



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

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

Jefferson Health Plans

2025 Premium Formulary

(List of Covered Drugs or “Drug List”)

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

Formulary ID 25397, Version 15

This formulary was updated on 6/1/2025. For more recent information or other questions, please contact Jefferson Health Plans Member Relations at 1-866-901-8000 (TTY users should call 1-877-454-8477) or visit JeffersonHealthPlans.com/medicare. From October 1 to March 31, we’re available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we’re available 8 a.m. to 8 p.m., Monday to Friday.

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

When this Drug List (Formulary) refers to “we,” “us”, or “our,” it means Jefferson Health Plans. When it refers to “plan” or “our plan,” it means Jefferson Health Plans Special (SNP HMO) and Dual Pearl (SNP HMO).

This document includes list of the drugs (formulary) for our plan which is current as of 06/01/2025. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025, and from time to time during the year.

What is the Jefferson Health Plans Premium Formulary?

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

For a complete listing of all prescription drugs covered by Jefferson Health Plans, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Can the Formulary change?

Most changes in drug coverage happen on January 1, but Jefferson Health Plans may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website at JeffersonHealthPlans.com/medicare.

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

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

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

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

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Jefferson Health Plans’ Premium Formulary?”

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

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product. We may make changes based on new clinical guidelines. If we remove drugs from our formulary or add prior authorization, quantity limits and/or step therapy restrictions on a drug, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Jefferson Health Plans’ Premium Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 6/1/2025. To get updated information about the drugs covered by Jefferson Health Plans please contact us. Our contact information appears on the front and back cover pages.

Our print formulary will be updated by reprinting in the event of mid-year non-maintenance formulary changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, Cardiovascular Agents. If you know what your drug is used for, look for the category name in the list that begins on A-7. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 103. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

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

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

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Jefferson Health Plans requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Jefferson Health Plans before you fill your prescriptions. If you don’t get approval, Jefferson Health Plans may not cover the drug.
- **Quantity Limits:** For certain drugs, Jefferson Health Plans limits the amount of the drug that Jefferson Health Plans will cover. For example, Jefferson Health Plans provides 60 tablets per prescription for atorvastatin 10 mg. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Jefferson Health Plans requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Jefferson Health Plans may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Jefferson Health Plans will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Jefferson Health Plans to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Jefferson Health Plans’ Premium formulary?” below for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Relations at 1-866-901-8000 (TTY 1-877-454-8477) and ask if your drug is covered.

If you learn that Jefferson Health Plans does not cover your drug, you have two options:

- You can ask Member Relations for a list of similar drugs that are covered by Jefferson Health Plans. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Jefferson Health Plans.
- You can ask Jefferson Health Plans to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Jefferson Health Plans' Premium Formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Jefferson Health Plans limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Jefferson Health Plans will only approve your request for an exception if the alternative drugs included on the plan's formulary or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You or your prescriber should contact us to ask for a formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum

30-day supply of medication. If coverage is not approved, after your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you are a current member and have a change in treatment setting due to a change in the level of care you require, you can ask us to make a formulary exception. Examples of level of care changes might include:

- Discharge from a hospital to home
- Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and you now need to use your Part D plan
- Changing from hospice status and reverting back to standard Medicare Part A and B coverage
- Ending a long-term care stay and returning to the community
- Discharges from chronic psychiatric hospitals with highly individualized drug regimens

For these unplanned transitions, you can ask us to make a formulary exception or appeal for continued coverage of your drug. In addition, we will review requests for continuation of therapy on a case-by-case basis for members that have had a change in their level of care and are stabilized on drug regimens that if altered are known to have risks.

For more information

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

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

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit <http://www.medicare.gov>.

Jefferson Health Plans Premium Formulary

The formulary that begins on the page 2 provides coverage information about the drugs covered by Jefferson Health Plans. If you have trouble finding your drug in the list, turn to the Index that begins on page 103.

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

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

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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		
<i>butalbital-aspirin-caffeine</i>	1-Covered	PA, QL (180 PER 30 DAYS)
<i>celecoxib (50 mg cap, 100 mg cap, 200 mg cap)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>celecoxib 400 mg cap</i>	1-Covered	QL (30 PER 30 DAYS)
<i>diclofenac potassium 50 mg tab</i>	1-Covered	QL (120 PER 30 DAYS)
<i>diclofenac sodium (25 mg tab dr, 50 mg tab dr, 75 mg tab dr)</i>	1-Covered	
<i>diclofenac sodium 1.5 % solution</i>	1-Covered	QL (300 PER 28 DAYS)
<i>diclofenac sodium er</i>	1-Covered	QL (60 PER 30 DAYS)
<i>diclofenac-misoprostol</i>	1-Covered	
<i>diflunisal</i>	1-Covered	QL (90 PER 30 DAYS)
<i>etodolac (200 mg cap, 300 mg cap)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>etodolac (400 mg tab, 500 mg tab)</i>	1-Covered	
<i>etodolac er</i>	1-Covered	
<i>flurbiprofen</i>	1-Covered	
<i>ibu</i>	1-Covered	
<i>ibuprofen (100 mg/5ml suspension, 200 mg/10ml suspension, 400 mg tab, 600 mg tab, 800 mg tab)</i>	1-Covered	
<i>lurbipr</i>	1-Covered	
<i>meloxicam (7.5 mg tab, 15 mg tab)</i>	1-Covered	
<i>nabumetone</i>	1-Covered	
<i>naproxen (250 mg tab, 375 mg tab, 375 mg tab dr, 500 mg tab, 500 mg tab dr)</i>	1-Covered	
<i>naproxen dr</i>	1-Covered	
<i>naproxen sodium</i>	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
<i>oxaprozin</i>	1-Covered	
<i>piroxicam 10 mg cap</i>	1-Covered	QL (60 PER 30 DAYS)
<i>piroxicam 20 mg cap</i>	1-Covered	QL (30 PER 30 DAYS)
<i>relafen</i>	1-Covered	
<i>sulindac</i>	1-Covered	QL (60 PER 30 DAYS)

OPIOID ANALGESICS, LONG-ACTING

<i>buprenorphine</i>	1-Covered	QL (4 PER 28 DAYS)
<i>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)</i>	1-Covered	QL (10 PER 30 DAYS)
<i>methadone hcl 10 mg tab</i>	1-Covered	QL (240 PER 30 DAYS)
<i>methadone hcl 10 mg/5ml solution</i>	1-Covered	QL (1800 PER 30 DAYS)
<i>methadone hcl 5 mg tab</i>	1-Covered	QL (480 PER 30 DAYS)
<i>methadone hcl 5 mg/5ml solution</i>	1-Covered	QL (3600 PER 30 DAYS)
<i>morphine sulfate er (15 mg tab er, 30 mg tab er, 60 mg tab er, 100 mg tab er, 200 mg tab er)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>tramadol hcl (er biphasic)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>tramadol hcl er (100 mg tab er 24h, 200 mg tab er 24h, 300 mg tab er 24h)</i>	1-Covered	QL (30 PER 30 DAYS)
XTAMPZA ER	1-Covered	QL (60 PER 30 DAYS)

OPIOID ANALGESICS, SHORT-ACTING

<i>acetaminophen-codeine (120-12 mg/5ml solution, 300-30 mg/12.5ml solution)</i>	1-Covered	QL (2700 PER 30 DAYS)
<i>acetaminophen-codeine 300-15 mg tab</i>	1-Covered	QL (390 PER 30 DAYS)
<i>acetaminophen-codeine 300-30 mg tab</i>	1-Covered	QL (360 PER 30 DAYS)
<i>acetaminophen-codeine 300-60 mg tab</i>	1-Covered	QL (180 PER 30 DAYS)
<i>butorphanol tartrate 10 mg/ml solution</i>	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
<i>endocet (2.5-325 mg tab, 5-325 mg tab)</i>	1-Covered	QL (360 PER 30 DAYS)
<i>endocet 10-325 mg tab</i>	1-Covered	QL (180 PER 30 DAYS)
<i>endocet 7.5-325 mg tab</i>	1-Covered	QL (240 PER 30 DAYS)
<i>hydrocodone-acetaminophen (2.5-108 mg/5ml solution, 5-217 mg/10ml solution, 7.5-325 mg/15ml solution)</i>	1-Covered	QL (2700 PER 30 DAYS)
<i>hydrocodone-acetaminophen 10-325 mg tab</i>	1-Covered	QL (180 PER 30 DAYS)
<i>hydrocodone-acetaminophen 5-325 mg tab</i>	1-Covered	QL (360 PER 30 DAYS)
<i>hydrocodone-acetaminophen 7.5-325 mg tab</i>	1-Covered	QL (240 PER 30 DAYS)
<i>hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)</i>	1-Covered	QL (180 PER 30 DAYS)
<i>hydromorphone hcl 1 mg/ml liquid</i>	1-Covered	QL (1500 PER 30 DAYS)
MORPHINE SULFATE (10 MG/5ML SOLUTION, 20 MG/5ML SOLUTION)	1-Covered	QL (900 PER 30 DAYS)
<i>morphine sulfate (15 mg tab, 30 mg tab)</i>	1-Covered	QL (180 PER 30 DAYS)
<i>morphine sulfate (concentrate)</i>	1-Covered	QL (180 PER 30 DAYS)
<i>oxycodone hcl (5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab, 100 mg/5ml conc)</i>	1-Covered	QL (180 PER 30 DAYS)
<i>oxycodone hcl 5 mg/5ml solution</i>	1-Covered	QL (900 PER 30 DAYS)
<i>oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab)</i>	1-Covered	QL (360 PER 30 DAYS)
<i>oxycodone-acetaminophen 10-325 mg tab</i>	1-Covered	QL (180 PER 30 DAYS)
<i>oxycodone-acetaminophen 7.5-325 mg tab</i>	1-Covered	QL (240 PER 30 DAYS)
<i>tramadol hcl 50 mg tab</i>	1-Covered	QL (240 PER 30 DAYS)
<i>tramadol-acetaminophen</i>	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		
<i>lidocaine 5 % ointment</i>	1-Covered	QL (50 PER 30 DAYS)
<i>lidocaine 5 % patch</i>	1-Covered	PA, QL (90 PER 30 DAYS)
<i>lidocaine viscous hcl</i>	1-Covered	
<i>lidocaine-prilocaine</i>	1-Covered	QL (30 PER 30 DAYS)
<i>lidocan</i>	1-Covered	PA, QL (90 PER 30 DAYS)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
<i>acamprosate calcium</i>	1-Covered	
<i>disulfiram</i>	1-Covered	
<i>naltrexone hcl</i>	1-Covered	
VIVITROL	1-Covered	NDS (Non-Extended Day Supply)
OPIOID DEPENDENCE		
<i>buprenorphine hcl 2 mg sl tab</i>	1-Covered	QL (90 PER 30 DAYS)
<i>buprenorphine hcl 8 mg sl tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl (2-0.5 mg film, 4-1 mg film, 8-2 mg film, 8-2 mg sl tab)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl 12-3 mg film</i>	1-Covered	QL (60 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab</i>	1-Covered	QL (120 PER 30 DAYS)
<i>lofexidine hcl</i>	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		
<i>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)</i>	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
OPVEE	1-Covered	
SMOKING CESSATION AGENTS		
<i>bupropion hcl er (smoking det)</i>	1-Covered	QL (60 PER 30 DAYS)
NICOTROL	1-Covered	
NICOTROL NS	1-Covered	
<i>varenicline tartrate</i>	1-Covered	
<i>varenicline tartrate (starter)</i>	1-Covered	
<i>varenicline tartrate(continue)</i>	1-Covered	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
<i>amikacin sulfate</i>	1-Covered	
ARIKAYCE	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>gentamicin in saline</i>	1-Covered	
<i>gentamicin sulfate (0.1 % cream, 0.1 % ointment)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>gentamicin sulfate (10 mg/ml solution, 40 mg/ml solution)</i>	1-Covered	
<i>neomycin sulfate</i>	1-Covered	
<i>streptomycin sulfate</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>tobramycin sulfate (10 mg/ml solution, 80 mg/2ml solution)</i>	1-Covered	
ANTIBACTERIALS, OTHER		
<i>aztreonam</i>	1-Covered	
<i>clindamycin hcl</i>	1-Covered	
<i>clindamycin palmitate hcl</i>	1-Covered	
<i>clindamycin phosphate (2 % cream, 300 mg/2ml solution, 900 mg/6ml solution)</i>	1-Covered	
<i>clindamycin phosphate in d5w</i>	1-Covered	
<i>colistimethate sodium (cba)</i>	1-Covered	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
<i>daptomycin 350 mg recon soln</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>daptomycin 500 mg recon soln</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>linezolid 100 mg/5ml recon susp</i>	1-Covered	QL (1800 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>linezolid 600 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>linezolid 600 mg/300ml solution</i>	1-Covered	
<i>methenamine hippurate</i>	1-Covered	
<i>metronidazole (0.75 % gel, 250 mg tab, 500 mg tab, 500 mg/100ml solution)</i>	1-Covered	
<i>nitrofurantoin macrocrystal (50 mg cap, 100 mg cap)</i>	1-Covered	
<i>nitrofurantoin monohyd macro</i>	1-Covered	
<i>polymyxin b sulfate</i>	1-Covered	
SIVEXTRO	1-Covered	PA, NDS (Non-Extended Day Supply)
TIGECYCLINE	1-Covered	NDS (Non-Extended Day Supply)
<i>tinidazole</i>	1-Covered	
<i>trimethoprim</i>	1-Covered	
<i>vancomycin hcl (1 gm recon soln, 5 gm recon soln, 10 gm recon soln, 500 mg recon soln, 750 mg recon soln)</i>	1-Covered	
<i>vancomycin hcl 125 mg cap</i>	1-Covered	QL (120 PER 30 DAYS)
<i>vancomycin hcl 250 mg cap</i>	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

<i>cefaclor (250 mg cap, 500 mg cap)</i>	1-Covered	
<i>cefadroxil (250 mg/5ml recon susp, 500 mg cap, 500 mg/5ml recon susp)</i>	1-Covered	
<i>cefazolin sodium (1 gm recon soln, 10 gm recon soln, 100 gm recon soln, 300 gm recon soln, 500 mg recon soln)</i>	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
<i>cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)</i>	1-Covered	
<i>cefepime hcl (1 gm recon soln, 2 gm recon soln)</i>	1-Covered	
<i>cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)</i>	1-Covered	
<i>cefotetan disodium</i>	1-Covered	
<i>cefoxitin sodium</i>	1-Covered	
<i>cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg tab, 100 mg/5ml recon susp, 200 mg tab)</i>	1-Covered	
<i>cefprozil (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)</i>	1-Covered	
<i>ceftazidime</i>	1-Covered	
<i>ceftriaxone sodium (1 gm recon soln, 2 gm recon soln, 10 gm recon soln, 250 mg recon soln, 500 mg recon soln)</i>	1-Covered	
<i>cefuroxime axetil</i>	1-Covered	
<i>cefuroxime sodium</i>	1-Covered	
<i>cephalexin (125 mg/5ml recon susp, 250 mg cap, 250 mg/5ml recon susp, 500 mg cap)</i>	1-Covered	
<i>tazicef</i>	1-Covered	
TEFLARO	1-Covered	NDS (Non-Extended Day Supply)

BETA-LACTAM, PENICILLINS

<i>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)</i>	1-Covered	
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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
<i>amoxicillin-pot clavulanate (200-28.5 mg/5ml recon susp, 250-125 mg tab, 250-62.5 mg/5ml recon susp, 400-57 mg chew tab, 400-57 mg/5ml recon susp, 500-125 mg tab, 600-42.9 mg/5ml recon susp, 875-125 mg tab)</i>	1-Covered	
<i>amoxicillin-pot clavulanate er</i>	1-Covered	
<i>ampicillin</i>	1-Covered	
<i>ampicillin sodium</i>	1-Covered	
<i>ampicillin-sulbactam sodium</i>	1-Covered	
BICILLIN L-A	1-Covered	
<i>dicloxacillin sodium</i>	1-Covered	
<i>nafcillin sodium (1 gm recon soln, 2 gm recon soln)</i>	1-Covered	
<i>nafcillin sodium 10 gm recon soln</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>oxacillin sodium</i>	1-Covered	
PENICILLIN G POT IN DEXTROSE	1-Covered	
<i>penicillin g potassium</i>	1-Covered	
<i>penicillin g sodium</i>	1-Covered	
<i>penicillin v potassium (125 mg/5ml recon soln, 250 mg tab, 250 mg/5ml recon soln, 500 mg tab)</i>	1-Covered	
<i>pfizerpen</i>	1-Covered	
<i>piperacillin sod-tazobactam so</i>	1-Covered	
CARBAPENEMS		
<i>ertapenem sodium</i>	1-Covered	
<i>imipenem-cilastatin</i>	1-Covered	
<i>meropenem</i>	1-Covered	
MACROLIDES		
<i>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)</i>	1-Covered	
<i>clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)</i>	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
<i>clarithromycin er</i>	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)
<i>ery-tab</i>	1-Covered	
<i>erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)</i>	1-Covered	
<i>erythromycin base</i>	1-Covered	
<i>erythromycin ethylsuccinate (200 mg/5ml recon susp, 400 mg tab)</i>	1-Covered	

QUINOLONES

<i>ciprofloxacin hcl (0.3 % solution, 250 mg tab, 500 mg tab, 750 mg tab)</i>	1-Covered
<i>ciprofloxacin in d5w 200 mg/100ml solution</i>	1-Covered
<i>ciprofloxacin in d5w 400 mg/200ml solution</i>	1-Covered
<i>levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)</i>	1-Covered
<i>levofloxacin in d5w</i>	1-Covered
<i>levofloxacin oral soln 25 mg/ml</i>	1-Covered
<i>moxifloxacin hcl 400 mg tab</i>	1-Covered
<i>moxifloxacin hcl in nacl</i>	1-Covered
<i>ofloxacin (300 mg tab, 400 mg tab)</i>	1-Covered

SULFONAMIDES

<i>sulfadiazine</i>	1-Covered
<i>sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab, 800-160 mg/20ml suspension)</i>	1-Covered

TETRACYCLINES

<i>demeclocycline hcl</i>	1-Covered
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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
<i>doxy 100</i>	1-Covered	
<i>doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg cap, 100 mg recon soln, 100 mg tab)</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)</i>	1-Covered	
<i>monodoxine nl</i>	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)
<i>tetracycline hcl (250 mg cap, 500 mg cap)</i>	1-Covered	

ANTICONSULSANTS

ANTICONSULSANTS, 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)
<i>divalproex sodium</i>	1-Covered	
<i>divalproex sodium er</i>	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)
<i>felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)</i>	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
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)
<i>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)</i>	1-Covered	
<i>lamotrigine er</i>	1-Covered	
<i>levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)</i>	1-Covered	
<i>levetiracetam er</i>	1-Covered	
LEVETIRACETAM IN NACL	1-Covered	
<i>roweepra</i>	1-Covered	
SPRITAM	1-Covered	ST
<i>topiramate</i>	1-Covered	
<i>valproate sodium</i>	1-Covered	
<i>valproic acid (250 mg cap, 250 mg/5ml solution, 500 mg/10ml solution)</i>	1-Covered	

CALCIUM CHANNEL MODIFYING AGENTS

<i>ethosuximide (250 mg cap, 250 mg/5ml solution)</i>	1-Covered
<i>methsuximide</i>	1-Covered

GAMMA-AMINOBUTYRIC ACID (GABA) MODULATING AGENTS

<i>clobazam (10 mg tab, 20 mg tab)</i>	1-Covered	PA2, QL (60 PER 30 DAYS)
<i>clobazam 2.5 mg/ml suspension</i>	1-Covered	PA2, QL (480 PER 30 DAYS)
<i>diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)</i>	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>gabapentin (100 mg cap, 600 mg tab)</i>	1-Covered	QL (180 PER 30 DAYS)
<i>gabapentin (250 mg/5ml solution, 300 mg/6ml solution)</i>	1-Covered	QL (2160 PER 30 DAYS)
<i>gabapentin 300 mg cap</i>	1-Covered	QL (360 PER 30 DAYS)
<i>gabapentin 400 mg cap</i>	1-Covered	QL (270 PER 30 DAYS)
<i>gabapentin 800 mg tab</i>	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)
<i>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)</i>	1-Covered	
<i>primidone</i>	1-Covered	
SYMPAZAN	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>tiagabine hcl</i>	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)
<i>vigabatrin</i>	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>vigadrone</i>	1-Covered	PA2, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIGAFYDE	1-Covered	QL (900 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>vigpoder</i>	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)

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
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	
<i>carbamazepine er</i>	1-Covered	
DILANTIN	1-Covered	
DILANTIN INFATABS	1-Covered	
<i>epitol</i>	1-Covered	
<i>lacosamide (10 mg/ml solution, 50 mg/5ml solution, 100 mg/10ml solution)</i>	1-Covered	QL (1200 PER 30 DAYS)
<i>lacosamide (100 mg tab, 150 mg tab, 200 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>lacosamide 200 mg/20ml solution</i>	1-Covered	
<i>lacosamide 50 mg tab</i>	1-Covered	QL (120 PER 30 DAYS)
<i>oxcarbazepine (150 mg tab, 300 mg tab, 300 mg/5ml suspension, 600 mg tab)</i>	1-Covered	
<i>phenytek</i>	1-Covered	
<i>phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)</i>	1-Covered	
<i>phenytoin infatabs</i>	1-Covered	
<i>phenytoin sodium</i>	1-Covered	
<i>phenytoin sodium extended</i>	1-Covered	
<i>rufinamide 200 mg tab</i>	1-Covered	PA2, QL (480 PER 30 DAYS)
<i>rufinamide 40 mg/ml suspension</i>	1-Covered	PA2, QL (2760 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>rufinamide 400 mg tab</i>	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)

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
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)
<i>zonisamide</i>	1-Covered	

ANTIDEMENTIA AGENTS

ANTIDEMENTIA AGENTS, OTHER

NAMZARIC	1-Covered
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CHOLINESTERASE INHIBITORS

<i>donepezil hcl (5 mg tab disp, 10 mg tab disp)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>donepezil hcl (5 mg tab, 10 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>galantamine hydrobromide (4 mg tab, 8 mg tab, 12 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>galantamine hydrobromide 4 mg/ml solution</i>	1-Covered	QL (360 PER 30 DAYS)
<i>galantamine hydrobromide er</i>	1-Covered	QL (30 PER 30 DAYS)
<i>rivastigmine</i>	1-Covered	QL (30 PER 30 DAYS)
<i>rivastigmine tartrate</i>	1-Covered	QL (60 PER 30 DAYS)

N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST

<i>memantine hcl (2 mg/ml solution, 10 mg/5ml solution)</i>	1-Covered	QL (360 PER 30 DAYS)
<i>memantine hcl (5 mg tab, 10 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>memantine hcl 28 x 5 mg & 21 x 10 mg tab</i>	1-Covered	QL (98 PER 365 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
<i>memantine hcl er</i>	1-Covered	QL (30 PER 30 DAYS)
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
AUVELITY	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>bupropion hcl</i>	1-Covered	QL (120 PER 30 DAYS)
<i>bupropion hcl er (sr)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>bupropion hcl er (xl) 150 mg tab er 24h</i>	1-Covered	QL (90 PER 30 DAYS)
<i>bupropion hcl er (xl) 300 mg tab er 24h</i>	1-Covered	QL (30 PER 30 DAYS)
<i>mirtazapine (15 mg tab, 15 mg tab disp)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>mirtazapine (30 mg tab, 30 mg tab disp)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>mirtazapine (7.5 mg tab, 45 mg tab, 45 mg tab disp)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>perphenazine-amitriptyline</i>	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)
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)
<i>phenelzine sulfate</i>	1-Covered	
<i>tranylcypromine sulfate</i>	1-Covered	
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)		
<i>citalopram hydrobromide (10 mg/5ml solution, 20 mg/10ml solution)</i>	1-Covered	QL (600 PER 30 DAYS)
<i>citalopram hydrobromide (20 mg tab, 40 mg tab)</i>	1-Covered	QL (45 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
<i>citalopram hydrobromide 10 mg tab</i>	1-Covered	QL (90 PER 30 DAYS)
<i>desvenlafaxine succinate er</i>	1-Covered	QL (30 PER 30 DAYS)
<i>escitalopram oxalate (5 mg/5ml solution, 10 mg/10ml solution)</i>	1-Covered	QL (600 PER 30 DAYS)
<i>escitalopram oxalate 10 mg tab</i>	1-Covered	QL (45 PER 30 DAYS)
<i>escitalopram oxalate 20 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>escitalopram oxalate 5 mg tab</i>	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)
<i>fluoxetine hcl (10 mg cap, 10 mg tab)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>fluoxetine hcl (20 mg cap, 20 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>fluoxetine hcl 20 mg/5ml solution</i>	1-Covered	
<i>fluoxetine hcl 40 mg cap</i>	1-Covered	QL (60 PER 30 DAYS)
<i>fluoxetine hcl 90 mg cap dr</i>	1-Covered	QL (4 PER 28 DAYS)
<i>fluvoxamine maleate</i>	1-Covered	QL (90 PER 30 DAYS)
<i>fluvoxamine maleate er</i>	1-Covered	QL (60 PER 30 DAYS)
<i>nefazodone hcl</i>	1-Covered	
<i>paroxetine hcl (10 mg tab, 20 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>paroxetine hcl (30 mg tab, 40 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>paroxetine hcl 10 mg/5ml suspension</i>	1-Covered	QL (900 PER 30 DAYS)
<i>paroxetine hcl er 12.5 mg tab er 24h</i>	1-Covered	QL (90 PER 30 DAYS)
<i>paroxetine hcl er 25 mg tab er 24h</i>	1-Covered	QL (30 PER 30 DAYS)
<i>paroxetine hcl er 37.5 mg tab er 24h</i>	1-Covered	QL (60 PER 30 DAYS)
RALDESY	1-Covered	PA2, QL (1200 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>sertraline hcl (25 mg tab, 50 mg tab)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>sertraline hcl 100 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>sertraline hcl 20 mg/ml conc</i>	1-Covered	QL (300 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
<i>trazodone hcl</i>	1-Covered	
TRINTELLIX	1-Covered	QL (30 PER 30 DAYS)
<i>venlafaxine hcl</i>	1-Covered	
<i>venlafaxine hcl er (37.5 mg cap er 24h, 75 mg cap er 24h)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>venlafaxine hcl er 150 mg cap er 24h</i>	1-Covered	QL (60 PER 30 DAYS)
<i>vilazodone hcl</i>	1-Covered	QL (30 PER 30 DAYS)

TRICYCLICS

<i>amitriptyline hcl</i>	1-Covered
<i>amoxapine</i>	1-Covered
<i>clomipramine hcl</i>	1-Covered
<i>desipramine hcl</i>	1-Covered
<i>doxepin hcl (10 mg cap, 10 mg/ml conc, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)</i>	1-Covered
<i>imipramine hcl</i>	1-Covered
<i>nortriptyline hcl (10 mg cap, 10 mg/5ml solution, 25 mg cap, 50 mg cap, 75 mg cap)</i>	1-Covered
<i>protriptyline hcl</i>	1-Covered
<i>trimipramine maleate</i>	1-Covered

ANTIEMETICS

ANTIEMETICS, OTHER

<i>compro</i>	1-Covered
<i>meclizine hcl (12.5 mg tab, 25 mg tab)</i>	1-Covered
<i>metoclopramide hcl (5 mg tab, 5 mg/5ml solution, 10 mg tab, 10 mg/10ml solution)</i>	1-Covered
<i>perphenazine</i>	1-Covered
<i>prochlorperazine</i>	1-Covered
<i>prochlorperazine edisylate</i>	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
<i>prochlorperazine maleate</i>	1-Covered	
<i>promethazine hcl (12.5 mg tab, 25 mg tab, 50 mg tab)</i>	1-Covered	PA
<i>scopolamine</i>	1-Covered	PA, QL (10 PER 30 DAYS)

EMETOGENIC THERAPY ADJUNCTS

<i>aprepitant</i>	1-Covered	PA3
<i>dronabinol</i>	1-Covered	PA, QL (60 PER 30 DAYS)
<i>granisetron hcl 1 mg tab</i>	1-Covered	PA3, QL (60 PER 30 DAYS)
<i>ondansetron 4 mg tab disp</i>	1-Covered	PA3, QL (180 PER 30 DAYS)
<i>ondansetron 8 mg tab disp</i>	1-Covered	PA3, QL (90 PER 30 DAYS)
<i>ondansetron hcl (4 mg/2ml soln prsyr, 4 mg/2ml solution, 40 mg/20ml solution)</i>	1-Covered	
<i>ondansetron hcl +rfid</i>	1-Covered	
<i>ondansetron hcl 4 mg tab</i>	1-Covered	PA3, QL (180 PER 30 DAYS)
<i>ondansetron hcl 8 mg tab</i>	1-Covered	PA3, QL (90 PER 30 DAYS)
<i>ondansetron hcl oral soln 4 mg/5ml</i>	1-Covered	PA3, QL (900 PER 30 DAYS)
SANCUSO	1-Covered	ST, QL (4 PER 28 DAYS), NDS (Non-Extended Day Supply)

ANTIFUNGALS

ABELCET	1-Covered	PA3
<i>amphotericin b</i>	1-Covered	PA3
<i>amphotericin b liposome</i>	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>caspofungin acetate</i>	1-Covered	
<i>clotrimazole 1 % cream</i>	1-Covered	QL (90 PER 30 DAYS)
<i>clotrimazole 1 % solution</i>	1-Covered	QL (30 PER 30 DAYS)
<i>clotrimazole 10 mg troche</i>	1-Covered	
<i>econazole nitrate</i>	1-Covered	QL (85 PER 30 DAYS)
<i>fluconazole (10 mg/ml recon susp, 40 mg/ml recon susp, 50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	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
<i>fluconazole in sodium chloride (200-0.9 mg/100ml-% solution, 400-0.9 mg/200ml-% solution)</i>	1-Covered	
<i>flucytosine</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)</i>	1-Covered	
<i>griseofulvin ultramicrosize (125 mg tab, 250 mg tab)</i>	1-Covered	
<i>itraconazole 100 mg cap</i>	1-Covered	
<i>ketoconazole 2 % cream</i>	1-Covered	QL (60 PER 30 DAYS)
<i>ketoconazole 2 % shampoo</i>	1-Covered	QL (120 PER 30 DAYS)
<i>ketoconazole 200 mg tab</i>	1-Covered	
<i>klayesta</i>	1-Covered	QL (60 PER 30 DAYS)
<i>micafungin sodium</i>	1-Covered	
<i>miconazole 3</i>	1-Covered	
<i>naftifine hcl 1 % cream</i>	1-Covered	QL (90 PER 30 DAYS)
<i>naftifine hcl 2 % cream</i>	1-Covered	QL (60 PER 30 DAYS)
<i>nyamyc</i>	1-Covered	QL (60 PER 30 DAYS)
<i>nystatin (100000 unit/gm cream, 100000 unit/gm ointment, 100000 unit/gm powder)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>nystatin (100000 unit/ml suspension, 500000 unit tab)</i>	1-Covered	
<i>nystop</i>	1-Covered	QL (60 PER 30 DAYS)
<i>posaconazole 100 mg tab dr</i>	1-Covered	PA, QL (93 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>posaconazole 40 mg/ml suspension</i>	1-Covered	PA, QL (630 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>terbinafine hcl</i>	1-Covered	QL (120 PER 30 DAYS)
<i>terconazole (0.4 % cream, 0.8 % cream, 80 mg suppos)</i>	1-Covered	
<i>voriconazole 200 mg recon soln</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>voriconazole 200 mg tab</i>	1-Covered	QL (120 PER 30 DAYS)
<i>voriconazole 40 mg/ml recon susp</i>	1-Covered	QL (600 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
<i>voriconazole 50 mg tab</i>	1-Covered	QL (480 PER 30 DAYS)
ANTIGOUT AGENTS		
<i>allopurinol (100 mg tab, 300 mg tab)</i>	1-Covered	
<i>colchicine 0.6 mg tab</i>	1-Covered	QL (120 PER 30 DAYS)
<i>colchicine-probenecid</i>	1-Covered	
<i>febuxostat</i>	1-Covered	ST
MITIGARE	1-Covered	QL (60 PER 30 DAYS)
<i>probenecid</i>	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)
ERGOT ALKALOIDS		
<i>dihydroergotamine mesylate 4 mg/ml solution</i>	1-Covered	PA, QL (8 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>ergotamine-caffeine</i>	1-Covered	
SEROTONIN (5-HT) RECEPTOR AGONIST		
<i>naratriptan hcl</i>	1-Covered	QL (9 PER 30 DAYS)
<i>rizatriptan benzoate</i>	1-Covered	QL (12 PER 30 DAYS)
<i>sumatriptan</i>	1-Covered	QL (12 PER 28 DAYS)
<i>sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)</i>	1-Covered	QL (9 PER 30 DAYS)
<i>sumatriptan succinate (4 mg/0.5ml soln a-inj, 6 mg/0.5ml soln a-inj, 6 mg/0.5ml solution)</i>	1-Covered	QL (6 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
<i>sumatriptan succinate refill</i>	1-Covered	QL (6 PER 30 DAYS)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
<i>pyridostigmine bromide 60 mg tab</i>	1-Covered	
<i>pyridostigmine bromide er</i>	1-Covered	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
<i>dapsone (25 mg tab, 100 mg tab)</i>	1-Covered	
<i>rifabutin</i>	1-Covered	
ANTITUBERCULARS		
<i>ethambutol hcl</i>	1-Covered	
<i>isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)</i>	1-Covered	
PRIFTIN	1-Covered	
<i>pyrazinamide</i>	1-Covered	
<i>rifampin</i>	1-Covered	
SIRTURO	1-Covered	PA, NDS (Non-Extended Day Supply)
TRECTOR	1-Covered	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
<i>carboplatin</i>	1-Covered	PA3
<i>cisplatin</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LEUKERAN	1-Covered	NDS (Non-Extended Day Supply)
MATULANE	1-Covered	NDS (Non-Extended Day Supply)
<i>oxaliplatin (50 mg recon soln, 50 mg/10ml solution, 100 mg recon soln, 100 mg/20ml solution)</i>	1-Covered	PA3
<i>paraplatin</i>	1-Covered	PA3
VALCHLOR	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

ANTIANDROGENS

<i>abiraterone acetate 250 mg tab</i>	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>abiraterone acetate 500 mg tab</i>	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>abirtega</i>	1-Covered	PA2, QL (120 PER 30 DAYS)
<i>bicalutamide</i>	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)
<i>nilutamide</i>	1-Covered	NDS (Non-Extended Day Supply)
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

<i>lenalidomide</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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		
<i>fulvestrant</i>	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)
<i>tamoxifen citrate</i>	1-Covered	
<i>toremifene citrate</i>	1-Covered	NDS (Non-Extended Day Supply)
ANTIMETABOLITES		
<i>azacitidine</i>	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>fluorouracil (1 gm/20ml solution, 2.5 gm/50ml solution, 5 gm/100ml solution, 500 mg/10ml solution)</i>	1-Covered	PA3
<i>mercaptopurine 2000 mg/100ml suspension</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>mercaptopurine 50 mg tab</i>	1-Covered	
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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
<i>hydroxyurea</i>	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)
<i>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)</i>	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)
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

<i>anastrozole</i>	1-Covered
<i>exemestane</i>	1-Covered
<i>letrozole</i>	1-Covered

ENZYME INHIBITORS

<i>etoposide</i>	1-Covered
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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>irinotecan hcl</i>	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)
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)
<i>bortezomib 3.5 mg recon soln</i>	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)
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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
<i>dasatinib (50 mg tab, 70 mg tab, 80 mg tab, 100 mg tab)</i>	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>dasatinib 140 mg tab</i>	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>dasatinib 20 mg tab</i>	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)
ERIVEDGE	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>erlotinib hcl (100 mg tab, 150 mg tab)</i>	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>erlotinib hcl 25 mg tab</i>	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>everolimus (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab)</i>	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>everolimus (3 mg tab sol, 5 mg tab sol)</i>	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>everolimus 2 mg tab sol</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>gefitinib</i>	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 TAB SOL, 2 MG CAP)	1-Covered	PA2, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
GOMEKLI 1 MG CAP	1-Covered	PA2, QL (42 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)
<i>imatinib mesylate 100 mg tab</i>	1-Covered	PA2, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>imatinib mesylate 400 mg tab</i>	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
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)
<i>lapatinib ditosylate</i>	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)

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
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)
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)
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)

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
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)
<i>paclitaxel</i>	1-Covered	PA3
<i>paclitaxel protein-bound part</i>	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>pazopanib hcl</i>	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)
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 (80 MG TAB, 120 MG TAB, 160 MG TAB)	1-Covered	PA2, QL (60 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)
RETEVMO 80 MG CAP	1-Covered	PA2, QL (120 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 (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
REZLIDHIA	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
SCSEMBLIX 100 MG TAB	1-Covered	PA2, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
SCSEMBLIX 20 MG TAB	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
SCSEMBLIX 40 MG TAB	1-Covered	PA2, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>sorafenib tosylate</i>	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)
<i>sunitinib malate</i>	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)

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
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)
<i>torpenz</i>	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)
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)

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
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)
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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
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		
<i>bexarotene 1 % gel</i>	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>bexarotene 75 mg cap</i>	1-Covered	PA2, NDS (Non-Extended Day Supply)
PANRETIN	1-Covered	PA2, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>tretinoin 10 mg cap</i>	1-Covered	NDS (Non-Extended Day Supply)
TREATMENT ADJUNCTS		
<i>mesna 400 mg tab</i>	1-Covered	NDS (Non-Extended Day Supply)
MESNEX 400 MG TAB	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIPARASITICS		
ANTHELMINTHICS		
<i>albendazole</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>ivermectin 3 mg tab</i>	1-Covered	
<i>praziquantel</i>	1-Covered	
ANTIPROTOZOALS		
<i>atovaquone</i>	1-Covered	QL (600 PER 30 DAYS)
<i>atovaquone-proguanil hcl</i>	1-Covered	
<i>chloroquine phosphate</i>	1-Covered	
COARTEM	1-Covered	
<i>hydroxychloroquine sulfate 200 mg tab</i>	1-Covered	
IMPAVIDO	1-Covered	QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
<i>mefloquine hcl</i>	1-Covered	
<i>nitazoxanide</i>	1-Covered	QL (6 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>pentamidine isethionate for nebulization soln 300 mg</i>	1-Covered	PA3
<i>pentamidine isethionate for soln 300 mg</i>	1-Covered	
<i>primaquine phosphate</i>	1-Covered	
<i>pyrimethamine</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>quinine sulfate</i>	1-Covered	PA
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
<i>benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1-Covered	
<i>trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)</i>	1-Covered	PA

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIPARKINSON AGENTS, OTHER		
<i>amantadine hcl (50 mg/5ml solution, 100 mg cap, 100 mg tab)</i>	1-Covered	
<i>carbidopa-levodopa-entacapone</i>	1-Covered	
<i>entacapone</i>	1-Covered	
DOPAMINE AGONISTS		
<i>apomorphine hcl</i>	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>bromocriptine mesylate</i>	1-Covered	
<i>pramipexole dihydrochloride</i>	1-Covered	
<i>ropinirole hcl</i>	1-Covered	
<i>ropinirole hcl er</i>	1-Covered	
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
<i>carbidopa</i>	1-Covered	
<i>carbidopa-levodopa</i>	1-Covered	
<i>carbidopa-levodopa er</i>	1-Covered	
INBRIJA	1-Covered	PA, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
<i>rasagiline mesylate</i>	1-Covered	
<i>selegiline hcl</i>	1-Covered	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
<i>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)</i>	1-Covered	
<i>fluphenazine decanoate</i>	1-Covered	
<i>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)</i>	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>haloperidol</i>	1-Covered	
<i>haloperidol decanoate</i>	1-Covered	
<i>haloperidol lactate</i>	1-Covered	
<i>loxapine succinate</i>	1-Covered	
<i>molindone hcl</i>	1-Covered	
<i>pimozide</i>	1-Covered	
<i>thioridazine hcl</i>	1-Covered	
<i>thiothixene</i>	1-Covered	
<i>trifluoperazine hcl</i>	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)
<i>aripiprazole (2 mg tab, 5 mg tab, 10 mg tab, 10 mg tab disp, 15 mg tab, 15 mg tab disp)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>aripiprazole (20 mg tab, 30 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>aripiprazole 1 mg/ml solution</i>	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)
<i>asenapine maleate</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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	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)
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)
<i>lurasidone hcl (20 mg tab, 40 mg tab, 60 mg tab, 120 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>lurasidone hcl 80 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
NUPLAZID	1-Covered	PA2, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>olanzapine (15 mg tab, 20 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>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)</i>	1-Covered	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>olanzapine 10 mg recon soln</i>	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)
<i>paliperidone er 1.5 mg tab er 24h</i>	1-Covered	QL (240 PER 30 DAYS)
<i>paliperidone er 3 mg tab er 24h</i>	1-Covered	QL (120 PER 30 DAYS)
<i>paliperidone er 6 mg tab er 24h</i>	1-Covered	QL (60 PER 30 DAYS)
<i>paliperidone er 9 mg tab er 24h</i>	1-Covered	QL (30 PER 30 DAYS)
<i>quetiapine fumarate (300 mg tab, 400 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>quetiapine fumarate (50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>quetiapine fumarate 25 mg tab</i>	1-Covered	QL (180 PER 30 DAYS)
<i>quetiapine fumarate er</i>	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)
REXULTI (2 MG TAB, 3 MG TAB, 4 MG TAB)	1-Covered	ST, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>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)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>risperidone 1 mg/ml solution</i>	1-Covered	QL (480 PER 30 DAYS)
<i>risperidone microspheres er</i>	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)
<i>ziprasidone hcl</i>	1-Covered	QL (60 PER 30 DAYS)
<i>ziprasidone mesylate</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TREATMENT-RESISTANT		
<i>clozapine</i>	1-Covered	
VERSACLOZ	1-Covered	QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTISPASTICITY AGENTS		
<i>baclofen (5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Covered	
<i>dantrolene sodium</i>	1-Covered	
<i>tizanidine hcl (2 mg tab, 4 mg tab)</i>	1-Covered	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
LIVTENCITY	1-Covered	PA, NDS (Non-Extended Day Supply)
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)
<i>valganciclovir hcl 450 mg tab</i>	1-Covered	
<i>valganciclovir hcl 50 mg/ml recon soln</i>	1-Covered	NDS (Non-Extended Day Supply)
ANTI-HEPATITIS B (HBV) AGENTS		
<i>adefovir dipivoxil</i>	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
<i>entecavir</i>	1-Covered	QL (30 PER 30 DAYS)
<i>lamivudine 100 mg tab</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
<i>ribavirin</i>	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)
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)

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
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)
<i>efavirenz</i>	1-Covered	QL (30 PER 30 DAYS)
<i>efavirenz-emtricitab-tenofo df</i>	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>efavirenz-lamivudine-tenofovir</i>	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>etravirine 100 mg tab</i>	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>etravirine 200 mg tab</i>	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
INTELENCE 25 MG TAB	1-Covered	QL (120 PER 30 DAYS)
<i>nevirapine 200 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>nevirapine 50 mg/5ml suspension</i>	1-Covered	QL (1200 PER 30 DAYS)
<i>nevirapine er</i>	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)

<i>abacavir sulfate 20 mg/ml solution</i>	1-Covered	QL (960 PER 30 DAYS)
<i>abacavir sulfate 300 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>abacavir sulfate-lamivudine</i>	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)

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
<i>emtricitabine</i>	1-Covered	QL (30 PER 30 DAYS)
<i>emtricitabine-tenofovir df (100-150 mg tab, 133-200 mg tab, 167-250 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>emtricitabine-tenofovir df 200-300 mg tab</i>	1-Covered	
EMTRIVA 10 MG/ML SOLUTION	1-Covered	QL (850 PER 30 DAYS)
<i>lamivudine (10 mg/ml solution, 300 mg/30ml solution)</i>	1-Covered	QL (960 PER 30 DAYS)
<i>lamivudine 150 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>lamivudine 300 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>lamivudine-zidovudine</i>	1-Covered	QL (60 PER 30 DAYS)
<i>tenofovir disoproxil fumarate</i>	1-Covered	QL (30 PER 30 DAYS)
TRIUMEQ	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
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)
<i>zidovudine 100 mg cap</i>	1-Covered	QL (180 PER 30 DAYS)
<i>zidovudine 300 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>zidovudine 50 mg/5ml syrup</i>	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)
<i>maraviroc 150 mg tab</i>	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>maraviroc 300 mg tab</i>	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, 75 MG TAB)	1-Covered	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
SELZENTRY 25 MG TAB	1-Covered	
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)
<i>atazanavir sulfate (150 mg cap, 200 mg cap)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>atazanavir sulfate 300 mg cap</i>	1-Covered	QL (30 PER 30 DAYS)
<i>darunavir 600 mg tab</i>	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>darunavir 800 mg tab</i>	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)
<i>fosamprenavir calcium</i>	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>lopinavir-ritonavir 100-25 mg tab</i>	1-Covered	QL (300 PER 30 DAYS)
<i>lopinavir-ritonavir 200-50 mg tab</i>	1-Covered	QL (120 PER 30 DAYS)
<i>lopinavir-ritonavir 400-100 mg/5ml solution</i>	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)

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
REYATAZ 50 MG PACKET	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>ritonavir</i>	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

<i>oseltamivir phosphate (45 mg cap, 75 mg cap)</i>	1-Covered	QL (84 PER 365 DAYS)
<i>oseltamivir phosphate 30 mg cap</i>	1-Covered	QL (168 PER 365 DAYS)
<i>oseltamivir phosphate 6 mg/ml recon susp</i>	1-Covered	QL (1080 PER 365 DAYS)
RELENZA DISKHALER	1-Covered	QL (120 PER 365 DAYS)
<i>rimantadine hcl</i>	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

<i>acyclovir (200 mg cap, 200 mg/5ml suspension, 400 mg tab, 800 mg tab, 800 mg/20ml suspension)</i>	1-Covered	
<i>acyclovir sodium</i>	1-Covered	PA3
<i>famciclovir</i>	1-Covered	QL (90 PER 30 DAYS)
<i>valacyclovir hcl</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
<i>buspirone hcl</i>	1-Covered	
<i>hydroxyzine pamoate</i>	1-Covered	
BENZODIAZEPINES		
<i>alprazolam (0.25 mg tab, 0.5 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>alprazolam (1 mg tab, 2 mg tab)</i>	1-Covered	QL (150 PER 30 DAYS)
<i>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)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>clonazepam (2 mg tab, 2 mg tab disp)</i>	1-Covered	QL (300 PER 30 DAYS)
<i>clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>clorazepate dipotassium 15 mg tab</i>	1-Covered	QL (180 PER 30 DAYS)
<i>diazepam (2 mg tab, 5 mg tab, 10 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>diazepam 5 mg/5ml solution</i>	1-Covered	QL (1200 PER 30 DAYS)
<i>diazepam 5 mg/ml conc</i>	1-Covered	QL (240 PER 30 DAYS)
<i>diazepam intensol</i>	1-Covered	QL (240 PER 30 DAYS)
<i>lorazepam (2 mg tab, 2 mg/ml conc)</i>	1-Covered	QL (150 PER 30 DAYS)
<i>lorazepam 0.5 mg tab</i>	1-Covered	QL (600 PER 30 DAYS)
<i>lorazepam 1 mg tab</i>	1-Covered	QL (300 PER 30 DAYS)
<i>lorazepam intensol</i>	1-Covered	QL (150 PER 30 DAYS)
<i>oxazepam</i>	1-Covered	QL (120 PER 30 DAYS)
BIPOLAR AGENTS		
MOOD STABILIZERS		
<i>lamotrigine (25 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	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
<i>lithium</i>	1-Covered	
<i>lithium carbonate</i>	1-Covered	
<i>lithium carbonate er</i>	1-Covered	
<i>subvenite</i>	1-Covered	

BLOOD GLUCOSE REGULATORS

ANTIDIABETIC AGENTS

<i>acarbose</i>	1-Covered	QL (90 PER 30 DAYS)
<i>alogliptin benzoate</i>	1-Covered	QL (30 PER 30 DAYS)
<i>alogliptin-metformin hcl</i>	1-Covered	QL (60 PER 30 DAYS)
<i>alogliptin-pioglitazone (12.5-30 mg tab, 25-15 mg tab, 25-30 mg tab, 25-45 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
CYCLOSET	1-Covered	QL (180 PER 30 DAYS)
<i>glimepiride (1 mg tab, 2 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>glimepiride 4 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>glipizide (5 mg tab, 10 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>glipizide er 10 mg tab er 24h</i>	1-Covered	QL (60 PER 30 DAYS)
<i>glipizide er 2.5 mg tab er 24h</i>	1-Covered	QL (120 PER 30 DAYS)
<i>glipizide er 5 mg tab er 24h</i>	1-Covered	QL (90 PER 30 DAYS)
<i>glipizide-metformin hcl</i>	1-Covered	QL (120 PER 30 DAYS)
<i>glyburide</i>	1-Covered	QL (120 PER 30 DAYS)
GLYBURIDE MICRONIZED	1-Covered	QL (60 PER 30 DAYS)
<i>glyburide-metformin</i>	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)

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
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)
<i>metformin hcl 1000 mg tab</i>	1-Covered	QL (75 PER 30 DAYS)
<i>metformin hcl 500 mg tab</i>	1-Covered	QL (150 PER 30 DAYS)
<i>metformin hcl 850 mg tab</i>	1-Covered	QL (90 PER 30 DAYS)
<i>metformin hcl er 500 mg tab er 24h</i>	1-Covered	QL (120 PER 30 DAYS)
<i>metformin hcl er 750 mg tab er 24h</i>	1-Covered	QL (60 PER 30 DAYS)
<i>miglitol</i>	1-Covered	QL (90 PER 30 DAYS)
MOUNJARO	1-Covered	PA, QL (2 PER 28 DAYS)
<i>nateglinide 120 mg tab</i>	1-Covered	QL (90 PER 30 DAYS)
<i>nateglinide 60 mg tab</i>	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)
OZEMPIC (1 MG/DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
OZEMPIC (2 MG/DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
<i>pioglitazone hcl</i>	1-Covered	QL (30 PER 30 DAYS)
<i>pioglitazone hcl-glimepiride</i>	1-Covered	QL (30 PER 30 DAYS)
<i>pioglitazone hcl-metformin hcl</i>	1-Covered	QL (90 PER 30 DAYS)
<i>repaglinide (0.5 mg tab, 1 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>repaglinide 2 mg tab</i>	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)

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
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	
<i>diazoxide</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>glucagon emergency (1 mg kit, 1 mg/ml recon soln)</i>	1-Covered	
<i>glucagon emergency 1 mg kit (generic)</i>	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	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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	

BLOOD PRODUCTS AND MODIFIERS

ANTICOAGULANTS

<i>dabigatran etexilate mesylate (75 mg cap, 150 mg cap)</i>	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)
<i>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)</i>	1-Covered	
<i>fondaparinux sodium (5 mg/0.4ml solution, 7.5 mg/0.6ml solution, 10 mg/0.8ml solution)</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>fondaparinux sodium 2.5 mg/0.5ml solution</i>	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
<i>heparin sodium (porcine) (1000 unit/ml solution, 5000 unit/ml solution, 10000 unit/ml solution, 20000 unit/ml solution)</i>	1-Covered	
<i>heparin sodium (porcine) pf 1000 unit/ml solution</i>	1-Covered	
<i>jantoven</i>	1-Covered	
<i>warfarin sodium</i>	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)
<i>anagrelide hcl</i>	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

<i>tranexamic acid 650 mg tab</i>	1-Covered	
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PLATELET MODIFYING AGENTS

<i>aspirin-dipyridamole er</i>	1-Covered	QL (60 PER 30 DAYS)
BRILINTA	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
<i>cilostazol</i>	1-Covered	
<i>clopidogrel bisulfate</i>	1-Covered	
<i>dipyridamole</i>	1-Covered	
DOPTelet	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>prasugrel hcl</i>	1-Covered	

CARDIOVASCULAR AGENTS

ALPHA-ADRENERGIC AGONISTS

<i>clonidine 0.1 mg/24hr patch wk</i>	1-Covered	QL (4 PER 28 DAYS)
<i>clonidine 0.2 mg/24hr patch wk</i>	1-Covered	QL (4 PER 28 DAYS)
<i>clonidine 0.3 mg/24hr patch wk</i>	1-Covered	QL (4 PER 28 DAYS)
<i>clonidine hcl</i>	1-Covered	
<i>droxidopa (200 mg cap, 300 mg cap)</i>	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>droxidopa 100 mg cap</i>	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>midodrine hcl</i>	1-Covered	

ALPHA-ADRENERGIC BLOCKING AGENTS

<i>doxazosin mesylate</i>	1-Covered	
<i>prazosin hcl</i>	1-Covered	
<i>terazosin hcl</i>	1-Covered	

ANGIOTENSIN II RECEPTOR ANTAGONISTS

<i>candesartan cilexetil (4 mg tab, 8 mg tab, 16 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>candesartan cilexetil 32 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>irbesartan (75 mg tab, 300 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>irbesartan 150 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>losartan potassium (25 mg tab, 50 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>losartan potassium 100 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>olmesartan medoxomil (20 mg tab, 40 mg tab)</i>	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
<i>olmesartan medoxomil 5 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>telmisartan</i>	1-Covered	QL (30 PER 30 DAYS)
<i>valsartan (40 mg tab, 80 mg tab, 160 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>valsartan 320 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)

ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

<i>benazepril hcl</i>	1-Covered	
<i>captopril</i>	1-Covered	
<i>enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Covered	
<i>fosinopril sodium</i>	1-Covered	
<i>lisinopril</i>	1-Covered	
<i>moexipril hcl</i>	1-Covered	
<i>perindopril erbumine (2 mg tab, 4 mg tab, 8 mg tab)</i>	1-Covered	
<i>quinapril hcl</i>	1-Covered	
<i>ramipril</i>	1-Covered	
<i>trandolapril</i>	1-Covered	

ANTIARRHYTHMICS

<i>amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)</i>	1-Covered	
<i>digoxin (125 mcg tab, 250 mcg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>digoxin 0.05 mg/ml solution</i>	1-Covered	
<i>dofetilide</i>	1-Covered	
<i>flecainide acetate</i>	1-Covered	
<i>mexiletine hcl</i>	1-Covered	
MULTAQ	1-Covered	
<i>pacerone</i>	1-Covered	
<i>propafenone hcl</i>	1-Covered	
<i>propafenone hcl er</i>	1-Covered	
<i>quinidine sulfate</i>	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
<i>sotalol hcl</i>	1-Covered	
<i>sotalol hcl (af)</i>	1-Covered	

BETA-ADRENERGIC BLOCKING AGENTS

<i>acebutolol hcl</i>	1-Covered	
<i>atenolol</i>	1-Covered	
<i>betaxolol hcl (10 mg tab, 20 mg tab)</i>	1-Covered	
<i>bisoprolol fumarate (5 mg tab, 10 mg tab)</i>	1-Covered	
<i>carvedilol</i>	1-Covered	
<i>labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)</i>	1-Covered	
<i>metoprolol succinate er</i>	1-Covered	
<i>metoprolol tartrate (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)</i>	1-Covered	
<i>nadolol</i>	1-Covered	
<i>nebivolol hcl (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>nebivolol hcl 20 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>pindolol</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>propranolol hcl er</i>	1-Covered	
<i>timolol maleate (5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Covered	

CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES

<i>amlodipine besylate</i>	1-Covered	
<i>felodipine er</i>	1-Covered	
<i>isradipine</i>	1-Covered	
<i>nicardipine hcl (20 mg cap, 30 mg cap)</i>	1-Covered	
<i>nifedipine er</i>	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
<i>nifedipine er osmotic release</i>	1-Covered	
<i>nimodipine 30 mg cap</i>	1-Covered	

CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES

<i>cartia xt</i>	1-Covered	
<i>dilt-xr</i>	1-Covered	
<i>diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)</i>	1-Covered	
<i>diltiazem hcl er</i>	1-Covered	
<i>diltiazem hcl er beads</i>	1-Covered	
<i>diltiazem hcl er coated beads</i>	1-Covered	
<i>matzim la</i>	1-Covered	
<i>tiadylt er</i>	1-Covered	
<i>verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)</i>	1-Covered	
<i>verapamil hcl er</i>	1-Covered	

CARDIOVASCULAR AGENTS, OTHER

<i>acetazolamide</i>	1-Covered	
<i>aliskiren fumarate</i>	1-Covered	QL (30 PER 30 DAYS)
<i>amiloride-hydrochlorothiazide</i>	1-Covered	
<i>amlodipine besy-benazepril hcl (2.5-10 mg cap, 5-10 mg cap, 5-20 mg cap, 10-20 mg cap)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>amlodipine besy-benazepril hcl (5-40 mg cap, 10-40 mg cap)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>amlodipine besylate-valsartan</i>	1-Covered	QL (30 PER 30 DAYS)
<i>amlodipine-atorvastatin</i>	1-Covered	QL (30 PER 30 DAYS)
<i>amlodipine-olmesartan</i>	1-Covered	QL (30 PER 30 DAYS)
<i>amlodipine-valsartan-hctz</i>	1-Covered	QL (30 PER 30 DAYS)
<i>atenolol-chlorthalidone</i>	1-Covered	
<i>benazepril-hydrochlorothiazide</i>	1-Covered	
<i>bisoprolol-hydrochlorothiazide</i>	1-Covered	
<i>candesartan cilexetil-hctz (32-12.5 mg tab, 32-25 mg tab)</i>	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
<i>candesartan cilexetil-hctz 16-12.5 mg tab</i>	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)
<i>enalapril-hydrochlorothiazide</i>	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)
<i>fosinopril sodium-hctz</i>	1-Covered	
<i>irbesartan-hydrochlorothiazide 150-12.5 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>irbesartan-hydrochlorothiazide 300-12.5 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>isosorb dinitrate-hydralazine</i>	1-Covered	
<i>ivabradine hcl</i>	1-Covered	PA, QL (60 PER 30 DAYS)
<i>lisinopril-hydrochlorothiazide</i>	1-Covered	
<i>losartan potassium-hctz (100-12.5 mg tab, 100-25 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>losartan potassium-hctz 50-12.5 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>metoprolol-hydrochlorothiazide</i>	1-Covered	
<i>metyrosine</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
NEXLETOL	1-Covered	PA, QL (30 PER 30 DAYS)
<i>olmesartan medoxomil-hctz</i>	1-Covered	QL (30 PER 30 DAYS)
<i>olmesartan-amlodipine-hctz</i>	1-Covered	QL (30 PER 30 DAYS)
<i>pentoxifylline er</i>	1-Covered	
<i>ranolazine er</i>	1-Covered	QL (60 PER 30 DAYS)
<i>spironolactone-hctz</i>	1-Covered	
<i>telmisartan-amlodipine</i>	1-Covered	QL (30 PER 30 DAYS)
<i>telmisartan-hctz (40-12.5 mg tab, 80-25 mg tab)</i>	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
<i>telmisartan-hctz 80-12.5 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>trandolapril-verapamil hcl er</i>	1-Covered	
<i>triamterene-hctz</i>	1-Covered	
<i>valsartan-hydrochlorothiazide</i>	1-Covered	QL (30 PER 30 DAYS)
VERQUVO	1-Covered	PA, QL (30 PER 30 DAYS)

DIURETICS, LOOP

<i>bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1-Covered	
<i>furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)</i>	1-Covered	
<i>torsemide</i>	1-Covered	

DIURETICS, POTASSIUM-SPARING

<i>amiloride hcl</i>	1-Covered	
<i>eplerenone</i>	1-Covered	

DIURETICS, THIAZIDE

<i>chlorthalidone</i>	1-Covered	
<i>hydrochlorothiazide</i>	1-Covered	
<i>indapamide</i>	1-Covered	
<i>metolazone</i>	1-Covered	

DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES

<i>fenofibrate (48 mg tab, 54 mg tab, 67 mg cap, 134 mg cap, 145 mg tab, 160 mg tab, 200 mg cap)</i>	1-Covered	
<i>fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)</i>	1-Covered	
<i>fenofibric acid (45 mg cap dr, 135 mg cap dr)</i>	1-Covered	
<i>gemfibrozil</i>	1-Covered	

DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS

<i>atorvastatin calcium (10 mg tab, 40 mg tab)</i>	1-Covered	QL (60 PER 30 DAYS)
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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
<i>atorvastatin calcium 20 mg tab</i>	1-Covered	QL (90 PER 30 DAYS)
<i>atorvastatin calcium 80 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>lovastatin (10 mg tab, 20 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>lovastatin 40 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>pitavastatin calcium</i>	1-Covered	QL (30 PER 30 DAYS)
<i>pravastatin sodium</i>	1-Covered	QL (30 PER 30 DAYS)
<i>rosuvastatin calcium</i>	1-Covered	QL (30 PER 30 DAYS)
<i>simvastatin</i>	1-Covered	QL (30 PER 30 DAYS)

DYSLIPIDEMICS, OTHER

<i>cholestyramine (4 gm packet, 4 gm/dose powder)</i>	1-Covered	
<i>cholestyramine light (4 gm packet, 4 gm/dose powder)</i>	1-Covered	
<i>colesevelam hcl</i>	1-Covered	
<i>colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)</i>	1-Covered	
<i>ezetimibe</i>	1-Covered	QL (30 PER 30 DAYS)
<i>ezetimibe-simvastatin</i>	1-Covered	QL (30 PER 30 DAYS)
NEXLIZET	1-Covered	PA, QL (30 PER 30 DAYS)
<i>niacin er (antihyperlipidemic)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>omega-3-acid ethyl esters</i>	1-Covered	QL (120 PER 30 DAYS)
<i>prevalite (4 gm packet, 4 gm/dose powder)</i>	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	1-Covered	PA, QL (30 PER 30 DAYS)
<i>spironolactone (25 mg tab, 50 mg tab, 100 mg tab)</i>	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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		
<i>hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)</i>	1-Covered	
<i>minoxidil</i>	1-Covered	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
<i>isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)</i>	1-Covered	
<i>isosorbide mononitrate</i>	1-Covered	
<i>isosorbide mononitrate er</i>	1-Covered	
NITRO-BID	1-Covered	
<i>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)</i>	1-Covered	
<i>nitroglycerin 0.4 % ointment</i>	1-Covered	QL (30 PER 30 DAYS)
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
<i>amphetamine-dextroamphet er</i>	1-Covered	QL (30 PER 30 DAYS)
<i>amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>amphetamine-dextroamphetamine 30 mg tab</i>	1-Covered	QL (60 PER 30 DAYS)
<i>dextroamphetamine sulfate (5 mg tab, 10 mg tab)</i>	1-Covered	QL (180 PER 30 DAYS)
<i>dextroamphetamine sulfate er</i>	1-Covered	QL (120 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
<i>atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>atomoxetine hcl 18 mg cap</i>	1-Covered	QL (120 PER 30 DAYS)
<i>dexmethylphenidate hcl</i>	1-Covered	QL (60 PER 30 DAYS)
<i>guanfacine hcl er</i>	1-Covered	QL (30 PER 30 DAYS)
<i>methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>methylphenidate hcl er (10 mg tab er, 20 mg tab er)</i>	1-Covered	QL (90 PER 30 DAYS)
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)
<i>bac (butalbital-acetamin-caff)</i>	1-Covered	PA, QL (180 PER 30 DAYS)
<i>butalbital-apap-caffeine 50-325-40 mg tab</i>	1-Covered	PA, QL (180 PER 30 DAYS)
FIRDAPSE	1-Covered	PA, QL (240 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
NUEDEXTA	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>riluzole</i>	1-Covered	
<i>tetrabenazine 12.5 mg tab</i>	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>tetrabenazine 25 mg tab</i>	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)
<i>duloxetine hcl (20 mg cp dr part, 30 mg cp dr part, 60 mg cp dr part)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>pregabalin (225 mg cap, 300 mg cap)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)</i>	1-Covered	QL (90 PER 30 DAYS)
<i>pregabalin 20 mg/ml solution</i>	1-Covered	QL (900 PER 30 DAYS)
<i>pregabalin er (82.5 mg tab er 24h, 165 mg tab er 24h)</i>	1-Covered	PA, QL (90 PER 30 DAYS)
<i>pregabalin er 330 mg tab er 24h</i>	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)
<i>dalfampridine er</i>	1-Covered	QL (60 PER 30 DAYS)
<i>dimethyl fumarate</i>	1-Covered	QL (60 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
<i>dimethyl fumarate starter pack</i>	1-Covered	QL (120 PER 365 DAYS), NDS (Non-Extended Day Supply)
<i>fingolimod hcl</i>	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)
<i>teriflunomide</i>	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

DENTAL AND ORAL AGENTS

<i>cevimeline hcl</i>	1-Covered	
<i>chlorhexidine gluconate</i>	1-Covered	
<i>kourzeq</i>	1-Covered	
<i>oralone</i>	1-Covered	
<i>periogard</i>	1-Covered	
<i>pilocarpine hcl (5 mg tab, 7.5 mg tab)</i>	1-Covered	
<i>triamcinolone acetonide 0.1 % paste</i>	1-Covered	

DERMATOLOGICAL AGENTS

ACNE AND ROSACEA AGENTS

<i>accutane</i>	1-Covered	
<i>acitretin</i>	1-Covered	PA2
<i>amnesteam</i>	1-Covered	
<i>benzoyl peroxide-erythromycin</i>	1-Covered	QL (46.6 PER 30 DAYS)
<i>claravis</i>	1-Covered	
<i>isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)</i>	1-Covered	
<i>metronidazole (0.75 % cream, 0.75 % lotion, 1 % gel)</i>	1-Covered	
<i>sulfacetamide sodium (acne)</i>	1-Covered	QL (118 PER 30 DAYS)
<i>tazarotene (0.05 % cream, 0.05 % gel, 0.1 % cream, 0.1 % gel)</i>	1-Covered	PA, QL (60 PER 30 DAYS)
TAZORAC 0.05 % CREAM	1-Covered	PA, QL (60 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
<i>tretinoin (0.01 % gel, 0.025 % cream, 0.025 % gel, 0.05 % cream, 0.1 % cream)</i>	1-Covered	PA, QL (45 PER 30 DAYS)
<i>zenatane</i>	1-Covered	

DERMATITIS AND PRURITUS AGENTS

<i>ala-cort</i>	1-Covered	
<i>alclometasone dipropionate</i>	1-Covered	
<i>ammonium lactate</i>	1-Covered	
<i>betamethasone dipropionate (0.05 % cream, 0.05 % lotion, 0.05 % ointment)</i>	1-Covered	
<i>betamethasone dipropionate aug (0.05 % cream, 0.05 % gel, 0.05 % ointment)</i>	1-Covered	
<i>betamethasone dipropionate aug 0.05 % lotion</i>	1-Covered	QL (120 PER 30 DAYS)
<i>betamethasone valerate (0.1 % cream, 0.1 % lotion, 0.1 % ointment)</i>	1-Covered	
<i>clobetasol prop emollient base</i>	1-Covered	QL (120 PER 30 DAYS)
<i>clobetasol propionate (0.05 % cream, 0.05 % gel, 0.05 % ointment)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>clobetasol propionate (0.05 % foam, 0.05 % solution)</i>	1-Covered	QL (100 PER 30 DAYS)
<i>clobetasol propionate 0.05 % shampoo</i>	1-Covered	QL (118 PER 30 DAYS)
<i>clobetasol propionate e</i>	1-Covered	QL (120 PER 30 DAYS)
<i>clobetasol propionate emulsion</i>	1-Covered	QL (100 PER 30 DAYS)
<i>clodan</i>	1-Covered	QL (118 PER 30 DAYS)
<i>desonide (0.05 % cream, 0.05 % ointment)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>desonide 0.05 % lotion</i>	1-Covered	QL (118 PER 30 DAYS)
<i>desoximetasone (0.05 % cream, 0.05 % gel, 0.05 % ointment, 0.25 % cream, 0.25 % ointment)</i>	1-Covered	QL (100 PER 30 DAYS)
<i>fluocinolone acetonide (0.025 % cream, 0.025 % ointment)</i>	1-Covered	QL (120 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
<i>fluocinolone acetonide 0.01 % cream</i>	1-Covered	QL (60 PER 30 DAYS)
<i>fluocinolone acetonide 0.01 % solution</i>	1-Covered	QL (90 PER 30 DAYS)
<i>fluocinolone acetonide body</i>	1-Covered	QL (118.28 PER 30 DAYS)
<i>fluocinolone acetonide scalp</i>	1-Covered	QL (118.28 PER 30 DAYS)
<i>fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>fluocinonide 0.05 % solution</i>	1-Covered	QL (60 PER 30 DAYS)
<i>fluocinonide emulsified base</i>	1-Covered	QL (120 PER 30 DAYS)
<i>fluticasone propionate (0.005 % ointment, 0.05 % cream)</i>	1-Covered	
<i>halobetasol propionate (0.05 % cream, 0.05 % ointment)</i>	1-Covered	QL (50 PER 30 DAYS)
<i>hydrocortisone (1 % cream, 1 % ointment, 2.5 % cream, 2.5 % lotion, 2.5 % ointment)</i>	1-Covered	
<i>hydrocortisone (perianal)</i>	1-Covered	
HYDROCORTISONE BUTYRATE 0.1 % OINTMENT	1-Covered	QL (45 PER 30 DAYS)
<i>hydrocortisone butyrate 0.1 % solution</i>	1-Covered	QL (60 PER 30 DAYS)
<i>hydrocortisone valerate 0.2 % cream</i>	1-Covered	
<i>hydrocortisone valerate 0.2 % ointment</i>	1-Covered	QL (60 PER 30 DAYS)
<i>mometasone furoate (0.1 % cream, 0.1 % ointment, 0.1 % solution)</i>	1-Covered	
<i>pimecrolimus</i>	1-Covered	QL (100 PER 30 DAYS)
<i>procto-med hc</i>	1-Covered	
<i>proctosol hc</i>	1-Covered	
<i>proctozone-hc</i>	1-Covered	
<i>selenium sulfide 2.5 % lotion</i>	1-Covered	
<i>tacrolimus (0.03 % ointment, 0.1 % ointment)</i>	1-Covered	QL (100 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
<i>tovet</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>triderm</i>	1-Covered	

DERMATOLOGICAL AGENTS, OTHER

<i>calcipotriene (0.005 % cream, 0.005 % ointment)</i>	1-Covered	QL (120 PER 30 DAYS)
<i>calcipotriene 0.005 % solution</i>	1-Covered	QL (60 PER 30 DAYS)
<i>calcitrene</i>	1-Covered	QL (120 PER 30 DAYS)
<i>clotrimazole-betamethasone 1-0.05 % cream</i>	1-Covered	QL (45 PER 30 DAYS)
CLOTRIMAZOLE-BETAMETHASONE 1-0.05 % LOTION	1-Covered	QL (60 PER 30 DAYS)
<i>fluorouracil (2 % solution, 5 % solution)</i>	1-Covered	QL (10 PER 30 DAYS)
<i>fluorouracil 5 % cream</i>	1-Covered	QL (80 PER 30 DAYS)
<i>imiquimod 5 % cream</i>	1-Covered	QL (24 PER 30 DAYS)
<i>methoxsalen rapid</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>nystatin-triamcinolone</i>	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)
<i>podofilox 0.5 % solution</i>	1-Covered	
REGRANEX	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
SANTYL	1-Covered	QL (90 PER 30 DAYS)
<i>silver sulfadiazine</i>	1-Covered	
<i>ssd</i>	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
PEDICULICIDES/SCABICIDES		
<i>malathion</i>	1-Covered	
<i>permethrin</i>	1-Covered	
TOPICAL ANTI-INFECTIVES		
<i>acyclovir 5 % ointment</i>	1-Covered	QL (30 PER 30 DAYS)
<i>ciclodan</i>	1-Covered	QL (13.2 PER 30 DAYS)
<i>ciclopirox 0.77 % gel</i>	1-Covered	QL (100 PER 30 DAYS)
<i>ciclopirox 1 % shampoo</i>	1-Covered	QL (120 PER 30 DAYS)
<i>ciclopirox 8 % solution</i>	1-Covered	QL (13.2 PER 30 DAYS)
<i>ciclopirox olamine 0.77 % cream</i>	1-Covered	QL (90 PER 30 DAYS)
<i>ciclopirox olamine 0.77 % suspension</i>	1-Covered	QL (60 PER 30 DAYS)
<i>clindamycin phos (once-daily)</i>	1-Covered	QL (75 PER 30 DAYS)
<i>clindamycin phos (twice-daily)</i>	1-Covered	QL (75 PER 30 DAYS)
<i>clindamycin phosphate (1 % lotion, 1 % solution, 1 % swab)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>ery 2% pad</i>	1-Covered	QL (60 PER 30 DAYS)
<i>erythromycin 2 % gel</i>	1-Covered	QL (60 PER 30 DAYS)
<i>erythromycin 2 % solution</i>	1-Covered	QL (120 PER 30 DAYS)
<i>mupirocin</i>	1-Covered	QL (66 PER 30 DAYS)
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
<i>carglumic acid</i>	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
<i>clinisol sf</i>	1-Covered	PA3
<i>dextrose (, 10 % solution, 50 % solution)</i>	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
<i>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)</i>	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	
<i>kcl in dextrose-nacl (, 40-5-0.9 meq/l-%-% solution)</i>	1-Covered	
KCL-LACTATED RINGERS-D5W	1-Covered	
<i>klor-con</i>	1-Covered	
<i>klor-con 10</i>	1-Covered	
<i>klor-con m10</i>	1-Covered	
<i>klor-con m15</i>	1-Covered	
<i>klor-con m20</i>	1-Covered	
<i>magnesium sulfate 50 % solution</i>	1-Covered	
<i>multiple electro type 1 ph 5.5</i>	1-Covered	
<i>multiple electro type 1 ph 7.4</i>	1-Covered	
<i>plenamine</i>	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	
<i>potassium chloride crys er</i>	1-Covered	
<i>potassium chloride er (8 cap er, 8 tab er, 10 cap er, 10 tab er, 20 tab er)</i>	1-Covered	
<i>potassium chloride in dextrose 20-5 meq/l-% solution</i>	1-Covered	
POTASSIUM CHLORIDE IN NACL (, 20-0.45 MEQ/L-% SOLUTION, 40-0.9 MEQ/L-% SOLUTION)	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
<i>potassium citrate er</i>	1-Covered	
PREMASOL	1-Covered	PA3
PROSOL	1-Covered	PA3
<i>sodium chloride (0.45 % solution, 0.9 % solution, 3 % solution, 5 % solution)</i>	1-Covered	
<i>sodium chloride (pf)</i>	1-Covered	
<i>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)</i>	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)
<i>deferasirox (90 mg packet, 180 mg packet, 250 mg tab sol, 360 mg packet, 500 mg tab sol)</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>deferasirox (90 mg tab, 125 mg tab sol, 180 mg tab, 360 mg tab)</i>	1-Covered	PA
<i>deferasirox granules</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>deferiprone</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>penicillamine 250 mg tab</i>	1-Covered	NDS (Non-Extended Day Supply)
<i>trientine hcl 250 mg cap</i>	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>trientine hcl 500 mg cap</i>	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)

POTASSIUM BINDERS

<i>kionex</i>	1-Covered	
LOKELMA	1-Covered	QL (90 PER 30 DAYS)
<i>sodium polystyrene sulfonate</i>	1-Covered	
<i>sps (sodium polystyrene sulf)</i>	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
VITAMINS		
<i>levocarnitine (1 gm/10ml solution, 330 mg tab)</i>	1-Covered	
<i>levocarnitine sf</i>	1-Covered	
PRENATAL VITAMIN ORAL TABLET	1-Covered	
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
<i>constulose</i>	1-Covered	
<i>enulose</i>	1-Covered	
<i>generlac</i>	1-Covered	
<i>lactulose (10 gm/15ml solution, 20 gm/30ml solution)</i>	1-Covered	
<i>lactulose encephalopathy</i>	1-Covered	
LINZESS	1-Covered	QL (30 PER 30 DAYS)
<i>lubiprostone</i>	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		
<i>alosetron hcl 0.5 mg tab</i>	1-Covered	PA, QL (60 PER 30 DAYS)
<i>alosetron hcl 1 mg tab</i>	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)</i>	1-Covered	
<i>loperamide hcl</i>	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)

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
ANTISPASMODICS, GASTROINTESTINAL		
<i>dicyclomine hcl (10 mg cap, 10 mg/5ml solution, 20 mg tab)</i>	1-Covered	
<i>glycopyrrolate (1 mg tab, 2 mg tab)</i>	1-Covered	
<i>methscopolamine bromide</i>	1-Covered	
GASTROINTESTINAL AGENTS, OTHER		
CLENPIQ	1-Covered	
GATTEX	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>gavilyte-c</i>	1-Covered	
<i>gavilyte-g</i>	1-Covered	
<i>gavilyte-n with flavor pack</i>	1-Covered	
MYALEPT	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>na sulfate-k sulfate-mg sulf</i>	1-Covered	
OCALIVA	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>peg 3350-kcl-na bicarb-nacl</i>	1-Covered	
<i>peg-3350/electrolytes</i>	1-Covered	
<i>ursodiol (250 mg tab, 300 mg cap, 500 mg tab)</i>	1-Covered	
VOWST	1-Covered	PA, QL (12 PER 30 DAYS), NDS (Non-Extended Day Supply)
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
<i>cimetidine</i>	1-Covered	
<i>famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)</i>	1-Covered	
<i>nizatidine (150 mg cap, 300 mg cap)</i>	1-Covered	
PROTECTANTS		
<i>misoprostol</i>	1-Covered	
<i>sucralfate (1 gm tab, 1 gm/10ml suspension)</i>	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
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>lansoprazole (15 mg cap dr, 30 mg cap dr)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>omeprazole</i>	1-Covered	QL (60 PER 30 DAYS)
<i>pantoprazole sodium (20 mg tab dr, 40 mg tab dr)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>rabeprazole sodium</i>	1-Covered	QL (30 PER 30 DAYS)
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
<i>betaine</i>	1-Covered	NDS (Non-Extended Day Supply)
CERDELGA	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
CREON	1-Covered	
<i>cromolyn sodium 100 mg/5ml conc</i>	1-Covered	
CYSTAGON	1-Covered	
CYSTARAN	1-Covered	PA, QL (60 PER 28 DAYS), NDS (Non-Extended Day Supply)
<i>javygtor</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>l-glutamine</i>	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>miglustat</i>	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>nitisinone</i>	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)
<i>sapropterin dihydrochloride</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>sodium phenylbutyrate (3 gm/tsp powder, 500 mg tab)</i>	1-Covered	PA, 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
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

<i>darifenacin hydrobromide er</i>	1-Covered	QL (30 PER 30 DAYS)
<i>fesoterodine fumarate er</i>	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)
<i>oxybutynin chloride (5 mg tab, 5 mg/5ml solution)</i>	1-Covered	
<i>oxybutynin chloride er</i>	1-Covered	QL (60 PER 30 DAYS)
<i>solifenacin succinate</i>	1-Covered	QL (30 PER 30 DAYS)
<i>tolterodine tartrate</i>	1-Covered	QL (60 PER 30 DAYS)
<i>tolterodine tartrate er</i>	1-Covered	QL (30 PER 30 DAYS)
<i>trospium chloride</i>	1-Covered	QL (60 PER 30 DAYS)
<i>trospium chloride er</i>	1-Covered	QL (30 PER 30 DAYS)

BENIGN PROSTATIC HYPERTROPHY AGENTS

<i>alfuzosin hcl er</i>	1-Covered	QL (30 PER 30 DAYS)
<i>dutasteride</i>	1-Covered	QL (30 PER 30 DAYS)
<i>dutasteride-tamsulosin hcl</i>	1-Covered	QL (30 PER 30 DAYS)
<i>finasteride</i>	1-Covered	QL (30 PER 30 DAYS)
<i>silodosin</i>	1-Covered	QL (30 PER 30 DAYS)
<i>tadalafil</i>	1-Covered	PA, QL (30 PER 30 DAYS)
<i>tamsulosin hcl</i>	1-Covered	QL (60 PER 30 DAYS)

GENITOURINARY AGENTS, OTHER

<i>bethanechol chloride</i>	1-Covered	
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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
ELMIRON	1-Covered	QL (90 PER 30 DAYS)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)

<i>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)</i>	1-Covered
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<i>dexamethasone sod phos +rfid</i>	1-Covered
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<i>dexamethasone sod phosphate pf 10 mg/ml solution</i>	1-Covered
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<i>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)</i>	1-Covered
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<i>fludrocortisone acetate</i>	1-Covered
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<i>methylprednisolone</i>	1-Covered
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<i>methylprednisolone acetate</i>	1-Covered
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<i>methylprednisolone sodium succ</i>	1-Covered
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<i>prednisolone 15 mg/5ml solution</i>	1-Covered
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<i>prednisolone sodium phosphate (6.7 (5 base) mg/5ml solution, 15 mg/5ml solution, 25 mg/5ml solution)</i>	1-Covered
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<i>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)</i>	1-Covered
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PREDNISONE INTENSOL	1-Covered
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SOLU-MEDROL 2 GM RECON SOLN	1-Covered
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HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)

<i>desmopressin ace spray refrig</i>	1-Covered
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<i>desmopressin acetate (0.1 mg tab, 0.2 mg tab, 4 mcg/ml solution)</i>	1-Covered
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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>desmopressin acetate pf</i>	1-Covered	
DESMOPRESSIN ACETATE SPRAY	1-Covered	
INCRELEX	1-Covered	PA, NDS (Non-Extended Day Supply)
NORDITROPIN FLEXPPO	1-Covered	PA, NDS (Non-Extended Day Supply)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)

ANDROGENS

<i>danazol</i>	1-Covered	
<i>testosterone (12.5 mg/act (1%) gel, 25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)</i>	1-Covered	PA, QL (300 PER 30 DAYS)
<i>testosterone 20.25 mg/act (1.62%) gel</i>	1-Covered	PA, QL (150 PER 30 DAYS)
<i>testosterone cypionate</i>	1-Covered	PA2
<i>testosterone enanthate</i>	1-Covered	PA2
<i>testosterone td gel pump 20.25 mg/act (1.62%)</i>	1-Covered	PA, QL (150 PER 30 DAYS)

ESTROGENS

<i>afirmelle</i>	1-Covered	
<i>altavera</i>	1-Covered	
<i>alyacen 1/35</i>	1-Covered	
<i>alyacen 7/7/7</i>	1-Covered	
<i>amethyst</i>	1-Covered	
<i>apri</i>	1-Covered	
<i>aranelle</i>	1-Covered	
<i>aubra eq</i>	1-Covered	
<i>aurovela 1.5/30</i>	1-Covered	
<i>aurovela 1/20</i>	1-Covered	
<i>aurovela 24 fe</i>	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
<i>aurovela fe 1.5/30</i>	1-Covered	
<i>aurovela fe 1/20</i>	1-Covered	
<i>aviane</i>	1-Covered	
<i>ayuna</i>	1-Covered	
<i>azurette</i>	1-Covered	
<i>balziva</i>	1-Covered	
<i>blisovi 24 fe</i>	1-Covered	
<i>blisovi fe 1.5/30</i>	1-Covered	
<i>blisovi fe 1/20</i>	1-Covered	
<i>briellyn</i>	1-Covered	
<i>camrese lo</i>	1-Covered	
<i>chateal eq</i>	1-Covered	
<i>cryselle-28</i>	1-Covered	
<i>cyred eq</i>	1-Covered	
<i>dasetta 1/35</i>	1-Covered	
<i>dasetta 7/7/7</i>	1-Covered	
<i>delyla</i>	1-Covered	
DEPO-ESTRADIOL	1-Covered	
<i>desogestrel-ethinyl estradiol</i>	1-Covered	
<i>dolishale</i>	1-Covered	
<i>dotti</i>	1-Covered	QL (8 PER 28 DAYS)
<i>drospirenone-ethinyl estradiol</i>	1-Covered	
<i>elinest</i>	1-Covered	
<i>eluryng</i>	1-Covered	
<i>enilloring</i>	1-Covered	
<i>enpresse-28</i>	1-Covered	
<i>enskyce</i>	1-Covered	
<i>estarylla</i>	1-Covered	
<i>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)</i>	1-Covered	QL (8 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
<i>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)</i>	1-Covered	QL (4 PER 28 DAYS)
<i>estradiol (0.1 mg/gm cream, 0.5 mg tab, 1 mg tab, 2 mg tab, 10 mcg tab)</i>	1-Covered	
<i>estradiol valerate</i>	1-Covered	
<i>ESTRING</i>	1-Covered	
<i>ethynodiol diac-eth estradiol</i>	1-Covered	
<i>etonogestrel-ethinyl estradiol</i>	1-Covered	
<i>falmina</i>	1-Covered	
<i>feirza 1.5/30</i>	1-Covered	
<i>feirza 1/20</i>	1-Covered	
<i>femynor</i>	1-Covered	
<i>fyavolv</i>	1-Covered	
<i>hailey 1.5/30</i>	1-Covered	
<i>hailey 24 fe</i>	1-Covered	
<i>hailey fe 1.5/30</i>	1-Covered	
<i>hailey fe 1/20</i>	1-Covered	
<i>haloette</i>	1-Covered	
<i>iclevia</i>	1-Covered	
<i>introvale</i>	1-Covered	
<i>isibloom</i>	1-Covered	
<i>jasmiel</i>	1-Covered	
<i>jinteli</i>	1-Covered	
<i>jolessa</i>	1-Covered	
<i>juleber</i>	1-Covered	
<i>junel 1.5/30</i>	1-Covered	
<i>junel 1/20</i>	1-Covered	
<i>junel fe 1.5/30</i>	1-Covered	
<i>junel fe 1/20</i>	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
<i>june fe 24</i>	1-Covered	
<i>kalliga</i>	1-Covered	
<i>kariva</i>	1-Covered	
<i>kelnor 1/35</i>	1-Covered	
<i>kelnor 1/50</i>	1-Covered	
<i>kurvelo</i>	1-Covered	
<i>larin 1.5/30</i>	1-Covered	
<i>larin 1/20</i>	1-Covered	
<i>larin 24 fe</i>	1-Covered	
<i>larin fe 1.5/30</i>	1-Covered	
<i>larin fe 1/20</i>	1-Covered	
<i>leena</i>	1-Covered	
<i>lessina</i>	1-Covered	
<i>levonest</i>	1-Covered	
<i>levonorg-eth estrad triphasic</i>	1-Covered	
<i>levonorgest-eth estrad 91-day (0.1-0.02 & 0.01 mg tab, 0.15-0.03 mg tab)</i>	1-Covered	
<i>levonorgestrel-ethinyl estrad</i>	1-Covered	
<i>levora 0.15/30 (28)</i>	1-Covered	
<i>lo-zumandimine</i>	1-Covered	
<i>loestrin 1.5/30 (21)</i>	1-Covered	
<i>loestrin 1/20 (21)</i>	1-Covered	
<i>loestrin fe 1.5/30</i>	1-Covered	
<i>loestrin fe 1/20</i>	1-Covered	
<i>lojaimiess</i>	1-Covered	
<i>loryna</i>	1-Covered	
<i>low-ogestrel</i>	1-Covered	
<i>lutra</i>	1-Covered	
<i>lyllana</i>	1-Covered	QL (8 PER 28 DAYS)
<i>marlissa</i>	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
MENEST	1-Covered	
<i>microgestin 1.5/30</i>	1-Covered	
<i>microgestin 1/20</i>	1-Covered	
<i>microgestin 24 fe</i>	1-Covered	
<i>microgestin fe 1.5/30</i>	1-Covered	
<i>microgestin fe 1/20</i>	1-Covered	
<i>mili</i>	1-Covered	
<i>mono-linyah</i>	1-Covered	
<i>necon 0.5/35 (28)</i>	1-Covered	
<i>nikki</i>	1-Covered	
<i>norelgestromin-eth estradiol</i>	1-Covered	
<i>norethin ace-eth estrad-fe (1-20 tab, 1.5-30 tab)</i>	1-Covered	
<i>norethin-eth estradiol-fe 0.4-35 mg-mcg chew tab</i>	1-Covered	
<i>norethindron-ethinyl estrad-fe</i>	1-Covered	
<i>norethindrone acet-ethinyl est</i>	1-Covered	
<i>norethindrone-eth estradiol</i>	1-Covered	
<i>norgestim-eth estrad triphasic</i>	1-Covered	
<i>norgestimate-eth estradiol</i>	1-Covered	
<i>nortrel 0.5/35 (28)</i>	1-Covered	
<i>nortrel 1/35 (21)</i>	1-Covered	
<i>nortrel 1/35 (28)</i>	1-Covered	
<i>nortrel 7/7/7</i>	1-Covered	
<i>nylia 1/35</i>	1-Covered	
<i>nylia 7/7/7</i>	1-Covered	
<i>nymyo</i>	1-Covered	
<i>ocella</i>	1-Covered	
<i>philith</i>	1-Covered	
<i>pimtrea</i>	1-Covered	
<i>pirmella 1/35</i>	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
<i>portia-28</i>	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	
<i>previfem</i>	1-Covered	
<i>reclipsen</i>	1-Covered	
<i>setlakin</i>	1-Covered	
<i>simliya</i>	1-Covered	
<i>sprintec 28</i>	1-Covered	
<i>sronyx</i>	1-Covered	
<i>syeda</i>	1-Covered	
<i>tarina 24 fe</i>	1-Covered	
<i>tarina fe 1/20 eq</i>	1-Covered	
<i>tilia fe</i>	1-Covered	
<i>tri femynor</i>	1-Covered	
<i>tri-estarylla</i>	1-Covered	
<i>tri-legest fe</i>	1-Covered	
<i>tri-linyah</i>	1-Covered	
<i>tri-lo-estarylla</i>	1-Covered	
<i>tri-lo-marzia</i>	1-Covered	
<i>tri-lo-mili</i>	1-Covered	
<i>tri-lo-sprintec</i>	1-Covered	
<i>tri-mili</i>	1-Covered	
<i>tri-nymyo</i>	1-Covered	
<i>tri-sprintec</i>	1-Covered	
<i>tri-vylibra</i>	1-Covered	
<i>tri-vylibra lo</i>	1-Covered	
<i>trivora (28)</i>	1-Covered	
<i>turqoz</i>	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
<i>valtya 1/50</i>	1-Covered	
<i>velivet</i>	1-Covered	
<i>vestura</i>	1-Covered	
<i>vienva</i>	1-Covered	
<i>vioarele</i>	1-Covered	
<i>volnea</i>	1-Covered	
<i>vyfemla</i>	1-Covered	
<i>vylibra</i>	1-Covered	
<i>wera</i>	1-Covered	
<i>wymzya fe</i>	1-Covered	
<i>xarah fe</i>	1-Covered	
<i>xelria fe</i>	1-Covered	
<i>xulane</i>	1-Covered	
<i>yuvaferm</i>	1-Covered	
<i>zafemy</i>	1-Covered	
<i>zovia 1/35 (28)</i>	1-Covered	
<i>zumandimine</i>	1-Covered	

PROGESTINS

<i>camila</i>	1-Covered	
<i>deblitane</i>	1-Covered	
DEPO-SUBQ PROVERA 104	1-Covered	
<i>emzahh</i>	1-Covered	
<i>errin</i>	1-Covered	
<i>gallifrey</i>	1-Covered	
<i>heather</i>	1-Covered	
<i>incassia</i>	1-Covered	
<i>jencycla</i>	1-Covered	
LILETTA (52 MG)	1-Covered	
<i>lyleq</i>	1-Covered	
<i>lyza</i>	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
<i>medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml susp prsyr, 150 mg/ml suspension)</i>	1-Covered	
<i>megestrol acetate (20 mg tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension, 800 mg/20ml suspension)</i>	1-Covered	
NEXPLANON	1-Covered	
<i>nora-be</i>	1-Covered	
<i>norethindrone</i>	1-Covered	
<i>norethindrone acetate</i>	1-Covered	
<i>norlyda</i>	1-Covered	
<i>norlyroc</i>	1-Covered	
<i>progesterone (100 mg cap, 200 mg cap)</i>	1-Covered	
<i>sharobel</i>	1-Covered	

SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS

DUAVEE	1-Covered	
<i>raloxifene hcl</i>	1-Covered	QL (30 PER 30 DAYS)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)

<i>euthyrox</i>	1-Covered	
<i>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)</i>	1-Covered	
<i>levoxyl</i>	1-Covered	
<i>liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)</i>	1-Covered	
SYNTHROID	1-Covered	
<i>unithroid</i>	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
<i>cabergoline</i>	1-Covered	
ELIGARD	1-Covered	PA3
FIRMAGON	1-Covered	PA3
FIRMAGON (240 MG DOSE)	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>lanreotide acetate</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>leuprolide acetate</i>	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)
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)
<i>mifepristone</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>octreotide acetate (50 mcg/ml soln prsyr, 50 mcg/ml solution, 100 mcg/ml soln prsyr, 100 mcg/ml solution, 200 mcg/ml solution)</i>	1-Covered	PA
<i>octreotide acetate (500 mcg/ml soln prsyr, 500 mcg/ml solution, 1000 mcg/ml solution)</i>	1-Covered	PA, NDS (Non-Extended Day Supply)
RECORLEV	1-Covered	PA, QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

<i>methimazole</i>	1-Covered
<i>propylthiouracil</i>	1-Covered

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)
<i>icatibant acetate</i>	1-Covered	PA, QL (27 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>sajazir</i>	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)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
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)

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
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)

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)
<i>azathioprine 50 mg tab</i>	1-Covered	PA3
AZATHIOPRINE SODIUM	1-Covered	PA3
<i>cyclosporine (25 mg cap, 100 mg cap)</i>	1-Covered	PA3
<i>cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)</i>	1-Covered	PA3
ENBREL	1-Covered	PA, 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
ENBREL MINI	1-Covered	PA, NDS (Non-Extended Day Supply)
ENBREL SURECLICK	1-Covered	PA, NDS (Non-Extended Day Supply)
ENVARUSUS XR	1-Covered	PA3
<i>everolimus (0.25 mg tab, 0.5 mg tab, 0.75 mg tab, 1 mg tab)</i>	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>gengraf (25 mg cap, 100 mg cap, 100 mg/ml solution)</i>	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)
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)

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
INFLECTRA	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>leflunomide 10 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>leflunomide 20 mg tab</i>	1-Covered	QL (150 PER 30 DAYS)
<i>methotrexate sodium (1 gm recon soln, 2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution)</i>	1-Covered	
<i>methotrexate sodium (pf) (1 gm/40ml solution, 50 mg/2ml solution, 250 mg/10ml solution, 1000 mg/40ml solution)</i>	1-Covered	
<i>mycophenolate mofetil (250 mg cap, 500 mg recon soln, 500 mg tab)</i>	1-Covered	PA3
<i>mycophenolate mofetil 200 mg/ml recon susp</i>	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>mycophenolate mofetil hcl</i>	1-Covered	PA3
<i>mycophenolate sodium</i>	1-Covered	PA3
<i>mycophenolic acid</i>	1-Covered	PA3
NULOJIX	1-Covered	PA3, NDS (Non-Extended Day Supply)
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)
<i>sirolimus (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1-Covered	PA3
<i>sirolimus 1 mg/ml solution</i>	1-Covered	PA3, NDS (Non-Extended Day Supply)
<i>tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)</i>	1-Covered	PA3
XATMEP	1-Covered	
VACCINES		
ABRYSVO	1-Covered	
ACTHIB	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
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	
ENGRIX-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	
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	
PREHEVBRIO	1-Covered	PA3
PRIORIX	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
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	

INFLAMMATORY BOWEL DISEASE AGENTS

AMINOSALICYLATES

<i>balsalazide disodium</i>	1-Covered	
<i>mesalamine (1.2 gm tab dr, 4 gm enema, 400 mg cap dr, 800 mg tab dr, 1000 mg suppos)</i>	1-Covered	
<i>mesalamine er 0.375 gm cap er 24h</i>	1-Covered	
<i>mesalamine-cleanser</i>	1-Covered	
<i>sulfasalazine</i>	1-Covered	

GLUCOCORTICOIDS

<i>budesonide 3 mg cp dr part</i>	1-Covered	
<i>budesonide er</i>	1-Covered	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
<i>hydrocortisone (5 mg tab, 10 mg tab, 20 mg tab, 100 mg/60ml enema)</i>	1-Covered	

METABOLIC BONE DISEASE AGENTS

<i>alendronate sodium (35 mg tab, 70 mg tab)</i>	1-Covered	QL (4 PER 28 DAYS)
<i>alendronate sodium 10 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>alendronate sodium 70 mg/75ml solution</i>	1-Covered	
<i>calcitonin (salmon) 200 unit/act solution</i>	1-Covered	
<i>calcitriol (0.25 mcg cap, 0.5 mcg cap)</i>	1-Covered	
<i>calcitriol oral soln 1 mcg/ml</i>	1-Covered	
<i>cinacalcet hcl (30 mg tab, 60 mg tab)</i>	1-Covered	PA3, QL (60 PER 30 DAYS)
<i>cinacalcet hcl 90 mg tab</i>	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	
<i>ibandronate sodium 150 mg tab</i>	1-Covered	QL (1 PER 30 DAYS)
<i>paricalcitol (1 mcg cap, 2 mcg cap, 4 mcg cap)</i>	1-Covered	
PROLIA	1-Covered	QL (1 PER 180 DAYS)
<i>risedronate sodium (35 mg tab, 35 mg tab dr)</i>	1-Covered	QL (4 PER 28 DAYS)
<i>risedronate sodium (5 mg tab, 30 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>risedronate sodium 150 mg tab</i>	1-Covered	QL (1 PER 28 DAYS)
TERIPARATIDE (RECOMBINANT)	1-Covered	PA, QL (2.48 PER 28 DAYS), NDS (Non-Extended Day Supply)
XGEVA	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)</i>	1-Covered	PA3

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
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
GAUZE PADS & DRESSINGS - PADS 2 X 2	1-Covered	PA
INSULIN PEN NEEDLE (NOVO/BD/ULTIMED/OWEN/TRIVI DIA)	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

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
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	
<i>sterile water for irrigation</i>	1-Covered	

OPHTHALMIC AGENTS

OPHTHALMIC AGENTS, OTHER

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

OPHTHALMIC ANTI-ALLERGY AGENTS

<i>azelastine hcl 0.05 % solution</i>	1-Covered
<i>cromolyn sodium 4 % solution</i>	1-Covered
<i>epinastine hcl</i>	1-Covered

OPHTHALMIC ANTI-INFECTIVES

AZASITE	1-Covered
<i>bacitracin</i>	1-Covered
<i>erythromycin 5 mg/gm ointment</i>	1-Covered
<i>gatifloxacin</i>	1-Covered
<i>gentamicin sulfate 0.3 % solution</i>	1-Covered
<i>moxifloxacin hcl (2x day)</i>	1-Covered
<i>moxifloxacin hcl 0.5 % solution</i>	1-Covered
<i>ofloxacin 0.3 % solution</i>	1-Covered
<i>polymyxin b-trimethoprim</i>	1-Covered
<i>sulfacetamide sodium (10 % ointment, 10 % solution)</i>	1-Covered
<i>tobramycin 0.3 % solution</i>	1-Covered
<i>trifluridine</i>	1-Covered
ZIRGAN	1-Covered

OPHTHALMIC ANTI-INFLAMMATORIES

<i>bromfenac sodium (once-daily)</i>	1-Covered
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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
<i>dexamethasone sodium phosphate 0.1 % solution</i>	1-Covered	
<i>diclofenac sodium 0.1 % solution</i>	1-Covered	QL (90 PER 30 DAYS)
<i>difluprednate</i>	1-Covered	
FLAREX	1-Covered	
<i>fluorometholone</i>	1-Covered	
<i>flurbiprofen sodium</i>	1-Covered	
ILEVRO	1-Covered	
<i>ketorolac tromethamine (0.4 % solution, 0.5 % solution)</i>	1-Covered	
<i>loteprednol etabonate (0.5 % gel, 0.5 % suspension)</i>	1-Covered	
<i>prednisolone acetate</i>	1-Covered	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	1-Covered	
PROLENSA	1-Covered	

OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS

<i>betaxolol hcl 0.5 % solution</i>	1-Covered
<i>carteolol hcl</i>	1-Covered
<i>levobunolol hcl</i>	1-Covered
<i>timolol maleate (0.25 % gel f soln, 0.25 % solution, 0.5 % (daily) solution, 0.5 % gel f soln, 0.5 % solution)</i>	1-Covered
<i>timolol maleate (once-daily)</i>	1-Covered

OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER

<i>acetazolamide er</i>	1-Covered
<i>apraclonidine hcl</i>	1-Covered
<i>brimonidine tartrate (0.1 % solution, 0.15 % solution, 0.2 % solution)</i>	1-Covered
<i>brinzolamide</i>	1-Covered
<i>dorzolamide hcl</i>	1-Covered
<i>methazolamide</i>	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
<i>pilocarpine hcl (1 % solution, 2 % solution, 4 % solution)</i>	1-Covered	
RHOPRESSA	1-Covered	
SIMBRINZA	1-Covered	

OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS

<i>bimatoprost</i>	1-Covered
<i>latanoprost</i>	1-Covered
LUMIGAN	1-Covered
<i>travoprost (bak free)</i>	1-Covered

OTIC AGENTS

<i>acetic acid 2 % solution</i>	1-Covered
<i>ciprofloxacin-dexamethasone</i>	1-Covered
<i>flac</i>	1-Covered
<i>fluocinolone acetonide 0.01 % oil</i>	1-Covered
<i>hydrocortisone-acetic acid</i>	1-Covered
<i>neomycin-polymyxin-hc (1 % solution, 3.5-10000-1 solution)</i>	1-Covered

RESPIRATORY TRACT/PULMONARY AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

ARNUITY ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
<i>budesonide (0.25 mg/2ml suspension, 0.5 mg/2ml suspension, 1 mg/2ml suspension)</i>	1-Covered	PA3
<i>flunisolide</i>	1-Covered	QL (50 PER 30 DAYS)
<i>fluticasone propionate 50 mcg/act suspension</i>	1-Covered	QL (16 PER 30 DAYS)
<i>fluticasone propionate diskus 100 mcg/act aer pow ba</i>	1-Covered	QL (60 PER 30 DAYS)
<i>fluticasone propionate diskus 250 mcg/act aer pow ba</i>	1-Covered	QL (240 PER 30 DAYS)
<i>fluticasone propionate diskus 50 mcg/act aer pow ba</i>	1-Covered	QL (120 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
<i>fluticasone propionate hfa (110 mcg/act aerosol, 220 mcg/act aerosol)</i>	1-Covered	QL (24 PER 30 DAYS)
<i>fluticasone propionate hfa 44 mcg/act aerosol</i>	1-Covered	QL (22 PER 30 DAYS)
<i>mometasone furoate 50 mcg/act suspension</i>	1-Covered	QL (34 PER 30 DAYS)
PULMICORT FLEXHALER	1-Covered	QL (2 PER 30 DAYS)

ANTIHISTAMINES

<i>azelastine hcl (0.1 % solution, 137 mcg/spray solution)</i>	1-Covered	QL (30 PER 25 DAYS)
<i>cetirizine hcl</i>	1-Covered	
<i>cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)</i>	1-Covered	
<i>desloratadine 5 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>diphenhydramine hcl 50 mg/ml solution</i>	1-Covered	
<i>hydroxyzine hcl (10 mg tab, 10 mg/5ml syrup, 25 mg tab, 50 mg tab)</i>	1-Covered	
<i>levocetirizine dihydrochloride 2.5 mg/5ml solution</i>	1-Covered	
<i>levocetirizine dihydrochloride 5 mg tab</i>	1-Covered	QL (30 PER 30 DAYS)
<i>olopatadine hcl 0.6 % solution</i>	1-Covered	QL (30.5 PER 30 DAYS)
<i>promethazine hcl (6.25 mg/5ml solution, 12.5 mg/10ml solution)</i>	1-Covered	PA

ANTILEUKOTRIENES

<i>montelukast sodium</i>	1-Covered	QL (30 PER 30 DAYS)
<i>zafirlukast</i>	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)
<i>ipratropium bromide 0.02 % solution</i>	1-Covered	PA3

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
<i>ipratropium bromide 0.03 % solution</i>	1-Covered	QL (30 PER 28 DAYS)
<i>ipratropium bromide 0.06 % solution</i>	1-Covered	QL (45 PER 30 DAYS)
YUPELRI	1-Covered	PA3, NDS (Non-Extended Day Supply)

BRONCHODILATORS, SYMPATHOMIMETIC

<i>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)</i>	1-Covered	PA3
<i>albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab, 8 mg/20ml syrup)</i>	1-Covered	
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)</i>	1-Covered	QL (17 PER 30 DAYS)
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)</i>	1-Covered	QL (13.4 PER 30 DAYS)
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)</i>	1-Covered	QL (36 PER 30 DAYS)
<i>arformoterol tartrate</i>	1-Covered	PA3
<i>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)</i>	1-Covered	QL (4 PER 30 DAYS)
<i>formoterol fumarate</i>	1-Covered	PA3
<i>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)</i>	1-Covered	PA3
<i>levalbuterol tartrate</i>	1-Covered	QL (30 PER 30 DAYS)
SEREVENT DISKUS	1-Covered	QL (60 PER 30 DAYS)
<i>terbutaline sulfate (2.5 mg tab, 5 mg tab)</i>	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)

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
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)
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)
<i>tobramycin 300 mg/5ml nebu soln</i>	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

<i>cromolyn sodium 20 mg/2ml nebu soln</i>	1-Covered	PA3
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PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE

<i>elixophyllin</i>	1-Covered	
<i>roflumilast</i>	1-Covered	QL (30 PER 30 DAYS)
<i>theophylline</i>	1-Covered	
<i>theophylline er (300 mg tab er 12h, 400 mg tab er 24h, 450 mg tab er 12h, 600 mg tab er 24h)</i>	1-Covered	

PULMONARY ANTIHYPERTENSIVES

ADEMPAS	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>alyq</i>	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>ambrisentan</i>	1-Covered	PA, 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
<i>bosentan</i>	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)
<i>sildenafil citrate 20 mg tab</i>	1-Covered	PA, QL (90 PER 30 DAYS)
<i>tadalafil (pah)</i>	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)
<i>pirfenidone (267 mg cap, 267 mg tab)</i>	1-Covered	PA, QL (270 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>pirfenidone (534 mg tab, 801 mg tab)</i>	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)

RESPIRATORY TRACT AGENTS, OTHER

<i>acetylcysteine (10 % solution, 20 % solution)</i>	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)
<i>breyna</i>	1-Covered	QL (10.3 PER 30 DAYS)
BREZTRI AEROSPHERE	1-Covered	QL (10.7 PER 30 DAYS)
<i>budesonide-formoterol fumarate</i>	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)

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
FASENRA PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
<i>fluticasone-salmeterol (100-50 mcg/act aer pow ba, 250-50 mcg/act aer pow ba, 500-50 mcg/act aer pow ba)</i>	1-Covered	QL (60 PER 30 DAYS)
<i>ipratropium-albuterol</i>	1-Covered	PA3
TRELEGY ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
<i>wixela inhub</i>	1-Covered	QL (60 PER 30 DAYS)

SKELETAL MUSCLE RELAXANTS

BOTOX	1-Covered	PA
<i>cyclobenzaprine hcl 10 mg tab</i>	1-Covered	PA, QL (90 PER 30 DAYS)
<i>cyclobenzaprine hcl 5 mg tab</i>	1-Covered	PA, QL (180 PER 30 DAYS)
<i>methocarbamol (500 mg tab, 750 mg tab)</i>	1-Covered	
XEOMIN	1-Covered	PA

SLEEP DISORDER AGENTS

SLEEP PROMOTING AGENTS

<i>doxepin hcl (3 mg tab, 6 mg tab)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>eszopiclone</i>	1-Covered	PA, QL (30 PER 30 DAYS)
HETLIOZ LQ	1-Covered	PA, QL (158 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>ramelteon</i>	1-Covered	QL (30 PER 30 DAYS)
<i>tasimelteon</i>	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
<i>temazepam (15 mg cap, 30 mg cap)</i>	1-Covered	QL (30 PER 30 DAYS)
<i>zaleplon 10 mg cap</i>	1-Covered	PA, QL (60 PER 30 DAYS)
<i>zaleplon 5 mg cap</i>	1-Covered	PA, QL (30 PER 30 DAYS)
<i>zolpidem tartrate 10 mg tab</i>	1-Covered	PA, QL (30 PER 30 DAYS)
<i>zolpidem tartrate 5 mg tab</i>	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
WAKEFULNESS PROMOTING AGENTS		
<i>armodafinil</i>	1-Covered	PA, QL (30 PER 30 DAYS)
<i>modafinil 100 mg tab</i>	1-Covered	PA, QL (30 PER 30 DAYS)
<i>modafinil 200 mg tab</i>	1-Covered	PA, QL (60 PER 30 DAYS)
SODIUM OXYBATE	1-Covered	PA, QL (540 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.

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