered | OTC |
| ***gnp motion sickness relief*** | Covered | OTC |
| ***hm motion relief*** | Covered | OTC |
| ***meclizine hcl*** | Covered | |
| ***motion sickness relief*** | Covered | OTC |
| ***motion-time*** | Covered | OTC |
| ***ra motion sickness relief*** | Covered | OTC |
| ***sm motion sickness*** | Covered | OTC |
| ***travel sickness*** | Covered | OTC |
| **DRAMAMINE LESS DROWSY** (***meclizine hcl***) | Covered | OTC |
| **WAL-DRAM II** (***meclizine hcl***) | Covered | OTC |
| ***Substance P/Neurokinin 1 (Nk1) Receptor Antagonists*** - Drugs For Vomiting And Nausea*** | | |
| ***aprepitant*** | Covered | QL (3 EA per 30 days) |

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|---|---|---|
| ***Antifungals* - Drugs For Infections** | | |
| ****Antifungal - Glucan Synthesis Inhibitors (Echinocandins)*** - Antibiotics*** | | |
| ***caspofungin acetate*** | Covered | PA |
| **ERAXIS** (***anidulafungin***) | Covered | PA |
| **MYCAMINE** (***micafungin sodium***) | Covered | PA |
| ****Antifungals*** - Drugs For Fungus*** | | |
| ***bio-statin*** | Covered | |
| ***griseofulvin microsize*** | Covered | ST |
| ***griseofulvin ultramicrosize*** | Covered | ST |
| ***nystatin*** | Covered | |
| ***terbinafine hcl*** | Covered | QL (1 EA per 1 day) |
| **ABELCET** (***amphotericin b lipid***) | Covered | PA |
| **AMBISOME** (***amphotericin b liposome***) | Covered | PA |
| ****Imidazoles*** - Drugs For Fungus*** | | |
| ***ketoconazole*** | Covered | QL (30 EA per 30 days) |
| ****Triazoles*** - Drugs For Fungus*** | | |
| ***fluconazole in dextrose*** | Covered | PA |
| ***fluconazole in sodium chloride*** | Covered | PA |
| ***fluconazole oral suspension reconstituted*** | Covered | |
| ***fluconazole oral tablet*** | Covered | QL (60 EA per 30 days) |
| ***itraconazole*** | Covered | QL (120 EA per 30 days) |
| ***voriconazole*** | Covered | PA |
| **CRESEMBA** (***isavuconazonium sulfate***) | Covered | PA |
| **NOXAFIL** (***posaconazole***) | Covered | PA |
| ***Antihistamines* - Drugs For The Lungs** | | |
| ****Antihistamines - Alkylamines*** - Drugs For Allergies*** | | |
| ***brompheniramine tannate*** | Covered | |
| ***chlorpheniramine maleate*** | Covered | OTC |
| ***ed chlorped jr*** | Covered | OTC; QL (120 mL per 30 days) |
| **DIABETIC TUSSIN ALLERGY** (***chlorpheniramine maleate***) | Covered | OTC; QL (120 mL per 30 days) |
| ****Antihistamines - Ethanolamines*** - Drugs For Allergies*** | | |
| ***allergy childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***allergy relief childrens oral liquid*** | Covered | OTC; QL (120 mL per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***allergy relief childrens oral tablet dispersible*** | Covered | OTC |
| ***carbinoxamine maleate*** | Covered | |
| ***childrens allergy*** | Covered | OTC; QL (120 mL per 30 days) |
| ***clemastine fumarate*** | Covered | |
| ***cvs allergy relief*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cvs allergy relief adult*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cvs childrens allergy*** | Covered | OTC; QL (120 mL per 30 days) |
| ***diphenhist*** | Covered | OTC; QL (120 mL per 30 days) |
| ***diphenhydramine hcl oral capsule*** | Covered | |
| ***diphenhydramine hcl oral elixir*** | Covered | QL (120 mL per 30 days) |
| ***diphenhydramine hcl oral liquid 12.5 mg/5ml*** | Covered | OTC; QL (120 ML per 30 days) |
| ***diphenhydramine hcl oral liquid 6.25 mg/ml*** | Covered | OTC |
| ***eq allergy relief childrens oral elixir*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eq allergy relief childrens oral liquid*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eq allergy relief childrens oral tablet dispersible*** | Covered | OTC |
| ***eql childrens allergy*** | Covered | OTC; QL (120 mL per 30 days) |
| ***gnp childrens allergy*** | Covered | OTC; QL (120 mL per 30 days) |
| ***hm allergy relief childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***kp diphenhydramine hcl*** | Covered | OTC |
| ***pharbedryl*** | Covered | OTC |
| ***px allergy*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra allergy*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra allergy medication*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra allergy relief childrens oral liquid*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra allergy relief childrens oral tablet dispersible*** | Covered | OTC |
| ***sb allergy medicine*** | Covered | OTC; QL (120 mL per 30 days) |
| ***siladryl allergy*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sm allergy relief*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sm allergy relief childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tgt allergy melts childrens*** | Covered | OTC |
| ***tgt allergy relief childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| **BANOPHEN ORAL CAPSULE** (***diphenhydramine hcl***) | Covered | OTC |
| **BANOPHEN ORAL LIQUID** (***diphenhydramine hcl***) | Covered | OTC; QL (120 mL per 30 days) |
| **NARAMIN** (***diphenhydramine hcl***) | Covered | OTC; QL (120 mL per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **PEDIACARE CHILDRENS ALLERGY** (***diphenhydramine hcl***) | Covered | OTC; QL (120 mL per 30 days) |
| **RA DIPHEDRYL ALLERGY** (***diphenhydramine hcl***) | Covered | OTC; QL (120 mL per 30 days) |
| **TOTAL ALLERGY MEDICINE** (***diphenhydramine hcl***) | Covered | OTC; QL (120 mL per 30 days) |
| **WAL-DRYL ALLERGY** (***diphenhydramine hcl***) | Covered | OTC; QL (120 mL per 30 days) |
| **WAL-DRYL ALLERGY CHILDRENS** (***diphenhydramine hcl***) | Covered | OTC; QL (120 mL per 30 days) |
| **WAL-DRYL ALLERGY REL CHILDRENS** (***diphenhydramine hcl***) | Covered | OTC |
| ****Antihistamines - Non-Sedating*** - Drugs For Allergies*** | | |
| ***all day allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***all day allergy childrens*** | Covered | OTC; QL (150 ML per 30 days) |
| ***allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***allergy childrens*** | Covered | OTC; QL (240 ML per 30 days) |
| ***allergy relief child*** | Covered | OTC; QL (240 ML per 30 days) |
| ***allergy relief childrens oral solution*** | Covered | OTC; QL (150 ML per 30 days) |
| ***allergy relief childrens oral syrup*** | Covered | OTC; QL (240 ML per 30 days) |
| ***allergy relief oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***allergy relief oral tablet dispersible*** | Covered | OTC; QL (1 EA per 1 day) |
| ***cetirizine hcl allergy child*** | Covered | QL (150 ML per 30 days) |
| ***cetirizine hcl childrens*** | Covered | OTC; QL (150 ML per 30 days) |
| ***cetirizine hcl hives relief*** | Covered | OTC; QL (150 ML per 30 days) |
| ***cetirizine hcl oral solution*** | Covered | QL (150 ML per 30 days) |
| ***cetirizine hcl oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***childrens loratadine*** | Covered | OTC; QL (240 ML per 30 days) |
| ***cvs allergy relief childrens oral solution*** | Covered | OTC; QL (150 ML per 30 days) |
| ***cvs allergy relief childrens oral syrup*** | Covered | OTC; QL (240 ML per 30 days) |
| ***cvs allergy relief oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***cvs allergy relief oral tablet dispersible*** | Covered | OTC; QL (1 EA per 1 day) |
| ***cvs indoor/outdoor allergy rlf*** | Covered | OTC; QL (30 EA per 30 days) |
| ***eq allergy relief*** | Covered | OTC; QL (30 EA per 30 days) |
| ***eq allergy relief (cetirizine) oral solution*** | Covered | OTC; QL (150 ML per 30 days) |
| ***eq allergy relief (cetirizine) oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***eq allergy relief childrens oral solution*** | Covered | OTC; QL (150 ML per 30 days) |
| ***eq allergy relief childrens oral syrup*** | Covered | OTC; QL (240 ML per 30 days) |
| ***eq childrens loratadine*** | Covered | OTC; QL (240 ML per 30 days) |
| ***eq loratadine*** | Covered | OTC; QL (30 EA per 30 days) |

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|---|---|---|
| ***eql all day allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***eql all day allergy childrens*** | Covered | OTC; QL (150 ML per 30 days) |
| ***eql allergy relief*** | Covered | OTC; QL (30 EA per 30 days) |
| ***gnp all day allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***gnp all day allergy childrens*** | Covered | OTC; QL (150 ML per 30 days) |
| ***gnp allergy relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***gnp loratadine oral syrup*** | Covered | OTC; QL (240 ML per 30 days) |
| ***gnp loratadine oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***goodsense all day allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***hm all day allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***hm allergy relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***hm cetirizine hcl childrens*** | Covered | OTC; QL (150 ML per 30 days) |
| ***hm loratadine*** | Covered | OTC; QL (30 EA per 30 days) |
| ***hm loratadine childrens*** | Covered | OTC; QL (240 ML per 30 days) |
| ***kp cetirizine hcl*** | Covered | OTC; QL (30 EA per 30 days) |
| ***kp loratadine*** | Covered | OTC; QL (30 EA per 30 days) |
| ***loradamed*** | Covered | OTC; QL (30 EA per 30 days) |
| ***loratadine childrens*** | Covered | OTC; QL (240 ML per 30 days) |
| ***loratadine oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***loratadine oral tablet chewable*** | Covered | OTC; QL (2 EA per 1 day) |
| ***meijer allergy relief oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***meijer allergy relief oral tablet dispersible*** | Covered | OTC; QL (1 EA per 1 day) |
| ***meijer loratadine*** | Covered | OTC; QL (240 ML per 30 days) |
| ***px allergy relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***px allergy relief cetirizine*** | Covered | OTC; QL (30 EA per 30 days) |
| ***px allergy relief loratadine*** | Covered | OTC; QL (30 EA per 30 days) |
| ***px childrens allergy*** | Covered | OTC; QL (150 ML per 30 days) |
| ***qc all day allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***qc allergy relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***qc allergy relief childrens oral syrup 1 mg/ml*** | Covered | OTC; QL (150 ML per 30 days) |
| ***qc allergy relief childrens oral syrup 5 mg/5ml*** | Covered | OTC; QL (240 ML per 30 days) |
| ***qc loratadine allergy relief*** | Covered | OTC; QL (30 EA per 30 days) |
| ***ra allergy relief childrens*** | Covered | OTC; QL (150 ML per 30 days) |
| ***ra allergy relief oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***ra allergy relief oral tablet dispersible*** | Covered | OTC; QL (1 EA per 1 day) |
| ***ra cetirizine*** | Covered | OTC; QL (30 EA per 30 days) |
| ***ra loratadine childrens*** | Covered | OTC; QL (240 ML per 30 days) |
| ***ra loratadine oral syrup*** | Covered | OTC; QL (240 ML per 30 days) |
| ***ra loratadine oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***ra loratadine oral tablet dispersible*** | Covered | OTC; QL (1 EA per 1 day) |
| ***sb allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***sb allergy relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***sb loratadine allergy relief*** | Covered | OTC; QL (30 EA per 30 days) |
| ***sb loratadine oral syrup*** | Covered | OTC; QL (240 ML per 30 days) |
| ***sb loratadine oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***sm all day allergy*** | Covered | OTC; QL (30 EA per 30 days) |
| ***sm all day allergy childrens*** | Covered | OTC; QL (150 ML per 30 days) |
| ***sm allergy relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***sm allergy relief loratadine*** | Covered | OTC; QL (30 EA per 30 days) |
| ***sm childrens loratadine*** | Covered | OTC; QL (240 ML per 30 days) |
| ***sm loratadine allergy relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***sm loratadine oral syrup*** | Covered | OTC; QL (240 ML per 30 days) |
| ***sm loratadine oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***tgt all day allergy relief*** | Covered | OTC; QL (30 EA per 30 days) |
| ***tgt allergy relief oral tablet*** | Covered | OTC; QL (30 EA per 30 days) |
| ***tgt allergy relief oral tablet dispersible*** | Covered | OTC; QL (1 EA per 1 day) |
| ***tgt loratadine childrens*** | Covered | OTC; QL (240 ML per 30 days) |
| **ALAVERT** (***loratadine***) | Covered | OTC; QL (1 EA per 1 day) |
| **KLS ALLERCLEAR** (***loratadine***) | Covered | OTC; QL (30 EA per 30 days) |
| **KLS ALLER-TEC** (***cetirizine hcl***) | Covered | OTC; QL (30 EA per 30 days) |
| **TRIAMINIC ALLERCHEWS** (***loratadine***) | Covered | OTC; QL (1 EA per 1 day) |
| **WAL-ITIN** (***loratadine***) | Covered | OTC; QL (30 EA per 30 days) |
| **WAL-ITIN ALLERGY REDITABS** (***loratadine***) | Covered | OTC; QL (1 EA per 1 day) |
| **WAL-ITIN ALLER-MELTS** (***loratadine***) | Covered | OTC; QL (1 EA per 1 day) |
| **WAL-VERT** (***loratadine***) | Covered | OTC; QL (1 EA per 1 day) |
| **WAL-ZYR** (***cetirizine hcl***) | Covered | OTC; QL (30 EA per 30 days) |
| **WAL-ZYR ALL DAY ALLERGY CHILD** (***cetirizine hcl***) | Covered | OTC; QL (150 ML per 30 days) |
| **WAL-ZYR CHILDRENS** (***cetirizine hcl***) | Covered | OTC; QL (150 ML per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Antihistamines - Phenothiazines*** - Drugs For Allergies*** | | |
| ***promethazine hcl oral solution*** | Covered | QL (180 mL per 30 days) |
| ***promethazine hcl oral syrup*** | Covered | QL (180 mL per 30 days) |
| ***promethazine hcl oral tablet*** | Covered | |
| ***promethazine hcl rectal*** | Covered | |
| ***promethazine hcl*** (Phenadoz) | Covered | |
| **PROMETHEGAN** (***promethazine hcl***) | Covered | |
| ***Antihistamines - Piperidines*** - Drugs For Allergies*** | | |
| ***cyproheptadine hcl*** | Covered | |
| ***Antihyperlipidemics* - Drugs For The Heart** | | |
| ***Antihyperlipidemics - Misc.*** - Drugs For Cholesterol*** | | |
| ***icosapent ethyl*** | Covered | PA; QL (4 EA per 1 day) |
| ***omega-3-acid ethyl esters*** | Covered | ST; QL (4 EA per 1 day) |
| ***Bile Acid Sequestrants*** - Drugs For Cholesterol*** | | |
| ***cholestyramine*** | Covered | |
| ***cholestyramine light*** | Covered | |
| ***colestipol hcl*** | Covered | |
| ***Fibric Acid Derivatives*** - Drugs For Cholesterol*** | | |
| ***fenofibrate*** | Covered | |
| ***fenofibrate micronized*** | Covered | |
| ***gemfibrozil*** | Covered | QL (60 EA per 30 days) |
| ***Hmg Coa Reductase Inhibitors*** - Drugs For Cholesterol*** | | |
| ***atorvastatin calcium*** | Covered | QL (30 EA per 30 days) |
| ***fluvastatin sodium*** | Covered | ST; QL (1 EA per 1 day) |
| ***fluvastatin sodium er*** | Covered | QL (30 EA per 30 days) |
| ***lovastatin oral tablet 10 mg, 20 mg*** | Covered | QL (30 EA per 30 days) |
| ***lovastatin oral tablet 40 mg*** | Covered | QL (60 EA per 30 days) |
| ***pravastatin sodium*** | Covered | QL (1 EA per 1 day) |
| ***rosuvastatin calcium*** | Covered | ST |
| ***simvastatin*** | Covered | QL (30 EA per 30 days) |
| ***Intestinal Cholesterol Absorption Inhibitors*** - Drugs For Cholesterol*** | | |
| ***ezetimibe*** | Covered | ST; QL (1 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Pcsk9 Inhibitors*** - Drugs For Cholesterol*** | | |
| **REPATHA** (***evolocumab***) | Covered | PA |
| **REPATHA PUSHTRONEX SYSTEM** (***evolocumab***) | Covered | PA |
| **REPATHA SURECLICK** (***evolocumab***) | Covered | PA |
| **Antihypertensives* - Drugs For The Heart** | | |
| ***Ace Inhibitor & Calcium Channel Blocker Combinations*** - Drugs For High Blood Pressure*** | | |
| ***amlodipine besy-benazepril hcl*** | Covered | QL (30 EA per 30 days) |
| ***Ace Inhibitors & Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure*** | | |
| ***benazepril-hydrochlorothiazide*** | Covered | QL (1 EA per 1 day) |
| ***enalapril-hydrochlorothiazide oral tablet 10-25 mg*** | Covered | QL (60 EA per 30 days) |
| ***enalapril-hydrochlorothiazide oral tablet 5-12.5 mg*** | Covered | QL (30 EA per 30 days) |
| ***fosinopril sodium-hctz*** | Covered | |
| ***lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg*** | Covered | QL (30 EA per 30 days) |
| ***lisinopril-hydrochlorothiazide oral tablet 20-25 mg*** | Covered | QL (60 EA per 30 days) |
| ***moexipril-hydrochlorothiazide*** | Covered | QL (30 EA per 30 days) |
| ***quinapril-hydrochlorothiazide*** | Covered | QL (30 EA per 30 days) |
| ***Ace Inhibitors*** - Drugs For High Blood Pressure*** | | |
| ***benazepril hcl*** | Covered | QL (2 EA per 1 day) |
| ***enalapril maleate*** | Covered | QL (2 EA per 1 day) |
| ***fosinopril sodium*** | Covered | QL (2 EA per 1 day) |
| ***lisinopril*** | Covered | QL (2 EA per 1 day) |
| ***perindopril erbumine oral tablet 2 mg, 4 mg*** | Covered | QL (1 EA per 1 day) |
| ***perindopril erbumine oral tablet 8 mg*** | Covered | QL (2 EA per 1 day) |
| ***quinapril hcl*** | Covered | QL (2 EA per 1 day) |
| ***ramipril*** | Covered | QL (2 EA per 1 day) |
| ***trandolapril oral tablet 1 mg, 2 mg*** | Covered | QL (30 EA per 30 days) |
| ***trandolapril oral tablet 4 mg*** | Covered | QL (60 EA per 30 days) |
| ***Adrenolytics-Central & Thiazide/Thiazide-Like Comb*** - Drugs For High Blood Pressure*** | | |
| ***methyldopa-hydrochlorothiazide*** | Covered | |
| ***Angiotensin Ii Receptor Antag & Ca Channel Blocker Comb*** - Drugs For High Blood Pressure*** | | |
| ***amlodipine besylate-valsartan*** | Covered | QL (1 EA per 1 day) |

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|---|---|---|
| ***Angiotensin Ii Receptor Antag & Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure*** | | |
| ***candesartan cilexetil-hctz*** | Covered | ST; QL (30 EA per 30 days) |
| ***irbesartan-hydrochlorothiazide*** | Covered | QL (30 EA per 30 days) |
| ***losartan potassium-hctz*** | Covered | QL (30 EA per 30 days) |
| ***valsartan-hydrochlorothiazide*** | Covered | QL (30 EA per 30 days) |
| ***Angiotensin Ii Receptor Antagonists*** - Drugs For High Blood Pressure*** | | |
| ***candesartan cilexetil*** | Covered | ST; QL (30 EA per 30 days) |
| ***irbesartan*** | Covered | QL (30 EA per 30 days) |
| ***losartan potassium oral tablet 100 mg*** | Covered | QL (1 EA per 1 day) |
| ***losartan potassium oral tablet 25 mg, 50 mg*** | Covered | QL (2 EA per 1 day) |
| ***telmisartan*** | Covered | QL (1 EA per 1 day) |
| ***valsartan*** | Covered | QL (1 EA per 1 day) |
| ***Antiadrenergics - Centrally Acting*** - Drugs For High Blood Pressure*** | | |
| ***clonidine hcl*** | Covered | |
| ***guanfacine hcl oral tablet 1 mg*** | Covered | QL (240 EA per 30 days) |
| ***guanfacine hcl oral tablet 2 mg*** | Covered | QL (120 EA per 30 days) |
| ***methyldopa*** | Covered | |
| ***Antiadrenergics - Peripherally Acting*** - Drugs For High Blood Pressure*** | | |
| ***doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg*** | Covered | QL (30 EA per 30 days) |
| ***doxazosin mesylate oral tablet 8 mg*** | Covered | QL (60 EA per 30 days) |
| ***prazosin hcl*** | Covered | QL (120 EA per 30 days) |
| ***terazosin hcl oral capsule 1 mg, 5 mg*** | Covered | QL (30 EA per 30 days) |
| ***terazosin hcl oral capsule 10 mg, 2 mg*** | Covered | QL (60 EA per 30 days) |
| ***Beta Blocker & Diuretic Combinations*** - Drugs For High Blood Pressure*** | | |
| ***atenolol-chlorthalidone*** | Covered | |
| ***bisoprolol-hydrochlorothiazide*** | Covered | |
| ***metoprolol-hydrochlorothiazide*** | Covered | |
| ***nadolol-bendroflumethiazide*** | Covered | |
| ***propranolol-hctz*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Vasodilators*** - Drugs For High Blood Pressure*** | | |
| ***hydralazine hcl*** | Covered | |
| ***minoxidil*** | Covered | |
| **Anti-Infective Agents - Misc.* - Drugs For Infections** | | |
| ***Anti-Infective Agents - Misc.*** - Drugs For Infections*** | | |
| ***metronidazole in nacl*** | Covered | PA |
| ***metronidazole intravenous*** | Covered | PA |
| ***metronidazole oral*** | Covered | |
| ***trimethoprim*** | Covered | |
| ***Anti-Infective Misc. - Combinations*** - Antibiotics*** | | |
| ***sulfamethoxazole-trimethoprim intravenous*** | Covered | PA |
| ***sulfamethoxazole-trimethoprim oral*** | Covered | |
| ***sulfamethoxazole-trimethoprim*** (Sulfatrim Pediatric) | Covered | |
| ***Carbapenem Combinations*** - Antibiotics*** | | |
| ***imipenem-cilastatin*** | Covered | PA |
| ***Carbapenems*** - Antibiotics*** | | |
| ***doripenem*** | Covered | PA |
| ***meropenem*** | Covered | PA |
| ***Chloramphenicals*** - Antibiotics*** | | |
| ***chloramphenicol sod succinate*** | Covered | PA |
| ***Cyclic Lipopeptides*** - Antibiotics*** | | |
| ***daptomycin*** | Covered | PA |
| ***Glycopeptides*** - Antibiotics*** | | |
| ***vancomycin hcl intravenous solution*** | Covered | |
| ***vancomycin hcl intravenous solution reconstituted 10 gm*** | Covered | |
| ***vancomycin hcl intravenous solution reconstituted 500 mg, 750 mg*** | Covered | PA |
| **FIRVANQ** (***vancomycin hcl***) | Covered | |
| ***Leprostatics*** - Antibiotics*** | | |
| ***dapsone*** | Covered | |
| ***Lincosamides*** - Antibiotics*** | | |
| ***clindamycin hcl*** | Covered | |
| ***clindamycin palmitate hcl*** | Covered | |
| ***clindamycin phosphate*** | Covered | PA |
| ***clindamycin phosphate in d5w*** | Covered | PA |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***clindamycin phosphate in nacl*** | Covered | PA |
| ****Monobactams*** - Antibiotics*** | | |
| **AZACTAM IN DEXTROSE** (***aztreonam-dextrose***) | Covered | PA |
| ****Oxazolidinones*** - Antibiotics*** | | |
| ***linezolid*** | Covered | PA |
| ***linezolid in sodium chloride*** | Covered | PA |
| **SIVEXTRO** (***tedizolid phosphate***) | Covered | PA |
| **ZYVOX** (***linezolid***) | Covered | PA |
| ****Streptogramin Combinations*** - Antibiotics*** | | |
| **SYNERCID** (***quinupristin-dalfopristin***) | Covered | PA |
| ****Urinary Anti-Infectives*** - Antibiotics*** | | |
| ***methenamine hippurate*** | Covered | |
| ***methenamine mandelate*** | Covered | |
| ***nitrofurantoin*** | Covered | AL (Max 12 Years) |
| ***nitrofurantoin macrocrystal*** | Covered | |
| ***nitrofurantoin monohyd macro*** | Covered | |
| ***Antimalarials* - Drugs For Infections** | | |
| ****Antimalarial Combinations*** - Drugs For Parasites*** | | |
| ***atovaquone-proguanil hcl oral tablet 250-100 mg*** | Covered | QL (1 EA per 1 day) |
| ***atovaquone-proguanil hcl oral tablet 62.5-25 mg*** | Covered | QL (3 EA per 1 day) |
| ****Antimalarials*** - Drugs For Parasites*** | | |
| ***chloroquine phosphate*** | Covered | |
| ***hydroxychloroquine sulfate*** | Covered | |
| ***mefloquine hcl*** | Covered | |
| ***primaquine phosphate*** | Covered | QL (2 EA per 1 day) |
| ***pyrimethamine*** | Covered | PA |
| ***Antimyasthenic/Cholinergic Agents* - Drugs For Nerves And Muscles** | | |
| ****Antimyasthenic/Cholinergic Agents*** - Drugs For Nerves And Muscles*** | | |
| ***pyridostigmine bromide*** | Covered | |
| ***Antimycobacterial Agents* - Drugs For Infections** | | |
| ****Antimycobacterial Agents*** - Antibiotics*** | | |
| ***ethambutol hcl*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***isoniazid*** | Covered | |
| ***pyrazinamide*** | Covered | |
| ***rifabutin*** | Covered | |
| ***rifampin intravenous*** | Covered | PA |
| ***rifampin oral*** | Covered | |
| **PRIFTIN** (***rifapentine***) | Covered | |
| ***Antineoplastics And Adjunctive Therapies* - Drugs For Cancer** | | |
| ****Alkylating Agents*** - Drugs For Cancer*** | | |
| **MYLERAN** (***busulfan***) | Covered | |
| ****Androgen Biosynthesis Inhibitors*** - Drugs For Cancer*** | | |
| ***abiraterone acetate*** | Covered | PA |
| ****Antiadrenals*** - Drugs For Cancer*** | | |
| **LYSODREN** (***mitotane***) | Covered | |
| ****Antiandrogens*** - Drugs For Cancer*** | | |
| ***bicalutamide*** | Covered | QL (30 EA per 30 days) |
| ***flutamide*** | Covered | |
| ****Antiestrogens*** - Drugs For Cancer*** | | |
| ***tamoxifen citrate*** | Covered | |
| ***toremifene citrate*** | Covered | |
| **SOLTAMOX** (***tamoxifen citrate***) | Covered | |
| ****Antimetabolites*** - Drugs For Cancer*** | | |
| ***capecitabine oral tablet 150 mg*** | Covered | PA; QL (140 EA per 21 days) |
| ***capecitabine oral tablet 500 mg*** | Covered | PA; QL (154 EA per 21 days) |
| ***mercaptopurine*** | Covered | |
| ***methotrexate*** | Covered | |
| ***methotrexate sodium (pf)*** | Covered | |
| **TABLOID** (***thioguanine***) | Covered | |
| ****Antineoplastic - Alk Inhibitors*** - Drugs For Cancer*** | | |
| **ALECENSA** (***alectinib hcl***) | Covered | PA |
| **ZYKADIA** (***ceritinib***) | Covered | PA |
| ****Antineoplastic - Anti-Cd20 Antibodies*** - Drugs For Cancer*** | | |
| **RITUXAN** (***rituximab***) | Covered | PA |
| ****Antineoplastic - Anti-Cd38 Antibodies*** - Drugs For Cancer*** | | |
| **DARZALEX** (***daratumumab***) | Covered | PA |

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|---|---|---|
| ***Antineoplastic - Anti-Her2 Agents*** - Drugs For Cancer*** | | |
| **HERCEPTIN** (***trastuzumab***) | Covered | PA |
| **TUKYSA** (***tucatinib***) | Covered | PA |
| ***Antineoplastic - Anti-Pd-1 Antibodies*** - Drugs For Cancer*** | | |
| **OPDIVO** (***nivolumab***) | Covered | PA |
| ***Antineoplastic - Bcl-2 Inhibitors*** - Drugs For Cancer*** | | |
| **VENCLEXTA** (***venetoclax***) | Covered | PA |
| **VENCLEXTA STARTING PACK** (***venetoclax***) | Covered | PA |
| ***Antineoplastic - Bcr-Abl Kinase Inhibitors*** - Drugs For Cancer*** | | |
| ***imatinib mesylate oral tablet 100 mg*** | Covered | PA; QL (3 EA per 1 day) |
| ***imatinib mesylate oral tablet 400 mg*** | Covered | PA; QL (2 EA per 1 day) |
| **SPRYCEL** (***dasatinib***) | Covered | QL (1 EA per 1 day) |
| **TASIGNA** (***nilotinib hcl***) | Covered | PA; QL (4 EA per 1 day) |
| ***Antineoplastic - Braf Kinase Inhibitors*** - Drugs For Cancer*** | | |
| **TAFINLAR** (***dabrafenib mesylate***) | Covered | PA |
| ***Antineoplastic - Btk Inhibitors*** - Drugs For Cancer*** | | |
| **IMBRUVICA ORAL CAPSULE 140 MG** (***ibrutinib***) | Covered | PA; QL (4 EA per 1 day) |
| **IMBRUVICA ORAL CAPSULE 70 MG** (***ibrutinib***) | Covered | PA; QL (1 EA per 1 day) |
| ***Antineoplastic - Egfr Inhibitors*** - Drugs For Cancer*** | | |
| ***erlotinib hcl*** | Covered | QL (1 EA per 1 day) |
| **GILOTRIF** (***afatinib dimaleate***) | Covered | PA |
| ***Antineoplastic - Hedgehog Pathway Inhibitors*** - Drugs For Cancer*** | | |
| **ERIVEDGE** (***vismodegib***) | Covered | PA |
| ***Antineoplastic - Mek Inhibitors*** - Drugs For Cancer*** | | |
| **MEKINIST** (***trametinib dimethyl sulfoxide***) | Covered | PA |
| ***Antineoplastic - Mtor Kinase Inhibitors*** - Drugs For Cancer*** | | |
| ***everolimus*** | Covered | PA; QL (1 EA per 1 day) |
| ***Antineoplastic - Multikinase Inhibitors*** - Drugs For Cancer*** | | |
| ***sunitinib malate*** | Covered | PA; QL (1 EA per 1 day) |
| **CABOMETYX** (***cabozantinib s-malate***) | Covered | PA; QL (1 EA per 1 day) |
| **RYDAPT** (***midostaurin***) | Covered | PA |
| **TYKERB** (***lapatinib ditosylate***) | Covered | PA; QL (6 EA per 1 day) |
| **VOTRIENT** (***pazopanib hcl***) | Covered | PA; QL (4 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Antineoplastic - Pdgfr-Alpha Inhibitors*** - Drugs For Cancer*** | | |
| **LARTRUVO** (***olaratumab***) | Covered | PA |
| ***Antineoplastic Antibiotics*** - Drugs For Cancer*** | | |
| ***doxorubicin hcl*** | Covered | PA |
| ***doxorubicin hcl*** (Adriamycin) | Covered | PA |
| ***Antineoplastics Misc.*** - Drugs For Cancer*** | | |
| ***hydroxyurea*** | Covered | |
| **ACTIMMUNE** (***interferon gamma-1b***) | Covered | PA |
| **INTRON A** (***interferon alfa-2b***) | Covered | PA |
| **MATULANE** (***procarbazine hcl***) | Covered | |
| ***Aromatase Inhibitors*** - Drugs For Cancer*** | | |
| ***anastrozole*** | Covered | QL (30 EA per 30 days) |
| ***exemestane*** | Covered | QL (30 EA per 30 days) |
| ***letrozole*** | Covered | QL (30 EA per 30 days) |
| ***Cyclin-Dependent Kinases (Cdk) Inhibitors*** - Drugs For Cancer*** | | |
| **IBRANCE** (***palbociclib***) | Covered | PA; QL (1 EA per 1 day) |
| ***Estrogens-Antineoplastic*** - Drugs For Cancer*** | | |
| **EMCYT** (***estramustine phosphate sodium***) | Covered | |
| ***Folic Acid Antagonists Rescue Agents*** - Drugs For Cancer*** | | |
| ***leucovorin calcium*** | Covered | |
| ***Imidazotetrazines*** - Drugs For Cancer*** | | |
| ***temozolomide*** | Covered | |
| ***Janus Associated Kinase (Jak) Inhibitors*** - Drugs For Cancer*** | | |
| **JAKAFI** (***ruxolitinib phosphate***) | Covered | PA |
| ***Lhrh Analogs*** - Drugs For Cancer*** | | |
| ***leuprolide acetate*** | Covered | PA |
| **ELIGARD** (***leuprolide acetate (3 month)***) | Covered | PA |
| **LUPRON DEPOT (3-MONTH)** (***leuprolide acetate (3 month)***) | Covered | PA |
| **ZOLADEX** (***goserelin acetate***) | Covered | PA |
| ***Mitotic Inhibitors*** - Drugs For Cancer*** | | |
| ***docetaxel*** | Covered | PA |
| ***etoposide*** | Covered | |
| ***vincristine sulfate*** | Covered | PA |
| ***vincristine sulfate*** (Vincasar Pfs) | Covered | PA |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Nitrogen Mustards And Related Analogues*** - Drugs For Cancer** | | |
| ***cyclophosphamide*** | Covered | |
| ***melphalan*** | Covered | |
| **LEUKERAN** (***chlorambucil***) | Covered | |
| ***Poly (Adp-Ribose) Polymerase (Parp) Inhibitors*** - Drugs For Cancer** | | |
| **LYNPARZA** (***olaparib***) | Covered | PA; QL (4 EA per 1 day) |
| ***Progestins-Antineoplastic*** - Drugs For Cancer** | | |
| ***megestrol acetate*** | Covered | |
| ***Retinoids*** - Drugs For Cancer** | | |
| ***tretinoin*** | Covered | |
| ***Urinary Tract Protective Agents*** - Drugs For Cancer** | | |
| **MESNEX** (***mesna***) | Covered | |
| ***Vascular Endothelial Growth Factor (Vegf) Inhibitors*** - Drugs For Cancer** | | |
| **INLYTA** (***axitinib***) | Covered | PA; QL (4 EA per 1 day) |
| **LENVIMA (10 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| **LENVIMA (12 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| **LENVIMA (14 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| **LENVIMA (18 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| **LENVIMA (20 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| **LENVIMA (24 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| **LENVIMA (4 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| **LENVIMA (8 MG DAILY DOSE)** (***lenvatinib mesylate***) | Covered | PA |
| ***Antiparkinson And Related Therapy Agents* - Drugs For The Nervous System** | | |
| ***Antiparkinson Anticholinergics*** - Drugs For Parkinson** | | |
| ***benztropine mesylate*** | State Carve Out | |
| ***trihexyphenidyl hcl*** | State Carve Out | |
| **COGENTIN** (***benztropine mesylate***) | State Carve Out | |
| ***Antiparkinson Dopaminergics*** - Drugs For Parkinson** | | |
| ***amantadine hcl*** | State Carve Out | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***bromocriptine mesylate*** | Covered | |
| **GOCOVRI** (***amantadine hcl***) | State Carve Out | |
| ****Antiparkinson Monoamine Oxidase Inhibitors*** - Drugs For Parkinson*** | | |
| ***selegiline hcl*** | Covered | |
| ****Levodopa Combinations*** - Drugs For Parkinson*** | | |
| ***carbidopa-levodopa*** | Covered | |
| ***carbidopa-levodopa er*** | Covered | |
| ***carbidopa-levodopa-entacapone*** | Covered | QL (9 EA per 1 day) |
| ****Nonergoline Dopamine Receptor Agonists*** - Drugs For Parkinson*** | | |
| ***pramipexole dihydrochloride*** | Covered | |
| ***ropinirole hcl*** | Covered | QL (90 EA per 30 days) |
| ***ropinirole hcl er oral tablet extended release 24 hour 12 mg*** | Covered | ST; QL (2 EA per 1 day) |
| ***ropinirole hcl er oral tablet extended release 24 hour 2 mg, 4 mg, 6 mg, 8 mg*** | Covered | ST; QL (1 EA per 1 day) |
| ****Peripheral Comt Inhibitors*** - Drugs For Parkinson*** | | |
| ***entacapone*** | Covered | QL (120 EA per 30 days) |
| ***Antipsychotics/Antimanic Agents* - Drugs For The Nervous System** | | |
| ****Antimanic Agents*** - Drugs For Severe Mental Disorders*** | | |
| ***lithium*** | State Carve Out | |
| ***lithium carbonate*** | State Carve Out | |
| ***lithium carbonate er*** | State Carve Out | |
| ****Antipsychotics - Misc.*** - Drugs For Severe Mental Disorders*** | | |
| ***ziprasidone hcl*** | State Carve Out | |
| **GEODON** (***ziprasidone mesylate***) | State Carve Out | |
| **LATUDA** (***lurasidone hcl***) | State Carve Out | |
| **NUPLAZID** (***pimavanserin tartrate***) | State Carve Out | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **VRAYLAR** (***cariprazine hcl***) | State Carve Out | |
| ***Benzisoxazoles*** - Drugs For Severe Mental Disorders*** | | |
| ***paliperidone er*** | State Carve Out | |
| ***risperidone*** | State Carve Out | |
| **FANAPT** (***iloperidone***) | State Carve Out | |
| **FANAPT TITRATION PACK** (***iloperidone***) | State Carve Out | |
| **INVEGA** (***paliperidone***) | State Carve Out | |
| **INVEGA SUSTENNA** (***paliperidone palmitate***) | State Carve Out | |
| **INVEGA TRINZA** (***paliperidone palmitate***) | State Carve Out | |
| **PERSERIS** (***risperidone***) | State Carve Out | |
| **RISPERDAL** (***risperidone***) | State Carve Out | |
| **RISPERDAL CONSTA** (***risperidone microspheres***) | State Carve Out | |
| ***risperidone*** (Risperidone M-Tab) | State Carve Out | QL (2 EA per 1 day); AL (Min 18 Years) |
| ***Butyrophenones*** - Drugs For Severe Mental Disorders*** | | |
| ***haloperidol*** | State Carve Out | |
| ***haloperidol decanoate*** | State Carve Out | |
| ***haloperidol lactate*** | State Carve Out | |
| ***Dibenzodiazepines*** - Drugs For Severe Mental Disorders*** | | |
| ***clozapine*** | State Carve Out | |
| ***Dibenzo-Oxepino Pyrroles*** - Drugs For Severe Mental Disorders*** | | |
| **SAPHRIS** (***asenapine maleate***) | State Carve Out | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Dibenzothiazepines*** - Drugs For Severe Mental Disorders*** | | |
| ***quetiapine fumarate*** | State Carve Out | |
| ***quetiapine fumarate er*** | State Carve Out | |
| **SEROQUEL XR** (***quetiapine fumarate***) | State Carve Out | |
| ***Dibenzoxazepines*** - Drugs For Severe Mental Disorders*** | | |
| ***loxapine succinate*** | State Carve Out | |
| ***Phenothiazines*** - Drugs For Severe Mental Disorders*** | | |
| ***chlorpromazine hcl*** | State Carve Out | |
| ***fluphenazine decanoate*** | State Carve Out | |
| ***fluphenazine hcl*** | State Carve Out | |
| ***perphenazine*** | State Carve Out | |
| ***prochlorperazine*** | Covered | |
| ***prochlorperazine maleate*** | Covered | |
| ***thioridazine hcl*** | State Carve Out | |
| ***trifluoperazine hcl*** | State Carve Out | |
| ***prochlorperazine*** (Compro) | Covered | |
| ***Quinolinone Derivatives*** - Drugs For Severe Mental Disorders*** | | |
| ***aripiprazole*** | State Carve Out | |
| **ABILIFY** (***aripiprazole***) | State Carve Out | |
| **ABILIFY MAINTENA** (***aripiprazole***) | State Carve Out | |
| **ARISTADA** (***aripiprazole lauroxil***) | State Carve Out | |
| **ARISTADA INITIO** (***aripiprazole lauroxil***) | State Carve Out | |

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|---|---|---|
| **REXULTI** (***brexpiprazole***) | State Carve Out | |
| ***Thienbenzodiazepines*** - Drugs For Severe Mental Disorders** | | |
| ***olanzapine*** | State Carve Out | |
| **ZYPREXA RELPREVV** (***olanzapine pamoate***) | State Carve Out | |
| ***Thioxanthenes*** - Drugs For Severe Mental Disorders** | | |
| ***thiothixene*** | State Carve Out | |
| ***Antiseptics & Disinfectants* - Antiseptics And Disinfectants** | | |
| ***Antiseptic Combinations*** - Antiseptics And Disinfectants** | | |
| ***antiseptic skin cleanser*** | Covered | OTC; QL (64 ML per 1 day) |
| **ALCO-GEL** (***antiseptic products, misc.***) | Covered | OTC; QL (53.33 ML per 1 day) |
| **DURAPREP** (***antiseptic products, misc.***) | Covered | OTC; QL (64 EA per 1 day) |
| **ISAGEL** (***antiseptic products, misc.***) | Covered | OTC; QL (53.33 ML per 1 day) |
| ***Chlorine Antiseptics*** - Antiseptics And Disinfectants** | | |
| ***chlorhexidine gluconate*** | Covered | |
| ***Antivirals* - Drugs For Infections** | | |
| ***Antiretroviral Combinations*** - Drugs For Viral Infections** | | |
| ***abacavir sulfate-lamivudine*** | State Carve Out | |
| ***abacavir-lamivudine-zidovudine*** | State Carve Out | |
| ***lamivudine-zidovudine*** | State Carve Out | |
| ***lopinavir-ritonavir*** | State Carve Out | |
| **ATRIPLA** (***efavirenz-emtricitab-tenofovir***) | State Carve Out | |
| **BIKTARVY** (***bictegravir-emtricitab-tenofov***) | State Carve Out | |
| **CIMDUO** (***lamivudine-tenofovir***) | State Carve Out | |
| **COMBIVIR** (***lamivudine-zidovudine***) | State Carve Out | |

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|---|---|---|
| **COMPLERA** (***emtricitab-rilpivir-tenofovir***) | State Carve Out | |
| **DELSTRIGO** (***doravirin-lamivudin-tenofov df***) | State Carve Out | |
| **DESCOVY** (***emtricitabine-tenofovir af***) | State Carve Out | |
| **DOVATO** (***dolutegravir-lamivudine***) | State Carve Out | |
| **EPZICOM** (***abacavir sulfate-lamivudine***) | State Carve Out | |
| **EVOTAZ** (***atazanavir-cobicistat***) | State Carve Out | |
| **GENVOYA** (***elviteg-cobic-emtricit-tenofaf***) | State Carve Out | |
| **JULUCA** (***dolutegravir-rilpivirine***) | State Carve Out | |
| **KALETRA** (***lopinavir-ritonavir***) | State Carve Out | |
| **ODEFSEY** (***emtricitab-rilpivir-tenofov af***) | State Carve Out | |
| **PREZCOBIX** (***darunavir-cobicistat***) | State Carve Out | |
| **STRIBILD** (***elviteg-cobic-emtricit-tenofdf***) | State Carve Out | |
| **SYMFI** (***efavirenz-lamivudine-tenofovir***) | State Carve Out | |
| **SYMFI LO** (***efavirenz-lamivudine-tenofovir***) | State Carve Out | |
| **SYMTUZA** (***darun-cobic-emtricit-tenofaf***) | State Carve Out | |
| **TRIUMEQ** (***abacavir-dolutegravir-lamivud***) | State Carve Out | |
| **TRIZIVIR** (***abacavir-lamivudine-zidovudine***) | State Carve Out | |
| **TRUVADA** (***emtricitabine-tenofovir df***) | State Carve Out | |

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|---|---|---|
| ***Antiretrovirals - Ccr5 Antagonists (Entry Inhibitor)*** - Drugs For Viral Infections*** | | |
| **SELZENTRY** (***maraviroc***) | State Carve Out | |
| ***Antiretrovirals - Cd4-Directed Post-Attachment Inhibitor*** - Drugs For Viral Infections*** | | |
| **TROGARZO** (***ibalizumab-uiyk***) | Covered | PA |
| ***Antiretrovirals - Fusion Inhibitors*** - Drugs For Viral Infections*** | | |
| **FUZEON** (***enfuvirtide***) | State Carve Out | |
| ***Antiretrovirals - Integrase Inhibitors*** - Drugs For Viral Infections*** | | |
| **ISENTRESS** (***raltegravir potassium***) | State Carve Out | |
| **ISENTRESS HD** (***raltegravir potassium***) | State Carve Out | |
| **TIVICAY** (***dolutegravir sodium***) | State Carve Out | |
| ***Antiretrovirals - Protease Inhibitors*** - Drugs For Viral Infections*** | | |
| ***atazanavir sulfate*** | State Carve Out | |
| ***fosamprenavir calcium*** | State Carve Out | |
| ***ritonavir*** | State Carve Out | |
| **APTIVUS** (***tipranavir***) | State Carve Out | |
| **CRIXIVAN** (***indinavir sulfate***) | State Carve Out | |
| **INVIRASE** (***saquinavir mesylate***) | State Carve Out | |
| **LEXIVA** (***fosamprenavir calcium***) | State Carve Out | |
| **NORVIR** (***ritonavir***) | State Carve Out | |
| **PREZISTA** (***darunavir ethanolate***) | State Carve Out | |
| **REYATAZ** (***atazanavir sulfate***) | State Carve Out | |

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**Coverage Requirements and Limits**
**AL** = Age Restrictions
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **VIRACEPT** (***nelfinavir mesylate***) | State Carve Out | |
| ****Antiretrovirals - Rti-Non-Nucleoside Analogues*** - Drugs For Viral Infections*** | | |
| ***efavirenz*** | State Carve Out | |
| ***nevirapine*** | State Carve Out | |
| ***nevirapine er*** | State Carve Out | |
| **EDURANT** (***rilpivirine hcl***) | State Carve Out | |
| **INTELENCE** (***etravirine***) | State Carve Out | |
| **PIFELTRO** (***doravirine***) | State Carve Out | |
| **RESCRIPTOR** (***delavirdine mesylate***) | State Carve Out | |
| **SUSTIVA** (***efavirenz***) | State Carve Out | |
| **VIRAMUNE** (***nevirapine***) | State Carve Out | |
| **VIRAMUNE XR** (***nevirapine***) | State Carve Out | |
| ****Antiretrovirals - Rti-Nucleoside Analogues-Purines*** - Drugs For Viral Infections*** | | |
| ***abacavir sulfate*** | State Carve Out | |
| ***didanosine*** | State Carve Out | |
| **VIDEX EC** (***didanosine***) | State Carve Out | |
| **ZIAGEN** (***abacavir sulfate***) | State Carve Out | |
| ****Antiretrovirals - Rti-Nucleoside Analogues-Pyrimidines*** - Drugs For Viral Infections*** | | |
| ***lamivudine*** | State Carve Out | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **EMTRIVA** (***emtricitabine***) | State Carve Out | |
| **EPIVIR** (***lamivudine***) | State Carve Out | |
| ***Antiretrovirals - Rti-Nucleoside Analogues-Thymidines*** - Drugs For Viral Infections*** | | |
| ***stavudine*** | State Carve Out | |
| ***zidovudine*** | State Carve Out | |
| **RETROVIR INTRAVENOUS** (***zidovudine***) | Covered | PA |
| **RETROVIR ORAL** (***zidovudine***) | State Carve Out | |
| **ZERIT** (***stavudine***) | State Carve Out | |
| ***Antiretrovirals - Rti-Nucleotide Analogues*** - Drugs For Viral Infections*** | | |
| ***tenofovir disoproxil fumarate*** | State Carve Out | |
| **VIREAD** (***tenofovir disoproxil fumarate***) | State Carve Out | |
| ***Antiretrovirals Adjuvants*** - Drugs For Viral Infections*** | | |
| **TYBOST** (***cobicistat***) | State Carve Out | |
| ***Cmv Agents*** - Drugs For Viral Infections*** | | |
| ***cidofovir*** | Covered | PA |
| ***ganciclovir*** | Covered | PA |
| ***ganciclovir sodium*** | Covered | PA |
| ***valganciclovir hcl*** | Covered | QL (2 EA per 1 day) |
| **FOSCAVIR** (***foscarnet sodium***) | Covered | PA |
| **PREVYMIS** (***letermovir***) | Covered | PA |
| ***Hepatitis B Agents*** - Drugs For Viral Infections*** | | |
| ***entecavir*** | Covered | QL (1 EA per 1 day) |
| ***lamivudine*** | State Carve Out | |
| **EPIVIR HBV** (***lamivudine***) | State Carve Out | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **VEMLIDY** (***tenofovir alafenamide fumarate***) | State Carve Out | |
| ***Hepatitis C Agent - Combinations*** - Drugs For Viral Infections*** | | |
| ***sofosbuvir-velpatasvir*** | Covered | PA; QL (1 EA per 1 day) |
| **MAVYRET** (***glecaprevir-pibrentasvir***) | Covered | PA |
| ***Hepatitis C Agents*** - Drugs For Viral Infections*** | | |
| **PEGASYS** (***peginterferon alfa-2a***) | Covered | PA; QL (4 Units per 28 days) |
| **PEGASYS PROCLICK** (***peginterferon alfa-2a***) | Covered | PA; QL (4 Units per 28 days) |
| **PEGINTRON** (***peginterferon alfa-2b***) | Covered | PA; QL (4 Units per 28 days) |
| ***ribavirin*** (Ribasphere) | Covered | ST |
| ***Herpes Agents - Purine Analogues*** - Drugs For Viral Infections*** | | |
| ***acyclovir oral capsule*** | Covered | QL (60 EA per 30 days) |
| ***acyclovir oral suspension*** | Covered | AL (Max 12 Years) |
| ***acyclovir oral tablet*** | Covered | QL (60 EA per 30 days) |
| ***acyclovir sodium*** | Covered | PA |
| ***valacyclovir hcl oral tablet 1 gm*** | Covered | QL (30 EA per 30 days) |
| ***valacyclovir hcl oral tablet 500 mg*** | Covered | QL (60 EA per 30 days) |
| ***Herpes Agents - Thymidine Analogues*** - Drugs For Viral Infections*** | | |
| ***famciclovir*** | Covered | QL (21 EA Max Qty Per Fill Retail) |
| ***Influenza Agents*** - Drugs For Viral Infections*** | | |
| ***rimantadine hcl*** | Covered | QL (14 EA Max Qty Per Fill Retail) |
| ***Neuraminidase Inhibitors*** - Drugs For Viral Infections*** | | |
| ***oseltamivir phosphate oral capsule 30 mg*** | Covered | QL (10 EA per 1 fill); AL (Max 12 Years) |
| ***oseltamivir phosphate oral capsule 45 mg, 75 mg*** | Covered | QL (10 EA per 1 fill) |
| ***oseltamivir phosphate oral suspension reconstituted*** | Covered | QL (180 ML per 1 fill); AL (Max 12 Years) |
| **RAPIVAB** (***peramivir***) | Covered | PA |
| **TAMIFLU** (***oseltamivir phosphate***) | Covered | QL (10 EA per 1 fill) |
| ***Beta Blockers* - Drugs For The Heart** | | |
| ***Alpha-Beta Blockers*** - Drugs For High Blood Pressure*** | | |
| ***carvedilol*** | Covered | QL (60 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***labetalol hcl*** | Covered | |
| ****Beta Blockers Cardio-Selective*** - Drugs For High Blood Pressure*** | | |
| ***acebutolol hcl*** | Covered | |
| ***atenolol*** | Covered | |
| ***bisoprolol fumarate oral tablet 10 mg*** | Covered | QL (120 EA per 30 days) |
| ***bisoprolol fumarate oral tablet 5 mg*** | Covered | QL (30 EA per 30 days) |
| ***metoprolol succinate er oral tablet extended release 24 hour 100 mg, 50 mg*** | Covered | QL (45 EA per 30 days) |
| ***metoprolol succinate er oral tablet extended release 24 hour 200 mg*** | Covered | QL (2 EA per 1 day) |
| ***metoprolol succinate er oral tablet extended release 24 hour 25 mg*** | Covered | QL (1 EA per 1 day) |
| ***metoprolol tartrate*** | Covered | |
| ****Beta Blockers Non-Selective*** - Drugs For High Blood Pressure*** | | |
| ***propranolol hcl*** | Covered | |
| ***propranolol hcl er*** | Covered | QL (1 EA per 1 day) |
| ***sotalol hcl*** | Covered | |
| ***sotalol hcl (af)*** | Covered | |
| ***timolol maleate*** | Covered | |
| ***sotalol hcl*** (Sorine) | Covered | |
| ***Calcium Channel Blockers* - Drugs For The Heart** | | |
| ****Calcium Channel Blockers*** - Drugs For High Blood Pressure*** | | |
| ***amlodipine besylate oral tablet 10 mg*** | Covered | QL (1 EA per 1 day) |
| ***amlodipine besylate oral tablet 2.5 mg, 5 mg*** | Covered | QL (2 EA per 1 day) |
| ***diltiazem hcl*** | Covered | QL (120 EA per 30 days) |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 300 mg, 360 mg, 420 mg*** | Covered | QL (30 EA per 30 days) |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 180 mg*** | Covered | QL (3 EA per 1 day) |
| ***diltiazem hcl er beads oral capsule extended release 24 hour 240 mg*** | Covered | QL (60 EA per 30 days) |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg*** | Covered | QL (1 EA per 1 day) |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg*** | Covered | QL (3 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg*** | Covered | QL (2 EA per 1 day) |
| ***diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg*** | Covered | QL (30 EA per 30 days) |
| ***diltiazem hcl er oral capsule extended release 24 hour 120 mg*** | Covered | QL (1 EA per 1 day) |
| ***diltiazem hcl er oral capsule extended release 24 hour 180 mg*** | Covered | QL (3 EA per 1 day) |
| ***diltiazem hcl er oral capsule extended release 24 hour 240 mg*** | Covered | QL (2 EA per 1 day) |
| ***dilt-xr oral capsule extended release 24 hour 120 mg*** | Covered | QL (1 EA per 1 day) |
| ***dilt-xr oral capsule extended release 24 hour 240 mg*** | Covered | QL (2 EA per 1 day) |
| ***felodipine er*** | Covered | QL (30 EA per 30 days) |
| ***isradipine*** | Covered | |
| ***nicardipine hcl*** | Covered | |
| ***nifedipine*** | Covered | |
| ***nifedipine er*** | Covered | QL (30 EA per 30 days) |
| ***nifedipine er osmotic release*** | Covered | QL (30 EA per 30 days) |
| ***verapamil hcl*** | Covered | QL (120 EA per 30 days) |
| ***verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 360 mg*** | Covered | QL (30 EA per 30 days) |
| ***verapamil hcl er oral capsule extended release 24 hour 240 mg*** | Covered | QL (60 EA per 30 days) |
| ***verapamil hcl er oral tablet extended release 120 mg*** | Covered | QL (2 EA per 1 day) |
| ***verapamil hcl er oral tablet extended release 180 mg, 240 mg*** | Covered | QL (60 EA per 30 days) |
| ***nifedipine*** (Afeditab Cr) | Covered | QL (30 EA per 30 days) |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg) | Covered | QL (1 EA per 1 day) |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 240 Mg) | Covered | QL (2 EA per 1 day) |
| ***diltiazem hcl coated beads*** (Cartia Xt Oral Capsule Extended Release 24 Hour 300 Mg) | Covered | QL (30 EA per 30 days) |
| ***nifedipine*** (Nifedical Xl) | Covered | QL (30 EA per 30 days) |
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 300 Mg, 360 Mg) | Covered | QL (30 EA per 30 days) |
| ***diltiazem hcl er beads*** (Taztia Xt Oral Capsule Extended Release 24 Hour 240 Mg) | Covered | QL (60 EA per 30 days) |
| ***Cardiotonics* - Drugs For The Heart** | | |
| ****Cardiac Glycosides*** - Drugs For The Heart*** | | |
| ***digoxin*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***digoxin*** (Digitek) | Covered | |
| ***digoxin*** (Digox) | Covered | |
| **LANOXIN** (***digoxin***) | Covered | |
| ***Cardiovascular Agents - Misc.* - Drugs For The Heart** | | |
| ****Calcium Channel Blocker & Hmg Coa Reductase Inhibit Comb*** - Drugs For Cholesterol*** | | |
| ***amlodipine-atorvastatin*** | Covered | QL (1 EA per 1 day) |
| ****Neprilysin Inhib (Arni)-Angiotensin Ii Recept Antag Comb*** - Drugs For High Blood Pressure*** | | |
| **ENTRESTO** (***sacubitril-valsartan***) | Covered | PA; QL (2 EA per 1 day) |
| ****Prostaglandin Vasodilators*** - Drugs For High Blood Pressure*** | | |
| ***epoprostenol sodium*** | Covered | PA |
| ****Pulmonary Hypertension - Endothelin Receptor Antagonists*** - Drugs For High Blood Pressure*** | | |
| ***ambrisentan*** | Covered | PA; QL (1 EA per 1 day) |
| ***bosentan*** | Covered | PA; QL (2 EA per 1 day) |
| **OPSUMIT** (***macitentan***) | Covered | PA; QL (1 EA per 1 day) |
| ****Pulmonary Hypertension - Phosphodiesterase Inhibitors*** - Drugs For High Blood Pressure*** | | |
| ***sildenafil citrate*** | Covered | PA; QL (3 EA per 1 day) |
| ***tadalafil (pah)*** | Covered | ST; QL (2 EA per 1 day) |
| ****Sinus Node Inhibitors** - Drugs For High Blood Pressure*** | | |
| **CORLANOR** (***ivabradine hcl***) | Covered | PA; QL (2 EA per 1 day) |
| ***Cephalosporins* - Drugs For Infections** | | |
| ****Cephalosporin Combinations*** - Antibiotics*** | | |
| **AVYCAZ** (***ceftazidime-avibactam***) | Covered | PA |
| **ZERBAXA** (***ceftolozane-tazobactam***) | Covered | PA |
| ****Cephalosporins - 1St Generation*** - Antibiotics*** | | |
| ***cefadroxil oral capsule*** | Covered | |
| ***cefadroxil oral suspension reconstituted*** | Covered | AL (Max 12 Years) |
| ***cefadroxil oral tablet*** | Covered | |
| ***cefazolin in sodium chloride*** | Covered | PA |
| ***cefazolin sodium*** | Covered | PA |
| ***cefazolin sodium-dextrose*** | Covered | PA |
| ***cefazolin sodium-nacl*** | Covered | PA |

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|---|---|---|
| ***cephalexin oral capsule*** | Covered | |
| ***cephalexin oral suspension reconstituted*** | Covered | AL (Max 12 Years) |
| ****Cephalosporins - 2Nd Generation*** - Antibiotics*** | | |
| ***cefaclor oral capsule 250 mg*** | Covered | |
| ***cefaclor oral capsule 500 mg*** | Covered | QL (14 EA Max Qty Per Fill Retail) |
| ***cefoxitin sodium*** | Covered | PA |
| ***cefoxitin sodium-dextrose*** | Covered | PA |
| ***cefprozil oral suspension reconstituted*** | Covered | AL (Max 12 Years) |
| ***cefprozil oral tablet*** | Covered | |
| ***cefuroxime axetil*** | Covered | |
| ***cefuroxime sodium*** | Covered | PA |
| ****Cephalosporins - 3Rd Generation*** - Antibiotics*** | | |
| ***cefdinir oral capsule*** | Covered | |
| ***cefdinir oral suspension reconstituted*** | Covered | AL (Max 12 Years) |
| ***cefixime*** | Covered | QL (1 EA Max Qty Per Fill Retail) |
| ***cefpodoxime proxetil oral suspension reconstituted*** | Covered | AL (Max 12 Years) |
| ***cefpodoxime proxetil oral tablet*** | Covered | |
| ***ceftriaxone sodium injection*** | Covered | QL (2 Grams Max Qty Per Fill Retail) |
| ***ceftriaxone sodium intravenous*** | Covered | PA |
| ***ceftazidime*** (Tazicef) | Covered | PA |
| ****Cephalosporins - 4Th Generation*** - Antibiotics*** | | |
| ***cefepime hcl*** | Covered | PA |
| ****Cephalosporins - 5Th Generation*** - Antibiotics*** | | |
| **TEFLARO** (***ceftaroline fosamil***) | Covered | PA |
| ***Chemicals*** | | |
| ****Bulk Chemicals - Am's****** | | |
| ***amantadine hcl*** | State Carve Out | |
| ***aminocaproic acid*** | State Carve Out | |
| ****Bulk Chemicals - Ca's****** | | |
| ***carbazochrome*** | State Carve Out | |

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|---|---|---|
| ***Bulk Chemicals - Ch's*** | | |
| ***chlorpromazine hcl*** | State Carve Out | |
| ***Bulk Chemicals - Et's*** | | |
| ***ethyl oleate*** | Covered | |
| ***Bulk Chemicals - Fe's*** | | |
| ***ferric chloride hexahydrate*** | State Carve Out | |
| ***ferric subsulfate powder*** | State Carve Out | OTC |
| ***ferric subsulfate solution*** | State Carve Out | |
| ***Bulk Chemicals - Fl's*** | | |
| ***fluphenazine decanoate*** | State Carve Out | |
| ***Bulk Chemicals - Ha's*** | | |
| ***haloperidol*** | State Carve Out | |
| ***haloperidol decanoate*** | State Carve Out | |
| ***Bulk Chemicals - La's*** | | |
| ***acidophilus lactobacillus*** | Covered | |
| ***Bulk Chemicals - Le's*** | | |
| ***calcium folinate*** | Covered | |
| ***leucovorin calcium*** | Covered | |
| ***Bulk Chemicals - Li*** | | |
| ***lithium citrate tetrahydrate*** | State Carve Out | |
| ***Bulk Chemicals - Na's*** | | |
| ***naloxone hcl*** | State Carve Out | |
| ***naloxone hcl dihydrate*** | State Carve Out | |
| ***Bulk Chemicals - Pe's*** | | |
| ***perphenazine*** | State Carve Out | |

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|---|---|---|
| ***Bulk Chemicals - Ph's**** | | |
| ***phenelzine sulfate*** | State Carve Out | |
| ***phytonadione*** | Covered | |
| ***vitamin k1*** | Covered | OTC |
| ***Bulk Chemicals - Py's**** | | |
| ***pyrimethamine*** | Covered | |
| ***Bulk Chemicals - Ra**** | | |
| ***racepinephrine hcl*** | State Carve Out | |
| ***Bulk Chemicals - St's**** | | |
| ***stevia extract*** | Covered | |
| ***steviol glycosides*** | Covered | |
| ***stevioside*** | Covered | |
| ***Bulk Chemicals - Th**** | | |
| ***thioridazine hcl*** | State Carve Out | |
| ***Bulk Chemicals - Tr's**** | | |
| ***tranexamic acid*** | State Carve Out | |
| ***Fixed Oils**** | | |
| ***castor oil*** | Covered | |
| ***cottonseed oil*** | Covered | |
| ***hm castor oil*** | Covered | OTC |
| ***olive oil*** | Covered | |
| ***qc castor oil*** | Covered | OTC |
| ***qc sweet oil*** | Covered | OTC |
| ***sesame oil*** | Covered | |
| ***sm sweet oil*** | Covered | OTC |
| ***sweet oil*** | Covered | OTC |
| ***Liquids**** | | |
| ***benzyl benzoate*** | Covered | |
| ***chlorhexidine gluconate*** | Covered | |
| ***glycerin*** | Covered | |
| ***glycerine*** | Covered | |

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|---|---|---|
| ***glycerol formal*** | Covered | |
| ***Solids*** | | |
| ***sorbitol*** | Covered | |
| ***Solvents*** | | |
| ***alcohol (rubbing)*** | Covered | OTC; QL (64 ML per 1 day) |
| ***cvs ethyl alcohol*** | Covered | OTC; QL (64 ML per 1 day) |
| ***eql ethyl alcohol (rubbing)*** | Covered | OTC; QL (64 ML per 1 day) |
| ***ethyl alcohol (rubbing)*** | Covered | OTC; QL (64 ML per 1 day) |
| ***gnp ethyl rubbing alcohol*** | Covered | OTC; QL (64 ML per 1 day) |
| ***gnp rubbing alcohol*** | Covered | OTC; QL (64 ML per 1 day) |
| ***hm ethyl rubbing alcohol*** | Covered | OTC; QL (64 ML per 1 day) |
| ***ra ethyl alcohol*** | Covered | OTC; QL (64 ML per 1 day) |
| ***ra ethyl rubbing alcohol*** | Covered | OTC; QL (64 ML per 1 day) |
| ***sm alcohol*** | Covered | OTC; QL (64 ML per 1 day) |
| ***sm ethyl alcohol (rubbing)*** | Covered | OTC; QL (64 ML per 1 day) |
| ***Contraceptives* - Drugs For Women** | | |
| ***Biphasic Contraceptives - Oral*** - Birth Control Pills*** | | |
| ***desogestrel-ethinyl estradiol*** | Covered | |
| ***viorele*** | Covered | |
| ***desogestrel-ethinyl estradiol*** (Azurette) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Bekyree) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Kariva) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Pimtrea) | Covered | |
| ***Combination Contraceptives - Oral*** - Birth Control Pills*** | | |
| ***alyacen 1/35*** | Covered | |
| ***briellyn*** | Covered | |
| ***desogestrel-ethinyl estradiol*** | Covered | |
| ***drospirenone-ethinyl estradiol*** | Covered | |
| ***ethynodiol diac-eth estradiol*** | Covered | |
| ***levonorgestrel-ethinyl estrad*** | Covered | |
| ***marlissa*** | Covered | |
| ***norethin ace-eth estrad-fe*** | Covered | |
| ***norethindrone acet-ethinyl est*** | Covered | |
| ***norgestimate-eth estradiol*** | Covered | |

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|---|---|---|
| ***levonorgestrel-ethinyl estrad*** (Altavera) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Apri) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Aubra) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Aviane) | Covered | |
| ***norethindrone-eth estradiol*** (Balziva) | Covered | |
| ***norethin ace-eth estrad-fe*** (Blisovi Fe 1.5/30) | Covered | |
| ***norethin ace-eth estrad-fe*** (Blisovi Fe 1/20) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Chateal) | Covered | |
| ***norgestrel-ethinyl estradiol*** (Cryselle-28) | Covered | |
| ***norethindrone-eth estradiol*** (Cyclafem 1/35) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Cyred) | Covered | |
| ***norethindrone-eth estradiol*** (Dasetta 1/35) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Delyla) | Covered | |
| ***norgestrel-ethinyl estradiol*** (Elinest) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Emoquette) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Enskyce) | Covered | |
| ***norgestimate-eth estradiol*** (Estarylla) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Falmina) | Covered | |
| ***drospirenone-ethinyl estradiol*** (Gianvi) | Covered | |
| ***norethin ace-eth estrad-fe*** (Gildess Fe 1.5/30) | Covered | |
| ***norethin ace-eth estrad-fe*** (Gildess Fe 1/20) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Juleber) | Covered | |
| ***norethindrone acet-ethinyl est*** (Junel 1.5/30) | Covered | |
| ***norethindrone acet-ethinyl est*** (Junel 1/20) | Covered | |
| ***norethin ace-eth estrad-fe*** (Junel Fe 1.5/30) | Covered | |
| ***norethin ace-eth estrad-fe*** (Junel Fe 1/20) | Covered | |
| ***ethynodiol diac-eth estradiol*** (Kelnor 1/35) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Kurvelo) | Covered | |
| ***norethindrone acet-ethinyl est*** (Larin 1.5/30) | Covered | |
| ***norethindrone acet-ethinyl est*** (Larin 1/20) | Covered | |
| ***norethin ace-eth estrad-fe*** (Larin Fe 1.5/30) | Covered | |
| ***norethin ace-eth estrad-fe*** (Larin Fe 1/20) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Lessina) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Levora 0.15/30 (28)) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***drospirenone-ethinyl estradiol*** (Loryna) | Covered | |
| ***norgestrel-ethinyl estradiol*** (Low-Ogestrel) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Lutera) | Covered | |
| ***norethindrone acet-ethinyl est*** (Microgestin 1.5/30) | Covered | |
| ***norethindrone acet-ethinyl est*** (Microgestin 1/20) | Covered | |
| ***norethin ace-eth estrad-fe*** (Microgestin Fe 1.5/30) | Covered | |
| ***norethin ace-eth estrad-fe*** (Microgestin Fe 1/20) | Covered | |
| ***norgestimate-eth estradiol*** (Mono-Linyah) | Covered | |
| ***norgestimate-eth estradiol*** (Mononessa) | Covered | |
| ***norethindrone-eth estradiol*** (Necon 0.5/35 (28)) | Covered | |
| ***norethindrone-eth estradiol*** (Necon 1/35 (28)) | Covered | |
| ***drospirenone-ethinyl estradiol*** (Nikki) | Covered | |
| ***norethindrone-eth estradiol*** (Nortrel 0.5/35 (28)) | Covered | |
| ***norethindrone-eth estradiol*** (Nortrel 1/35 (21)) | Covered | |
| ***norethindrone-eth estradiol*** (Nortrel 1/35 (28)) | Covered | |
| ***drospirenone-ethinyl estradiol*** (Ocella) | Covered | |
| **OGESTREL** (***norgestrel-ethinyl estradiol***) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Orsythia) | Covered | |
| ***norethindrone-eth estradiol*** (Philith) | Covered | |
| ***norethindrone-eth estradiol*** (Pirmella 1/35) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Portia-28) | Covered | |
| ***norgestimate-eth estradiol*** (Previfem) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Reclipsen) | Covered | |
| ***norgestimate-eth estradiol*** (Sprintec 28) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Sronyx) | Covered | |
| ***drospirenone-ethinyl estradiol*** (Syeda) | Covered | |
| ***norethin ace-eth estrad-fe*** (Tarina Fe 1/20) | Covered | |
| ***drospirenone-ethinyl estradiol*** (Vestura) | Covered | |
| ***levonorgestrel-ethinyl estrad*** (Vienva) | Covered | |
| ***norethindrone-eth estradiol*** (Vyfemla) | Covered | |
| ***norethindrone-eth estradiol*** (Wera) | Covered | |
| ***drospirenone-ethinyl estradiol*** (Zarah) | Covered | |
| ***ethynodiol diac-eth estradiol*** (Zovia 1/35E (28)) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Combination Contraceptives - Transdermal*** - Birth Control Pills*** | | |
| ***norelgestromin-eth estradiol*** (Xulane) | Covered | |
| ***Combination Contraceptives - Vaginal*** - Birth Control Pills*** | | |
| ***etonogestrel-ethinyl estradiol*** | Covered | QL (1 EA per 30 days) |
| ***Continuous Contraceptives - Oral*** - Birth Control Pills*** | | |
| ***levonorgestrel-ethinyl estrad*** | Covered | |
| ***Emergency Contraceptives*** - Birth Control Pills*** | | |
| **ELLA** (***ulipristal acetate***) | Covered | |
| **NEXT CHOICE ONE DOSE** (***levonorgestrel***) | Covered | OTC; QL (3 Packages per 1 Year) |
| ***Extended-Cycle Contraceptives - Oral*** - Birth Control Pills*** | | |
| ***levonorgest-eth estrad 91-day*** | Covered | |
| ***levonorgest-eth estrad 91-day*** (Introvale) | Covered | |
| ***levonorgest-eth estrad 91-day*** (Jolessa) | Covered | |
| ***levonorgest-eth estrad 91-day*** (Quasense) | Covered | |
| ***levonorgest-eth estrad 91-day*** (Setlakin) | Covered | |
| ***Progestin Contraceptives - Implants*** - Birth Control Pills*** | | |
| **NEXPLANON** (***etonogestrel***) | Covered | |
| ***Progestin Contraceptives - Injectable*** - Birth Control Pills*** | | |
| ***medroxyprogesterone acetate*** | Covered | |
| **DEPO-SUBQ PROVERA 104** (***medroxyprogesterone acetate***) | Covered | |
| ***Progestin Contraceptives - Oral*** - Birth Control Pills*** | | |
| ***norethindrone*** | Covered | |
| ***norethindrone*** (Camila) | Covered | |
| ***norethindrone*** (Deblitane) | Covered | |
| ***norethindrone*** (Errin) | Covered | |
| ***norethindrone*** (Heather) | Covered | |
| ***norethindrone*** (Jencycla) | Covered | |
| ***norethindrone*** (Jolivette) | Covered | |
| ***norethindrone*** (Lyza) | Covered | |
| ***norethindrone*** (Nora-Be) | Covered | |
| ***norethindrone*** (Norlyroc) | Covered | |
| ***norethindrone*** (Sharobel) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Triphasic Contraceptives - Oral*** - Birth Control Pills*** | | |
| ***alyacen 7/7/7*** | Covered | |
| ***levonorg-eth estrad triphasic*** | Covered | |
| ***norgestim-eth estrad triphasic*** | Covered | |
| ***norethin-eth estrad triphasic*** (Aranelle) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Caziant) | Covered | |
| ***norethin-eth estrad triphasic*** (Cyclafem 7/7/7) | Covered | |
| ***norethin-eth estrad triphasic*** (Dasetta 7/7/7) | Covered | |
| ***levonorg-eth estrad triphasic*** (Enpresse-28) | Covered | |
| ***norethin-eth estrad triphasic*** (Leena) | Covered | |
| ***levonorg-eth estrad triphasic*** (Levonest) | Covered | |
| ***levonorg-eth estrad triphasic*** (Myzilra) | Covered | |
| ***norethin-eth estrad triphasic*** (Nortrel 7/7/7) | Covered | |
| ***norethin-eth estrad triphasic*** (Pirmella 7/7/7) | Covered | |
| ***norethindron-ethinyl estrad-fe*** (Tilia Fe) | Covered | |
| ***norgestim-eth estrad triphasic*** (Tri-Estarylla) | Covered | |
| ***norethindron-ethinyl estrad-fe*** (Tri-Legest Fe) | Covered | |
| ***norgestim-eth estrad triphasic*** (Tri-Linyah) | Covered | |
| ***norgestim-eth estrad triphasic*** (Tri-Lo-Sprintec) | Covered | |
| ***norgestim-eth estrad triphasic*** (Trinessa (28)) | Covered | |
| ***norgestim-eth estrad triphasic*** (Tri-Previfem) | Covered | |
| ***norgestim-eth estrad triphasic*** (Tri-Sprintec) | Covered | |
| ***levonorg-eth estrad triphasic*** (Trivora (28)) | Covered | |
| ***desogestrel-ethinyl estradiol*** (Velivet) | Covered | |
| ***Corticosteroids* - Hormones** | | |
| ***Glucocorticosteroids*** - Drugs For Inflammation*** | | |
| ***cortisone acetate*** | Covered | |
| ***dexamethasone*** | Covered | |
| ***dexamethasone sodium phosphate*** | Covered | |
| ***hydrocortisone*** | Covered | |
| ***methylprednisolone oral tablet*** | Covered | |
| ***methylprednisolone oral tablet therapy pack*** | Covered | QL (21 EA per 1 Fill) |
| ***prednisolone*** | Covered | |
| ***prednisolone sodium phosphate*** | Covered | |

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|---|---|---|
| ***prednisone oral solution*** | Covered | AL (Max 12 Years) |
| ***prednisone oral tablet*** | Covered | |
| **DEXAMETHASONE INTENSOL** (***dexamethasone***) | Covered | |
| **SOLU-CORTEF** (***hydrocortisone sod succinate***) | Covered | |
| ****Mineralocorticoids*** - Drugs For Inflammation*** | | |
| ***fludrocortisone acetate*** | Covered | |
| ***Cough/Cold/Allergy* - Drugs For The Lungs** | | |
| ****Antitussive - Nonnarcotic*** - Drugs For Allergies*** | | |
| ***benzonatate oral capsule 100 mg*** | Covered | QL (6 EA per 1 day); AL (Min 10 Years) |
| ***benzonatate oral capsule 200 mg*** | Covered | QL (3 EA per 1 day); AL (Min 10 Years) |
| ***cvs tussin cough*** | Covered | OTC |
| ***cvs tussin maximum strength*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eql tussin cough long-acting*** | Covered | OTC; QL (120 mL per 30 days) |
| ***father johns medicine*** | Covered | OTC |
| ***gnp cough relief*** | Covered | OTC; QL (120 mL per 30 days) |
| ***gnp tussin cough long acting*** | Covered | OTC; QL (120 mL per 30 days) |
| ***hm cough relief*** | Covered | OTC; QL (120 mL per 30 days) |
| ***px tussin max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***qc cough relief*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra tussin cough*** | Covered | OTC |
| ***ra tussin cough adult*** | Covered | OTC |
| ***ra tussin long acting cough*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra tussin maximum strength*** | Covered | OTC; QL (120 mL per 30 days) |
| ***robafen cough*** | Covered | OTC |
| ***silphen dm cough*** | Covered | OTC |
| ***sm cough relief*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tussin cough oral capsule*** | Covered | OTC |
| ***tussin cough oral syrup*** | Covered | OTC; QL (120 mL per 30 days) |
| **ROBITUSSIN LINGERING LA COUGH** (***dextromethorphan hbr***) | Covered | OTC; QL (120 mL per 30 days) |
| **WAL-TUSSIN COUGH LONG ACTING** (***dextromethorphan hbr***) | Covered | OTC; QL (120 mL per 30 days) |
| **WAL-TUSSIN COUGH ORAL CAPSULE** (***dextromethorphan hbr***) | Covered | OTC |
| **WAL-TUSSIN COUGH ORAL SYRUP** (***dextromethorphan hbr***) | Covered | OTC; QL (120 mL per 30 days) |

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|---|---|---|
| ***Antitussive - Opioid*** - Drugs For Cough And Cold*** | | |
| ***hydrocodone-homatropine oral syrup*** | Covered | QL (30 ML per 1 day); AL (Min 18 Years) |
| ***hydrocodone-homatropine oral tablet*** | Covered | QL (6 EA per 1 day); AL (Min 18 Years) |
| ***Antitussive-Expectorant*** - Drugs For Cough And Cold*** | | |
| ***altarussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***biocotron*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cheratussin ac*** | Covered | OTC; QL (180 mL per 30 days); AL (Min 18 Years) |
| ***chest congestion/cough relief*** | Covered | OTC |
| ***childrens cough*** | Covered | OTC; QL (120 mL per 30 days) |
| ***childrens mucus relief cough*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cvs chest congest/cough child*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cvs chest congestion relief dm*** | Covered | OTC |
| ***cvs dm maximum adult*** | Covered | OTC; QL (120 mL per 30 days) |
| ***diabetic siltussin-dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***diabetic siltussin-dm max st*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eq cough childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eq tussin dm cough/chest*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eq tussin dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eql tussin cough/chest dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***eql tussin dm cough/chest cong*** | Covered | OTC; QL (120 mL per 30 days) |
| ***extra action cough*** | Covered | OTC; QL (120 mL per 30 days) |
| ***geri-tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***g-fen dm*** | Covered | OTC |
| ***gnp mucus relief cough child*** | Covered | OTC; QL (120 mL per 30 days) |
| ***gnp mucus relief dm*** | Covered | OTC |
| ***gnp tab tussin dm*** | Covered | OTC |
| ***gnp tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***gnp tussin dm cough*** | Covered | OTC; QL (120 mL per 30 days) |
| ***gnp tussin dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***guaiasorb dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***guaiatussin ac*** | Covered | OTC; QL (180 mL per 30 days); AL (Min 18 Years) |

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|---|---|---|
| ***guaicon dms*** | Covered | OTC; QL (120 mL per 30 days) |
| ***guaifenesin ac*** | Covered | OTC; QL (180 mL per 30 days); AL (Min 18 Years) |
| ***guaifenesin dm*** | Covered | OTC |
| ***guaifenesin-codeine*** | Covered | OTC; QL (180 mL per 30 days); AL (Min 18 Years) |
| ***guaifenesin-dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***hm chest congestion relief dm*** | Covered | OTC |
| ***hm tussin adult dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***medi-tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***mucosa dm*** | Covered | OTC |
| ***mucus relief cough childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***mucus relief dm*** | Covered | OTC |
| ***mucus relief dm cough*** | Covered | OTC |
| ***mucus relief dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***pediatric formula cough/congst*** | Covered | OTC; QL (120 mL per 30 days) |
| ***px tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***qc medifin dm*** | Covered | OTC |
| ***ra tussin cgh/chest congest dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra tussin cough*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra tussin cough dm sugar free*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra tussin cough/chest dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***recofen d*** | Covered | OTC; QL (120 mL per 30 days) |
| ***refenesen dm*** | Covered | OTC |
| ***robafen dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sb cough control dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sb cough control dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***siltussin dm das*** | Covered | OTC; QL (120 mL per 30 days) |
| ***siltussin-dm alcohol free*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sm chest congestion relief dm*** | Covered | OTC |
| ***sm mucus relief cough children*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sm tussin cough/chest congest*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sm tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |

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|---|---|---|
| ***sm tussin dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tgt cough formula dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tgt mucus/cough relief*** | Covered | OTC |
| ***tusnel diabetic*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tussin dm max*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tussin dm max adult*** | Covered | OTC; QL (120 mL per 30 days) |
| ***virtussin a/c*** | Covered | OTC; QL (180 mL per 30 days); AL (Min 18 Years) |
| ***wal-tussin dm*** | Covered | OTC; QL (120 mL per 30 days) |
| **DELSYM CGH/CHEST CONG DM CHILD** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **DELSYM COUGH/CHEST CONGEST DM** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **DIABETIC TUSSIN DM** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **DIABETIC TUSSIN FOR CHILDREN** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **DIABETIC TUSSIN MAX ST** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **FENESIN DM IR** (***dextromethorphan-guaifenesin***) | Covered | OTC |
| **G-TRON** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **MUCINEX COUGH CHILDRENS** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **MUCINEX FAST-MAX DM MAX** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **ROBAFEN DM CGH/CHEST CONGEST** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **ROBAFEN DM COUGH CLEAR** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **ROBITUSSIN COLD COUGH+ CHEST** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **ROBITUSSIN COUGH+CHEST CONG DM** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **ROBITUSSIN TO GO CGH/CHEST DM** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **SAFE TUSSIN DM** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **SORBUGEN NR** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **WAL-TUSSIN COUGH/CHEST DM** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **WAL-TUSSIN COUGH/CHEST DM MAX** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |

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|---|---|---|
| **WAL-TUSSIN DM CGH/CHEST CONG** (***dextromethorphan-guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| ****Antitussive-Expectorants-Decongestant*** - Drugs For Cough And Cold*** | | |
| **TUSNEL C** (***pseudoephedrine-codeine-gg***) | Covered | OTC |
| ****Decongestant & Antihistamine*** - Drugs For Cough And Cold*** | | |
| ***all day allergy d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***all day allergy d-12*** | Covered | OTC; QL (2 EA per 1 day) |
| ***all day allergy-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***allergy d-12*** | Covered | OTC; QL (2 EA per 1 day) |
| ***cetirizine-pseudoephedrine er*** | Covered | OTC; QL (2 EA per 1 day) |
| ***cvs allergy relief-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***eql all day allergy-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***gnp all day allergy-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***hm allergy complete-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***promethazine-phenylephrine*** | Covered | |
| ***px allergy relief d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***ra cetiri-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***sm all day allergy-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***sw allergy relief-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***tgt all day allergy-d*** | Covered | OTC; QL (2 EA per 1 day) |
| ***tgt allergy+ congestion relief*** | Covered | OTC; QL (2 EA per 1 day) |
| **ALAHIST D** (***pheniramine-phenylephrine***) | Covered | OTC |
| **KLS ALLER-TEC D** (***cetirizine-pseudoephedrine***) | Covered | OTC; QL (2 EA per 1 day) |
| **SHOPKO ALLERGY RELIEF-D (CETI)** (***cetirizine-pseudoephedrine***) | Covered | OTC; QL (2 EA per 1 day) |
| **WAL-ZYR D** (***cetirizine-pseudoephedrine***) | Covered | OTC; QL (2 EA per 1 day) |
| ****Expectorants*** - Drugs For Cough And Cold*** | | |
| ***altarussin*** | Covered | OTC; QL (120 mL per 30 days) |
| ***chest congestion childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***childrens mucus relief expect*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cough syrup*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cvs chest congestion childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***cvs tussin adult chest congest*** | Covered | OTC; QL (120 mL per 30 days) |
| ***diabetic siltussin das-na*** | Covered | OTC; QL (120 mL per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***geri-tussin*** | Covered | OTC; QL (120 mL per 30 days) |
| ***gnp mucus relief childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***guaifenesin er*** | Covered | |
| ***guaifenesin oral liquid*** | Covered | OTC |
| ***guaifenesin oral solution 100 mg/5ml*** | Covered | OTC; QL (120 ML per 30 days) |
| ***guaifenesin oral solution 200 mg/10ml, 300 mg/15ml*** | Covered | OTC; QL (120 mL per 30 days) |
| ***guaifenesin oral syrup*** | Covered | OTC; QL (120 mL per 30 days) |
| ***hm tussin adult*** | Covered | OTC; QL (120 mL per 30 days) |
| ***mucus relief chest congestion*** | Covered | OTC; QL (120 mL per 30 days) |
| ***mucus relief er*** | Covered | OTC |
| ***pa mucus relief*** | Covered | OTC |
| ***px tussin*** | Covered | OTC; QL (120 mL per 30 days) |
| ***qc medifin mucus relief child*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra mucus relief*** | Covered | OTC |
| ***ra tussin*** | Covered | OTC; QL (120 mL per 30 days) |
| ***ra tussin chest congestion*** | Covered | OTC; QL (120 mL per 30 days) |
| ***robafen*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sb cough control*** | Covered | OTC; QL (120 mL per 30 days) |
| ***scot-tussin expectorant*** | Covered | OTC; QL (120 mL per 30 days) |
| ***siltussin das*** | Covered | OTC; QL (120 mL per 30 days) |
| ***siltussin sa*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sm mucus relief childrens*** | Covered | OTC; QL (120 mL per 30 days) |
| ***sm tussin mucus+chest congest*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tussin*** | Covered | OTC; QL (120 mL per 30 days) |
| ***tussin mucus+chest congestion*** | Covered | OTC; QL (120 mL per 30 days) |
| ***wal-tussin*** | Covered | OTC; QL (120 mL per 30 days) |
| **BUCKLEYS CHEST CONGESTION** (***guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **DIABETIC TUSSIN** (***guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **DIABETIC TUSSIN EX** (***guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **EQ MUCUS ER** (***guaifenesin***) | Covered | OTC |
| **MUCINEX CHEST CONGESTION CHILD** (***guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| **ROBITUSSIN MUCUS+CHEST CONGEST** (***guaifenesin***) | Covered | OTC; QL (120 mL per 30 days) |
| ****Misc. Respiratory Inhalants*** - Drugs For Allergies*** | | |
| ***nasal mist*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***sodium chloride*** | Covered | |
| **HYPERSAL** (***sodium chloride***) | Covered | |
| **NEBUSAL** (***sodium chloride***) | Covered | |
| ***sodium chloride*** (Pulmosal) | Covered | |
| **SIMPLY SALINE BABY** (***sodium chloride***) | Covered | OTC |
| ****Mucolytics*** - Drugs For The Lungs*** | | |
| ***acetylcysteine*** | Covered | |
| ****Non-Narc Antitussive-Antihistamine*** - Drugs For Cough And Cold*** | | |
| ***promethazine-dm*** | Covered | QL (180 mL per 30 days) |
| ****Non-Narc Antitussive-Decongestant-Antihistamine*** - Drugs For Cough And Cold*** | | |
| ***lohist-dm*** | Covered | OTC |
| ****Opioid Antitussive-Antihistamine*** - Drugs For Cough And Cold*** | | |
| ***promethazine-codeine*** | Covered | QL (180 mL per 30 days); AL (Min 18 Years) |
| **Z-TUSS AC** (***chlorpheniramine-codeine***) | Covered | OTC; AL (Min 18 Years) |
| ****Opioid Antitussive-Decongestant-Antihistamine*** - Drugs For Cough And Cold*** | | |
| ***promethazine vc/codeine*** | Covered | QL (180 mL per 30 days); AL (Min 18 Years) |
| ***Dermatologicals* - Drugs For The Skin** | | |
| ****Acne Antibiotics*** - Drugs For The Skin*** | | |
| ***clindamycin phosphate external gel*** | Covered | QL (1 GM per 1 day) |
| ***clindamycin phosphate external lotion*** | Covered | QL (2 ML per 1 day) |
| ***clindamycin phosphate external solution*** | Covered | QL (2 ML per 1 day) |
| ***clindamycin phosphate external swab*** | Covered | QL (2 EA per 1 day) |
| ***ery*** | Covered | QL (2 EA per 1 day) |
| ***erythromycin external gel*** | Covered | QL (1 GM per 1 day) |
| ***erythromycin external pad*** | Covered | QL (2 EA per 1 day) |
| ***erythromycin external solution*** | Covered | QL (2 ML per 1 day) |
| ***sulfacetamide sodium (acne)*** | Covered | QL (118 ML per 30 days) |
| ***clindamycin phosphate*** (Clindacin Etz) | Covered | QL (2 EA per 1 day) |
| ***clindamycin phosphate*** (Clindacin-P) | Covered | QL (2 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Acne Products*** - Drugs For The Skin** | | |
| ***acne foaming wash*** | Covered | OTC |
| ***acne medication 10*** | Covered | OTC |
| ***acne medication 5*** | Covered | OTC |
| ***acne-clear*** | Covered | OTC |
| ***adapalene*** | Covered | ST; QL (45 GM per 30 days); AL (Max 35 Years) |
| ***benzoyl peroxide cleanser*** | Covered | |
| ***benzoyl peroxide external gel 10 %*** | Covered | |
| ***benzoyl peroxide external gel 2.5 %*** | Covered | OTC |
| ***benzoyl peroxide external lotion*** | Covered | OTC |
| ***benzoyl peroxide wash external liquid 10 %*** | Covered | |
| ***benzoyl peroxide wash external liquid 5 %*** | Covered | OTC |
| ***bp gel*** | Covered | OTC |
| ***bp wash*** | Covered | OTC |
| ***cvs acne foaming face wash*** | Covered | OTC |
| ***cvs acne treatment*** | Covered | OTC |
| ***cvs advanced 3-in-1 cleanser*** | Covered | OTC |
| ***cvs creamy acne face wash*** | Covered | OTC |
| ***cvs foaming acne face wash*** | Covered | OTC |
| ***isotretinoin oral capsule 10 mg, 20 mg, 30 mg*** | Covered | ST; QL (2 EA per 1 day) |
| ***isotretinoin oral capsule 40 mg*** | Covered | ST |
| ***kp benzoyl peroxide*** | Covered | OTC |
| ***kp benzoyl peroxide wash*** | Covered | OTC |
| ***tretinoin*** | Covered | ST; QL (45 GM per 30 days); AL (Max 35 Years) |
| **BENZIQ WASH** (***benzoyl peroxide***) | Covered | |
| ***isotretinoin*** (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg) | Covered | ST; QL (2 EA per 1 day) |
| ***isotretinoin*** (Claravis Oral Capsule 40 Mg) | Covered | ST |
| **CLEAN & CLEAR PERSA-GEL MAX ST** (***benzoyl peroxide***) | Covered | OTC |
| **DIFFERIN** (***adapalene***) | Covered | QL (45 GM per 30 days); AL (Max 35 Years) |
| **PANOXYL WASH** (***benzoyl peroxide***) | Covered | OTC |
| **RA RENEWAL ACNE TREATMENT** (***benzoyl peroxide***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Antibiotic Mixtures Topical*** - Drugs For The Skin*** | | |
| ***cvs antibiotic plus*** | Covered | OTC |
| ***eq antibiotic + pain relief*** | Covered | OTC |
| ***eql antibiotic + pain relief*** | Covered | OTC |
| ***gnp antibiotic plus pramoxine*** | Covered | OTC |
| ***gnp triple antibiotic plus*** | Covered | OTC |
| ***hm triple antibiotic max st*** | Covered | OTC |
| ***multi antibiotic plus*** | Covered | OTC |
| ***ra antibiotic plus*** | Covered | OTC |
| ***ra antibiotic/pain relief*** | Covered | OTC |
| ***ra triple antibiotic plus*** | Covered | OTC |
| ***sm antibiotic plus pain relief*** | Covered | OTC |
| ***sm triple antibiotic max st*** | Covered | OTC |
| ***tgt first aid antibiotic*** | Covered | OTC |
| ***tri-biozene*** | Covered | OTC |
| ***triple antibiotic pain relief*** | Covered | OTC |
| ***triple antibiotic plus*** | Covered | OTC |
| ***triple antibiotic plus max st*** | Covered | OTC |
| **NEOSPORIN + PAIN RELIEF MAX ST** (***neomy-bacit-polymyx-pramoxine***) | Covered | OTC |
| ***Antibiotics - Topical*** - Drugs For The Skin*** | | |
| ***bacitracin*** | Covered | OTC |
| ***bacitracin zinc*** | Covered | |
| ***cvs bacitracin*** | Covered | OTC |
| ***eql bacitracin zinc*** | Covered | OTC |
| ***gentamicin sulfate*** | Covered | |
| ***gnp bacitracin zinc*** | Covered | OTC |
| ***hm bacitracin*** | Covered | OTC |
| ***kp bacitracin zinc*** | Covered | OTC |
| ***mupirocin*** | Covered | QL (110 GM per 30 days) |
| ***qc bacitracin*** | Covered | OTC |
| ***ra bacitracin*** | Covered | OTC |
| ***sb bacitracin*** | Covered | OTC |
| **BACITRAYCIN PLUS** (***bacitracin***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Antifungals - Topical Combinations*** - Drugs For The Skin*** | | |
| ***clotrimazole-betamethasone*** | Covered | QL (60 GM per 30 days) |
| ***Antifungals - Topical*** - Drugs For The Skin*** | | |
| ***antifungal*** | Covered | OTC; QL (133 GM per 30 days) |
| ***athletes foot spray*** | Covered | OTC; QL (133 GM per 30 days) |
| ***butenafine hcl*** | Covered | OTC; QL (30 GM per 30 days) |
| ***ciclopirox external shampoo*** | Covered | ST; QL (120 ML per 30 days) |
| ***ciclopirox external solution*** | Covered | QL (6.6 ML per 30 days) |
| ***ciclopirox olamine external cream*** | Covered | ST; QL (60 GM per 30 days) |
| ***ciclopirox olamine external suspension*** | Covered | ST; QL (30 ML per 30 days) |
| ***nystatin*** | Covered | QL (60 GM per 30 days) |
| ***terbinafine hcl*** | Covered | OTC; QL (60 GM per 30 days) |
| ***tolnaftate external aerosol powder*** | Covered | OTC; QL (133 GM per 30 days) |
| ***tolnaftate external cream*** | Covered | OTC; QL (90 GM per 30 days) |
| ***tolnaftate external powder*** | Covered | OTC; QL (45 GM per 30 days) |
| ***ciclopirox*** (Ciclodan) | Covered | QL (6.6 ML per 30 days) |
| ***nystatin*** (Nyamyc) | Covered | QL (60 GM per 30 days) |
| ***nystatin*** (Nystop) | Covered | QL (60 GM per 30 days) |
| ***Anti-Inflammatory Agents - Topical*** - Drugs For The Skin*** | | |
| ***diclofenac sodium transdermal gel*** | Covered | QL (6.6667 GM per 1 day) |
| ***diclofenac sodium transdermal solution*** | Covered | ST; QL (10 ML per 1 day) |
| ***Antineoplastic Antimetabolites - Topical*** - Drugs For The Skin*** | | |
| ***fluorouracil*** | Covered | |
| **FLUOROPLEX** (***fluorouracil***) | Covered | |
| ***Antipsoriatics*** - Drugs For The Skin*** | | |
| ***calcipotriene external cream*** | Covered | PA; QL (4 GM per 1 day) |
| ***calcipotriene external ointment*** | Covered | PA; QL (4 GM per 1 day) |
| ***calcipotriene external solution*** | Covered | PA; QL (2 ML per 1 day) |
| ***tazarotene*** | Covered | ST; QL (3 GM per 1 day) |
| ***Antiseborrheic Products*** - Drugs For The Skin*** | | |
| ***selenium sulfide*** | Covered | |
| ***sulfacetamide sodium*** | Covered | |
| ***Antivirals - Topical*** - Drugs For The Skin*** | | |
| ***acyclovir*** | Covered | ST; QL (15 GM per 30 days) |

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|---|---|---|
| ***docosanol*** | Covered | OTC; QL (2 GM per 30 days) |
| ****Astringents*** - Drugs For The Skin*** | | |
| ***cvs diaper rash*** | Covered | OTC |
| ***cvs zinc oxide*** | Covered | OTC |
| ***diaper rash*** | Covered | OTC |
| ***gnp zinc oxide*** | Covered | OTC |
| ***meijer zinc oxide*** | Covered | OTC |
| ***ra diaper rash*** | Covered | OTC |
| ***ra zinc oxide*** | Covered | OTC |
| ***zinc oxide*** | Covered | OTC |
| **BOUDREAUXS BUTT PASTE** (***zinc oxide***) | Covered | OTC |
| ****Burn Products*** - Drugs For The Skin*** | | |
| ***silver sulfadiazine*** | Covered | |
| ***silver sulfadiazine*** (Ssd) | Covered | |
| ***silver sulfadiazine*** (Thermazene) | Covered | |
| ****Cauterizing Agent Combinations*** - Drugs For The Skin*** | | |
| **ARZOL SILVER NIT APPLICATORS** (***silver nitrate-pot nitrate***) | Covered | |
| ****Corticosteroids - Topical*** - Drugs For The Skin*** | | |
| ***ala-cort*** | Covered | QL (90 GM per 30 days) |
| ***alclometasone dipropionate*** | Covered | QL (60 GM per 30 days) |
| ***anti-itch maximum strength*** | Covered | OTC; QL (90 GM per 30 days) |
| ***beta hc*** | Covered | OTC |
| ***betamethasone dipropionate aug external cream*** | Covered | QL (50 GM per 30 days) |
| ***betamethasone dipropionate aug external gel*** | Covered | QL (60 GM per 30 days) |
| ***betamethasone dipropionate aug external lotion*** | Covered | QL (60 ML per 30 days) |
| ***betamethasone dipropionate aug external ointment*** | Covered | QL (60 GM per 30 days) |
| ***betamethasone dipropionate external cream*** | Covered | QL (60 GM per 30 days) |
| ***betamethasone dipropionate external lotion*** | Covered | QL (120 ML per 30 days) |
| ***betamethasone dipropionate external ointment*** | Covered | QL (2 GM per 1 day) |
| ***betamethasone valerate external cream*** | Covered | QL (60 GM per 30 days) |
| ***betamethasone valerate external lotion*** | Covered | QL (120 ML per 30 days) |
| ***betamethasone valerate external ointment*** | Covered | QL (45 GM per 30 days) |
| ***clobetasol propionate e*** | Covered | QL (60 GM per 30 days) |
| ***clobetasol propionate external cream*** | Covered | ST; QL (60 GM per 30 days) |

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|---|---|---|
| ***clobetasol propionate external gel*** | Covered | ST; QL (60 GM per 30 days) |
| ***clobetasol propionate external ointment*** | Covered | ST; QL (60 GM per 30 days) |
| ***clobetasol propionate external solution*** | Covered | QL (60 ML per 30 days) |
| ***cvs anti-itch maximum strength*** | Covered | OTC; QL (90 GM per 30 days) |
| ***cvs cortisone intense healing*** | Covered | OTC; QL (90 GM per 30 days) |
| ***cvs cortisone maximum strength*** | Covered | OTC; QL (90 GM per 30 days) |
| ***cvs eczema anti-itch*** | Covered | OTC; QL (90 GM per 30 days) |
| ***cvs hydrocortisone anti-itch*** | Covered | OTC; QL (90 GM per 30 days) |
| ***cvs hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***desoximetasone*** | Covered | |
| ***eq hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***eq hydrocortisone plus*** | Covered | OTC; QL (90 GM per 30 days) |
| ***eql anti-itch intensive heal*** | Covered | OTC; QL (90 GM per 30 days) |
| ***eql anti-itch maximum strength*** | Covered | OTC; QL (90 GM per 30 days) |
| ***fluocinolone acetonide*** | Covered | |
| ***fluocinolone acetonide external cream 0.01 %*** | Covered | |
| ***fluocinolone acetonide external cream 0.025 %*** | Covered | QL (2 GM per 1 day) |
| ***fluocinolone acetonide external ointment*** | Covered | QL (2 GM per 1 day) |
| ***fluocinonide*** | Covered | QL (60 GM per 30 days) |
| ***fluticasone propionate*** | Covered | QL (60 GM per 30 days) |
| ***gnp hydrocortisone*** | Covered | OTC; QL (90 GM per 30 days) |
| ***gnp hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***gnp hydrocortisone plus*** | Covered | OTC; QL (90 GM per 30 days) |
| ***halobetasol propionate*** | Covered | QL (50 GM per 30 days) |
| ***hydrocortisone*** | Covered | |
| ***hydrocortisone acetate*** | Covered | |
| ***hydrocortisone external cream 0.5 %*** | Covered | OTC; QL (90 GM per 30 days) |
| ***hydrocortisone external cream 1 %, 2.5 %*** | Covered | QL (90 GM per 30 days) |
| ***hydrocortisone external lotion 1 %*** | Covered | OTC; QL (120 GM per 30 days) |
| ***hydrocortisone external lotion 2.5 %*** | Covered | QL (120 ML per 30 days) |
| ***hydrocortisone external ointment 0.5 %*** | Covered | OTC; QL (90 GM per 30 days) |
| ***hydrocortisone external ointment 1 %, 2.5 %*** | Covered | QL (90 GM per 30 days) |
| ***hydrocortisone intensive heal*** | Covered | OTC; QL (90 GM per 30 days) |
| ***hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |

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|---|---|---|
| ***hydrocortisone max st/12 moist*** | Covered | OTC; QL (90 GM per 30 days) |
| ***hydrocortisone micronized*** | Covered | |
| ***hydrocortisone plus*** | Covered | OTC; QL (90 GM per 30 days) |
| ***instacort 5*** | Covered | OTC; QL (90 GM per 30 days) |
| ***kp hydrocortisone*** | Covered | OTC; QL (90 GM per 30 days) |
| ***kp hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***meijer hydrocortisone*** | Covered | OTC; QL (90 GM per 30 days) |
| ***mometasone furoate external cream*** | Covered | QL (45 GM per 30 days) |
| ***mometasone furoate external ointment*** | Covered | QL (45 GM per 30 days) |
| ***mometasone furoate external solution*** | Covered | QL (60 ML per 30 days) |
| ***prednicarbate*** | Covered | QL (60 GM per 30 days) |
| ***px hydrocream*** | Covered | OTC; QL (90 GM per 30 days) |
| ***qc hydrocortisone*** | Covered | OTC; QL (90 GM per 30 days) |
| ***qc hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***ra anti-itch maximum strength*** | Covered | OTC; QL (90 GM per 30 days) |
| ***ra hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***ra hydrocortisone plus 12*** | Covered | OTC; QL (90 GM per 30 days) |
| ***recort plus*** | Covered | OTC; QL (90 GM per 30 days) |
| ***sb hydrocortisone*** | Covered | OTC; QL (90 GM per 30 days) |
| ***sb hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***scalp relief maximum strength*** | Covered | OTC; QL (75 ML per 30 days) |
| ***sm hydrocortisone*** | Covered | OTC; QL (90 GM per 30 days) |
| ***sm hydrocortisone max st*** | Covered | OTC; QL (90 GM per 30 days) |
| ***tgt anti-itch plus oatmeal*** | Covered | OTC; QL (90 GM per 30 days) |
| ***tgt anti-itch/aloe/vit e*** | Covered | OTC; QL (90 GM per 30 days) |
| ***triamcinolone acetonide*** | Covered | |
| ***triamcinolone acetonide external cream*** | Covered | QL (90 GM per 30 days) |
| ***triamcinolone acetonide external lotion*** | Covered | QL (120 ML per 30 days) |
| ***triamcinolone acetonide external ointment 0.025 %, 0.5 %*** | Covered | QL (90 GM per 30 days) |
| ***triamcinolone acetonide external ointment 0.1 %*** | Covered | |
| **AVEENO ANTI-ITCH MAX ST** (***hydrocortisone***) | Covered | OTC; QL (90 GM per 30 days) |
| **CORTAID MAXIMUM STRENGTH** (***hydrocortisone***) | Covered | OTC; QL (90 GM per 30 days) |
| **CORTIZONE-10** (***hydrocortisone***) | Covered | OTC; QL (90 GM per 30 days) |
| **GYNECORT 10** (***hydrocortisone acetate***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **KERICORT 10** (***hydrocortisone***) | Covered | OTC; QL (90 GM per 30 days) |
| **LANACORT 10** (***hydrocortisone acetate***) | Covered | OTC |
| **NOBLE FORMULA HC EXTERNAL CREAM** (***hydrocortisone***) | Covered | OTC; QL (90 GM per 30 days) |
| **NOBLE FORMULA HC EXTERNAL SOLUTION** (***hydrocortisone***) | Covered | OTC; QL (75 ML per 30 days) |
| **PREPARATION H** (***hydrocortisone***) | Covered | OTC; QL (90 GM per 30 days) |
| **SCALPICIN MAXIMUM STRENGTH** (***hydrocortisone***) | Covered | OTC; QL (75 ML per 30 days) |
| ***triamcinolone acetonide*** (Triderm) | Covered | QL (90 GM per 30 days) |
| ****Diaper Rash Products*** - Drugs For The Skin*** | | |
| ***cvs all-purpose skin protect*** | Covered | OTC |
| ***cvs pediatric ointment*** | Covered | OTC |
| **MEDI-PASTE** (***diaper rash products***) | Covered | OTC |
| **PALADIN** (***diaper rash products***) | Covered | OTC |
| **PINXAV** (***diaper rash products***) | Covered | OTC |
| ****Emollient Combinations*** - Drugs For The Skin*** | | |
| ***mineral oil-hydrophil petrolat*** | Covered | OTC |
| ****Emollient/Keratolytic Agents*** - Drugs For The Skin*** | | |
| **LANAPHILIC/UREA** (***urea***) | Covered | OTC |
| ****Emollients*** - Drugs For The Skin*** | | |
| ***advanced healing/baby*** | Covered | OTC |
| ***ammonium lactate*** | Covered | |
| ***beauty lotion*** | Covered | OTC |
| ***beta care*** | Covered | OTC |
| ***cocoa butter*** | Covered | OTC |
| ***cocoa butter hand & body*** | Covered | OTC |
| ***cocoa butter skin*** | Covered | OTC |
| ***coconut oil beauty*** | Covered | OTC |
| ***collagen*** | Covered | OTC |
| ***complete moisture*** | Covered | OTC |
| ***cvs advanced healing*** | Covered | OTC |
| ***cvs daily ultra moisture*** | Covered | OTC |
| ***cvs dry skin care*** | Covered | OTC |
| ***cvs extra moisturizing*** | Covered | OTC |
| ***cvs gentle skin cleanser*** | Covered | OTC |
| ***cvs hydrating skin treatment*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***cvs moisturizing*** | Covered | OTC |
| ***cvs moisturizing extra dry*** | Covered | OTC |
| ***cvs pure glycerin*** | Covered | OTC |
| ***cvs skin treatment*** | Covered | OTC |
| ***cvs special care*** | Covered | OTC |
| ***dermaide aloe*** | Covered | OTC |
| ***dhea*** | Covered | OTC |
| ***dmae*** | Covered | OTC |
| ***dry skin treatment*** | Covered | OTC |
| ***dry skin treatment adv therapy*** | Covered | OTC |
| ***e-ointment*** | Covered | OTC |
| ***eq therapeutic moisturizing*** | Covered | OTC |
| ***gentle*** | Covered | OTC |
| ***glycerin*** | Covered | OTC |
| ***gnp advanced recovery*** | Covered | OTC |
| ***gnp glycerin*** | Covered | OTC |
| ***gordomatic*** | Covered | OTC |
| ***hm glycerin*** | Covered | OTC |
| ***hydrophor*** | Covered | OTC |
| ***leader finger cream*** | Covered | OTC |
| ***lubricating lotion*** | Covered | OTC |
| ***moisture*** | Covered | OTC |
| ***moisture recovery*** | Covered | OTC |
| ***moisturizing cream*** | Covered | OTC |
| ***moisturizing lotion*** | Covered | OTC |
| ***moisturizing sensitive skin*** | Covered | OTC |
| ***msm skin*** | Covered | OTC |
| ***ointment base*** | Covered | OTC |
| ***qc glycerin*** | Covered | OTC |
| ***ra advanced recovery*** | Covered | OTC |
| ***ra calming daily moisturizing*** | Covered | OTC |
| ***ra derma*** | Covered | OTC |
| ***ra gentle skin*** | Covered | OTC |
| ***ra glycerin*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***ra hydrating healing*** | Covered | OTC |
| ***ra moisturizing oatmeal*** | Covered | OTC |
| ***ra moisturizing therapy*** | Covered | OTC |
| ***ra renewal dry skin therapy*** | Covered | OTC |
| ***ra renewal moisturizing*** | Covered | OTC |
| ***ra total moisture*** | Covered | OTC |
| ***radiaguard advanced*** | Covered | OTC |
| ***refreshing aloe*** | Covered | OTC |
| ***sm dry skin therapy*** | Covered | OTC |
| ***sm glycerin*** | Covered | OTC |
| ***special care*** | Covered | OTC |
| ***thera-derm*** | Covered | OTC |
| ***therapeutic moisturizing*** | Covered | OTC |
| ***vitamin e with panthenol*** | Covered | OTC |
| **A+D PREVENT** (***vitamins a & d***) | Covered | OTC |
| **AL12** (***ammonium lactate***) | Covered | OTC |
| **AMLACTIN** (***ammonium lactate***) | Covered | OTC |
| **GERI-HYDROLAC 12** (***ammonium lactate***) | Covered | OTC |
| ****Imidazole-Related Antifungals - Topical*** - Drugs For The Skin*** | | |
| ***anti-fungal*** | Covered | OTC; QL (60 GM per 30 days) |
| ***athletes foot*** | Covered | OTC; QL (90 GM per 30 days) |
| ***clotrimazole*** | Covered | QL (30 ML per 30 days) |
| ***clotrimazole af*** | Covered | OTC; QL (60 GM per 30 days) |
| ***cvs anti-fungal*** | Covered | OTC; QL (90 GM per 30 days) |
| ***cvs clotrimazole*** | Covered | OTC; QL (60 GM per 30 days) |
| ***cvs itch relief*** | Covered | OTC; QL (60 GM per 30 days) |
| ***cvs ringworm*** | Covered | OTC; QL (60 GM per 30 days) |
| ***eq antifungal*** | Covered | OTC; QL (60 GM per 30 days) |
| ***eq athletes foot*** | Covered | OTC; QL (60 GM per 30 days) |
| ***eq athletes foot spray*** | Covered | OTC; QL (133 GM per 30 days) |
| ***eq jock itch*** | Covered | OTC; QL (60 GM per 30 days) |
| ***eql antifungal*** | Covered | OTC; QL (60 GM per 30 days) |
| ***eql athletes foot*** | Covered | OTC; QL (60 GM per 30 days) |
| ***gnp athletes foot*** | Covered | OTC; QL (60 GM per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***gnp miconazole nitrate*** | Covered | OTC; QL (133 GM per 30 days) |
| ***gnp miconazorb af*** | Covered | OTC; QL (90 GM per 30 days) |
| ***jock itch*** | Covered | OTC; QL (60 GM per 30 days) |
| ***jock itch relief*** | Covered | OTC; QL (60 GM per 30 days) |
| ***ketoconazole external cream*** | Covered | ST; QL (60 GM per 30 days) |
| ***ketoconazole external shampoo*** | Covered | QL (120 ML per 30 days) |
| ***kp clotrimazole*** | Covered | OTC; QL (60 GM per 30 days) |
| ***miconazole nitrate*** | Covered | QL (90 GM per 30 days) |
| ***pro-ex antifungal*** | Covered | OTC; QL (60 GM per 30 days) |
| ***px athletic foot*** | Covered | OTC; QL (60 GM per 30 days) |
| ***qc clotrimazole*** | Covered | OTC; QL (60 GM per 30 days) |
| ***ra atheletes foot*** | Covered | OTC; QL (133 GM per 30 days) |
| ***ra athletes foot*** | Covered | OTC; QL (60 GM per 30 days) |
| ***ra clotrimazole*** | Covered | OTC; QL (60 GM per 30 days) |
| ***ra jock itch*** | Covered | OTC; QL (60 GM per 30 days) |
| ***sb clotrimazole foot*** | Covered | OTC; QL (60 GM per 30 days) |
| ***sm antifungal clotrimazole*** | Covered | OTC; QL (60 GM per 30 days) |
| ***tgt clotrimazole*** | Covered | OTC; QL (60 GM per 30 days) |
| **CRUEX PRESCRIPTION STRENGTH** (***miconazole nitrate***) | Covered | OTC; QL (133 GM per 30 days) |
| **DESENEX** (***miconazole nitrate***) | Covered | OTC; QL (90 GM per 30 days) |
| **DESENEX JOCK ITCH** (***miconazole nitrate***) | Covered | OTC; QL (133 GM per 30 days) |
| **FUNGICURE INTENSIVE/NAILGUARD** (***clotrimazole***) | Covered | OTC; QL (30 ML per 30 days) |
| **LOTRIMIN AF** (***miconazole nitrate***) | Covered | OTC; QL (90 GM per 30 days) |
| **LOTRIMIN AF DEODORANT POWDER** (***miconazole nitrate***) | Covered | OTC; QL (133 GM per 30 days) |
| **LOTRIMIN AF JOCK ITCH POWDER** (***miconazole nitrate***) | Covered | OTC; QL (133 GM per 30 days) |
| **LOTRIMIN AF POWDER** (***miconazole nitrate***) | Covered | OTC; QL (133 GM per 30 days) |
| **MICRO GUARD** (***miconazole nitrate***) | Covered | OTC; QL (90 GM per 30 days) |
| **REMEDY ANTIFUNGAL** (***miconazole nitrate***) | Covered | OTC; QL (90 GM per 30 days) |
| **REMEDY PHYTOPLEX ANTIFUNGAL** (***miconazole nitrate***) | Covered | OTC; QL (90 GM per 30 days) |
| **ZEASORB-AF** (***miconazole nitrate***) | Covered | OTC; QL (90 GM per 30 days) |
| ****Immunomodulators Imidazoquinolinamines - Topical*** - Drugs For The Skin*** | | |
| ***imiquimod*** | Covered | QL (12 Packets per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Keratolytic/Antimitotic Agents*** - Drugs For The Skin*** | | |
| ***gnp scalp relief*** | Covered | OTC |
| ***podofilox*** | Covered | |
| ***ra scalp itch/dandruff relief*** | Covered | OTC |
| ***salicylic acid*** | Covered | |
| **PSORIASIN** (***salicylic acid***) | Covered | OTC |
| **SCALPICIN** (***salicylic acid***) | Covered | OTC |
| **SCALPICIN 2 IN 1** (***salicylic acid***) | Covered | OTC |
| ***Local Anesthetics - Topical*** - Drugs For The Skin*** | | |
| ***arthritis pain relieving*** | Covered | OTC; QL (114 GM per 30 days) |
| ***capsaicin*** | Covered | OTC |
| ***gnp lidocaine pain relief*** | Covered | OTC; QL (1 EA per 1 day) |
| ***lc-4 lidocaine*** | Covered | OTC; QL (2 Tubes per 30 days) |
| ***lidocaine external cream*** | Covered | OTC; QL (2 Tubes per 30 days) |
| ***lidocaine external ointment*** | Covered | PA; QL (50 GM per 30 days) |
| ***lidocaine external patch*** | Covered | PA; QL (90 EA per 30 days); AL (Min 18 Years) |
| ***lidocaine hcl*** | Covered | |
| ***qc lidocaine pain relief*** | Covered | OTC; QL (1 EA per 1 day) |
| **ANECREAM** (***lidocaine***) | Covered | OTC; QL (2 Tubes per 30 days) |
| ***lidocaine hcl*** (Glydo) | Covered | |
| **REGENECARE HA** (***lidocaine hcl***) | Covered | OTC; QL (2 GM per 1 day) |
| ***Macrolide Immunosuppressants - Topical*** - Drugs For The Skin*** | | |
| ***tacrolimus*** | Covered | ST; QL (30 GM per 30 days) |
| ***Powders*** - Drugs For The Skin*** | | |
| ***cvs baby powder*** | Covered | OTC |
| **JOHNSONS BABY POWDER** (***corn starch***) | Covered | OTC |
| ***Prostaglandins - Topical*** - Drugs For The Skin*** | | |
| ***bimatoprost*** | Covered | ST |
| ***Rosacea Agents*** - Drugs For The Skin*** | | |
| ***metronidazole*** | Covered | |
| ***metronidazole*** (Rosadan) | Covered | |
| ***Scabicide Combinations*** - Drugs For The Skin*** | | |
| ***cvs lice killing*** | Covered | OTC; QL (240 ML per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***eq lice killing max st*** | Covered | OTC; QL (240 ML per 30 days) |
| ***lice killing maximum strength*** | Covered | OTC; QL (240 ML per 30 days) |
| ***sm lice killing*** | Covered | OTC; QL (118 ML per 30 days) |
| ***stop lice maximum strength*** | Covered | OTC; QL (118 ML per 30 days) |
| **LICIDE** (***pyrethrins-piperonyl butoxide***) | Covered | OTC; QL (240 ML per 30 days) |
| **LICIDE MAXIMUM STRENGTH** (***pyrethrins-piperonyl butoxide***) | Covered | OTC; QL (118 ML per 30 days) |
| **RID LICE KILLING SHAMPOO** (***pyrethrins-piperonyl butoxide***) | Covered | OTC; QL (240 ML per 30 days) |
| ****Scabicides & Pediculicides*** - Drugs For The Skin*** | | |
| ***lice treatment*** | Covered | OTC; QL (120 ML per 30 days) |
| ***malathion*** | Covered | ST; QL (59 ML per 180 days) |
| ***permethrin*** | Covered | QL (60 GM per 30 days) |
| ***sm lice treatment*** | Covered | OTC; QL (120 ML per 30 days) |
| ***spinosad*** | Covered | ST |
| ****Skin Cleansers*** - Drugs For The Skin*** | | |
| ***advanced hand sanitizer*** | Covered | OTC; QL (31.46 ML per 1 day) |
| ***advanced hand sanitizer/aloe*** | Covered | OTC; QL (31.46 ML per 1 day) |
| ***cvs instant hand sanitizer*** | Covered | OTC; QL (53.3 ML per 1 day) |
| ***cvs isopropyl alcohol wipes*** | Covered | OTC |
| ***eql hand sanitizer*** | Covered | OTC; QL (31.46 ML per 1 day) |
| ***eql hand sanitizer advanced*** | Covered | OTC; QL (31.46 ML per 1 day) |
| ***eql hand sanitizer/aloe*** | Covered | OTC; QL (31.46 ML per 1 day) |
| ***essentra wipes 9x9"*** | Covered | |
| ***gnp isopropyl alcohol wipes*** | Covered | OTC |
| ***instant hand sanitizer*** | Covered | OTC; QL (53.3 ML per 1 day) |
| ***isopropyl alcohol external*** | Covered | OTC |
| ***isopropyl alcohol external liquid*** | Covered | OTC; QL (31.6 ML per 1 day) |
| ***isopropyl alcohol wipes*** | Covered | OTC |
| ***ra instant hand sanitizer*** | Covered | OTC; QL (53.3 ML per 1 day) |
| ***ra instant hand sanitizer/aloe*** | Covered | OTC; QL (53.3 ML per 1 day) |
| ***ra isopropyl alcohol wipes*** | Covered | OTC |
| ***ra renewal hand sanitizer*** | Covered | OTC; QL (53.3 ML per 1 day) |
| ***sm advanced hand sanitizer*** | Covered | OTC; QL (31.46 ML per 1 day) |
| **ANTISEPTIC HAND RINSE** (***ethyl alcohol (skin cleanser)***) | Covered | OTC; QL (53.33 ML per 1 day) |
| **GELRITE HAND SANITIZER** (***ethyl alcohol (skin cleanser)***) | Covered | OTC; QL (53.3 ML per 1 day) |

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|---|---|---|
| **MEDI-FIRST ANTISEPTIC CLEANER** (***ethyl alcohol (skin cleanser)***) | Covered | OTC; QL (5.6 ML per 1 day) |
| **PREVACARE ANTIMICROBIAL** (***ethyl alcohol (skin cleanser)***) | Covered | OTC; QL (53.33 ML per 1 day) |
| **PROTECTEAV** (***ethyl alcohol (skin cleanser)***) | Covered | OTC; QL (31.46 ML per 1 day) |
| **RA GERM DEFENSE** (***ethyl alcohol (skin cleanser)***) | Covered | OTC; QL (53.3 ML per 1 day) |
| ****Soaps*** - Drugs For The Skin*** | | |
| ***gentle skin cleanser*** | Covered | OTC |
| ****Tar Products*** - Drugs For The Skin*** | | |
| ***cvs therapeutic*** | Covered | OTC |
| ***eql therapeutic*** | Covered | OTC |
| ***pc-tar*** | Covered | OTC |
| ***ra therapeutic*** | Covered | OTC |
| ***sm anti-dandruff coal tar*** | Covered | OTC |
| ***therapeutic*** | Covered | OTC |
| **BETA CARE BETATAR GEL** (***coal tar extract***) | Covered | OTC |
| **IONIL-T** (***coal tar extract***) | Covered | OTC |
| **TERA-GEL TAR** (***coal tar extract***) | Covered | OTC |
| **THERAPEUTIC T+PLUS** (***coal tar extract***) | Covered | OTC |
| **X-SEB T PEARL** (***coal tar extract***) | Covered | OTC |
| **X-SEB T PLUS** (***coal tar extract***) | Covered | OTC |
| ****Topical Anesthetic Combinations*** - Drugs For The Skin*** | | |
| ***lidocaine-prilocaine*** | Covered | QL (30 GM per 30 days) |
| ****Topical Steroid Combinations*** - Drugs For The Skin*** | | |
| ***gnp hydrocortisone/aloe*** | Covered | OTC |
| ***hm hydrocortisone plus*** | Covered | OTC |
| ***hm hydrocortisone-aloe max st*** | Covered | OTC |
| ***hydrocortisone-aloe*** | Covered | OTC |
| ***kls hydrocortisone plus*** | Covered | OTC |
| ***ra hydrocortisone plus*** | Covered | OTC |
| ***sm hydrocortisone plus*** | Covered | OTC |
| ***sm hydrocortisone-aloe max st*** | Covered | OTC |
| ***tgt anti-itch/aloe max st*** | Covered | OTC |
| **CORTIZONE-10 INTENSIVE HEALING** (***hydrocortisone-aloe vera***) | Covered | OTC |
| **CORTIZONE-10 PLUS** (***hydrocortisone-aloe vera***) | Covered | OTC |
| **CORTIZONE-10/ALOE** (***hydrocortisone-aloe vera***) | Covered | OTC |

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|---|---|---|
| ***Wound Dressings*** - Drugs For The Skin** | | |
| **CARRACOLLOID 4"X4"** (***wound dressings***) | Covered | OTC |
| **CARRACOLLOID 6"X6"** (***wound dressings***) | Covered | OTC |
| **DRS CHOICE BLISTER CARE** (***wound dressings***) | Covered | OTC |
| **HYDROCOL** (***wound dressings***) | Covered | OTC |
| ***Diagnostic Products*** | | |
| ***Diagnostic Tests*** | | |
| ***ketone test*** | Covered | OTC |
| ***universal ph*** | Covered | OTC |
| **CHEMSTRIP 2** (***ph test***) | Covered | OTC |
| **CHEMSTRIP K** (***acetone (urine) test***) | Covered | OTC |
| **CHEMSTRIP MICRAL** (***albumin (urine) test***) | Covered | OTC |
| **DIASTIX** (***glucose urine test-glucose ox***) | Covered | OTC |
| **KETOCARE** (***acetone (urine) test***) | Covered | OTC |
| **KETOSTIX** (***acetone (urine) test***) | Covered | OTC |
| **NITRATEST PAPER** (***ph test***) | Covered | OTC |
| **NOVA MAX PLUS KETONE TEST** (***ketone blood test***) | Covered | OTC |
| **ONETOUCH ULTRA** (***glucose blood***) | Covered | OTC; QL (5 EA per 1 day) |
| **ONETOUCH VERIO** (***glucose blood***) | Covered | OTC; QL (5 EA per 1 day) |
| **PRECISION XTRA KETONE** (***ketone blood test***) | Covered | OTC |
| **PTS PANELS KETONE TEST** (***ketone blood test***) | Covered | OTC |
| **RELION KETONE** (***acetone (urine) test***) | Covered | OTC |
| **RELION KETONE TEST** (***acetone (urine) test***) | Covered | OTC |
| ***Multiple Urine Tests*** | | |
| **CHEMSTRIP 10 MD** (***multiple urine tests***) | Covered | OTC |
| **CHEMSTRIP 10/SG** (***multiple urine tests***) | Covered | OTC |
| **CHEMSTRIP 2 GP** (***multiple urine tests***) | Covered | OTC |
| **CHEMSTRIP 5 OB** (***multiple urine tests***) | Covered | OTC |
| **CHEMSTRIP 7** (***multiple urine tests***) | Covered | OTC |
| **CHEMSTRIP 9** (***multiple urine tests***) | Covered | OTC |
| **CHEMSTRIP UGK** (***urine glucose-ketones test***) | Covered | OTC |
| **CVS KETONE CARE** (***urine glucose-ketones test***) | Covered | OTC |
| **KETO-DIASTIX** (***urine glucose-ketones test***) | Covered | OTC |

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|---|---|---|
| ***Dietary Products/Dietary Management Products* - Drugs For Nutrition** | | |
| ****Nutritional Supplements*** - Drugs For Nutrition*** | | |
| ***antioxidant formula*** | Covered | OTC |
| ***Digestive Aids* - Drugs For The Stomach** | | |
| ****Digestive Enzymes*** - Drugs For The Stomach*** | | |
| **CREON** (***pancrelipase (lip-prot-amyl)***) | Covered | |
| **VIOKACE** (***pancrelipase (lip-prot-amyl)***) | Covered | |
| **ZENPEP** (***pancrelipase (lip-prot-amyl)***) | Covered | |
| ***Diuretics* - Drugs For The Heart** | | |
| ****Carbonic Anhydrase Inhibitors*** - Drugs For High Blood Pressure*** | | |
| ***acetazolamide*** | Covered | |
| ***acetazolamide er*** | Covered | |
| ***methazolamide*** | Covered | ST |
| ****Diuretic Combinations*** - Drugs For High Blood Pressure*** | | |
| ***amiloride-hydrochlorothiazide*** | Covered | |
| ***spironolactone-hctz*** | Covered | |
| ***triamterene-hctz*** | Covered | |
| ****Loop Diuretics*** - Drugs For High Blood Pressure*** | | |
| ***bumetanide*** | Covered | |
| ***furosemide*** | Covered | |
| ***torsemide*** | Covered | |
| ****Potassium Sparing Diuretics*** - Drugs For High Blood Pressure*** | | |
| ***amiloride hcl*** | Covered | |
| ***spironolactone*** | Covered | |
| ****Thiazides And Thiazide-Like Diuretics*** - Drugs For High Blood Pressure*** | | |
| ***chlorthalidone*** | Covered | |
| ***hydrochlorothiazide*** | Covered | |
| ***indapamide*** | Covered | |
| ***metolazone*** | Covered | |
| ***Endocrine And Metabolic Agents - Misc.* - Hormones** | | |
| ****Bisphosphonates*** - Drugs For Menopause And Bone Loss*** | | |
| ***alendronate sodium oral solution*** | Covered | QL (300 Bottles per 28 days) |

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**AL** = Age Restrictions
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***alendronate sodium oral tablet 10 mg, 40 mg, 5 mg*** | Covered | QL (30 EA per 30 days) |
| ***alendronate sodium oral tablet 35 mg, 70 mg*** | Covered | QL (4 EA per 28 days) |
| ***etidronate disodium oral tablet 200 mg*** | Covered | QL (90 EA per 30 days) |
| ***etidronate disodium oral tablet 400 mg*** | Covered | QL (150 EA per 30 days) |
| ***ibandronate sodium intravenous*** | Covered | QL (3 ML per 84 days) |
| ***ibandronate sodium oral*** | Covered | QL (1 EA per 30 days) |
| ***pamidronate disodium*** | Covered | |
| ****Calcimimetic Agents*** - Drugs For Menopause And Bone Loss*** | | |
| **SENSIPAR** (***cinacalcet hcl***) | Covered | |
| ****Calcitonins*** - Drugs For Menopause And Bone Loss*** | | |
| ***calcitonin (salmon)*** | Covered | QL (3.7 ML per 30 days) |
| ****Carnitine Replenisher - Agents*** - Drugs For Menopause And Bone Loss*** | | |
| ***levocarnitine*** | Covered | |
| ****Dopamine Receptor Agonists*** - Drugs For Women*** | | |
| ***cabergoline*** | Covered | QL (16 EA per 30 days) |
| ****Growth Hormones*** - Drugs For Growth*** | | |
| **OMNITROPE** (***somatropin***) | Covered | PA |
| ****Hyperparathyroid Treatment - Vitamin D Analogs*** - Drugs For Menopause And Bone Loss*** | | |
| ***calcitriol*** | Covered | |
| ***paricalcitol*** | Covered | ST; QL (1 EA per 1 day) |
| ****Parathyroid Hormone And Derivatives*** - Drugs For Menopause And Bone Loss*** | | |
| **TYMLOS** (***abaloparatide***) | Covered | PA; QL (1.56 ML per 30 days) |
| ****Rank Ligand (Rankl) Inhibitors*** - Drugs For Menopause And Bone Loss*** | | |
| **PROLIA** (***denosumab***) | Covered | PA; QL (1 ML per 168 days) |
| ****Selective Estrogen Receptor Modulators (Serms)*** - Drugs For Menopause And Bone Loss*** | | |
| ***raloxifene hcl*** | Covered | QL (30 EA per 30 days) |
| ****Somatostatic Agents*** - Drugs For Growth*** | | |
| ***octreotide acetate*** | Covered | PA |
| **SANDOSTATIN LAR DEPOT** (***octreotide acetate***) | Covered | PA |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Vasopressin*** - Hormones*** | | |
| ***desmopressin ace spray refrig*** | Covered | QL (150 ML per 30 days) |
| ***desmopressin acetate*** | Covered | QL (90 EA per 30 days) |
| ***desmopressin acetate spray*** | Covered | QL (5 ML per 30 days) |
| ***Estrogens* - Hormones** | | |
| ***Estrogen & Progestin*** - Drugs For Women*** | | |
| ***estradiol-norethindrone acet*** | Covered | QL (30 EA per 30 days) |
| ***jevantique lo*** | Covered | |
| ***norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg*** | Covered | |
| ***norethindrone-eth estradiol oral tablet 1-5 mg-mcg*** | Covered | QL (30 EA per 30 days) |
| **COMBIPATCH** (***estradiol-norethindrone acet***) | Covered | QL (8 Patches per 28 days) |
| ***norethindrone-eth estradiol*** (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg) | Covered | |
| ***norethindrone-eth estradiol*** (Fyavolv Oral Tablet 1-5 Mg-Mcg) | Covered | QL (30 EA per 30 days) |
| ***norethindrone-eth estradiol*** (Jinteli) | Covered | QL (30 EA per 30 days) |
| ***estradiol-norethindrone acet*** (Mimvey) | Covered | QL (30 EA per 30 days) |
| ***estradiol-norethindrone acet*** (Mimvey Lo) | Covered | QL (30 EA per 30 days) |
| ***Estrogens*** - Drugs For Women*** | | |
| ***estradiol oral*** | Covered | |
| ***estradiol transdermal*** | Covered | QL (4 EA per 28 days) |
| ***Fluoroquinolones* - Drugs For Infections** | | |
| ***Fluoroquinolones*** - Antibiotics*** | | |
| ***ciprofloxacin*** | Covered | |
| ***ciprofloxacin hcl*** | Covered | QL (28 EA per 30 days) |
| ***ciprofloxacin in d5w*** | Covered | PA |
| ***levofloxacin in d5w*** | Covered | PA |
| ***levofloxacin intravenous*** | Covered | PA |
| ***levofloxacin oral solution*** | Covered | QL (280 mL Max Qty Per Fill Retail); AL (Max 12 Years) |
| ***levofloxacin oral tablet*** | Covered | QL (14 EA Max Qty Per Fill Retail) |
| ***moxifloxacin hcl*** | Covered | PA |
| ***moxifloxacin hcl in nacl*** | Covered | PA |
| **BAXDELA** (***delafloxacin meglumine***) | Covered | PA |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Gastrointestinal Agents - Misc.* - Drugs For The Stomach** | | |
| ****Antiflatulents*** - Drugs For The Stomach*** | | |
| ***cvs gas relief*** | Covered | OTC |
| ***cvs gas relief drops ex st*** | Covered | OTC |
| ***cvs infants gas relief*** | Covered | OTC |
| ***eq gas relief*** | Covered | OTC |
| ***eq infants gas relief*** | Covered | OTC |
| ***eql gas relief*** | Covered | OTC |
| ***eql infants gas relief*** | Covered | OTC |
| ***gas relief*** | Covered | OTC |
| ***gas relief extra strength*** | Covered | OTC |
| ***gnp gas relief extra strength*** | Covered | OTC |
| ***gnp infants gas relief*** | Covered | OTC |
| ***hm gas relief infants drops*** | Covered | OTC |
| ***infants gas relief*** | Covered | OTC |
| ***infants simethicone*** | Covered | OTC |
| ***px gas relief extra strength*** | Covered | OTC |
| ***px gas relief infants*** | Covered | OTC |
| ***qc gas relief*** | Covered | OTC |
| ***ra gas relief*** | Covered | OTC |
| ***ra gas relief extra strength*** | Covered | OTC |
| ***ra gas relief/infants*** | Covered | OTC |
| ***sb gas relief*** | Covered | OTC |
| ***simeped*** | Covered | OTC |
| ***simethicone*** | Covered | OTC |
| ***sm gas relief extra strength*** | Covered | OTC |
| ***sm gas relief infants*** | Covered | OTC |
| ***sm gas relief infants drops*** | Covered | OTC |
| ***tgt gas relief extra strength*** | Covered | OTC |
| ***tgt gas relief infants*** | Covered | OTC |
| **GAS-X EXTRA STRENGTH** (***simethicone***) | Covered | OTC |
| **GAS-X INFANT DROPS** (***simethicone***) | Covered | OTC |
| **LITTLE REMEDIES FOR TUMMYS** (***simethicone***) | Covered | OTC |
| **LITTLE TUMMYS GAS RELIEF** (***simethicone***) | Covered | OTC |

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|---|---|---|
| **PEDIACARE INFANTS GAS RELIEF** (***simethicone***) | Covered | OTC |
| ***Gallstone Solubilizing Agents*** - Drugs For The Stomach** | | |
| ***ursodiol*** | Covered | |
| ***Gastrointestinal Chloride Channel Activators*** - Drugs For Irritable Bowel Syndrome** | | |
| **AMITIZA** (***lubiprostone***) | Covered | PA; QL (2 EA per 1 day); AL (Min 18 Years) |
| ***Gastrointestinal Stimulants*** - Drugs For The Stomach** | | |
| ***metoclopramide hcl*** | Covered | |
| ***Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For Constipation** | | |
| **LINZESS** (***linaclotide***) | Covered | PA; QL (1 EA per 1 day) |
| ***Inflammatory Bowel Agents*** - Drugs For Inflammatory Bowel Disease** | | |
| ***balsalazide disodium*** | Covered | |
| ***mesalamine oral capsule delayed release*** | Covered | QL (6 EA per 1 day) |
| ***mesalamine oral tablet delayed release 1.2 gm*** | Covered | QL (120 EA per 30 days) |
| ***mesalamine oral tablet delayed release 800 mg*** | Covered | QL (6 EA per 1 day) |
| ***mesalamine rectal enema*** | Covered | |
| ***mesalamine rectal suppository*** | Covered | QL (42 EA per 30 days) |
| ***sulfasalazine*** | Covered | |
| **APRISO** (***mesalamine***) | Covered | QL (4 EA per 1 day) |
| ***Intestinal Acidifiers*** - Drugs For The Stomach** | | |
| ***enulose*** | Covered | |
| ***generlac*** | Covered | |
| ***lactulose encephalopathy*** | Covered | |
| ***Peripheral Opioid Receptor Antagonists*** - Drugs For The Stomach** | | |
| **MOVANTIK** (***naloxegol oxalate***) | Covered | PA; QL (1 EA per 1 day) |
| **SYMPROIC** (***naldemedine tosylate***) | Covered | PA; QL (1 EA per 1 day) |
| ***Phosphate Binder Agents*** - Drugs For The Stomach** | | |
| ***calcium acetate (phos binder)*** | Covered | |
| ***sevelamer carbonate*** | Covered | ST |
| **AURYXIA** (***ferric citrate***) | Covered | ST; QL (12 EA per 1 day) |
| **CALPHRON** (***calcium acetate (phos binder)***) | Covered | OTC |

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| 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*** | | |
| ***finasteride*** | Covered | QL (30 EA per 30 days) |
| ****Alpha 1-Adrenoceptor Antagonists*** - Drugs For The Prostate*** | | |
| ***alfuzosin hcl er*** | Covered | QL (1 EA per 1 day) |
| ***tamsulosin hcl*** | Covered | QL (2 EA per 1 day) |
| ****Citrates*** - Drugs For Infections*** | | |
| ***cytra k crystals*** | Covered | |
| ***pot & sod cit-cit ac*** | Covered | |
| ***potassium citrate er*** | Covered | |
| ***potassium citrate-citric acid*** | Covered | |
| ***potassium citrate-citric acid*** (Taron-Crystals) | Covered | |
| ****Genitourinary Irrigants*** - Drugs For The Urinary System*** | | |
| ***sodium chloride*** | Covered | |
| ***sodium chloride (gu irrigant)*** (Argyle Sterile Saline) | Covered | |
| ***sodium chloride (gu irrigant)*** (Curity Sterile Saline) | Covered | |
| ****Interstitial Cystitis Agents*** - Drugs For The Urinary System*** | | |
| **ELMIRON** (***pentosan polysulfate sodium***) | Covered | PA |
| ****Phosphates*** - Drugs For Infections*** | | |
| **K-PHOS NO 2** (***pot & sod ac phosphates***) | Covered | |
| ****Urinary Analgesics*** - Drugs For Infections*** | | |
| ***cvs urinary pain relief*** | Covered | OTC |
| ***eq urinary pain relief*** | Covered | OTC |
| ***phenazopyridine hcl*** | Covered | |
| ***phenazopyridine hcl*** (Phenazo) | Covered | |
| ***Gout Agents* - Drugs For Pain And Fever** | | |
| ****Gout Agent Combinations*** - Gout Drugs*** | | |
| ***colchicine-probenecid*** | Covered | |
| ****Gout Agents*** - Gout Drugs*** | | |
| ***allopurinol*** | Covered | |
| ***colchicine*** | Covered | QL (9 EA per 30 days) |
| ***febuxostat*** | Covered | ST; QL (1 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Uricosurics*** - Gout Drugs*** | | |
| ***probenecid*** | Covered | |
| **Hematological Agents - Misc.* - Drugs For The Blood** | | |
| ***Antihemophilic Products - Monoclonal Antibodies*** - Drugs For The Blood*** | | |
| **HEMLIBRA** (***emicizumab-kxwh***) | State Carve Out | |
| ***Antihemophilic Products*** - Drugs To Prevent Bleeding*** | | |
| ***adynovate*** | State Carve Out | |
| ***obizur*** | State Carve Out | |
| ***rixubis*** | State Carve Out | |
| **ADVATE** (***antihemophil factor (rahf-pfm)***) | State Carve Out | |
| **AFSTYLA** (***antihemophil fact single chain***) | State Carve Out | |
| **ALPHANATE/VWF COMPLEX/HUMAN** (***antihemophilic factor-vwf***) | State Carve Out | |
| **ALPHANINE SD** (***coagulation factor ix***) | State Carve Out | |
| **ALPROLIX** (***coagulation factor ix (rfixfc)***) | State Carve Out | |
| **BENEFIX** (***coagulation factor ix (recomb)***) | State Carve Out | |
| **COAGADEX** (***coagulation factor x (human)***) | State Carve Out | |
| **CORIFACT** (***factor xiii concentrate human***) | State Carve Out | |
| **ELOCTATE** (***antihem fact (bdd-rfviiifc)***) | State Carve Out | |
| **FEIBA** (***antiinhibitor coagulant cmplx***) | State Carve Out | |
| **HELIXATE FS** (***antihem factor recomb (rfviii)***) | State Carve Out | |
| **HEMOFIL M** (***antihemophilic factor***) | State Carve Out | |

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|---|---|---|
| **HUMATE-P** (***antihemophilic factor-vwf***) | State Carve Out | |
| **IDELVION** (***coagulation factor ix (rix-fp)***) | State Carve Out | |
| **IXINITY** (***coagulation factor ix (recomb)***) | State Carve Out | |
| **JIVI** (***ahf (bdd-rfviii peg-aucl)***) | State Carve Out | |
| **KCENTRA** (***prothrombin complex conc human***) | State Carve Out | |
| **KOATE** (***antihemophilic factor***) | State Carve Out | |
| **KOATE-DVI** (***antihemophilic factor***) | State Carve Out | |
| **KOGENATE FS** (***antihem factor recomb (rfviii)***) | State Carve Out | |
| **KOVALTRY** (***antihemophil factor (rahf-pfm)***) | State Carve Out | |
| **MONOCLATE-P** (***antihemophilic factor***) | State Carve Out | |
| **MONONINE** (***coagulation factor ix***) | State Carve Out | |
| **NOVOEIGHT** (***antihemophil fact bd truncated***) | State Carve Out | |
| **NOVOSEVEN RT** (***coagulation factor viia recomb***) | State Carve Out | |
| **NUWIQ** (***antihem fact (bdd-rfviii,sim)***) | State Carve Out | |
| **PROFILNINE** (***factor ix complex***) | State Carve Out | |
| **REBINYN** (***coagulation factor ix glycopeg***) | State Carve Out | |
| **RECOMBINATE** (***antihem factor recomb (rfviii)***) | State Carve Out | |
| **RIASTAP** (***fibrinogen concentrate (human)***) | State Carve Out | |
| **TRETTEN** (***coagulation factor xiii a-sub***) | State Carve Out | |

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|---|---|---|
| **VONVENDI** (***von willebrand factor (recomb)***) | State Carve Out | |
| **WILATE** (***antihemophilic factor-vwf***) | State Carve Out | |
| **XYNTHA** (***antihem fact (bdd-rfviii,mor)***) | State Carve Out | |
| **XYNTHA SOLOFUSE** (***antihem fact (bdd-rfviii,mor)***) | State Carve Out | |
| ***Complement Inhibitors*** - Drugs For The Blood** | | |
| **SOLIRIS** (***eculizumab***) | Covered | PA |
| ***Hematorheologic Agents*** - Drugs For The Blood** | | |
| ***pentoxifylline er*** | Covered | |
| ***Phosphodiesterase Iii Inhibitors*** - Drugs For The Blood** | | |
| ***cilostazol*** | Covered | |
| ***Platelet Aggregation Inhibitors*** - Drugs For The Blood** | | |
| ***dipyridamole*** | Covered | |
| ***Quinazoline Agents*** - Drugs For The Blood** | | |
| ***anagrelide hcl*** | Covered | |
| ***Thienopyridine Derivatives*** - Drugs For The Blood** | | |
| ***clopidogrel bisulfate*** | Covered | QL (30 EA per 30 days) |
| ***prasugrel hcl*** | Covered | QL (1 EA per 1 day) |
| **Hematopoietic Agents* - Drugs For Nutrition** | | |
| ***Amino Acids*** - Drugs For Nutrition** | | |
| **ENDARI** (***glutamine (sickle cell)***) | Covered | PA |
| ***Cobalamins*** - Drugs For Nutrition** | | |
| ***cyanocobalamin*** | Covered | |
| ***Cytotoxic Agents*** - Drugs For Nutrition** | | |
| **DROXIA** (***hydroxyurea***) | Covered | |
| ***Erythropoiesis-Stimulating Agents (Esas)*** - Drugs For Nutrition** | | |
| **EPOGEN** (***epoetin alfa***) | Covered | PA |
| **RETACRIT** (***epoetin alfa-epbx***) | Covered | PA |
| ***Folic Acid/Folate Combinations*** - Drugs For Nutrition** | | |
| ***fa-vitamin b-6-vitamin b-12*** | Covered | |
| ***folplex 2.2*** | Covered | |

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|---|---|---|
| ***Folic Acid/Folates*** - Drugs For Nutrition*** | | |
| ***folic acid*** | Covered | |
| ***Granulocyte Colony-Stimulating Factors (G-Csf)*** - Drugs For Nutrition*** | | |
| **GRANIX** (***tbo-filgrastim***) | Covered | PA |
| **UDENYCA** (***pegfilgrastim-cbqv***) | Covered | PA |
| **ZARXIO** (***filgrastim-sndz***) | Covered | PA |
| ***Granulocyte/Macrophage Colony-Stimulating Factor(Gm-Csf)*** - Drugs For Nutrition*** | | |
| **LEUKINE** (***sargramostim***) | Covered | PA |
| ***Iron Combinations*** - Drugs For Nutrition*** | | |
| ***fe c tab plus*** | Covered | OTC |
| ***iron 100 plus*** | Covered | OTC |
| ***Iron*** - Drugs For Nutrition*** | | |
| ***cvs iron*** | Covered | OTC |
| ***cvs slow release iron*** | Covered | OTC |
| ***eql iron supplement therapy*** | Covered | OTC |
| ***fe tabs*** | Covered | OTC |
| ***ferrous gluconate*** | Covered | OTC |
| ***ferrous sulfate*** | Covered | OTC |
| ***ferrousul*** | Covered | OTC |
| ***gnp iron*** | Covered | OTC |
| ***gnp slow release iron*** | Covered | OTC |
| ***iron*** | Covered | OTC |
| ***kp ferrous gluconate*** | Covered | OTC |
| ***kp ferrous sulfate*** | Covered | OTC |
| ***meijer ferrous sulfate*** | Covered | OTC |
| ***px iron*** | Covered | OTC |
| ***qc ferrous sulfate*** | Covered | OTC |
| ***ra high potency iron*** | Covered | OTC |
| ***ra iron*** | Covered | OTC |
| ***ra slow release iron*** | Covered | OTC |
| ***slow release iron*** | Covered | OTC |
| ***sm iron*** | Covered | OTC |

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|---|---|---|
| ***sm slow release iron*** | Covered | OTC |
| **FEROSUL** (***ferrous sulfate***) | Covered | OTC |
| **INJECTAFER** (***ferric carboxymaltose***) | Covered | PA |
| **VENOFER** (***iron sucrose***) | Covered | PA |
| ****Thrombopoietin (Tpo) Receptor Agonists*** - Drugs For Nutrition*** | | |
| **PROMACTA** (***eltrombopag olamine***) | Covered | PA; QL (1 EA per 1 day) |
| ***Hemostatics* - Drugs For The Blood** | | |
| ****Hemostatic Combinations - Topical*** - Drugs To Prevent Bleeding*** | | |
| **GELFOAM-JMI POWDER** (***gelatin absorb-thrombin***) | State Carve Out | |
| **GELFOAM-JMI SPONGE** (***gelatin absorb-thrombin***) | State Carve Out | |
| **THROMBI-GEL 10** (***thrombin-cmc-cacl-gelatin***) | State Carve Out | |
| **THROMBI-PAD** (***thrombin-cmc-cacl***) | State Carve Out | |
| ****Hemostatics - Systemic*** - Drugs To Prevent Bleeding*** | | |
| ***aminocaproic acid*** | State Carve Out | |
| **AMICAR** (***aminocaproic acid***) | State Carve Out | |
| **CYKLOKAPRON** (***tranexamic acid***) | State Carve Out | |
| ****Hemostatics - Topical*** - Drugs To Prevent Bleeding*** | | |
| ***monsels ferric subsulfate*** | State Carve Out | |
| **ACTIFOAM COLLAGEN SPONGE** (***absorbable collagen hemostat***) | State Carve Out | |
| **AVITENE** (***microfibrillar coll hemostat***) | State Carve Out | |
| **AVITENE FLOUR** (***microfibrillar coll hemostat***) | State Carve Out | |
| **GELFILM** (***gelatin absorbable***) | State Carve Out | |
| **GEL-FLOW NT** (***gelatin absorbable***) | State Carve Out | |

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**Coverage Requirements and Limits**
**AL** = Age Restrictions
**OTC** = OTC Medications
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **GELFOAM** (***gelatin absorbable***) | State Carve Out | |
| **GELFOAM COMPRESSED SIZE 100** (***gelatin absorbable***) | State Carve Out | |
| **GELFOAM DENTAL PACK SIZE 4** (***gelatin absorbable***) | State Carve Out | |
| **GELFOAM SPONGE** (***gelatin absorbable***) | State Carve Out | |
| **GELFOAM SPONGE SIZE 100** (***gelatin absorbable***) | State Carve Out | |
| **GELFOAM SPONGE SIZE 200** (***gelatin absorbable***) | State Carve Out | |
| **GELFOAM SPONGE SIZE 50** (***gelatin absorbable***) | State Carve Out | |
| **INSTAT** (***absorbable collagen hemostat***) | State Carve Out | |
| **NASALCEASE** (***calcium alginate (hemostatic)***) | State Carve Out | OTC |
| **NOSEBLEEDQR** (***hydrophilic polymer***) | State Carve Out | OTC |
| **RECOTHROM** (***thrombin (recombinant)***) | State Carve Out | |
| **THROMBIN-JMI** (***thrombin***) | State Carve Out | |
| **THROMBIN-JMI EPISTAXIS** (***thrombin***) | State Carve Out | |
| **THROMBOGEN** (***thrombin***) | State Carve Out | |
| **ULTRAFOAM SPONGE 2X6.25X7CM** (***microfibrillar coll hemostat***) | State Carve Out | |
| **ULTRAFOAM SPONGE 8X12.5X1CM** (***microfibrillar coll hemostat***) | State Carve Out | |
| **ULTRAFOAM SPONGE 8X12.5X3CM** (***microfibrillar coll hemostat***) | State Carve Out | |
| **ULTRAFOAM SPONGE 8X25X1CM** (***microfibrillar coll hemostat***) | State Carve Out | |
| **ULTRAFOAM SPONGE 8X6.25X1CM** (***microfibrillar coll hemostat***) | State Carve Out | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **WOUNDSEAL** (***hydrophilic polymer***) | State Carve Out | OTC |
| ***Hypnotics/Sedatives/Sleep Disorder Agents* - Drugs For The Nervous System** | | |
| ****Antihistamine Hypnotics*** - Drugs For Insomnia*** | | |
| ***compoz*** | Covered | OTC |
| ***cvs sleep aid*** | Covered | OTC |
| ***cvs sleep aid nighttime*** | Covered | OTC |
| ***cvs sleep-aid nighttime*** | Covered | OTC |
| ***cvs ultra sleep*** | Covered | OTC |
| ***eq nighttime sleep aid*** | Covered | OTC |
| ***eq nighttime sleep aid max st*** | Covered | OTC |
| ***eql nighttime sleep aid*** | Covered | OTC |
| ***eql sleep aid*** | Covered | OTC |
| ***gnp nighttime sleep aid*** | Covered | OTC |
| ***gnp sleep aid*** | Covered | OTC |
| ***hm nighttime sleep aid*** | Covered | OTC |
| ***hm sleep aid*** | Covered | OTC |
| ***night time sleep aid*** | Covered | OTC |
| ***nighttime sleep aid*** | Covered | OTC |
| ***ormir*** | Covered | OTC |
| ***qc rest simply*** | Covered | OTC |
| ***qc sleep aid max st*** | Covered | OTC |
| ***ra night sleep aid*** | Covered | OTC |
| ***ra nighttime sleep aid*** | Covered | OTC |
| ***ra sleep aid*** | Covered | OTC |
| ***ra sleep aid (diphenhydramine)*** | Covered | OTC |
| ***sb sleep*** | Covered | OTC |
| ***sleep aid*** | Covered | OTC |
| ***sleep aid (diphenhydramine)*** | Covered | OTC |
| ***sleep ii*** | Covered | OTC |
| ***sleep tabs*** | Covered | OTC |
| ***sleep-tabs*** | Covered | OTC |
| ***sm sleep aid*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***sm sleep aid maximum strength*** | Covered | OTC |
| ***sm sleep aid night time*** | Covered | OTC |
| ***tgt nighttime sleep aid*** | Covered | OTC |
| ***tgt sleep aid max strength*** | Covered | OTC |
| ***wal-som*** | Covered | OTC |
| ***wal-som maximum strength*** | Covered | OTC |
| **NYTOL** (***diphenhydramine hcl (sleep)***) | Covered | OTC |
| **SIMPLY SLEEP** (***diphenhydramine hcl (sleep)***) | Covered | OTC |
| ****Barbiturate Hypnotics*** - Drugs For Insomnia*** | | |
| ***phenobarbital*** | Covered | |
| ****Benzodiazepine Hypnotics*** - Drugs For Seizures /Personality Disorder/Nerve Pain*** | | |
| ***estazolam*** | Covered | QL (30 EA per 30 days); AL (Min 18 Years) |
| ***flurazepam hcl*** | Covered | QL (30 EA per 30 days); AL (Min 15 Years) |
| ***temazepam*** | Covered | QL (30 EA per 30 days); AL (Min 18 Years) |
| ****Non-Benzodiazepine - Gaba-Receptor Modulators*** - Drugs For Insomnia*** | | |
| ***zaleplon*** | Covered | QL (30 EA per 30 days); AL (Min 18 Years) |
| ***zolpidem tartrate*** | Covered | QL (1 EA per 1 day); AL (Min 18 Years) |
| ****Selective Melatonin Receptor Agonists*** - Drugs For Insomnia*** | | |
| **ROZEREM** (***ramelteon***) | Covered | ST; QL (1 EA per 1 day) |
| ***Laxatives* - Drugs For The Stomach** | | |
| ****Bowel Evacuant Combinations*** - Drugs To Prevent Constipation*** | | |
| ***peg 3350/electrolytes*** | Covered | QL (4000 ML per 30 days) |
| ***peg 3350-kcl-na bicarb-nacl*** | Covered | |
| ***peg-3350/electrolytes*** | Covered | QL (4000 ML per 30 days) |
| **GAVILYTE-C** (***peg 3350-kcl-nabcb-nacl-nasulf***) | Covered | QL (4000 ML per 30 days) |
| ***peg 3350-kcl-nabcb-nacl-nasulf*** (Gavilyte-G) | Covered | QL (4000 ML per 30 days) |
| ***peg 3350-kcl-na bicarb-nacl*** (Gavilyte-N With Flavor Pack) | Covered | |
| ***peg 3350-kcl-na bicarb-nacl*** (Trilyte) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Bulk Laxatives*** - Drugs To Prevent Constipation*** | | |
| ***cvs natural daily fiber*** | Covered | OTC |
| ***eq natural fiber laxative*** | Covered | OTC |
| ***eql natural fiber*** | Covered | OTC |
| ***gnp natural fiber*** | Covered | OTC |
| ***goodsense natural fiber*** | Covered | OTC |
| ***hm fiber*** | Covered | OTC |
| ***kls natural psyllium fiber*** | Covered | OTC |
| ***konsyl daily fiber*** | Covered | OTC |
| ***natural fiber*** | Covered | OTC |
| ***natural fiber laxative*** | Covered | OTC |
| ***ra fiber*** | Covered | OTC |
| ***ra fiber supplement*** | Covered | OTC |
| ***sm fiber*** | Covered | OTC |
| ***tgt fiber therapy*** | Covered | OTC |
| **METAMUCIL SMOOTH TEXTURE** (***psyllium***) | Covered | OTC |
| **REGULOID** (***psyllium***) | Covered | OTC |
| **WAL-MUCIL** (***psyllium***) | Covered | OTC |
| ***Laxatives - Miscellaneous*** - Drugs To Prevent Constipation*** | | |
| ***constulose*** | Covered | |
| ***cvs glycerin adult*** | Covered | OTC |
| ***glycerin (adult)*** | Covered | OTC |
| ***glycerin (infants & children)*** | Covered | OTC |
| ***glycerin (pediatric)*** | Covered | OTC |
| ***gnp glycerin (adult)*** | Covered | OTC |
| ***gnp glycerin (infant)*** | Covered | OTC |
| ***gnp glycerin child*** | Covered | OTC |
| ***lactulose*** | Covered | |
| ***peg 3350*** | Covered | OTC; QL (30 EA per 30 days) |
| ***polyethylene glycol 3350 oral packet*** | Covered | QL (1 EA per 1 day) |
| ***polyethylene glycol 3350 oral powder*** | Covered | QL (17 GM per 1 day) |
| ***px glycerin*** | Covered | OTC |
| ***ra glycerin adult*** | Covered | OTC |
| ***ra glycerin child*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***ra laxative*** | Covered | OTC; QL (30 EA per 30 days) |
| ***sb glycerin adult*** | Covered | OTC |
| ***sb glycerin pediatric*** | Covered | OTC |
| ***sm glycerin pediatric*** | Covered | OTC |
| ***sorbitol*** | Covered | OTC |
| **CVS PURELAX** (***polyethylene glycol 3350***) | Covered | OTC; QL (30 EA per 30 days) |
| **HEALTHYLAX** (***polyethylene glycol 3350***) | Covered | OTC; QL (30 EA per 30 days) |
| **SMOOTH LAX** (***polyethylene glycol 3350***) | Covered | OTC; QL (30 EA per 30 days) |
| ****Lubricant Laxatives*** - Drugs To Prevent Constipation*** | | |
| ***mineral oil heavy*** | Covered | |
| ***mineral oil light*** | Covered | |
| ****Saline Laxatives*** - Drugs To Prevent Constipation*** | | |
| ***milk of magnesia concentrate*** | Covered | OTC |
| ****Stimulant Laxatives*** - Drugs To Prevent Constipation*** | | |
| ***castor oil stimulant laxative*** | Covered | OTC |
| ***gnp castor oil*** | Covered | OTC |
| ***senexon*** | Covered | OTC |
| ***senna oral syrup 176 mg/5ml*** | Covered | OTC |
| ***senna oral syrup 8.8 mg/5ml*** | Covered | |
| ***senna-grx*** | Covered | OTC |
| ***sennazon*** | Covered | OTC |
| ***sm castor oil*** | Covered | OTC |
| **FLEET BISACODYL** (***bisacodyl***) | Covered | OTC |
| **LITTLE TUMMYS LAXATIVE** (***sennosides***) | Covered | OTC |
| ****Surfactant Laxatives*** - Drugs To Prevent Constipation*** | | |
| ***cvs stool softener*** | Covered | OTC |
| ***diocto*** | Covered | OTC |
| ***docu*** | Covered | OTC |
| ***docuprene*** | Covered | OTC |
| ***docusate sodium oral capsule*** | Covered | |
| ***docusate sodium oral liquid*** | Covered | OTC |
| ***docusate sodium oral tablet*** | Covered | OTC |
| ***dss*** | Covered | OTC |
| ***gnp stool softener*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***hm stool softener*** | Covered | OTC |
| ***ra col-rite*** | Covered | OTC |
| ***silace*** | Covered | OTC |
| ***sm stool softener*** | Covered | OTC |
| ***stool softener*** | Covered | OTC |
| **DOCUSOL PLUS MINI-ENEMA** (***benzocaine-docusate sodium***) | Covered | OTC |
| **DOK** (***docusate sodium***) | Covered | OTC |
| **ENEMEEZ PLUS** (***benzocaine-docusate sodium***) | Covered | OTC |
| **HEALTHY MAMA MOVE IT ALONG** (***docusate sodium***) | Covered | OTC |
| **PEDIA-LAX** (***docusate sodium***) | Covered | OTC |
| **PROMOLAXIN** (***docusate sodium***) | Covered | OTC |
| ***Macrolides* - Drugs For Infections** | | |
| ****Azithromycin*** - Antibiotics*** | | |
| ***azithromycin intravenous*** | Covered | PA |
| ***azithromycin oral packet*** | Covered | |
| ***azithromycin oral suspension reconstituted*** | Covered | QL (30 mL Max Qty Per Fill Retail); AL (Max 12 Years) |
| ***azithromycin oral tablet 250 mg*** | Covered | QL (12 EA per 30 days) |
| ***azithromycin oral tablet 500 mg*** | Covered | QL (3 EA per 30 days) |
| ***azithromycin oral tablet 600 mg*** | Covered | QL (8 EA per 30 days) |
| ****Clarithromycin*** - Antibiotics*** | | |
| ***clarithromycin oral suspension reconstituted*** | Covered | QL (150 mL Max Qty Per Fill Retail); AL (Max 12 Years) |
| ***clarithromycin oral tablet*** | Covered | QL (28 EA per 30 days) |
| ***Medical Devices And Supplies* - Medical Supplies And Durable Medical Equipment** | | |
| ****Applicators,Cotton Balls,Etc*** - Medical Supplies And Durable Medical Equipment*** | | |
| ***alcohol pads*** | Covered | OTC |
| ***alcohol prep*** | Covered | OTC |
| ***alcohol swabs*** | Covered | OTC |
| ***alcohol wipes*** | Covered | OTC |
| ***cvs prep*** | Covered | OTC |
| ***global alcohol prep ease*** | Covered | OTC |
| ***gnp alcohol swabs*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***hm sterile alcohol prep*** | Covered | OTC |
| ***meijer alcohol swabs*** | Covered | OTC |
| ***qc alcohol swabs*** | Covered | OTC |
| ***ra alcohol swabs*** | Covered | OTC |
| ***reality swabs*** | Covered | OTC |
| ***sb alcohol prep*** | Covered | OTC |
| ***sm alcohol prep*** | Covered | OTC |
| ***sure comfort alcohol prep*** | Covered | OTC |
| ***tgt alcohol swabs*** | Covered | OTC |
| ***true comfort alcohol prep pads*** | Covered | OTC |
| **BD SWAB SINGLE USE REGULAR** (***alcohol swabs***) | Covered | OTC |
| **BD SWABS SINGLE USE BUTTERFLY** (***alcohol swabs***) | Covered | OTC |
| **CURITY ALCOHOL PREPS** (***alcohol swabs***) | Covered | OTC |
| **CURITY ALCOHOL SWABS** (***alcohol swabs***) | Covered | OTC |
| **EASY TOUCH ALCOHOL PREP MEDIUM** (***alcohol swabs***) | Covered | OTC |
| **FIFTY50 ALCOHOL PREP** (***alcohol swabs***) | Covered | OTC |
| **RELION ALCOHOL SWABS** (***alcohol swabs***) | Covered | OTC |
| **SHOPKO ALCOHOL SWABS** (***alcohol swabs***) | Covered | OTC |
| **SURE-PREP ALCOHOL PREP** (***alcohol swabs***) | Covered | OTC |
| **WEBCOL ALCOHOL PREP LARGE** (***alcohol swabs***) | Covered | OTC |
| **WEBCOL ALCOHOL PREP MEDIUM** (***alcohol swabs***) | Covered | OTC |
| ****Cervical Caps*** - Medical Supplies And Durable Medical Equipment*** | | |
| **FEMCAP** (***cervical caps***) | Covered | |
| ****Condoms - Male*** - Medical Supplies And Durable Medical Equipment*** | | |
| ***aimsco lubricated*** | Covered | OTC |
| ***kimono*** | Covered | OTC |
| ***kimono micro thin*** | Covered | OTC |
| ***kimono micro thin plus*** | Covered | OTC |
| ***kimono plus*** | Covered | OTC |
| ***kimono ps*** | Covered | OTC |
| ***kimono ps plus*** | Covered | OTC |
| ***kimono sensation*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***kimono sensation plus*** | Covered | OTC |
| ***maxx*** | Covered | OTC |
| ***maxx plus*** | Covered | OTC |
| ***premium condoms lubricated*** | Covered | OTC |
| **DUREX EXTRA SENSITIVE** (***condoms latex lubricated***) | Covered | OTC |
| **FANTASY LUBRICATED** (***condoms latex lubricated***) | Covered | OTC |
| **FANTASY LUBRICATED/SPERMICIDE** (***condoms latex lubricated***) | Covered | OTC |
| **KAMELEON LUBRICATED** (***condoms latex lubricated***) | Covered | OTC |
| **KIMONO COLORS** (***condoms latex lubricated***) | Covered | OTC |
| **KIMONO SPECIAL** (***condoms latex lubricated***) | Covered | OTC |
| **REALITY LATEX CONDOMS** (***condoms latex lubricated***) | Covered | OTC |
| **REALITY LATEX/ULTRA TEXTURED** (***condoms latex lubricated***) | Covered | OTC |
| **REALITY LATEX/ULTRA THIN** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX COLOR CONDOMS + LUBE** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX LUB/RIBBED/STUDDED** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX LUB/SPERMICIDE EX ST** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX LUB/SPERMICIDE XL** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX LUBRICATED** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX LUBRICATED EX LARGE** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX LUBRICATED EXTRA ST** (***condoms latex lubricated***) | Covered | OTC |
| **TRUSTEX LUBRICATED/SPERMICIDE** (***condoms latex lubricated***) | Covered | OTC; QL (12 EA per 30 days) |
| **TRUSTEX NATURAL CONDOMS + LUBE** (***condoms latex lubricated***) | Covered | OTC; QL (12 EA per 30 days) |
| **TRUSTEX NON-LUBRICATED** (***condoms latex non-lubricated***) | Covered | OTC |
| **TRUSTEX RIA LUB/SPERMICIDE** (***condoms latex lubricated***) | Covered | OTC; QL (12 EA per 30 days) |
| **TRUSTEX RIA LUBRICATED** (***condoms latex lubricated***) | Covered | OTC; QL (12 EA per 30 days) |
| **TRUSTEX RIA NON-LUBRICATED** (***condoms latex non-lubricated***) | Covered | OTC |
| **TRUSTEX-NONOXYNOL-9/RIB/STUD** (***condoms latex lubricated***) | Covered | OTC; QL (12 EA per 30 days) |
| ****Diaphragms*** - Medical Supplies And Durable Medical Equipment*** | | |
| **OMNIFLEX DIAPHRAGM** (***diaphragms***) | Covered | |
| **WIDE-SEAL DIAPHRAGM 60** (***diaphragm wide seal***) | Covered | |
| **WIDE-SEAL DIAPHRAGM 65** (***diaphragm wide seal***) | Covered | |
| **WIDE-SEAL DIAPHRAGM 70** (***diaphragm wide seal***) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **WIDE-SEAL DIAPHRAGM 75** (***diaphragm wide seal***) | Covered | |
| **WIDE-SEAL DIAPHRAGM 80** (***diaphragm wide seal***) | Covered | |
| **WIDE-SEAL DIAPHRAGM 85** (***diaphragm wide seal***) | Covered | |
| **WIDE-SEAL DIAPHRAGM 90** (***diaphragm wide seal***) | Covered | |
| **WIDE-SEAL DIAPHRAGM 95** (***diaphragm wide seal***) | Covered | |
| ****Disposable Gloves*** - Medical Supplies And Durable Medical Equipment*** | | |
| ***cvs nyplex gloves*** | Covered | OTC; QL (50 EA per 30 days) |
| ***cvs super-soft vinyl gloves*** | Covered | OTC; QL (50 EA per 30 days) |
| ***nitrile gloves/size 10*** | Covered | QL (50 EA per 30 days) |
| ***nitrile gloves/size 6*** | Covered | QL (50 EA per 30 days) |
| ***nitrile gloves/size 6.5*** | Covered | QL (50 EA per 30 days) |
| ***nitrile gloves/size 7*** | Covered | QL (50 EA per 30 days) |
| ***nitrile gloves/size 7.5*** | Covered | QL (50 EA per 30 days) |
| ***nitrile gloves/size 8*** | Covered | QL (50 EA per 30 days) |
| ***nitrile gloves/size 9*** | Covered | QL (50 EA per 30 days) |
| ***ra extended cuff nitrile glove*** | Covered | OTC; QL (50 EA per 30 days) |
| ***ra vinyl gloves*** | Covered | OTC; QL (50 EA per 30 days) |
| ***ra vinyl medical gloves*** | Covered | OTC; QL (50 EA per 30 days) |
| ***ultra-soft gloves*** | Covered | OTC; QL (50 EA per 30 days) |
| ***vinyl gloves*** | Covered | OTC; QL (50 EA per 30 days) |
| ***vinyl gloves one size*** | Covered | OTC; QL (50 EA per 30 days) |
| ****Glucose Monitoring Test Supplies*** - Medical Supplies And Durable Medical Equipment*** | | |
| ***1st tier unilet comfortouch*** | Covered | OTC |
| ***acti-lance 28g*** | Covered | OTC |
| ***acti-lance lite lancets 28g*** | Covered | OTC |
| ***acti-lance special lancets 17g*** | Covered | OTC |
| ***acti-lance universal 23g*** | Covered | OTC |
| ***adjustable lancing device*** | Covered | OTC |
| ***alternate site lancing device*** | Covered | OTC |
| ***aqua lance adjustable lancing*** | Covered | OTC |
| ***assure comfort lancets 28g*** | Covered | OTC |
| ***aurora lancet super thin 30g*** | Covered | OTC |

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|---|---|---|
| ***aurora lancet thin 23g*** | Covered | OTC |
| ***bullseye mini safety lancets*** | Covered | OTC |
| ***careone advanced lancing dev*** | Covered | OTC |
| ***careone lancet thin 23g*** | Covered | OTC |
| ***careone lancet ultra thin 28g*** | Covered | OTC |
| ***comfort assured lancets 28g*** | Covered | OTC |
| ***comfort assured lancets 33g*** | Covered | OTC |
| ***comfort lancets*** | Covered | OTC |
| ***control*** | Covered | OTC |
| ***cvs lancets 21g*** | Covered | OTC |
| ***cvs lancets micro thin 33g*** | Covered | OTC |
| ***cvs lancets original*** | Covered | OTC |
| ***cvs lancets thin 26g*** | Covered | OTC |
| ***cvs lancets ultra thin 30g*** | Covered | OTC |
| ***cvs lancing device*** | Covered | OTC |
| ***cvs ultra thin lancets*** | Covered | OTC |
| ***diatrue control level 1*** | Covered | OTC |
| ***diatrue control level 2*** | Covered | OTC |
| ***diatrue control level 3*** | Covered | OTC |
| ***drug mart lancets thin 26g*** | Covered | OTC |
| ***easy comfort lancets*** | Covered | OTC |
| ***easy mini eject lancing device*** | Covered | OTC |
| ***easy mini lancing device*** | Covered | OTC |
| ***easy plus ii control*** | Covered | OTC |
| ***easy talk control*** | Covered | OTC |
| ***easy trak control*** | Covered | OTC |
| ***element compact control 2*** | Covered | OTC |
| ***element compact control 3*** | Covered | OTC |
| ***eql color lancets 21g*** | Covered | OTC |
| ***eql color lancets micro 33g*** | Covered | OTC |
| ***eql super thin lancets 30g*** | Covered | OTC |
| ***eql thin lancets 26g*** | Covered | OTC |
| ***freds pharmacy autolet lancing*** | Covered | OTC |
| ***freds pharmacy unilet lanc 28g*** | Covered | OTC |

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**Coverage Requirements and Limits**
**AL** = Age Restrictions
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***freds pharmacy unilet lanc 30g*** | Covered | OTC |
| ***ge100 control*** | Covered | OTC |
| ***global inject ease lancets 28g*** | Covered | OTC |
| ***global inject ease lancets 30g*** | Covered | OTC |
| ***global lancing device*** | Covered | OTC |
| ***glucose control*** | Covered | OTC |
| ***gnp lancets*** | Covered | OTC |
| ***gnp lancets 21g*** | Covered | OTC |
| ***gnp lancets micro thin 33g*** | Covered | OTC |
| ***gnp lancets super thin 30g*** | Covered | OTC |
| ***gnp lancets thin*** | Covered | OTC |
| ***gnp lancets thin 26g*** | Covered | OTC |
| ***gnp micro thin lancets 33g*** | Covered | OTC |
| ***gnp super thin lancets 30g*** | Covered | OTC |
| ***healthy accents lancing device*** | Covered | OTC |
| ***healthy accents unilet lancets*** | Covered | OTC |
| ***h-e-b incontrol adv lancing*** | Covered | OTC |
| ***h-e-b incontrol lancets 28g*** | Covered | OTC |
| ***h-e-b incontrol lancets 30g*** | Covered | OTC |
| ***h-e-b incontrol lancets 33g*** | Covered | OTC |
| ***hy-vee thin lancets*** | Covered | OTC |
| ***kinney lancets*** | Covered | OTC |
| ***kinney thin lancets*** | Covered | OTC |
| ***kroger lancets*** | Covered | OTC |
| ***kroger lancets 21g*** | Covered | OTC |
| ***kroger lancets micro thin 33g*** | Covered | OTC |
| ***kroger lancets super thin*** | Covered | OTC |
| ***kroger lancets thin*** | Covered | OTC |
| ***kroger lancets thin 26g*** | Covered | OTC |
| ***kroger lancets ultrathin 30g*** | Covered | OTC |
| ***kroger lancing device*** | Covered | OTC |
| ***lancet device*** | Covered | OTC |
| ***lancet device with ejector*** | Covered | OTC |
| ***lancet transporter case*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***lancets*** | Covered | OTC |
| ***lancets 28g*** | Covered | OTC |
| ***lancets 30g*** | Covered | OTC |
| ***lancets micro thin 33g*** | Covered | OTC |
| ***lancets super thin 28g*** | Covered | OTC |
| ***lancets thin*** | Covered | OTC |
| ***lancets ultra thin 30g*** | Covered | OTC |
| ***lancing device*** | Covered | OTC |
| ***leader advanced lancing device*** | Covered | OTC |
| ***lite touch lancets*** | Covered | OTC |
| ***longs lancets standard*** | Covered | OTC |
| ***longs lancets thin*** | Covered | OTC |
| ***longs lancets ultra thin*** | Covered | OTC |
| ***medichoice safety lancet*** | Covered | OTC |
| ***medichoice safety lancet extra*** | Covered | OTC |
| ***medichoice safety lancet norm*** | Covered | OTC |
| ***mini lancing device*** | Covered | OTC |
| ***multi-lancet device*** | Covered | OTC |
| ***pc lancets super thin 30g*** | Covered | OTC |
| ***preferred plus lancets colored*** | Covered | OTC |
| ***preferred plus lancets thin*** | Covered | OTC |
| ***px advanced lancing device*** | Covered | OTC |
| ***px lancet auto injector*** | Covered | OTC |
| ***px lancets ultra thin*** | Covered | OTC |
| ***qc advanced lancing device*** | Covered | OTC |
| ***qc lancets super thin 30g*** | Covered | OTC |
| ***qc lancets ultra thin*** | Covered | OTC |
| ***qc unilet lancets micro thin*** | Covered | OTC |
| ***ra lancing device*** | Covered | OTC |
| ***reality lancets*** | Covered | OTC |
| ***reality trigger lancets*** | Covered | OTC |
| ***safety lancet 21g/pressure act*** | Covered | OTC |
| ***safety lancet 28g/pressure act*** | Covered | OTC |
| ***safety lancets 28g*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***sapscare twist top lancets*** | Covered | OTC |
| ***sb lancets thin*** | Covered | OTC |
| ***sb lancets ultra thin*** | Covered | OTC |
| ***select-lite device/lancets*** | Covered | OTC |
| ***select-lite lancing device*** | Covered | OTC |
| ***sm lancets 33g*** | Covered | OTC |
| ***super thin lancets*** | Covered | OTC |
| ***supreme ii confidence paddles*** | Covered | OTC |
| ***supreme ii high/low control*** | Covered | OTC |
| ***sure comfort lancets 28g*** | Covered | OTC |
| ***sure comfort lancets 30g*** | Covered | OTC |
| ***sure comfort lancing pen*** | Covered | OTC |
| ***tgt lancet micro thin 33g*** | Covered | OTC |
| ***tgt lancet thin 26g*** | Covered | OTC |
| ***tgt lancet ultra thin 30g*** | Covered | OTC |
| ***tgt lancing device*** | Covered | OTC |
| ***todays health lancing device*** | Covered | OTC |
| ***todays health thin lancets 28g*** | Covered | OTC |
| ***todays health thin lancets 30g*** | Covered | OTC |
| ***travel lancets*** | Covered | OTC |
| ***value plus lancet standard 21g*** | Covered | OTC |
| ***value plus lancets super thin*** | Covered | OTC |
| ***value plus lancets thin 26g*** | Covered | OTC |
| ***value plus lancing device*** | Covered | OTC |
| ***valumark lancet super thin 30g*** | Covered | OTC |
| ***valumark lancet ultra thin 28g*** | Covered | OTC |
| ***walgreens adv travel lancets*** | Covered | OTC |
| ***walgreens lancets micro thin*** | Covered | OTC |
| ***walgreens lancets super thin*** | Covered | OTC |
| **ACCU-CHEK AVIVA** (***blood glucose calibration***) | Covered | OTC |
| **ACCU-CHEK COMPACT PLUS CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ACCU-CHEK FASTCLIX LANCET** (***lancets misc.***) | Covered | OTC |
| **ACCU-CHEK FASTCLIX LANCETS** (***lancets***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **ACCU-CHEK MULTICLIX LANCET DEV** (***lancets misc.***) | Covered | OTC |
| **ACCU-CHEK MULTICLIX LANCETS** (***lancets***) | Covered | OTC |
| **ACCU-CHEK SAFE-T PRO LANCETS** (***lancets***) | Covered | OTC |
| **ACCU-CHEK SMARTVIEW CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ACCU-CHEK SOFT TOUCH LANCETS** (***lancets***) | Covered | OTC |
| **ACCU-CHEK SOFTCLIX LANCET DEV** (***lancets misc.***) | Covered | OTC |
| **ACCU-CHEK SOFTCLIX LANCETS** (***lancets***) | Covered | OTC |
| **ACCUTREND GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ADVANCE INTUITION CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ADVANCE MICRO-DRAW CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ADVANCE MICRO-DRAW NORMAL** (***blood glucose calibration***) | Covered | OTC |
| **ADVOCATE CONTROL SOLUTION** (***blood glucose calibration***) | Covered | OTC |
| **ADVOCATE LANCETS** (***lancets***) | Covered | OTC |
| **ADVOCATE LANCETS 30G** (***lancets***) | Covered | OTC |
| **ADVOCATE LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **ADVOCATE RAPID-SAFE LANCING** (***lancet devices***) | Covered | OTC |
| **ADVOCATE REDI-CODE+ CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ADVOCATE SAFETY LANCETS** (***lancets***) | Covered | OTC |
| **ADVOCATE SAFETY LANCETS 26G** (***lancets***) | Covered | OTC |
| **AGAMATRIX CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **AGAMATRIX ULTRA-THIN LANCETS** (***lancets***) | Covered | OTC |
| **ASSURE 3 CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ASSURE 4 CONTROL LEVEL 1 & 2** (***blood glucose calibration***) | Covered | OTC |
| **ASSURE DOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ASSURE DOSE NORM/HIGH CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ASSURE HAEMOLANCE PLUS HIGH** (***lancets***) | Covered | OTC |
| **ASSURE HAEMOLANCE PLUS LOW** (***lancets***) | Covered | OTC |
| **ASSURE HAEMOLANCE PLUS MICRO** (***lancets***) | Covered | OTC |
| **ASSURE HAEMOLANCE PLUS NORMAL** (***lancets***) | Covered | OTC |
| **ASSURE HAEMOLANCE PLUS PED** (***lancets***) | Covered | OTC |
| **ASSURE II CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ASSURE II CONTROL LEVEL 1 & 2** (***blood glucose calibration***) | Covered | OTC |
| **ASSURE LANCE LANCETS** (***lancets***) | Covered | OTC |
| **ASSURE LANCE LANCETS 21G** (***lancets***) | Covered | OTC |

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|---|---|---|
| **ASSURE LANCE PLUS SAFETY 25G** (***lancets***) | Covered | OTC |
| **ASSURE LANCE PLUS SAFETY 30G** (***lancets***) | Covered | OTC |
| **ASSURE LANCETS** (***lancets***) | Covered | OTC |
| **ASSURE PRISM CONTROL LEVEL 1&2** (***blood glucose calibration***) | Covered | OTC |
| **ASSURE PRO CONTROL LEVEL 1 & 2** (***blood glucose calibration***) | Covered | OTC |
| **AUTO-LANCET** (***lancet devices***) | Covered | OTC |
| **AUTO-LANCET MINI** (***lancet devices***) | Covered | OTC |
| **AUTOLET II CLINISAFE** (***lancets misc.***) | Covered | OTC |
| **AUTOLET LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **AUTOLET LITE CLINISAFE** (***lancets misc.***) | Covered | OTC |
| **AUTOLET LITE STARTER PACK** (***lancets misc.***) | Covered | OTC |
| **AUTOLET MINI** (***lancet devices***) | Covered | OTC |
| **AUTOLET PLATFORMS** (***lancets misc.***) | Covered | OTC |
| **BAYER BREEZE 2 CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **BAYER CONTOUR** (***blood glucose calibration***) | Covered | OTC |
| **BAYER MICROLET 2 LANCING DEVIC** (***lancet devices***) | Covered | OTC |
| **BAYER MICROLET LANCETS** (***lancets***) | Covered | OTC |
| **BD LANCET ULTRAFINE 30G** (***lancets***) | Covered | OTC |
| **BD LANCET ULTRAFINE 33G** (***lancets***) | Covered | OTC |
| **BD MICROTAINER LANCETS** (***lancets***) | Covered | OTC |
| **BULLSEYE SAFETY LANCETS** (***lancets***) | Covered | OTC |
| **CARDIOCOM LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **CARESENS CONTROL A** (***blood glucose calibration***) | Covered | OTC |
| **CHEMSTRIP BG LOG BOOK** (***blood glucose monitoring suppl***) | Covered | OTC |
| **CLEANLET LANCETS 28G** (***lancets***) | Covered | OTC |
| **CLEVER CHEK LANCETS** (***lancets***) | Covered | OTC |
| **CLEVER CHOICE GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **COAGUCHEK LANCETS** (***lancets***) | Covered | OTC |
| **COOL CONTROL A** (***blood glucose calibration***) | Covered | OTC |
| **COOL CONTROL B** (***blood glucose calibration***) | Covered | OTC |
| **DROPLET LANCETS ULTRA THIN 30G** (***lancets***) | Covered | OTC |
| **DROPLET LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **DRUG MART LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **DRUG MART ON-THE-GO LANCET 30G** (***lancets***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **DRUG MART UNILET LANCETS 28G** (***lancets***) | Covered | OTC |
| **DRUG MART UNILET LANCETS 30G** (***lancets***) | Covered | OTC |
| **DUO-CARE CONTROL SOLUTION** (***blood glucose calibration***) | Covered | OTC |
| **EASY STEP CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EASY TOUCH CONTROL HIGH & LOW** (***blood glucose calibration***) | Covered | OTC |
| **EASY TOUCH HEALTHPRO CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EASY TOUCH LANCETS 21G** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 23G** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 26G** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 26G/TWIST** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 28G** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 28G/TWIST** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 30G** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 30G/TWIST** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 32G** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 32G/TWIST** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCETS 33G/TWIST** (***lancets***) | Covered | OTC |
| **EASY TOUCH LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **EASY TOUCH SAFETY LANCETS 21G** (***lancets***) | Covered | OTC |
| **EASY TOUCH SAFETY LANCETS 23G** (***lancets***) | Covered | OTC |
| **EASY TOUCH SAFETY LANCETS 26G** (***lancets***) | Covered | OTC |
| **EASY TOUCH SAFETY LANCETS 28G** (***lancets***) | Covered | OTC |
| **EASY TWIST & CAP LANCETS** (***lancets***) | Covered | OTC |
| **EASYGLUCO CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EASYMAX 15 LEVEL 1 CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EASYMAX 15 LEVEL 2 CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EASYMAX CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ELEMENT CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EMBRACE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EMBRACE EVO CONTROL LEVEL 1** (***blood glucose calibration***) | Covered | OTC |
| **EMBRACE EVO CONTROL LEVEL 2** (***blood glucose calibration***) | Covered | OTC |
| **EMBRACE GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EMBRACE LANCETS ULTRA THIN 30G** (***lancets***) | Covered | OTC |
| **EMBRACE PRO GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |

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|---|---|---|
| **EVENCARE CONTROL LOW/HIGH** (***blood glucose calibration***) | Covered | OTC |
| **EVENCARE G2 LOW/HIGH CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EVENCARE G3 LOW/HIGH CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EVENCARE MINI CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **EVOLUTION CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **E-Z JECT LANCET MICRO-THIN 33G** (***lancets***) | Covered | OTC |
| **E-Z JECT LANCET SUPER THIN 30G** (***lancets***) | Covered | OTC |
| **E-Z JECT LANCETS** (***lancets***) | Covered | OTC |
| **E-Z JECT LANCETS 21G** (***lancets***) | Covered | OTC |
| **E-Z JECT LANCETS THIN 26G** (***lancets***) | Covered | OTC |
| **EZ SMART BLOOD GLUCOSE LANCETS** (***lancets***) | Covered | OTC |
| **EZ-LETS LANCETS 21G** (***lancets***) | Covered | OTC |
| **EZ-LETS LANCETS 23G** (***lancets***) | Covered | OTC |
| **EZ-LETS LANCETS 26G** (***lancets***) | Covered | OTC |
| **EZ-LETS LANCETS 28G** (***lancets***) | Covered | OTC |
| **EZ-LETS LANCETS 30G** (***lancets***) | Covered | OTC |
| **FIFTY50 SAFETY SEAL LANCETS** (***lancets***) | Covered | OTC |
| **FIFTY50 UNILET LANCETS 33G** (***lancets***) | Covered | OTC |
| **FINE 30** (***lancets***) | Covered | OTC |
| **FINGERSTIX LANCETS** (***lancets***) | Covered | OTC |
| **FORA CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **FORA LANCETS** (***lancets***) | Covered | OTC |
| **FORA LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **FORACARE GDH CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **FORTISCARE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **FREESTYLE CONTROL SOLUTION** (***blood glucose calibration***) | Covered | OTC |
| **FREESTYLE LANCETS** (***lancets***) | Covered | OTC |
| **FREESTYLE UNISTICK II LANCETS** (***lancets***) | Covered | OTC |
| **GENTLE-LET GP LANCETS** (***lancets***) | Covered | OTC |
| **GENTLE-LET LANCETS** (***lancets***) | Covered | OTC |
| **GENTLE-LET PLATFORMS** (***lancets misc.***) | Covered | OTC |
| **GLUCOCARD 01 CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **GLUCOCARD EXPRESSION CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **GLUCOCARD SHINE CONTROL** (***blood glucose calibration***) | Covered | OTC |

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|---|---|---|
| **GLUCOCARD X-SENSOR CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **GLUCOCOM AUTOLINK TELEMONITOR** (***blood glucose monitoring suppl***) | Covered | OTC |
| **GLUCOCOM CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **GLUCOCOM LANCETS 28G** (***lancets***) | Covered | OTC |
| **GLUCOCOM LANCETS 30G** (***lancets***) | Covered | OTC |
| **GLUCOCOM LANCETS 33G** (***lancets***) | Covered | OTC |
| **HAEMOLANCE** (***lancets***) | Covered | OTC |
| **HAEMOLANCE LOW FLOW LANCETS** (***lancets***) | Covered | OTC |
| **HAEMOLANCE PLUS** (***lancets***) | Covered | OTC |
| **HAEMOLANCE PLUS HIGH FLOW** (***lancets***) | Covered | OTC |
| **HAEMOLANCE PLUS LOW FLOW** (***lancets***) | Covered | OTC |
| **HAEMOLANCE PLUS MAX FLOW** (***lancets***) | Covered | OTC |
| **HAEMOLANCE PLUS PEDIATRIC FLOW** (***lancets***) | Covered | OTC |
| **HEALTH CARE LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **HYPOLANCE AST LANCING** (***lancets misc.***) | Covered | OTC |
| **HY-VEE LANCETS** (***lancets***) | Covered | OTC |
| **IN TOUCH** (***blood glucose monitoring suppl***) | Covered | OTC |
| **IN TOUCH GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **IN TOUCH LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **IN TOUCH STERILE LANCETS 30G** (***lancets***) | Covered | OTC |
| **INFINITY CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **LANCETS ULTRA FINE** (***lancets***) | Covered | OTC |
| **LANCETS ULTRA THIN** (***lancets***) | Covered | OTC |
| **LANZO** (***lancet devices***) | Covered | OTC |
| **LIBERTY GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **LIBERTY GLUCOSE CONTROL MID** (***blood glucose calibration***) | Covered | OTC |
| **LIBERTY MEDICAL LANCETS** (***lancets***) | Covered | OTC |
| **LIBERTY MINI LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **LIFESCAN UNISTIK 2** (***lancets***) | Covered | OTC |
| **LIFESCAN UNISTIK II LANCETS** (***lancets***) | Covered | OTC |
| **LITE TOUCH LANCING PEN** (***lancet devices***) | Covered | OTC |
| **LITETOUCH LANCETS** (***lancets***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **MEDISENSE GLUCOSE KETONE CONTR** (***blood glucose calibration***) | Covered | OTC |
| **MEDISENSE HI/MID/LOW CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **MEDISENSE HIGH/LOW CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **MEDISENSE MID CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **MEDISENSE THIN LANCETS** (***lancets***) | Covered | OTC |
| **MEDLANCE EXTRA 21G** (***lancets***) | Covered | OTC |
| **MEDLANCE LITE 25G** (***lancets***) | Covered | OTC |
| **MEDLANCE PLUS EXTRA 21G** (***lancets***) | Covered | OTC |
| **MEDLANCE PLUS LANCETS** (***lancets***) | Covered | OTC |
| **MEDLANCE PLUS LITE 25G** (***lancets***) | Covered | OTC |
| **MEDLANCE PLUS SPECIAL 0.8MM** (***lancets***) | Covered | OTC |
| **MEDLANCE PLUS SUPERLITE 30G** (***lancets***) | Covered | OTC |
| **MEDLANCE PLUS UNIVERSAL 21G** (***lancets***) | Covered | OTC |
| **MEDLANCE UNIVERSAL 21G** (***lancets***) | Covered | OTC |
| **MEIJER LANCETS** (***lancets***) | Covered | OTC |
| **MEIJER LANCETS THIN** (***lancets***) | Covered | OTC |
| **MEIJER LANCETS UNIVERSAL 21G** (***lancets***) | Covered | OTC |
| **MEIJER LANCETS UNIVERSAL 30G** (***lancets***) | Covered | OTC |
| **MEIJER LANCETS UNIVERSAL 33G** (***lancets***) | Covered | OTC |
| **MEIJER SUPER THIN LANCETS** (***lancets***) | Covered | OTC |
| **MICRODOT CONTROL HIGH/LOW** (***blood glucose calibration***) | Covered | OTC |
| **MICROLET LANCETS** (***lancets***) | Covered | OTC |
| **MICROTAINER SAFETY FLOW LANCET** (***lancets***) | Covered | OTC |
| **MONOJECTOR END CAPS** (***lancets misc.***) | Covered | OTC |
| **MONOJECTOR OPD END CAPS** (***lancets misc.***) | Covered | OTC |
| **MONOLET LANCETS** (***lancets***) | Covered | OTC |
| **MONOLET OPD LANCETS** (***lancets***) | Covered | OTC |
| **MONOLETTOR SAFETY LANCETS** (***lancets***) | Covered | OTC |
| **MULTI-LANCET DEVICE 2** (***lancets misc.***) | Covered | OTC |
| **MYGLUCOHEALTH CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **MYGLUCOHEALTH LANCETS 30G** (***lancets***) | Covered | OTC |
| **NEUTEK 2TEK CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **NOVA MAX PLUS GLU/KET CONTROL** (***blood glucose calibration***) | Covered | OTC |

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|---|---|---|
| **NOVA SAFETY LANCETS 23G** (***lancets***) | Covered | OTC |
| **NOVA SAFETY LANCETS 28G** (***lancets***) | Covered | OTC |
| **NOVA SUREFLEX LANCETS** (***lancets***) | Covered | OTC |
| **NOVA SUREFLEX LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **ON CALL EXPRESS GLUCOSE CONTR** (***blood glucose calibration***) | Covered | OTC |
| **ON CALL LANCETS** (***lancets***) | Covered | OTC |
| **ON CALL LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **ON CALL PLUS GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ON CALL PLUS LANCETS** (***lancets***) | Covered | OTC |
| **ON CALL PLUS LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **ON CALL VIVID GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ONETOUCH CLUB LANCETS FINE PT** (***lancets***) | Covered | OTC |
| **ONETOUCH COMBO PACK** (***lancets***) | Covered | OTC |
| **ONETOUCH DELICA LANCETS 33G** (***lancets***) | Covered | OTC |
| **ONETOUCH DELICA LANCETS FINE** (***lancets***) | Covered | OTC |
| **ONETOUCH DELICA LANCING DEV** (***lancet devices***) | Covered | OTC |
| **ONETOUCH FINEPOINT LANCETS** (***lancets***) | Covered | OTC |
| **ONETOUCH SURESOFT LANCING DEV** (***lancets misc.***) | Covered | OTC |
| **ONETOUCH ULTRA 2** (***blood glucose monitoring suppl***) | Covered | OTC |
| **ONETOUCH ULTRA CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ONETOUCH ULTRA MINI** (***blood glucose monitoring suppl***) | Covered | OTC |
| **ONETOUCH ULTRALINK** (***blood glucose monitoring suppl***) | Covered | OTC |
| **ONETOUCH ULTRASOFT LANCETS** (***lancets***) | Covered | OTC |
| **ONETOUCH VERIO** (***blood glucose calibration***) | Covered | OTC |
| **ONETOUCH VERIO IQ SYSTEM** (***blood glucose monitoring suppl***) | Covered | OTC |
| **OPTUMRX GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **PENLET II BLOOD SAMPLER** (***lancets misc.***) | Covered | OTC |
| **PENLET II REPLACEMENT CAP** (***lancets misc.***) | Covered | OTC |
| **PERFECT LANCETS 28G** (***lancets***) | Covered | OTC |
| **PERFECT LANCETS 30G** (***lancets***) | Covered | OTC |
| **PHARMACIST CHOICE LANCETS** (***lancets***) | Covered | OTC |
| **PHARMACY COUNTER LANCETS** (***lancets***) | Covered | OTC |
| **POCKETCHEM EZ CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **PRECISION GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |

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|---|---|---|
| **PRECISION GLUCOSE CONTROL SOLN** (***blood glucose calibration***) | Covered | OTC |
| **PRECISION GLUCOSE KETONE CONTR** (***blood glucose calibration***) | Covered | OTC |
| **PRECISION GLUCOSE/KETONE CONTR** (***blood glucose calibration***) | Covered | OTC |
| **PRECISION THINS GP LANCETS** (***lancets***) | Covered | OTC |
| **PRODIGY CONTROL SOLUTION** (***blood glucose calibration***) | Covered | OTC |
| **PRODIGY LANCETS 28G** (***lancets***) | Covered | OTC |
| **PRODIGY LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **PRODIGY TWIST TOP LANCETS 28G** (***lancets***) | Covered | OTC |
| **PSS SELECT GP LANCETS** (***lancets***) | Covered | OTC |
| **PSS SELECT PLATFORMS** (***lancets misc.***) | Covered | OTC |
| **PSS SELECT SAFETY LANCETS** (***lancets***) | Covered | OTC |
| **QUICKTEK CONTROL SOLUTION** (***blood glucose calibration***) | Covered | OTC |
| **QUINTET CONTROL HIGH/NORMAL** (***blood glucose calibration***) | Covered | OTC |
| **RA E-ZJECT COLOR LANCETS 33G** (***lancets***) | Covered | OTC |
| **RA E-ZJECT LANCETS 28G** (***lancets***) | Covered | OTC |
| **RA E-ZJECT LANCETS THIN 26G** (***lancets***) | Covered | OTC |
| **RA E-ZJECT LANCETS THIN 28G** (***lancets***) | Covered | OTC |
| **RA E-ZJECT LANCETS ULTRA THIN** (***lancets***) | Covered | OTC |
| **REFUAH PLUS GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **RELION LANCETS MICRO-THIN 33G** (***lancets***) | Covered | OTC |
| **RELION LANCETS STANDARD 21G** (***lancets***) | Covered | OTC |
| **RELION LANCETS THIN 26G** (***lancets***) | Covered | OTC |
| **RELION LANCETS ULTRA-THIN 30G** (***lancets***) | Covered | OTC |
| **RELION LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **RELION ULTRA THIN LANCETS 30G** (***lancets***) | Covered | OTC |
| **RELION ULTRA THIN PLUS LANCETS** (***lancets***) | Covered | OTC |
| **REXALL LANCETS ULTRA THIN 30G** (***lancets***) | Covered | OTC |
| **RIGHTEST ALTERNATE SITE ADAPT** (***lancets misc.***) | Covered | OTC |
| **RIGHTEST GC300 CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **RIGHTEST GD500 LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **RIGHTEST GL300 LANCETS** (***lancets***) | Covered | OTC |
| **SAFE-T-LANCE** (***lancets***) | Covered | OTC |

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|---|---|---|
| **SAFE-T-LANCE PLUS** (***lancets***) | Covered | OTC |
| **SAFETY LANCETS** (***lancets***) | Covered | OTC |
| **SAFETY LANCETS 21G** (***lancets***) | Covered | OTC |
| **SAFETY LET LANCETS** (***lancets***) | Covered | OTC |
| **SAFETY SEAL LANCETS** (***lancets***) | Covered | OTC |
| **SHOPKO AUTOLET LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **SHOPKO ON-THE-GO LANCETS 30G** (***lancets***) | Covered | OTC |
| **SHOPKO UNILET LANCETS 28G** (***lancets***) | Covered | OTC |
| **SHOPKO UNILET LANCETS 30G** (***lancets***) | Covered | OTC |
| **SIMPLE DIAGNOSTICS LANCING DEV** (***lancet devices***) | Covered | OTC |
| **SINGLE-LET** (***lancets***) | Covered | OTC |
| **SMART DIABETES VANTAGE LANCING** (***lancet devices***) | Covered | OTC |
| **SMART SENSE COLOR LANCETS 33G** (***lancets***) | Covered | OTC |
| **SMART SENSE STANDARD LANCETS** (***lancets***) | Covered | OTC |
| **SMART SENSE SUPER THIN LANCETS** (***lancets***) | Covered | OTC |
| **SMART SENSE THIN LANCETS 26G** (***lancets***) | Covered | OTC |
| **SMARTEST CONTROL MEDIUM** (***blood glucose calibration***) | Covered | OTC |
| **SMARTEST LANCETS 28G** (***lancets***) | Covered | OTC |
| **SOLARTEK GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **SOLUS V2 CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **SOLUS V2 LANCETS 28G** (***lancets***) | Covered | OTC |
| **SOLUS V2 LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **SOLUS V2 TWIST LANCETS 30G** (***lancets***) | Covered | OTC |
| **STERILANCE PA** (***lancets misc.***) | Covered | OTC |
| **STERILANCE TL** (***lancets***) | Covered | OTC |
| **SURE-LANCE FLAT LANCETS** (***lancets***) | Covered | OTC |
| **SURE-LANCE LANCETS 26G** (***lancets***) | Covered | OTC |
| **SURE-LANCE THIN LANCETS 28G** (***lancets***) | Covered | OTC |
| **SURE-LANCE ULTRA THIN LANCETS** (***lancets***) | Covered | OTC |
| **SURELITE LANCETS** (***lancets***) | Covered | OTC |
| **SURE-PEN** (***lancet devices***) | Covered | OTC |
| **SURESTEP GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **SURESTEP PRO HIGH GLUCOSE** (***blood glucose calibration***) | Covered | OTC |
| **SURESTEP PRO LINEARITY** (***blood glucose monitoring suppl***) | Covered | OTC |

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| **SURESTEP PRO LOW GLUCOSE** (***blood glucose calibration***) | Covered | OTC |
| **SURESTEP PRO NORMAL GLUCOSE** (***blood glucose calibration***) | Covered | OTC |
| **SURE-TOUCH LANCETS UNIVERSAL** (***lancets***) | Covered | OTC |
| **TAI DOC CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **TECHLITE AST LANCETS** (***lancets***) | Covered | OTC |
| **TECHLITE LANCETS** (***lancets***) | Covered | OTC |
| **TECHLITE LANCETS 30G** (***lancets***) | Covered | OTC |
| **TELCARE GLUCOSE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **THINLETS GP LANCETS** (***lancets***) | Covered | OTC |
| **TRACER II 3 VOLT BATTERY** (***blood glucose monitoring suppl***) | Covered | OTC |
| **TRUE METRIX LEVEL 1** (***blood glucose calibration***) | Covered | OTC |
| **TRUE METRIX LEVEL 2** (***blood glucose calibration***) | Covered | OTC |
| **TRUE METRIX LEVEL 3** (***blood glucose calibration***) | Covered | OTC |
| **TRUECONTROL GLUCOSE CONT LEV 0** (***blood glucose calibration***) | Covered | OTC |
| **TRUECONTROL GLUCOSE CONT LEV 1** (***blood glucose calibration***) | Covered | OTC |
| **TRUEDRAW LANCING DEVICE** (***lancet devices***) | Covered | OTC |
| **TRUEPLUS LANCETS 26G** (***lancets***) | Covered | OTC |
| **TRUEPLUS LANCETS 28G** (***lancets***) | Covered | OTC |
| **TRUEPLUS LANCETS 30G** (***lancets***) | Covered | OTC |
| **TRUEPLUS LANCETS 33G** (***lancets***) | Covered | OTC |
| **TRUEPLUS SAFETY LANCETS 28G** (***lancets***) | Covered | OTC |
| **ULTI-LANCE AUTOMATIC** (***lancet devices***) | Covered | OTC |
| **ULTILET CLASSIC LANCETS** (***lancets***) | Covered | OTC |
| **ULTILET LANCETS** (***lancets***) | Covered | OTC |
| **ULTILET SAFETY LANCETS 23G** (***lancets***) | Covered | OTC |
| **ULTRALANCE** (***lancets misc.***) | Covered | OTC |
| **ULTRA-THIN II AUTO LANCET** (***lancets***) | Covered | OTC |
| **ULTRA-THIN II LANCETS** (***lancets***) | Covered | OTC |
| **ULTRATRAK PRO CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **ULTRATRAK ULTIMATE CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **UNILET COMFORTOUCH LANCET** (***lancets***) | Covered | OTC |
| **UNILET EXCELITE** (***lancets***) | Covered | OTC |

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|---|---|---|
| **UNILET EXCELITE II** (***lancets***) | Covered | OTC |
| **UNILET G.P. LANCET** (***lancets***) | Covered | OTC |
| **UNILET G.P. SUPERLITE LANCET** (***lancets***) | Covered | OTC |
| **UNILET GP 28 ULTRA THIN** (***lancets***) | Covered | OTC |
| **UNILET LANCET** (***lancets***) | Covered | OTC |
| **UNILET MICRO-THIN 33G** (***lancets***) | Covered | OTC |
| **UNILET SUPERLITE LANCET** (***lancets***) | Covered | OTC |
| **UNILET SUPER-THIN 30G** (***lancets***) | Covered | OTC |
| **UNILET ULTRA-THIN 28G** (***lancets***) | Covered | OTC |
| **UNISTIK 1** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 2** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 2 COMFORT** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 2 EXTRA** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 2 NEONATAL** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 2 NORMAL** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 2 SUPER** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 3** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 3 COMFORT** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 3 EXTRA** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 3 GENTLE** (***lancets***) | Covered | OTC |
| **UNISTIK 3 NEONATAL** (***lancets misc.***) | Covered | OTC |
| **UNISTIK 3 NORMAL** (***lancets misc.***) | Covered | OTC |
| **UNISTIK CZT COMFORT** (***lancets misc.***) | Covered | OTC |
| **UNISTIK CZT NORMAL** (***lancets misc.***) | Covered | OTC |
| **UNISTIK SAFETY LANCETS 28G** (***lancets***) | Covered | OTC |
| **UNISTIK SAFETY LANCETS 30G** (***lancets***) | Covered | OTC |
| **UNISTIK TOUCH SAFETY LANC 21G** (***lancets***) | Covered | OTC |
| **UNISTIK TOUCH SAFETY LANC 23G** (***lancets***) | Covered | OTC |
| **UNISTIK TOUCH SAFETY LANC 28G** (***lancets***) | Covered | OTC |
| **UNISTIK TOUCH SAFETY LANC 30G** (***lancets***) | Covered | OTC |
| **UNISTRIP CONTROL** (***blood glucose calibration***) | Covered | OTC |
| **UNIVERSAL 1 LANCETS THIN 26G** (***lancets***) | Covered | OTC |
| **UNIVERSAL 1 LANCETS ULTRA THIN** (***lancets***) | Covered | OTC |
| **VICTORY CONTROL LEVEL 1/2** (***blood glucose calibration***) | Covered | OTC |

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|---|---|---|
| **VIDA MIA AUTOLET LANCING DEV** (***lancet devices***) | Covered | OTC |
| **VIDA MIA UNILET LANCETS 28G** (***lancets***) | Covered | OTC |
| **VIDA MIA UNILET LANCETS 30G** (***lancets***) | Covered | OTC |
| **VITALET PRO LANCETS** (***lancets***) | Covered | OTC |
| **VITALET PRO PLUS LANCETS** (***lancets***) | Covered | OTC |
| **WALGREENS LANCETS** (***lancets***) | Covered | OTC |
| **WALGREENS THIN LANCETS** (***lancets***) | Covered | OTC |
| **WALGREENS ULTRA THIN LANCETS** (***lancets***) | Covered | OTC |
| ****Needles & Syringes*** - Medical Supplies And Durable Medical Equipment*** | | |
| ***careone insulin syringe*** | Covered | OTC |
| ***easy comfort insulin syringe*** | Covered | OTC |
| ***elite-thin insulin syringe*** | Covered | OTC |
| ***eql insulin syringe*** | Covered | OTC |
| ***global inject ease insulin syr*** | Covered | OTC |
| ***gnp insulin syringe*** | Covered | OTC |
| ***gnp ultra com insulin syringe*** | Covered | OTC |
| ***insulin syringe*** | Covered | OTC |
| ***insulin syringe/needle*** | Covered | OTC |
| ***kinray insulin syringe*** | Covered | OTC |
| ***kmart valu insulin syringe 29g*** | Covered | OTC |
| ***kmart valu insulin syringe 30g*** | Covered | OTC |
| ***kroger insulin syringe*** | Covered | OTC |
| ***leader insulin syringe*** | Covered | OTC |
| ***longs insulin syringe*** | Covered | OTC |
| ***medic insulin syringe*** | Covered | OTC |
| ***ms insulin syringe*** | Covered | OTC |
| ***preferred plus insulin syringe*** | Covered | OTC |
| ***px insulin syringe*** | Covered | OTC |
| ***ra insulin syringe*** | Covered | OTC |
| ***reality insulin syringe*** | Covered | OTC |
| ***sb insulin syringe*** | Covered | OTC |
| ***sure comfort insulin syringe*** | Covered | OTC |
| ***syringe*** | Covered | OTC |

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|---|---|---|
| ***syringe luer slip*** | Covered | OTC |
| ***topcare ultra comfort ins syr*** | Covered | OTC; QL (100 EA per 30 days) |
| ***ultra comfort insulin syringe*** | Covered | OTC |
| ***ultra-comfort insulin syringe*** | Covered | OTC |
| ***value health insulin syringe*** | Covered | OTC |
| ***vp insulin syringe*** | Covered | OTC |
| **ADVOCATE INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **ASSURE ID INSULIN SAFETY SYR** (***insulin syringe-needle u-100***) | Covered | |
| **BD ECLIPSE SYRINGE** (***syringe/needle (disp)***) | Covered | OTC |
| **BD INSULIN SYR ULTRAFINE II** (***insulin syringe-needle u-100***) | Covered | ST; OTC |
| **BD INSULIN SYRINGE 25G X 1" 1 ML, 25G X 5/8" 1 ML, 26G X 1/2" 1 ML, 27.5G X 5/8" 2 ML, 27G X 1/2" 1 ML** (***insulin syringe-needle u-100***) | Covered | OTC |
| **BD INSULIN SYRINGE 29G X 1/2" 1 ML** (***insulin syringe-needle u-100***) | Covered | ST; OTC |
| **BD INSULIN SYRINGE MICROFINE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **BD INSULIN SYRINGE U/F 30G X 1/2" 1 ML** (***insulin syringe-needle u-100***) | Covered | OTC |
| **BD INSULIN SYRINGE U/F 31G X 5/16" 0.3 ML** (***insulin syringe-needle u-100***) | Covered | ST; OTC |
| **BD INSULIN SYRINGE U-100 1 ML** (***insulin syringes (disposable)***) | Covered | OTC |
| **BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 31G X 5/16" 0.5 ML** (***insulin syringe-needle u-100***) | Covered | ST; OTC |
| **BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML** (***insulin syringe-needle u-100***) | Covered | OTC |
| **BD LUER-LOK SYRINGE** (***syringe/needle (disp)***) | Covered | OTC |
| **BD PEN NEEDLE MICRO U/F** (***insulin pen needle***) | Covered | ST; OTC |
| **BD PEN NEEDLE MINI U/F** (***insulin pen needle***) | Covered | ST; OTC |
| **BD PEN NEEDLE NANO 2ND GEN** (***insulin pen needle***) | Covered | ST; OTC |
| **BD PEN NEEDLE NANO U/F** (***insulin pen needle***) | Covered | ST |
| **BD PEN NEEDLE ORIGINAL U/F** (***insulin pen needle***) | Covered | ST; OTC |
| **BD PEN NEEDLE SHORT U/F** (***insulin pen needle***) | Covered | ST; OTC |
| **BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML** (***insulin syringe-needle u-100***) | Covered | OTC |
| **BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML** (***insulin syringe-needle u-100***) | Covered | ST; OTC |

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**AL** = Age Restrictions
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **BD SAFETYGLIDE SYRINGE/NEEDLE** (***syringe/needle (disp)***) | Covered | OTC |
| **BD SAFETY-LOK INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | ST; OTC |
| **BD SYRINGE/NEEDLE** (***syringe/needle (disp)***) | Covered | OTC |
| **BD SYRINGE/NEEDLE SLIP TIP** (***syringe/needle (disp)***) | Covered | OTC |
| **COMFORT ASSIST INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **COMFORT EZ INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **EASY TOUCH FLIPLOCK INSULIN SY** (***insulin syringe-needle u-100***) | Covered | OTC |
| **EASY TOUCH FLIPLOCK SAFETY SYR** (***syringe/needle (disp)***) | Covered | OTC |
| **EASY TOUCH FLURINGE** (***syringe/needle (disp)***) | Covered | OTC |
| **EASY TOUCH FLURINGE FLIPLOCK** (***syringe/needle (disp)***) | Covered | OTC |
| **EASY TOUCH FLURINGE SHEATHLOCK** (***syringe/needle (disp)***) | Covered | OTC |
| **EASY TOUCH INSULIN SAFETY SYR** (***insulin syringe-needle u-100***) | Covered | OTC |
| **EASY TOUCH INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **EASY TOUCH SAFETY SYRINGE** (***syringe/needle (disp)***) | Covered | OTC |
| **EASY TOUCH SHEATHLOCK SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC; QL (100 EA per 30 days) |
| **EASY TOUCH TB SHEATHLOCK SYR** (***syringe/needle (disp)***) | Covered | OTC |
| **EXEL COMFORT POINT INSULIN SYR** (***insulin syringe-needle u-100***) | Covered | OTC |
| **FIFTY50 SUPERIOR COMFORT SYR** (***insulin syringe-needle u-100***) | Covered | OTC; QL (100 EA per 30 days) |
| **FREESTYLE PRECISION INS SYR** (***insulin syringe-needle u-100***) | Covered | OTC; QL (100 EA per 30 days) |
| **GLUCOPRO INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **HM ULTICARE INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **LITETOUCH INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **MAGELLAN INSULIN SAFETY SYR** (***insulin syringe-needle u-100***) | Covered | |
| **MAXI-COMFORT INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML, 31G X 5/16" 1 ML** (***insulin syringe-needle u-100***) | Covered | OTC |
| **MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML** (***insulin syringe-needle u-100***) | Covered | |
| **MONOJECT INSULIN SYRINGE U-100 1 ML** (***insulin syringes (disposable)***) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **MONOJECT LIFESHIELD SYRINGE** (***syringe/needle (disp)***) | Covered | |
| **MONOJECT MAGELLAN SYRINGE** (***syringe/needle (disp)***) | Covered | |
| **MONOJECT SYRINGE 18G X 1" 12 ML, 20G X 1-1/2" 6 ML, 21G X 1" 12 ML, 21G X 1" 6 ML, 21G X 1-1/2" 6 ML, 22G X 1-1/2" 6 ML** (***syringe/needle (disp)***) | Covered | |
| **MONOJECT SYRINGE 20G X 1-1/2" 12 ML, 21G X 1-1/2" 12 ML** (***syringe/needle (disp)***) | Covered | OTC |
| **MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML** (***insulin syringe-needle u-100***) | Covered | QL (100 EA per 30 days) |
| **MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML** (***insulin syringe-needle u-100***) | Covered | OTC; QL (100 EA per 30 days) |
| **PRECISION SUREDOSE PLUS SYR** (***insulin syringe-needle u-100***) | Covered | OTC; QL (100 EA per 30 days) |
| **PRECISION SURE-DOSE SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC; QL (100 EA per 30 days) |
| **PRODIGY INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **RELION INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **RELI-ON INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **SAFESNAP INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **SURE-JECT INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **TRUEPLUS INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **ULTICARE INSULIN SAFETY SYR** (***insulin syringe-needle u-100***) | Covered | |
| **ULTICARE INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **ULTICARE SYRINGE** (***syringe/needle (disp)***) | Covered | OTC |
| **ULTILET INSULIN SYRINGE SHORT** (***insulin syringe-needle u-100***) | Covered | OTC |
| **ULTRA-THIN II INS SYR SHORT** (***insulin syringe-needle u-100***) | Covered | OTC; QL (100 EA per 30 days) |
| **ULTRA-THIN II INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **VANISHPOINT INSULIN SYRINGE** (***insulin syringe-needle u-100***) | Covered | OTC |
| **VANISHPOINT SYRINGE** (***syringe/needle (disp)***) | Covered | OTC |
| ****Peak Flow Meters*** - Medical Supplies And Durable Medical Equipment*** | | |
| ***peak flow meter universal rang*** | Covered | OTC; QL (2 EA per 1 Year) |
| **AIRZONE PEAK FLOW METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **ASSESS FULL RANGE PEAK METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **ASSESS LOW RANGE PEAK METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **ASSESS PEAK FLOW METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **ASTHMA CHECK METER-ZONE SYSTEM** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **ASTHMAMENTOR** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **MICROLIFE DIGITAL PEAK FLOW** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **MINI WRIGHT PEAK FLOW METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **PEAK AIR PEAK FLOW METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **PERSONAL BEST FULL RANGE** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **PERSONAL BEST LOW RANGE** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **PIKO 1** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **POCKET PEAK FLOW METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **POCKETPEAK PEAK FLOW METER** (***peak flow meter***) | Covered | OTC; QL (2 EA per 1 Year) |
| **TRUZONE PEAK FLOW METER** (***peak flow meter***) | Covered | QL (2 EA per 1 Year) |
| ****Respiratory Therapy Supplies*** - Medical Supplies And Durable Medical Equipment*** | | |
| **BREATHERITE VALVED MDI CHAMBER** (***respiratory therapy supplies***) | Covered | QL (2 EA per 1 year) |
| **PRIMEAIRE HOLDING CHAMBER** (***respiratory therapy supplies***) | Covered | QL (2 EA per 1 year) |
| **VORTEX HOLDING CHAMBER/MASK** (***respiratory therapy supplies***) | Covered | QL (2 EA per 1 year) |
| ****Spacer/Aerosol-Holding Chambers & Supplies*** - Medical Supplies And Durable Medical Equipment*** | | |
| ***valved holding chamber*** | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER MINI CHAMBER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER MV** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS FLO-VU** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS FLO-VU LARGE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS FLO-VU MEDIUM** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS FLO-VU SMALL** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS FLO-VU W/MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS FLOW VU** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER PLUS W/MASK SMALL** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **AEROCHAMBER W/FLOWSIGNAL** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER Z-STAT PLUS** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER Z-STAT PLUS CHAMBR** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER Z-STAT PLUS/LARGE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER Z-STAT PLUS/MEDIUM** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROCHAMBER Z-STAT PLUS/SMALL** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **AEROVENT PLUS** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **ARIAL CHAMBER** (***spacer/aero-holding chambers***) | Covered | OTC; QL (2 EA per 1 year) |
| **BREATHERITE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE COLL SPACER ADULT** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE COLL SPACER CHILD** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE COLL SPACER INFANT** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE RIGID SPACER/MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE SPACER NEONATE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE SPACER SMALL CHILD** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE/LARGE MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE/MEDIUM MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **BREATHERITE/SMALL MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **COMPACT SPACE CHAMBER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **COMPACT SPACE CHAMBER/LG MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **COMPACT SPACE CHAMBER/MED MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **COMPACT SPACE CHAMBER/SM MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **EASIVENT** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **EASIVENT MASK LARGE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **EASIVENT MASK MEDIUM** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **EASIVENT MASK SMALL** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **FLEXICHAMBER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **FLEXICHAMBER ADULT MASK/SMALL** (***spacer/aero-hold chamber mask***) | Covered | QL (2 EA per 1 year) |
| **FLEXICHAMBER CHILD MASK/LARGE** (***spacer/aero-hold chamber mask***) | Covered | QL (2 EA per 1 year) |
| **FLEXICHAMBER CHILD MASK/SMALL** (***spacer/aero-hold chamber mask***) | Covered | QL (2 EA per 1 year) |
| **INSPIRACHAMBER/LARGE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **INSPIRACHAMBER/MEDIUM** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **INSPIRACHAMBER/MOUTHPIECE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **INSPIRACHAMBER/SMALL** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **INSPIREASE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **LITEAIRE** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **MICROCHAMBER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **MICROSPACER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER ADVANTAGE-LG MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER ADVANTAGE-MED MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER ADVANTAGE-SM MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER DIAMOND** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER DIAMOND-LG MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER DIAMOND-MD MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER DIAMOND-SM MASK** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **OPTICHAMBER FACE MASK-LARGE** (***spacer/aero-holding chambers***) | Covered | OTC; QL (2 EA per 1 year) |
| **OPTICHAMBER FACE MASK-MEDIUM** (***spacer/aero-holding chambers***) | Covered | OTC; QL (2 EA per 1 year) |
| **OPTICHAMBER FACE MASK-SMALL** (***spacer/aero-holding chambers***) | Covered | OTC; QL (2 EA per 1 year) |
| **OPTIHALER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |

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|---|---|---|
| **POCKET CHAMBER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **POCKET SPACER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **RITEFLO** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| **VORTEX VALVED HOLDING CHAMBER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 year) |
| **WATCHHALER** (***spacer/aero-holding chambers***) | Covered | QL (2 EA per 1 Year) |
| ***Migraine Products* - Drugs For The Nervous System** | | |
| ****Selective Serotonin Agonists 5-Ht(1)*** - Drugs For Migraine Headaches*** | | |
| ***naratriptan hcl*** | Covered | QL (9 EA per 30 days) |
| ***rizatriptan benzoate*** | Covered | QL (9 EA per 30 days) |
| ***sumatriptan*** | Covered | QL (6 EA per 30 days) |
| ***sumatriptan succinate oral*** | Covered | QL (9 EA per 30 days) |
| ***sumatriptan succinate refill*** | Covered | QL (4 Vials per 30 days) |
| ***sumatriptan succinate subcutaneous*** | Covered | QL (4 Vials per 30 days) |
| ***Minerals & Electrolytes* - Drugs For Nutrition** | | |
| ****Bicarbonates*** - Drugs For Nutrition*** | | |
| ***sodium acetate*** | Covered | PA |
| ***sodium bicarbonate*** | Covered | |
| ****Calcium Combinations*** - Drugs For Nutrition*** | | |
| ***calcium*** | Covered | OTC |
| ***calcium + d3*** | Covered | OTC |
| ***calcium 500 + d*** | Covered | OTC |
| ***calcium 500 +d*** | Covered | OTC |
| ***calcium 500/d*** | Covered | OTC |
| ***calcium 500/vitamin d*** | Covered | OTC |
| ***calcium 500+d*** | Covered | OTC |
| ***calcium 500+d high potency*** | Covered | OTC |
| ***calcium 600 + d*** | Covered | OTC |
| ***calcium 600 + minerals*** | Covered | OTC |
| ***calcium 600/vitamin d*** | Covered | OTC |
| ***calcium 600+d*** | Covered | OTC |
| ***calcium 600+d high potency*** | Covered | OTC |
| ***calcium 600+d plus minerals*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***calcium 600+d3*** | Covered | OTC |
| ***calcium 600-d*** | Covered | OTC |
| ***calcium carbonate-vitamin d*** | Covered | OTC |
| ***calcium carbonate-vitamin d3*** | Covered | OTC |
| ***calcium high potency/vitamin d*** | Covered | OTC |
| ***calcium-vitamin d*** | Covered | OTC |
| ***calcium-vitamin d3*** | Covered | OTC |
| ***calcium-vitamin d-minerals*** | Covered | OTC |
| ***cvs oyster shell calcium+vit d*** | Covered | OTC |
| ***eq calcium 500+d*** | Covered | OTC |
| ***eql calcium/vitamin d*** | Covered | OTC |
| ***gnp calcium 500/d*** | Covered | OTC |
| ***gnp calcium 600 plus d/mineral*** | Covered | OTC |
| ***gnp calcium 600/d*** | Covered | OTC |
| ***gnp calcium plus 600 +d*** | Covered | OTC |
| ***gnp calcium/vitamin d/minerals*** | Covered | OTC |
| ***hm calcium-vitamin d*** | Covered | OTC |
| ***hm calcium-vitamin d-minerals*** | Covered | OTC |
| ***kp calcium 600+d*** | Covered | OTC |
| ***oscal 500/200 d-3*** | Covered | OTC |
| ***oyster calcium + d*** | Covered | OTC |
| ***oyster shell calcium*** | Covered | OTC |
| ***oyster shell calcium + d*** | Covered | OTC |
| ***oyster shell calcium + d3*** | Covered | OTC |
| ***oyster shell calcium 250+d*** | Covered | OTC |
| ***oyster shell calcium 500 + d*** | Covered | OTC |
| ***oyster shell calcium 500+d*** | Covered | OTC |
| ***oyster shell calcium plus d*** | Covered | OTC |
| ***oyster shell calcium/d*** | Covered | OTC |
| ***oyster shell calcium/d3*** | Covered | OTC |
| ***oyster shell calcium/vitamin d*** | Covered | OTC |
| ***oyster shell/vitamin d*** | Covered | OTC |
| ***pa calcium/vitamin d*** | Covered | OTC |
| ***pa oyster shell calcium*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***px calcium&d*** | Covered | OTC |
| ***qc calcium/minerals/vitamin d*** | Covered | OTC |
| ***ra calcium 600/vit d/minerals*** | Covered | OTC |
| ***ra calcium 600/vitamin d-3*** | Covered | OTC |
| ***ra calcium plus vitamin d*** | Covered | OTC |
| ***ra calcium plus vitamin d3*** | Covered | OTC |
| ***ra calcium/vitamin d/minerals*** | Covered | OTC |
| ***ra oyster shell calcium/d*** | Covered | OTC |
| ***risacal-d*** | Covered | OTC |
| ***sb calcium + d*** | Covered | OTC |
| ***sm calcium 500/vitamin d3*** | Covered | OTC |
| ***sm calcium 600/vitamin d*** | Covered | OTC |
| ***sm calcium-vitamin d*** | Covered | OTC |
| ***sm oyster shell calcium/vit d*** | Covered | OTC |
| ***sm oyster shell calcium/vit d3*** | Covered | OTC |
| ***super calcium 600 + d 400*** | Covered | OTC |
| ***super calcium 600 + d3*** | Covered | OTC |
| **OS-CAL CALCIUM + D3** (***calcium carb-cholecalciferol***) | Covered | OTC |
| **OYSCO 500+D** (***calcium carb-cholecalciferol***) | Covered | OTC |
| **OYSTERCAL-D** (***calcium carb-cholecalciferol***) | Covered | OTC |
| **RA HI CAL** (***calcium carb-cholecalciferol***) | Covered | OTC |
| **RA HI-CAL PLUS VITAMIN D** (***calcium carb-cholecalciferol***) | Covered | OTC |
| ****Calcium*** - Drugs For Nutrition*** | | |
| ***calcium*** | Covered | OTC |
| ***calcium 600*** | Covered | OTC |
| ***calcium 600 high potency*** | Covered | OTC |
| ***calcium carbonate*** | Covered | |
| ***calcium carbonate extra light*** | Covered | OTC |
| ***calcium carbonate light*** | Covered | |
| ***calcium carbonate oral*** | Covered | OTC |
| ***calcium chloride*** | Covered | PA |
| ***calcium citrate*** | Covered | OTC |
| ***calcium high potency*** | Covered | OTC |
| ***calcium oyster shell*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***cvs calcium carbonate*** | Covered | OTC |
| ***gnp calcium*** | Covered | OTC |
| ***oyster shell calcium*** | Covered | OTC |
| ***qc calcium fast dissolution*** | Covered | OTC |
| ***ra calcium*** | Covered | OTC |
| ***ra calcium 600*** | Covered | OTC |
| ***ra calcium hi-cal*** | Covered | OTC |
| ***ra calcium high potency*** | Covered | OTC |
| ***ra oyster shell calcium*** | Covered | OTC |
| ***sb oyster shell calcium*** | Covered | OTC |
| ***super calcium*** | Covered | OTC |
| **CAL-CARB FORTE** (***calcium carbonate***) | Covered | OTC |
| **CALCITRATE** (***calcium citrate***) | Covered | OTC |
| **CALTRATE 600** (***calcium carbonate***) | Covered | OTC |
| **HIGH POTENCY CALCIUM** (***calcium carbonate***) | Covered | OTC |
| **OYSCO 500** (***oyster shell***) | Covered | OTC |
| **OYSTERCAL** (***oyster shell***) | Covered | OTC |
| **RA HI-CAL** (***oyster shell***) | Covered | OTC |
| ****Electrolytes & Dextrose*** - Drugs For Nutrition*** | | |
| ***dextrose 5%/electrolyte #48*** | Covered | |
| ***dextrose in lactated ringers*** | Covered | |
| ***dextrose-nacl*** | Covered | |
| ***kcl in d5w lactated ringers*** | Covered | |
| ***kcl in dextrose-nacl*** | Covered | |
| ***kcl-lactated ringers-d5w*** | Covered | |
| ***kcl-lidocaine in d5w*** | Covered | |
| ***potassium chloride in dextrose*** | Covered | |
| **IONOSOL-MB IN D5W** (***electrolyte-mb in dextrose***) | Covered | |
| **ISOLYTE-P IN D5W** (***electrolyte-p in dextrose***) | Covered | |
| **NORMOSOL-M IN D5W** (***electrolyte-m in dextrose***) | Covered | |
| **NORMOSOL-R IN D5W** (***electrolyte-r in dextrose***) | Covered | |
| ****Electrolytes Oral*** - Drugs For Nutrition*** | | |
| ***cvs electrolyte solution*** | Covered | OTC |
| ***cvs ped electrolyte freeze pop*** | Covered | OTC |

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|---|---|---|
| ***cvs pediatric electrolyte*** | Covered | OTC |
| ***gnp pediatric electrolyte*** | Covered | OTC |
| ***h-e-b oral electrolyte*** | Covered | OTC |
| ***hm pediatric electrolyte*** | Covered | OTC |
| ***oral electrolyte freezer pops*** | Covered | OTC |
| ***oral electrolytes*** | Covered | OTC |
| ***ped electrolyte freeze pops*** | Covered | OTC |
| ***ped electrolyte freezer pops*** | Covered | OTC |
| ***pediatric electrolyte*** | Covered | OTC |
| ***pediatric electrolyte-zinc*** | Covered | OTC |
| ***ra ped electrolyte freezer pop*** | Covered | OTC |
| ***ra pediatric electrolyte*** | Covered | OTC |
| ***sb pediatric electrolyte*** | Covered | OTC |
| ***sm pediatric electrolyte*** | Covered | OTC |
| **ADVANTAGE CARE ELECTROLYTE PED** (***oral electrolytes***) | Covered | OTC |
| **CERALYTE 70** (***oral electrolytes***) | Covered | OTC |
| **ORALYTE** (***oral electrolytes***) | Covered | OTC |
| **ORALYTE FREEZER POPS** (***oral electrolytes***) | Covered | OTC |
| **PEDIA VANCE** (***oral electrolytes***) | Covered | OTC |
| **REHYDRALYTE** (***oral electrolytes***) | Covered | OTC |
| ****Electrolytes Parenteral*** - Drugs For Nutrition*** | | |
| ***kcl-lidocaine-nacl*** | Covered | |
| ***lactated ringers*** | Covered | |
| ***potassium chloride in nacl*** | Covered | |
| ***ringers*** | Covered | |
| **HYPERLYTE-CR** (***parenteral electrolytes***) | Covered | |
| **ISOLYTE-S** (***electrolyte-s***) | Covered | |
| **ISOLYTE-S PH 7.4** (***electrolyte-s (ph 7.4)***) | Covered | |
| **NORMOSOL-R** (***electrolyte-r***) | Covered | |
| **NORMOSOL-R PH 7.4** (***electrolyte-r (ph 7.4)***) | Covered | |
| **PLASMA-LYTE 148** (***electrolyte-148***) | Covered | |
| **PLASMA-LYTE A** (***electrolyte-a***) | Covered | |
| **TPN ELECTROLYTES** (***parenteral electrolytes***) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Fluoride*** - Drugs For Nutrition*** | | |
| ***fluoritab*** | Covered | |
| ***sodium fluoride*** | Covered | |
| ***sodium fluoride*** (Ludent) | Covered | |
| ***sodium fluoride*** (Nafrinse) | Covered | |
| ***Magnesium*** - Drugs For Nutrition*** | | |
| ***cvs magnesium*** | Covered | OTC |
| ***cvs magnesium oxide*** | Covered | OTC |
| ***essential magnesium*** | Covered | OTC |
| ***gnp magnesium*** | Covered | OTC |
| ***magnesium*** | Covered | OTC |
| ***magnesium oxide*** | Covered | OTC |
| ***magnesium oxide -mg supplement*** | Covered | OTC |
| ***ra magnesium*** | Covered | OTC |
| ***ra natural magnesium*** | Covered | OTC |
| ***sm magnesium*** | Covered | OTC |
| ***Phosphate*** - Drugs For Nutrition*** | | |
| ***av-phos 250 neutral*** | Covered | |
| ***virt-phos 250 neutral*** | Covered | |
| **K-PHOS** (***potassium phosphate monobasic***) | Covered | |
| ***k phos mono-sod phos di & mono*** (Phospha 250 Neutral) | Covered | |
| ***Potassium Combinations*** - Drugs For Nutrition*** | | |
| ***effervescent pot chloride*** | Covered | |
| ***pot bicarb-pot chloride*** | Covered | |
| ***Potassium*** - Drugs For Nutrition*** | | |
| ***k-effervescent*** | Covered | |
| ***k-vescent*** | Covered | |
| ***potassium bicarbonate*** | Covered | |
| ***potassium chloride crys er*** | Covered | |
| ***potassium chloride er*** | Covered | |
| ***potassium bicarbonate*** (Effer-K) | Covered | |
| ***potassium chloride*** (Klor-Con 10) | Covered | |
| ***potassium chloride crys er*** (Klor-Con M10) | Covered | |
| ***potassium chloride crys er*** (Klor-Con M15) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***potassium chloride crys er*** (Klor-Con M20) | Covered | |
| ***potassium chloride*** (Klor-Con Sprinkle) | Covered | |
| ***potassium bicarbonate*** (Klor-Con/Ef) | Covered | |
| ***potassium bicarbonate*** (K-Prime) | Covered | |
| ****Sodium*** - Drugs For Nutrition*** | | |
| ***sodium chloride*** | Covered | |
| ****Trace Mineral Combinations*** - Drugs For Nutrition*** | | |
| ***multitrace-4 concentrate*** | Covered | PA |
| ***multitrace-5 concentrate*** | Covered | PA |
| **MULTITRACE-4** (***trace minerals cr-cu-mn-zn***) | Covered | PA |
| **MULTITRACE-4 NEONATAL** (***trace minerals cr-cu-mn-zn***) | Covered | PA |
| **MULTITRACE-4 PEDIATRIC** (***trace minerals cr-cu-mn-zn***) | Covered | PA |
| **MULTITRACE-5** (***trace minerals cr-cu-mn-se-zn***) | Covered | PA |
| **THE LIQUILIFT TRACE** (***trace minerals cr-cu-mn-se-zn***) | Covered | PA |
| **TRACE ELEMENTS 4/PEDIATRIC** (***trace minerals cr-cu-mn-zn***) | Covered | PA |
| ****Trace Minerals*** - Drugs For Nutrition*** | | |
| ***copper chloride*** | Covered | PA |
| ***selenium*** | Covered | PA |
| ***Miscellaneous Therapeutic Classes* - Vitamins And Minerals** | | |
| ****Chelating Agents*** - Vitamins And Minerals*** | | |
| ***penicillamine*** | Covered | PA; QL (8 EA per 1 day) |
| ****Cyclosporine Analogs*** - Vitamins And Minerals*** | | |
| ***cyclosporine*** | Covered | |
| ***cyclosporine modified*** | Covered | |
| ****Immunomodulators For Myelodysplastic Syndromes*** - Vitamins And Minerals*** | | |
| **REVLIMID** (***lenalidomide***) | Covered | PA; QL (1 EA per 1 day) |
| ****Inosine Monophosphate Dehydrogenase Inhibitors*** - Vitamins And Minerals*** | | |
| ***mycophenolate mofetil*** | Covered | |
| ****Irrigation Solutions*** - Vitamins And Minerals*** | | |
| ***sterile water for irrigation*** | Covered | |
| ***water for irrigation, sterile*** (Argyle Sterile Water) | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Macrolide Immunosuppressants*** - Vitamins And Minerals*** | | |
| ***sirolimus*** | Covered | |
| ***tacrolimus*** | Covered | |
| ***Potassium Removing Agents*** - Vitamins And Minerals*** | | |
| ***sodium polystyrene sulfonate*** | Covered | |
| ***sodium polystyrene sulfonate*** (Kionex) | Covered | |
| ***Purine Analogs*** - Vitamins And Minerals*** | | |
| ***azathioprine*** | Covered | |
| ***Mouth/Throat/Dental Agents* - Drugs For The Mouth And Throat** | | |
| ***Anesthetics Topical Oral*** - Drugs For The Mouth And Throat*** | | |
| ***lidocaine hcl*** | Covered | |
| ***lidocaine viscous*** | Covered | |
| ***Anti-Infectives - Throat*** - Drugs For The Mouth And Throat*** | | |
| ***clotrimazole*** | Covered | |
| ***nystatin*** | Covered | |
| ***Antiseptics - Mouth/Throat*** - Drugs For The Mouth And Throat*** | | |
| ***chlorhexidine gluconate*** | Covered | |
| ***chlorhexidine gluconate*** (Paroex) | Covered | |
| ***Fluoride Dental Products*** - Drugs For The Mouth And Throat*** | | |
| ***sf*** | Covered | |
| ***sf 5000 plus*** | Covered | |
| ***sodium fluoride*** (Cavarest) | Covered | |
| ***sodium fluoride*** (Denta 5000 Plus) | Covered | |
| ***sodium fluoride*** (Dentagel) | Covered | |
| **PERIOMED** (***stannous fluoride***) | Covered | OTC |
| ***Saliva Stimulants*** - Drugs For The Mouth And Throat*** | | |
| ***pilocarpine hcl*** | Covered | |
| ***Steroids - Mouth/Throat/Dental*** - Drugs For The Mouth And Throat*** | | |
| ***triamcinolone acetonide*** | Covered | |
| ***triamcinolone acetonide*** (Oralone) | Covered | |
| ***Multivitamins* - Drugs For Nutrition** | | |
| ***B-Complex W/ Minerals*** - Drugs For Nutrition*** | | |
| ***geriaton*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***rabano yodado*** | Covered | OTC |
| ****Multiple Vitamins W/ Iron*** - Drugs For Nutrition*** | | |
| ***daily multiple vitamins/iron*** | Covered | OTC |
| ***daily vitamin formula+iron*** | Covered | OTC |
| ***daily-vitamin/iron*** | Covered | OTC |
| ***daily-vite/iron/beta-carotene*** | Covered | OTC |
| ***gnp one daily plus iron*** | Covered | OTC |
| ***hm one daily/iron*** | Covered | OTC |
| ***multi-day plus iron*** | Covered | OTC |
| ***multiple vitamins/iron*** | Covered | OTC |
| ***multi-vitamin/iron*** | Covered | OTC |
| ***once daily/iron*** | Covered | OTC |
| ***one daily multivitamin/iron*** | Covered | OTC |
| ***one-daily/iron*** | Covered | OTC |
| ***qc daily multivitamins/iron*** | Covered | OTC |
| ***ra one daily multi-vit plus fe*** | Covered | OTC |
| ***sm multiple vitamins/iron*** | Covered | OTC |
| ***stress b complex/iron*** | Covered | OTC |
| ***stress formula/iron*** | Covered | OTC |
| ***tab-a-vite/iron*** | Covered | OTC |
| ****Multiple Vitamins W/ Minerals*** - Drugs For Nutrition*** | | |
| ***50+ adult eye health*** | Covered | OTC |
| ***a thru z advanced*** | Covered | OTC |
| ***a thru z high potency*** | Covered | OTC |
| ***a thru z select*** | Covered | OTC |
| ***a thru z select 50+ advanced*** | Covered | OTC |
| ***a thru z select 50+ mens*** | Covered | OTC |
| ***a thru z select advanced*** | Covered | OTC |
| ***a thru z select ultimate women*** | Covered | OTC |
| ***a thru z ultimate mens*** | Covered | OTC |
| ***abc plus*** | Covered | OTC |
| ***actical*** | Covered | OTC |
| ***adult gummy*** | Covered | OTC |
| ***adult one daily gummies*** | Covered | OTC |

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|---|---|---|
| ***antioxidant*** | Covered | OTC |
| ***antioxidant a\|c\|e\|selenium*** | Covered | OTC |
| ***antioxidant formula*** | Covered | OTC |
| ***anti-oxidant formula*** | Covered | OTC |
| ***antioxidant formula\|minerals*** | Covered | OTC |
| ***antioxidant protection formula*** | Covered | OTC |
| ***antioxidant vitamins*** | Covered | OTC |
| ***biosupp*** | Covered | OTC |
| ***biotin plus\|calcium\|vit d3*** | Covered | OTC |
| ***body\|hair\|skin\|nails*** | Covered | OTC |
| ***b-redi\|red hearts\|red roosters*** | Covered | OTC |
| ***centavite a-z complete-mineral*** | Covered | OTC |
| ***centravites*** | Covered | OTC |
| ***centravites 50 plus*** | Covered | OTC |
| ***century*** | Covered | OTC |
| ***century mature*** | Covered | OTC |
| ***certa plus*** | Covered | OTC |
| ***certagen*** | Covered | OTC |
| ***companion*** | Covered | OTC |
| ***complere*** | Covered | OTC |
| ***complete*** | Covered | OTC |
| ***complete daily\|lutein*** | Covered | OTC |
| ***complete energy*** | Covered | OTC |
| ***complete pms support complex*** | Covered | OTC |
| ***complete senior*** | Covered | OTC |
| ***complete womens*** | Covered | OTC |
| ***coral calcium plus*** | Covered | OTC |
| ***cvs daily gummies*** | Covered | OTC |
| ***cvs daily multiple for men*** | Covered | OTC |
| ***cvs daily multiple for women*** | Covered | OTC |
| ***cvs daily multiple women 50+*** | Covered | OTC |
| ***cvs mens daily gummies*** | Covered | OTC |
| ***cvs spectravite adult 50+*** | Covered | OTC |
| ***cvs spectravite advanced*** | Covered | OTC |

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|---|---|---|
| ***cvs spectravite senior*** | Covered | OTC |
| ***cvs spectravite ultra mens*** | Covered | OTC |
| ***cvs spectravite womens senior*** | Covered | OTC |
| ***cvs womens active daily*** | Covered | OTC |
| ***cvs womens daily gummies*** | Covered | OTC |
| ***daily betic*** | Covered | OTC |
| ***daily combo multi vitamins*** | Covered | OTC |
| ***daily mens health formula*** | Covered | OTC |
| ***daily multi*** | Covered | OTC |
| ***daily multi 50+*** | Covered | OTC |
| ***daily multiple vitamins/min*** | Covered | OTC |
| ***daily multivitamin*** | Covered | OTC |
| ***daily vitamin formula+minerals*** | Covered | OTC |
| ***daily vitamin plus*** | Covered | OTC |
| ***daily womens health formula*** | Covered | OTC |
| ***daily-vitamin maximum formula*** | Covered | OTC |
| ***diabetes health formula*** | Covered | OTC |
| ***dialyvite 800/ultra d*** | Covered | OTC |
| ***eq complete multivit adult 50+*** | Covered | OTC |
| ***eq one daily womens health*** | Covered | OTC |
| ***eql century*** | Covered | OTC |
| ***eql century mature*** | Covered | OTC |
| ***eql one daily mens health*** | Covered | OTC |
| ***eql vision formula*** | Covered | OTC |
| ***essential balance*** | Covered | OTC |
| ***eyeprotect*** | Covered | OTC |
| ***gerivite complete*** | Covered | OTC |
| ***glucoten*** | Covered | OTC |
| ***gnp century*** | Covered | OTC |
| ***gnp century adults 50+ senior*** | Covered | OTC |
| ***gnp century cardio health*** | Covered | OTC |
| ***gnp century mature*** | Covered | OTC |
| ***gnp century ultimate mens*** | Covered | OTC |
| ***gnp century ultimate womens*** | Covered | OTC |

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|---|---|---|
| ***gnp diabetic support formula*** | Covered | OTC |
| ***gnp hair/skin/nails*** | Covered | OTC |
| ***gnp healthy eyes*** | Covered | OTC |
| ***gnp healthy eyes supervision*** | Covered | OTC |
| ***gnp maximum one daily*** | Covered | OTC |
| ***gnp mega multi for men*** | Covered | OTC |
| ***gnp mega multi for women*** | Covered | OTC |
| ***gnp one daily maximum*** | Covered | OTC |
| ***gnp one daily mens 50+advanced*** | Covered | OTC |
| ***gnp one daily mens health 50+*** | Covered | OTC |
| ***gnp one daily mens/lycopene*** | Covered | OTC |
| ***gnp one daily womens*** | Covered | OTC |
| ***gnp one daily womens 50+*** | Covered | OTC |
| ***gnp opti-vitamins*** | Covered | OTC |
| ***gnp therapeutic-m*** | Covered | OTC |
| ***gnp womens one daily*** | Covered | OTC |
| ***hair formula extra strength*** | Covered | OTC |
| ***hair vitamins*** | Covered | OTC |
| ***hair/skin/nails*** | Covered | OTC |
| ***hair/skin/nails/biotin*** | Covered | OTC |
| ***healthy eyes*** | Covered | OTC |
| ***hi-kovite 2-part formula*** | Covered | OTC |
| ***hi-potency multi-vitamin*** | Covered | OTC |
| ***hm antioxidant vitamins*** | Covered | OTC |
| ***hm complete*** | Covered | OTC |
| ***hm complete 50+*** | Covered | OTC |
| ***hm multivitamin adult gummy*** | Covered | OTC |
| ***i-vite*** | Covered | OTC |
| ***i-vite protect*** | Covered | OTC |
| ***kp adults 50+ daily formula*** | Covered | OTC |
| ***kp adults daily formula*** | Covered | OTC |
| ***kp mens 50+ daily formula*** | Covered | OTC |
| ***kp mens daily formula*** | Covered | OTC |
| ***kp womens 50+ daily formula*** | Covered | OTC |

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|---|---|---|
| ***kp womens daily formula*** | Covered | OTC |
| ***magnum-75*** | Covered | OTC |
| ***maximum daily green*** | Covered | OTC |
| ***mega vm-80*** | Covered | OTC |
| ***mega-marathon 100 tr*** | Covered | OTC |
| ***meijer advanced formula*** | Covered | OTC |
| ***mens daily formula/lycopene*** | Covered | OTC |
| ***multi + omega-3 adult gummies*** | Covered | OTC |
| ***multi adult gummies*** | Covered | OTC |
| ***multi complete/iron*** | Covered | OTC |
| ***multi for her*** | Covered | OTC |
| ***multi for her 50+*** | Covered | OTC |
| ***multi for him 50+*** | Covered | OTC |
| ***multi vitamin/minerals*** | Covered | OTC |
| ***multi-day plus minerals*** | Covered | OTC |
| ***multilex*** | Covered | OTC |
| ***multilex-t&m*** | Covered | OTC |
| ***multimineral plus*** | Covered | OTC |
| ***multiple vit/minerals/no iron*** | Covered | OTC |
| ***multiple vitamins/womens*** | Covered | OTC |
| ***multivitamin adults 50+*** | Covered | OTC |
| ***multi-vitamin gummies*** | Covered | OTC |
| ***multivitamin gummies adult*** | Covered | OTC |
| ***multivitamin gummies mens*** | Covered | OTC |
| ***multivitamin gummies womens*** | Covered | OTC |
| ***multi-vitamin menopausal*** | Covered | OTC |
| ***multi-vitamin/minerals*** | Covered | OTC |
| ***myamulti*** | Covered | OTC |
| ***my-vitalife*** | Covered | OTC |
| ***ocutabs*** | Covered | OTC |
| ***ocutabs-lutein*** | Covered | OTC |
| ***one daily 50 plus*** | Covered | OTC |
| ***one daily adults 50+*** | Covered | OTC |
| ***one daily calcium/iron*** | Covered | OTC |

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**Coverage Requirements and Limits**
**AL** = Age Restrictions
**OTC** = OTC Medications
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***one daily complete*** | Covered | OTC |
| ***one daily for men 50+ advanced*** | Covered | OTC |
| ***one daily for men/lycopene*** | Covered | OTC |
| ***one daily for women*** | Covered | OTC |
| ***one daily for women 50+ adv*** | Covered | OTC |
| ***one daily healthy weight*** | Covered | OTC |
| ***one daily healthy weight adv*** | Covered | OTC |
| ***one daily maximum*** | Covered | OTC |
| ***one daily mens*** | Covered | OTC |
| ***one daily mens health*** | Covered | OTC |
| ***one daily multivitamin men*** | Covered | OTC |
| ***one daily multivitamin women*** | Covered | OTC |
| ***one daily plus minerals*** | Covered | OTC |
| ***one daily womens*** | Covered | OTC |
| ***one daily womens 50 plus*** | Covered | OTC |
| ***one daily womens 50+*** | Covered | OTC |
| ***one daily/minerals*** | Covered | OTC |
| ***optic-vites*** | Covered | OTC |
| ***optimum airvites*** | Covered | OTC |
| ***optimum pms*** | Covered | OTC |
| ***prevent*** | Covered | OTC |
| ***px advanced formula multivits*** | Covered | OTC |
| ***px complete senior multivits*** | Covered | OTC |
| ***px mens multivitamins*** | Covered | OTC |
| ***qc daily multivit/multimineral*** | Covered | OTC |
| ***qc mens daily multivitamin*** | Covered | OTC |
| ***qc multi-vite*** | Covered | OTC |
| ***qc multi-vite 50 & over*** | Covered | OTC |
| ***qc therin-m*** | Covered | OTC |
| ***qc womens daily multivitamin*** | Covered | OTC |
| ***quintabs-m*** | Covered | OTC |
| ***ra central-vite energy*** | Covered | OTC |
| ***ra central-vite mens mature*** | Covered | OTC |
| ***ra central-vite senior*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***ra central-vite womens mature*** | Covered | OTC |
| ***ra hair/skin/nails*** | Covered | OTC |
| ***ra mature womens dietary supp*** | Covered | OTC |
| ***ra one daily energy formula*** | Covered | OTC |
| ***ra one daily gummy vites*** | Covered | OTC |
| ***ra one daily maximum*** | Covered | OTC |
| ***ra one daily mens 50+ w/vit d3*** | Covered | OTC |
| ***ra one daily mens multi*** | Covered | OTC |
| ***ra one daily mens/vit d-3*** | Covered | OTC |
| ***ra one daily womens*** | Covered | OTC |
| ***ra stress formula advanced*** | Covered | OTC |
| ***ra stress formula energy*** | Covered | OTC |
| ***ra therapeutic m plus beta car*** | Covered | OTC |
| ***ra vision vite plus zinc*** | Covered | OTC |
| ***senior tabs*** | Covered | OTC |
| ***sentry*** | Covered | OTC |
| ***sentry adult*** | Covered | OTC |
| ***sentry senior*** | Covered | OTC |
| ***sm antioxidant vitamins*** | Covered | OTC |
| ***sm complete*** | Covered | OTC |
| ***sm complete 50+*** | Covered | OTC |
| ***sm complete 50+ ultimate mens*** | Covered | OTC |
| ***sm complete 50+ ultimate women*** | Covered | OTC |
| ***sm complete advanced formula*** | Covered | OTC |
| ***sm complete senior formula*** | Covered | OTC |
| ***sm daily diet support*** | Covered | OTC |
| ***sm hair/skin/nails*** | Covered | OTC |
| ***sm opti-vitamins*** | Covered | OTC |
| ***stress b-complex/c/zinc*** | Covered | OTC |
| ***stress formula/zinc*** | Covered | OTC |
| ***super 28 formula*** | Covered | OTC |
| ***super antioxidants protector*** | Covered | OTC |
| ***super aytinal*** | Covered | OTC |
| ***super aytinal 50 plus*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***super multiple*** | Covered | OTC |
| ***super natrul-100*** | Covered | OTC |
| ***super thera vite m*** | Covered | OTC |
| ***super vikaps*** | Covered | OTC |
| ***super vita-mins*** | Covered | OTC |
| ***superior 35*** | Covered | OTC |
| ***support*** | Covered | |
| ***tgt multivitamin/multimineral*** | Covered | OTC |
| ***thera vital m*** | Covered | OTC |
| ***therabasic-m*** | Covered | OTC |
| ***thera-m*** | Covered | OTC |
| ***therapeutic formula/hematinics*** | Covered | OTC |
| ***therapeutic m*** | Covered | OTC |
| ***therapeutic-m*** | Covered | OTC |
| ***therapeutic-m/lutein*** | Covered | OTC |
| ***theravim-m*** | Covered | OTC |
| ***totalday multiple*** | Covered | OTC |
| ***ultra antioxidant formula*** | Covered | OTC |
| ***ultra freeda*** | Covered | OTC |
| ***ultra freeda/iron*** | Covered | OTC |
| ***ultra multi formula/iron*** | Covered | OTC |
| ***ultra-mega*** | Covered | OTC |
| ***vision formula/lutein*** | Covered | OTC |
| ***vision plus*** | Covered | OTC |
| ***vision vitamins*** | Covered | OTC |
| ***visivites*** | Covered | OTC |
| ***visivites/lutein*** | Covered | OTC |
| ***vita hair*** | Covered | OTC |
| ***vitabasic complete*** | Covered | OTC |
| ***vitabasic senior*** | Covered | OTC |
| ***vitabex*** | Covered | OTC |
| ***vitamins a-d-e/selenium*** | Covered | OTC |
| ***vitamins/minerals*** | Covered | OTC |
| ***vitatrum*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***womens 50+ advanced*** | Covered | OTC |
| ***womens daily form/fa/ca/fe*** | Covered | OTC |
| ***womens daily formula*** | Covered | OTC |
| ***womens multi*** | Covered | OTC |
| ***womens one daily*** | Covered | OTC |
| **BIOTECT PLUS** (***multiple vitamins-minerals***) | Covered | OTC |
| **BURIED TREASURE ACTIVE 55 PLUS** (***multiple vitamins-minerals***) | Covered | OTC |
| **CENTRUM** (***multiple vitamins-minerals***) | Covered | OTC |
| **FORTAVIT** (***multiple vitamins-minerals***) | Covered | OTC |
| **PROTECT PLUS NF** (***multiple vitamins-minerals***) | Covered | OTC |
| ****Multivitamins*** - Drugs For Nutrition*** | | |
| ***antioxidant formula*** | Covered | OTC |
| ***multivitamins*** | Covered | OTC |
| ***mv-one*** | Covered | OTC |
| ***stress formula*** | Covered | OTC |
| ***vitamin e/folic acid/b-6/b-12*** | Covered | OTC |
| **INFUVITE ADULT** (***multiple vitamin***) | Covered | PA |
| **M.V.I. ADULT** (***multiple vitamin***) | Covered | PA |
| **M.V.I.-12 (WITHOUT VITAMIN K)** (***multiple vitamin***) | Covered | PA |
| ****Ped Multiple Vitamins W/ Minerals & C*** - Drugs For Nutrition*** | | |
| ***childrens animal shapes*** | Covered | OTC |
| ***cvs childrens complete*** | Covered | OTC |
| ***eq complete multivitamin child*** | Covered | OTC |
| ***eql child multivit/minerals*** | Covered | OTC |
| ***hm animal shapes*** | Covered | OTC |
| ***polyvitamin/iron*** | Covered | OTC |
| ***qc childrens complete*** | Covered | OTC |
| ***ra vitamins complete childrens*** | Covered | OTC |
| ***sm animal shapes complete*** | Covered | OTC |
| ***zoo friends*** | Covered | OTC |
| **ALIVE MULTI-VITAMIN CHILDRENS** (***pediatric multivit-minerals-c***) | Covered | OTC |
| **CENTRUM KIDS COMPLETE** (***pediatric multivit-minerals-c***) | Covered | OTC |
| **CEROVITE JR** (***pediatric multivit-minerals-c***) | Covered | OTC |
| **FLINTSTONES COMPLETE** (***pediatric multivit-minerals-c***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **FLINTSTONES GUMMIES BONE BUILD** (***pediatric multivit-minerals-c***) | Covered | OTC |
| **PX CHILDRENS VITAMIN** (***pediatric multivit-minerals-c***) | Covered | OTC |
| **SEA BUDDIES DAILY MULTIPLE** (***pediatric multivit-minerals-c***) | Covered | OTC |
| ****Ped Mv W/ Fluoride*** - Drugs For Nutrition*** | | |
| ***multi-vit/fluoride*** | Covered | |
| ***multivitamin/fluoride*** | Covered | |
| ***multi-vitamin/fluoride*** | Covered | |
| ***multivitamins/fluoride*** | Covered | |
| ****Ped Mv W/ Iron*** - Drugs For Nutrition*** | | |
| ***bite-a-mins/iron*** | Covered | OTC |
| ***chewable vite/iron childrens*** | Covered | OTC |
| ***child chewable vitamins/iron*** | Covered | OTC |
| ***childrens multivitamin/iron*** | Covered | OTC |
| ***childrens vitamins/iron*** | Covered | OTC |
| ***fruity chews/iron*** | Covered | OTC |
| ***gnp animal shapes plus iron*** | Covered | OTC |
| ***gnp childrens chewables/iron*** | Covered | OTC |
| ***little animals plus iron*** | Covered | OTC |
| ***multivitamin drops/iron*** | Covered | OTC |
| ***qc childrens vitamins/iron*** | Covered | OTC |
| ***ra childrens chewable vit/iron*** | Covered | OTC |
| ***zoo friends plus iron*** | Covered | OTC |
| **BPROTECTED PEDIA POLY-VITE/FE** (***pediatric multivitamins-iron***) | Covered | OTC |
| **FLINTSTONES PLUS IRON** (***pediatric multivitamins-iron***) | Covered | OTC |
| **LAND BEFORE TIME MULTIVITAMIN** (***pediatric multivitamins-iron***) | Covered | OTC |
| ****Ped Vitamins Acd W/ Fluoride*** - Drugs For Nutrition*** | | |
| ***tri-vitamin/fluoride*** | Covered | |
| ***vitamins acd-fluoride*** | Covered | |
| ****Pediatric Multiple Vitamins W/ C & Fa*** - Drugs For Nutrition*** | | |
| ***animal chews*** | Covered | OTC |
| ***bite-a-mins*** | Covered | OTC |
| ***chewable vite childrens*** | Covered | OTC |
| ***childrens chewable vitamins*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***fruity chews*** | Covered | OTC |
| ***gnp animal shapes*** | Covered | OTC |
| ***gnp little ones childrens*** | Covered | OTC |
| ***little animals*** | Covered | OTC |
| ***poly vitamin*** | Covered | OTC |
| ***sm animal shapes kids first*** | Covered | OTC |
| ***zoo friends gummies*** | Covered | OTC |
| **ANIMAL SHAPES** (***pediatric multiple vit-c-fa***) | Covered | OTC |
| **BOUNTY BEARS/C** (***pediatric multiple vit-c-fa***) | Covered | OTC |
| **DINO-LIFE** (***pediatric multiple vit-c-fa***) | Covered | OTC |
| **FLINSTONES GUMMIES OMEGA-3 DHA** (***pediatric multiple vit-c-fa***) | Covered | OTC |
| **FLINTSTONES PLUS CALCIUM** (***pediatric multiple vit-c-fa***) | Covered | OTC |
| **FLINTSTONES/MY FIRST** (***pediatric multiple vit-c-fa***) | Covered | OTC |
| ****Pediatric Multiple Vitamins W/ C*** - Drugs For Nutrition*** | | |
| ***polyvitamin*** | Covered | OTC |
| **BPROTECTED PEDIA POLY-VITE** (***pediatric multiple vit-vit c***) | Covered | OTC |
| ****Pediatric Multiple Vitamins W/ Extra C & Fa*** - Drugs For Nutrition*** | | |
| ***gnp animal shapes plus extra c*** | Covered | OTC |
| ***gnp childrens chewables/ex c*** | Covered | OTC |
| ***qc childrens vitamins/extra c*** | Covered | OTC |
| ***zoo friends plus extra c*** | Covered | OTC |
| **DINO-LIFE W/EXTRA C** (***pediatric multi vit-extra c-fa***) | Covered | OTC |
| **FLINTSTONES/EXTRA C** (***pediatric multi vit-extra c-fa***) | Covered | OTC |
| **LAND BEFORE TIME MULTIVITAMIN** (***pediatric multi vit-extra c-fa***) | Covered | OTC |
| **ZOO FRIENDS/EXTRA C** (***pediatric multi vit-extra c-fa***) | Covered | OTC |
| ****Pediatric Multiple Vitamins*** - Drugs For Nutrition*** | | |
| **INFUVITE PEDIATRIC** (***pediatric multiple vitamins***) | Covered | PA |
| ****Prenatal Mv & Min W/Fe-Fa*** - Drugs For Nutrition*** | | |
| ***completenate*** | Covered | QL (100 EA per 90 days) |
| ***kp prenatal multivitamins*** | Covered | OTC; QL (100 EA per 90 days) |
| ***pnv folic acid + iron*** | Covered | QL (100 EA per 90 days) |
| ***pnv prenatal plus multivitamin*** | Covered | QL (100 EA per 90 days) |
| ***prenatal*** | Covered | QL (100 EA per 90 days) |

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|---|---|---|
| ***prenatal 19 oral tablet*** | Covered | OTC; QL (100 EA per 90 days) |
| ***prenatal 19 oral tablet chewable*** | Covered | QL (100 EA per 90 days) |
| ***prenatal plus*** | Covered | QL (100 EA per 90 days) |
| ***prenatal vitamin plus low iron*** | Covered | QL (100 EA per 90 days) |
| ***preplus*** | Covered | QL (100 EA per 90 days) |
| ***pretab*** | Covered | QL (100 EA per 90 days) |
| ***se-natal 19*** | Covered | QL (100 EA per 90 days) |
| ***trinatal rx 1*** | Covered | QL (100 EA per 90 days) |
| ***vol-nate*** | Covered | QL (100 EA per 90 days) |
| ***vol-plus*** | Covered | QL (100 EA per 90 days) |
| ***vol-tab rx*** | Covered | QL (100 EA per 90 days) |
| **CO-NATAL FA** (***prenatal vit-fe fumarate-fa***) | Covered | QL (100 EA per 90 days) |
| **CONCEPT DHA** (***prenat-fefum-fepo-fa-omega 3***) | Covered | QL (100 EA per 90 days) |
| **CONCEPT OB** (***prenat w/o a vit-fefum-fepo-fa***) | Covered | QL (100 EA per 90 days) |
| **FOLIVANE-OB** (***prenat w/o a vit-fefum-fepo-fa***) | Covered | QL (100 EA per 90 days) |
| **INATAL GT** (***prenatal vit-dss-fe cbn-fa***) | Covered | QL (100 EA per 90 days) |
| **M-VIT** (***prenatal vit-fe fumarate-fa***) | Covered | QL (100 EA per 90 days) |
| **NIVA-PLUS** (***prenatal vit-fe fumarate-fa***) | Covered | QL (100 EA per 90 days) |
| **O-CAL FA** (***prenatal vit-fe fumarate-fa***) | Covered | QL (100 EA per 90 days) |
| **PRENATABS RX** (***prenatal vit-iron carbonyl-fa***) | Covered | QL (100 EA per 90 days) |
| **PRENATAL-U** (***prenatal w/o a vit-fe fum-fa***) | Covered | QL (100 EA per 90 days) |
| **PROVIDA OB** (***prenat w/o a vit-fefum-fepo-fa***) | Covered | QL (100 EA per 90 days) |
| **THERANATAL CORE NUTRITION** (***prenatal vit-fe fumarate-fa***) | Covered | OTC; QL (100 EA per 90 days) |
| **TRINATE** (***prenatal vit-fe fumarate-fa***) | Covered | QL (100 EA per 90 days) |
| **VINATE II** (***prenatal vit w/ fe bisg-fa***) | Covered | QL (100 EA per 90 days) |
| **VINATE M** (***prenatal vit-sel-fe fum-fa***) | Covered | QL (100 EA per 90 days) |
| **VINATE ONE** (***prenatal vit-fe fumarate-fa***) | Covered | QL (100 EA per 90 days) |
| ****Prenatal Mv & Min W/Fe-Fa-Ca-Omega 3 Fish Oil*** - Drugs For Nutrition*** | | |
| ***complete natal dha*** | Covered | QL (100 EA per 90 days) |
| ****Prenatal Mv & Min W/Fe-Fa-Dha*** - Drugs For Nutrition*** | | |
| **ENFAMIL EXPECTA** (***prenatal mv-min-fe fum-fa-dha***) | Covered | OTC; QL (100 EA per 90 days) |
| ****Specialty Vitamins Products*** - Drugs For Nutrition*** | | |
| ***a thru z advantage*** | Covered | OTC |

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|---|---|---|
| ***cvs hair/skin/nails*** | Covered | OTC |
| ***cvs menopause support*** | Covered | OTC |
| ***ra central-vite cardio*** | Covered | OTC |
| ***ra central-vite performance*** | Covered | OTC |
| ***ra menopause support*** | Covered | OTC |
| ***ultimate fat burner*** | Covered | OTC |
| ***varisan vitality*** | Covered | OTC |
| ***vitamins for hair*** | Covered | OTC |
| ***weight loss daily multi*** | Covered | OTC |
| ***Musculoskeletal Therapy Agents* - Drugs For Muscles, Ligaments, Tendons, And Bones** | | |
| ****Central Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones*** | | |
| ***baclofen oral tablet 10 mg, 20 mg*** | Covered | QL (120 EA per 30 days) |
| ***baclofen oral tablet 5 mg*** | Covered | QL (4 EA per 1 day) |
| ***carisoprodol*** | Covered | QL (90 EA per 30 days) |
| ***chlorzoxazone*** | Covered | QL (180 EA per 30 days) |
| ***cyclobenzaprine hcl oral tablet 10 mg*** | Covered | QL (90 EA per 30 days) |
| ***cyclobenzaprine hcl oral tablet 5 mg*** | Covered | QL (3 EA per 1 day) |
| ***methocarbamol*** | Covered | QL (120 EA per 30 days) |
| ***orphenadrine citrate er*** | Covered | QL (2 EA per 1 day) |
| ***tizanidine hcl oral tablet 2 mg*** | Covered | QL (3 EA per 1 day) |
| ***tizanidine hcl oral tablet 4 mg*** | Covered | QL (6 EA per 1 day) |
| ****Direct Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones*** | | |
| ***dantrolene sodium*** | Covered | QL (120 EA per 30 days) |
| ****Muscle Relaxant Combinations*** - Drugs For Muscles, Ligaments, Tendons, And Bones*** | | |
| ***carisoprodol-aspirin*** | Covered | QL (120 EA per 30 days) |
| ***carisoprodol-aspirin-codeine*** | Covered | QL (4 EA per 1 day); AL (Min 18 Years) |
| ****Viscosupplements*** - Drugs For Muscles, Ligaments, Tendons, And Bones*** | | |
| **GEL-ONE** (***cross-linked hyaluronate***) | Covered | PA |
| **VISCO-3** (***sodium hyaluronate (viscosup)***) | Covered | PA |

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|---|---|---|
| ***Nasal Agents - Systemic And Topical* - Drugs For The Nose** | | |
| ****Nasal Anticholinergics*** - Allergy*** | | |
| ***ipratropium bromide nasal solution 0.03 %*** | Covered | QL (30 ML per 30 days) |
| ***ipratropium bromide nasal solution 0.06 %*** | Covered | QL (15 ML per 30 days) |
| ****Nasal Antihistamines*** - Allergy*** | | |
| ***azelastine hcl*** | Covered | QL (1 EA per 30 days) |
| ****Nasal Mast Cell Stabilizers*** - Allergy*** | | |
| ***cromolyn sodium*** | Covered | OTC; QL (52 ML per 30 days) |
| ****Nasal Steroids*** - Allergy*** | | |
| ***budesonide*** | Covered | OTC; QL (8.6 ML per 30 days) |
| ***cvs fluticasone propionate*** | Covered | OTC; QL (16 ML per 30 days) |
| ***eql fluticasone propionate*** | Covered | OTC; QL (16 ML per 30 days) |
| ***flunisolide*** | Covered | ST; QL (50 ML per 30 days) |
| ***fluticasone propionate*** | Covered | ST; QL (16 GM per 30 days) |
| ***gnp fluticasone propionate*** | Covered | OTC; QL (16 ML per 30 days) |
| ***mometasone furoate*** | Covered | ST; QL (34 GM per 30 days) |
| ***nasal allergy 24 hour*** | Covered | OTC; QL (17 ML per 30 days) |
| **RHINOCORT ALLERGY** (***budesonide***) | Covered | OTC; QL (8.6 ML per 30 days) |
| ****Systemic Decongestants*** - Allergy*** | | |
| ***kp pseudoephedrine hcl*** | Covered | OTC |
| ***pseudoephedrine hcl*** | Covered | |
| **SUDOGEST** (***pseudoephedrine hcl***) | Covered | OTC |
| ***Neuromuscular Agents* - Drugs For Nerves And Muscles** | | |
| ****Benzathiazoles*** - Drugs For Nerves And Muscles*** | | |
| ***riluzole*** | Covered | |
| ***Nutrients* - Drugs For Nutrition** | | |
| ****Amino Acid Mixtures*** - Drugs For Nutrition*** | | |
| ***amino acid*** | Covered | PA |
| **AMINOSYN** (***amino acid infusion***) | Covered | PA |
| **AMINOSYN II** (***amino acid infusion***) | Covered | PA |
| ***amino acd electrolyte infusion*** (Aminosyn Ii/Electrolytes) | Covered | PA |
| **AMINOSYN M** (***amino acd electrolyte infusion***) | Covered | PA |
| **AMINOSYN/ELECTROLYTES** (***amino acd electrolyte infusion***) | Covered | PA |
| **AMINOSYN-HBC** (***amino acid infusion***) | Covered | PA |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **AMINOSYN-PF** (***amino acid infusion***) | Covered | PA |
| **AMINOSYN-RF** (***amino acid infusion***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (2.75/10)** (***amino ac elect-calc in d10w***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (2.75/5)** (***amino ac elect-calc in d5w***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (4.25/10)** (***amino ac elect-calc in d10w***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (4.25/25)** (***amino ac elect-calc in d25w***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (4.25/5)** (***amino ac elect-calc in d5w***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (5/15)** (***amino ac elect-calc in d15w***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (5/20)** (***amino ac elect-calc in d20w***) | Covered | PA |
| **CLINIMIX E/DEXTROSE (5/25)** (***amino ac elect-calc in d25w***) | Covered | PA |
| **CLINIMIX N14G30E** (***amino ac elect-calc in d15w***) | Covered | PA |
| **CLINIMIX N9G15E** (***amino ac elect-calc in d7.5w***) | Covered | PA |
| **CLINIMIX N9G20E** (***amino ac elect-calc in d10w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (2.75/5)** (***amino acid infusion in d5w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (4.25/10)** (***amino acid infusion in d10w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (4.25/20)** (***amino acid infusion in d20w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (4.25/25)** (***amino acid infusion in d25w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (4.25/5)** (***amino acid infusion in d5w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (5/15)** (***amino acid infusion in d15w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (5/20)** (***amino acid infusion in d20w***) | Covered | PA |
| **CLINIMIX/DEXTROSE (5/25)** (***amino acid infusion in d25w***) | Covered | PA |
| ***amino acid infusion*** (Clinisol Sf) | Covered | PA |
| **COMPLETE AMINO ACID MIX** (***amino acids***) | Covered | PA; OTC |
| **COMPLEX ESSENTIAL MSD** (***amino acids***) | Covered | PA; OTC |
| **COMPLEX JUNIOR MSD** (***amino acids***) | Covered | PA; OTC |
| **COMPLEX MSUD** (***amino acids***) | Covered | PA; OTC |
| **ESSENTIAL AMINO ACID MIX** (***amino acids***) | Covered | PA; OTC |
| **FREAMINE HBC** (***amino acid infusion***) | Covered | PA |
| **FREAMINE III** (***amino acid infusion***) | Covered | PA |
| **GLUTARADE AMINO ACID BLEND** (***amino acids***) | Covered | PA; OTC |
| **GLUTARADE ESSENTIAL GA-1** (***amino acids***) | Covered | PA; OTC |
| **GLUTARADE JUNIOR GA-1** (***amino acids***) | Covered | PA; OTC |
| **HEPATAMINE** (***amino acid infusion***) | Covered | PA |
| **NEPHRAMINE** (***amino acid infusion***) | Covered | PA |

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|---|---|---|
| **PERIFLEX LQ PKU** (***amino acids***) | Covered | PA; OTC |
| **PHENYLADE** (***amino acids***) | Covered | PA; OTC |
| **PHENYLADE MTE** (***amino acids***) | Covered | PA; OTC |
| **PHENYLADE PHEBLOC** (***amino acids***) | Covered | PA; OTC |
| ***amino acid infusion*** (Plenamine) | Covered | PA |
| **PREMASOL** (***amino acid infusion***) | Covered | PA |
| **PROCALAMINE** (***amino acd electrolyte infusion***) | Covered | PA |
| **PROSOL** (***amino acid infusion***) | Covered | PA |
| **SYNTHAMIN 17** (***amino acid infusion***) | Covered | PA |
| **TRAVASOL** (***amino acid infusion***) | Covered | PA |
| **TROPHAMINE** (***amino acid infusion***) | Covered | PA |
| **XPHE MAXAMUM** (***amino acids***) | Covered | PA; OTC |
| ****Amino Acids-Single*** - Drugs For Nutrition*** | | |
| ***l-cysteine hcl*** | Covered | PA |
| ****Carbohydrates*** - Drugs For Nutrition*** | | |
| ***dextrose intravenous solution 10 %, 250 mg/ml, 30 %, 5 %, 50 %, 70 %*** | Covered | |
| ***dextrose intravenous solution 20 %, 40 %*** | Covered | PA |
| ***glucose*** | Covered | |
| ****Lipids*** - Drugs For Nutrition*** | | |
| **BETAQUIK** (***medium chain triglycerides***) | Covered | PA; OTC |
| **INTRALIPID** (***fat emulsion plant based (soy)***) | Covered | PA |
| **LIQUIGEN** (***medium chain triglycerides***) | Covered | PA; OTC |
| **MCT OIL** (***medium chain triglycerides***) | Covered | PA; OTC |
| **NUTRILIPID** (***fat emulsion plant based (soy)***) | Covered | PA |
| ****Misc. Nutritional Substances*** - Drugs For Nutrition*** | | |
| ***cvs fish oil*** | Covered | OTC |
| ***cvs natural fish oil*** | Covered | OTC |
| ***epa*** | Covered | OTC |
| ***eql fish oil*** | Covered | OTC |
| ***eql omega 3 fish oil*** | Covered | OTC |
| ***fish oil*** | Covered | OTC |
| ***fish oil burp-less*** | Covered | OTC |
| ***fish oil concentrate*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***fish oil double strength*** | Covered | OTC |
| ***fish oil extra strength*** | Covered | OTC |
| ***fish oil maximum strength*** | Covered | OTC |
| ***fish oil triple strength*** | Covered | OTC |
| ***fish oil/super potent/no burp*** | Covered | OTC |
| ***gnp fish oil*** | Covered | OTC |
| ***gnp fish oil max st*** | Covered | OTC |
| ***hm fish oil*** | Covered | OTC |
| ***kp fish oil*** | Covered | OTC |
| ***kp omega-3 fish oil*** | Covered | OTC |
| ***maxepa*** | Covered | OTC |
| ***norwegian salmon oil*** | Covered | OTC |
| ***omega 3*** | Covered | OTC |
| ***omega iii epa+dha*** | Covered | OTC |
| ***omega-3*** | Covered | OTC |
| ***omega-3 cf*** | Covered | OTC |
| ***omega-3 fish oil*** | Covered | OTC |
| ***omega-3 plus*** | Covered | OTC |
| ***pa fish oil*** | Covered | OTC |
| ***px fish oil*** | Covered | OTC |
| ***ra fish oil*** | Covered | OTC |
| ***sb omega-3 fish oil*** | Covered | OTC |
| ***sm fish oil*** | Covered | OTC |
| ***sm omega-3 fish oil*** | Covered | OTC |
| ***super omega 3 epa/dha*** | Covered | OTC |
| ***ultra omega-3 fish oil*** | Covered | OTC |
| **ESKIMO PUREFA** (***omega-3 fatty acids***) | Covered | OTC |
| **FISH OIL PEARLS** (***omega-3 fatty acids***) | Covered | OTC |
| **MAXIMUM EPA** (***omega-3 fatty acids***) | Covered | OTC |
| **OMERA** (***omega-3 fatty acids***) | Covered | OTC |
| **SEA-OMEGA 30** (***omega-3 fatty acids***) | Covered | OTC |
| **SUPER DHA GEMS** (***omega-3 fatty acids***) | Covered | OTC |
| **SUPER OMEGA-3** (***omega-3 fatty acids***) | Covered | OTC |
| **THERAGRAN-M FISH OIL CONC** (***omega-3 fatty acids***) | Covered | OTC |

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| **THEROMEGA** (***omega-3 fatty acids***) | Covered | OTC |
| ***Protein Products*** - Drugs For Nutrition*** | | |
| **BENEPROTEIN** (***protein***) | Covered | PA; OTC |
| ***Protein-Carbohydrate-Lipid With Electrolyte Combinations*** - Drugs For Nutrition*** | | |
| **KABIVEN** (***amino ac-dext-lipid-electrolyt***) | Covered | PA |
| **PERIKABIVEN** (***amino ac-dext-lipid-electrolyt***) | Covered | PA |
| ***Ophthalmic Agents* - Drugs For The Eye** | | |
| ***Artificial Tear And Lubricant Combinations*** - Drugs For The Eye*** | | |
| ***cvs natural tears*** | Covered | OTC; QL (15 mL per 30 days) |
| ***tears pure*** | Covered | OTC; QL (15 mL per 30 days) |
| ***tgt lubricant eye drops*** | Covered | OTC; QL (15 mL per 30 days) |
| **SYSTANE** (***polyethyl glycol-propyl glycol***) | Covered | OTC |
| **TEARS NATURALE FREE** (***dextran 70-hypromellose***) | Covered | OTC; QL (15 mL per 30 days) |
| ***Artificial Tear Solutions*** - Drugs For The Eye*** | | |
| ***just tears eye drops*** | Covered | OTC; QL (15 mL per 30 days) |
| ***sm artificial tears*** | Covered | OTC; QL (15 mL per 30 days) |
| ***tears again*** | Covered | OTC; QL (15 mL per 30 days) |
| **SOOTHE HYDRATION** (***artificial tear solution***) | Covered | OTC; QL (15 mL per 30 days) |
| **SOOTHE XP** (***artificial tear solution***) | Covered | OTC; QL (15 mL per 30 days) |
| **SYSTANE CONTACTS** (***artificial tear solution***) | Covered | OTC; QL (15 mL per 30 days) |
| **TEARS AGAIN ADVANCED EYELID** (***artificial tear solution***) | Covered | OTC; QL (15 mL per 30 days) |
| ***Artificial Tears And Lubricants*** - Drugs For The Eye*** | | |
| ***artificial tears*** | Covered | OTC; QL (15 mL per 30 days) |
| ***cvs lubricant eye drops*** | Covered | OTC |
| ***eq restore tears*** | Covered | OTC; QL (15 mL per 30 days) |
| ***liquitears*** | Covered | OTC; QL (15 mL per 30 days) |
| ***lubricant eye drops*** | Covered | OTC |
| ***polyvinyl alcohol*** | Covered | QL (15 ML per 30 days) |
| **SYSTANE BALANCE** (***propylene glycol***) | Covered | OTC; QL (10 mL per 30 days) |
| ***Beta-Blockers - Ophthalmic Combinations*** - Drugs For Glaucoma*** | | |
| ***dorzolamide hcl-timolol mal*** | Covered | ST; QL (10 mL per 30 days) |
| **COMBIGAN** (***brimonidine tartrate-timolol***) | Covered | ST; QL (5 mL per 30 days) |

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|---|---|---|
| ***Beta-Blockers - Ophthalmic*** - Drugs For Glaucoma*** | | |
| ***betaxolol hcl*** | Covered | QL (10 ML per 30 days) |
| ***carteolol hcl*** | Covered | QL (10 ML per 30 days) |
| ***levobunolol hcl*** | Covered | QL (10 ML per 30 days) |
| ***metipranolol*** | Covered | QL (10 ML per 30 days) |
| ***timolol maleate ophthalmic gel forming solution 0.25 %*** | Covered | ST; QL (5 ML per 30 days) |
| ***timolol maleate ophthalmic gel forming solution 0.5 %*** | Covered | ST; QL (5 mL per 30 days) |
| ***timolol maleate ophthalmic solution*** | Covered | QL (10 ML per 30 days) |
| ***Cycloplegic Mydriatics*** - Drugs For The Eye*** | | |
| ***atropine sulfate*** | Covered | QL (3.5 GM per 30 days) |
| ***cyclopentolate hcl*** | Covered | QL (3 ML per 30 days) |
| ***phenylephrine hcl ophthalmic solution 10 %*** | Covered | |
| ***phenylephrine hcl ophthalmic solution 2.5 %*** | Covered | QL (2 ML per 30 days) |
| ***tropicamide*** | Covered | QL (15 mL per 30 days) |
| ***phenylephrine hcl*** (Altafrin) | Covered | |
| **ISOPTO ATROPINE** (***atropine sulfate***) | Covered | QL (5 ML per 30 days) |
| ***Miotics - Direct Acting*** - Drugs For Glaucoma*** | | |
| ***pilocarpine hcl*** | Covered | QL (15 mL per 30 days) |
| ***Ophthalmic Antiallergic*** - Drugs For Itchy Eye*** | | |
| ***allergy eye drops*** | Covered | OTC; QL (10 mL per 30 days) |
| ***azelastine hcl*** | Covered | ST; QL (6 ML per 30 days) |
| ***cromolyn sodium*** | Covered | QL (10 mL per 30 days) |
| ***cvs allergy eye drops*** | Covered | OTC; QL (10 mL per 30 days) |
| ***cvs eye itch relief*** | Covered | OTC; QL (10 mL per 30 days) |
| ***eye itch relief*** | Covered | OTC; QL (10 mL per 30 days) |
| ***gnp eye itch relief*** | Covered | OTC; QL (10 mL per 30 days) |
| ***gnp itchy eye*** | Covered | OTC; QL (10 mL per 30 days) |
| ***hm eye itch relief*** | Covered | OTC; QL (10 mL per 30 days) |
| ***ketotifen fumarate*** | Covered | QL (10 ML per 30 days) |
| ***kp ketotifen fumarate*** | Covered | OTC; QL (10 mL per 30 days) |
| ***olopatadine hcl*** | Covered | ST; QL (5 ML per 30 days) |
| ***ra antihistamine eye drops*** | Covered | OTC; QL (10 mL per 30 days) |
| ***ra eye itch relief*** | Covered | OTC; QL (10 mL per 30 days) |
| ***sm eye itch relief*** | Covered | OTC; QL (10 mL per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **ALAWAY** (***ketotifen fumarate***) | Covered | OTC; QL (10 ML per 30 days) |
| **ALAWAY CHILDRENS ALLERGY** (***ketotifen fumarate***) | Covered | OTC; QL (10 ML per 30 days) |
| **CLARITIN EYE** (***ketotifen fumarate***) | Covered | OTC; QL (10 ML per 30 days) |
| **THERATEARS ALLERGY** (***ketotifen fumarate***) | Covered | OTC; QL (10 ML per 30 days) |
| ****Ophthalmic Antibiotics*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***bacitracin*** | Covered | |
| ***ciprofloxacin hcl*** | Covered | QL (5 mL per 30 days) |
| ***erythromycin*** | Covered | |
| ***gentamicin sulfate*** | Covered | QL (5 mL per 30 days) |
| ***levofloxacin*** | Covered | QL (5 ML per 30 days) |
| ***ofloxacin*** | Covered | QL (5 mL per 30 days) |
| ***tobramycin*** | Covered | QL (5 mL per 30 days) |
| **GENTAK** (***gentamicin sulfate***) | Covered | |
| ****Ophthalmic Antifungal*** - Drugs For The Eye*** | | |
| **NATACYN** (***natamycin***) | Covered | QL (15 ML per 30 days) |
| ****Ophthalmic Anti-Infective Combinations*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***bacitracin-polymyxin b*** | Covered | |
| ***neomycin-bacitracin zn-polymyx*** | Covered | QL (5 mL per 30 days) |
| ***neomycin-polymyxin-gramicidin*** | Covered | QL (10 mL per 30 days) |
| ***polymyxin b-trimethoprim*** | Covered | QL (10 mL per 30 days) |
| ***neomycin-bacitracin zn-polymyx*** (Neo-Polycin) | Covered | QL (5 mL per 30 days) |
| ***bacitracin-polymyxin b*** (Polycin) | Covered | |
| ****Ophthalmic Antivirals*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***trifluridine*** | Covered | QL (7.5 ML per 30 days) |
| ****Ophthalmic Carbonic Anhydrase Inhibitors*** - Drugs For Glaucoma*** | | |
| ***brinzolamide*** | Covered | ST; QL (10 ML per 30 days) |
| ***dorzolamide hcl*** | Covered | QL (10 mL per 30 days) |
| ****Ophthalmic Immunomodulators*** - Anti-Infective/Anti-Inflammatories*** | | |
| **CEQUA** (***cyclosporine***) | Covered | PA |
| ****Ophthalmic Local Anesthetics*** - Drugs For The Eye*** | | |
| ***proparacaine hcl*** | Covered | |

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|---|---|---|
| ***Ophthalmic Nonsteroidal Anti-Inflammatory Agents*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***diclofenac sodium*** | Covered | QL (5 mL per 30 days) |
| ***flurbiprofen sodium*** | Covered | |
| ***ketorolac tromethamine ophthalmic solution 0.4 %*** | Covered | QL (5 mL per 30 days) |
| ***ketorolac tromethamine ophthalmic solution 0.5 %*** | Covered | |
| ***Ophthalmic Rho Kinase Inhibitors*** - Drugs For Glaucoma*** | | |
| **RHOPRESSA** (***netarsudil dimesylate***) | Covered | |
| ***Ophthalmic Selective Alpha Adrenergic Agonists*** - Drugs For Glaucoma*** | | |
| ***brimonidine tartrate*** | Covered | QL (10 ML per 30 days) |
| ***Ophthalmic Steroid Combinations*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***bacitra-neomycin-polymyxin-hc*** | Covered | |
| ***neomycin-polymyxin-dexameth ophthalmic ointment*** | Covered | QL (3.5 GM per 30 days) |
| ***neomycin-polymyxin-dexameth ophthalmic suspension*** | Covered | QL (5 mL per 30 days) |
| ***sulfacetamide-prednisolone*** | Covered | QL (5 mL per 30 days) |
| ***bacitracin-polymyx-neo-hc*** (Neo-Polycin Hc) | Covered | |
| ***Ophthalmic Steroids*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***dexamethasone sodium phosphate*** | Covered | QL (5 mL per 30 days) |
| ***fluorometholone*** | Covered | QL (10 mL per 30 days) |
| ***prednisolone acetate*** | Covered | QL (10 mL per 30 days) |
| ***prednisolone sodium phosphate*** | Covered | QL (10 mL per 30 days) |
| ***Ophthalmic Sulfonamides*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***sulfacetamide sodium ophthalmic ointment*** | Covered | |
| ***sulfacetamide sodium ophthalmic solution*** | Covered | QL (15 mL per 30 days) |
| ***Ophthalmic Surgical Aids*** - Drugs For The Eye*** | | |
| **GELFILM** (***gelatin adsorbable***) | State Carve Out | |
| ***Prostaglandins - Ophthalmic*** - Drugs For Glaucoma*** | | |
| ***latanoprost*** | Covered | QL (2.5 ML per 25 days) |
| ***Otic Agents* - Drugs For The Ear** | | |
| ***Otic Agents - Miscellaneous*** - Wax Removal*** | | |
| ***acetic acid*** | Covered | |
| ***auraphene-b*** | Covered | OTC; QL (15 ML per 30 days) |

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|---|---|---|
| ***cvs ear drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***cvs ear wax removal system*** | Covered | OTC; QL (15 ML per 30 days) |
| ***cvs earwax removal kit*** | Covered | OTC; QL (15 ML per 30 days) |
| ***ear drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***ear drops earwax aid*** | Covered | OTC; QL (15 ML per 30 days) |
| ***ear wax drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***ear wax removal drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***earwax removal*** | Covered | OTC; QL (15 ML per 30 days) |
| ***earwax removal kit*** | Covered | OTC; QL (15 ML per 30 days) |
| ***earwax treatment drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***eq ear drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***eq ear wax removal aid*** | Covered | OTC; QL (15 ML per 30 days) |
| ***gnp ear drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***gnp ear systems*** | Covered | OTC; QL (15 ML per 30 days) |
| ***gnp earwax removal drops*** | Covered | OTC; QL (15 ML per 30 days) |
| ***gnp earwax removal kit*** | Covered | OTC; QL (15 ML per 30 days) |
| ***goodsense ear wax kit*** | Covered | OTC; QL (15 ML per 30 days) |
| ***goodsense ear wax removal*** | Covered | OTC; QL (15 ML per 30 days) |
| ***hm earwax removal aid*** | Covered | OTC; QL (15 ML per 30 days) |
| ***hm earwax removal kit*** | Covered | OTC; QL (15 ML per 30 days) |
| ***qc ear wax removal*** | Covered | OTC; QL (15 ML per 30 days) |
| ***qc earwax removal*** | Covered | OTC; QL (15 ML per 30 days) |
| ***qc earwax removal kit*** | Covered | OTC; QL (15 ML per 30 days) |
| ***ra ear drops*** | Covered | OTC; QL (15 ML per 30 days) |
| **CLEARCANAL EARWAX SOFTENER** (***carbamide peroxide***) | Covered | OTC; QL (15 ML per 30 days) |
| **MURINE EAR** (***carbamide peroxide***) | Covered | OTC; QL (15 ML per 30 days) |
| **MURINE EAR WAX REMOVAL SYSTEM** (***carbamide peroxide***) | Covered | OTC; QL (15 ML per 30 days) |
| **OTIX** (***carbamide peroxide***) | Covered | OTC; QL (15 ML per 30 days) |
| ****Otic Anti-Infectives*** - Antibiotics*** | | |
| ***ciprofloxacin hcl*** | Covered | QL (28 EA per 30 days) |
| ***ofloxacin*** | Covered | QL (15 ML per 30 days) |
| ****Otic Steroid-Anti-Infective Combinations*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***neomycin-polymyxin-hc*** | Covered | QL (15 ML per 30 days) |

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|---|---|---|
| ***Otic Steroids*** - Anti-Infective/Anti-Inflammatories*** | | |
| ***hydrocortisone-acetic acid*** | Covered | QL (10 ML per 30 days) |
| ***hydrocortisone-acetic acid*** (Acetasol Hc) | Covered | QL (10 ML per 30 days) |
| ***Oxytocics* - Hormones** | | |
| ***Oxytocics*** - Drugs For Women*** | | |
| ***methylergonovine maleate*** | Covered | |
| ***Passive Immunizing And Treatment Agents* - Biological Agents** | | |
| ***Antiviral Monoclonal Antibodies*** - Biological Agents*** | | |
| **SYNAGIS** (***palivizumab***) | Covered | PA; QL (1 Vial per 26 days) |
| ***Immune Serums*** - Biological Agents*** | | |
| **CYTOGAM** (***cytomegalovirus immune glob***) | Covered | PA |
| **GAMMAGARD** (***immune globulin (human)***) | Covered | PA |
| **GAMUNEX-C** (***immune globulin (human)***) | Covered | PA |
| **HEPAGAM B** (***hepatitis b immune globulin***) | Covered | |
| **HIZENTRA** (***immune globulin (human)***) | Covered | PA |
| **HYPERHEP B S/D** (***hepatitis b immune globulin***) | Covered | |
| **HYPERRHO S/D** (***rho d immune globulin***) | Covered | |
| **MICRHOGAM ULTRA-FILTERED PLUS** (***rho d immune globulin***) | Covered | |
| **NABI-HB** (***hepatitis b immune globulin***) | Covered | |
| **PRIVIGEN** (***immune globulin (human)***) | Covered | PA |
| **RHOGAM ULTRA-FILTERED PLUS** (***rho d immune globulin***) | Covered | |
| **RHOPHYLAC** (***rho d immune globulin***) | Covered | QL (2 mL per 1 Year) |
| ***Penicillins* - Drugs For Infections** | | |
| ***Aminopenicillins*** - Antibiotics*** | | |
| ***amoxicillin*** | Covered | |
| ***ampicillin*** | Covered | |
| ***ampicillin sodium*** | Covered | PA |
| ***Natural Penicillins*** - Antibiotics*** | | |
| ***penicillin g pot in dextrose*** | Covered | PA |
| ***penicillin g procaine*** | Covered | |
| ***penicillin v potassium*** | Covered | |
| ***Penicillin Combinations*** - Antibiotics*** | | |
| ***amoxicillin-pot clavulanate er*** | Covered | QL (28 EA per 30 days) |
| ***amoxicillin-pot clavulanate oral suspension reconstituted*** | Covered | |

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**Coverage Requirements and Limits**
**AL** = Age Restrictions
**OTC** = OTC Medications
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***amoxicillin-pot clavulanate oral tablet*** | Covered | QL (28 EA per 30 days) |
| ***amoxicillin-pot clavulanate oral tablet chewable*** | Covered | QL (28 EA per 30 days) |
| ***ampicillin-sulbactam sodium*** | Covered | PA |
| ***piperacillin sod-tazobactam so*** | Covered | PA |
| **ZOSYN** (***piperacillin-tazobactam in dex***) | Covered | PA |
| ****Penicillinase-Resistant Penicillins*** - Antibiotics*** | | |
| ***dicloxacillin sodium*** | Covered | |
| ***nafcillin sodium*** | Covered | PA |
| ***nafcillin sodium in dextrose*** | Covered | PA |
| **BACTOCILL IN DEXTROSE** (***oxacillin sodium in dextrose***) | Covered | PA |
| ***Pharmaceutical Adjuvants*** | | |
| ****Antimicrobial Agents****** | | |
| ***benzyl alcohol*** | Covered | |
| ****External Vehicle Ingredients****** | | |
| ***gelatin*** | State Carve Out | |
| ****Flavoring Agents****** | | |
| ***almond oil bitter flavor*** | Covered | |
| ***anise extract*** | Covered | |
| ***apple flavor*** | Covered | |
| ***apricot flavor*** | Covered | |
| ***bacon flavor*** | Covered | |
| ***banana concentrate*** | Covered | |
| ***banana cream flavor*** | Covered | |
| ***banana creme flavor*** | Covered | |
| ***banana flavor*** | Covered | |
| ***beef (grilled) flavor oil sol*** | Covered | OTC |
| ***beef flavor*** | Covered | |
| ***beef type flavor natural*** | Covered | |
| ***bitter stop flavor*** | Covered | |
| ***bitterness mask flavor*** | Covered | |
| ***blackberry flavor*** | Covered | |
| ***blueberry flavor*** | Covered | |
| ***bubble gum concentrate*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***bubble gum flavor*** | Covered | |
| ***butter flavor*** | Covered | |
| ***butter rum flavor*** | Covered | |
| ***butterscotch flavor*** | Covered | |
| ***caramel flavor*** | Covered | |
| ***cheesecake flavor*** | Covered | |
| ***cherry flavor*** | Covered | |
| ***chicken (grilled) flavor*** | Covered | OTC |
| ***chicken flavor*** | Covered | OTC |
| ***chicken flavor oil miscible*** | Covered | OTC |
| ***chicken flavor oil soluble*** | Covered | |
| ***chicken flavor water miscible*** | Covered | |
| ***chocolate flavor*** | Covered | |
| ***chocolate hazelnut flavor*** | Covered | |
| ***coconut flavor*** | Covered | |
| ***coffee flavor*** | Covered | |
| ***cola flavor*** | Covered | |
| ***cotton candy flavor*** | Covered | |
| ***cran-raspberry flavor*** | Covered | |
| ***creme dementhe flavor*** | Covered | |
| ***english toffee flavor*** | Covered | |
| ***eugenol flavor*** | Covered | |
| ***fish flavor*** | Covered | |
| ***grape flavor*** | Covered | |
| ***guava flavor*** | Covered | |
| ***ham flavor*** | Covered | |
| ***honey flavor*** | Covered | |
| ***kahlua flavor*** | Covered | |
| ***lemon extract*** | Covered | |
| ***lemon flavor*** | Covered | OTC |
| ***licorice flavor*** | Covered | |
| ***liver flavor*** | Covered | |
| ***mango flavor*** | Covered | |
| ***maple flavor*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***marshmallow flavor*** | Covered | |
| ***mint chocolate chip flavor*** | Covered | |
| ***orange concentrate*** | Covered | OTC |
| ***orange cream flavor*** | Covered | |
| ***orange flavor*** | Covered | |
| ***orange oil flavor*** | Covered | |
| ***peach flavor*** | Covered | |
| ***peanut butter flavor*** | Covered | |
| ***pina colada flavor*** | Covered | |
| ***pineapple flavor*** | Covered | |
| ***pralines and cream flavor*** | Covered | |
| ***pumpkin flavor*** | Covered | |
| ***raspberry flavor*** | Covered | |
| ***root beer flavor*** | Covered | |
| ***sardine flavor*** | Covered | OTC |
| ***shrimp flavor*** | Covered | |
| ***stevia glycerite extract*** | Covered | |
| ***strawberry flavor*** | Covered | |
| ***sweetening enhancer*** | Covered | |
| ***tropical punch flavor*** | Covered | |
| ***tuna flavor*** | Covered | OTC |
| ***tutti frutti flavor*** | Covered | |
| ***tutti-frutti flavor*** | Covered | |
| ***vanilla butternut flavor*** | Covered | |
| ***vanilla flavor*** | Covered | |
| ***watermelon flavor*** | Covered | |
| ***wild cherry flavor*** | Covered | |
| **FLAVORX** (***flavoring agent***) | Covered | OTC |
| **PCCA SWEETNESS ENHANCER** (***flavoring agent***) | Covered | |
| ****Gelatin Capsules (Empty)****** | | |
| ***capsule coni-snap #0 blu/white*** | Covered | |
| ***capsule coni-snap #0 clear*** | Covered | |
| ***capsule coni-snap #0 dark blue*** | Covered | |
| ***capsule coni-snap #0 green/clr*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***capsule coni-snap #0 pink*** | Covered | |
| ***capsule coni-snap #0 red/white*** | Covered | |
| ***capsule coni-snap #0 white*** | Covered | |
| ***capsule coni-snap #00 clear*** | Covered | |
| ***capsule coni-snap #00 white*** | Covered | |
| ***capsule coni-snap #000 clear*** | Covered | |
| ***capsule coni-snap #1 aqua blue*** | Covered | |
| ***capsule coni-snap #1 blue*** | Covered | |
| ***capsule coni-snap #1 blue/pink*** | Covered | |
| ***capsule coni-snap #1 blue/wht*** | Covered | |
| ***capsule coni-snap #1 brown*** | Covered | |
| ***capsule coni-snap #1 brwn/ivry*** | Covered | |
| ***capsule coni-snap #1 clear*** | Covered | |
| ***capsule coni-snap #1 dk grn/or*** | Covered | |
| ***capsule coni-snap #1 drk green*** | Covered | |
| ***capsule coni-snap #1 grey/pink*** | Covered | |
| ***capsule coni-snap #1 grn/ylw*** | Covered | |
| ***capsule coni-snap #1 orange*** | Covered | |
| ***capsule coni-snap #1 pink*** | Covered | |
| ***capsule coni-snap #1 pink/blue*** | Covered | |
| ***capsule coni-snap #1 pink/clr*** | Covered | |
| ***capsule coni-snap #1 pink/whit*** | Covered | |
| ***capsule coni-snap #1 pink/yllw*** | Covered | |
| ***capsule coni-snap #1 purple*** | Covered | |
| ***capsule coni-snap #1 red/blue*** | Covered | |
| ***capsule coni-snap #1 red/white*** | Covered | |
| ***capsule coni-snap #1 white*** | Covered | |
| ***capsule coni-snap #1 white/grn*** | Covered | |
| ***capsule coni-snap #1 wht/clr*** | Covered | |
| ***capsule coni-snap #1 yellow*** | Covered | |
| ***capsule coni-snap #1 yellow/gr*** | Covered | |
| ***capsule coni-snap #2 clear*** | Covered | |
| ***capsule coni-snap #2 white*** | Covered | |
| ***capsule coni-snap #3 blu/clear*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***capsule coni-snap #3 brn/blue*** | Covered | |
| ***capsule coni-snap #3 clear*** | Covered | |
| ***capsule coni-snap #3 gray/ylw*** | Covered | |
| ***capsule coni-snap #3 green/blu*** | Covered | |
| ***capsule coni-snap #3 grey/pink*** | Covered | |
| ***capsule coni-snap #3 maron/blu*** | Covered | |
| ***capsule coni-snap #3 mint grn*** | Covered | |
| ***capsule coni-snap #3 olive/clr*** | Covered | |
| ***capsule coni-snap #3 orange*** | Covered | |
| ***capsule coni-snap #3 pink/pink*** | Covered | |
| ***capsule coni-snap #3 pnk/clear*** | Covered | |
| ***capsule coni-snap #3 red/clear*** | Covered | |
| ***capsule coni-snap #3 red/red*** | Covered | |
| ***capsule coni-snap #3 white*** | Covered | |
| ***capsule coni-snap #3 wht/clr*** | Covered | |
| ***capsule coni-snap #3 yellow*** | Covered | |
| ***capsule coni-snap #4 black/grn*** | Covered | |
| ***capsule coni-snap #4 clear*** | Covered | |
| ***capsule coni-snap #4 white*** | Covered | |
| ***capsule size 1 lactose*** | Covered | OTC |
| ***empty capsule*** | Covered | OTC |
| ***empty capsule #0 red/white*** | Covered | OTC |
| ***empty capsule #00 black/red*** | Covered | OTC |
| ***empty capsule #00 blue/white*** | Covered | OTC |
| ***empty capsule #00 pink/pink*** | Covered | OTC |
| ***empty capsule #00 purple*** | Covered | OTC |
| ***empty capsule #00 purple/white*** | Covered | OTC |
| ***empty capsule #00 red/white*** | Covered | OTC |
| ***empty capsule #00 yellow/yello*** | Covered | OTC |
| ***empty capsule size 0*** | Covered | OTC |
| ***empty capsule size 0 blue*** | Covered | OTC |
| ***empty capsule size 0 blue/wht*** | Covered | OTC |
| ***empty capsule size 0 clear*** | Covered | |
| ***empty capsule size 0 fun caps*** | Covered | OTC |

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|---|---|---|
| ***empty capsule size 0 green*** | Covered | OTC |
| ***empty capsule size 0 green/clr*** | Covered | OTC |
| ***empty capsule size 0 grn/clear*** | Covered | OTC |
| ***empty capsule size 0 maroon*** | Covered | OTC |
| ***empty capsule size 0 orange*** | Covered | OTC |
| ***empty capsule size 0 pink*** | Covered | |
| ***empty capsule size 0 purp/wht*** | Covered | |
| ***empty capsule size 0 purple*** | Covered | |
| ***empty capsule size 0 red*** | Covered | OTC |
| ***empty capsule size 0 red/clear*** | Covered | OTC |
| ***empty capsule size 0 red/white*** | Covered | OTC |
| ***empty capsule size 0 white*** | Covered | OTC |
| ***empty capsule size 0 white/clr*** | Covered | OTC |
| ***empty capsule size 0 yellow*** | Covered | OTC |
| ***empty capsule size 00 blue*** | Covered | OTC |
| ***empty capsule size 00 blue opq*** | Covered | |
| ***empty capsule size 00 clear*** | Covered | |
| ***empty capsule size 00 drk grn*** | Covered | OTC |
| ***empty capsule size 00 green*** | Covered | OTC |
| ***empty capsule size 00 orange*** | Covered | OTC |
| ***empty capsule size 00 red*** | Covered | OTC |
| ***empty capsule size 00 white*** | Covered | OTC |
| ***empty capsule size 000 clear*** | Covered | OTC |
| ***empty capsule size 000 white*** | Covered | OTC |
| ***empty capsule size 1 aqua blue*** | Covered | OTC |
| ***empty capsule size 1 blue*** | Covered | OTC |
| ***empty capsule size 1 blue/pink*** | Covered | OTC |
| ***empty capsule size 1 blue/red*** | Covered | OTC |
| ***empty capsule size 1 blue/wht*** | Covered | OTC |
| ***empty capsule size 1 blueclear*** | Covered | OTC |
| ***empty capsule size 1 brn/ivory*** | Covered | |
| ***empty capsule size 1 clear*** | Covered | |
| ***empty capsule size 1 drk green*** | Covered | |
| ***empty capsule size 1 green*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***empty capsule size 1 grey/pink*** | Covered | |
| ***empty capsule size 1 grn/ornge*** | Covered | |
| ***empty capsule size 1 grn/white*** | Covered | |
| ***empty capsule size 1 grn/yllw*** | Covered | |
| ***empty capsule size 1 ivory*** | Covered | |
| ***empty capsule size 1 lght blue*** | Covered | OTC |
| ***empty capsule size 1 maroon/cl*** | Covered | |
| ***empty capsule size 1 mint grn*** | Covered | |
| ***empty capsule size 1 orange*** | Covered | |
| ***empty capsule size 1 orge/clr*** | Covered | |
| ***empty capsule size 1 orge/yllw*** | Covered | |
| ***empty capsule size 1 ornge/wht*** | Covered | OTC |
| ***empty capsule size 1 pink*** | Covered | |
| ***empty capsule size 1 pink/blue*** | Covered | OTC |
| ***empty capsule size 1 pink/clr*** | Covered | |
| ***empty capsule size 1 pink/yllw*** | Covered | |
| ***empty capsule size 1 pnk/white*** | Covered | |
| ***empty capsule size 1 purple*** | Covered | OTC |
| ***empty capsule size 1 pwdr blue*** | Covered | |
| ***empty capsule size 1 red*** | Covered | |
| ***empty capsule size 1 red/blue*** | Covered | |
| ***empty capsule size 1 red/white*** | Covered | |
| ***empty capsule size 1 white*** | Covered | |
| ***empty capsule size 1 wht/clear*** | Covered | |
| ***empty capsule size 1 yellow*** | Covered | |
| ***empty capsule size 10 clear*** | Covered | OTC |
| ***empty capsule size 11 clear*** | Covered | OTC |
| ***empty capsule size 13 clear*** | Covered | OTC |
| ***empty capsule size 2 blue*** | Covered | OTC |
| ***empty capsule size 2 clear*** | Covered | |
| ***empty capsule size 2 green*** | Covered | OTC |
| ***empty capsule size 2 white*** | Covered | OTC |
| ***empty capsule size 3 black/grn*** | Covered | |
| ***empty capsule size 3 blue*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***empty capsule size 3 blue opq*** | Covered | |
| ***empty capsule size 3 blue/clr*** | Covered | |
| ***empty capsule size 3 blue/wht*** | Covered | |
| ***empty capsule size 3 clear*** | Covered | |
| ***empty capsule size 3 dark grn*** | Covered | |
| ***empty capsule size 3 gray/pink*** | Covered | OTC |
| ***empty capsule size 3 gray/yllw*** | Covered | OTC |
| ***empty capsule size 3 green*** | Covered | OTC |
| ***empty capsule size 3 grey/pink*** | Covered | |
| ***empty capsule size 3 grey/yllw*** | Covered | |
| ***empty capsule size 3 grn/blue*** | Covered | |
| ***empty capsule size 3 marn/blue*** | Covered | |
| ***empty capsule size 3 marn/clr*** | Covered | |
| ***empty capsule size 3 maroon*** | Covered | OTC |
| ***empty capsule size 3 mint grn*** | Covered | |
| ***empty capsule size 3 olive*** | Covered | OTC |
| ***empty capsule size 3 olive/clr*** | Covered | |
| ***empty capsule size 3 orange*** | Covered | |
| ***empty capsule size 3 orange/wh*** | Covered | |
| ***empty capsule size 3 pink*** | Covered | |
| ***empty capsule size 3 pink/blue*** | Covered | |
| ***empty capsule size 3 pink/wh*** | Covered | |
| ***empty capsule size 3 pink/yllw*** | Covered | |
| ***empty capsule size 3 pnk/clear*** | Covered | |
| ***empty capsule size 3 prple/clr*** | Covered | |
| ***empty capsule size 3 purple*** | Covered | |
| ***empty capsule size 3 pwdr blue*** | Covered | |
| ***empty capsule size 3 red*** | Covered | |
| ***empty capsule size 3 red/clear*** | Covered | |
| ***empty capsule size 3 red/white*** | Covered | |
| ***empty capsule size 3 white*** | Covered | |
| ***empty capsule size 3 white/clr*** | Covered | |
| ***empty capsule size 3 yellow*** | Covered | |
| ***empty capsule size 3 yellw/clr*** | Covered | |

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**OTC** = OTC Medications
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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***empty capsule size 4 black*** | Covered | OTC |
| ***empty capsule size 4 blue/whit*** | Covered | OTC |
| ***empty capsule size 4 clear*** | Covered | |
| ***empty capsule size 4 dark blue*** | Covered | OTC |
| ***empty capsule size 4 purple*** | Covered | |
| ***empty capsule size 4 red/white*** | Covered | |
| ***empty capsule size 4 white*** | Covered | |
| ***empty capsule size 4 yellow*** | Covered | |
| ***empty capsule size 5 clear*** | Covered | |
| ***empty capsule size 7 clear*** | Covered | |
| **DRCAPS SIZE 0** (***gelatin capsules (empty)***) | Covered | |
| **DRCAPS SIZE 00** (***gelatin capsules (empty)***) | Covered | |
| **DRCAPS SIZE 1** (***gelatin capsules (empty)***) | Covered | |
| ****Oral Vehicles****** | | |
| ***cherry*** | Covered | |
| ***flavor plus*** | Covered | |
| ***flavor sweet*** | Covered | |
| ***grape syrup*** | Covered | OTC |
| ***oral suspend*** | Covered | OTC |
| ***raspberry syrup*** | Covered | |
| ***simple syrup*** | Covered | |
| ***sorbitol*** | Covered | |
| ***suspension vehicle*** | Covered | |
| ***syrpalta*** | Covered | |
| ***syrup vehicle*** | Covered | |
| ***syrup vehicle sf*** | Covered | |
| **FLAVOR BLEND** (***oral vehicles***) | Covered | |
| **GERBER GOOD START WATER** (***sterile water***) | Covered | OTC |
| **GOOD START STERILE WATER** (***sterile water***) | Covered | OTC |
| **MX-SOL** (***oral vehicles***) | Covered | OTC |
| **MX-SOL BLEND** (***oral vehicles***) | Covered | OTC |
| **MX-SOL BLEND SF** (***oral vehicles***) | Covered | OTC |
| **MX-SOL SF** (***oral vehicles***) | Covered | OTC |
| **MX-SOL SUSPEND** (***oral vehicles***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **ORA-BLEND** (***oral vehicles***) | Covered | |
| **ORA-BLEND SF** (***oral vehicles***) | Covered | |
| **ORA-PLUS** (***oral vehicles***) | Covered | |
| **ORA-SWEET** (***oral vehicles***) | Covered | |
| **ORA-SWEET SF** (***oral vehicles***) | Covered | |
| **PCCA SWEET-SF** (***oral vehicles***) | Covered | |
| **PCCA SYRUP VEHICLE** (***oral vehicles***) | Covered | |
| **PCCA-PLUS** (***oral vehicles***) | Covered | |
| **SIMILAC STERILIZED WATER** (***sterile water***) | Covered | OTC |
| **SYRPALTA (RED)** (***oral vehicles***) | Covered | |
| **SYRSPEND SF ALKA** (***oral vehicles***) | Covered | OTC |
| **SYRSPEND SF ORAL LIQUID** (***oral vehicles***) | Covered | |
| **SYRSPEND SF ORAL SUSPENSION RECONSTITUTED** (***oral vehicles***) | Covered | OTC |
| **SYRSPEND SF PH4** (***oral vehicles***) | Covered | |
| **VERSAFREE** (***oral vehicles***) | Covered | |
| **VERSAPLUS** (***oral vehicles***) | Covered | |
| ***Parenteral Vehicles**** | | |
| ***sterile diluent/epoprostenol*** | Covered | |
| ***sterile water for injection*** | Covered | |
| ***Pharmaceutical Excipients**** | | |
| ***lactose monohydrate*** | Covered | |
| ***xanthan gum*** | Covered | |
| **PCCA SORBITOL LOLLIPOP BASE** (***sorbitol lollipop base***) | Covered | |
| ***Progestins* - Hormones** | | |
| ***Progestins**** ***- Drugs For Women*** | | |
| ***hydroxyprogesterone caproate*** | Covered | PA |
| ***medroxyprogesterone acetate*** | Covered | |
| ***megestrol acetate*** | Covered | |
| ***norethindrone acetate*** | Covered | ST |
| ***progesterone micronized*** | Covered | QL (60 EA per 30 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Psychotherapeutic And Neurological Agents - Misc.* - Drugs For The Nervous System** | | |
| ***Agents For Opioid Withdrawal*** - Drugs For The Nervous System** | | |
| **LUCEMYRA** (***lofexidine hcl***) | State Carve Out | |
| ***Alcohol Deterrents*** - Drugs For The Nervous System** | | |
| ***acamprosate calcium*** | State Carve Out | |
| ***disulfiram*** | Covered | |
| ***Benzodiazepines & Tricyclic Agents*** - Drugs For Seizures /Personality Disorder/Nerve Pain** | | |
| ***chlordiazepoxide-amitriptyline*** | Covered | |
| ***Cholinomimetics - Ache Inhibitors*** - Drugs For Alzheimer's Disease** | | |
| ***donepezil hcl oral tablet*** | Covered | QL (30 EA per 30 days); AL (Min 40 Years) |
| ***donepezil hcl oral tablet dispersible*** | Covered | QL (1 EA per 1 day); AL (Min 40 Years) |
| ***galantamine hydrobromide*** | Covered | QL (2 EA per 1 day); AL (Min 40 Years) |
| ***galantamine hydrobromide er*** | Covered | QL (1 EA per 1 day); AL (Min 40 Years) |
| ***rivastigmine tartrate*** | Covered | QL (60 EA per 30 days); AL (Min 40 Years) |
| ***Fibromyalgia Agent - Snris*** - Drugs For Seizures /Personality Disorder/Nerve Pain** | | |
| **SAVELLA** (***milnacipran hcl***) | Covered | ST; QL (2 EA per 1 day) |
| **SAVELLA TITRATION PACK** (***milnacipran hcl***) | Covered | ST; QL (55 EA per 90 days) |
| ***Movement Disorder Drug Therapy*** - Drugs For The Nervous System** | | |
| **AUSTEDO** (***deutetrabenazine***) | Covered | PA |
| ***Ms Agents - Pyrimidine Synthesis Inhibitors*** - Drugs For Multiple Sclerosis** | | |
| **AUBAGIO** (***teriflunomide***) | Covered | PA; QL (1 EA per 1 day) |
| ***Multiple Sclerosis Agents - Interferons*** - Drugs For Multiple Sclerosis** | | |
| **AVONEX** (***interferon beta-1a***) | Covered | PA; QL (4 EA per 28 days) |
| **AVONEX PEN** (***interferon beta-1a***) | Covered | PA; QL (1 KIT per 28 days) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **AVONEX PREFILLED** (***interferon beta-1a***) | Covered | PA; QL (1 KIT per 28 days) |
| **EXTAVIA** (***interferon beta-1b***) | Covered | PA; QL (15 Vials per 30 days) |
| **REBIF** (***interferon beta-1a***) | Covered | PA; QL (6 ML per 28 days) |
| **REBIF REBIDOSE** (***interferon beta-1a***) | Covered | PA; QL (6 ML per 28 days) |
| **REBIF REBIDOSE TITRATION PACK** (***interferon beta-1a***) | Covered | PA; QL (12 ML per 28 days) |
| **REBIF TITRATION PACK** (***interferon beta-1a***) | Covered | PA; QL (12 ML per 28 days) |
| ****Multiple Sclerosis Agents - Monoclonal Antibodies*** - Drugs For Multiple Sclerosis*** | | |
| **OCREVUS** (***ocrelizumab***) | Covered | PA; QL (0.12 ML per 1 day) |
| ****Multiple Sclerosis Agents - Nrf2 Pathway Activators*** - Drugs For Multiple Sclerosis*** | | |
| ***dimethyl fumarate*** | Covered | PA; QL (2 EA per 1 day) |
| ***dimethyl fumarate starter pack*** | Covered | PA; QL (60 EA per 90 days) |
| ****Multiple Sclerosis Agents*** - Drugs For Multiple Sclerosis*** | | |
| ***glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml*** | Covered | QL (1 ML per 1 day) |
| ***glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml*** | Covered | PA; QL (12 Syringes per 28 days) |
| **COPAXONE** (***glatiramer acetate***) | Covered | PA; QL (12 Syringes per 28 days) |
| ***glatiramer acetate*** (Glatopa) | Covered | PA; QL (1 ML per 1 day) |
| ****N-Methyl-D-Aspartate (Nmda) Receptor Antagonists*** - Drugs For Alzheimer's Disease*** | | |
| ***memantine hcl oral solution*** | Covered | AL (Min 40 Years) |
| ***memantine hcl oral tablet 10 mg, 5 mg*** | Covered | QL (1 EA per 1 day); AL (Min 40 Years) |
| ***memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg*** | Covered | AL (Min 40 Years) |
| ****Phenothiazines & Tricyclic Agents*** - Drugs For Depression*** | | |
| ***perphenazine-amitriptyline*** | Covered | |
| ****Premenstrual Dysphoric Disorder (Pmdd) Agents - Ssris*** - Drugs For Depression*** | | |
| ***fluoxetine hcl (pmdd)*** | Covered | |
| ****Psychotherapeutic And Neurological Agents - Misc.*** - Drugs For Severe Mental Disorders*** | | |
| ***pimozide*** | State Carve Out | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Smoking Deterrents*** - Drugs For Depression*** | | |
| ***bupropion hcl er (smoking det)*** | Covered | QL (2 EA per 1 day) |
| ***cvs nicotine mouth/throat*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***cvs nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***cvs nicotine transdermal*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***eq nicotine mouth/throat*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***eq nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***eq nicotine step 3*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***eq nicotine transdermal*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***eql nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***gnp nicotine mini*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***gnp nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***goodsense nicotine*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***hm nicotine*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***hm nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***nicotine mini*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***nicotine step 1*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***nicotine step 2*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***nicotine step 3*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***nicotine transdermal kit*** | Covered | OTC; QL (1 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***nicotine transdermal patch 24 hour 14 mg/24hr, 7 mg/24hr*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***nicotine transdermal patch 24 hour 21 mg/24hr*** | Covered | OTC; QL (1 EA per 1 day); AL (Min 18 Years) |
| ***px stop smoking aid*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***ra mini nicotine*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***ra nicotine mouth/throat*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***ra nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***ra nicotine transdermal*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***sm nicotine mouth/throat*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***sm nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***sm nicotine transdermal*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***sr nicotine*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***tgt nicotine*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***tgt nicotine polacrilex*** | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***tgt nicotine step one*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***tgt nicotine step three*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***tgt nicotine step two*** | Covered | OTC; QL (30 EA per 30 days); AL (Min 18 Years) |
| **CHANTIX** (***varenicline tartrate***) | Covered | |
| **CHANTIX CONTINUING MONTH PAK** (***varenicline tartrate***) | Covered | |
| **CHANTIX STARTING MONTH PAK** (***varenicline tartrate***) | Covered | |
| **KLS QUIT2** (***nicotine polacrilex***) | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| **KLS QUIT4** (***nicotine polacrilex***) | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **NICORELIEF** (***nicotine polacrilex***) | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| **NICOTROL** (***nicotine***) | Covered | |
| **NICOTROL NS** (***nicotine***) | Covered | |
| **THRIVE** (***nicotine polacrilex***) | Covered | OTC; QL (200 EA per 30 days); AL (Min 18 Years) |
| ***Sphingosine 1-Phosphate (S1p) Receptor Modulators*** - Drugs For Multiple Sclerosis*** | | |
| **GILENYA** (***fingolimod hcl***) | Covered | PA; QL (1 EA per 1 day) |
| ***Thienbenzodiazepines & Ssris*** - Drugs For Severe Mental Disorders*** | | |
| ***olanzapine-fluoxetine hcl*** | State Carve Out | |
| ***Respiratory Agents - Misc.* - Drugs For The Lungs** | | |
| ***Cftr Potentiators*** - Drugs For Cystic Fibrosis*** | | |
| **KALYDECO** (***ivacaftor***) | Covered | PA |
| ***Cystic Fibrosis Agent - Combinations*** - Drugs For Cystic Fibrosis*** | | |
| **ORKAMBI** (***lumacaftor-ivacaftor***) | Covered | PA |
| **SYMDEKO** (***tezacaftor-ivacaftor***) | Covered | PA |
| ***Hydrolytic Enzymes*** - Drugs For The Lungs*** | | |
| **PULMOZYME** (***dornase alfa***) | Covered | PA; QL (5 ML per 1 day) |
| ***Pulmonary Fibrosis Agents*** - Drugs For The Lungs*** | | |
| **ESBRIET** (***pirfenidone***) | Covered | PA |
| ***Sulfonamides* - Drugs For Infections** | | |
| ***Sulfonamides*** - Antibiotics*** | | |
| ***sulfadiazine*** | Covered | |
| ***Tetracyclines* - Drugs For Infections** | | |
| ***Glycylcyclines*** - Antibiotics*** | | |
| ***tigecycline*** | Covered | PA |
| ***Tetracyclines*** - Antibiotics*** | | |
| ***doxycycline hyclate intravenous*** | Covered | PA |
| ***doxycycline hyclate oral*** | Covered | |
| ***doxycycline monohydrate oral capsule*** | Covered | |
| ***doxycycline monohydrate oral suspension reconstituted*** | Covered | AL (Max 12 Years) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***minocycline hcl*** | Covered | |
| ***doxycycline hyclate*** (Doxy 100) | Covered | PA |
| ***Thyroid Agents* - Hormones** | | |
| ****Antithyroid Agents*** - Drugs For Thyroid*** | | |
| ***methimazole*** | Covered | |
| ***propylthiouracil*** | Covered | |
| ****Thyroid Hormones*** - Drugs For Thyroid*** | | |
| ***levothyroxine sodium*** | Covered | QL (30 EA per 30 days) |
| ***liothyronine sodium oral tablet 25 mcg, 50 mcg*** | Covered | QL (2 EA per 1 day) |
| ***liothyronine sodium oral tablet 5 mcg*** | Covered | QL (4 EA per 1 day) |
| ***np thyroid*** | Covered | QL (1 EA per 1 day) |
| **ARMOUR THYROID** (***thyroid***) | Covered | QL (1 EA per 1 day) |
| ***levothyroxine sodium*** (Levo-T) | Covered | QL (30 EA per 30 days) |
| ***levothyroxine sodium*** (Levoxyl) | Covered | QL (30 EA per 30 days) |
| ***levothyroxine sodium*** (Unithroid) | Covered | QL (30 EA per 30 days) |
| ***levothyroxine sodium*** (Unithroid Direct) | Covered | QL (30 EA per 30 days) |
| ***Toxoids* - Biological Agents** | | |
| ****Toxoid Combinations*** - Vaccines*** | | |
| ***diphtheria-tetanus toxoids dt*** | Covered | AL (Min 19 Years) |
| ***tetanus-diphtheria toxoids td*** | Covered | |
| **ADACEL** (***tetanus-diphth-acell pertussis***) | Covered | AL (Min 19 Years) |
| **DECAVAC** (***tetanus-diphtheria toxoids td***) | Covered | |
| **DIPHTHERIA-TETANUS TOXOIDS** (***tetanus-diphtheria toxoids td***) | Covered | |
| **TDVAX** (***tetanus-diphtheria toxoids td***) | Covered | |
| **TENIVAC** (***tetanus-diphtheria toxoids td***) | Covered | |
| ***Ulcer Drugs/Antispasmodics/Anticholinergics* - Drugs For The Stomach** | | |
| ****Antispasmodics*** - Drugs For Stomach Cramps*** | | |
| ***dicyclomine hcl oral capsule*** | Covered | |
| ***dicyclomine hcl oral solution*** | Covered | AL (Max 12 Years) |
| ***dicyclomine hcl oral tablet*** | Covered | |
| ****Belladonna Alkaloids*** - Drugs For Stomach Cramps*** | | |
| ***ed-spaz*** | Covered | |
| ***hyoscyamine sulfate*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***hyoscyamine sulfate er*** | Covered | |
| ***hyosyne*** | Covered | |
| ***oscimin*** | Covered | |
| ***oscimin sr*** | Covered | |
| ***hyoscyamine sulfate*** (Nulev) | Covered | |
| ***hyoscyamine sulfate*** (Symax-Sl) | Covered | |
| ***hyoscyamine sulfate*** (Symax-Sr) | Covered | |
| ****H-2 Antagonists*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***acid control maximum strength*** | Covered | OTC |
| ***acid controller*** | Covered | OTC; QL (60 EA per 30 days) |
| ***acid controller max st*** | Covered | OTC |
| ***acid reducer maximum strength*** | Covered | OTC |
| ***acid reducer oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***acid reducer oral tablet 150 mg*** | Covered | OTC |
| ***cimetidine 200*** | Covered | OTC |
| ***cimetidine acid reducer*** | Covered | OTC |
| ***cimetidine hcl*** | Covered | |
| ***cimetidine oral tablet 200 mg*** | Covered | |
| ***cimetidine oral tablet 300 mg, 400 mg, 800 mg*** | Covered | QL (60 EA per 30 days) |
| ***cvs acid controller max st*** | Covered | OTC |
| ***cvs acid reducer max st*** | Covered | OTC |
| ***cvs heartburn relief*** | Covered | OTC |
| ***eq acid reducer max st*** | Covered | OTC |
| ***eq acid reducer oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***eq acid reducer oral tablet 150 mg, 200 mg*** | Covered | OTC |
| ***eq heartburn relief*** | Covered | OTC |
| ***eql heartburn prevention oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***eql heartburn prevention oral tablet 20 mg*** | Covered | OTC |
| ***famotidine oral suspension reconstituted*** | Covered | AL (Max 12 Years) |
| ***famotidine oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***famotidine oral tablet 20 mg*** | Covered | |
| ***famotidine oral tablet 40 mg*** | Covered | QL (2 EA per 1 day) |
| ***gnp acid control 150 max st*** | Covered | OTC |
| ***gnp acid reducer*** | Covered | OTC; QL (60 EA per 30 days) |

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|---|---|---|
| ***gnp acid reducer max st*** | Covered | OTC |
| ***gnp heartburn relief*** | Covered | OTC |
| ***gnp heartburn relief 200*** | Covered | OTC |
| ***goodsense acid reducer*** | Covered | OTC |
| ***heartburn relief 150 max st*** | Covered | OTC |
| ***heartburn relief max st*** | Covered | OTC |
| ***heartburn relief oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***heartburn relief oral tablet 200 mg*** | Covered | OTC |
| ***hm acid reducer*** | Covered | OTC |
| ***hm famotidine oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***hm famotidine oral tablet 20 mg*** | Covered | OTC |
| ***kls acid controller max st*** | Covered | OTC |
| ***kls acid reducer max st*** | Covered | OTC |
| ***nizatidine oral capsule 150 mg*** | Covered | QL (60 EA per 30 days) |
| ***nizatidine oral capsule 300 mg*** | Covered | QL (30 EA per 30 days) |
| ***px acid reducer max st*** | Covered | OTC |
| ***px acid reducer oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***px acid reducer oral tablet 200 mg*** | Covered | OTC |
| ***qc acid controller*** | Covered | OTC; QL (60 EA per 30 days) |
| ***qc acid controller max st*** | Covered | OTC |
| ***ra acid reducer max st*** | Covered | OTC |
| ***ra acid reducer oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***ra acid reducer oral tablet 200 mg*** | Covered | OTC |
| ***ranitidine hcl oral syrup*** | Covered | |
| ***ranitidine hcl oral tablet 150 mg*** | Covered | |
| ***ranitidine hcl oral tablet 300 mg*** | Covered | QL (2 EA per 1 day) |
| ***sb acid controller*** | Covered | OTC; QL (60 EA per 30 days) |
| ***sb acid controller max st*** | Covered | OTC |
| ***sb acid reducer*** | Covered | OTC; QL (60 EA per 30 days) |
| ***sb cimetidine*** | Covered | OTC |
| ***sm acid reducer max st*** | Covered | OTC |
| ***sm acid reducer oral tablet 10 mg*** | Covered | OTC; QL (60 EA per 30 days) |
| ***sm acid reducer oral tablet 200 mg*** | Covered | OTC |
| **WAL-ZAN 150 MAXIMUM STRENGTH** (***ranitidine hcl***) | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***Misc. Anti-Ulcer*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***sucralfate oral suspension*** | Covered | AL (Max 12 Years) |
| ***sucralfate oral tablet*** | Covered | |
| ***Proton Pump Inhibitors*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***cvs lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***cvs omeprazole oral capsule delayed release*** | Covered | OTC |
| ***cvs omeprazole oral tablet delayed release*** | Covered | OTC; QL (2 EA per 1 day) |
| ***eq lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***eq omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***eq omeprazole magnesium*** | Covered | OTC |
| ***eql lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***eql omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***esomeprazole magnesium*** | Covered | OTC |
| ***gnp lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***gnp omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***goodsense lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***heartburn treatment 24 hour*** | Covered | OTC; QL (60 EA per 30 days) |
| ***hm lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***hm omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***kls lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***kls omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***kp omeprazole magnesium*** | Covered | OTC |
| ***lansoprazole oral capsule delayed release 15 mg*** | Covered | QL (60 EA per 30 days) |
| ***lansoprazole oral capsule delayed release 30 mg*** | Covered | |
| ***omeprazole magnesium*** | Covered | OTC |
| ***omeprazole oral capsule delayed release 10 mg, 40 mg*** | Covered | |
| ***omeprazole oral capsule delayed release 20 mg*** | Covered | QL (60 EA per 30 days) |
| ***omeprazole oral tablet delayed release*** | Covered | OTC; QL (2 EA per 1 day) |
| ***omeprazole oral tablet delayed release dispersible*** | Covered | OTC; QL (2 EA per 1 day) |
| ***pantoprazole sodium*** | Covered | QL (30 EA per 30 days) |
| ***px omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***qc omeprazole magnesium*** | Covered | OTC |
| ***ra lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***ra omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***rabeprazole sodium*** | Covered | QL (2 EA per 1 day) |
| ***sb omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***sm lansoprazole*** | Covered | OTC; QL (60 EA per 30 days) |
| ***sm omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| ***tgt omeprazole*** | Covered | OTC; QL (2 EA per 1 day) |
| **FIRST-LANSOPRAZOLE** (***lansoprazole***) | Covered | AL (Max 12 Years) |
| **FIRST-OMEPRAZOLE** (***omeprazole***) | Covered | AL (Max 12 Years) |
| **NEXIUM 24HR** (***esomeprazole magnesium***) | Covered | OTC; QL (2 EA per 1 day) |
| **OMEPRAZOLE+SYRSPEND SF ALKA** (***omeprazole***) | Covered | AL (Max 12 Years) |
| ****Quaternary Anticholinergics*** - Drugs For Stomach Cramps*** | | |
| ***glycopyrrolate*** | Covered | |
| ****Ulcer Drugs - Prostaglandins*** - Drugs For Ulcers And Stomach Acid*** | | |
| ***misoprostol*** | Covered | |
| ***Urinary Antispasmodics* - Drugs For The Urinary System** | | |
| ****Urinary Antispasmodic - Antimuscarinic (Anticholinergic)*** - Drugs For The Bladder*** | | |
| ***oxybutynin chloride er oral tablet extended release 24 hour 10 mg*** | Covered | QL (1 EA per 1 day) |
| ***oxybutynin chloride er oral tablet extended release 24 hour 15 mg*** | Covered | QL (2 EA per 1 day) |
| ***oxybutynin chloride er oral tablet extended release 24 hour 5 mg*** | Covered | QL (30 EA per 30 days) |
| ***oxybutynin chloride oral syrup*** | Covered | QL (20 ML per 1 day) |
| ***oxybutynin chloride oral tablet*** | Covered | QL (4 EA per 1 day) |
| ***solifenacin succinate*** | Covered | ST; QL (1 EA per 1 day) |
| ***tolterodine tartrate*** | Covered | ST; QL (2 EA per 1 day) |
| ***tolterodine tartrate er*** | Covered | ST; QL (1 EA per 1 day) |
| ***trospium chloride*** | Covered | ST; QL (2 EA per 1 day) |
| ***trospium chloride er*** | Covered | ST; QL (1 EA per 1 day) |
| ****Urinary Antispasmodics - Cholinergic Agonists*** - Drugs For The Bladder*** | | |
| ***bethanechol chloride*** | Covered | |
| ***Vaccines* - Biological Agents** | | |
| ****Bacterial Vaccines*** - Vaccines*** | | |
| **ACTHIB** (***haemophilus b polysac conj vac***) | Covered | PA; AL (Min 19 Years) |
| **BEXSERO** (***meningococcal b recomb omv adj***) | Covered | QL (2 EA per 1 Lifetime); AL (Min 19 Years) |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| **HIBERIX** (***haemophilus b polysac conj vac***) | Covered | |
| **MENACTRA** (***meningococcal a c y&w-135 conj***) | Covered | AL (Min 19 Years) |
| **MENVEO** (***meningococcal a c y&w-135 olig***) | Covered | QL (1 EA per 1 Lifetime); AL (Min 19 Years) |
| **PEDVAX HIB** (***haemophilus b polysac conj vac***) | Covered | |
| **PNEUMOVAX 23** (***pneumococcal vac polyvalent***) | Covered | QL (2 doses per 1 Lifetime); AL (Min 19 Years) |
| **PREVNAR 13** (***pneumococcal 13-val conj vacc***) | Covered | QL (1 dose per 1 Lifetime); AL (Min 19 Years) |
| **TRUMENBA** (***meningococcal b vac (recomb)***) | Covered | QL (3 EA per 1 Lifetime); AL (Min 19 Years) |
| ****Viral Vaccine Combinations*** - Vaccines*** | | |
| **M-M-R II** (***measles, mumps & rubella vac***) | Covered | QL (2 EA per 1 Lifetime) |
| **TWINRIX** (***hepatitis a-hep b recomb vac***) | Covered | AL (Min 19 Years) |
| ****Viral Vaccines*** - Vaccines*** | | |
| **AFLURIA** (***influenza virus vaccine split***) | Covered | AL (Min 19 Years) |
| **AFLURIA PRESERVATIVE FREE** (***influenza virus vacc split pf***) | Covered | AL (Min 19 Years) |
| **AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.25 ML** (***influenza vac split quad***) | Covered | AL (Min 19 Years and Max 64 Years) |
| **AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** (***influenza vac split quad***) | Covered | |
| **ENGERIX-B** (***hepatitis b vac recombinant***) | Covered | AL (Min 19 Years) |
| **FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION** (***influenza vac split quad***) | Covered | AL (Min 19 Years and Max 64 Years) |
| **FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE** (***influenza vac split quad***) | Covered | |
| **FLUBLOK QUADRIVALENT** (***influenza vac recomb ha quad***) | Covered | AL (Min 19 Years and Max 64 Years) |
| **FLUCELVAX QUADRIVALENT** (***influenza vac subunit quad***) | Covered | AL (Min 19 Years and Max 64 Years) |
| **FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION** (***influenza vac split quad***) | Covered | AL (Min 19 Years) |
| **FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION 0.5 ML** (***influenza vac split quad***) | Covered | AL (Min 19 Years and Max 64 Years) |
| **FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE** (***influenza vac split quad***) | Covered | |
| **FLUMIST QUADRIVALENT** (***influenza virus vac live quad***) | Covered | AL (Min 19 Years and Max 64 Years) |

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|---|---|---|
| **FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION** (***influenza vac split quad***) | Covered | AL (Min 19 Years) |
| **FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION 0.5 ML** (***influenza vac split quad***) | Covered | AL (Min 19 Years and Max 64 Years) |
| **FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.25 ML** (***influenza vac split quad***) | Covered | AL (Min 19 Years and Max 64 Years) |
| **FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** (***influenza vac split quad***) | Covered | |
| **GARDASIL 9** (***hpv 9-valent recomb vaccine***) | Covered | QL (3 doses per 1 Lifetime); AL (Min 19 Years and Max 26 Years) |
| **HAVRIX** (***hepatitis a vaccine***) | Covered | QL (2 doses per 1 Lifetime); AL (Min 19 Years) |
| **HEPLISAV-B** (***hepatitis b vac recomb adj***) | Covered | AL (Min 19 Years) |
| **IMOVAX RABIES** (***rabies virus vaccine, hdc***) | Covered | |
| **RABAVERT** (***rabies vaccine, pcec***) | Covered | AL (Min 19 Years) |
| **RECOMBIVAX HB** (***hepatitis b vac recombinant***) | Covered | AL (Min 19 Years) |
| **VAQTA** (***hepatitis a vaccine***) | Covered | QL (2 doses per 1 Lifetime); AL (Min 19 Years) |
| **VARIVAX** (***varicella virus vaccine live***) | Covered | QL (2 EA per 1 Lifetime); AL (Min 19 Years) |
| **ZOSTAVAX** (***zoster vaccine live***) | Covered | AL (Min 50 Years) |
| ***Vaginal And Related Products* - Drugs For Women** | | |
| ****Imidazole-Related Antifungals*** - Drugs For Infections*** | | |
| ***cvs miconazole 3 combo pack*** | Covered | OTC |
| ***eq miconazole 3 combo pack*** | Covered | OTC |
| ***eql miconazole 3*** | Covered | OTC |
| ***gnp miconazole 3*** | Covered | OTC |
| ***miconazole 3 combo pack*** | Covered | OTC |
| ***miconazole 3 combo pack app*** | Covered | OTC |
| ***px miconazole 3-day combo*** | Covered | OTC |
| ***ra miconazole 3 combo pack*** | Covered | OTC |
| ***ra miconazole 3 combo pack app*** | Covered | OTC |
| ***sm miconazole 3*** | Covered | OTC |
| ***sm miconazole 3 applicator*** | Covered | OTC |
| ***terconazole*** | Covered | |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***tgt miconazole 3 combo pack*** | Covered | OTC |
| **MONISTAT 7 COMBO PACK APP** (***miconazole nitrate***) | Covered | OTC |
| ****Spermicides*** - Birth Control Pills*** | | |
| **TODAY SPONGE** (***nonoxynol-9***) | Covered | OTC; QL (3 Sponges per 30 days) |
| **VCF VAGINAL CONTRACEPTIVE** (***nonoxynol-9***) | Covered | OTC; QL (12 Films per 30 days) |
| ****Vaginal Anti-Infectives*** - Drugs For Infections*** | | |
| ***clindamycin phosphate*** | Covered | |
| ***metronidazole*** | Covered | |
| ***metronidazole*** (Vandazole) | Covered | |
| ****Vaginal Estrogens*** - Drugs For Women*** | | |
| ***estradiol*** | Covered | PA |
| **ESTRING** (***estradiol***) | Covered | QL (1 EA per 90 days) |
| ***estradiol*** (Yuvafem) | Covered | PA |
| ***Vasopressors* - Drugs For The Heart** | | |
| ****Anaphylaxis Therapy Agents*** - Drugs For Serious Allergic Reaction*** | | |
| ***epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.3 mg/0.3ml*** | Covered | QL (4 Units per 365 days) |
| ***epinephrine injection solution auto-injector 0.15 mg/0.3ml*** | Covered | QL (4 EA per 365 days) |
| ****Vasopressors*** - Drugs For Serious Allergic Reaction*** | | |
| ***midodrine hcl*** | Covered | |
| ***Vitamins* - Drugs For Nutrition** | | |
| ****Vitamin B-1*** - Drugs For Nutrition*** | | |
| ***b-1*** | Covered | OTC |
| ***b1 natural*** | Covered | OTC |
| ***ra vitamin b-1*** | Covered | OTC |
| ***thiamine*** | Covered | OTC |
| ***thiamine hcl*** | Covered | OTC |
| ***vitamin b-1*** | Covered | OTC |
| ****Vitamin B-3*** - Drugs For Nutrition*** | | |
| ***gnp niacin*** | Covered | OTC |
| ***gnp niacin tr*** | Covered | OTC |
| ***hm niacin*** | Covered | OTC |
| ***niacin*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***niacin er*** | Covered | OTC |
| ***niacin-50*** | Covered | OTC |
| ***px niacin*** | Covered | OTC |
| ***ra niacin*** | Covered | OTC |
| ***ra no flush niacin*** | Covered | OTC |
| ***sm niacin cr*** | Covered | OTC |
| **ENDUR-ACIN** (***niacin***) | Covered | OTC |
| **SLO-NIACIN** (***niacin***) | Covered | OTC |
| ****Vitamin B-6*** - Drugs For Nutrition*** | | |
| ***b-6*** | Covered | OTC |
| ***b6 natural*** | Covered | OTC |
| ***eql b-6*** | Covered | OTC |
| ***gnp vitamin b-6*** | Covered | OTC |
| ***hm vitamin b6*** | Covered | OTC |
| ***neuro-k-50*** | Covered | OTC |
| ***pyridoxine hcl*** | Covered | OTC |
| ***ra vitamin b-6*** | Covered | OTC |
| ***sm vitamin b-6*** | Covered | OTC |
| ***vitamin b6*** | Covered | OTC |
| ***vitamin b-6*** | Covered | OTC |
| ***yl vitamin b-6*** | Covered | OTC |
| ****Vitamin C*** - Drugs For Nutrition*** | | |
| **ASCOR** (***ascorbic acid***) | Covered | PA |
| ****Vitamin D*** - Drugs For Nutrition*** | | |
| ***cvs d3*** | Covered | OTC |
| ***cvs vitamin d3*** | Covered | OTC |
| ***d 1000*** | Covered | OTC |
| ***d 2000*** | Covered | OTC |
| ***d 400*** | Covered | OTC |
| ***d 5000*** | Covered | OTC |
| ***d-1000*** | Covered | OTC |
| ***d-1000 extra strength*** | Covered | OTC |
| ***d-2000 maximum strength*** | Covered | OTC |
| ***d2000 ultra strength*** | Covered | OTC |

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| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|---|---|
| ***d3 adult*** | Covered | OTC |
| ***d3 high potency*** | Covered | OTC |
| ***d3 kids*** | Covered | OTC |
| ***d3 maximum strength*** | Covered | OTC |
| ***d3 super strength*** | Covered | OTC |
| ***d3-1000*** | Covered | OTC |
| ***d-3-5*** | Covered | OTC |
| ***d-400*** | Covered | OTC |
| ***d-5000*** | Covered | OTC |
| ***delta d3*** | Covered | OTC |
| ***ergocal*** | Covered | QL (1 EA per 1 day) |
| ***ergocalciferol oral capsule*** | Covered | |
| ***ergocalciferol oral solution*** | Covered | OTC |
| ***gnp vitamin d*** | Covered | OTC |
| ***gnp vitamin d maximum strength*** | Covered | OTC |
| ***gnp vitamin d super strength*** | Covered | OTC |
| ***gnp vitamin d3 extra strength*** | Covered | OTC |
| ***hm vitamin d*** | Covered | OTC |
| ***hm vitamin d3*** | Covered | OTC |
| ***kp vitamin d*** | Covered | OTC |
| ***nat-rul vitamin d*** | Covered | OTC |
| ***natural vitamin d-3*** | Covered | OTC |
| ***pa vitamin d-3*** | Covered | OTC |
| ***pa vitamin d-3 gummy*** | Covered | OTC |
| ***ra vitamin d-3*** | Covered | OTC |
| ***sm vitamin d*** | Covered | OTC |
| ***sm vitamin d3*** | Covered | OTC |
| ***vitamin d*** | Covered | OTC |
| ***vitamin d (cholecalciferol)*** | Covered | OTC |
| ***vitamin d (ergocalciferol)*** | Covered | |
| ***vitamin d2*** | Covered | OTC |
| ***vitamin d3*** | Covered | OTC |
| ***vitamin d-3*** | Covered | OTC |
| ***vitamin d3 adult gummies*** | Covered | OTC |

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|---|---|---|
| ***vitamin d3 maximum strength*** | Covered | OTC |
| ***vitamin d3 super strength*** | Covered | OTC |
| ***vitamin d-400*** | Covered | OTC |
| **CALCIDOL** (***ergocalciferol***) | Covered | OTC |
| **CALCIFEROL** (***ergocalciferol***) | Covered | OTC |
| **D3 DOTS** (***cholecalciferol***) | Covered | OTC |
| **DIALYVITE VITAMIN D 5000** (***cholecalciferol***) | Covered | OTC |
| **HEALTHY KIDS VITAMIN D3** (***cholecalciferol***) | Covered | OTC |
| **PRONUTRIENTS VITAMIN D3** (***cholecalciferol***) | Covered | OTC |
| **REPLESTA** (***cholecalciferol***) | Covered | OTC |
| **THERA-D 2000** (***cholecalciferol***) | Covered | OTC |
| **THERA-D RAPID REPLETION** (***cholecalciferol***) | Covered | OTC |
| **VITAJOY DAILY D GUMMIES** (***cholecalciferol***) | Covered | OTC |
| **VITAMIN D-1000 MAX ST** (***cholecalciferol***) | Covered | OTC |
| ****Vitamin K*** - Drugs For Nutrition*** | | |
| ***phytonadione*** | Covered | |

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