Jefferson Health Plans
2025 Premium Formulary
(List of Covered Drugs)

Special (HMO SNP) | Dual Pearl (HMO SNP)

Jefferson
Health Plans

Jefferson Health Plans

Formulario Premium 2025

(Lista de medicamentos cubiertos o "Lista de medicamentos")

LEE LA SIGUIENTE INFORMACIÓN: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

Id. del formulario 25397, Versión 17

Este formulario se actualizó el 01/08/2025. Para obtener información más reciente o si tienes otras preguntas, comunícate con Servicios para Miembros de Jefferson Health Plans al 1-866-901-8000 (los usuarios de TTY deben llamar al 1-877-454-8477) o visita JeffersonHealthPlans.com/medicare. Del 1.º de octubre al 31 de marzo, estamos disponibles de 8:00 a.m. a 8:00 p.m., los 7 días de la semana. Y del 1.º de abril al 30 de septiembre, estamos disponibles de 8:00 a.m. a 8:00 p.m., de lunes a viernes.

Nota para los miembros existentes: Este formulario se cambió el año pasado. Revisa este documento para asegurarte de que aún contiene los medicamentos que tomas.

Cuando esta lista de medicamentos (formulario) dice "nosotros", "nos" o "nuestro/nuestra/nuestros/nuestras", se refiere a Jefferson Health Plans. Cuando se refiere a "plan" o "nuestro plan", hace referencia a Jefferson Health Plans Complete (HMO), Prime (HMO), Silver (HMO), Platinum (HMO), Flex Plus (PPO) y Flex Pro (PPO).

Este documento incluye una lista de los medicamentos (formulario) de nuestro plan que entró en vigor el 01/08/2025. Para obtener una lista de medicamentos (formulario) actualizada, comunícate con nosotros. Nuestra información de contacto, junto con la fecha en la que actualizamos la lista de medicamentos (formulario), aparece en las páginas de portada y contraportada.

Generalmente, debes usar las farmacias de la red para usar tu beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias o los copagos o el coseguro pueden cambiar el 1.º de enero de 2025, y de vez en cuando durante el año.

¿Qué es el formulario Premium de Jefferson Health Plans?

En este documento, usamos los términos Lista de medicamentos y formulario para referirnos a lo mismo. Un formulario es una lista de medicamentos cubiertos seleccionados por Jefferson Health Plans junto con un equipo de proveedores de atención médica, que representa las terapias recetadas que se consideran parte necesaria de un programa de tratamiento de calidad. Jefferson Health Plans, por lo general, cubre los medicamentos que se detallan en nuestro formulario siempre y cuando el medicamento sea médicamente necesario, la receta se surta en una farmacia de la red de Jefferson Health Plans y se cumplan otras reglas del plan. Para obtener más información sobre cómo surtir las recetas, revisa tu Evidencia de cobertura.

Para obtener una lista completa de todos los medicamentos recetados cubiertos por Jefferson Health Plans, visita nuestro sitio web o llámanos. Nuestra información de contacto, junto con la fecha en la que actualizamos el formulario, aparece en las páginas de portada y contraportada.

¿Puede cambiar el Formulario?

La mayoría de los cambios en la cobertura de medicamentos ocurren el 1.º de enero, pero es posible que Jefferson Health Plans agregue o elimine medicamentos de la Lista de Medicamentos durante el año, los mueva a un nivel distinto de costos compartidos o agregue nuevas restricciones. Debemos seguir las reglas de Medicare al realizar estos cambios. Las actualizaciones del formulario se publican mensualmente en nuestro sitio web en JeffersonHealthPlans.com/medicare.

Cambios que pueden afectarte este año: En los casos a continuación, tú te verás afectado por los cambios de cobertura durante el año:

- **Sustituciones inmediatas de ciertas versiones nuevas de medicamentos de marca y productos biológicos originales.** Podemos retirar directamente un medicamento de nuestro formulario si lo reemplazaremos por una determinada versión genérica nueva de dicho medicamento que aparecerá en el mismo nivel de costos compartidos o un nivel más bajo y con las mismas o menos cantidad de restricciones. Cuando agregamos una nueva versión de un medicamento a nuestro formulario, podemos decidir mantener el medicamento de marca o producto biológico original en nuestro formulario, pero transferirlo de inmediato a un nivel de costo compartido diferente o agregar nuevas restricciones.

  Podemos hacer estos cambios inmediatos solo si agregamos una nueva versión genérica de un medicamento de marca o agregamos ciertas nuevas versiones biosimilares de un producto biológico original que ya estaba en el formulario (por ejemplo, agregamos un biosimilar intercambiable que puede sustituirse por un producto biológico original por una farmacia sin una nueva receta).

  Si actualmente estás tomando el medicamento de marca o el producto biológico original, es posible que no te notifiquemos por adelantado antes de realizar el cambio inmediato, pero posteriormente te brindaremos información acerca de los cambios específicos que hagamos.

  Si realizamos tal cambio, tú o el profesional que te receta pueden solicitarnos que hagamos una excepción y que continuemos cubriéndote el medicamento que se está cambiando. Para obtener más información, consulta la sección a continuación titulada “¿Cómo solicito una excepción al Formulario Premium de Jefferson Health Plans?”

  Algunos de estos tipos de medicamentos pueden ser nuevos para ti. Para obtener más información, consulta la sección a continuación titulada “¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?”

- **Medicamentos retirados del mercado.** Si el fabricante retira un medicamento de la venta o la Administración de Alimentos y Medicamentos (Food and Drug Administration, FDA) determina que se retira por motivos de seguridad o eficacia, podemos retirar el medicamento de nuestro formulario de inmediato y luego notificar a los miembros que lo toman.

- **Otros cambios.** Podemos realizar otros cambios que afecten a miembros que actualmente estén tomando un medicamento. Por ejemplo, podemos eliminar un medicamento de marca del formulario al agregar un equivalente genérico o eliminar un producto biológico original al agregar un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o producto biológico original, o transferirlo a un nivel de costo compartido diferente, o ambas opciones. Podemos realizar cambios basados en nuevas pautas clínicas. Si retiramos medicamentos de nuestro formulario, agregamos autorización previa, límites de cantidad o restricciones de terapia escalonada para un medicamento, o cambiamos un medicamento a nivel superior de costos compartidos, debemos informar sobre el cambio a los miembros afectados al menos 30 días antes de que el cambio entre en vigencia. Como alternativa, al momento en que el miembro solicite otra reposición del medicamento, se le entregará un suministro de 30 días del medicamento y un aviso del cambio.

  Si realizamos tales cambios, tú o el profesional que te receta pueden solicitarnos que hagamos una excepción y que continuemos cubriéndote el medicamento de marca. El aviso que te daremos incluirá información sobre cómo solicitar una excepción, y también puedes encontrar información en la sección que aparece a continuación titulada "¿Cómo solicito una excepción al Formulario Premium de Jefferson Health Plans?"

Cambios que no te afectarán si estás tomando el medicamento actualmente. Por lo general, si estás tomando un medicamento que aparece en nuestro formulario de 2025 que tenía cobertura a principio de año, no interrumpiremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2025, excepto como se describe anteriormente. Esto significa que estos medicamentos permanecerán disponibles en el mismo nivel de costos compartidos para los miembros que los tomen durante el resto del año de cobertura. No recibirás un aviso directo este año sobre los cambios que no te afectan. Sin embargo, el 1.º de enero del próximo año, dichos cambios podrían afectarte, y es importante consultar el Formulario para el nuevo año de beneficios para ver si hay cambios en los medicamentos.

El formulario adjunto entró en vigor el 01/08/2025. Para obtener información actualizada sobre los medicamentos cubiertos por Jefferson Health Plans, comunícate con nosotros. Nuestra información de contacto aparece en las páginas de portada y contraportada.

Nuestro formulario impreso se actualizará mediante otra impresión en el caso de que haya cambios en el formulario que no sean de mantenimiento y que ocurran a mitad de año.

¿Cómo uso el Formulario?

Hay dos maneras de encontrar tu medicamento en el formulario:

Afección médica

El formulario comienza en la página 2. Los medicamentos de este formulario se agrupan en categorías según el tipo de afecciones médicas que tratan. Por ejemplo, los medicamentos que se usan para tratar una enfermedad cardíaca se enumeran en la categoría "Agentes cardiovasculares". Si sabes para qué se usa tu medicamento, busca el nombre de la categoría en la lista que comienza en la página R-8. Luego, busca el medicamento debajo del nombre de la categoría.

Listado en orden alfabético

Si no estás seguro de la categoría en la que debes buscar, busca el medicamento en el Índice que comienza en la página 103. El Índice proporciona una lista en orden alfabético de todos los medicamentos que se incluyen en este documento. Tanto los medicamentos genéricos como los medicamentos de marca aparecen en el Índice. Busca en el Índice y encuentra el medicamento. Junto al medicamento, verás el número de página donde podrás encontrar la información de cobertura. Recurre a la página que aparece en el Índice y encuentra el nombre del medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Jefferson Health Plans cubre tanto medicamentos de marca como medicamentos genéricos. Un medicamento genérico está aprobado por la FDA como un medicamento que tiene los mismos ingredientes activos que el medicamento de marca. Generalmente, los medicamentos genéricos funcionan tan bien como el medicamento de marca y normalmente cuestan menos. Hay medicamentos genéricos sustitutos disponibles para muchos medicamentos de marca. Los medicamentos genéricos generalmente pueden sustituirse por el medicamento de marca en la farmacia sin necesidad de una nueva receta, según las leyes estatales.

¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?

En el formulario, cuando nos referimos a medicamentos, esto podría significar un medicamento o un producto biológico. Los productos biológicos son medicamentos que son más complejos que los medicamentos típicos. Dado que los productos biológicos son más complejos que los medicamentos típicos, en lugar de tener una forma genérica, tienen alternativas que se denominan biosimilares. Por lo general, los biosimilares funcionan tan bien como el producto biológico original y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son biosimilares intercambiables y, según las leyes estatales, pueden sustituirse por el producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden sustituirse por medicamentos de marca.

- Para conocer los tipos de medicamentos, consulta la Evidencia de cobertura, Capítulo 5*,* Sección 3.1, "La 'Lista de medicamentos' indica qué medicamentos de la Parte D están cubiertos".

Hay alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener límites o requisitos adicionales en la cobertura. Se pueden aplicar los siguientes límites y requisitos:

- **Autorización previa:** Jefferson Health Plans requiere que tú o tu médico obtengan una autorización previa para determinados medicamentos. Significa que deberás obtener la aprobación de Jefferson Health Plans antes de surtir tus recetas. Si no obtienes la aprobación, es posible que Jefferson Health Plans no cubra el medicamento.

- **Límites de cantidad:** Para determinados medicamentos, Jefferson Health Plans limita la cantidad de medicamento que cubrirá. Por ejemplo, Jefferson Health Plans proporciona 60 comprimidos por receta para atorvastatina 10 mg. Es posible que esto se aplique además de un suministro estándar de un mes o tres meses.

- **Terapia escalonada:** En algunos casos, Jefferson Health Plans requiere que primero pruebes algunos medicamentos para tratar tu afección médica antes de que cubramos otro medicamento para esa afección. Por ejemplo, si el medicamento A y el medicamento B tratan tu afección médica, es posible que Jefferson Health Plans no cubra el medicamento B, salvo que antes pruebes el medicamento A. Si el medicamento A no te funciona, Jefferson Health Plans cubrirá el medicamento B.

Para averiguar si tu medicamento tiene límites o requisitos adicionales, consulta el formulario que comienza en la página 2. También puedes obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos en nuestro sitio web. Publicamos documentos en línea que explican nuestra autorización previa y las restricciones de terapia escalonada. También puedes solicitarnos que te enviemos una copia. Nuestra información de contacto, junto con la fecha en la que actualizamos el formulario, aparece en las páginas de portada y contraportada.

Puedes solicitar a Jefferson Health Plans que haga una excepción para estas restricciones o límites, o pedir una lista de otros medicamentos similares que puedan tratar tu afección médica. Consulta la sección "¿Cómo solicito una excepción al formulario Premium de Jefferson Health Plans?" a continuación para obtener información acerca de cómo solicitar una excepción.

¿Qué sucede si mi medicamento no aparece en el Formulario?

Si tu medicamento no se incluye en este formulario (lista de medicamentos cubiertos), primero debes comunicarte con Servicios para Miembros al 1-866-901-8000 (TTY 1-877-454-8477) y consultar si se cubre tu medicamento.

Si te enteras de que Jefferson Health Plans no cubre tu medicamento, tienes dos opciones:

- Puedes solicitarle a Servicios para Miembros una lista de medicamentos similares que estén cubiertos por Jefferson Health Plans. Cuando recibas la lista, muéstrasela al médico y pídele que te recete un medicamento similar que esté cubierto por Jefferson Health Plans.

- Puedes solicitar a Jefferson Health Plans que haga una excepción y que cubra tu medicamento. Consulta a continuación para obtener información acerca de cómo solicitar una excepción.

¿Cómo solicito una excepción al Formulario Premium de Jefferson Health Plans?

Puedes solicitar a Jefferson Health Plans que haga una excepción a nuestras reglas de cobertura. Hay varios tipos de excepciones que puedes solicitarnos.

- Puedes solicitarnos que cubramos un medicamento si no aparece en nuestro formulario. Si se aprueba, este medicamento será cubierto a un nivel predeterminado de gastos compartidos, y no podrás pedirnos que te proporcionemos el medicamento a un nivel más bajo de gastos compartidos.

- Puedes solicitarnos que anulemos una restricción de cobertura, incluida la autorización previa, la terapia escalonada o un límite de cantidad en tu medicamento. Por ejemplo, para algunos medicamentos, Jefferson Health Plans limita la cantidad del medicamento que cubriremos. Si tu

medicamento tiene un límite de cantidad, puedes solicitarnos que retiremos el límite y que cubramos una cantidad mayor.

- Puedes pedirnos que cubramos un medicamento del formulario a un nivel menor de costos compartidos a menos que el medicamento no esté en el nivel de especialidades. Si se aprueba, se reduciría la cantidad que debes pagar por el medicamento.

Por lo general, Jefferson Health Plans solo aprobará tu solicitud de una excepción si los medicamentos alternativos que se incluyen en el formulario del plan, los medicamentos de costos compartidos más bajos o las restricciones de utilización adicionales no fueran tan efectivos para tratar tu enfermedad o te causaran efectos médicos adversos.

Tú o la persona que extiende la receta deben comunicarse con nosotros para solicitar una excepción de nivel o del formulario, incluida una excepción a una restricción de cobertura. **Cuando solicitas una excepción, la persona que extiende la receta deberá explicar los motivos médicos por los que necesitas la excepción.** Por lo general, debemos tomar la decisión en el plazo de 72 horas de haber recibido la declaración del profesional que te receta. Puedes solicitar una excepción urgente (acelerada) si tú o tu médico creen que tu salud podría dañarse gravemente si esperaras hasta 72 horas para obtener una decisión. Si estamos de acuerdo, o si la persona que extiende la receta solicita una decisión rápida, debemos darte una decisión a más tardar 24 horas después de recibir la declaración de respaldo de la persona que extiende la receta.

¿Qué puedo hacer si mi medicamento no está en el formulario o tiene una restricción?

Como miembro nuevo o permanente de nuestro plan, es posible que estés tomando medicamentos que no se encuentren en nuestro formulario. O bien, es posible que estés tomando un medicamento que está en nuestro formulario, pero que tiene una restricción de cobertura, como una autorización previa. Debes hablar con la persona que extiende la receta sobre solicitar una decisión de cobertura para demostrar que cumples con los criterios de aprobación, cambiar a un medicamento alternativo que cubramos o solicitar una excepción al formulario para que cubramos el medicamento que tomas. Mientras tú y tu médico determinan el procedimiento correcto para ti, es posible que cubramos tu medicamento en algunos casos durante los primeros 90 días que seas miembro de nuestro plan.

Para cada uno de tus medicamentos que no esté en nuestro formulario o que tenga una restricción de cobertura, cubriremos un suministro temporal de 30 días. Si tu receta está escrita para menos días, permitiremos reposiciones para brindar un suministro de 30 días de medicamento, como máximo. Si no se aprueba la cobertura, después de tu primer suministro de 30 días, no pagaremos estos medicamentos, incluso si has sido miembro del plan durante menos de 90 días.

Si eres residente de un centro de atención prolongada y necesitas un medicamento que no se encuentra en nuestro formulario o si tu capacidad para obtener los medicamentos es limitada, pero ya han pasado los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia de 31 días de ese medicamento mientras intentas obtener una excepción del formulario.

Si eres un miembro actual y te cambian el ámbito del tratamiento debido a algún cambio en el nivel de atención que requieres, puedes solicitarnos que hagamos una excepción del formulario. Algunos ejemplos de modificaciones en los niveles de atención incluyen:

- Alta del hospital a la casa.

- Finalizar la estadía en un centro de enfermería especializada de la Parte A de Medicare (donde los pagos incluyen gastos de farmacia) y necesitar el plan de la Parte D.
- Cambiar de la condición de cuidados paliativos y volver a la cobertura estándar de la Parte A y B de Medicare.
- Finalizar una estadía en un centro de atención prolongada y regresar a la comunidad.
- Altas de hospitales psiquiátricos con regímenes farmacológicos altamente individualizados.

Para estas transiciones imprevistas, puedes solicitarnos que hagamos una excepción al formulario o puedes apelar para continuar con la cobertura de tu medicamento. Además, revisaremos las solicitudes de continuación de terapia de forma individual, para los miembros que han tenido una modificación en su nivel de atención y se estabilizan con regímenes farmacológicos que, de cambiarse, producirían riesgos.

Para más información

Para obtener más información sobre tu cobertura de medicamentos con receta de Jefferson Health Plans, revisa tu Evidencia de cobertura y otros documentos del plan.

Si tienes alguna pregunta sobre Jefferson Health Plans, comunícate con nosotros. Nuestra información de contacto, junto con la fecha en la que actualizamos el formulario, aparece en las páginas de portada y contraportada.

Si tienes preguntas generales sobre la cobertura de medicamentos con receta de Medicare, llama a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O visita http://www.medicare.gov.

Formulario Premium de Jefferson Health Plans

En el formulario que comienza en la página 2, se proporciona información de cobertura sobre los medicamentos cubiertos por Jefferson Health Plans. Si tienes problemas para encontrar tu medicamento en la lista, recurre al Índice que comienza en la página 103.

En la primera columna del cuadro aparece el nombre del medicamento. Los medicamentos de marca están escritos en mayúscula (por ejemplo, ENTRESTO) y los medicamentos genéricos están escritos en cursiva y minúscula (por ejemplo, *valsartán*).

La información que aparece en la columna Requisitos/Límites te indica si Jefferson Health Plans tiene algún requisito especial para la cobertura de tu medicamento.

El cuadro en la página siguiente muestra los costos compartidos de cada nivel de medicamentos que se muestra en este formulario.

Category Listing

LEGEND

TIER	NAME
1	Covered

SYMBOL	NAME	DESCRIPTION
QL	Quantity Limit	There is a limit on the amount of this drug that is covered per prescription, or within a specific time frame.
PA2	Prior Authorization (New Starts Only)	Prior authorization applies to new starts only. You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug.
PA	Prior Authorization	You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug.
PA3	Prior Authorization (Part B vs. Part D)	This prescription may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
ST	Step Therapy	In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition.
NDS	Non-Extended Day Supply	You cannot obtain an extended day supply for this type of drug. We will cover up to a 30-day supply per prescription only.

JEFFERSON HEALTH PLANS 1 TIER PREMIUM FORMULARY (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
butalbital-aspirin-caffeine	1-Covered	PA, QL (180 PER 30 DAYS)
celecoxib (50 mg cap, 100 mg cap, 200 mg cap)	1-Covered	QL (60 PER 30 DAYS)
celecoxib 400 mg cap	1-Covered	QL (30 PER 30 DAYS)
diclofenac potassium 50 mg tab	1-Covered	QL (120 PER 30 DAYS)
diclofenac sodium (25 mg tab dr, 50 mg tab dr, 75 mg tab dr)	1-Covered	
diclofenac sodium 1.5 % solution	1-Covered	QL (300 PER 28 DAYS)
diclofenac sodium er	1-Covered	QL (60 PER 30 DAYS)
diclofenac-misoprostol	1-Covered	
diflunisal	1-Covered	QL (90 PER 30 DAYS)
etodolac (200 mg cap, 300 mg cap)	1-Covered	QL (120 PER 30 DAYS)
etodolac (400 mg tab, 500 mg tab)	1-Covered	
etodolac er	1-Covered	
flurbiprofen	1-Covered	
ibu	1-Covered	
ibuprofen (100 mg/5ml suspension, 200 mg/10ml suspension, 400 mg tab, 600 mg tab, 800 mg tab)	1-Covered	
LURBIPR	1-Covered	
meloxicam (7.5 mg tab, 15 mg tab)	1-Covered	
nabumetone	1-Covered	
naproxen (250 mg tab, 375 mg tab, 375 mg tab dr, 500 mg tab, 500 mg tab dr)	1-Covered	
naproxen dr	1-Covered	
naproxen sodium	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
oxaprozin	1-Covered	
piroxicam 10 mg cap	1-Covered	QL (60 PER 30 DAYS)
piroxicam 20 mg cap	1-Covered	QL (30 PER 30 DAYS)
relafen	1-Covered	
sulindac	1-Covered	QL (60 PER 30 DAYS)
OPIOID ANALGESICS, LONG-ACTING		
buprenorphine	1-Covered	QL (4 PER 28 DAYS)
fentanyl (12 mcg/hr patch 72hr, 25 mcg/hr patch 72hr, 50 mcg/hr patch 72hr, 75 mcg/hr patch 72hr, 100 mcg/hr patch 72hr)	1-Covered	QL (10 PER 30 DAYS)
methadone hcl 10 mg tab	1-Covered	QL (240 PER 30 DAYS)
methadone hcl 10 mg/5ml solution	1-Covered	QL (1800 PER 30 DAYS)
methadone hcl 5 mg tab	1-Covered	QL (480 PER 30 DAYS)
methadone hcl 5 mg/5ml solution	1-Covered	QL (3600 PER 30 DAYS)
morphine sulfate er (15 mg tab er, 30 mg tab er, 60 mg tab er, 100 mg tab er, 200 mg tab er)	1-Covered	QL (90 PER 30 DAYS)
tramadol hcl (er biphasic)	1-Covered	QL (30 PER 30 DAYS)
tramadol hcl er (100 mg tab er 24h, 200 mg tab er 24h, 300 mg tab er 24h)	1-Covered	QL (30 PER 30 DAYS)
XTAMPZA ER	1-Covered	QL (60 PER 30 DAYS)
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen-codeine (120-12 mg/5ml solution, 300-30 mg/12.5ml solution)	1-Covered	QL (2700 PER 30 DAYS)
acetaminophen-codeine 300-15 mg tab	1-Covered	QL (390 PER 30 DAYS)
acetaminophen-codeine 300-30 mg tab	1-Covered	QL (360 PER 30 DAYS)
acetaminophen-codeine 300-60 mg tab	1-Covered	QL (180 PER 30 DAYS)
butorphanol tartrate 10 mg/ml solution	1-Covered	QL (5 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
endocet (2.5-325 mg tab, 5-325 mg tab)	1-Covered	QL (360 PER 30 DAYS)
endocet 10-325 mg tab	1-Covered	QL (180 PER 30 DAYS)
endocet 7.5-325 mg tab	1-Covered	QL (240 PER 30 DAYS)
hydrocodone-acetaminophen (2.5-108 mg/5ml solution, 5-217 mg/10ml solution, 7.5-325 mg/15ml solution)	1-Covered	QL (2700 PER 30 DAYS)
hydrocodone-acetaminophen 10-325 mg tab	1-Covered	QL (180 PER 30 DAYS)
hydrocodone-acetaminophen 5-325 mg tab	1-Covered	QL (360 PER 30 DAYS)
hydrocodone-acetaminophen 7.5-325 mg tab	1-Covered	QL (240 PER 30 DAYS)
hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)	1-Covered	QL (180 PER 30 DAYS)
hydromorphone hcl 1 mg/ml liquid	1-Covered	QL (1500 PER 30 DAYS)
MORPHINE SULFATE (10 MG/5ML SOLUTION, 20 MG/5ML SOLUTION)	1-Covered	QL (900 PER 30 DAYS)
morphine sulfate (15 mg tab, 30 mg tab)	1-Covered	QL (180 PER 30 DAYS)
morphine sulfate (concentrate)	1-Covered	QL (180 PER 30 DAYS)
oxycodone hcl (5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab, 100 mg/5ml conc)	1-Covered	QL (180 PER 30 DAYS)
oxycodone hcl 5 mg/5ml solution	1-Covered	QL (900 PER 30 DAYS)
oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab)	1-Covered	QL (360 PER 30 DAYS)
oxycodone-acetaminophen 10-325 mg tab	1-Covered	QL (180 PER 30 DAYS)
oxycodone-acetaminophen 7.5-325 mg tab	1-Covered	QL (240 PER 30 DAYS)
tramadol hcl 50 mg tab	1-Covered	QL (240 PER 30 DAYS)
tramadol-acetaminophen	1-Covered	QL (240 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine 5 % ointment	1-Covered	QL (50 PER 30 DAYS)
lidocaine 5 % patch	1-Covered	PA, QL (90 PER 30 DAYS)
lidocaine viscous hcl	1-Covered	
lidocaine-prilocaine	1-Covered	QL (30 PER 30 DAYS)
lidocan	1-Covered	PA, QL (90 PER 30 DAYS)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate calcium	1-Covered	
disulfiram	1-Covered	
naltrexone hcl	1-Covered	
VIVITROL	1-Covered	NDS (Non-Extended Day Supply)
OPIOID DEPENDENCE		
buprenorphine hcl 2 mg sl tab	1-Covered	QL (90 PER 30 DAYS)
buprenorphine hcl 8 mg sl tab	1-Covered	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl (2-0.5 mg film, 4-1 mg film, 8-2 mg film, 8-2 mg sl tab)	1-Covered	QL (90 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 12-3 mg film	1-Covered	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab	1-Covered	QL (120 PER 30 DAYS)
lofexidine hcl	1-Covered	PA, QL (16 PER 1 DAYS), NDS (Non-Extended Day Supply)
LUCEMYRA	1-Covered	PA, QL (16 PER 1 DAYS), NDS (Non-Extended Day Supply)
OPIOID REVERSAL AGENTS		
naloxone hcl (0.4 mg/ml soln cart, 0.4 mg/ml solution, 2 mg/2ml soln prsyr, 4 mg/0.1ml liquid, 4 mg/10ml solution)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPVEE	1-Covered	
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det)	1-Covered	QL (60 PER 30 DAYS)
NICOTROL	1-Covered	
NICOTROL NS	1-Covered	
varenicline tartrate	1-Covered	
varenicline tartrate (starter)	1-Covered	
varenicline tartrate(continue)	1-Covered	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulfate	1-Covered	
ARIKAYCE	1-Covered	PA, NDS (Non-Extended Day Supply)
gentamicin in saline	1-Covered	
gentamicin sulfate (0.1 % cream, 0.1 % ointment)	1-Covered	QL (30 PER 30 DAYS)
gentamicin sulfate (10 mg/ml solution, 40 mg/ml solution)	1-Covered	
neomycin sulfate	1-Covered	
streptomycin sulfate	1-Covered	NDS (Non-Extended Day Supply)
tobramycin sulfate (10 mg/ml solution, 80 mg/2ml solution)	1-Covered	
ANTIBACTERIALS, OTHER		
aztreonam	1-Covered	
clindamycin hcl	1-Covered	
clindamycin palmitate hcl	1-Covered	
clindamycin phosphate (2 % cream, 300 mg/2ml solution, 900 mg/6ml solution)	1-Covered	
clindamycin phosphate in d5w	1-Covered	
colistimethate sodium (cba)	1-Covered	NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
daptomycin 350 mg recon soln	1-Covered	NDS (Non-Extended Day Supply)
daptomycin 500 mg recon soln	1-Covered	NDS (Non-Extended Day Supply)
linezolid 100 mg/5ml recon susp	1-Covered	QL (1800 PER 30 DAYS), NDS (Non-Extended Day Supply)
linezolid 600 mg tab	1-Covered	QL (60 PER 30 DAYS)
linezolid 600 mg/300ml solution	1-Covered	
methenamine hippurate	1-Covered	
metronidazole (0.75 % gel, 250 mg tab, 500 mg tab, 500 mg/100ml solution)	1-Covered	
nitrofurantoin macrocrystal (50 mg cap, 100 mg cap)	1-Covered	
nitrofurantoin monohyd macro	1-Covered	
polymyxin b sulfate	1-Covered	
SIVEXTRO	1-Covered	PA, NDS (Non-Extended Day Supply)
TIGECYCLINE	1-Covered	NDS (Non-Extended Day Supply)
tinidazole	1-Covered	
trimethoprim	1-Covered	
vancomycin hcl (1 gm recon soln, 5 gm recon soln, 10 gm recon soln, 500 mg recon soln, 750 mg recon soln)	1-Covered	
vancomycin hcl 125 mg cap	1-Covered	QL (120 PER 30 DAYS)
vancomycin hcl 250 mg cap	1-Covered	QL (240 PER 30 DAYS)
XIFAXAN 200 MG TAB	1-Covered	PA
XIFAXAN 550 MG TAB	1-Covered	PA, NDS (Non-Extended Day Supply)

BETA-LACTAM, CEPHALOSPORINS

cefaclor (250 mg cap, 500 mg cap)	1-Covered	
cefadroxil (250 mg/5ml recon susp, 500 mg cap, 500 mg/5ml recon susp)	1-Covered	
cefazolin sodium (1 gm recon soln, 10 gm recon soln, 100 gm recon soln, 300 gm recon soln, 500 mg recon soln)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)	1-Covered	
cefepime hcl (1 gm recon soln, 2 gm recon soln)	1-Covered	
cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)	1-Covered	
cefotetan disodium	1-Covered	
cefoxitin sodium	1-Covered	
cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg tab, 100 mg/5ml recon susp, 200 mg tab)	1-Covered	
cefprozil (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)	1-Covered	
ceftazidime	1-Covered	
ceftriaxone sodium (1 gm recon soln, 2 gm recon soln, 10 gm recon soln, 250 mg recon soln, 500 mg recon soln)	1-Covered	
cefuroxime axetil	1-Covered	
cefuroxime sodium	1-Covered	
cephalexin (125 mg/5ml recon susp, 250 mg cap, 250 mg/5ml recon susp, 500 mg cap)	1-Covered	
tazicef	1-Covered	
TEFLARO	1-Covered	NDS (Non-Extended Day Supply)
BETA-LACTAM, PENICILLINS		
amoxicillin (125 mg chew tab, 125 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg cap, 250 mg chew tab, 250 mg/5ml recon susp, 400 mg/5ml recon susp, 500 mg cap, 500 mg tab, 875 mg tab)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amoxicillin-pot clavulanate (200-28.5 mg/5ml recon susp, 250-125 mg tab, 250-62.5 mg/5ml recon susp, 400-57 mg/5ml recon susp, 500-125 mg tab, 600-42.9 mg/5ml recon susp, 875-125 mg tab)	1-Covered	
amoxicillin-pot clavulanate er	1-Covered	
ampicillin	1-Covered	
ampicillin sodium	1-Covered	
ampicillin-sulbactam sodium	1-Covered	
BICILLIN L-A	1-Covered	
dicloxacillin sodium	1-Covered	
nafcillin sodium (1 gm recon soln, 2 gm recon soln)	1-Covered	
nafcillin sodium 10 gm recon soln	1-Covered	NDS (Non-Extended Day Supply)
oxacillin sodium	1-Covered	
PENICILLIN G POT IN DEXTROSE	1-Covered	
penicillin g potassium	1-Covered	
penicillin g sodium	1-Covered	
penicillin v potassium (125 mg/5ml recon soln, 250 mg tab, 250 mg/5ml recon soln, 500 mg tab)	1-Covered	
pfizerpen	1-Covered	
piperacillin sod-tazobactam so	1-Covered	
CARBAPENEMS		
ertapenem sodium	1-Covered	
imipenem-cilastatin	1-Covered	
meropenem (1 gm recon soln, 500 mg recon soln)	1-Covered	
MACROLIDES		
azithromycin (1 gm packet, 100 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg tab, 500 mg recon soln, 500 mg tab, 600 mg tab)	1-Covered	
clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clarithromycin er	1-Covered	
DIFICID 200 MG TAB	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
DIFICID 40 MG/ML RECON SUSP	1-Covered	QL (408 PER 30 DAYS), NDS (Non-Extended Day Supply)
ery-tab	1-Covered	
erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)	1-Covered	
erythromycin base	1-Covered	
erythromycin ethylsuccinate (200 mg/5ml recon susp, 400 mg tab)	1-Covered	
QUINOLONES		
ciprofloxacin hcl (0.3 % solution, 250 mg tab, 500 mg tab, 750 mg tab)	1-Covered	
ciprofloxacin in d5w 200 mg/100ml solution	1-Covered	
ciprofloxacin in d5w 400 mg/200ml solution	1-Covered	
levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)	1-Covered	
levofloxacin in d5w	1-Covered	
levofloxacin oral soln 25 mg/ml	1-Covered	
moxifloxacin hcl 400 mg tab	1-Covered	
moxifloxacin hcl in nacl	1-Covered	
ofloxacin (300 mg tab, 400 mg tab)	1-Covered	
SULFONAMIDES		
sulfadiazine	1-Covered	
sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab, 800-160 mg/20ml suspension)	1-Covered	
TETRACYCLINES		
demeclocycline hcl	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
doxy 100	1-Covered	
doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg cap, 100 mg recon soln, 100 mg tab)	1-Covered	
doxycycline monohydrate (25 mg/5ml recon susp, 50 mg cap, 50 mg tab, 75 mg tab, 100 mg cap, 100 mg tab, 150 mg tab)	1-Covered	
minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)	1-Covered	
mondoxyne nl	1-Covered	
NUZYRA 100 MG RECON SOLN	1-Covered	PA, NDS (Non-Extended Day Supply)
NUZYRA 150 MG TAB	1-Covered	NDS (Non-Extended Day Supply)
tetracycline hcl (250 mg cap, 500 mg cap)	1-Covered	
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT (10 MG TAB, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
BRIVIACT 10 MG/ML SOLUTION	1-Covered	PA2, QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
BRIVIACT 50 MG/5ML SOLUTION	1-Covered	PA2, NDS (Non-Extended Day Supply)
DIACOMIT (250 MG CAP, 250 MG PACKET)	1-Covered	PA2, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
DIACOMIT (500 MG CAP, 500 MG PACKET)	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
divalproex sodium	1-Covered	
divalproex sodium er	1-Covered	
EPIDIOLEX	1-Covered	PA2, QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
EPRONTIA	1-Covered	PA2, QL (480 PER 30 DAYS)
felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FINTEPLA	1-Covered	PA2, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
FYCOMPA (4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
FYCOMPA 0.5 MG/ML SUSPENSION	1-Covered	PA2, QL (720 PER 30 DAYS), NDS (Non-Extended Day Supply)
FYCOMPA 2 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS)
lamotrigine (5 mg chew tab, 25 mg chew tab, 25 mg tab disp, 50 mg tab disp, 100 mg tab disp, 200 mg tab disp)	1-Covered	
lamotrigine er	1-Covered	
levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)	1-Covered	
levetiracetam er	1-Covered	
LEVETIRACETAM IN NACL	1-Covered	
perampanel (4 mg tab, 6 mg tab, 8 mg tab, 10 mg tab, 12 mg tab)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
perampanel 2 mg tab	1-Covered	PA2, QL (30 PER 30 DAYS)
roweepra	1-Covered	
SPRITAM	1-Covered	ST
topiramate (15 mg cap sprink, 25 mg cap sprink, 25 mg tab, 50 mg cap sprink, 50 mg tab, 100 mg tab, 200 mg tab)	1-Covered	
valproate sodium	1-Covered	
valproic acid (250 mg cap, 250 mg/5ml solution, 500 mg/10ml solution)	1-Covered	
CALCIUM CHANNEL MODIFYING AGENTS		
ethosuximide (250 mg cap, 250 mg/5ml solution)	1-Covered	
methsuximide	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GAMMA-AMINOBUTYRIC ACID (GABA) MODULATING AGENTS		
clobazam (10 mg tab, 20 mg tab)	1-Covered	PA2, QL (60 PER 30 DAYS)
clobazam 2.5 mg/ml suspension	1-Covered	PA2, QL (480 PER 30 DAYS)
diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)	1-Covered	
gabapentin (100 mg cap, 600 mg tab)	1-Covered	QL (180 PER 30 DAYS)
gabapentin (250 mg/5ml solution, 300 mg/6ml solution)	1-Covered	QL (2160 PER 30 DAYS)
gabapentin 300 mg cap	1-Covered	QL (360 PER 30 DAYS)
gabapentin 400 mg cap	1-Covered	QL (270 PER 30 DAYS)
gabapentin 800 mg tab	1-Covered	QL (120 PER 30 DAYS)
LIBERVANT	1-Covered	PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
NAYZILAM	1-Covered	PA2, QL (10 PER 30 DAYS)
phenobarbital (15 mg tab, 16.2 mg tab, 20 mg/5ml elixir, 30 mg tab, 30 mg/7.5ml elixir, 32.4 mg tab, 60 mg tab, 60 mg/15ml elixir, 64.8 mg tab, 97.2 mg tab, 100 mg tab)	1-Covered	
primidone	1-Covered	
SYMPAZAN	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
tiagabine hcl	1-Covered	
VALTOCO 10 MG DOSE	1-Covered	PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 15 MG DOSE	1-Covered	PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 20 MG DOSE	1-Covered	PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 5 MG DOSE	1-Covered	PA2, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
vigabatrin	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
vigadrone	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIGAFYDE	1-Covered	QL (900 PER 30 DAYS), NDS (Non-Extended Day Supply)
vigpoder	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZTALMY	1-Covered	PA2, QL (1100 PER 30 DAYS), NDS (Non-Extended Day Supply)
SODIUM CHANNEL AGENTS		
APTIOM (200 MG TAB, 400 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
APTIOM (600 MG TAB, 800 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
CARBAMAZEPINE (100 MG CHEW TAB, 100 MG/5ML SUSPENSION, 200 MG CHEW TAB, 200 MG TAB, 200 MG/10ML SUSPENSION)	1-Covered	
carbamazepine er	1-Covered	
DILANTIN	1-Covered	
DILANTIN INFATABS	1-Covered	
epitol	1-Covered	
eslicarbazepine acetate (200 mg tab, 400 mg tab)	1-Covered	QL (30 PER 30 DAYS)
eslicarbazepine acetate (600 mg tab, 800 mg tab)	1-Covered	QL (60 PER 30 DAYS)
lacosamide (10 mg/ml solution, 50 mg/5ml solution, 100 mg/10ml solution)	1-Covered	QL (1200 PER 30 DAYS)
lacosamide (100 mg tab, 150 mg tab, 200 mg tab)	1-Covered	QL (60 PER 30 DAYS)
lacosamide 200 mg/20ml solution	1-Covered	
lacosamide 50 mg tab	1-Covered	QL (120 PER 30 DAYS)
oxcarbazepine (150 mg tab, 300 mg tab, 300 mg/5ml suspension, 600 mg tab)	1-Covered	
phenytek	1-Covered	
phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
phenytoin infatabs	1-Covered	
phenytoin sodium	1-Covered	
phenytoin sodium extended	1-Covered	
rufinamide 200 mg tab	1-Covered	PA2, QL (480 PER 30 DAYS)
rufinamide 40 mg/ml suspension	1-Covered	PA2, QL (2760 PER 30 DAYS), NDS (Non-Extended Day Supply)
rufinamide 400 mg tab	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
XCOPRI (14 X 150 MG & 14 X200 MG TAB THPK, 14 X 50 MG & 14 X100 MG TAB THPK)	1-Covered	PA2, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
XCOPRI (150 MG TAB, 200 MG TAB)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
XCOPRI (25 MG TAB, 50 MG TAB, 100 MG TAB)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
XCOPRI (250 MG DAILY DOSE)	1-Covered	PA2, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
XCOPRI (350 MG DAILY DOSE)	1-Covered	PA2, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	1-Covered	PA2, QL (28 PER 28 DAYS)
ZONISADE	1-Covered	QL (900 PER 30 DAYS), NDS (Non-Extended Day Supply)
zonisamide	1-Covered	
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
NAMZARIC	1-Covered	
CHOLINESTERASE INHIBITORS		
donepezil hcl (5 mg tab disp, 10 mg tab disp)	1-Covered	QL (30 PER 30 DAYS)
donepezil hcl (5 mg tab, 10 mg tab)	1-Covered	QL (60 PER 30 DAYS)
galantamine hydrobromide (4 mg tab, 8 mg tab, 12 mg tab)	1-Covered	QL (60 PER 30 DAYS)
galantamine hydrobromide 4 mg/ml solution	1-Covered	QL (360 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
galantamine hydrobromide er	1-Covered	QL (30 PER 30 DAYS)
rivastigmine	1-Covered	QL (30 PER 30 DAYS)
rivastigmine tartrate	1-Covered	QL (60 PER 30 DAYS)
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
memantine hcl (2 mg/ml solution, 10 mg/5ml solution)	1-Covered	QL (360 PER 30 DAYS)
memantine hcl (5 mg tab, 10 mg tab)	1-Covered	QL (60 PER 30 DAYS)
memantine hcl 28 x 5 mg & 21 x 10 mg tab	1-Covered	QL (98 PER 365 DAYS)
memantine hcl er	1-Covered	QL (30 PER 30 DAYS)
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
AUVELITY	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
bupropion hcl	1-Covered	QL (120 PER 30 DAYS)
bupropion hcl er (sr)	1-Covered	QL (60 PER 30 DAYS)
bupropion hcl er (xl) 150 mg tab er 24h	1-Covered	QL (90 PER 30 DAYS)
bupropion hcl er (xl) 300 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
mirtazapine (15 mg tab, 15 mg tab disp)	1-Covered	QL (90 PER 30 DAYS)
mirtazapine (30 mg tab, 30 mg tab disp)	1-Covered	QL (60 PER 30 DAYS)
mirtazapine (7.5 mg tab, 45 mg tab, 45 mg tab disp)	1-Covered	QL (30 PER 30 DAYS)
perphenazine-amitriptyline	1-Covered	
ZURZUVAE (20 MG CAP, 25 MG CAP)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZURZUVAE 30 MG CAP	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MONOAMINE OXIDASE INHIBITORS		
EMSAM	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
MARPLAN	1-Covered	QL (180 PER 30 DAYS)
phenelzine sulfate	1-Covered	
tranylcypromine sulfate	1-Covered	
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)		
citalopram hydrobromide (10 mg/5ml solution, 20 mg/10ml solution)	1-Covered	QL (600 PER 30 DAYS)
citalopram hydrobromide (20 mg tab, 40 mg tab)	1-Covered	QL (45 PER 30 DAYS)
citalopram hydrobromide 10 mg tab	1-Covered	QL (90 PER 30 DAYS)
desvenlafaxine succinate er	1-Covered	QL (30 PER 30 DAYS)
escitalopram oxalate (5 mg/5ml solution, 10 mg/10ml solution)	1-Covered	QL (600 PER 30 DAYS)
escitalopram oxalate 10 mg tab	1-Covered	QL (45 PER 30 DAYS)
escitalopram oxalate 20 mg tab	1-Covered	QL (30 PER 30 DAYS)
escitalopram oxalate 5 mg tab	1-Covered	QL (90 PER 30 DAYS)
FETZIMA	1-Covered	PA2, QL (30 PER 30 DAYS)
FETZIMA TITRATION	1-Covered	PA2, QL (28 PER 28 DAYS)
fluoxetine hcl (10 mg cap, 10 mg tab)	1-Covered	QL (90 PER 30 DAYS)
fluoxetine hcl (20 mg cap, 20 mg tab)	1-Covered	QL (120 PER 30 DAYS)
fluoxetine hcl 20 mg/5ml solution	1-Covered	
fluoxetine hcl 40 mg cap	1-Covered	QL (60 PER 30 DAYS)
fluoxetine hcl 90 mg cap dr	1-Covered	QL (4 PER 28 DAYS)
fluvoxamine maleate	1-Covered	QL (90 PER 30 DAYS)
fluvoxamine maleate er	1-Covered	QL (60 PER 30 DAYS)
nefazodone hcl	1-Covered	
paroxetine hcl (10 mg tab, 20 mg tab)	1-Covered	QL (30 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
paroxetine hcl (30 mg tab, 40 mg tab)	1-Covered	QL (60 PER 30 DAYS)
PAROXETINE HCL 10 MG/5ML SUSPENSION	1-Covered	QL (900 PER 30 DAYS)
paroxetine hcl er 12.5 mg tab er 24h	1-Covered	QL (90 PER 30 DAYS)
paroxetine hcl er 25 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
paroxetine hcl er 37.5 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
RALDESY	1-Covered	PA2, QL (1200 PER 30 DAYS), NDS (Non-Extended Day Supply)
sertraline hcl (25 mg tab, 50 mg tab)	1-Covered	QL (90 PER 30 DAYS)
sertraline hcl 100 mg tab	1-Covered	QL (60 PER 30 DAYS)
sertraline hcl 20 mg/ml conc	1-Covered	QL (300 PER 30 DAYS)
trazodone hcl	1-Covered	
TRINTELLIX	1-Covered	QL (30 PER 30 DAYS)
venlafaxine hcl	1-Covered	
venlafaxine hcl er (37.5 mg cap er 24h, 75 mg cap er 24h)	1-Covered	QL (90 PER 30 DAYS)
venlafaxine hcl er 150 mg cap er 24h	1-Covered	QL (60 PER 30 DAYS)
vilazodone hcl	1-Covered	QL (30 PER 30 DAYS)
TRICYCLICS		
amitriptyline hcl	1-Covered	
amoxapine	1-Covered	
clomipramine hcl	1-Covered	
desipramine hcl	1-Covered	
doxepin hcl (10 mg cap, 10 mg/ml conc, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)	1-Covered	
imipramine hcl	1-Covered	
nortriptyline hcl (10 mg cap, 10 mg/5ml solution, 25 mg cap, 50 mg cap, 75 mg cap)	1-Covered	
protriptyline hcl	1-Covered	
trimipramine maleate	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIEMETICS		
ANTIEMETICS, OTHER		
compro	1-Covered	
meclizine hcl (12.5 mg tab, 25 mg tab)	1-Covered	
metoclopramide hcl (5 mg tab, 5 mg/5ml solution, 10 mg tab, 10 mg/10ml solution)	1-Covered	
perphenazine	1-Covered	
prochlorperazine	1-Covered	
prochlorperazine edisylate	1-Covered	
prochlorperazine maleate	1-Covered	
promethazine hcl (12.5 mg tab, 25 mg tab, 50 mg tab)	1-Covered	PA
scopolamine	1-Covered	PA, QL (10 PER 30 DAYS)
EMETOGENIC THERAPY ADJUNCTS		
aprepitant	1-Covered	PA3
dronabinol	1-Covered	PA, QL (60 PER 30 DAYS)
granisetron hcl 1 mg tab	1-Covered	PA3, QL (60 PER 30 DAYS)
ondansetron 4 mg tab disp	1-Covered	PA3, QL (180 PER 30 DAYS)
ondansetron 8 mg tab disp	1-Covered	PA3, QL (90 PER 30 DAYS)
ondansetron hcl (4 mg/2ml soln prsyr, 4 mg/2ml solution, 40 mg/20ml solution)	1-Covered	
ondansetron hcl +rfid	1-Covered	
ondansetron hcl 4 mg tab	1-Covered	PA3, QL (180 PER 30 DAYS)
ondansetron hcl 8 mg tab	1-Covered	PA3, QL (90 PER 30 DAYS)
ondansetron hcl oral soln 4 mg/5ml	1-Covered	PA3, QL (900 PER 30 DAYS)
SANCUSO	1-Covered	ST, QL (4 PER 28 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIFUNGALS		
ABELCET	1-Covered	PA3
amphotericin b	1-Covered	PA3
amphotericin b liposome	1-Covered	PA3, NDS (Non-Extended Day Supply)
caspofungin acetate	1-Covered	
clotrimazole 1 % cream	1-Covered	QL (90 PER 30 DAYS)
clotrimazole 1 % solution	1-Covered	QL (30 PER 30 DAYS)
clotrimazole 10 mg troche	1-Covered	
econazole nitrate	1-Covered	QL (85 PER 30 DAYS)
fluconazole (10 mg/ml recon susp, 40 mg/ml recon susp, 50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)	1-Covered	
fluconazole in sodium chloride (200-0.9 mg/100ml-% solution, 400-0.9 mg/200ml-% solution)	1-Covered	
flucytosine	1-Covered	NDS (Non-Extended Day Supply)
griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)	1-Covered	
griseofulvin ultramicrosize (125 mg tab, 250 mg tab)	1-Covered	
itraconazole 100 mg cap	1-Covered	
ketoconazole 2 % cream	1-Covered	QL (60 PER 30 DAYS)
ketoconazole 2 % shampoo	1-Covered	QL (120 PER 30 DAYS)
ketoconazole 200 mg tab	1-Covered	
klayesta	1-Covered	QL (60 PER 30 DAYS)
micafungin sodium	1-Covered	
miconazole 3	1-Covered	
naftifine hcl 1 % cream	1-Covered	QL (90 PER 30 DAYS)
naftifine hcl 2 % cream	1-Covered	QL (60 PER 30 DAYS)
nyamyc	1-Covered	QL (60 PER 30 DAYS)
nystatin (100000 unit/gm cream, 100000 unit/gm ointment, 100000 unit/gm powder)	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nystatin (100000 unit/ml suspension, 500000 unit tab)	1-Covered	
nystop	1-Covered	QL (60 PER 30 DAYS)
posaconazole 100 mg tab dr	1-Covered	PA, QL (93 PER 30 DAYS), NDS (Non-Extended Day Supply)
posaconazole 40 mg/ml suspension	1-Covered	PA, QL (630 PER 30 DAYS), NDS (Non-Extended Day Supply)
terbinafine hcl	1-Covered	QL (120 PER 30 DAYS)
terconazole (0.4 % cream, 0.8 % cream, 80 mg suppos)	1-Covered	
voriconazole 200 mg recon soln	1-Covered	PA, NDS (Non-Extended Day Supply)
voriconazole 200 mg tab	1-Covered	QL (120 PER 30 DAYS)
voriconazole 40 mg/ml recon susp	1-Covered	QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
voriconazole 50 mg tab	1-Covered	QL (480 PER 30 DAYS)
ANTIGOUT AGENTS		
allopurinol (100 mg tab, 300 mg tab)	1-Covered	
colchicine 0.6 mg tab	1-Covered	QL (120 PER 30 DAYS)
colchicine-probenecid	1-Covered	
febuxostat	1-Covered	ST
MITIGARE	1-Covered	QL (60 PER 30 DAYS)
probenecid	1-Covered	
ANTIMIGRAINE AGENTS		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONISTS		
AIMOVIG	1-Covered	PA, QL (1 PER 28 DAYS)
EMGALITY	1-Covered	PA, QL (2 PER 28 DAYS)
EMGALITY (300 MG DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
NURTEC	1-Covered	QL (16 PER 30 DAYS), NDS (Non-Extended Day Supply)
UBRELVY	1-Covered	QL (16 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ERGOT ALKALOIDS		
dihydroergotamine mesylate 4 mg/ml solution	1-Covered	PA, QL (8 PER 30 DAYS), NDS (Non-Extended Day Supply)
ergotamine-caffeine	1-Covered	
SEROTONIN (5-HT) RECEPTOR AGONIST		
naratriptan hcl	1-Covered	QL (9 PER 30 DAYS)
rizatriptan benzoate	1-Covered	QL (12 PER 30 DAYS)
sumatriptan	1-Covered	QL (12 PER 28 DAYS)
sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	QL (9 PER 30 DAYS)
sumatriptan succinate (4 mg/0.5ml soln a-inj, 6 mg/0.5ml soln a-inj, 6 mg/0.5ml solution)	1-Covered	QL (6 PER 30 DAYS)
sumatriptan succinate refill	1-Covered	QL (6 PER 30 DAYS)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
pyridostigmine bromide 60 mg tab	1-Covered	
pyridostigmine bromide er	1-Covered	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone (25 mg tab, 100 mg tab)	1-Covered	
rifabutin	1-Covered	
ANTITUBERCULARS		
ethambutol hcl	1-Covered	
isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)	1-Covered	
PRIFTIN	1-Covered	
pyrazinamide	1-Covered	
rifampin	1-Covered	
SIRTURO	1-Covered	PA, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TRECATOR	1-Covered	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
carboplatin	1-Covered	PA3
cisplatin	1-Covered	PA3
CYCLOPHOSPHAMIDE (25 MG CAP, 25 MG TAB, 50 MG CAP, 50 MG TAB)	1-Covered	PA3
GLEOSTINE (10 MG CAP, 40 MG CAP)	1-Covered	PA2
GLEOSTINE 100 MG CAP	1-Covered	PA2, NDS (Non-Extended Day Supply)
LEUKERAN	1-Covered	NDS (Non-Extended Day Supply)
MATULANE	1-Covered	NDS (Non-Extended Day Supply)
oxaliplatin (50 mg recon soln, 50 mg/10ml solution, 100 mg recon soln, 100 mg/20ml solution)	1-Covered	PA3
paraplatin	1-Covered	PA3
VALCHLOR	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTIANDROGENS		
abiraterone acetate 250 mg tab	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
abiraterone acetate 500 mg tab	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
abirtega	1-Covered	PA2, QL (120 PER 30 DAYS)
bicalutamide	1-Covered	
ERLEADA 240 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ERLEADA 60 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
EULEXIN	1-Covered	PA2, NDS (Non-Extended Day Supply)
nilutamide	1-Covered	NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NUBEQA	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
XTANDI (40 MG CAP, 40 MG TAB)	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
XTANDI 80 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTIANGIOGENIC AGENTS		
lenalidomide	1-Covered	PA2, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
POMALYST	1-Covered	PA2, QL (21 PER 28 DAYS), NDS (Non-Extended Day Supply)
THALOMID (150 MG CAP, 200 MG CAP)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
THALOMID 100 MG CAP	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
THALOMID 50 MG CAP	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTIESTROGENS/MODIFIERS		
fulvestrant	1-Covered	PA3, NDS (Non-Extended Day Supply)
ORSERDU 345 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ORSERDU 86 MG TAB	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
SOLTAMOX	1-Covered	NDS (Non-Extended Day Supply)
tamoxifen citrate	1-Covered	
toremifene citrate	1-Covered	NDS (Non-Extended Day Supply)
ANTIMETABOLITES		
azacitidine	1-Covered	PA3, NDS (Non-Extended Day Supply)
fluorouracil (1 gm/20ml solution, 2.5 gm/50ml solution, 5 gm/100ml solution, 500 mg/10ml solution)	1-Covered	PA3
mercaptopurine 2000 mg/100ml suspension	1-Covered	NDS (Non-Extended Day Supply)
mercaptopurine 50 mg tab	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ONUREG	1-Covered	PA2, QL (14 PER 28 DAYS), NDS (Non-Extended Day Supply)
PURIXAN	1-Covered	NDS (Non-Extended Day Supply)
TABLOID	1-Covered	
ANTINEOPLASTICS, OTHER		
AKEEGA	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUGTYRO 160 MG CAP	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUGTYRO 40 MG CAP	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
DOCETAXEL	1-Covered	PA3, NDS (Non-Extended Day Supply)
DROXIA	1-Covered	
FRUZAQLA 1 MG CAP	1-Covered	PA2, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
FRUZAQLA 5 MG CAP	1-Covered	PA2, QL (21 PER 28 DAYS), NDS (Non-Extended Day Supply)
hydroxyurea	1-Covered	
INQOVI	1-Covered	PA2, QL (5 PER 28 DAYS), NDS (Non-Extended Day Supply)
IWILFIN	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab, 50 mg recon soln, 100 mg recon soln, 200 mg recon soln, 350 mg recon soln, 500 mg recon soln)	1-Covered	
LONSURF 15-6.14 MG TAB	1-Covered	PA2, QL (100 PER 28 DAYS), NDS (Non-Extended Day Supply)
LONSURF 20-8.19 MG TAB	1-Covered	PA2, QL (80 PER 28 DAYS), NDS (Non-Extended Day Supply)
LYSODREN	1-Covered	NDS (Non-Extended Day Supply)
OJJAARA	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ORGOVYX	1-Covered	PA2, QL (32 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
QINLOCK	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
WELIREG	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZOLINZA	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole	1-Covered	
exemestane	1-Covered	
letrozole	1-Covered	
ENZYME INHIBITORS		
etoposide	1-Covered	
irinotecan hcl	1-Covered	PA3
MOLECULAR TARGET INHIBITORS		
ALECENSA	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
ALUNBRIG (90 & 180 MG TAB THPK, 90 MG TAB, 180 MG TAB)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ALUNBRIG 30 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
AVMAPKI FAKZYNJA CO-PACK	1-Covered	PA2, QL (66 PER 28 DAYS), NDS (Non-Extended Day Supply)
AYVAKIT	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
BALVERSA 3 MG TAB	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
BALVERSA 4 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
BALVERSA 5 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
bortezomib 3.5 mg recon soln	1-Covered	PA3, NDS (Non-Extended Day Supply)
BOSULIF (100 MG CAP, 100 MG TAB)	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
BOSULIF (400 MG TAB, 500 MG TAB)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BOSULIF 50 MG CAP	1-Covered	PA2, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
BRAFTOVI	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
BRUKINSA	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
CABOMETYX (20 MG TAB, 60 MG TAB)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
CABOMETYX 40 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
CALQUENCE	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
CAPRELSA 100 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
CAPRELSA 300 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
COMETRIQ (100 MG DAILY DOSE)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
COMETRIQ (140 MG DAILY DOSE)	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
COMETRIQ (60 MG DAILY DOSE)	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
COPIKTRA	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
COTELLIC	1-Covered	PA2, QL (63 PER 28 DAYS), NDS (Non-Extended Day Supply)
DANZITEN	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
dasatinib (50 mg tab, 70 mg tab, 80 mg tab, 100 mg tab)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
dasatinib 140 mg tab	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
dasatinib 20 mg tab	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
DAURISMO 100 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DAURISMO 25 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ERIVEDGE	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
erlotinib hcl (100 mg tab, 150 mg tab)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
erlotinib hcl 25 mg tab	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
everolimus (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
everolimus (3 mg tab sol, 5 mg tab sol)	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
everolimus 2 mg tab sol	1-Covered	PA2, QL (150 PER 30 DAYS), NDS (Non-Extended Day Supply)
FOTIVDA	1-Covered	PA2, QL (21 PER 28 DAYS), NDS (Non-Extended Day Supply)
GAVRETO	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
gefitinib	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
GILOTRIF	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
GOMEKLI 1 MG CAP	1-Covered	PA2, QL (126 PER 28 DAYS), NDS (Non-Extended Day Supply)
GOMEKLI 1 MG TAB SOL	1-Covered	PA2, QL (168 PER 28 DAYS), NDS (Non-Extended Day Supply)
GOMEKLI 2 MG CAP	1-Covered	PA2, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
IBRANCE	1-Covered	PA2, QL (21 PER 28 DAYS), NDS (Non-Extended Day Supply)
ICLUSIG (10 MG TAB, 30 MG TAB, 45 MG TAB)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ICLUSIG 15 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
IDHIFA	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
imatinib mesylate 100 mg tab	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
imatinib mesylate 400 mg tab	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMBRUVICA (70 MG CAP, 140 MG TAB, 280 MG TAB, 420 MG TAB)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
IMBRUVICA 140 MG CAP	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
IMBRUVICA 70 MG/ML SUSPENSION	1-Covered	PA2, QL (324 PER 30 DAYS), NDS (Non-Extended Day Supply)
IMKELDI	1-Covered	PA2, QL (280 PER 28 DAYS), NDS (Non-Extended Day Supply)
INLYTA 1 MG TAB	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
INLYTA 5 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
INREBIC	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
ITOVEBI 3 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ITOVEBI 9 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
JAKAFI	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
JAYPIRCA 100 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
JAYPIRCA 50 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
KISQALI (200 MG DOSE)	1-Covered	PA2, QL (21 PER 28 DAYS), NDS (Non-Extended Day Supply)
KISQALI (400 MG DOSE)	1-Covered	PA2, QL (42 PER 28 DAYS), NDS (Non-Extended Day Supply)
KISQALI (600 MG DOSE)	1-Covered	PA2, QL (63 PER 28 DAYS), NDS (Non-Extended Day Supply)
KISQALI FEMARA (200 MG DOSE)	1-Covered	PA2, QL (49 PER 28 DAYS), NDS (Non-Extended Day Supply)
KISQALI FEMARA (400 MG DOSE)	1-Covered	PA2, QL (70 PER 28 DAYS), NDS (Non-Extended Day Supply)
KISQALI FEMARA (600 MG DOSE)	1-Covered	PA2, QL (91 PER 28 DAYS), NDS (Non-Extended Day Supply)
KOSELUGO 10 MG CAP	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
KOSELUGO 25 MG CAP	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
KRAZATI	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
lapatinib ditosylate	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
LAZCLUZE 240 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
LAZCLUZE 80 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
LENVIMA (10 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LENVIMA (12 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LENVIMA (14 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LENVIMA (18 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LENVIMA (20 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LENVIMA (24 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LENVIMA (4 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LENVIMA (8 MG DAILY DOSE)	1-Covered	PA2, NDS (Non-Extended Day Supply)
LORBRENA 100 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
LORBRENA 25 MG TAB	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
LUMAKRAS (120 MG TAB, 240 MG TAB)	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
LUMAKRAS 320 MG TAB	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
LYNPARZA	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
LYTGOBI (12 MG DAILY DOSE)	1-Covered	PA2, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LYTGOBI (16 MG DAILY DOSE)	1-Covered	PA2, QL (112 PER 28 DAYS), NDS (Non-Extended Day Supply)
LYTGOBI (20 MG DAILY DOSE)	1-Covered	PA2, QL (140 PER 28 DAYS), NDS (Non-Extended Day Supply)
MEKINIST 0.05 MG/ML RECON SOLN	1-Covered	PA2, QL (1350 PER 30 DAYS), NDS (Non-Extended Day Supply)
MEKINIST 0.5 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
MEKINIST 2 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
MEKTOVI	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
NERLYNX	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
nilotinib hcl	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
NINLARO	1-Covered	PA2, QL (3 PER 28 DAYS), NDS (Non-Extended Day Supply)
ODOMZO	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
OGSIVEO (100 MG TAB, 150 MG TAB)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
OGSIVEO 50 MG TAB	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
OJEMDA 100 MG TAB	1-Covered	PA2, QL (24 PER 28 DAYS), NDS (Non-Extended Day Supply)
OJEMDA 25 MG/ML RECON SUSP	1-Covered	PA2, QL (96 PER 28 DAYS), NDS (Non-Extended Day Supply)
paclitaxel	1-Covered	PA3
paclitaxel protein-bound part	1-Covered	PA3, NDS (Non-Extended Day Supply)
pazopanib hcl	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
PEMAZYRE	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
PIQRAY (200 MG DAILY DOSE)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PIQRAY (250 MG DAILY DOSE)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
PIQRAY (300 MG DAILY DOSE)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
RETEVMO (120 MG TAB, 160 MG TAB)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
RETEVMO (80 MG CAP, 80 MG TAB)	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
RETEVMO 40 MG CAP	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
RETEVMO 40 MG TAB	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
REVUFORJ 110 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
REVUFORJ 160 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
REVUFORJ 25 MG TAB	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
REZLIDHIA	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ROMVIMZA	1-Covered	PA2, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply)
ROZLYTREK 100 MG CAP	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
ROZLYTREK 200 MG CAP	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
ROZLYTREK 50 MG PACKET	1-Covered	PA2, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
RUBRACA	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
RYDAPT	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
SCEMBLIX 100 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
SCEMBLIX 20 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
SCEMBLIX 40 MG TAB	1-Covered	PA2, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
sorafenib tosylate	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
SPRYCEL (50 MG TAB, 70 MG TAB, 80 MG TAB, 100 MG TAB)	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
SPRYCEL 140 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
SPRYCEL 20 MG TAB	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
STIVARGA	1-Covered	PA2, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
sunitinib malate	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TABRECTA	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
TAFINLAR (50 MG CAP, 75 MG CAP)	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
TAFINLAR 10 MG TAB SOL	1-Covered	PA2, QL (900 PER 30 DAYS), NDS (Non-Extended Day Supply)
TAGRISSO	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TALZENNA (0.1 MG CAP, 0.35 MG CAP, 0.5 MG CAP, 0.75 MG CAP, 1 MG CAP)	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TALZENNA 0.25 MG CAP	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
TASIGNA	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
TAZVERIK	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
TEPMETKO	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
TIBSOVO	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
torpenz	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TRUQAP	1-Covered	PA2, QL (64 PER 28 DAYS), NDS (Non-Extended Day Supply)
TUKYSA 150 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TUKYSA 50 MG TAB	1-Covered	PA2, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)
TURALIO	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
VANFLYTA	1-Covered	PA2, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
VENCLEXTA 10 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS)
VENCLEXTA 100 MG TAB	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
VENCLEXTA 50 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
VENCLEXTA STARTING PACK	1-Covered	PA2, QL (42 PER 28 DAYS), NDS (Non-Extended Day Supply)
VERZENIO	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
VITRAKVI 100 MG CAP	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
VITRAKVI 20 MG/ML SOLUTION	1-Covered	PA2, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)
VITRAKVI 25 MG CAP	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIZIMPRO	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VONJO	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
VORANIGO 10 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
VORANIGO 40 MG TAB	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
XALKORI (20 MG CAP SPRINK, 50 MG CAP SPRINK, 200 MG CAP, 250 MG CAP)	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
XALKORI 150 MG CAP SPRINK	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
XOSPATA	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
XPOVIO (100 MG ONCE WEEKLY)	1-Covered	PA2, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XPOVIO (40 MG ONCE WEEKLY) 10 MG TAB THPK	1-Covered	PA2, QL (16 PER 28 DAYS), NDS (Non-Extended Day Supply)
XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK	1-Covered	PA2, QL (4 PER 28 DAYS), NDS (Non-Extended Day Supply)
XPOVIO (40 MG TWICE WEEKLY)	1-Covered	PA2, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply)
XPOVIO (60 MG ONCE WEEKLY)	1-Covered	PA2, QL (4 PER 28 DAYS), NDS (Non-Extended Day Supply)
XPOVIO (60 MG TWICE WEEKLY)	1-Covered	PA2, QL (24 PER 28 DAYS), NDS (Non-Extended Day Supply)
XPOVIO (80 MG ONCE WEEKLY)	1-Covered	PA2, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply)
XPOVIO (80 MG TWICE WEEKLY)	1-Covered	PA2, QL (32 PER 28 DAYS), NDS (Non-Extended Day Supply)
ZEJULA	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZELBORAF	1-Covered	PA2, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZYDELIG	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZYKADIA	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE		
AVASTIN	1-Covered	PA3, NDS (Non-Extended Day Supply)
HERCEPTIN HYLECTA	1-Covered	PA3, NDS (Non-Extended Day Supply)
KADCYLA	1-Covered	PA3, NDS (Non-Extended Day Supply)
KANJINTI	1-Covered	PA3, NDS (Non-Extended Day Supply)
KEYTRUDA	1-Covered	PA3, NDS (Non-Extended Day Supply)
MVASI	1-Covered	PA3, NDS (Non-Extended Day Supply)
OGIVRI	1-Covered	PA3, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RUXIENCE	1-Covered	PA3, NDS (Non-Extended Day Supply)
TRAZIMERA	1-Covered	PA3, NDS (Non-Extended Day Supply)
TRUXIMA	1-Covered	PA3, NDS (Non-Extended Day Supply)
ZIRABEV	1-Covered	PA3, NDS (Non-Extended Day Supply)
RETINOIDS		
bexarotene 1 % gel	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
bexarotene 75 mg cap	1-Covered	PA2, NDS (Non-Extended Day Supply)
PANRETIN	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
tretinoin 10 mg cap	1-Covered	NDS (Non-Extended Day Supply)
TREATMENT ADJUNCTS		
mesna 400 mg tab	1-Covered	NDS (Non-Extended Day Supply)
MESNEX 400 MG TAB	1-Covered	NDS (Non-Extended Day Supply)
ANTIPARASITICS		
ANTHELMINTHICS		
albendazole	1-Covered	NDS (Non-Extended Day Supply)
ivermectin 3 mg tab	1-Covered	
praziquantel	1-Covered	
ANTIPROTOZOALS		
atovaquone	1-Covered	QL (600 PER 30 DAYS)
atovaquone-proguanil hcl	1-Covered	
chloroquine phosphate	1-Covered	
COARTEM	1-Covered	
hydroxychloroquine sulfate 200 mg tab	1-Covered	
IMPAVIDO	1-Covered	QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
mefloquine hcl	1-Covered	
nitazoxanide	1-Covered	QL (6 PER 30 DAYS), NDS (Non-Extended Day Supply)
pentamidine isethionate for nebulization soln 300 mg	1-Covered	PA3
pentamidine isethionate for soln 300 mg	1-Covered	
primaquine phosphate	1-Covered	
pyrimethamine	1-Covered	PA, NDS (Non-Extended Day Supply)
quinine sulfate	1-Covered	PA
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	
trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)	1-Covered	PA
ANTIPARKINSON AGENTS, OTHER		
amantadine hcl (50 mg/5ml solution, 100 mg cap, 100 mg tab)	1-Covered	
carbidopa-levodopa-entacapone	1-Covered	
entacapone	1-Covered	
DOPAMINE AGONISTS		
apomorphine hcl	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
bromocriptine mesylate	1-Covered	
pramipexole dihydrochloride	1-Covered	
ropinirole hcl	1-Covered	
ropinirole hcl er	1-Covered	
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
carbidopa-levodopa	1-Covered	
carbidopa-levodopa er	1-Covered	
INBRIJA	1-Covered	PA, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
rasagiline mesylate	1-Covered	
selegiline hcl	1-Covered	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
chlorpromazine hcl (10 mg tab, 25 mg tab, 25 mg/ml solution, 30 mg/ml conc, 50 mg tab, 50 mg/2ml solution, 100 mg tab, 100 mg/ml conc, 200 mg tab)	1-Covered	
fluphenazine decanoate	1-Covered	
fluphenazine hcl (1 mg tab, 2.5 mg tab, 2.5 mg/5ml elixir, 2.5 mg/ml solution, 5 mg tab, 5 mg/ml conc, 10 mg tab)	1-Covered	
haloperidol	1-Covered	
haloperidol decanoate	1-Covered	
haloperidol lactate	1-Covered	
loxapine succinate	1-Covered	
molindone hcl	1-Covered	
pimozide	1-Covered	
thioridazine hcl	1-Covered	
thiothixene	1-Covered	
trifluoperazine hcl	1-Covered	
2ND GENERATION/ATYPICAL		
ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR	1-Covered	QL (2.4 PER 56 DAYS), NDS (Non-Extended Day Supply)
ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR	1-Covered	QL (3.2 PER 56 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
aripiprazole (2 mg tab, 5 mg tab, 10 mg tab, 10 mg tab disp, 15 mg tab, 15 mg tab disp)	1-Covered	QL (60 PER 30 DAYS)
aripiprazole (20 mg tab, 30 mg tab)	1-Covered	QL (30 PER 30 DAYS)
aripiprazole 1 mg/ml solution	1-Covered	QL (900 PER 30 DAYS)
ARISTADA 1064 MG/3.9ML PRSYR	1-Covered	QL (3.9 PER 56 DAYS), NDS (Non-Extended Day Supply)
ARISTADA 441 MG/1.6ML PRSYR	1-Covered	QL (1.6 PER 28 DAYS), NDS (Non-Extended Day Supply)
ARISTADA 662 MG/2.4ML PRSYR	1-Covered	QL (2.4 PER 28 DAYS), NDS (Non-Extended Day Supply)
ARISTADA 882 MG/3.2ML PRSYR	1-Covered	QL (3.2 PER 28 DAYS), NDS (Non-Extended Day Supply)
ARISTADA INITIO	1-Covered	QL (4.8 PER 365 DAYS), NDS (Non-Extended Day Supply)
asenapine maleate	1-Covered	QL (60 PER 30 DAYS)
CAPLYTA	1-Covered	ST, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
COBENFY	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
COBENFY STARTER PACK	1-Covered	QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
FANAPT	1-Covered	ST, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
FANAPT TITRATION PACK A	1-Covered	ST, QL (16 PER 365 DAYS)
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	1-Covered	QL (3.5 PER 180 DAYS), NDS (Non-Extended Day Supply)
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	1-Covered	QL (5 PER 180 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	1-Covered	QL (0.75 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	1-Covered	QL (1.5 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	1-Covered	QL (0.25 PER 28 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	1-Covered	QL (0.5 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	1-Covered	QL (0.88 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	1-Covered	QL (1.32 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	1-Covered	QL (1.75 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	1-Covered	QL (2.63 PER 84 DAYS), NDS (Non-Extended Day Supply)
lurasidone hcl (20 mg tab, 40 mg tab, 60 mg tab, 120 mg tab)	1-Covered	QL (30 PER 30 DAYS)
lurasidone hcl 80 mg tab	1-Covered	QL (60 PER 30 DAYS)
NUPLAZID	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
olanzapine (15 mg tab, 20 mg tab)	1-Covered	QL (30 PER 30 DAYS)
olanzapine (2.5 mg tab, 5 mg tab, 5 mg tab disp, 7.5 mg tab, 10 mg tab, 10 mg tab disp, 15 mg tab disp, 20 mg tab disp)	1-Covered	QL (60 PER 30 DAYS)
olanzapine 10 mg recon soln	1-Covered	QL (90 PER 30 DAYS)
OPIPZA (5 MG FILM, 10 MG FILM)	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
OPIPZA 2 MG FILM	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
paliperidone er 1.5 mg tab er 24h	1-Covered	QL (240 PER 30 DAYS)
paliperidone er 3 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
paliperidone er 6 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
paliperidone er 9 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
quetiapine fumarate (300 mg tab, 400 mg tab)	1-Covered	QL (60 PER 30 DAYS)
quetiapine fumarate (50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)	1-Covered	QL (120 PER 30 DAYS)
quetiapine fumarate 25 mg tab	1-Covered	QL (180 PER 30 DAYS)
quetiapine fumarate er	1-Covered	QL (60 PER 30 DAYS)
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB)	1-Covered	ST, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REXULTI (2 MG TAB, 3 MG TAB, 4 MG TAB)	1-Covered	ST, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
risperidone (0.25 mg tab, 0.25 mg tab disp, 0.5 mg tab, 0.5 mg tab disp, 1 mg tab, 1 mg tab disp, 2 mg tab, 2 mg tab disp, 3 mg tab, 3 mg tab disp, 4 mg tab, 4 mg tab disp)	1-Covered	QL (60 PER 30 DAYS)
risperidone 1 mg/ml solution	1-Covered	QL (480 PER 30 DAYS)
risperidone microspheres er	1-Covered	QL (2 PER 28 DAYS)
SECUADO	1-Covered	ST, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VRAYLAR	1-Covered	ST, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ziprasidone hcl	1-Covered	QL (60 PER 30 DAYS)
ziprasidone mesylate	1-Covered	QL (60 PER 30 DAYS)
ZYPREXA RELPREVV (210 MG RECON SUSP, 300 MG RECON SUSP)	1-Covered	QL (2 PER 28 DAYS)
ZYPREXA RELPREVV 405 MG RECON SUSP	1-Covered	QL (1 PER 28 DAYS)
TREATMENT-RESISTANT		
clozapine	1-Covered	
VERSACLOZ	1-Covered	QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTISPASTICITY AGENTS		
baclofen (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
dantrolene sodium	1-Covered	
tizanidine hcl (2 mg tab, 4 mg tab)	1-Covered	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
LIVTENCITY	1-Covered	PA, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PREVYMIS (20 MG PACKET, 120 MG PACKET)	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
PREVYMIS (240 MG TAB, 480 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
valganciclovir hcl 450 mg tab	1-Covered	
valganciclovir hcl 50 mg/ml recon soln	1-Covered	NDS (Non-Extended Day Supply)
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir dipivoxil	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
entecavir	1-Covered	QL (30 PER 30 DAYS)
lamivudine 100 mg tab	1-Covered	
VEMLIDY	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-HEPATITIS C (HCV) AGENTS		
EPCLUSA (150-37.5 MG PACKET, 400-100 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
EPCLUSA (200-50 MG PACKET, 200-50 MG TAB)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
HARVONI (33.75-150 MG PACKET, 90-400 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
HARVONI (45-200 MG PACKET, 45-200 MG TAB)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
MAVYRET 100-40 MG TAB	1-Covered	PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
MAVYRET 50-20 MG PACKET	1-Covered	PA, QL (140 PER 28 DAYS), NDS (Non-Extended Day Supply)
ribavirin	1-Covered	
SOFOSBUVIR-VELPATASVIR	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DOVATO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GENVOYA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ISENTRESS (100 MG CHEW TAB, 100 MG PACKET)	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
ISENTRESS 25 MG CHEW TAB	1-Covered	QL (180 PER 30 DAYS)
ISENTRESS 400 MG TAB	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ISENTRESS HD	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
JULUCA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
STRIBILD	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TIVICAY (25 MG TAB, 50 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
TIVICAY 10 MG TAB	1-Covered	QL (60 PER 30 DAYS)
TIVICAY PD	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
COMPLERA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DELSTRIGO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EDURANT	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EDURANT PED	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
efavirenz	1-Covered	QL (30 PER 30 DAYS)
efavirenz-emtricitab-tenofo df	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EFAVIRENZ-LAMIVUDINE-TENOFOVIR (400-300-300 MG TAB, 600-300-300 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
emtricitab-rilpivir-tenofov df	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
etravirine 100 mg tab	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
etravirine 200 mg tab	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
INTELENCE 25 MG TAB	1-Covered	QL (120 PER 30 DAYS)
nevirapine 200 mg tab	1-Covered	QL (60 PER 30 DAYS)
nevirapine 50 mg/5ml suspension	1-Covered	QL (1200 PER 30 DAYS)
nevirapine er	1-Covered	QL (30 PER 30 DAYS)
ODEFSEY	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
PIFELTRO	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate 20 mg/ml solution	1-Covered	QL (960 PER 30 DAYS)
abacavir sulfate 300 mg tab	1-Covered	QL (60 PER 30 DAYS)
abacavir sulfate-lamivudine	1-Covered	QL (30 PER 30 DAYS)
CIMDUO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DESCOVY 120-15 MG TAB	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DESCOVY 200-25 MG TAB	1-Covered	NDS (Non-Extended Day Supply)
emtricitabine	1-Covered	QL (30 PER 30 DAYS)
emtricitabine-tenofovir df (100-150 mg tab, 133-200 mg tab, 167-250 mg tab)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
emtricitabine-tenofovir df 200-300 mg tab	1-Covered	
EMTRIVA 10 MG/ML SOLUTION	1-Covered	QL (850 PER 30 DAYS)
lamivudine (10 mg/ml solution, 300 mg/30ml solution)	1-Covered	QL (960 PER 30 DAYS)
lamivudine 150 mg tab	1-Covered	QL (60 PER 30 DAYS)
lamivudine 300 mg tab	1-Covered	QL (30 PER 30 DAYS)
lamivudine-zidovudine	1-Covered	QL (60 PER 30 DAYS)
tenofovir disoproxil fumarate	1-Covered	QL (30 PER 30 DAYS)
TRIUMEQ	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TRIUMEQ PD	1-Covered	QL (180 PER 30 DAYS)
VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIREAD 40 MG/GM POWDER	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
zidovudine 100 mg cap	1-Covered	QL (180 PER 30 DAYS)
zidovudine 300 mg tab	1-Covered	QL (60 PER 30 DAYS)
zidovudine 50 mg/5ml syrup	1-Covered	QL (1920 PER 30 DAYS)
ANTI-HIV AGENTS, OTHER		
CABENUVA	1-Covered	NDS (Non-Extended Day Supply)
FUZEON	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
maraviroc 150 mg tab	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
maraviroc 300 mg tab	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
RUKOBIA	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
SELZENTRY 20 MG/ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
SUNLENCA (4 X 300 MG TAB THPK, 300 MG TAB)	1-Covered	QL (4 PER 28 DAYS), NDS (Non-Extended Day Supply)
SUNLENCA 463.5 MG/1.5ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
SUNLENCA 5 X 300 MG TAB THPK	1-Covered	QL (5 PER 28 DAYS), NDS (Non-Extended Day Supply)
TROGARZO	1-Covered	NDS (Non-Extended Day Supply)
TYBOST	1-Covered	QL (30 PER 30 DAYS)
ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)		
APTIVUS	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
atazanavir sulfate (150 mg cap, 200 mg cap)	1-Covered	QL (60 PER 30 DAYS)
atazanavir sulfate 300 mg cap	1-Covered	QL (30 PER 30 DAYS)
darunavir 600 mg tab	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
darunavir 800 mg tab	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EVOTAZ	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
fosamprenavir calcium	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
KALETRA 400-100 MG/5ML SOLUTION	1-Covered	QL (480 PER 30 DAYS)
lopinavir-ritonavir 100-25 mg tab	1-Covered	QL (300 PER 30 DAYS)
lopinavir-ritonavir 200-50 mg tab	1-Covered	QL (120 PER 30 DAYS)
lopinavir-ritonavir 400-100 mg/5ml solution	1-Covered	QL (480 PER 30 DAYS)
NORVIR 100 MG PACKET	1-Covered	QL (360 PER 30 DAYS)
PREZCOBIX	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
PREZISTA 100 MG/ML SUSPENSION	1-Covered	QL (400 PER 30 DAYS), NDS (Non-Extended Day Supply)
PREZISTA 150 MG TAB	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
PREZISTA 75 MG TAB	1-Covered	QL (480 PER 30 DAYS)
REYATAZ 50 MG PACKET	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
ritonavir	1-Covered	QL (360 PER 30 DAYS)
SYMTUZA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIRACEPT 250 MG TAB	1-Covered	QL (270 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIRACEPT 625 MG TAB	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-INFLUENZA AGENTS		
oseltamivir phosphate (45 mg cap, 75 mg cap)	1-Covered	QL (84 PER 365 DAYS)
oseltamivir phosphate 30 mg cap	1-Covered	QL (168 PER 365 DAYS)
oseltamivir phosphate 6 mg/ml recon susp	1-Covered	QL (1080 PER 365 DAYS)
RELENZA DISKHALER	1-Covered	QL (120 PER 365 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
rimantadine hcl	1-Covered	
XOFLUZA (40 MG DOSE)	1-Covered	QL (6 PER 365 DAYS)
XOFLUZA (80 MG DOSE)	1-Covered	QL (6 PER 365 DAYS)
ANTIHERPETIC AGENTS		
acyclovir (200 mg cap, 200 mg/5ml suspension, 400 mg tab, 800 mg tab, 800 mg/20ml suspension)	1-Covered	
acyclovir sodium	1-Covered	PA3
famciclovir	1-Covered	QL (90 PER 30 DAYS)
valacyclovir hcl	1-Covered	QL (120 PER 30 DAYS)
ANTIVIRAL, CORONAVIRUS AGENTS		
LAGEVRIO	1-Covered	
PAXLOVID	1-Covered	QL (22 PER 30 DAYS)
PAXLOVID (150/100)	1-Covered	QL (40 PER 30 DAYS)
PAXLOVID (300/100)	1-Covered	QL (60 PER 30 DAYS)
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone hcl	1-Covered	
hydroxyzine pamoate	1-Covered	
BENZODIAZEPINES		
alprazolam (0.25 mg tab, 0.5 mg tab)	1-Covered	QL (120 PER 30 DAYS)
alprazolam (1 mg tab, 2 mg tab)	1-Covered	QL (150 PER 30 DAYS)
clonazepam (0.125 mg tab disp, 0.25 mg tab disp, 0.5 mg tab, 0.5 mg tab disp, 1 mg tab, 1 mg tab disp)	1-Covered	QL (120 PER 30 DAYS)
clonazepam (2 mg tab, 2 mg tab disp)	1-Covered	QL (300 PER 30 DAYS)
clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)	1-Covered	QL (90 PER 30 DAYS)
clorazepate dipotassium 15 mg tab	1-Covered	QL (180 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
diazepam (2 mg tab, 5 mg tab, 10 mg tab)	1-Covered	QL (120 PER 30 DAYS)
diazepam 5 mg/5ml solution	1-Covered	QL (1200 PER 30 DAYS)
diazepam 5 mg/ml conc	1-Covered	QL (240 PER 30 DAYS)
diazepam intensol	1-Covered	QL (240 PER 30 DAYS)
lorazepam (2 mg tab, 2 mg/ml conc)	1-Covered	QL (150 PER 30 DAYS)
lorazepam 0.5 mg tab	1-Covered	QL (600 PER 30 DAYS)
lorazepam 1 mg tab	1-Covered	QL (300 PER 30 DAYS)
lorazepam intensol	1-Covered	QL (150 PER 30 DAYS)
oxazepam	1-Covered	QL (120 PER 30 DAYS)
BIPOLAR AGENTS		
MOOD STABILIZERS		
lamotrigine (25 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)	1-Covered	
lithium	1-Covered	
lithium carbonate	1-Covered	
lithium carbonate er	1-Covered	
subvenite	1-Covered	
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose	1-Covered	QL (90 PER 30 DAYS)
alogliptin benzoate	1-Covered	QL (30 PER 30 DAYS)
alogliptin-metformin hcl	1-Covered	QL (60 PER 30 DAYS)
alogliptin-pioglitazone (12.5-30 mg tab, 25-15 mg tab, 25-30 mg tab, 25-45 mg tab)	1-Covered	QL (30 PER 30 DAYS)
CYCLOSET	1-Covered	QL (180 PER 30 DAYS)
glimepiride (1 mg tab, 2 mg tab)	1-Covered	QL (120 PER 30 DAYS)
glimepiride 4 mg tab	1-Covered	QL (60 PER 30 DAYS)
glipizide (5 mg tab, 10 mg tab)	1-Covered	QL (120 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
glipizide er 10 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
glipizide er 2.5 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
glipizide er 5 mg tab er 24h	1-Covered	QL (90 PER 30 DAYS)
glipizide-metformin hcl	1-Covered	QL (120 PER 30 DAYS)
glyburide	1-Covered	QL (120 PER 30 DAYS)
GLYBURIDE MICRONIZED	1-Covered	QL (60 PER 30 DAYS)
glyburide-metformin	1-Covered	QL (120 PER 30 DAYS)
GLYXAMBI	1-Covered	QL (30 PER 30 DAYS)
JANUMET	1-Covered	QL (60 PER 30 DAYS)
JANUMET XR (50-1000 MG TAB ER 24H, 50-500 MG TAB ER 24H)	1-Covered	QL (60 PER 30 DAYS)
JANUMET XR 100-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
JANUVIA	1-Covered	QL (30 PER 30 DAYS)
JENTADUETO (2.5-1000 MG TAB, 2.5-500 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
JENTADUETO XR 2.5-1000 MG TAB ER 24H	1-Covered	QL (60 PER 30 DAYS)
JENTADUETO XR 5-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
metformin hcl 1000 mg tab	1-Covered	QL (75 PER 30 DAYS)
metformin hcl 500 mg tab	1-Covered	QL (150 PER 30 DAYS)
metformin hcl 850 mg tab	1-Covered	QL (90 PER 30 DAYS)
metformin hcl er 500 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
metformin hcl er 750 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
miglitol	1-Covered	QL (90 PER 30 DAYS)
MOUNJARO	1-Covered	PA, QL (2 PER 28 DAYS)
nateglinide 120 mg tab	1-Covered	QL (90 PER 30 DAYS)
nateglinide 60 mg tab	1-Covered	QL (180 PER 30 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/1.5ML SOLN PEN	1-Covered	PA, QL (1.5 PER 28 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN	1-Covered	PA, QL (3 PER 28 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OZEMPIC (1 MG/DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
OZEMPIC (2 MG/DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
pioglitazone hcl	1-Covered	QL (30 PER 30 DAYS)
pioglitazone hcl-glimepiride	1-Covered	QL (30 PER 30 DAYS)
pioglitazone hcl-metformin hcl	1-Covered	QL (90 PER 30 DAYS)
repaglinide (0.5 mg tab, 1 mg tab)	1-Covered	QL (120 PER 30 DAYS)
repaglinide 2 mg tab	1-Covered	QL (240 PER 30 DAYS)
RYBELSUS	1-Covered	PA, QL (30 PER 30 DAYS)
SOLIQUA	1-Covered	QL (18 PER 30 DAYS)
SYNJARDY (5-1000 MG TAB, 12.5-1000 MG TAB, 12.5-500 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
SYNJARDY 5-500 MG TAB	1-Covered	QL (120 PER 30 DAYS)
SYNJARDY XR (5-1000 MG TAB ER 24H, 10-1000 MG TAB ER 24H, 12.5-1000 MG TAB ER 24H)	1-Covered	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
TRADJENTA	1-Covered	QL (30 PER 30 DAYS)
TRIJARDY XR (10-5-1000 MG TAB ER 24H, 25-5-1000 MG TAB ER 24H)	1-Covered	QL (30 PER 30 DAYS)
TRIJARDY XR (5-2.5-1000 MG TAB ER 24H, 12.5-2.5-1000 MG TAB ER 24H)	1-Covered	QL (60 PER 30 DAYS)
TRULICITY	1-Covered	PA, QL (2 PER 28 DAYS)
XIGDUO XR (10-1000 MG TAB ER 24H, 10-500 MG TAB ER 24H)	1-Covered	QL (30 PER 30 DAYS)
XIGDUO XR (2.5-1000 MG TAB ER 24H, 5-1000 MG TAB ER 24H, 5-500 MG TAB ER 24H)	1-Covered	QL (60 PER 30 DAYS)
GLYCEMIC AGENTS		
BAQSIMI ONE PACK	1-Covered	
BAQSIMI TWO PACK	1-Covered	
diazoxide	1-Covered	NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
glucagon emergency (1 mg kit, 1 mg/ml recon soln)	1-Covered	
glucagon emergency 1 mg kit (generic)	1-Covered	
ZEGALOGUE	1-Covered	
INSULINS		
BASAGLAR KWIKPEN	1-Covered	
FIASP	1-Covered	
FIASP FLEXTOUCH	1-Covered	
FIASP PENFILL	1-Covered	
FIASP PUMPCART	1-Covered	
HUMULIN R U-500 (CONCENTRATED)	1-Covered	NDS (Non-Extended Day Supply)
HUMULIN R U-500 KWIKPEN	1-Covered	NDS (Non-Extended Day Supply)
LANTUS	1-Covered	
LANTUS SOLOSTAR	1-Covered	
NOVOLIN 70/30	1-Covered	
NOVOLIN 70/30 FLEXPEN	1-Covered	
NOVOLIN N	1-Covered	
NOVOLIN N FLEXPEN	1-Covered	
NOVOLIN R	1-Covered	
NOVOLIN R FLEXPEN	1-Covered	
NOVOLOG	1-Covered	
NOVOLOG FLEXPEN	1-Covered	
NOVOLOG MIX 70/30	1-Covered	
NOVOLOG MIX 70/30 FLEXPEN	1-Covered	
NOVOLOG PENFILL	1-Covered	
TOUJEO MAX SOLOSTAR	1-Covered	
TOUJEO SOLOSTAR	1-Covered	
TRESIBA	1-Covered	
TRESIBA FLEXTOUCH	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BLOOD PRODUCTS AND MODIFIERS		
ANTICOAGULANTS		
dabigatran etexilate mesylate (75 mg cap, 150 mg cap)	1-Covered	QL (60 PER 30 DAYS)
ELIQUIS 2.5 MG TAB	1-Covered	QL (60 PER 30 DAYS)
ELIQUIS 5 MG TAB	1-Covered	QL (74 PER 30 DAYS)
ELIQUIS DVT/PE STARTER PACK	1-Covered	QL (74 PER 30 DAYS)
enoxaparin sodium (30 mg/0.3ml soln prsyr, 40 mg/0.4ml soln prsyr, 60 mg/0.6ml soln prsyr, 80 mg/0.8ml soln prsyr, 100 mg/ml soln prsyr, 120 mg/0.8ml soln prsyr, 150 mg/ml soln prsyr)	1-Covered	
fondaparinux sodium (5 mg/0.4ml solution, 7.5 mg/0.6ml solution, 10 mg/0.8ml solution)	1-Covered	NDS (Non-Extended Day Supply)
fondaparinux sodium 2.5 mg/0.5ml solution	1-Covered	
heparin sodium (porcine) (1000 unit/ml solution, 5000 unit/ml solution, 10000 unit/ml solution, 20000 unit/ml solution)	1-Covered	
heparin sodium (porcine) pf 1000 unit/ml solution	1-Covered	
jantoven	1-Covered	
warfarin sodium	1-Covered	
XARELTO (10 MG TAB, 20 MG TAB)	1-Covered	QL (30 PER 30 DAYS)
XARELTO (2.5 MG TAB, 15 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
XARELTO 1 MG/ML RECON SUSP	1-Covered	QL (620 PER 30 DAYS)
XARELTO STARTER PACK	1-Covered	QL (51 PER 30 DAYS)
BLOOD PRODUCTS AND MODIFIERS, OTHER		
ALVAIZ	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
anagrelide hcl	1-Covered	
FULPHILA	1-Covered	PA, NDS (Non-Extended Day Supply)
PROCRIT (2000 UNIT/ML SOLUTION, 3000 UNIT/ML SOLUTION, 4000 UNIT/ML SOLUTION, 10000 UNIT/ML SOLUTION)	1-Covered	PA3
PROCRIT (20000 UNIT/ML SOLUTION, 40000 UNIT/ML SOLUTION)	1-Covered	PA3, NDS (Non-Extended Day Supply)
RETACRIT	1-Covered	PA3
ZARXIO	1-Covered	PA, NDS (Non-Extended Day Supply)
HEMOSTASIS AGENTS		
tranexamic acid 650 mg tab	1-Covered	
PLATELET MODIFYING AGENTS		
aspirin-dipyridamole er	1-Covered	QL (60 PER 30 DAYS)
BRILINTA	1-Covered	
cilostazol	1-Covered	
clopidogrel bisulfate	1-Covered	
dipyridamole	1-Covered	
DOPTELET	1-Covered	PA, NDS (Non-Extended Day Supply)
prasugrel hcl	1-Covered	
ticagrelor 90 mg tab	1-Covered	
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine 0.1 mg/24hr patch wk	1-Covered	QL (4 PER 28 DAYS)
clonidine 0.2 mg/24hr patch wk	1-Covered	QL (4 PER 28 DAYS)
clonidine 0.3 mg/24hr patch wk	1-Covered	QL (4 PER 28 DAYS)
clonidine hcl	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
droxidopa (200 mg cap, 300 mg cap)	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
droxidopa 100 mg cap	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
midodrine hcl	1-Covered	
ALPHA-ADRENERGIC BLOCKING AGENTS		
doxazosin mesylate	1-Covered	
prazosin hcl	1-Covered	
terazosin hcl	1-Covered	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil (4 mg tab, 8 mg tab, 16 mg tab)	1-Covered	QL (60 PER 30 DAYS)
candesartan cilexetil 32 mg tab	1-Covered	QL (30 PER 30 DAYS)
irbesartan (75 mg tab, 300 mg tab)	1-Covered	QL (30 PER 30 DAYS)
irbesartan 150 mg tab	1-Covered	QL (60 PER 30 DAYS)
losartan potassium (25 mg tab, 50 mg tab)	1-Covered	QL (60 PER 30 DAYS)
losartan potassium 100 mg tab	1-Covered	QL (30 PER 30 DAYS)
olmesartan medoxomil (20 mg tab, 40 mg tab)	1-Covered	QL (30 PER 30 DAYS)
olmesartan medoxomil 5 mg tab	1-Covered	QL (60 PER 30 DAYS)
telmisartan	1-Covered	QL (30 PER 30 DAYS)
valsartan (40 mg tab, 80 mg tab, 160 mg tab)	1-Covered	QL (60 PER 30 DAYS)
valsartan 320 mg tab	1-Covered	QL (30 PER 30 DAYS)
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril hcl	1-Covered	
captopril	1-Covered	
enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
fosinopril sodium	1-Covered	
lisinopril	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
moexipril hcl	1-Covered	
perindopril erbumine (2 mg tab, 4 mg tab, 8 mg tab)	1-Covered	
quinapril hcl	1-Covered	
ramipril	1-Covered	
trandolapril	1-Covered	
ANTIARRHYTHMICS		
amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)	1-Covered	
digoxin (125 mcg tab, 250 mcg tab)	1-Covered	QL (30 PER 30 DAYS)
digoxin 0.05 mg/ml solution	1-Covered	
dofetilide	1-Covered	
flecainide acetate	1-Covered	
mexiletine hcl	1-Covered	
MULTAQ	1-Covered	
pacerone	1-Covered	
propafenone hcl	1-Covered	
propafenone hcl er	1-Covered	
quinidine sulfate	1-Covered	
sotalol hcl	1-Covered	
sotalol hcl (af)	1-Covered	
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	1-Covered	
atenolol	1-Covered	
betaxolol hcl (10 mg tab, 20 mg tab)	1-Covered	
bisoprolol fumarate (5 mg tab, 10 mg tab)	1-Covered	
carvedilol	1-Covered	
labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)	1-Covered	
metoprolol succinate er	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
metoprolol tartrate (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)	1-Covered	
nadolol	1-Covered	
nebivolol hcl (2.5 mg tab, 5 mg tab, 10 mg tab)	1-Covered	QL (30 PER 30 DAYS)
nebivolol hcl 20 mg tab	1-Covered	QL (60 PER 30 DAYS)
pindolol	1-Covered	
propranolol hcl (10 mg tab, 20 mg tab, 20 mg/5ml solution, 40 mg tab, 40 mg/5ml solution, 60 mg tab, 80 mg tab)	1-Covered	
propranolol hcl er	1-Covered	
timolol maleate (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES		
amlodipine besylate	1-Covered	
felodipine er	1-Covered	
isradipine	1-Covered	
nicardipine hcl (20 mg cap, 30 mg cap)	1-Covered	
nifedipine er	1-Covered	
nifedipine er osmotic release	1-Covered	
nimodipine 30 mg cap	1-Covered	
CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES		
cartia xt	1-Covered	
dilt-xr	1-Covered	
diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)	1-Covered	
diltiazem hcl er	1-Covered	
diltiazem hcl er beads	1-Covered	
diltiazem hcl er coated beads	1-Covered	
matzim la	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tiadylt er	1-Covered	
verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)	1-Covered	
verapamil hcl er	1-Covered	
CARDIOVASCULAR AGENTS, OTHER		
acetazolamide	1-Covered	
aliskiren fumarate	1-Covered	QL (30 PER 30 DAYS)
amiloride-hydrochlorothiazide	1-Covered	
amlodipine besy-benazepril hcl (2.5-10 mg cap, 5-10 mg cap, 5-20 mg cap, 10-20 mg cap)	1-Covered	QL (60 PER 30 DAYS)
amlodipine besy-benazepril hcl (5-40 mg cap, 10-40 mg cap)	1-Covered	QL (30 PER 30 DAYS)
amlodipine besylate-valsartan	1-Covered	QL (30 PER 30 DAYS)
amlodipine-atorvastatin	1-Covered	QL (30 PER 30 DAYS)
amlodipine-olmesartan	1-Covered	QL (30 PER 30 DAYS)
amlodipine-valsartan-hctz	1-Covered	QL (30 PER 30 DAYS)
atenolol-chlorthalidone	1-Covered	
benazepril-hydrochlorothiazide	1-Covered	
bisoprolol-hydrochlorothiazide	1-Covered	
candesartan cilexetil-hctz (32-12.5 mg tab, 32-25 mg tab)	1-Covered	QL (30 PER 30 DAYS)
candesartan cilexetil-hctz 16-12.5 mg tab	1-Covered	QL (60 PER 30 DAYS)
CORLANOR (5 MG TAB, 7.5 MG TAB)	1-Covered	PA, QL (60 PER 30 DAYS)
CORLANOR 5 MG/5ML SOLUTION	1-Covered	PA, QL (450 PER 30 DAYS)
enalapril-hydrochlorothiazide	1-Covered	
ENTRESTO (24-26 MG TAB, 49-51 MG TAB, 97-103 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
ENTRESTO (6-6 MG CAP SPRINK, 15-16 MG CAP SPRINK)	1-Covered	QL (240 PER 30 DAYS)
fosinopril sodium-hctz	1-Covered	
irbesartan-hydrochlorothiazide 150-12.5 mg tab	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
irbesartan-hydrochlorothiazide 300-12.5 mg tab	1-Covered	QL (30 PER 30 DAYS)
isosorb dinitrate-hydralazine	1-Covered	
ivabradine hcl	1-Covered	PA, QL (60 PER 30 DAYS)
lisinopril-hydrochlorothiazide	1-Covered	
losartan potassium-hctz (100-12.5 mg tab, 100-25 mg tab)	1-Covered	QL (30 PER 30 DAYS)
losartan potassium-hctz 50-12.5 mg tab	1-Covered	QL (60 PER 30 DAYS)
metoprolol-hydrochlorothiazide	1-Covered	
metyrosine	1-Covered	PA, NDS (Non-Extended Day Supply)
NEXLETOL	1-Covered	PA, QL (30 PER 30 DAYS)
olmesartan medoxomil-hctz	1-Covered	QL (30 PER 30 DAYS)
olmesartan-amlodipine-hctz	1-Covered	QL (30 PER 30 DAYS)
pentoxifylline er	1-Covered	
ranolazine er	1-Covered	QL (60 PER 30 DAYS)
spironolactone-hctz	1-Covered	
telmisartan-amlodipine	1-Covered	QL (30 PER 30 DAYS)
telmisartan-hctz (40-12.5 mg tab, 80-25 mg tab)	1-Covered	QL (30 PER 30 DAYS)
telmisartan-hctz 80-12.5 mg tab	1-Covered	QL (60 PER 30 DAYS)
trandolapril-verapamil hcl er	1-Covered	
triamterene-hctz	1-Covered	
valsartan-hydrochlorothiazide	1-Covered	QL (30 PER 30 DAYS)
VERQUVO	1-Covered	PA, QL (30 PER 30 DAYS)
DIURETICS, LOOP		
bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	
furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)	1-Covered	
torsemide	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DIURETICS, POTASSIUM-SPARING		
amiloride hcl	1-Covered	
eplerenone	1-Covered	
DIURETICS, THIAZIDE		
chlorthalidone	1-Covered	
hydrochlorothiazide	1-Covered	
indapamide	1-Covered	
metolazone	1-Covered	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
fenofibrate (48 mg tab, 54 mg tab, 67 mg cap, 134 mg cap, 145 mg tab, 160 mg tab, 200 mg cap)	1-Covered	
fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)	1-Covered	
fenofibric acid (45 mg cap dr, 135 mg cap dr)	1-Covered	
gemfibrozil	1-Covered	
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin calcium (10 mg tab, 40 mg tab)	1-Covered	QL (60 PER 30 DAYS)
atorvastatin calcium 20 mg tab	1-Covered	QL (90 PER 30 DAYS)
atorvastatin calcium 80 mg tab	1-Covered	QL (30 PER 30 DAYS)
lovastatin (10 mg tab, 20 mg tab)	1-Covered	QL (30 PER 30 DAYS)
lovastatin 40 mg tab	1-Covered	QL (60 PER 30 DAYS)
pitavastatin calcium	1-Covered	QL (30 PER 30 DAYS)
pravastatin sodium	1-Covered	QL (30 PER 30 DAYS)
rosuvastatin calcium	1-Covered	QL (30 PER 30 DAYS)
simvastatin	1-Covered	QL (30 PER 30 DAYS)
DYSLIPIDEMICS, OTHER		
cholestyramine (4 gm packet, 4 gm/dose powder)	1-Covered	
cholestyramine light (4 gm packet, 4 gm/dose powder)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
colesevelam hcl	1-Covered	
colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)	1-Covered	
ezetimibe	1-Covered	QL (30 PER 30 DAYS)
ezetimibe-simvastatin	1-Covered	QL (30 PER 30 DAYS)
NEXLIZET	1-Covered	PA, QL (30 PER 30 DAYS)
niacin er (antihyperlipidemic)	1-Covered	QL (60 PER 30 DAYS)
omega-3-acid ethyl esters	1-Covered	QL (120 PER 30 DAYS)
prevalite (4 gm packet, 4 gm/dose powder)	1-Covered	
REPATHA	1-Covered	PA, QL (3 PER 28 DAYS)
REPATHA PUSHTRONEX SYSTEM	1-Covered	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	1-Covered	PA, QL (3 PER 28 DAYS)
VASCEPA	1-Covered	
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA (10 MG TAB, 20 MG TAB)	1-Covered	PA, QL (30 PER 30 DAYS)
spironolactone (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	
SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITORS (SGLT2I)		
FARXIGA	1-Covered	QL (30 PER 30 DAYS)
JARDIANCE	1-Covered	QL (30 PER 30 DAYS)
VASODILATORS, DIRECT-ACTING ARTERIAL		
hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	
minoxidil	1-Covered	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)	1-Covered	
isosorbide mononitrate	1-Covered	
isosorbide mononitrate er	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NITRO-BID	1-Covered	
nitroglycerin (0.1 mg/hr patch 24hr, 0.2 mg/hr patch 24hr, 0.3 mg sl tab, 0.4 mg sl tab, 0.4 mg/hr patch 24hr, 0.4 mg/spray solution, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)	1-Covered	
nitroglycerin 0.4 % ointment	1-Covered	QL (30 PER 30 DAYS)

CENTRAL NERVOUS SYSTEM AGENTS

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES

amphetamine-dextroamphet er	1-Covered	QL (30 PER 30 DAYS)
amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)	1-Covered	QL (90 PER 30 DAYS)
amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab)	1-Covered	QL (120 PER 30 DAYS)
amphetamine-dextroamphetamine 30 mg tab	1-Covered	QL (60 PER 30 DAYS)
dextroamphetamine sulfate (5 mg tab, 10 mg tab)	1-Covered	QL (180 PER 30 DAYS)
dextroamphetamine sulfate er	1-Covered	QL (120 PER 30 DAYS)

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES

atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)	1-Covered	QL (60 PER 30 DAYS)
atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)	1-Covered	QL (30 PER 30 DAYS)
atomoxetine hcl 18 mg cap	1-Covered	QL (120 PER 30 DAYS)
dexmethylphenidate hcl	1-Covered	QL (60 PER 30 DAYS)
guanfacine hcl er	1-Covered	QL (30 PER 30 DAYS)
methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	QL (90 PER 30 DAYS)
methylphenidate hcl er (10 mg tab er, 20 mg tab er)	1-Covered	QL (90 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CENTRAL NERVOUS SYSTEM, OTHER		
AUSTEDO (9 MG TAB, 12 MG TAB)	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO 6 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO XR (12 MG TAB ER 24H, 24 MG TAB ER 24H)	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO XR (18 MG TAB ER 24H, 30 MG TAB ER 24H, 36 MG TAB ER 24H, 42 MG TAB ER 24H, 48 MG TAB ER 24H)	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO XR 6 MG TAB ER 24H	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO XR PATIENT TITRATION 12 & 18 & 24 & 30 MG TBER THPK	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO XR PATIENT TITRATION 6 & 12 & 24 MG TBER THPK	1-Covered	PA, QL (42 PER 28 DAYS), NDS (Non-Extended Day Supply)
bac (butalbital-acetamin-caff)	1-Covered	PA, QL (180 PER 30 DAYS)
butalbital-apap-caffeine 50-325-40 mg tab	1-Covered	PA, QL (180 PER 30 DAYS)
FIRDAPSE	1-Covered	PA, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
NUEDEXTA	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
riluzole	1-Covered	
tetrabenazine 12.5 mg tab	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
tetrabenazine 25 mg tab	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
FIBROMYALGIA AGENTS		
DRIZALMA SPRINKLE (20 MG CAP DR, 30 MG CAP DR, 60 MG CAP DR)	1-Covered	PA2, QL (60 PER 30 DAYS)
duloxetine hcl (20 mg cp dr part, 30 mg cp dr part, 60 mg cp dr part)	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
pregabalin (225 mg cap, 300 mg cap)	1-Covered	QL (60 PER 30 DAYS)
pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)	1-Covered	QL (90 PER 30 DAYS)
pregabalin 20 mg/ml solution	1-Covered	QL (900 PER 30 DAYS)
pregabalin er (82.5 mg tab er 24h, 165 mg tab er 24h)	1-Covered	PA, QL (90 PER 30 DAYS)
pregabalin er 330 mg tab er 24h	1-Covered	PA, QL (60 PER 30 DAYS)
MULTIPLE SCLEROSIS AGENTS		
AVONEX PEN	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
AVONEX PREFILLED	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
BETASERON	1-Covered	QL (14 PER 28 DAYS), NDS (Non-Extended Day Supply)
COPAXONE 20 MG/ML SOLN PRSYR	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
COPAXONE 40 MG/ML SOLN PRSYR	1-Covered	QL (12 PER 28 DAYS), NDS (Non-Extended Day Supply)
dalfampridine er	1-Covered	QL (60 PER 30 DAYS)
dimethyl fumarate	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
dimethyl fumarate starter pack	1-Covered	QL (120 PER 365 DAYS), NDS (Non-Extended Day Supply)
fingolimod hcl	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
KESIMPTA	1-Covered	PA, QL (1.2 PER 28 DAYS), NDS (Non-Extended Day Supply)
teriflunomide	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DENTAL AND ORAL AGENTS		
cevimeline hcl	1-Covered	
chlorhexidine gluconate	1-Covered	
kourzeq	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
oralone	1-Covered	
periogard	1-Covered	
pilocarpine hcl (5 mg tab, 7.5 mg tab)	1-Covered	
triamcinolone acetonide 0.1 % paste	1-Covered	
DERMATOLOGICAL AGENTS		
ACNE AND ROSACEA AGENTS		
accutane	1-Covered	
acitretin	1-Covered	PA2
amnesteem	1-Covered	
benzoyl peroxide-erythromycin	1-Covered	QL (46.6 PER 30 DAYS)
claravis	1-Covered	
isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)	1-Covered	
metronidazole (0.75 % cream, 0.75 % lotion, 1 % gel)	1-Covered	
sulfacetamide sodium (acne)	1-Covered	QL (118 PER 30 DAYS)
tazarotene (0.05 % cream, 0.05 % gel, 0.1 % cream, 0.1 % gel)	1-Covered	PA, QL (60 PER 30 DAYS)
TAZORAC 0.05 % CREAM	1-Covered	PA, QL (60 PER 30 DAYS)
tretinoin (0.01 % gel, 0.025 % cream, 0.025 % gel, 0.05 % cream, 0.1 % cream)	1-Covered	PA, QL (45 PER 30 DAYS)
zenatane	1-Covered	
DERMATITIS AND PRURITUS AGENTS		
ala-cort	1-Covered	
alclometasone dipropionate	1-Covered	
ammonium lactate	1-Covered	
betamethasone dipropionate (0.05 % cream, 0.05 % lotion, 0.05 % ointment)	1-Covered	
betamethasone dipropionate aug (0.05 % cream, 0.05 % gel, 0.05 % ointment)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
betamethasone dipropionate aug 0.05 % lotion	1-Covered	QL (120 PER 30 DAYS)
betamethasone valerate (0.1 % cream, 0.1 % lotion, 0.1 % ointment)	1-Covered	
clobetasol prop emollient base	1-Covered	QL (120 PER 30 DAYS)
clobetasol propionate (0.05 % cream, 0.05 % gel, 0.05 % ointment)	1-Covered	QL (60 PER 30 DAYS)
clobetasol propionate (0.05 % foam, 0.05 % solution)	1-Covered	QL (100 PER 30 DAYS)
clobetasol propionate 0.05 % shampoo	1-Covered	QL (118 PER 30 DAYS)
clobetasol propionate e	1-Covered	QL (120 PER 30 DAYS)
clobetasol propionate emulsion	1-Covered	QL (100 PER 30 DAYS)
clodan	1-Covered	QL (118 PER 30 DAYS)
desonide (0.05 % cream, 0.05 % ointment)	1-Covered	QL (60 PER 30 DAYS)
desonide 0.05 % lotion	1-Covered	QL (118 PER 30 DAYS)
desoximetasone (0.05 % cream, 0.05 % gel, 0.05 % ointment, 0.25 % cream, 0.25 % ointment)	1-Covered	QL (100 PER 30 DAYS)
fluocinolone acetonide (0.025 % cream, 0.025 % ointment)	1-Covered	QL (120 PER 30 DAYS)
fluocinolone acetonide 0.01 % cream	1-Covered	QL (60 PER 30 DAYS)
fluocinolone acetonide 0.01 % solution	1-Covered	QL (90 PER 30 DAYS)
fluocinolone acetonide body	1-Covered	QL (118.28 PER 30 DAYS)
fluocinolone acetonide scalp	1-Covered	QL (118.28 PER 30 DAYS)
fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment)	1-Covered	QL (120 PER 30 DAYS)
fluocinonide 0.05 % solution	1-Covered	QL (60 PER 30 DAYS)
fluocinonide emulsified base	1-Covered	QL (120 PER 30 DAYS)
fluticasone propionate (0.005 % ointment, 0.05 % cream)	1-Covered	
halobetasol propionate (0.05 % cream, 0.05 % ointment)	1-Covered	QL (50 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydrocortisone (1 % cream, 1 % ointment, 2.5 % cream, 2.5 % lotion, 2.5 % ointment)	1-Covered	
hydrocortisone (perianal)	1-Covered	
HYDROCORTISONE BUTYRATE 0.1 % OINTMENT	1-Covered	QL (45 PER 30 DAYS)
hydrocortisone butyrate 0.1 % solution	1-Covered	QL (60 PER 30 DAYS)
hydrocortisone valerate 0.2 % cream	1-Covered	
hydrocortisone valerate 0.2 % ointment	1-Covered	QL (60 PER 30 DAYS)
mometasone furoate (0.1 % cream, 0.1 % ointment, 0.1 % solution)	1-Covered	
pimecrolimus	1-Covered	QL (100 PER 30 DAYS)
procto-med hc	1-Covered	
proctosol hc	1-Covered	
proctozone-hc	1-Covered	
selenium sulfide 2.5 % lotion	1-Covered	
tacrolimus (0.03 % ointment, 0.1 % ointment)	1-Covered	QL (100 PER 30 DAYS)
tovet	1-Covered	
triamcinolone acetonide (0.025 % cream, 0.025 % lotion, 0.025 % ointment, 0.1 % cream, 0.1 % lotion, 0.1 % ointment, 0.5 % cream, 0.5 % ointment)	1-Covered	
triderm	1-Covered	
DERMATOLOGICAL AGENTS, OTHER		
calcipotriene (0.005 % cream, 0.005 % ointment)	1-Covered	QL (120 PER 30 DAYS)
calcipotriene 0.005 % solution	1-Covered	QL (60 PER 30 DAYS)
calcitrene	1-Covered	QL (120 PER 30 DAYS)
clotrimazole-betamethasone 1-0.05 % cream	1-Covered	QL (45 PER 30 DAYS)
CLOTRIMAZOLE-BETAMETHASONE 1-0.05 % LOTION	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
fluorouracil (2 % solution, 5 % solution)	1-Covered	QL (10 PER 30 DAYS)
fluorouracil 5 % cream	1-Covered	QL (80 PER 30 DAYS)
imiquimod 5 % cream	1-Covered	QL (24 PER 30 DAYS)
methoxsalen rapid	1-Covered	NDS (Non-Extended Day Supply)
nystatin-triamcinolone	1-Covered	QL (60 PER 30 DAYS)
OTEZLA (20 MG TAB, 30 MG TAB)	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
OTEZLA (4 X 10 & 51 X20 MG TAB THPK, 10 & 20 & 30 MG TAB THPK)	1-Covered	PA, QL (110 PER 365 DAYS), NDS (Non-Extended Day Supply)
podofilox 0.5 % solution	1-Covered	
REGRANEX	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
SANTYL	1-Covered	QL (90 PER 30 DAYS)
silver sulfadiazine	1-Covered	
ssd	1-Covered	
PEDICULICIDES/SCABICIDES		
malathion	1-Covered	
permethrin	1-Covered	
TOPICAL ANTI-INFECTIVES		
acyclovir 5 % ointment	1-Covered	QL (30 PER 30 DAYS)
ciclodan	1-Covered	QL (13.2 PER 30 DAYS)
ciclopirox 0.77 % gel	1-Covered	QL (100 PER 30 DAYS)
ciclopirox 1 % shampoo	1-Covered	QL (120 PER 30 DAYS)
ciclopirox 8 % solution	1-Covered	QL (13.2 PER 30 DAYS)
ciclopirox olamine 0.77 % cream	1-Covered	QL (90 PER 30 DAYS)
ciclopirox olamine 0.77 % suspension	1-Covered	QL (60 PER 30 DAYS)
clindamycin phos (once-daily)	1-Covered	QL (75 PER 30 DAYS)
clindamycin phos (twice-daily)	1-Covered	QL (75 PER 30 DAYS)
clindamycin phosphate (1 % lotion, 1 % solution, 1 % swab)	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ery 2% pad	1-Covered	QL (60 PER 30 DAYS)
erythromycin 2 % gel	1-Covered	QL (60 PER 30 DAYS)
erythromycin 2 % solution	1-Covered	QL (120 PER 30 DAYS)
mupirocin	1-Covered	QL (66 PER 30 DAYS)

ELECTROLYTES/MINERALS/METALS/VITAMINS

ELECTROLYTE/MINERAL REPLACEMENT

carglumic acid	1-Covered	PA, NDS (Non-Extended Day Supply)
CLINIMIX/DEXTROSE (4.25/10)	1-Covered	PA3
CLINIMIX/DEXTROSE (4.25/5)	1-Covered	PA3
CLINIMIX/DEXTROSE (5/15)	1-Covered	PA3
CLINIMIX/DEXTROSE (5/20)	1-Covered	PA3
clinisol sf	1-Covered	PA3
dextrose (, 10 % solution)	1-Covered	
dextrose-sodium chloride (2.5-0.45 % solution, 5-0.2 % solution, 5-0.45 % solution, 5-0.9 % solution, 10-0.2 % solution, 10-0.45 % solution)	1-Covered	
FREAMINE III	1-Covered	PA3
ISOLYTE-P IN D5W	1-Covered	
ISOLYTE-S	1-Covered	
ISOLYTE-S PH 7.4	1-Covered	
kcl (0.149%) in nacl	1-Covered	
kcl in dextrose-nacl (, 40-5-0.9 meq/l-%-% solution)	1-Covered	
KCL-LACTATED RINGERS-D5W	1-Covered	
klor-con	1-Covered	
klor-con 10	1-Covered	
klor-con m10	1-Covered	
klor-con m15	1-Covered	
klor-con m20	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
magnesium sulfate 50 % solution	1-Covered	
multiple electro type 1 ph 5.5	1-Covered	
multiple electro type 1 ph 7.4	1-Covered	
plenamine	1-Covered	PA3
POTASSIUM CHLORIDE (2 MEQ/ML SOLUTION, 10 % SOLUTION, 10 MEQ/100ML SOLUTION, 20 MEQ PACKET, 20 MEQ/100ML SOLUTION, 20 MEQ/15ML (10%) SOLUTION, 40 MEQ/100ML SOLUTION, 40 MEQ/15ML (20%) SOLUTION)	1-Covered	
potassium chloride crys er	1-Covered	
potassium chloride er (8 cap er, 8 tab er, 10 cap er, 10 tab er, 20 tab er)	1-Covered	
potassium chloride in dextrose 20-5 meq/l-% solution	1-Covered	
POTASSIUM CHLORIDE IN NACL (, 20-0.45 MEQ/L-% SOLUTION, 40-0.9 MEQ/L-% SOLUTION)	1-Covered	
potassium citrate er	1-Covered	
PREMASOL	1-Covered	PA3
PROSOL	1-Covered	PA3
sodium chloride (0.45 % solution, 0.9 % solution, 3 % solution, 5 % solution)	1-Covered	
sodium chloride (pf)	1-Covered	
sodium fluoride (0.55 (0.25 f) mg chew tab, 1.1 (0.5 f) mg chew tab, 2.2 (1 f) mg chew tab)	1-Covered	
TPN ELECTROLYTES	1-Covered	PA3
TRAVASOL	1-Covered	PA3
TROPHAMINE	1-Covered	PA3
ELECTROLYTE/MINERAL/METAL MODIFIERS		
CHEMET	1-Covered	NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
deferasirox (90 mg packet, 180 mg packet, 250 mg tab sol, 360 mg packet, 500 mg tab sol)	1-Covered	PA, NDS (Non-Extended Day Supply)
deferasirox (90 mg tab, 125 mg tab sol, 180 mg tab, 360 mg tab)	1-Covered	PA
deferasirox granules	1-Covered	PA, NDS (Non-Extended Day Supply)
deferiprone	1-Covered	PA, NDS (Non-Extended Day Supply)
penicillamine 250 mg tab	1-Covered	NDS (Non-Extended Day Supply)
trientine hcl 250 mg cap	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
trientine hcl 500 mg cap	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
POTASSIUM BINDERS		
kionex	1-Covered	
LOKELMA	1-Covered	QL (90 PER 30 DAYS)
sodium polystyrene sulfonate	1-Covered	
sps (sodium polystyrene sulf)	1-Covered	
VITAMINS		
levocarnitine (1 gm/10ml solution, 330 mg tab)	1-Covered	
levocarnitine sf	1-Covered	
PNV 27-CA/FE/FA	1-Covered	
PRENATAL VITAMIN ORAL TABLET	1-Covered	
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
constulose	1-Covered	
enulose	1-Covered	
generlac	1-Covered	
lactulose (10 gm/15ml solution, 20 gm/30ml solution)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lactulose encephalopathy	1-Covered	
LINZESS	1-Covered	QL (30 PER 30 DAYS)
lubiprostone	1-Covered	QL (60 PER 30 DAYS)
MOVANTIK	1-Covered	QL (30 PER 30 DAYS)
RELISTOR (8 MG/0.4ML SOLUTION, 12 MG/0.6ML SOLUTION, 150 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
ANTI-DIARRHEAL AGENTS		
alosetron hcl 0.5 mg tab	1-Covered	PA, QL (60 PER 30 DAYS)
alosetron hcl 1 mg tab	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)	1-Covered	
loperamide hcl	1-Covered	
VIBERZI	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
XERMELO	1-Covered	PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
ANTISPASMODICS, GASTROINTESTINAL		
dicyclomine hcl (10 mg cap, 10 mg/5ml solution, 20 mg tab)	1-Covered	
glycopyrrolate (1 mg tab, 2 mg tab)	1-Covered	
methscopolamine bromide	1-Covered	
GASTROINTESTINAL AGENTS, OTHER		
CLENPIQ	1-Covered	
GATTEX	1-Covered	PA, NDS (Non-Extended Day Supply)
gavilyte-c	1-Covered	
gavilyte-g	1-Covered	
gavilyte-n with flavor pack	1-Covered	
MYALEPT	1-Covered	PA, NDS (Non-Extended Day Supply)
na sulfate-k sulfate-mg sulf	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OCALIVA	1-Covered	PA, NDS (Non-Extended Day Supply)
peg 3350-kcl-na bicarb-nacl	1-Covered	
peg-3350/electrolytes	1-Covered	
ursodiol (250 mg tab, 300 mg cap, 500 mg tab)	1-Covered	
VOWST	1-Covered	PA, QL (12 PER 30 DAYS), NDS (Non-Extended Day Supply)
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
cimetidine	1-Covered	
famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)	1-Covered	
nizatidine (150 mg cap, 300 mg cap)	1-Covered	
PROTECTANTS		
misoprostol	1-Covered	
sucralfate (1 gm tab, 1 gm/10ml suspension)	1-Covered	
PROTON PUMP INHIBITORS		
esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
lansoprazole (15 mg cap dr, 30 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
omeprazole	1-Covered	QL (60 PER 30 DAYS)
pantoprazole sodium (20 mg tab dr, 40 mg tab dr)	1-Covered	QL (60 PER 30 DAYS)
rabeprazole sodium	1-Covered	QL (30 PER 30 DAYS)
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
betaine	1-Covered	NDS (Non-Extended Day Supply)
CERDELGA	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
CREON	1-Covered	
cromolyn sodium 100 mg/5ml conc	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CYSTAGON	1-Covered	
CYSTARAN	1-Covered	PA, QL (60 PER 28 DAYS), NDS (Non-Extended Day Supply)
javygtor	1-Covered	PA, NDS (Non-Extended Day Supply)
l-glutamine	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
miglustat	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
nitisinone	1-Covered	NDS (Non-Extended Day Supply)
PROLASTIN-C	1-Covered	PA, NDS (Non-Extended Day Supply)
RAVICTI	1-Covered	PA, QL (525 PER 30 DAYS), NDS (Non-Extended Day Supply)
sapropterin dihydrochloride	1-Covered	PA, NDS (Non-Extended Day Supply)
sodium phenylbutyrate (3 gm/tsp powder, 500 mg tab)	1-Covered	PA, NDS (Non-Extended Day Supply)
SUCRAID	1-Covered	NDS (Non-Extended Day Supply)
yargesa	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZENPEP	1-Covered	
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
darifenacin hydrobromide er	1-Covered	QL (30 PER 30 DAYS)
fesoterodine fumarate er	1-Covered	QL (30 PER 30 DAYS)
GEMTESA	1-Covered	QL (30 PER 30 DAYS)
MYRBETRIQ (25 MG TAB ER 24H, 50 MG TAB ER 24H)	1-Covered	QL (30 PER 30 DAYS)
MYRBETRIQ 8 MG/ML SRER	1-Covered	QL (300 PER 30 DAYS)
oxybutynin chloride (5 mg tab, 5 mg/5ml solution)	1-Covered	
oxybutynin chloride er	1-Covered	QL (60 PER 30 DAYS)
solifenacin succinate	1-Covered	QL (30 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tolterodine tartrate	1-Covered	QL (60 PER 30 DAYS)
tolterodine tartrate er	1-Covered	QL (30 PER 30 DAYS)
trospium chloride	1-Covered	QL (60 PER 30 DAYS)
trospium chloride er	1-Covered	QL (30 PER 30 DAYS)
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl er	1-Covered	QL (30 PER 30 DAYS)
dutasteride	1-Covered	QL (30 PER 30 DAYS)
dutasteride-tamsulosin hcl	1-Covered	QL (30 PER 30 DAYS)
finasteride	1-Covered	QL (30 PER 30 DAYS)
silodosin	1-Covered	QL (30 PER 30 DAYS)
tadalafil	1-Covered	PA, QL (30 PER 30 DAYS)
tamsulosin hcl	1-Covered	QL (60 PER 30 DAYS)
GENITOURINARY AGENTS, OTHER		
bethanechol chloride	1-Covered	
ELMIRON	1-Covered	QL (90 PER 30 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
dexamethasone (0.5 mg tab, 0.5 mg/5ml elixir, 0.5 mg/5ml solution, 0.75 mg tab, 1 mg tab, 1.5 mg tab, 2 mg tab, 4 mg tab, 6 mg tab)	1-Covered	
dexamethasone sod phos +rfid	1-Covered	
dexamethasone sod phosphate pf 10 mg/ml solution	1-Covered	
dexamethasone sodium phosphate (4 mg/ml soln prsyr, 4 mg/ml solution, 10 mg/ml solution, 20 mg/5ml solution, 100 mg/10ml solution, 120 mg/30ml solution)	1-Covered	
fludrocortisone acetate	1-Covered	
methylprednisolone	1-Covered	
methylprednisolone acetate	1-Covered	
methylprednisolone sodium succ	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
prednisolone 15 mg/5ml solution	1-Covered	
prednisolone sodium phosphate (6.7 (5 base) mg/5ml solution, 15 mg/5ml solution, 25 mg/5ml solution)	1-Covered	
prednisone (1 mg tab, 2.5 mg tab, 5 mg (21) tab thpk, 5 mg (48) tab thpk, 5 mg tab, 5 mg/5ml solution, 10 mg (21) tab thpk, 10 mg (48) tab thpk, 10 mg tab, 20 mg tab, 50 mg tab)	1-Covered	
PREDNISONE INTENSOL	1-Covered	
SOLU-MEDROL 2 GM RECON SOLN	1-Covered	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
desmopressin ace spray refrig	1-Covered	
desmopressin acetate (0.1 mg tab, 0.2 mg tab, 4 mcg/ml solution)	1-Covered	
desmopressin acetate pf	1-Covered	
DESMOPRESSIN ACETATE SPRAY	1-Covered	
INCRELEX	1-Covered	PA, NDS (Non-Extended Day Supply)
NORDITROPIN FLEXPRO	1-Covered	PA, NDS (Non-Extended Day Supply)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANDROGENS		
danazol	1-Covered	
testosterone (12.5 mg/act (1%) gel, 25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)	1-Covered	PA, QL (300 PER 30 DAYS)
testosterone 20.25 mg/act (1.62%) gel	1-Covered	PA, QL (150 PER 30 DAYS)
testosterone cypionate	1-Covered	PA2
testosterone enanthate	1-Covered	PA2

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
testosterone td gel pump 20.25 mg/act (1.62%)	1-Covered	PA, QL (150 PER 30 DAYS)
ESTROGENS		
afirmelle	1-Covered	
altavera	1-Covered	
alyacen 1/35	1-Covered	
alyacen 7/7/7	1-Covered	
amethyst	1-Covered	
apri	1-Covered	
aranelle	1-Covered	
aubra eq	1-Covered	
aurovela 1.5/30	1-Covered	
aurovela 1/20	1-Covered	
aurovela 24 fe	1-Covered	
aurovela fe 1.5/30	1-Covered	
aurovela fe 1/20	1-Covered	
aviane	1-Covered	
ayuna	1-Covered	
azurette	1-Covered	
balziva	1-Covered	
blisovi 24 fe	1-Covered	
blisovi fe 1.5/30	1-Covered	
blisovi fe 1/20	1-Covered	
briellyn	1-Covered	
camrese lo	1-Covered	
chateal eq	1-Covered	
cryselle-28	1-Covered	
cyred eq	1-Covered	
dasetta 1/35	1-Covered	
dasetta 7/7/7	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
delyla	1-Covered	
DEPO-ESTRADIOL	1-Covered	
desogestrel-ethinyl estradiol	1-Covered	
dolishale	1-Covered	
dotti	1-Covered	QL (8 PER 28 DAYS)
drospirenone-ethinyl estradiol	1-Covered	
elinest	1-Covered	
eluryng	1-Covered	
enilloring	1-Covered	
enpresse-28	1-Covered	
enskyce	1-Covered	
estarylla	1-Covered	
estradiol (0.025 mg/24hr patch tw, 0.0375 mg/24hr patch tw, 0.05 mg/24hr patch tw, 0.075 mg/24hr patch tw, 0.1 mg/24hr patch tw)	1-Covered	QL (8 PER 28 DAYS)
estradiol (0.025 mg/24hr patch wk, 0.0375 mg/24hr patch wk, 0.05 mg/24hr patch wk, 0.06 mg/24hr patch wk, 0.075 mg/24hr patch wk, 0.1 mg/24hr patch wk)	1-Covered	QL (4 PER 28 DAYS)
estradiol (0.1 mg/gm cream, 0.5 mg tab, 1 mg tab, 2 mg tab, 10 mcg tab)	1-Covered	
estradiol valerate	1-Covered	
ESTRING	1-Covered	
ethynodiol diac-eth estradiol	1-Covered	
etonogestrel-ethinyl estradiol	1-Covered	
falmina	1-Covered	
feirza 1.5/30	1-Covered	
feirza 1/20	1-Covered	
femynor	1-Covered	
fyavolv	1-Covered	
hailey 1.5/30	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hailey 24 fe	1-Covered	
hailey fe 1.5/30	1-Covered	
hailey fe 1/20	1-Covered	
haloette	1-Covered	
iclevia	1-Covered	
introvale	1-Covered	
isibloom	1-Covered	
jasmiel	1-Covered	
jinteli	1-Covered	
jolessa	1-Covered	
juleber	1-Covered	
junel 1.5/30	1-Covered	
junel 1/20	1-Covered	
junel fe 1.5/30	1-Covered	
junel fe 1/20	1-Covered	
junel fe 24	1-Covered	
kalliga	1-Covered	
kariva	1-Covered	
kelnor 1/35	1-Covered	
kelnor 1/50	1-Covered	
kurvelo	1-Covered	
larin 1.5/30	1-Covered	
larin 1/20	1-Covered	
larin 24 fe	1-Covered	
larin fe 1.5/30	1-Covered	
larin fe 1/20	1-Covered	
leena	1-Covered	
lessina	1-Covered	
levonest	1-Covered	
levonorg-eth estrad triphasic	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
levonorgest-eth estrad 91-day (0.1-0.02 & 0.01 mg tab, 0.15-0.03 mg tab)	1-Covered	
levonorgestrel-ethinyl estrad	1-Covered	
levora 0.15/30 (28)	1-Covered	
lo-zumandimine	1-Covered	
loestrin 1.5/30 (21)	1-Covered	
loestrin 1/20 (21)	1-Covered	
loestrin fe 1.5/30	1-Covered	
loestrin fe 1/20	1-Covered	
lojaimiess	1-Covered	
loryna	1-Covered	
low-ogestrel	1-Covered	
lutera	1-Covered	
lyllana	1-Covered	QL (8 PER 28 DAYS)
marlissa	1-Covered	
MENEST	1-Covered	
microgestin 1.5/30	1-Covered	
microgestin 1/20	1-Covered	
microgestin 24 fe	1-Covered	
microgestin fe 1.5/30	1-Covered	
microgestin fe 1/20	1-Covered	
mili	1-Covered	
mono-linyah	1-Covered	
necon 0.5/35 (28)	1-Covered	
nikki	1-Covered	
norelgestromin-eth estradiol	1-Covered	
norethin ace-eth estrad-fe (1-20 tab, 1.5-30 tab)	1-Covered	
norethin-eth estradiol-fe 0.4-35 mg-mcg chew tab	1-Covered	
norethindron-ethinyl estrad-fe	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
norethindrone acet-ethinyl est	1-Covered	
norethindrone-eth estradiol	1-Covered	
norgestim-eth estrad triphasic	1-Covered	
norgestimate-eth estradiol	1-Covered	
nortrel 0.5/35 (28)	1-Covered	
nortrel 1/35 (21)	1-Covered	
nortrel 1/35 (28)	1-Covered	
nortrel 7/7/7	1-Covered	
nylia 1/35	1-Covered	
nylia 7/7/7	1-Covered	
nymyo	1-Covered	
ocella	1-Covered	
philith	1-Covered	
pimtrea	1-Covered	
pirmella 1/35	1-Covered	
portia-28	1-Covered	
PREMARIN (0.3 MG TAB, 0.45 MG TAB, 0.625 MG TAB, 0.625 MG/GM CREAM, 0.9 MG TAB, 1.25 MG TAB)	1-Covered	
PREMPRO	1-Covered	
previfem	1-Covered	
reclipsen	1-Covered	
setlakin	1-Covered	
simliya	1-Covered	
sprintec 28	1-Covered	
sronyx	1-Covered	
syeda	1-Covered	
tarina 24 fe	1-Covered	
tarina fe 1/20 eq	1-Covered	
tilia fe	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tri femynor	1-Covered	
tri-estarylla	1-Covered	
tri-legest fe	1-Covered	
tri-linyah	1-Covered	
tri-lo-estarylla	1-Covered	
tri-lo-marzia	1-Covered	
tri-lo-mili	1-Covered	
tri-lo-sprintec	1-Covered	
tri-mili	1-Covered	
tri-nymyo	1-Covered	
tri-sprintec	1-Covered	
tri-vylibra	1-Covered	
tri-vylibra lo	1-Covered	
trivora (28)	1-Covered	
turqoz	1-Covered	
valtya 1/50	1-Covered	
velivet	1-Covered	
vestura	1-Covered	
vienva	1-Covered	
viorele	1-Covered	
volnea	1-Covered	
vyfemla	1-Covered	
vylibra	1-Covered	
wera	1-Covered	
wymzya fe	1-Covered	
xarah fe	1-Covered	
xelria fe	1-Covered	
xulane	1-Covered	
yuvafem	1-Covered	
zafemy	1-Covered	

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on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
zovia 1/35 (28)	1-Covered	
zumandimine	1-Covered	
PROGESTINS		
camila	1-Covered	
deblitane	1-Covered	
DEPO-SUBQ PROVERA 104	1-Covered	
emzahh	1-Covered	
errin	1-Covered	
gallifrey	1-Covered	
heather	1-Covered	
incassia	1-Covered	
jencycla	1-Covered	
LILETTA (52 MG)	1-Covered	
lyleq	1-Covered	
lyza	1-Covered	
medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml susp prsyr, 150 mg/ml suspension)	1-Covered	
megestrol acetate (20 mg tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension, 800 mg/20ml suspension)	1-Covered	
meleya	1-Covered	
NEXPLANON	1-Covered	
nora-be	1-Covered	
norethindrone	1-Covered	
norethindrone acetate	1-Covered	
norlyda	1-Covered	
norlyroc	1-Covered	
orquidea	1-Covered	
progesterone (100 mg cap, 200 mg cap)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
sharobel	1-Covered	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
DUAVEE	1-Covered	
raloxifene hcl	1-Covered	QL (30 PER 30 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
euthyrox	1-Covered	
levothyroxine sodium (25 mcg tab, 50 mcg tab, 75 mcg tab, 88 mcg tab, 100 mcg tab, 112 mcg tab, 125 mcg tab, 137 mcg tab, 150 mcg tab, 175 mcg tab, 200 mcg tab, 300 mcg tab)	1-Covered	
levoxyl	1-Covered	
liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)	1-Covered	
SYNTHROID	1-Covered	
unithroid	1-Covered	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
cabergoline	1-Covered	
ELIGARD	1-Covered	PA3
FIRMAGON	1-Covered	PA3
FIRMAGON (240 MG DOSE)	1-Covered	PA3, NDS (Non-Extended Day Supply)
lanreotide acetate	1-Covered	PA, NDS (Non-Extended Day Supply)
leuprolide acetate	1-Covered	PA3
leuprolide acetate (3 month)	1-Covered	PA3
LUPRON DEPOT (1-MONTH)	1-Covered	PA3, NDS (Non-Extended Day Supply)
LUPRON DEPOT (3-MONTH)	1-Covered	PA3, NDS (Non-Extended Day Supply)
LUPRON DEPOT (4-MONTH)	1-Covered	PA3, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LUPRON DEPOT (6-MONTH)	1-Covered	PA3, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED (1-MONTH)	1-Covered	PA3, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED (3-MONTH)	1-Covered	PA3, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED (6-MONTH)	1-Covered	PA3, NDS (Non-Extended Day Supply)
mifepristone	1-Covered	PA, NDS (Non-Extended Day Supply)
octreotide acetate (50 mcg/ml soln prsyr, 50 mcg/ml solution, 100 mcg/ml soln prsyr, 100 mcg/ml solution, 200 mcg/ml solution)	1-Covered	PA
octreotide acetate (500 mcg/ml soln prsyr, 500 mcg/ml solution, 1000 mcg/ml solution)	1-Covered	PA, NDS (Non-Extended Day Supply)
RECORLEV	1-Covered	PA, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
SIGNIFOR	1-Covered	PA, NDS (Non-Extended Day Supply)
SOMATULINE DEPOT (60 MG/0.2ML SOLUTION, 90 MG/0.3ML SOLUTION)	1-Covered	PA, NDS (Non-Extended Day Supply)
SOMAVERT	1-Covered	PA, NDS (Non-Extended Day Supply)
SYNAREL	1-Covered	NDS (Non-Extended Day Supply)
TRELSTAR MIXJECT (3.75 MG RECON SUSP, 22.5 MG RECON SUSP)	1-Covered	PA3
TRELSTAR MIXJECT 11.25 MG RECON SUSP	1-Covered	PA3, NDS (Non-Extended Day Supply)

HORMONAL AGENTS, SUPPRESSANT (THYROID)

ANTITHYROID AGENTS

methimazole	1-Covered	
propylthiouracil	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
BERINERT	1-Covered	PA, NDS (Non-Extended Day Supply)
CINRYZE	1-Covered	PA, NDS (Non-Extended Day Supply)
HAEGARDA	1-Covered	PA, NDS (Non-Extended Day Supply)
icatibant acetate	1-Covered	PA, QL (27 PER 30 DAYS), NDS (Non-Extended Day Supply)
sajazir	1-Covered	PA, QL (27 PER 30 DAYS), NDS (Non-Extended Day Supply)
IMMUNOGLOBULINS		
BIVIGAM	1-Covered	PA, NDS (Non-Extended Day Supply)
FLEBOGAMMA DIF	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAGARD	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAGARD S/D LESS IGA	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAKED	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAPLEX	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMUNEX-C	1-Covered	PA, NDS (Non-Extended Day Supply)
OCTAGAM	1-Covered	PA, NDS (Non-Extended Day Supply)
PANZYGA	1-Covered	PA, NDS (Non-Extended Day Supply)
PRIVIGEN	1-Covered	PA, NDS (Non-Extended Day Supply)
IMMUNOLOGICAL AGENTS, OTHER		
ARCALYST	1-Covered	PA, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AURANOFIN	1-Covered	NDS (Non-Extended Day Supply)
BENLYSTA (120 MG RECON SOLN, 400 MG RECON SOLN)	1-Covered	PA, NDS (Non-Extended Day Supply)
BENLYSTA (200 MG/ML SOLN A-INJ, 200 MG/ML SOLN PRSYR)	1-Covered	PA, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply)
DUPIXENT	1-Covered	PA, NDS (Non-Extended Day Supply)
RIDAURA	1-Covered	NDS (Non-Extended Day Supply)
RINVOQ	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
RINVOQ LQ	1-Covered	PA, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
SKYRIZI	1-Covered	PA, NDS (Non-Extended Day Supply)
SKYRIZI PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
STELARA	1-Covered	PA, NDS (Non-Extended Day Supply)
TALTZ	1-Covered	PA, NDS (Non-Extended Day Supply)
TAVNEOS	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
XELJANZ (1 MG/ML SOLUTION, 5 MG TAB, 10 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
XELJANZ XR	1-Covered	PA, NDS (Non-Extended Day Supply)
XOLAIR (75 MG/0.5ML SOLN A-INJ, 75 MG/0.5ML SOLN PRSYR, 150 MG RECON SOLN, 150 MG/ML SOLN A-INJ, 150 MG/ML SOLN PRSYR, 300 MG/2ML SOLN A-INJ, 300 MG/2ML SOLN PRSYR)	1-Covered	PA, NDS (Non-Extended Day Supply)
IMMUNOSTIMULANTS		
ACTIMMUNE	1-Covered	PA, NDS (Non-Extended Day Supply)
BESREMI	1-Covered	PA2, QL (2 PER 28 DAYS), NDS (Non-Extended Day Supply)
PEGASYS	1-Covered	NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMMUNOSUPPRESSANTS		
ADALIMUMAB-AACF (2 PEN)	1-Covered	PA, NDS (Non-Extended Day Supply)
ADALIMUMAB-AACF (2 SYRINGE)	1-Covered	PA, NDS (Non-Extended Day Supply)
ADALIMUMAB-AACF(CD/UC/HS STRT)	1-Covered	PA, NDS (Non-Extended Day Supply)
ADALIMUMAB-AACF(PS/UV STARTER)	1-Covered	PA, NDS (Non-Extended Day Supply)
azathioprine 50 mg tab	1-Covered	PA3
AZATHIOPRINE SODIUM	1-Covered	PA3
cyclosporine (25 mg cap, 100 mg cap)	1-Covered	PA3
cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)	1-Covered	PA3
ENBREL	1-Covered	PA, NDS (Non-Extended Day Supply)
ENBREL MINI	1-Covered	PA, NDS (Non-Extended Day Supply)
ENBREL SURECLICK	1-Covered	PA, NDS (Non-Extended Day Supply)
ENVARSUS XR	1-Covered	PA3
everolimus (0.25 mg tab, 0.5 mg tab, 0.75 mg tab, 1 mg tab)	1-Covered	PA3, NDS (Non-Extended Day Supply)
gengraf (25 mg cap, 100 mg cap, 100 mg/ml solution)	1-Covered	PA3
HADLIMA	1-Covered	PA, NDS (Non-Extended Day Supply)
HADLIMA PUSHTOUCH	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA (2 PEN) 40 MG/0.4ML AUT-IJ KIT (ABBVIE PRODUCT ONLY)	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA (2 PEN) 40 MG/0.8ML AUT-IJ KIT	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA (2 PEN) 80 MG/0.8ML AUT-IJ KIT (ABBVIE PRODUCT ONLY)	1-Covered	PA, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMIRA (2 SYRINGE) 40 MG/0.8ML PREF SY KT	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA 10 MG/0.1ML PREF SY KT (ABBVIE PRODUCT ONLY)	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA 20 MG/0.2ML PREF SY KT (ABBVIE PRODUCT ONLY)	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA 40 MG/0.4ML PREF SY KT (ABBVIE PRODUCT ONLY)	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA-PSORIASIS/UVEIT STARTER	1-Covered	PA, NDS (Non-Extended Day Supply)
IDACIO (2 PEN)	1-Covered	PA, NDS (Non-Extended Day Supply)
IDACIO (2 SYRINGE)	1-Covered	PA, NDS (Non-Extended Day Supply)
IDACIO-CROHNS/UC STARTER	1-Covered	PA, NDS (Non-Extended Day Supply)
IDACIO-PSORIASIS STARTER	1-Covered	PA, NDS (Non-Extended Day Supply)
INFLECTRA	1-Covered	PA3, NDS (Non-Extended Day Supply)
leflunomide 10 mg tab	1-Covered	QL (30 PER 30 DAYS)
leflunomide 20 mg tab	1-Covered	QL (150 PER 30 DAYS)
methotrexate sodium (1 gm recon soln, 2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution)	1-Covered	
methotrexate sodium (pf) (1 gm/40ml solution, 50 mg/2ml solution, 250 mg/10ml solution, 1000 mg/40ml solution)	1-Covered	
mycophenolate mofetil (250 mg cap, 500 mg recon soln, 500 mg tab)	1-Covered	PA3
mycophenolate mofetil 200 mg/ml recon susp	1-Covered	PA3, NDS (Non-Extended Day Supply)
mycophenolate mofetil hcl	1-Covered	PA3
mycophenolate sodium	1-Covered	PA3
mycophenolic acid	1-Covered	PA3
NULOJIX	1-Covered	PA3, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PROGRAF (0.2 MG PACKET, 1 MG PACKET)	1-Covered	PA3
RENFLEXIS	1-Covered	PA3, NDS (Non-Extended Day Supply)
REZUROCK	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
sirolimus (0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	PA3
sirolimus 1 mg/ml solution	1-Covered	PA3, NDS (Non-Extended Day Supply)
tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)	1-Covered	PA3
XATMEP	1-Covered	
VACCINES		
ABRYSVO	1-Covered	
ACTHIB	1-Covered	
ADACEL	1-Covered	
AREXVY	1-Covered	
BCG VACCINE	1-Covered	
BEXSERO	1-Covered	
BOOSTRIX	1-Covered	
DAPTACEL	1-Covered	
DIPHTHERIA-TETANUS TOXOIDS DT	1-Covered	
ENGERIX-B	1-Covered	PA3
GARDASIL 9	1-Covered	
HAVRIX	1-Covered	
HEPLISAV-B	1-Covered	PA3
HIBERIX	1-Covered	
IMOVAX RABIES	1-Covered	
INFANRIX	1-Covered	
IPOL	1-Covered	
IXCHIQ	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IXIARO	1-Covered	
JYNNEOS	1-Covered	PA3
KINRIX	1-Covered	
M-M-R II	1-Covered	
MENACTRA	1-Covered	
MENQUADFI	1-Covered	
MENVEO (RECON SOLN, SOLUTION)	1-Covered	
MRESVIA	1-Covered	
PEDIARIX	1-Covered	
PEDVAX HIB	1-Covered	
PENTACEL	1-Covered	
PRIORIX	1-Covered	
PROQUAD	1-Covered	
QUADRACEL	1-Covered	
RABAVERT	1-Covered	
RECOMBIVAX HB	1-Covered	PA3
ROTARIX	1-Covered	
ROTATEQ	1-Covered	
SHINGRIX	1-Covered	
TENIVAC	1-Covered	
TICOVAC	1-Covered	
TRUMENBA	1-Covered	
TWINRIX	1-Covered	
TYPHIM VI	1-Covered	
VAQTA	1-Covered	
VARIVAX	1-Covered	
VAXCHORA	1-Covered	
VIMKUNYA	1-Covered	
VIVOTIF	1-Covered	
YF-VAX	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
balsalazide disodium	1-Covered	
mesalamine (1.2 gm tab dr, 4 gm enema, 400 mg cap dr, 800 mg tab dr, 1000 mg suppos)	1-Covered	
mesalamine er 0.375 gm cap er 24h	1-Covered	
mesalamine-cleanser	1-Covered	
sulfasalazine	1-Covered	
GLUCOCORTICOIDS		
budesonide 3 mg cp dr part	1-Covered	
budesonide er	1-Covered	NDS (Non-Extended Day Supply)
hydrocortisone (5 mg tab, 10 mg tab, 20 mg tab, 100 mg/60ml enema)	1-Covered	
METABOLIC BONE DISEASE AGENTS		
alendronate sodium (35 mg tab, 70 mg tab)	1-Covered	QL (4 PER 28 DAYS)
alendronate sodium 10 mg tab	1-Covered	QL (30 PER 30 DAYS)
alendronate sodium 70 mg/75ml solution	1-Covered	
calcitonin (salmon) 200 unit/act solution	1-Covered	
calcitriol (0.25 mcg cap, 0.5 mcg cap)	1-Covered	
calcitriol oral soln 1 mcg/ml	1-Covered	
cinacalcet hcl (30 mg tab, 60 mg tab)	1-Covered	PA3, QL (60 PER 30 DAYS)
cinacalcet hcl 90 mg tab	1-Covered	PA3, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
DOXERCALCIFEROL (0.5 MCG CAP, 1 MCG CAP, 2.5 MCG CAP)	1-Covered	
ibandronate sodium 150 mg tab	1-Covered	QL (1 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
paricalcitol (1 mcg cap, 2 mcg cap, 4 mcg cap)	1-Covered	
PROLIA	1-Covered	QL (1 PER 180 DAYS)
risedronate sodium (35 mg tab, 35 mg tab dr)	1-Covered	QL (4 PER 28 DAYS)
risedronate sodium (5 mg tab, 30 mg tab)	1-Covered	QL (30 PER 30 DAYS)
risedronate sodium 150 mg tab	1-Covered	QL (1 PER 28 DAYS)
TERIPARATIDE 560 MCG/2.24ML SOLN PEN (ALVOGEN, NDC 47781065289)	1-Covered	PA, QL (2.48 PER 28 DAYS), NDS (Non-Extended Day Supply)
XGEVA	1-Covered	PA, NDS (Non-Extended Day Supply)
zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)	1-Covered	PA3
MISCELLANEOUS THERAPEUTIC AGENTS		
BD ALCOHOL PADS	1-Covered	PA
CLINOLIPID	1-Covered	PA3
DROPLET INSULIN SYRINGE (29G X 1/2" 0.3 ML MISC, 29G X 1/2" 0.5 ML MISC, 29G X 1/2" 1 ML MISC, 30G X 1/2" 0.3 ML MISC, 30G X 1/2" 0.5 ML MISC, 30G X 1/2" 1 ML MISC, 30G X 5/16" 0.3 ML MISC, 30G X 5/16" 0.5 ML MISC, 30G X 5/16" 1 ML MISC, 31G X 5/16" 0.3 ML MISC, 31G X 5/16" 0.5 ML MISC, 31G X 5/16" 1 ML MISC)	1-Covered	PA
DROPLET MICRON	1-Covered	PA
DROPLET PEN NEEDLES (29G X 10MM MISC, 29G X 12MM MISC, 31G X 5 MM MISC, 31G X 6 MM MISC, 31G X 8 MM MISC, 32G X 4 MM MISC, 32G X 5 MM MISC, 32G X 6 MM MISC, 32G X 8 MM MISC)	1-Covered	PA
EMBECTA AUTOSHIELD DUO	1-Covered	PA
EMBECTA INS SYR U/F 1/2 UNIT	1-Covered	PA

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EMBECTA INSULIN SYRINGE	1-Covered	PA
EMBECTA INSULIN SYRINGE U/F	1-Covered	PA
EMBECTA PEN NEEDLE NANO	1-Covered	PA
EMBECTA PEN NEEDLE NANO 2 GEN	1-Covered	PA
EMBECTA PEN NEEDLE U/F	1-Covered	PA
GAUZE PADS & DRESSINGS - PADS 2 X 2	1-Covered	PA
INSULIN PEN NEEDLE (NOVO/BD/ULTIMED/OWEN/TRIVIDIA)	1-Covered	PA
INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC)	1-Covered	PA
INSULIN SYRINGE (DISP) U-100 1 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC)	1-Covered	PA
INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC)	1-Covered	PA
INSUPEN PEN NEEDLES	1-Covered	PA
INTRALIPID	1-Covered	PA3
ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD	1-Covered	PA
NEEDLES, INSULIN DISP., SAFETY	1-Covered	PA
NUTRILIPID	1-Covered	PA3
PENBRAYA	1-Covered	
sterile water for irrigation	1-Covered	
UNIFINE PENTIPS	1-Covered	PA

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
ak-poly-bac	1-Covered	
atropine sulfate 1 % solution	1-Covered	
bacitra-neomycin-polymyxin-hc	1-Covered	
bacitracin-polymyxin b	1-Covered	
COMBIGAN	1-Covered	
cyclopentolate hcl	1-Covered	
dorzolamide hcl-timolol mal	1-Covered	
dorzolamide hcl-timolol mal pf	1-Covered	
MIEBO	1-Covered	QL (3 PER 30 DAYS)
neo-polycin	1-Covered	
neo-polycin hc	1-Covered	
neomycin-bacitracin zn-polymyx	1-Covered	
neomycin-polymyxin-dexameth (0.1 % suspension, 3.5-10000-0.1 ointment, 3.5-10000-0.1 suspension)	1-Covered	
neomycin-polymyxin-gramicidin	1-Covered	
neomycin-polymyxin-hc 3.5-10000-1 suspension	1-Covered	
OXERVATE	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
polycin	1-Covered	
RESTASIS	1-Covered	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	1-Covered	QL (5.5 PER 28 DAYS)
ROCKLATAN	1-Covered	
sulfacetamide-prednisolone	1-Covered	
TOBRADEX 0.3-0.1 % OINTMENT	1-Covered	
tobramycin-dexamethasone	1-Covered	
XDEMVY	1-Covered	PA, QL (10 PER 42 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XIIDRA	1-Covered	QL (60 PER 30 DAYS)
ZYLET	1-Covered	
OPHTHALMIC ANTI-ALLERGY AGENTS		
azelastine hcl 0.05 % solution	1-Covered	
cromolyn sodium 4 % solution	1-Covered	
epinastine hcl	1-Covered	
OPHTHALMIC ANTI-INFECTIVES		
AZASITE	1-Covered	
bacitracin	1-Covered	
erythromycin 5 mg/gm ointment	1-Covered	
gatifloxacin	1-Covered	
gentamicin sulfate 0.3 % solution	1-Covered	
moxifloxacin hcl (2x day)	1-Covered	
moxifloxacin hcl 0.5 % solution	1-Covered	
ofloxacin 0.3 % solution	1-Covered	
polymyxin b-trimethoprim	1-Covered	
sulfacetamide sodium (10 % ointment, 10 % solution)	1-Covered	
tobramycin 0.3 % solution	1-Covered	
trifluridine	1-Covered	
ZIRGAN	1-Covered	
OPHTHALMIC ANTI-INFLAMMATORIES		
bromfenac sodium (once-daily)	1-Covered	
bromfenac sodium 0.07 % solution	1-Covered	
dexamethasone sodium phosphate 0.1 % solution	1-Covered	
diclofenac sodium 0.1 % solution	1-Covered	QL (90 PER 30 DAYS)
difluprednate	1-Covered	
FLAREX	1-Covered	
fluorometholone	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
flurbiprofen sodium	1-Covered	
ILEVRO	1-Covered	
ketorolac tromethamine (0.4 % solution, 0.5 % solution)	1-Covered	
loteprednol etabonate (0.5 % gel, 0.5 % suspension)	1-Covered	
prednisolone acetate	1-Covered	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	1-Covered	
PROLENSA	1-Covered	
OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS		
betaxolol hcl 0.5 % solution	1-Covered	
carteolol hcl	1-Covered	
levobunolol hcl	1-Covered	
timolol maleate (0.25 % gel f soln, 0.25 % solution, 0.5 % (daily) solution, 0.5 % gel f soln, 0.5 % solution)	1-Covered	
timolol maleate (once-daily)	1-Covered	
OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER		
acetazolamide er	1-Covered	
apraclonidine hcl	1-Covered	
brimonidine tartrate (0.1 % solution, 0.15 % solution, 0.2 % solution)	1-Covered	
brinzolamide	1-Covered	
dorzolamide hcl	1-Covered	
methazolamide	1-Covered	
pilocarpine hcl (1 % solution, 2 % solution, 4 % solution)	1-Covered	
RHOPRESSA	1-Covered	
SIMBRINZA	1-Covered	
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
bimatoprost	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
latanoprost	1-Covered	
LUMIGAN	1-Covered	
travoprost (bak free)	1-Covered	
OTIC AGENTS		
acetic acid 2 % solution	1-Covered	
ciprofloxacin-dexamethasone	1-Covered	
flac	1-Covered	
fluocinolone acetonide 0.01 % oil	1-Covered	
hydrocortisone-acetic acid	1-Covered	
neomycin-polymyxin-hc (1 % solution, 3.5-10000-1 solution)	1-Covered	
RESPIRATORY TRACT/PULMONARY AGENTS		
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ARNUITY ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
budesonide (0.25 mg/2ml suspension, 0.5 mg/2ml suspension, 1 mg/2ml suspension)	1-Covered	PA3
flunisolide	1-Covered	QL (50 PER 30 DAYS)
fluticasone propionate 50 mcg/act suspension	1-Covered	QL (16 PER 30 DAYS)
fluticasone propionate diskus 100 mcg/act aer pow ba	1-Covered	QL (60 PER 30 DAYS)
fluticasone propionate diskus 250 mcg/act aer pow ba	1-Covered	QL (240 PER 30 DAYS)
fluticasone propionate diskus 50 mcg/act aer pow ba	1-Covered	QL (120 PER 30 DAYS)
fluticasone propionate hfa (110 mcg/act aerosol, 220 mcg/act aerosol)	1-Covered	QL (24 PER 30 DAYS)
fluticasone propionate hfa 44 mcg/act aerosol	1-Covered	QL (22 PER 30 DAYS)
mometasone furoate 50 mcg/act suspension	1-Covered	QL (34 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PULMICORT FLEXHALER	1-Covered	QL (2 PER 30 DAYS)
ANTIHISTAMINES		
azelastine hcl (0.1 % solution, 137 mcg/spray solution)	1-Covered	QL (30 PER 25 DAYS)
cetirizine hcl	1-Covered	
cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)	1-Covered	
desloratadine 5 mg tab	1-Covered	QL (30 PER 30 DAYS)
diphenhydramine hcl 50 mg/ml solution	1-Covered	
hydroxyzine hcl (10 mg tab, 10 mg/5ml syrup, 25 mg tab, 50 mg tab)	1-Covered	
levocetirizine dihydrochloride 2.5 mg/5ml solution	1-Covered	
levocetirizine dihydrochloride 5 mg tab	1-Covered	QL (30 PER 30 DAYS)
olopatadine hcl 0.6 % solution	1-Covered	QL (30.5 PER 30 DAYS)
promethazine hcl (6.25 mg/5ml solution, 12.5 mg/10ml solution)	1-Covered	PA
ANTILEUKOTRIENES		
montelukast sodium	1-Covered	QL (30 PER 30 DAYS)
zafirlukast	1-Covered	QL (60 PER 30 DAYS)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	1-Covered	QL (25.8 PER 30 DAYS)
INCRUSE ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
ipratropium bromide 0.02 % solution	1-Covered	PA3
ipratropium bromide 0.03 % solution	1-Covered	QL (30 PER 28 DAYS)
ipratropium bromide 0.06 % solution	1-Covered	QL (45 PER 30 DAYS)
YUPELRI	1-Covered	PA3, NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BRONCHODILATORS, SYMPATHOMIMETIC		
albuterol sulfate (0.63 mg/3ml nebu soln, 1.25 mg/3ml nebu soln, (2.5 mg/3ml) 0.083% nebu soln, 2.5 mg/0.5ml nebu soln, (5 mg/ml) 0.5% nebu soln)	1-Covered	PA3
albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab, 8 mg/20ml syrup)	1-Covered	
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)	1-Covered	QL (17 PER 30 DAYS)
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)	1-Covered	QL (13.4 PER 30 DAYS)
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)	1-Covered	QL (36 PER 30 DAYS)
arformoterol tartrate	1-Covered	PA3
epinephrine (0.15 mg/0.15ml soln a-inj, 0.15 mg/0.3ml soln a-inj, 0.3 mg/0.3ml soln a-inj)	1-Covered	QL (4 PER 30 DAYS)
formoterol fumarate	1-Covered	PA3
levalbuterol hcl (0.31 mg/3ml nebu soln, 0.63 mg/3ml nebu soln, 1.25 mg/0.5ml nebu soln, 1.25 mg/3ml nebu soln)	1-Covered	PA3
levalbuterol tartrate	1-Covered	QL (30 PER 30 DAYS)
SEREVENT DISKUS	1-Covered	QL (60 PER 30 DAYS)
terbutaline sulfate (2.5 mg tab, 5 mg tab)	1-Covered	
CYSTIC FIBROSIS AGENTS		
BRONCHITOL	1-Covered	PA, QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
CAYSTON	1-Covered	PA, NDS (Non-Extended Day Supply)
KALYDECO	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
ORKAMBI (75-94 MG PACKET, 100-125 MG PACKET, 150-188 MG PACKET)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ORKAMBI 100-125 MG TAB	1-Covered	PA, QL (112 PER 28 DAYS), NDS (Non-Extended Day Supply)
ORKAMBI 200-125 MG TAB	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
PULMOZYME	1-Covered	PA3, NDS (Non-Extended Day Supply)
tobramycin 300 mg/5ml nebu soln	1-Covered	PA3, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)
TRIKAFTA (50-25-37.5 & 75 MG TAB THPK, 100-50-75 & 150 MG TAB THPK)	1-Covered	PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
TRIKAFTA (80-40-60 & 59.5 MG THER PACK, 100-50-75 & 75 MG THER PACK)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
MAST CELL STABILIZERS		
cromolyn sodium 20 mg/2ml nebu soln	1-Covered	PA3
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
elixophyllin	1-Covered	
roflumilast	1-Covered	QL (30 PER 30 DAYS)
theophylline	1-Covered	
theophylline er (300 mg tab er 12h, 400 mg tab er 24h, 450 mg tab er 12h, 600 mg tab er 24h)	1-Covered	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
alyq	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ambrisentan	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
bosentan	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
OPSUMIT	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
sildenafil citrate 20 mg tab	1-Covered	PA, QL (90 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tadalafil (pah)	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
UPTRAVI (400 MCG TAB, 600 MCG TAB, 800 MCG TAB, 1000 MCG TAB, 1200 MCG TAB, 1400 MCG TAB, 1600 MCG TAB)	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
UPTRAVI 200 & 800 MCG TAB THPK	1-Covered	PA, QL (200 PER 30 DAYS), NDS (Non-Extended Day Supply)
UPTRAVI 200 MCG TAB	1-Covered	PA, QL (150 PER 30 DAYS), NDS (Non-Extended Day Supply)
PULMONARY FIBROSIS AGENTS		
OFEV	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
pirfenidone (267 mg cap, 267 mg tab)	1-Covered	PA, QL (270 PER 30 DAYS), NDS (Non-Extended Day Supply)
pirfenidone (534 mg tab, 801 mg tab)	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine (10 % solution, 20 % solution)	1-Covered	PA3
ADVAIR HFA	1-Covered	QL (12 PER 30 DAYS)
ANORO ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
BEVESPI AEROSPHERE	1-Covered	QL (10.7 PER 30 DAYS)
BREO ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
breyna	1-Covered	QL (10.3 PER 30 DAYS)
BREZTRI AEROSPHERE	1-Covered	QL (10.7 PER 30 DAYS)
budesonide-formoterol fumarate	1-Covered	QL (10.2 PER 30 DAYS)
COMBIVENT RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
FASENRA	1-Covered	PA, NDS (Non-Extended Day Supply)
FASENRA PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
fluticasone-salmeterol (100-50 mcg/act aer pow ba, 250-50 mcg/act aer pow ba, 500-50 mcg/act aer pow ba)	1-Covered	QL (60 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ipratropium-albuterol	1-Covered	PA3
TRELEGY ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
wixela inhub	1-Covered	QL (60 PER 30 DAYS)
SKELETAL MUSCLE RELAXANTS		
BOTOX	1-Covered	PA
cyclobenzaprine hcl 10 mg tab	1-Covered	PA, QL (90 PER 30 DAYS)
cyclobenzaprine hcl 5 mg tab	1-Covered	PA, QL (180 PER 30 DAYS)
methocarbamol (500 mg tab, 750 mg tab)	1-Covered	
XEOMIN	1-Covered	PA
SLEEP DISORDER AGENTS		
SLEEP PROMOTING AGENTS		
doxepin hcl (3 mg tab, 6 mg tab)	1-Covered	QL (30 PER 30 DAYS)
eszopiclone	1-Covered	PA, QL (30 PER 30 DAYS)
HETLIOZ LQ	1-Covered	PA, QL (158 PER 30 DAYS), NDS (Non-Extended Day Supply)
ramelteon	1-Covered	QL (30 PER 30 DAYS)
tasimelteon	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
temazepam (15 mg cap, 30 mg cap)	1-Covered	QL (30 PER 30 DAYS)
zaleplon 10 mg cap	1-Covered	PA, QL (60 PER 30 DAYS)
zaleplon 5 mg cap	1-Covered	PA, QL (30 PER 30 DAYS)
zolpidem tartrate 10 mg tab	1-Covered	PA, QL (30 PER 30 DAYS)
zolpidem tartrate 5 mg tab	1-Covered	QL (30 PER 30 DAYS)
WAKEFULNESS PROMOTING AGENTS		
armodafinil	1-Covered	PA, QL (30 PER 30 DAYS)
modafinil 100 mg tab	1-Covered	PA, QL (30 PER 30 DAYS)
modafinil 200 mg tab	1-Covered	PA, QL (60 PER 30 DAYS)
SODIUM OXYBATE	1-Covered	PA, QL (540 PER 30 DAYS), NDS (Non-Extended Day Supply)

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Este formulario se actualizó el 01/08/2025. Para obtener información más reciente o si tienes otras preguntas, comunícate con Jefferson Health Plans al 1-866-901-8000 (TTY 1-877-454-8477) o visita www.JeffersonHealthPlans.com/Medicare. Del 1.º de octubre al 31 de marzo, estamos disponibles de 8:00 a.m. a 8:00 p.m., los 7 días de la semana. Y del 1.º de abril al 30 de septiembre, estamos disponibles de 8:00 a.m. a 8:00 p.m., de lunes a viernes.

Jefferson Health Plans contrata a Medicare para ofrecer planes HMO, HMO-DSNP y PPO. Nuestro HMO-DSNP también tiene un contrato con el programa Medicaid del estado de Pennsylvania. La inscripción en nuestros planes depende de la renovación del contrato.

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01/08/2025

Jefferson Health Plans
1101 Market Street, Suite 3000
Philadelphia, PA 19107

1-866-901-8000 (TTY 1-877-454-8477)

www.JeffersonHealthPlans.com/Medicare

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Health Plans