



National Drug List

Drug list — Three Tier Drug Plan

Your prescription benefit comes with a drug list, which is also called a formulary. This list is made up of brand-name and generic prescription drugs approved by the U.S. Food & Drug Administration (FDA).

The following is a list of plan names to which this formulary may apply. Additional plans may be applicable. If you are a current Anthem member with questions about your pharmacy benefits, we're here to help. Just call us at the Pharmacy Member Services number on your ID card.

Solution PPO 1500/15/20	\$5/\$15/\$50/\$65/30% to \$250 after deductible
Solution PPO 2000/20/20	\$5/\$20/\$30/\$50/30% to \$250
Solution PPO 2500/25/20	\$5/\$20/\$40/\$60/30% to \$250
Solution PPO 3500/30/30	\$5/\$20/\$40/\$60/30% to \$250 Rx ded \$150
Solution PPO 4500/30/30	\$5/\$20/\$40/\$75/30% to \$250
Solution PPO 5500/30/30	\$5/\$20/\$40/\$75/30% to \$250 Rx ded \$250
\$5/\$15/\$25/\$45/30% to \$250	\$5/\$20/\$50/\$65/30% to \$250 Rx ded \$500
\$5/\$15/\$30/\$50/30% to \$250	\$5/\$20/\$50/\$70/30% to \$250
\$5/\$15/\$40/\$60/30% to \$250	\$5/\$20/\$50/\$70/30% to \$250 after deductible

Here are a few things to remember:

- You can view and search our current drug lists when you visit [anthem.com/ca](https://www.anthem.com/ca) and choose Prescription Benefits. Please note: The formulary is subject to change and all previous versions of the formulary are no longer in effect.
- Additional tools and resources are available for current Anthem members to view the most up-to-date list of drugs for your plan - including drugs that have been added, generic drugs and more – by logging in at [anthem.com/ca](https://www.anthem.com/ca).
- Your coverage has limitations and exclusions, which means there are certain rules about what's covered by your plan and what isn't. Already a member? You can view your Certificate/Evidence of Coverage or your Summary Plan Description by logging in at [anthem.com/ca](https://www.anthem.com/ca) and go to **My Plan ->Benefits-> Plan Documents**.
- You and your doctor can use this list as a guide to choose drugs that are best for you. Drugs that aren't on this list may not be covered by your plan and may cost you more out of pocket. To help you see how the drug list works with your drug benefit, we've included some frequently asked questions (FAQ) in this document about how the list is set up and what to do if a drug you take isn't on it.

National Drug List

Three Tier

Table of Contents

INFORMATIONAL SECTION	4
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS FOR THE NERVOUS SYSTEM	11
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - BIOLOGICAL AGENTS	14
AMEBICIDES - DRUGS FOR INFECTIONS	15
AMINOGLYCOSIDES - DRUGS FOR INFECTIONS	15
ANALGESICS - ANTI-INFLAMMATORY - DRUGS FOR PAIN AND FEVER	15
ANALGESICS - NONNARCOTIC - DRUGS FOR PAIN AND FEVER	18
ANALGESICS - OPIOID - DRUGS FOR PAIN AND FEVER	20
ANDROGENS-ANABOLIC - HORMONES	24
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS	24
ANTHELMINTICS - DRUGS FOR INFECTIONS	25
ANTIANGINAL AGENTS - DRUGS FOR THE HEART	25
ANTIANKXIETY AGENTS - DRUGS FOR THE NERVOUS SYSTEM	26
ANTIARRHYTHMICS - DRUGS FOR THE HEART	27
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS FOR THE LUNGS	28
ANTICOAGULANTS - DRUGS FOR THE BLOOD	31
ANTICONVULSANTS - DRUGS FOR THE NERVOUS SYSTEM	33
ANTIDEPRESSANTS - DRUGS FOR THE NERVOUS SYSTEM	37
ANTIDIABETICS - HORMONES	40
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS FOR THE STOMACH	45
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING	45
ANTIEMETICS - DRUGS FOR THE STOMACH	47
ANTIFUNGALS - DRUGS FOR INFECTIONS	48
ANTIHIISTAMINES - DRUGS FOR THE LUNGS	50
ANTIHYPERLIPIDEMICS - DRUGS FOR THE HEART	51
ANTIHYPERTENSIVES - DRUGS FOR THE HEART	53
ANTI-INFECTIVE AGENTS - MISC. - DRUGS FOR INFECTIONS	57
ANTIMALARIALS - DRUGS FOR INFECTIONS	61
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS FOR NERVES AND MUSCLES	61
ANTIMYCOBACTERIAL AGENTS - DRUGS FOR INFECTIONS	62
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS FOR CANCER	62
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS FOR THE NERVOUS SYSTEM	82
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS FOR THE NERVOUS SYSTEM	84
ANTISEPTICS & DISINFECTANTS - ANTISEPTICS AND DISINFECTANTS	89
ANTIVIRALS - DRUGS FOR INFECTIONS	89
BETA BLOCKERS - DRUGS FOR THE HEART	94
CALCIUM CHANNEL BLOCKERS - DRUGS FOR THE HEART	96
CARDIOTONICS - DRUGS FOR THE HEART	98
CARDIOVASCULAR AGENTS - MISC. - DRUGS FOR THE HEART	99
CEPHALOSPORINS - DRUGS FOR INFECTIONS	101
CONTRACEPTIVES - DRUGS FOR WOMEN	103
CORTICOSTEROIDS - HORMONES	109
COUGH/COLD/ALLERGY - DRUGS FOR THE LUNGS	111
DERMATOLOGICALS - DRUGS FOR THE SKIN	112
DIAGNOSTIC PRODUCTS	124
DIGESTIVE AIDS - DRUGS FOR THE STOMACH	124
DIURETICS - DRUGS FOR THE HEART	124
ENDOCRINE AND METABOLIC AGENTS - MISC. - HORMONES	125
ESTROGENS - HORMONES	133
FLUOROQUINOLONES - DRUGS FOR INFECTIONS	135
GASTROINTESTINAL AGENTS - MISC. - DRUGS FOR THE STOMACH	135
GENERAL ANESTHETICS - DRUGS FOR PAIN AND FEVER	138
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS FOR THE URINARY SYSTEM	139
GOUT AGENTS - DRUGS FOR PAIN AND FEVER	140
HEMATOLOGICAL AGENTS - MISC. - DRUGS FOR THE BLOOD	141
HEMATOPOIETIC AGENTS - DRUGS FOR NUTRITION	146
HEMOSTATICS - DRUGS FOR THE BLOOD	148
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS FOR THE NERVOUS SYSTEM	150

LAXATIVES - DRUGS FOR THE STOMACH	151
LOCAL ANESTHETICS-PARENTERAL - DRUGS FOR PAIN AND FEVER	155
MACROLIDES - DRUGS FOR INFECTIONS	156
MEDICAL DEVICES AND SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT	157
MIGRAINE PRODUCTS - DRUGS FOR THE NERVOUS SYSTEM	178
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION	179
MISCELLANEOUS THERAPEUTIC CLASSES - VITAMINS AND MINERALS	182
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT	186
MULTIVITAMINS - DRUGS FOR NUTRITION	188
MUSCULOSKELETAL THERAPY AGENTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES	197
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE	199
NEUROMUSCULAR AGENTS - DRUGS FOR NERVES AND MUSCLES	199
NUTRIENTS - DRUGS FOR NUTRITION	201
OPHTHALMIC AGENTS - DRUGS FOR THE EYE	202
OTIC AGENTS - DRUGS FOR THE EAR	209
OXYTOCICS - HORMONES	210
PASSIVE IMMUNIZING AND TREATMENT AGENTS - BIOLOGICAL AGENTS	210
PENICILLINS - DRUGS FOR INFECTIONS	211
PROGESTINS - HORMONES	213
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS FOR THE NERVOUS SYSTEM	213
RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS	220
SULFONAMIDES - DRUGS FOR INFECTIONS	221
TETRACYCLINES - DRUGS FOR INFECTIONS	221
THYROID AGENTS - HORMONES	222
TOXOIDS - BIOLOGICAL AGENTS	222
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR THE STOMACH	223
URINARY ANTISPASMODICS - DRUGS FOR THE URINARY SYSTEM	225
VACCINES - BIOLOGICAL AGENTS	226
VAGINAL AND RELATED PRODUCTS - DRUGS FOR WOMEN	229
VASOPRESSORS - DRUGS FOR THE HEART	230
VITAMINS - DRUGS FOR NUTRITION	231



National Drug List- Informational Section

Definitions

“**\$0**” next to a drug means this is a preventive drug. For some members, this product may be covered at 100% with \$0 cost share with a prescription from your provider if specified criteria are met.

“**BRAND name drug**” means a drug that is marketed under a proprietary, trademark-protected name. A BRAND name drug is listed in this formulary in all CAPITAL letters.

“**Coinsurance**” means a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“**Copayment**” means a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“**Deductible**” means the amount an enrollee pays for covered health care benefits before the enrollee’s health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

“**Dose Optimization (DO)**” means dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

“**Drug Tier**” is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan’s prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee’s portion of the cost for the drug.

“**Enrollee**” is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this this formulary template shall also include subscriber as defined in this section below.

“**Exception request**” is a request for coverage of a prescription drug. If an enrollee, his or her designee or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee’s condition.

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

“**Formulary**” or “**prescription drug list**” is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.

“**Generic drug**” is the same drug as its BRAND name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.

“**Limited Distribution (LD)**” means limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

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

“**Nonformulary drug**” is a prescription drug that is not listed on the health plan’s formulary.

“**Oral Chemotherapy (OC)**” Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars (\$250) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.



“Out-of-pocket costs” are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

“Prescribing provider” is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

“Prescription” is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

“Prescription drug” is a drug that is prescribed by the enrollee’s prescribing provider and requires a prescription under applicable law.

“Prior Authorization (PA)” is a health plan’s requirement that the enrollee or the enrollee’s prescribing provider obtain the health plan’s authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

“Quantity limit (QL)” means a restriction on the number of doses of a prescription drug covered by a health insurance product during a specific time period, or any other limitation on the quantity of a drug that is covered.

“Specialty Drugs (SP)” means specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

“Step therapy (ST)” is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee’s medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request.

“Subscriber” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.



Frequently Asked Questions

How do I know what drugs are covered under my benefits?

This is a complete listing of all the drugs on the drug list. But, it's possible a drug(s) on this list may not be covered, depending on your plan's design.

Your pharmacy benefit covers prescription drugs, including Specialty Drugs, that may be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. Benefits that are administered to you in your provider's office are typically covered under your medical benefit. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables and any drug that must be administered by a Provider.

How can I find a drug on the list?

- (A) A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the BRAND name or **generic** name of the drug in the alphabetical index; and
- (B) If a **generic** equivalent for a BRAND name drug is not available on the market or is not covered, the drug will not be separately listed by its **generic** name.

You can search the PDF drug list by:

- Drug name, using Ctrl + F on your keyboard, then type in the name of the drug you're looking for.
- Drug class, using the categories listed in alphabetical order.

How are drugs shown on the list?

- A drug is listed alphabetically by its BRAND name and **generic** names in the therapeutic category and class to which it belongs;
- The **generic** for a BRAND name drug is included after the BRAND name in parentheses and all **bold and italicized lowercase** letters;

**PSEUDOBLBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS
TYPE - DRUGS FOR SEVERE MENTAL DISORDERS**

NUEDEXTA ORAL CAPSULE (dextromethorphan)

- If a **generic** equivalent for a BRAND name drug is both available and covered, the **generic** drug will be listed separately from the BRAND name drug in all **bold and italicized lowercase letters**; and

AMINOPENICILLIN ANTIBIOTIC - ANTIBIOTICS

amoxicillin oral capsule

- If a **generic** drug is marketed under a proprietary, trademark-protected BRAND name, the BRAND name will be listed after the **generic** name in parentheses and regular typeface with the first letter of each word capitalized.

levonorgestrel-ethinyl estrad (Portia 28 Oral Tablet)

The "Under Coverage Requirements and Limits" section will indicate if you need preapproval before you can take the drug (called prior authorization or PA), or if you need to try other drugs first for your treatment (called step therapy or ST).

Note: The presence of a prescription drug on the formulary does not guarantee that your doctor will prescribe that prescription drug for a particular medical condition



What are my options for getting my prescriptions?

You have plenty of choices about how and where to get your prescription medicines, including local pharmacies in your plan, convenient home delivery or specialty pharmacies. Most plans include our home delivery program at no extra cost to you.

Current Anthem members can find out more by logging in at [anthem.com/ca](https://www.anthem.com/ca) and choose Prescription Benefits or call 833-203-1739. For more details about your coverage, you can call the phone number on your member ID card.

What if my drug isn't on the list?

We understand that only you and your doctor know what is best for you. If you want to take a drug that's not on the drug list, you may have to pay the full cost for it. You can also talk to your doctor or pharmacist to see if there's another drug covered by your plan that will work just as well, or if generic or OTC drugs are an option. Only you and your doctor can decide what drugs are right for you.

If a drug you're taking isn't covered, your doctor can ask us to review the coverage. This process is called preapproval or prior authorization.

Your doctor can get the process started by completing an electronic Prior Authorization, calling the Member Services number on the back of your member ID card or by downloading a prior authorization form from our website and submitting it. If your request is approved, the amount you pay for the drug will depend on your plan's benefit.

There are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to <https://www.covermyeds.com/main/partners/anthem>.
2. Log in at [anthem.com/ca](https://www.anthem.com/ca) and choose **Pharmacy**.
 - o Go to **Pharmacy Resources** and **Search Your Drug List** for your medication.
 - o Choose the correct medication strength and form.
 - o Scroll down to **Definition of Restrictions** and locate the applicable Fax Form in the table.
 - o Your doctor [completes and faxes the form](#) to us at 844-474-3347.
3. Calling Member Services number on the back of your member ID card.

If the contraceptive you are taking is not on the formulary, your doctor can contact us if it is medically necessary because the preferred contraceptives are inappropriate for you, and we will waive your cost share.

Who decides what drugs are on the list?

The drugs on the list are reviewed through our Pharmacy and Therapeutics (P&T) process. In this process, a group of independent doctors, pharmacists and other health care professionals decides which drugs we include on our lists. This group meets regularly to look at new and existing drugs and recommends drugs based on how safe they are, how well they work and the value they offer our members.

What is a specialty drug and how do I get them?

If you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered. Specialty drugs come in many forms like pills, liquids, injections (shots), infusions or inhalers and may need special storage and handling. Typically benefits for specialty drugs that are self-administered will be covered under the pharmacy benefit. Benefits for specialty drugs that are administered to you in your provider's office are typically covered under your medical benefit. If you use pharmacies that are not in the network, your medicine may not be covered and you may have to pay the full cost. For more details about your coverage, you can call the phone number on your member ID card.

Does the drug list change, and how will I know if it does?

Drugs on our list are reviewed and updated on a monthly basis. Sometimes, drugs are added, removed, change tiers or have updated requirements. The changes will usually go into effect the first day of the month. But don't worry, we'll let you know if a drug you take is taken off the list and, in some cases, if a drug you take is moved to a higher tier.

You can always check the drug list to make sure medicines you take are still on it. You'll find the most up-to-date drug list when you log in at [anthem.com/ca](https://www.anthem.com/ca).



What kind of drugs can I find on the formulary?

We cover FDA-approved preventive care drugs with zero cost share in compliance with the Affordable Care Act (ACA) and California state regulations. Your doctor may need to write a prescription for these preventive services to be covered by your plan, even if they are listed as over-the-counter. The availability or coverage of these medications without cost-sharing may be subject to criteria established by the health plan.

We cover FDA-approved equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program authorized by the State's Diabetes Control Project within the Bureau of Health.

What drugs can I find in each tier?

We place drugs on different tiers based on how well they work to improve health, whether there are over-the-counter (OTC) options and their costs compared to other drugs used for the same type of treatment. The lower the tier, the lower your share of the cost. Here's a breakdown of the tiers in your plan:

- Tier 1 drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions. Some plans split Tier 1 into Tier 1a and Tier 1b:
 - Tier 1a drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.
 - Tier 1b drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.
- Tier 2 drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.
- Tier 3 drugs have the highest cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition. Tier 3 may also include drugs that were recently approved by the FDA or specialty drugs that are used to treat serious, long-term health conditions and that may need special handling.

How will I know if my drug is covered and how much will it cost?

You can go online and with the [Price a Medication](#) tool, get pharmacy-specific drug coverage details and pricing from a number of local retail pharmacies in your zip code.

Note: For oral chemotherapy drugs - Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars (\$250) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.

How does Anthem promote safety?

When you go to a pharmacy, the pharmacist will get an electronic message from Anthem if a drug needs prior authorization, requires step therapy or has a limit on the amount that can be given. Here's a closer look at all of the programs we've put into place to help make sure you get the care you need, while helping to keep you safe.¹



Our clinical edit programs are:

- Prior authorization, which requires you to get approval before taking a medicine. This helps make sure a drug is used properly and focuses on drugs that may have:
 - Risk of side effects.
 - Risk of harmful effects when taken with other drugs.
 - Potential for incorrect use or abuse.
 - Rules for use with certain conditions.
- Step therapy, which requires that other drugs be tried first. It focuses on whether a drug is right for your condition.
- Dose optimization, which involves changing from taking a dose twice a day to once a day, when medically appropriate. Taking fewer doses may lower your costs; a single higher dose of a drug taken once a day may cost less than a lower dose taken twice a day.
- Quantity Limits impose a limit on the amount in a prescription and how often it can be refilled.
 - If a refill request is submitted too soon or the doctor prescribes an amount that's higher than what is allowed, the drug won't be covered at that time.
 - If there are medical reasons to prescribe the drug as originally dosed, the doctor can ask for review by our Prior Authorization Center.

Also, If you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered.

How does my doctor start the Prior Authorization process?

If your drug is on our formulary but requires a PA or Step Therapy, there are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to <https://www.covermymeds.com/main/partners/anthem>.
2. Log in at anthem.com/ca and choose Pharmacy.
 - Go to Pharmacy Resources and Search Your Drug List for your medication.
 - Choose the correct medication strength and form.
 - Scroll down to Definition of Restrictions and locate the applicable Fax Form in the table.
 - Your doctor completes the form and faxes it to Anthem at 844-474-3347.
3. Calling Pharmacy Member Services number on the back of your member ID card.

What is Step Therapy? How does it work?

Step therapy requires trying other drugs before certain medications may be covered. The pharmacy will let you know if step therapy is required, and you must first try the drug or treatment included in the program. If the drug or treatment does not treat the condition well, the doctor can contact our Prior Authorization Center to ask that we approve the original drug.¹

A few more notes about the exception process:

- If we fail to respond to a completed prior authorization or step therapy exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed approved, and we may not deny any subsequent requests for this medication.
- Don't worry, if you've changed policies, we won't ask you to repeat an approved step therapy request that is already being used to treat a medical condition provided that the drug is still appropriately prescribed and is considered safe and effective.

A note about opioid analgesics. The member cost share for certain abuse-deterrent opioid analgesics may be lower in some states because of laws in those states. Opioid analgesics are a type of painkiller. In response to the global opioid epidemic, the U.S. Food and Drug Administration (FDA) has encouraged drug manufacturers to develop opioids with properties that help deter their misuse and abuse.

Drug(s) may be excluded from the list based on your plan's benefit design.

¹ If the Prior Authorization Center concludes the prescription claim should be denied, members and their doctors will get letters that explain the appeals and/or grievance process.

KEY

Here are some terms and notes you'll find on the drug list.

BRAND name drugs are in **UPPER CASE**, plain type.

generic drugs are in lower case, **italic bold** type.

\$0 = preventive drugs. For some members, this product may be covered at 100% with \$0 cost share with a prescription from your provider if specified criteria are met.

BE = benefit exclusion. This drug may not be covered depending on your plans design. To find out if your drug is covered, log into your member portal or use the Sydney app to [Price a Medication](#) and refer to your plan documents.

DO = dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

LD = limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

OC = oral chemotherapy. These drugs after deductible shall not exceed \$250 per an individual prescription for up to a 30 day supply.

PA = prior authorization. You may need to get benefits approved before certain prescriptions can be filled.

QL = quantity limits. There are limits on the amount of medicine covered within a certain amount of time.

SP = specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

ST = step therapy. You may need to use another recommended drug first before a prescribed drug is covered.

Tier 1 = drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions.

Tier 1a = drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.

Tier 1b = drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.

Tier 2 = drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.

Tier 3 = drugs have the highest cost share. They often include non-preferred brand and generic drugs. They may cost more than drugs on lower tiers that are used to treat the same condition.

Three Tier

CURRENT AS OF 1/1/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS FOR THE NERVOUS SYSTEM		
*ADHD AGENT - SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>clonidine hcl er oral tablet extended release 12 hour</i>	1 or 1b*	PA
<i>guanfacine hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA
*ADHD AGENT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>atomoxetine hcl oral capsule</i>	1 or 1b*	PA
*AMPHETAMINE MIXTURES*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 5 mg, 7.5 mg</i>	1 or 1b*	PA; DO
<i>amphetamine-dextroamphetamine oral tablet 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>amphetamine-dextroamphetamine oral tablet 30 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
*AMPHETAMINES*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>amphetamine sulfate oral tablet 10 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>amphetamine sulfate oral tablet 5 mg</i>	1 or 1b*	DO
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg</i>	1 or 1b*	PA; QL (4 capsules per 1 day)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</i>	1 or 1b*	PA; DO
<i>dextroamphetamine sulfate oral solution</i>	1 or 1b*	PA; QL (60 mL per 1 day)
<i>dextroamphetamine sulfate oral tablet 10 mg, 7.5 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>dextroamphetamine sulfate oral tablet 15 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>dextroamphetamine sulfate oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>dextroamphetamine sulfate oral tablet 20 mg, 30 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>procentra oral solution</i>	1 or 1b*	PA; QL (60 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; DO
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; QL (1 capsule per 1 day)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; DO
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; QL (1 tablet per 1 day)
<i>zenzedi oral tablet 10 mg, 7.5 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>zenzedi oral tablet 15 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>zenzedi oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>zenzedi oral tablet 20 mg, 30 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
*ANALEPTICS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>caffeine citrate intravenous solution</i>	3	
<i>caffeine citrate oral solution</i>	1 or 1b*	
DOPRAM INTRAVENOUS SOLUTION (<i>doxapram hcl</i>)	3	
*ANOREXIANTS NON-AMPHETAMINE*** - DRUGS FOR THE NERVOUS SYSTEM		
ADIPEX-P ORAL TABLET (<i>phentermine hcl</i>)	3	PA; BE; QL (1 tablet per 1 day)
<i>benzphetamine hcl oral tablet</i>	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
<i>diethylpropion hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
<i>diethylpropion hcl oral tablet</i>	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
LOMAIRA ORAL TABLET (<i>phentermine hcl</i>)	3	PA; BE; QL (3 tablets per 1 day)
PHENDIMETRAZINE TARTRATE ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR	3	PA; BE; QL (1 capsule per 1 day)
<i>phendimetrazine tartrate oral tablet</i>	1 or 1b*	PA; BE; QL (6 tablets per 1 day)
<i>phentermine hcl oral capsule</i>	1 or 1b*	PA; BE; QL (1 capsule per 1 day)
<i>phentermine hcl oral tablet</i>	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
*ANTI-OBESITY - GIP & GLP-1 RECEPTOR AGONISTS*** - DRUGS FOR THE NERVOUS SYSTEM		
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tirzepatide-weight management</i>)	2	PA; BE; QL (1 pen per 1 week)
*ANTI-OBESITY - GLP-1 RECEPTOR AGONISTS*** - DRUGS FOR THE NERVOUS SYSTEM		
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>liraglutide - weight management</i>)	3	PA; BE; QL (3 mg per 1 day)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>semaglutide-weight management</i>)	2	PA; BE; QL (1 pen per 1 week)
*DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)*** - DRUGS FOR SLEEP DISORDER		
SUNOSI ORAL TABLET 150 MG (<i>solriamfetol hcl</i>)	3	PA; QL (1 tablet per 1 day)
SUNOSI ORAL TABLET 75 MG (<i>solriamfetol hcl</i>)	3	PA; DO

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS*** - DRUGS FOR SLEEP DISORDER		
WAKIX ORAL TABLET 17.8 MG (<i>pitolisant hcl</i>)	3	PA; LD; QL (2 tablets per 1 day)
WAKIX ORAL TABLET 4.45 MG (<i>pitolisant hcl</i>)	3	PA; LD; DO
*LIPASE INHIBITORS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>orlistat oral capsule</i>	1 or 1b*	PA; BE; QL (3 capsules per 1 day)
*MELANOCORTIN 4 (MC4) RECEPTOR AGONISTS*** - DRUGS FOR THE NERVOUS SYSTEM		
IMCIVREE SUBCUTANEOUS SOLUTION (<i>setmelanotide acetate</i>)	3	PA; LD; BE; QL (9 vials per 30 days)
*STIMULANTS - MISC.*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>armodafinil oral tablet 50 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg</i>	1 or 1b*	ST; DO
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg</i>	1 or 1b*	ST; QL (1 capsule per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 5 mg</i>	1 or 1b*	PA; DO
<i>dexmethylphenidate hcl oral tablet 10 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg</i>	1 or 1b*	PA; QL (2 capsules per 1 day)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 45 mg, 63 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 54 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
METHYLPHENIDATE HCL ER (OSM) ORAL TABLET EXTENDED RELEASE 72 MG	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 40 mg, 50 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	1 or 1b*	PA; DO

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	1 or 1b*	PA; QL (30 mL per 1 day)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	1 or 1b*	PA; QL (60 mL per 1 day)
<i>methylphenidate hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl oral tablet 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl oral tablet chewable 10 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl oral tablet chewable 2.5 mg</i>	1 or 1b*	ST; DO
<i>methylphenidate hcl oral tablet chewable 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr</i>	1 or 1b*	ST; DO
<i>methylphenidate transdermal patch 20 mg/9hr, 30 mg/9hr</i>	1 or 1b*	ST; QL (1 patch per 1 day)
<i>modafinil oral tablet 100 mg</i>	1 or 1b*	PA; DO
<i>modafinil oral tablet 200 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - BIOLOGICAL AGENTS		
*ALLERGENIC EXTRACTS*** - BIOLOGICAL AGENTS		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL (<i>timothy grass pollen allergen</i>)	3	PA; QL (1 tablet per 1 day)
PALFORZIA (12 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (120 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (160 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (20 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (200 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (240 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (3 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (300 MG MAINTENANCE) ORAL PACKET (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 packet per 1 day)
PALFORZIA (300 MG TITRATION) ORAL PACKET (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (40 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (6 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA (80 MG DAILY DOSE) ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
PALFORZIA INITIAL ESCALATION ORAL (<i>peanut powder-dnfp</i>)	3	PA; LD; QL (1 kit per 1 fill)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL (<i>short ragweed pollen ext</i>)	3	PA; QL (1 tablet per 1 day)
*MIXED ALLERGENIC EXTRACTS*** - BIOLOGICAL AGENTS		
ODACTRA SUBLINGUAL TABLET SUBLINGUAL (<i>dust mite mixed allergen ext</i>)	3	PA; QL (1 tablet per 1 day)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL (<i>grass mix pollens allergen ext</i>)	3	PA; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMEBICIDES - DRUGS FOR INFECTIONS		
*AMEBICIDES*** - DRUGS FOR PARASITES		
SOLOSEC ORAL PACKET (<i>secnidazole</i>)	3	PA; QL (2 grams per 1 fill)
AMINOGLYCOSIDES - DRUGS FOR INFECTIONS		
*AMINOGLYCOSIDES*** - ANTIBIOTICS		
<i>amikacin sulfate injection solution</i>	1 or 1b*	
ARIKAYCE INHALATION SUSPENSION (<i>amikacin sulfate liposome</i>)	3	PA; LD; QL (1 kit per 28 days)
BETHKIS INHALATION NEBULIZATION SOLUTION (<i>tobramycin</i>)	3	LD; QL (224 mL per 28 days)
<i>gentamicin in saline intravenous solution</i>	1 or 1b*	
<i>gentamicin sulfate injection solution</i>	1 or 1b*	
HUMATIN ORAL CAPSULE (<i>paromomycin sulfate</i>)	3	PA
<i>neomycin sulfate oral tablet</i>	1 or 1a*	
<i>streptomycin sulfate intramuscular solution reconstituted</i>	1 or 1b*	
TOBI PODHALER INHALATION CAPSULE (<i>tobramycin</i>)	3	LD; QL (224 capsules per 28 days)
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	1 or 1b*	LD; QL (224 mL per 28 days)
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	1 or 1b*	LD; QL (10 mL per 1 day)
<i>tobramycin sulfate injection solution 1.2 gm/30ml</i>	1 or 1b*	QL (900 mL per 30 days)
<i>tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml</i>	1 or 1b*	QL (180 mL per 30 days)
<i>tobramycin sulfate injection solution 2 gm/50ml</i>	1 or 1b*	QL (1500 mL per 30 days)
<i>tobramycin sulfate injection solution reconstituted</i>	1 or 1b*	QL (30 vials per 30 days)
ZEMDRI INTRAVENOUS SOLUTION (<i>plazomicin sulfate</i>)	3	
ANALGESICS - ANTI-INFLAMMATORY - DRUGS FOR PAIN AND FEVER		
*ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
RINVOQ LQ ORAL SOLUTION (<i>upadacitinib</i>)	3	PA; LD; QL (12 mL per 1 day)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (<i>upadacitinib</i>)	3	PA; LD; QL (1 tablet per 1 day)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (<i>upadacitinib</i>)	3	PA; LD; QL (84 tablets per 12 weeks)
XELJANZ ORAL SOLUTION (<i>tofacitinib citrate</i>)	3	PA; LD; QL (10 mL per 1 day)
XELJANZ ORAL TABLET (<i>tofacitinib citrate</i>)	3	PA; LD; QL (2 tablets per 1 day)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>tofacitinib citrate</i>)	3	PA; LD; QL (1 tablet per 1 day)
*ANTIRHEUMATIC ANTIMETABOLITES*** - ARTHRITIS AND PAIN DRUGS		
OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>methotrexate (anti-rheumatic)</i>)	3	PA; LD; QL (4 auto-injector per 28 days)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>methotrexate (anti-rheumatic)</i>)	3	PA; LD; QL (4 auto-injector per 28 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES*** - ARTHRITIS AND PAIN DRUGS		
<i>adalimumab-adbm (2 pen) subcutaneous auto-injector kit</i>	3	PA; LD; QL (2 auto-injectors per 28 days)
<i>adalimumab-adbm (2 syringe) subcutaneous prefilled syringe kit</i>	3	PA; LD; QL (2 syringes per 28 days)
<i>adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.4ml</i>	3	PA; LD; QL (1 month per 6 one-time fills)
<i>adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.8ml</i>	3	PA; LD; QL (1 kit per 1 one-time fill)
<i>adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.4ml</i>	3	PA; LD; QL (1 month per 6 one-time fills)
<i>adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.8ml</i>	3	PA; LD; QL (1 kit per 1 one-time fill)
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab</i>)	3	PA; LD; QL (2 pens per 28 days)
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	3	PA; LD; QL (2 pens per 28 days (QL exception needed for maintenance therapy))
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT (<i>adalimumab</i>)	3	PA; LD; QL (2 syringes per 28 days)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (<i>adalimumab</i>)	3	PA; LD; QL (1 kit per 1 one-time fill)
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (<i>adalimumab</i>)	3	PA; LD; QL (1 kit per 1 one-time fill)
SIMPONI ARIA INTRAVENOUS SOLUTION (<i>golimumab</i>)	3	PA; LD
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>golimumab</i>)	3	PA; LD; QL (1 pen per 28 days)
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>golimumab</i>)	3	PA; LD; QL (1 syringe per 28 days)
*CYCLOOXYGENASE 2 (COX-2) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>celecoxib oral capsule 400 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
*GOLD COMPOUNDS*** - ARTHRITIS AND PAIN DRUGS		
RIDAURA ORAL CAPSULE (<i>auranofin</i>)	2	QL (3 capsules per 1 day)
*INTERLEUKIN-1 BLOCKERS*** - ARTHRITIS AND PAIN DRUGS		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>rilonacept</i>)	3	PA; LD; QL (4 vials per 28 days)
*INTERLEUKIN-1BETA BLOCKERS*** - ARTHRITIS AND PAIN DRUGS		
ILARIS SUBCUTANEOUS SOLUTION (<i>canakinumab</i>)	3	PA; LD; QL (2 vials per 28 days)
*NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
COMBOGESIC INTRAVENOUS SOLUTION (<i>ibuprofen-acetaminophen</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diclofenac-misoprostol oral tablet delayed release 75-0.2 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*** - ARTHRITIS AND PAIN DRUGS		
ANAPROX DS ORAL TABLET (<i>naproxen sodium</i>)	3	QL (2 tablets per 1 day)
CALDOLOR INTRAVENOUS SOLUTION (<i>ibuprofen</i>)	3	
DAYPRO ORAL TABLET (<i>oxaprozin</i>)	3	QL (2 tablets per 1 day)
<i>diclofenac potassium oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diclofenac sodium er oral tablet extended release 24 hour</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 25 mg</i>	1 or 1b*	QL (5 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>ec-naproxen oral tablet delayed release</i>	1 or 1b*	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>etodolac er oral tablet extended release 24 hour 600 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>etodolac oral capsule 200 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>etodolac oral capsule 300 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>etodolac oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>flurbiprofen oral tablet 100 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>flurbiprofen oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>ibu oral tablet</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>ibuprofen lysine intravenous solution</i>	1 or 1b*	
<i>ibuprofen oral suspension</i>	1 or 1a*	QL (4 mL per 1 day)
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>indomethacin er oral capsule extended release</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>indomethacin oral capsule 25 mg</i>	1 or 1b*	QL (3 capsule per 1 day)
<i>indomethacin oral capsule 50 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>indomethacin sodium intravenous solution reconstituted</i>	3	
<i>ketoprofen er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>ketorolac tromethamine injection solution 15 mg/ml</i>	1 or 1b*	QL (4 mL per 30 days)
KETOROLAC TROMETHAMINE INJECTION SOLUTION 30 MG/ML	1 or 1b*	QL (2 mL per 30 days)
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	1 or 1b*	QL (2 mL per 30 days)
<i>ketorolac tromethamine oral tablet</i>	1 or 1a*	QL (20 tablets per 30 days)
LODINE ORAL TABLET (<i>etodolac</i>)	3	QL (2 tablets per 1 day)
<i>meclofenamate sodium oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>mefenamic acid oral capsule</i>	1 or 1b*	QL (29 capsule per 1 fill)
<i>meloxicam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>nabumetone oral tablet 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>nabumetone oral tablet 750 mg</i>	1 or 1b*	QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>naproxen dr oral tablet delayed release</i>	1 or 1b*	
<i>naproxen oral tablet 250 mg, 375 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>naproxen oral tablet 500 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>naproxen oral tablet delayed release</i>	1 or 1b*	
<i>naproxen sodium oral tablet 275 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>naproxen sodium oral tablet 550 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
NEOPROFEN INTRAVENOUS SOLUTION (<i>ibuprofen lysine</i>)	3	
<i>oxaprozin oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>piroxicam oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>sulindac oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>tolmetin sodium oral capsule</i>	1 or 1b*	QL (3 capsules per 1 day)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
OTEZLA ORAL TABLET (<i>apremilast</i>)	3	PA; LD; QL (2 tablets per 1 day)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	3	PA; LD; QL (1 pack per 365 days)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	3	PA; LD; QL (1 pack per 1 one-time fill)
*PYRIMIDINE SYNTHESIS INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
ARAVA ORAL TABLET (<i>leflunomide</i>)	3	QL (1 tablet per 1 day)
<i>leflunomide oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS*** - ARTHRITIS AND PAIN DRUGS		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE (<i>etanercept</i>)	3	PA; LD; QL (4 cartridge per 28 days)
ENBREL SUBCUTANEOUS SOLUTION (<i>etanercept</i>)	3	PA; LD; QL (8 injections per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (<i>etanercept</i>)	3	PA; LD; QL (8 syringes per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (<i>etanercept</i>)	3	PA; LD; QL (4 syringes per 28 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>etanercept</i>)	3	PA; LD; QL (4 pens per 28 days)
ANALGESICS - NONNARCOTIC - DRUGS FOR PAIN AND FEVER		
*ANALGESICS OTHER*** - ARTHRITIS AND PAIN DRUGS		
<i>acetaminophen intravenous solution</i>	1 or 1b*	
*ANALGESICS-SEDATIVES*** - ARTHRITIS AND PAIN DRUGS		
<i>bac oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-acetaminophen oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	1 or 1b*	QL (6 capsules per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>butalbital-apap-caffeine oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-aspirin-caffeine oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>tencon oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*SALICYLATES*** - ARTHRITIS AND PAIN DRUGS		
<i>aspirin 81 oral tablet chewable</i>	1 or 1a*; \$0	
<i>aspirin 81 oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin adult low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin adult low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin childrens oral tablet chewable</i>	1 or 1a*; \$0	
<i>aspirin ec adult low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin ec low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin ec low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>aspirin oral tablet delayed release 81 mg</i>	1 or 1a*; \$0	
<i>aspirin regimen oral tablet delayed release</i>	1 or 1a*; \$0	
<i>bayer aspirin ec low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>bayer low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>bayer low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>childrens aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>cvs aspirin adult low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>cvs aspirin adult low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs aspirin ec oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs aspirin low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>diflunisal oral tablet</i>	1 or 1b*	
<i>ecotrin low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>eq aspirin adult low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>eq aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>eql aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>eql aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ft aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ft aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>gnp adult aspirin low strength oral tablet chewable</i>	1 or 1a*; \$0	
<i>gnp aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	1 or 1a*; \$0	
<i>goodsense aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>goodsense aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>h-e-b aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>kls aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>kp aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>mm aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>qc aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>qc aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>qc childrens aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin adult low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin adult low strength oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin childrens oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin ec adult low st oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ra aspirin ec oral tablet delayed release 81 mg</i>	1 or 1a*; \$0	
<i>sb childrens aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>sb low dose asa ec oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sm aspirin adult low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sm aspirin ec low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sm aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>sm aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>st joseph aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>st joseph low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>st joseph low dose oral tablet delayed release</i>	1 or 1a*; \$0	
ANALGESICS - OPIOID - DRUGS FOR PAIN AND FEVER		
*CODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>acetaminophen-codeine oral solution</i>	1 or 1a*	AL; QL (30 mL per 1 day)
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	1 or 1a*	AL; QL (6 tablets per 1 day)
<i>acetaminophen-codeine oral tablet 300-30 mg, 300-60 mg</i>	1 or 1a*	AL; QL (6 tablet per 1 day)
<i>ascomp-codeine oral capsule</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg</i>	1 or 1b*	AL; QL (6 capsules per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
<i>butalbital-asa-caff-codeine oral capsule</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
*DIHYDROCODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>apap-caff-dihydrocodeine oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>trezix oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
*HYDROCODONE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>hydrocodone-acetaminophen oral solution</i>	1 or 1b*	QL (90 mL per 1 day)
<i>hydrocodone-acetaminophen oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocodone-ibuprofen oral tablet</i>	1 or 1b*	QL (5 tablets per 1 day)
*OPIOID AGONISTS*** - ARTHRITIS AND PAIN DRUGS		
CODEINE SULFATE ORAL TABLET 15 MG, 60 MG	3	AL; QL (6 tablets per 1 day)
<i>codeine sulfate oral tablet 30 mg</i>	1 or 1b*	AL; QL (6 tablets per 1 day)
DEMEROL INJECTION SOLUTION (<i>meperidine hcl</i>)	3	
DILAUDID INJECTION SOLUTION (<i>hydromorphone hcl</i>)	3	
DILAUDID ORAL LIQUID (<i>hydromorphone hcl</i>)	3	QL (24 mL per 1 day)
DILAUDID ORAL TABLET (<i>hydromorphone hcl</i>)	3	QL (6 tablets per 1 day)
DSUVIA SUBLINGUAL TABLET SUBLINGUAL (<i>sufentanil citrate</i>)	3	
<i>duramorph injection solution</i>	1 or 1b*	
FENTANYL CITRATE (PF) INJECTION SOLUTION 100 MCG/2ML, 250 MCG/5ML	1 or 1b*	
<i>fentanyl citrate (pf) injection solution 1000 mcg/20ml, 2500 mcg/50ml, 500 mcg/10ml</i>	1 or 1b*	
FENTANYL CITRATE (PF) INJECTION SOLUTION 50 MCG/ML	3	
<i>fentanyl citrate buccal lozenge on a handle</i>	1 or 1b*	PA; QL (4 lozenge per 1 day)
<i>fentanyl citrate buccal tablet</i>	1 or 1b*	PA; QL (4 tablet per 1 day)
<i>fentanyl citrate pf injection solution prefilled syringe 25 mcg/0.5ml</i>	3	
FENTANYL CITRATE PF INJECTION SOLUTION PREFILLED SYRINGE 50 MCG/ML	3	
<i>fentanyl transdermal patch 72 hour</i>	1 or 1b*	PA; QL (15 patches per 30 days)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>hydromorphone hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>hydromorphone hcl injection solution 0.25 mg/0.5ml</i>	3	
<i>hydromorphone hcl injection solution 4 mg/ml</i>	1 or 1b*	
<i>hydromorphone hcl oral liquid</i>	1 or 1b*	QL (24 mL per 1 day)
<i>hydromorphone hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
HYDROMORPHONE HCL PF INJECTION SOLUTION 1 MG/ML, 10 MG/ML, 2 MG/ML, 4 MG/ML	3	
<i>hydromorphone hcl pf injection solution 50 mg/5ml, 500 mg/50ml</i>	1 or 1b*	
INFUMORPH 200 INJECTION SOLUTION (<i>morphine sulfate microinfusion</i>)	3	
INFUMORPH 500 INJECTION SOLUTION (<i>morphine sulfate microinfusion</i>)	3	
<i>levorphanol tartrate oral tablet 3 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>meperidine hcl injection solution</i>	1 or 1b*	
<i>meperidine hcl oral solution</i>	1 or 1b*	QL (7 days per 1 fill)
<i>meperidine hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
METHADONE HCL INJECTION SOLUTION	3	PA; QL (1 mL per 1 day)
<i>methadone hcl intensol oral concentrate</i>	1 or 1b*	PA; QL (6 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methadone hcl oral concentrate</i>	1 or 1b*	PA; QL (6 mL per 1 day)
<i>methadone hcl oral solution</i>	1 or 1b*	PA; QL (30 mL per 1 day)
<i>methadone hcl oral tablet 10 mg</i>	1 or 1b*	PA; QL (6 tablet per 1 day)
<i>methadone hcl oral tablet 5 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>methadone hcl oral tablet soluble</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
METHADOSE ORAL CONCENTRATE 10 MG/ML (<i>methadone hcl</i>)	3	PA; QL (6 mL per 1 day)
<i>methadose oral tablet soluble</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
METHADOSE SUGAR-FREE ORAL CONCENTRATE (<i>methadone hcl</i>)	3	PA; QL (6 mL per 1 day)
<i>mitigo injection solution</i>	1 or 1b*	
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml</i>	1 or 1b*	QL (6 mL per 1 day)
<i>morphine sulfate (pf) injection solution 0.5 mg/ml, 1 mg/ml</i>	1 or 1b*	
MORPHINE SULFATE (PF) INJECTION SOLUTION 10 MG/ML, 2 MG/ML, 4 MG/ML, 5 MG/ML, 8 MG/ML	3	
MORPHINE SULFATE (PF) INTRAVENOUS SOLUTION	3	
<i>morphine sulfate er beads oral capsule extended release 24 hour</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>morphine sulfate er oral capsule extended release 24 hour</i>	1 or 1b*	PA; QL (2 capsules per 1 day)
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg</i>	1 or 1b*	PA; QL (3 tablet per 1 day)
MORPHINE SULFATE INJECTION SOLUTION 2 MG/ML, 4 MG/ML	3	
<i>morphine sulfate intravenous solution 10 mg/ml, 4 mg/ml, 8 mg/ml</i>	1 or 1b*	
<i>morphine sulfate intravenous solution 50 mg/ml</i>	3	
<i>morphine sulfate oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>morphine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
NUCYNTA ORAL TABLET 100 MG (<i>tapentadol hcl</i>)	3	QL (181 tablets per 30 days)
NUCYNTA ORAL TABLET 50 MG (<i>tapentadol hcl</i>)	3	QL (6 tablets per 1 day)
NUCYNTA ORAL TABLET 75 MG (<i>tapentadol hcl</i>)	3	QL (8 tablet per 1 day)
OLINVYK INTRAVENOUS SOLUTION (<i>oliceridine fumarate</i>)	3	
<i>oxycodone hcl oral capsule</i>	1 or 1b*	QL (7 days per 1 fill)
<i>oxycodone hcl oral concentrate</i>	1 or 1b*	QL (6 mL per 1 day)
<i>oxycodone hcl oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>oxycodone hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>oxycodone hcl oral tablet abuse-deterrent</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>oxymorphone hcl er oral tablet extended release 12 hour</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>oxymorphone hcl oral tablet 10 mg</i>	1 or 1b*	QL (6 tablet per 1 day)
<i>oxymorphone hcl oral tablet 5 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
QDOLO ORAL SOLUTION (<i>tramadol hcl</i>)	3	AL; QL (80 mL per 1 day)
<i>remifentanil hcl intravenous solution reconstituted</i>	1 or 1b*	
ROXICODONE ORAL TABLET (<i>oxycodone hcl</i>)	3	QL (6 tablets per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT (<i>oxycodone hcl</i>)	3	PA; QL (6 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUFENTANIL CITRATE INTRAVENOUS SOLUTION	1 or 1b*	
<i>tramadol hcl (er biphasic) oral capsule extended release 24 hour</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>tramadol hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
TRAMADOL HCL ORAL SOLUTION	3	AL; QL (80 mL per 1 day)
<i>tramadol hcl oral tablet 100 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>tramadol hcl oral tablet 25 mg</i>	1 or 1b*	PA; QL (16 tablets per 1 day)
<i>tramadol hcl oral tablet 50 mg</i>	1 or 1b*	AL; QL (8 tablets per 1 day)
ULTIVA INTRAVENOUS SOLUTION RECONSTITUTED (<i>remifentanil hcl</i>)	3	
*OPIOID COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
APADAZ ORAL TABLET (<i>benzhydrocodone-acetaminophen</i>)	3	QL (6 tablets per 1 day)
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET	3	QL (6 tablets per 1 day)
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>endocet oral tablet 5-325 mg</i>	1 or 1b*	QL (6 tablet per 1 day)
OXYCODONE-ACETAMINOPHEN ORAL SOLUTION 5-325 MG/5ML	1 or 1b*	QL (30 ML per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>oxycodone-acetaminophen oral tablet 5-325 mg</i>	1 or 1b*	QL (6 tablet per 1 day)
*OPIOID PARTIAL AGONISTS*** - ARTHRITIS AND PAIN DRUGS		
BELBUCA BUCCAL FILM (<i>buprenorphine hcl</i>)	3	PA; QL (2 film per 1 day)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>buprenorphine</i>)	3	LD; QL (4 syringes per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>buprenorphine</i>)	3	LD; QL (1 syringe per 28 days)
<i>buprenorphine hcl injection solution</i>	1 or 1b*	
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	1 or 1b*	QL (12 tablets per 90 days)
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	1 or 1b*	QL (3 tablets per 90 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1 or 1b*	QL (2 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg</i>	1 or 1b*	QL (16 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 4-1 mg</i>	1 or 1b*	QL (8 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	1 or 1b*	QL (4 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>buprenorphine transdermal patch weekly</i>	1 or 1b*	PA; QL (1 package per 28 days)
<i>butorphanol tartrate injection solution</i>	1 or 1b*	
<i>butorphanol tartrate nasal solution</i>	1 or 1b*	QL (2 bottles per 30 days)
<i>nalbuphine hcl injection solution</i>	1 or 1b*	QL (2 mL per 1 day)
<i>pentazocine-naloxone hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>buprenorphine</i>)	3	LD; QL (1 syringe per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	QL (23 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 1.4-0.36 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	QL (12 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	QL (1 tablet per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	QL (5 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 5.7-1.4 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	QL (3 tablets per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	3	QL (2 tablets per 1 day)
*TRAMADOL COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>tramadol-acetaminophen oral tablet</i>	1 or 1b*	AL; QL (8 tablet per 1 day)
ANDROGENS-ANABOLIC - HORMONES		
*ANDROGENS*** - DRUGS FOR MEN		
<i>danazol oral capsule 100 mg, 50 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>danazol oral capsule 200 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION (<i>testosterone cypionate</i>)	1 or 1b*	PA
JATENZO ORAL CAPSULE 158 MG, 198 MG (<i>testosterone undecanoate</i>)	3	PA; QL (4 capsules per 1 day)
JATENZO ORAL CAPSULE 237 MG (<i>testosterone undecanoate</i>)	3	PA; QL (2 capsules per 1 day)
NATESTO NASAL GEL (<i>testosterone</i>)	3	PA; QL (3 pump bottles per 30 days)
TESTOPEL IMPLANT PELLETT (<i>testosterone</i>)	3	PA; LD
<i>testosterone cypionate intramuscular solution</i>	1 or 1b*	PA
<i>testosterone enanthate intramuscular solution</i>	1 or 1b*	PA
<i>testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)</i>	1 or 1b*	PA; QL (1 bottle per 30 days)
<i>testosterone transdermal gel 10 mg/act (2%)</i>	1 or 1b*	PA; QL (1 pump per 30 days)
<i>testosterone transdermal gel 12.5 mg/act (1%)</i>	1 or 1b*	PA; QL (2 bottles per 30 days)
<i>testosterone transdermal gel 20.25 mg/1.25gm (1.62%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)</i>	1 or 1b*	PA; QL (1 packet per 1 day)
<i>testosterone transdermal gel 25 mg/2.5gm (1%)</i>	1 or 1b*	PA; QL (2 packet per 1 day)
<i>testosterone transdermal solution</i>	1 or 1b*	PA; QL (1 pump bottle per 30 days)
XYOSTED SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>testosterone enanthate</i>)	3	PA
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS		
*INTRARECTAL STEROIDS*** - RECTAL PREPARATIONS		
<i>budesonide rectal foam 2 mg</i>	1 or 1b*	QL (4.78 gm per 1 day)
<i>budesonide rectal foam 2 mg/act</i>	1 or 1b*	QL (4.78 grams per 1 day)
CORTENEMA RECTAL ENEMA (<i>hydrocortisone</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTIFOAM EXTERNAL FOAM (<i>hydrocortisone acetate</i>)	3	QL (2.15 gram per 1 day)
<i>hydrocortisone rectal enema</i>	1 or 1b*	
*NITRATE VASODILATING AGENTS*** - RECTAL PREPARATIONS		
<i>nitroglycerin rectal ointment</i>	1 or 1b*	QL (1 unit per 1 day)
RECTIV RECTAL OINTMENT (<i>nitroglycerin</i>)	3	QL (1 unit per 1 day)
*RECTAL ANESTHETIC/STEROIDS*** - RECTAL PREPARATIONS		
ANALPRAM-HC EXTERNAL CREAM (<i>hydrocortisone ace-pramoxine</i>)	3	
ANALPRAM-HC EXTERNAL LOTION (<i>hydrocortisone ace-pramoxine</i>)	3	
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	1 or 1b*	
PROCTOFOAM HC EXTERNAL FOAM (<i>hydrocortisone ace-pramoxine</i>)	3	
*RECTAL STEROIDS*** - RECTAL PREPARATIONS		
ANUSOL-HC EXTERNAL CREAM (<i>hydrocortisone</i>)	3	
<i>hydrocortisone (perianal) external cream</i>	1 or 1b*	
PROCTOCORT EXTERNAL CREAM (<i>hydrocortisone</i>)	1 or 1b*	
<i>procto-med hc external cream</i>	1 or 1b*	
<i>proctosol hc external cream</i>	1 or 1b*	
<i>proctozone-hc external cream</i>	1 or 1b*	
ANTHELMINTICS - DRUGS FOR INFECTIONS		
*ANTHELMINTICS*** - DRUGS FOR PARASITES		
<i>albendazole oral tablet</i>	1 or 1b*	PA; QL (4 tablets per 1 day)
BENZNIDAZOLE ORAL TABLET	3	
BILTRICIDE ORAL TABLET (<i>praziquantel</i>)	3	
EMVERM ORAL TABLET CHEWABLE (<i>mebendazole</i>)	3	
<i>ivermectin oral tablet</i>	1 or 1b*	QL (9 tablets per 1 fill)
<i>praziquantel oral tablet</i>	1 or 1b*	
STROMEKTOL ORAL TABLET (<i>ivermectin</i>)	3	QL (9 tablets per 1 fill)
ANTIANGINAL AGENTS - DRUGS FOR THE HEART		
*ANTIANGINALS-OTHER*** - DRUGS FOR ANGINA		
ASPRUZYO SPRINKLE ORAL PACKET (<i>ranolazine</i>)	3	PA; QL (2 sachets per 1 day)
<i>ranolazine er oral tablet extended release 12 hour</i>	1 or 1b*	QL (2 tablets per 1 day)
*NITRATES*** - DRUGS FOR ANGINA		
ISORDIL TITRADOSE ORAL TABLET (<i>isosorbide dinitrate</i>)	3	
<i>isosorbide dinitrate oral tablet</i>	1 or 1b*	
<i>isosorbide mononitrate er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>isosorbide mononitrate oral tablet</i>	1 or 1b*	
NITRO-BID TRANSDERMAL OINTMENT (<i>nitroglycerin</i>)	3	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR (<i>nitroglycerin</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR (<i>nitroglycerin</i>)	2	
<i>nitroglycerin in d5w intravenous solution</i>	1 or 1b*	
NITROGLYCERIN INTRAVENOUS SOLUTION	3	
<i>nitroglycerin sublingual tablet sublingual</i>	1 or 1b*	
<i>nitroglycerin transdermal patch 24 hour</i>	1 or 1b*	
<i>nitroglycerin translingual solution</i>	1 or 1b*	
NITROLINGUAL TRANSLINGUAL SOLUTION (<i>nitroglycerin</i>)	3	
NITROSTAT SUBLINGUAL TABLET SUBLINGUAL (<i>nitroglycerin</i>)	3	
ANTI-ANXIETY AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTI-ANXIETY AGENTS - MISC.*** - DRUGS FOR ANXIETY		
<i>bupirone hcl oral tablet</i>	1 or 1b*	
<i>droperidol injection solution</i>	1 or 1b*	
<i>hydroxyzine hcl intramuscular solution</i>	1 or 1b*	
<i>hydroxyzine hcl oral syrup</i>	1 or 1b*	
<i>hydroxyzine hcl oral tablet</i>	1 or 1b*	
<i>hydroxyzine pamoate oral capsule</i>	1 or 1a*	
<i>meprobamate oral tablet</i>	3	
*BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg</i>	1 or 1b*	DO
<i>alprazolam er oral tablet extended release 24 hour 2 mg, 3 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
ALPRAZOLAM INTENSOL ORAL CONCENTRATE (<i>alprazolam</i>)	3	QL (4 mL per 1 day)
<i>alprazolam oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>alprazolam oral tablet dispersible</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg</i>	1 or 1b*	DO
<i>alprazolam xr oral tablet extended release 24 hour 2 mg, 3 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>chlordiazepoxide hcl oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>clorazepate dipotassium oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diazepam injection solution 10 mg/2ml</i>	1 or 1a*	
<i>diazepam intensol oral concentrate</i>	1 or 1a*	QL (8 mL per 1 day)
<i>diazepam oral concentrate</i>	1 or 1a*	QL (8 mL per 1 day)
<i>diazepam oral solution</i>	1 or 1a*	
<i>diazepam oral tablet</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lorazepam injection solution</i>	1 or 1b*	
<i>lorazepam intensol oral concentrate</i>	1 or 1b*	QL (3 mL per 1 day)
<i>lorazepam oral concentrate 2 mg/ml</i>	1 or 1b*	QL (3 mL per 1 day)
<i>lorazepam oral tablet 0.5 mg</i>	1 or 1b*	DO
<i>lorazepam oral tablet 1 mg, 2 mg</i>	1 or 1b*	QL (3 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxazepam oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
ANTIARRHYTHMICS - DRUGS FOR THE HEART		
*ANTIARRHYTHMICS - MISC.*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>adenosine intravenous solution 12 mg/4ml, 6 mg/2ml</i>	1 or 1b*	
*ANTIARRHYTHMICS TYPE I-A**** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>disopyramide phosphate oral capsule</i>	1 or 1b*	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR (<i>disopyramide phosphate</i>)	2	
NORPACE ORAL CAPSULE (<i>disopyramide phosphate</i>)	3	
<i>procainamide hcl injection solution</i>	1 or 1b*	
<i>quinidine gluconate er oral tablet extended release</i>	1 or 1b*	
<i>quinidine sulfate oral tablet</i>	1 or 1a*	
*ANTIARRHYTHMICS TYPE I-B**** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>lidocaine hcl (cardiac) intravenous solution prefilled syringe 50 mg/5ml</i>	1 or 1b*	
LIDOCAINE HCL (CARDIAC) PF INTRAVENOUS SOLUTION	3	
<i>lidocaine hcl (cardiac) pf intravenous solution prefilled syringe</i>	1 or 1b*	
<i>lidocaine in d5w intravenous solution 4-5 mg/ml-%, 8-5 mg/ml-%</i>	1 or 1b*	
<i>mexiletine hcl oral capsule</i>	1 or 1b*	
*ANTIARRHYTHMICS TYPE I-C**** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>flecainide acetate oral tablet 100 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>flecainide acetate oral tablet 150 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>flecainide acetate oral tablet 50 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>propafenone hcl er oral capsule extended release 12 hour</i>	1 or 1b*	
<i>propafenone hcl oral tablet</i>	1 or 1b*	
*ANTIARRHYTHMICS TYPE III**** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>amiodarone hcl intravenous solution</i>	1 or 1b*	
<i>amiodarone hcl oral tablet 100 mg, 400 mg</i>	1 or 1b*	
<i>amiodarone hcl oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
CORVERT INTRAVENOUS SOLUTION (<i>ibutilide fumarate</i>)	3	
<i>dofetilide oral capsule</i>	1 or 1b*	LD
<i>ibutilide fumarate intravenous solution</i>	1 or 1b*	
MULTAQ ORAL TABLET (<i>dronedarone hcl</i>)	3	QL (2 tablets per 1 day)
NEXTERONE INTRAVENOUS SOLUTION (<i>amiodarone hcl in dextrose</i>)	3	
<i>pacerone oral tablet 100 mg, 400 mg</i>	1 or 1b*	
<i>pacerone oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS FOR THE LUNGS		
*ADRENERGIC COMBINATIONS*** - DRUGS FOR ASTHMA/COPD		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>umeclidinium-vilanterol</i>)	2	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>fluticasone furoate-vilanterol</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide-formoterol fumarate</i> (Breyna Inhalation Aerosol)	1 or 1b*	QL (1.03 grams per 1 day)
BREZTRI AEROSPHERE INHALATION AEROSOL (<i>budeson-glycopyrrol-formoterol</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol</i>	1 or 1b*	QL (1.03 grams per 1 day)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION (<i>ipratropium-albuterol</i>)	2	QL (2 inhalers per 30 days)
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol inhalation aerosol</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1 or 1b*	QL (1 package per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>ipratropium-albuterol inhalation solution</i>	1 or 1b*	QL (540 mL per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION (<i>tiotropium bromide-olodaterol</i>)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	2	QL (2 EA per 1 day)
<i>wixela inhub inhalation aerosol powder breath activated</i>	1 or 1b*	QL (1 package per 30 days)
*ANTI-IGE MONOCLONAL ANTIBODIES*** - DRUGS FOR ASTHMA/COPD		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	3	PA; LD; QL (4 auto-injectors per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	3	PA; LD; QL (2 auto-injectors per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	3	PA; LD; QL (4 prefilled syringes per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	3	PA; LD; QL (2 prefilled syringes per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>omalizumab</i>)	3	PA; LD; QL (4 vials/syringes/autoinjectors per 28 days)
*ANTI-INFLAMMATORY AGENTS*** - DRUGS FOR ASTHMA/COPD		
<i>cromolyn sodium inhalation nebulization solution</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*BETA ADRENERGICS*** - DRUGS FOR ASTHMA/COPD		
<i>albuterol sulfate hfa inhalation aerosol solution</i>	1 or 1b*	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml</i>	1 or 1b*	QL (360 mL per 30 days)
ALBUTEROL SULFATE INHALATION NEBULIZATION SOLUTION (5 MG/ML) 0.5%	1 or 1b*	QL (4 boxes per 30 days)
<i>albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml</i>	1 or 1b*	QL (4 boxes per 30 days)
<i>albuterol sulfate oral syrup</i>	1 or 1b*	
<i>albuterol sulfate oral tablet</i>	1 or 1b*	
<i>arformoterol tartrate inhalation nebulization solution</i>	1 or 1b*	QL (60 vial per 30 days)
BROVANA INHALATION NEBULIZATION SOLUTION (<i>arformoterol tartrate</i>)	3	QL (60 vial per 30 days)
<i>formoterol fumarate inhalation nebulization solution</i>	1 or 1b*	QL (120 ML per 30 days)
<i>isoproterenol hcl injection solution</i>	1 or 1b*	
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml</i>	1 or 1b*	QL (90 vials per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml</i>	1 or 1b*	QL (90 mL per 30 days)
<i>levalbuterol tartrate inhalation aerosol</i>	1 or 1b*	ST; QL (2 inhalers per 30 days)
PERFORMIST INHALATION NEBULIZATION SOLUTION (<i>formoterol fumarate</i>)	3	QL (120 ML per 30 days)
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>albuterol sulfate</i>)	2	QL (2 inhalers per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>salmeterol xinafoate</i>)	2	QL (1 inhaler per 30 days)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION (<i>olodaterol hcl</i>)	3	QL (1 inhaler per 30 days)
<i>terbutaline sulfate injection solution</i>	1 or 1b*	
<i>terbutaline sulfate oral tablet</i>	1 or 1b*	
*BRONCHODILATORS - ANTICHOLINERGICS*** - DRUGS FOR ASTHMA/COPD		
ATROVENT HFA INHALATION AEROSOL SOLUTION (<i>ipratropium bromide hfa</i>)	2	QL (2 inhalers per 30 days)
<i>ipratropium bromide inhalation solution</i>	1 or 1b*	QL (300 ML per 30 days)
SPIRIVA HANDHALER INHALATION CAPSULE (<i>tiotropium bromide monohydrate</i>)	2	QL (1 capsule per 1 day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION (<i>tiotropium bromide monohydrate</i>)	2	QL (1 inhaler per 30 days)
<i>tiotropium bromide monohydrate inhalation capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
YUPELRI INHALATION SOLUTION (<i>revefenacin</i>)	3	ST; QL (1 vial per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*INTERLEUKIN-5 ANTAGONISTS (IGG1 KAPPA)*** - DRUGS FOR ASTHMA/COPD		
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>benralizumab</i>)	3	PA; LD; QL (1 autoinjector per 8 weekss)
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (<i>benralizumab</i>)	3	PA; LD; QL (1 syringe per 8 weeks)
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML (<i>benralizumab</i>)	3	PA; LD; QL (1 syringes per 8 weekss)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>mepolizumab</i>)	3	PA; LD; QL (1 autoinjector per 4 weekss)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	3	PA; LD; QL (1 syringe per 4 weekss)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	3	PA; LD; QL (1 injection per 28 days)
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>mepolizumab</i>)	3	PA; LD; QL (1 injections per 28 days)
*INTERLEUKIN-5 ANTAGONISTS (IGG4 KAPPA)*** - DRUGS FOR ASTHMA/COPD		
CINQAIR INTRAVENOUS SOLUTION (<i>reslizumab</i>)	3	PA; LD
*LEUKOTRIENE RECEPTOR ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD		
ACCOLATE ORAL TABLET (<i>zafirlukast</i>)	3	QL (2 tablets per 1 day)
<i>montelukast sodium oral packet</i>	1 or 1b*	QL (1 packet per 1 day)
<i>montelukast sodium oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>montelukast sodium oral tablet chewable</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zafirlukast oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*PHOSPHODIESTERASE 3 & 4 (PDE3 & PDE4) INHIBITORS*** - DRUGS FOR THE LUNGS		
OHTUVAYRE INHALATION SUSPENSION (<i>ensifentrine</i>)	3	PA; LD; QL (1 carton per 30 days)
*SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - DRUGS FOR ASTHMA/COPD		
DALIRESP ORAL TABLET (<i>roflumilast</i>)	3	PA; QL (1 tablet per 1 day)
<i>roflumilast oral tablet</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
*STEROID INHALANTS*** - DRUGS FOR ASTHMA/COPD		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>fluticasone furoate</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1 or 1b*	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	1 or 1b*	QL (60 ML per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 50 mcg/act</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 250 mcg/act</i>	1 or 1b*	QL (4 inhalers per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 44 mcg/act</i>	1 or 1b*	QL (1 inhaler per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone propionate hfa inhalation aerosol 220 mcg/act</i>	1 or 1b*	QL (2 inhalers per 30 days)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (1 inhaler per 30 days)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (2 inhalers per 30 days)
*THYMIC STROMAL LYMPHOPOIETIN (TSLP) ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD		
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tezepelumab-ekko</i>)	3	PA; LD; QL (1 syringe per 28 days)
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>tezepelumab-ekko</i>)	3	PA; LD; QL (1 syringe per 28 days)
*XANTHINES*** - DRUGS FOR ASTHMA/COPD		
<i>aminophylline intravenous solution</i>	1 or 1b*	
ELIXOPHYLLIN ORAL ELIXIR (<i>theophylline</i>)	1 or 1b*	QL (112.5 mL per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (<i>theophylline</i>)	2	QL (4 tablets per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG (<i>theophylline</i>)	2	QL (3 capsules per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 400 MG (<i>theophylline</i>)	2	QL (2 capsules per 1 day)
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	
<i>theophylline er oral tablet extended release 12 hour 300 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>theophylline er oral tablet extended release 12 hour 450 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>theophylline er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>theophylline oral elixir</i>	1 or 1b*	QL (112.5 mL per 1 day)
<i>theophylline oral solution</i>	1 or 1b*	QL (112.5 mL per 1 day)
ANTICOAGULANTS - DRUGS FOR THE BLOOD		
*COUMARIN ANTICOAGULANTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>jantoven oral tablet</i>	1 or 1a*	
<i>warfarin sodium oral tablet</i>	1 or 1a*	
*DIRECT FACTOR XA INHIBITORS*** - DRUGS TO PREVENT BLOOD CLOTS		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK (<i>apixaban</i>)	2	QL (74 tablets per 365 days)
ELIQUIS ORAL TABLET 2.5 MG (<i>apixaban</i>)	2	QL (2 tablets per 1 day)
ELIQUIS ORAL TABLET 5 MG (<i>apixaban</i>)	2	QL (74 tablets per 30 days)
XARELTO ORAL SUSPENSION RECONSTITUTED (<i>rivaroxaban</i>)	2	QL (20 mL per 1 day)
XARELTO ORAL TABLET 10 MG, 20 MG (<i>rivaroxaban</i>)	2	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG, 2.5 MG (<i>rivaroxaban</i>)	2	QL (2 tablets per 1 day)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK (<i>rivaroxaban</i>)	2	QL (1 pack per 365 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*HEPARINS AND HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>bd heparin posiflush intravenous solution</i>	1 or 1b*	
<i>heparin (porcine) in nacl intravenous solution 1000-0.9 ut/500ml-%, 2000-0.9 unit/l-%</i>	1 or 1b*	
HEPARIN (PORCINE) IN NACL INTRAVENOUS SOLUTION 12500-0.45 UT/250ML-%, 25000-0.45 UT/250ML-%, 25000-0.45 UT/500ML-%	3	
<i>heparin na (pork) lock flsh pf intravenous solution</i>	1 or 1b*	
HEPARIN SOD (PORCINE) IN D5W INTRAVENOUS SOLUTION 100 UNIT/ML, 25000-5 UT/500ML-%	3	
<i>heparin sod (porcine) in d5w intravenous solution 40-5 unit/ml-%</i>	1 or 1b*	
<i>heparin sod (pork) lock flush intravenous solution</i>	1 or 1b*	
<i>heparin sodium (porcine) injection solution</i>	1 or 1b*	
HEPARIN SODIUM (PORCINE) INJECTION SOLUTION PREFILLED SYRINGE	3	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml</i>	1 or 1b*	
HEPARIN SODIUM (PORCINE) PF INJECTION SOLUTION 5000 UNIT/ML	3	
*LOW MOLECULAR WEIGHT HEPARINS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>enoxaparin sodium injection solution</i>	1 or 1b*	QL (30 syringes per 30 days)
<i>enoxaparin sodium injection solution prefilled syringe</i>	1 or 1b*	QL (2 syringes per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML (<i>dalteparin sodium</i>)	3	QL (8 mL per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (<i>dalteparin sodium</i>)	3	QL (6 vials per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>dalteparin sodium</i>)	3	QL (30 syringes per 30 days)
*SYNTHETIC HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS		
ARIXTRA SUBCUTANEOUS SOLUTION (<i>fondaparinux sodium</i>)	3	QL (30 syringes per 30 days)
<i>fondaparinux sodium subcutaneous solution</i>	1 or 1b*	QL (30 syringes per 30 days)
*THROMBIN INHIBITORS - HIRUDIN TYPE*** - DRUGS TO PREVENT BLOOD CLOTS		
ANGIOMAX INTRAVENOUS SOLUTION RECONSTITUTED (<i>bivalirudin trifluoroacetate</i>)	3	
<i>bivalirudin trifluoroacetate intravenous solution</i>	1 or 1b*	
<i>bivalirudin trifluoroacetate intravenous solution reconstituted</i>	1 or 1b*	
*THROMBIN INHIBITORS - SELECTIVE DIRECT & REVERSIBLE*** - DRUGS TO PREVENT BLOOD CLOTS		
ARGATROBAN IN SODIUM CHLORIDE INTRAVENOUS SOLUTION	3	
ARGATROBAN INTRAVENOUS SOLUTION	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS - DRUGS FOR THE NERVOUS SYSTEM		
*AMPA GLUTAMATE RECEPTOR ANTAGONISTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
FYCOMPA ORAL SUSPENSION (<i>perampanel</i>)	3	QL (24 mL per 1 day)
FYCOMPA ORAL TABLET (<i>perampanel</i>)	3	QL (1 tablet per 1 day)
*ANTICONVULSANTS - BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>clobazam oral suspension</i>	1 or 1b*	QL (16 mL per 1 day)
<i>clobazam oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>clonazepam oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>clonazepam oral tablet dispersible</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>diazepam rectal gel</i>	1 or 1b*	QL (2 syringes per 1 fill)
NAYZILAM NASAL SOLUTION (<i>midazolam (anticonvulsant)</i>)	3	PA; QL (10 mL per 30 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG (<i>clobazam</i>)	3	QL (2 film strips per 1 day)
SYMPAZAN ORAL FILM 5 MG (<i>clobazam</i>)	3	QL (1 film strip per 1 day)
VALTOCO 10 MG DOSE NASAL LIQUID (<i>diazepam</i>)	3	PA; QL (10 blister packs per 30 days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK (<i>diazepam</i>)	3	PA; QL (10 blister packs per 30 days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK (<i>diazepam</i>)	3	PA; QL (10 blister packs per 30 days)
VALTOCO 5 MG DOSE NASAL LIQUID (<i>diazepam</i>)	3	PA; QL (10 blister packs per 30 days)
*ANTICONVULSANTS - MISC.*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
APTIOM ORAL TABLET 200 MG, 400 MG (<i>eslicarbazepine acetate</i>)	3	DO
APTIOM ORAL TABLET 600 MG, 800 MG (<i>eslicarbazepine acetate</i>)	3	QL (2 tablets per 1 day)
BANZEL ORAL SUSPENSION (<i>rufinamide</i>)	3	QL (80 mL per 1 day)
BANZEL ORAL TABLET 200 MG (<i>rufinamide</i>)	3	DO
BANZEL ORAL TABLET 400 MG (<i>rufinamide</i>)	3	QL (8 tablets per 1 day)
BRIVIACT INTRAVENOUS SOLUTION (<i>brivaracetam</i>)	3	
BRIVIACT ORAL SOLUTION (<i>brivaracetam</i>)	3	QL (20 mL per 1 day)
BRIVIACT ORAL TABLET (<i>brivaracetam</i>)	3	QL (2 tablets per 1 day)
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>carbamazepine er oral capsule extended release 12 hour 300 mg</i>	1 or 1b*	QL (5 capsules per 1 day)
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>carbamazepine er oral tablet extended release 12 hour 400 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carbamazepine oral suspension</i>	1 or 1b*	QL (50 mL per 1 day)
<i>carbamazepine oral tablet</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>carbamazepine oral tablet chewable 100 mg</i>	1 or 1b*	QL (10 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbamazepine oral tablet chewable 200 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
DIACOMIT ORAL CAPSULE 250 MG (<i>stiripentol</i>)	3	PA; LD; DO
DIACOMIT ORAL CAPSULE 500 MG (<i>stiripentol</i>)	3	PA; LD; QL (6 capsules per 1 day)
DIACOMIT ORAL PACKET 250 MG (<i>stiripentol</i>)	3	PA; LD; DO
DIACOMIT ORAL PACKET 500 MG (<i>stiripentol</i>)	3	PA; LD; QL (6 packets per 1 day)
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>levetiracetam</i>)	3	QL (2 tablets per 1 day)
EPIDIOLEX ORAL SOLUTION (<i>cannabidiol</i>)	3	PA; LD
<i>epitol oral tablet</i>	1 or 1b*	QL (8 tablets per 1 day)
FINTEPLA ORAL SOLUTION (<i>fenfluramine hcl</i>)	3	PA; LD; QL (26 mg per 1 day)
<i>gabapentin oral capsule</i>	1 or 1b*	DO
<i>gabapentin oral solution</i>	1 or 1b*	QL (72 mL per 1 day)
<i>gabapentin oral tablet 600 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>gabapentin oral tablet 800 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lacosamide intravenous solution</i>	1 or 1b*	
<i>lacosamide oral solution</i>	1 or 1b*	QL (40 mL per 1 day)
<i>lacosamide oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	1 or 1b*	DO
<i>lamotrigine er oral tablet extended release 24 hour 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>lamotrigine er oral tablet extended release 24 hour 250 mg, 300 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg</i>	1 or 1b*	QL (1 kit per 28 days)
<i>lamotrigine oral kit 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg</i>	1 or 1b*	QL (1 kit per 35 days)
<i>lamotrigine oral tablet</i>	1 or 1b*	DO
<i>lamotrigine oral tablet chewable 25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lamotrigine oral tablet chewable 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lamotrigine oral tablet dispersible 25 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>lamotrigine oral tablet dispersible 50 mg</i>	1 or 1b*	DO
<i>lamotrigine starter kit-blue oral kit</i>	1 or 1b*	QL (1 kit per 28 days)
<i>lamotrigine starter kit-green oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>lamotrigine starter kit-orange oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>levetiracetam er oral tablet extended release 24 hour 500 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>levetiracetam er oral tablet extended release 24 hour 750 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
LEVETIRACETAM IN NAACL INTRAVENOUS SOLUTION	3	
<i>levetiracetam intravenous solution</i>	1 or 1b*	
<i>levetiracetam oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>levetiracetam oral tablet 1000 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>levetiracetam oral tablet 250 mg, 500 mg, 750 mg</i>	1 or 1b*	DO
<i>oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg</i>	1 or 1b*	DO

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxcarbazepine er oral tablet extended release 24 hour 600 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>oxcarbazepine oral suspension</i>	1 or 1b*	QL (40 mL per 1 day)
<i>oxcarbazepine oral tablet 150 mg, 300 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>oxcarbazepine oral tablet 600 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg</i>	1 or 1b*	QL (3 capsule per 1 day)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>pregabalin oral capsule 75 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>pregabalin oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>primidone oral tablet 125 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>primidone oral tablet 250 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>primidone oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 50 MG (<i>topiramate</i>)	3	ST; QL (1 capsule per 1 day)
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 150 MG, 200 MG (<i>topiramate</i>)	3	ST; QL (2 capsules per 1 day)
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 25 MG (<i>topiramate</i>)	3	ST; DO
<i>roweepra oral tablet</i>	1 or 1b*	DO
<i>rufinamide oral suspension</i>	1 or 1b*	QL (80 mL per 1 day)
<i>rufinamide oral tablet 200 mg</i>	1 or 1b*	DO
<i>rufinamide oral tablet 400 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG (<i>levetiracetam</i>)	3	QL (2 tablets per 1 day)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG (<i>levetiracetam</i>)	3	QL (4 tablets per 1 day)
<i>subvenite oral tablet</i>	1 or 1b*	DO
<i>subvenite starter kit-blue oral kit</i>	1 or 1b*	QL (1 kit per 28 days)
<i>subvenite starter kit-green oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>subvenite starter kit-orange oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>topiramate er oral capsule er 24 hour sprinkle 100 mg, 50 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>topiramate er oral capsule er 24 hour sprinkle 150 mg, 200 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>topiramate er oral capsule er 24 hour sprinkle 25 mg</i>	1 or 1b*	DO
<i>topiramate er oral capsule extended release 24 hour 100 mg, 50 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>topiramate er oral capsule extended release 24 hour 200 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>topiramate er oral capsule extended release 24 hour 25 mg</i>	1 or 1b*	DO
<i>topiramate oral capsule sprinkle</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>topiramate oral tablet 100 mg, 25 mg, 50 mg</i>	1 or 1b*	DO
<i>topiramate oral tablet 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>zonisamide oral capsule</i>	1 or 1b*	QL (6 capsule per 1 day)
ZTALMY ORAL SUSPENSION (<i>ganaxolone</i>)	3	LD; QL (10 bottles per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CARBAMATES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>felbamate oral suspension</i>	1 or 1b*	QL (30 mL per 1 day)
<i>felbamate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>cenobamate</i>)	3	QL (1 blister pack per 28 days)
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>cenobamate</i>)	3	QL (1 pack per 28 days)
XCOPRI ORAL TABLET 100 MG, 150 MG, 25 MG, 50 MG (<i>cenobamate</i>)	3	QL (1 tablet per 1 day)
XCOPRI ORAL TABLET 200 MG (<i>cenobamate</i>)	3	QL (2 tablets per 1 day)
XCOPRI ORAL TABLET THERAPY PACK (<i>cenobamate</i>)	3	QL (1 pack per 28 days)
*GABA MODULATORS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>tiagabine hcl oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>vigabatrin oral packet</i>	1 or 1b*	LD; QL (6 packets per 1 day)
<i>vigabatrin oral tablet</i>	1 or 1b*	LD; QL (6 tablets per 1 day)
<i>vigadrone oral packet</i>	1 or 1b*	LD; QL (6 packets per 1 day)
<i>vigabatrin</i> (Vigadrone Oral Tablet)	1 or 1b*	LD; QL (6 tablets per 1 day)
VIGAFYDE ORAL SOLUTION (<i>vigabatrin</i>)	3	LD; QL (25 mL per 1 day)
<i>vigabatrin</i> (Vigpoder Oral Packet)	1 or 1b*	LD; QL (6 packets per 1 day)
*HYDANTOINS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
CEREBYX INJECTION SOLUTION (<i>fosphenytoin sodium</i>)	3	
DILANTIN INFATABS ORAL TABLET CHEWABLE (<i>phenytoin</i>)	3	
DILANTIN ORAL CAPSULE 100 MG (<i>phenytoin sodium extended</i>)	3	
DILANTIN ORAL CAPSULE 30 MG (<i>phenytoin sodium extended</i>)	2	
DILANTIN ORAL SUSPENSION (<i>phenytoin</i>)	3	
DILANTIN-125 ORAL SUSPENSION (<i>phenytoin</i>)	3	
<i>fosphenytoin sodium injection solution</i>	1 or 1b*	
PHENYTEK ORAL CAPSULE (<i>phenytoin sodium extended</i>)	1 or 1b*	
<i>phenytoin infatabs oral tablet chewable</i>	1 or 1b*	
<i>phenytoin oral suspension</i>	1 or 1b*	
<i>phenytoin oral tablet chewable</i>	1 or 1b*	
<i>phenytoin sodium extended oral capsule</i>	1 or 1b*	
<i>phenytoin sodium injection solution</i>	1 or 1b*	
*SUCCINIMIDES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
CELONTIN ORAL CAPSULE (<i>methsuximide</i>)	3	QL (4 capsules per 1 day)
<i>ethosuximide oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>ethosuximide oral solution</i>	1 or 1b*	QL (30 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methsuximide oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
*VALPROIC ACID*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>divalproex sodium er oral tablet extended release 24 hour 500 mg</i>	1 or 1b*	QL (7 tablets per 1 day)
<i>divalproex sodium oral capsule delayed release sprinkle</i>	1 or 1b*	QL (8 capsules per 1 day)
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>divalproex sodium oral tablet delayed release 500 mg</i>	1 or 1b*	QL (7 tablets per 1 day)
<i>valproate sodium intravenous solution 100 mg/ml</i>	1 or 1b*	
<i>valproic acid oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>valproic acid oral solution</i>	1 or 1b*	
ANTIDEPRESSANTS - DRUGS FOR THE NERVOUS SYSTEM		
*ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)*** - DRUGS FOR DEPRESSION		
<i>mirtazapine oral tablet</i>	1 or 1b*	
<i>mirtazapine oral tablet dispersible</i>	1 or 1b*	
REMERON ORAL TABLET (<i>mirtazapine</i>)	3	
REMERON SOLTAB ORAL TABLET DISPERSIBLE (<i>mirtazapine</i>)	3	
*ANTIDEPRESSANTS - MISC.*** - DRUGS FOR DEPRESSION		
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg</i>	1 or 1b*	DO
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg</i>	1 or 1b*	DO
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg, 450 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>bupropion hcl oral tablet 100 mg</i>	1 or 1b*	QL (4.5 tablet per 1 day)
<i>bupropion hcl oral tablet 75 mg</i>	1 or 1b*	DO
*GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID*** - DRUGS FOR DEPRESSION		
ZULRESSO INTRAVENOUS SOLUTION (<i>brexanolone</i>)	3	PA; LD
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (<i>zuranolone</i>)	3	PA; LD; QL (28 capsules per 1 fill)
ZURZUVAE ORAL CAPSULE 30 MG (<i>zuranolone</i>)	3	PA; LD; QL (14 capsules per 1 fill)
*MONOAMINE OXIDASE INHIBITORS (MAOIS)*** - DRUGS FOR DEPRESSION		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 9 MG/24HR (<i>selegiline</i>)	3	QL (1 patch per 1 day)
EMSAM TRANSDERMAL PATCH 24 HOUR 6 MG/24HR (<i>selegiline</i>)	3	DO
MARPLAN ORAL TABLET (<i>isocarboxazid</i>)	3	QL (6 tablets per 1 day)
NARDIL ORAL TABLET (<i>phenelzine sulfate</i>)	3	QL (6 tablets per 1 day)
PARNATE ORAL TABLET (<i>tranylcypromine sulfate</i>)	3	QL (6 tablets per 1 day)
<i>phenelzine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>tranylcypromine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS*** - DRUGS FOR DEPRESSION		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK (<i>esketamine hcl</i>)	3	PA; LD; QL (4 kits per 28 days)
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK (<i>esketamine hcl</i>)	3	PA; LD; QL (4 kits per 28 days)
*SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)*** - DRUGS FOR DEPRESSION		
<i>citalopram hydrobromide oral solution</i>	1 or 1b*	
<i>citalopram hydrobromide oral tablet</i>	1 or 1b*	
<i>escitalopram oxalate oral solution</i>	1 or 1b*	
<i>escitalopram oxalate oral tablet</i>	1 or 1b*	
<i>fluoxetine hcl oral capsule</i>	1 or 1b*	
<i>fluoxetine hcl oral capsule delayed release</i>	1 or 1b*	
<i>fluoxetine hcl oral solution</i>	1 or 1b*	
<i>fluoxetine hcl oral tablet 10 mg, 20 mg</i>	1 or 1b*	
FLUOXETINE HCL ORAL TABLET 60 MG	3	
<i>fluvoxamine maleate er oral capsule extended release 24 hour</i>	1 or 1b*	
<i>fluvoxamine maleate oral tablet</i>	1 or 1b*	
<i>paroxetine hcl er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>paroxetine hcl oral suspension</i>	1 or 1b*	
<i>paroxetine hcl oral tablet</i>	1 or 1b*	
PAXIL ORAL SUSPENSION (<i>paroxetine hcl</i>)	3	ST
<i>sertraline hcl oral concentrate</i>	1 or 1b*	
<i>sertraline hcl oral tablet</i>	1 or 1b*	
*SEROTONIN MODULATORS**** - DRUGS FOR DEPRESSION		
<i>nefazodone hcl oral tablet 100 mg, 50 mg</i>	1 or 1b*	DO
<i>nefazodone hcl oral tablet 150 mg, 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>nefazodone hcl oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg</i>	1 or 1a*	DO
<i>trazodone hcl oral tablet 300 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
TRINTELLIX ORAL TABLET 10 MG, 5 MG (<i>vortioxetine hbr</i>)	2	DO
TRINTELLIX ORAL TABLET 20 MG (<i>vortioxetine hbr</i>)	2	QL (1 tablet per 1 day)
<i>vilazodone hcl oral tablet 10 mg, 20 mg</i>	1 or 1b*	DO
<i>vilazodone hcl oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)*** - DRUGS FOR DEPRESSION		
DESVENLAFAXINE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG	3	ST; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DESVENLAFAXINE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 50 MG	3	ST; DO
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg</i>	1 or 1b*	DO
<i>duloxetine hcl oral capsule delayed release particles 20 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 30 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	1 or 1b*	QL (3 capsule per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 60 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR (<i>levomilnacipran hcl</i>)	3	ST; QL (1 capsule per 1 day)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK (<i>levomilnacipran hcl</i>)	3	ST; QL (28 pack per 365 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour 225 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>venlafaxine hcl oral tablet</i>	1 or 1b*	QL (3 tablet per 1 day)
*TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION		
<i>amitriptyline hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg</i>	1 or 1a*	DO
<i>amitriptyline hcl oral tablet 100 mg</i>	1 or 1a*	QL (3 tablets per 1 day)
<i>amitriptyline hcl oral tablet 150 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>amoxapine oral tablet 100 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>amoxapine oral tablet 150 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>amoxapine oral tablet 25 mg, 50 mg</i>	1 or 1b*	DO
<i>clomipramine hcl oral capsule 25 mg</i>	1 or 1b*	DO
<i>clomipramine hcl oral capsule 50 mg</i>	1 or 1b*	QL (5 capsules per 1 day)
<i>clomipramine hcl oral capsule 75 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>desipramine hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg</i>	1 or 1b*	DO
<i>desipramine hcl oral tablet 100 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>desipramine hcl oral tablet 150 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>doxepin hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	1 or 1b*	DO
<i>doxepin hcl oral capsule 100 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>doxepin hcl oral capsule 150 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxepin hcl oral concentrate</i>	1 or 1b*	QL (30 mL per 1 day)
<i>imipramine hcl oral tablet 10 mg, 25 mg</i>	1 or 1b*	DO
<i>imipramine hcl oral tablet 50 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>imipramine pamoate oral capsule 100 mg, 75 mg</i>	1 or 1b*	DO
<i>imipramine pamoate oral capsule 125 mg, 150 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
NORPRAMIN ORAL TABLET (<i>desipramine hcl</i>)	3	DO

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nortriptyline hcl oral capsule 10 mg, 25 mg</i>	1 or 1b*	DO
<i>nortriptyline hcl oral capsule 50 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>nortriptyline hcl oral capsule 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>nortriptyline hcl oral solution</i>	1 or 1b*	QL (75 mL per 1 day)
PAMELOR ORAL CAPSULE 10 MG, 25 MG (<i>nortriptyline hcl</i>)	3	DO
PAMELOR ORAL CAPSULE 50 MG (<i>nortriptyline hcl</i>)	3	QL (3 capsules per 1 day)
PAMELOR ORAL CAPSULE 75 MG (<i>nortriptyline hcl</i>)	3	QL (2 capsules per 1 day)
<i>protriptyline hcl oral tablet 10 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>protriptyline hcl oral tablet 5 mg</i>	1 or 1b*	DO
<i>trimipramine maleate oral capsule 100 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>trimipramine maleate oral capsule 25 mg, 50 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
ANTIDIABETICS - HORMONES		
*ALPHA-GLUCOSIDASE INHIBITORS*** - DRUGS FOR DIABETES		
<i>acarbose oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>miglitol oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
*ANTIDIABETIC - AMYLIN ANALOGS*** - DRUGS FOR DIABETES		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>pramlintide acetate</i>)	2	QL (4 pens per 30 days)
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>pramlintide acetate</i>)	2	QL (2 boxes per 30 days)
*ANTIDIABETIC-ANTI-CD3 ANTIBODIES*** - HORMONES		
TZIELD INTRAVENOUS SOLUTION (<i>teplizumab-mzww</i>)	3	PA; LD
*BIGUANIDES*** - DRUGS FOR DIABETES		
<i>metformin hcl er oral tablet extended release 24 hour 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>metformin hcl er oral tablet extended release 24 hour 750 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metformin hcl oral solution</i>	3	PA; QL (2 bottles per 30 days)
<i>metformin hcl oral tablet 1000 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metformin hcl oral tablet 500 mg</i>	1 or 1b*	QL (5 tablets per 1 day)
<i>metformin hcl oral tablet 850 mg</i>	1 or 1b*; \$0	QL (3 tablets per 1 day)
RIOMET ORAL SOLUTION (<i>metformin hcl</i>)	3	PA; QL (2 bottles per 30 days)
*DIABETIC OTHER*** - DRUGS FOR DIABETES		
BAQSIMI ONE PACK NASAL POWDER (<i>glucagon</i>)	3	QL (2 packs per 30 days)
BAQSIMI TWO PACK NASAL POWDER (<i>glucagon</i>)	3	QL (1 pack per 30 days)
<i>diazoxide oral suspension</i>	1 or 1b*	
GLUCAGON EMERGENCY INJECTION KIT	1 or 1b*	QL (2 kits per 30 days)
GLUCAGON EMERGENCY INJECTION SOLUTION RECONSTITUTED	3	QL (2 kits per 30 days)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>glucagon</i>)	3	QL (2 packs per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>glucagon</i>)	3	QL (1 pack per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GVOKE KIT SUBCUTANEOUS SOLUTION (<i>glucagon</i>)	3	QL (2 kits per 30 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>glucagon</i>)	3	QL (2 packs per 30 days)
PROGLYCEM ORAL SUSPENSION (<i>diazoxide</i>)	3	
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>dasiglucagon hcl</i>)	3	QL (1.2 mL per 30 days)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>dasiglucagon hcl</i>)	3	QL (1.2 mL per 30 days)
*DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS*** - DRUGS FOR DIABETES		
<i>alogliptin benzoate oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
JANUVIA ORAL TABLET (<i>sitagliptin phosphate</i>)	2	ST; QL (1 tablet per 1 day)
*DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>alogliptin-metformin hcl oral tablet</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
JANUMET ORAL TABLET (<i>sitagliptin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (<i>sitagliptin-metformin hcl</i>)	2	ST; QL (1 tablet per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (<i>sitagliptin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
*DOPAMINE RECEPTOR AGONISTS - ERGOT DERIVATIVES*** - DRUGS FOR DIABETES		
CYCLOSET ORAL TABLET (<i>bromocriptine mesylate</i>)	3	
*DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>alogliptin-pioglitazone oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
*HUMAN INSULIN*** - DRUGS FOR DIABETES		
HUMALOG INJECTION SOLUTION (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin nph isophane & regular</i>)	2	QL (30 mL per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (<i>insulin nph isophane & regular</i>)	2	QL (30 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin nph human (isophane)</i>)	2	QL (30 mL per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION (<i>insulin nph human (isophane)</i>)	2	QL (30 mL per 30 days)
HUMULIN R INJECTION SOLUTION (<i>insulin regular human</i>)	2	QL (30 mL per 30 days)
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION (<i>insulin regular human</i>)	2	PA; QL (20 mL per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin regular human</i>)	2	PA; QL (18 mL per 30 days)
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR	2	ST; QL (30 mL per 30 days)
INSULIN LISPRO INJECTION SOLUTION	2	QL (30 mL per 30 days)
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	2	QL (30 mL per 30 days)
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR	2	QL (30 mL per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (30 mL per 30 days)
LANTUS SUBCUTANEOUS SOLUTION (<i>insulin glargine</i>)	2	QL (30 mL per 30 days)
LYUMJEV INJECTION SOLUTION (<i>insulin lispro-aabc</i>)	2	QL (30 mL per 30 days)
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro-aabc</i>)	2	QL (30 mL per 30 days)
MYXREDLIN INTRAVENOUS SOLUTION (<i>insulin regular(human) in nacl</i>)	3	
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (12 mL per 30 days)
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (13.5 mL per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin degludec</i>)	2	QL (30 mL per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (<i>insulin degludec</i>)	2	QL (18 mL per 30 days)
TRESIBA SUBCUTANEOUS SOLUTION (<i>insulin degludec</i>)	2	QL (30 mL per 30 days)
*INCRETIN MIMETIC AGENTS (GIP & GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES		
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tirzepatide</i>)	2	PA; QL (4 pens per 28 days)
*INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES		
<i>liraglutide subcutaneous solution pen-injector</i>	1 or 1b*	PA; QL (1 box per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (1 pen per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (1 unit per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (0.11 mL per 1 day)
RYBELSUS ORAL TABLET 14 MG, 7 MG (<i>semaglutide</i>)	2	PA; QL (1 carton per 30 days)
RYBELSUS ORAL TABLET 3 MG (<i>semaglutide</i>)	2	PA; QL (1 carton per 1 lifetime)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (<i>dulaglutide</i>)	2	PA; QL (4 pens per 28 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	2	PA; QL (4 syringes per 28 days)
*INSULIN-INCRETIN MIMETIC COMBINATIONS*** - DRUGS FOR DIABETES		
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine-lixisenatide</i>)	2	ST; QL (5 pen per 25 days)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin degludec-liraglutide</i>)	2	ST; QL (5 pen per 30 days)
*MEGLITINIDE ANALOGUES*** - DRUGS FOR DIABETES		
<i>nateglinide oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>repaglinide oral tablet 2 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
*PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR DIABETES		
<i>mifepristone oral tablet 300 mg</i>	1 or 1b*	PA; LD; QL (4 tablets per 1 day)
*SGLT2 INHIBITOR - DPP-4 INHIBITOR - BIGUANIDE COMB*** - DRUGS FOR DIABETES		
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	ST; QL (1 tablet per 1 day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	ST; QL (2 tablets per 1 day)
*SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS*** - DRUGS FOR DIABETES		
GLYXAMBI ORAL TABLET (<i>empagliflozin-linagliptin</i>)	2	ST; QL (1 tablet per 1 day)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS*** - DRUGS FOR DIABETES		
<i>dapagliflozin propanediol oral tablet</i>	2	ST; QL (1 tablet per 1 day)
FARXIGA ORAL TABLET (<i>dapagliflozin propanediol</i>)	2	ST; QL (1 tablet per 1 day)
JARDIANCE ORAL TABLET (<i>empagliflozin</i>)	2	ST; QL (1 tablet per 1 day)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB*** - DRUGS FOR DIABETES		
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg</i>	2	ST; QL (1 tablet per 1 day)
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 5-1000 mg</i>	2	ST; QL (2 tablets per 1 day)
SYNJARDY ORAL TABLET (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (2 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (2 tablets per 1 day)
*SULFONYLUREA-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
*SULFONYLUREAS*** - DRUGS FOR DIABETES		
<i>glimepiride oral tablet 1 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glimepiride oral tablet 2 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>glimepiride oral tablet 4 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 10 mg</i>	1 or 1a*	ST; QL (2 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 2.5 mg</i>	1 or 1a*	ST; QL (8 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 5 mg</i>	1 or 1a*	ST; QL (4 tablets per 1 day)
<i>glipizide oral tablet 10 mg</i>	1 or 1a*	ST; QL (4 tablets per 1 day)
<i>glipizide oral tablet 2.5 mg</i>	1 or 1a*	ST; QL (16 tablets per 1 day)
<i>glipizide oral tablet 5 mg</i>	1 or 1a*	ST; QL (8 tablets per 1 day)
<i>glipizide xl oral tablet extended release 24 hour 10 mg</i>	1 or 1a*	ST; QL (2 tablets per 1 day)
<i>glipizide xl oral tablet extended release 24 hour 2.5 mg</i>	1 or 1a*	ST; QL (8 tablets per 1 day)
<i>glipizide xl oral tablet extended release 24 hour 5 mg</i>	1 or 1a*	ST; QL (4 tablets per 1 day)
<i>glyburide micronized oral tablet 1.5 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glyburide micronized oral tablet 3 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>glyburide micronized oral tablet 6 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>glyburide oral tablet 1.25 mg</i>	1 or 1b*	ST; QL (16 tablets per 1 day)
<i>glyburide oral tablet 2.5 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glyburide oral tablet 5 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
*SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES		
DUETACT ORAL TABLET (<i>pioglitazone hcl-glimepiride</i>)	3	ST; QL (1 tablet per 1 day)
<i>pioglitazone hcl-glimepiride oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl-metformin hcl oral tablet</i>	1 or 1b*	ST; QL (3 tablets per 1 day)
*THIAZOLIDINEDIONES*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS FOR THE STOMACH		
*ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS*** - DRUGS FOR DIARRHEA		
MYTESI ORAL TABLET DELAYED RELEASE (<i>crofelemer</i>)	3	PA; QL (2 tablets per 1 day)
*ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.*** - DRUGS FOR DIARRHEA		
<i>surebiotic probiotic support oral capsule</i>	3	
*ANTIPERISTALTIC AGENTS*** - DRUGS FOR DIARRHEA		
<i>diphenoxylate-atropine oral liquid</i>	1 or 1b*	
<i>diphenoxylate-atropine oral tablet</i>	1 or 1b*	
LOMOTIL ORAL TABLET (<i>diphenoxylate-atropine</i>)	3	
<i>loperamide hcl oral capsule</i>	1 or 1b*	QL (8 capsules per 1 day)
MOTOFEN ORAL TABLET (<i>difenoxin-atropine</i>)	3	
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
*ANTIDOTE COMBINATIONS*** - DRUGS FOR OVERDOSE OR POISONING		
NITHIODOTE INTRAVENOUS KIT (<i>sodium nitrite-sod thiosulfate</i>)	3	
PREVDUO INTRAVENOUS SOLUTION PREFILLED SYRINGE (<i>neostigmine-glycopyrrolate</i>)	3	
*ANTIDOTES - CHELATING AGENTS*** - DRUGS FOR OVERDOSE OR POISONING		
CHEMET ORAL CAPSULE (<i>succimer</i>)	3	
<i>deferasirox granules oral packet</i>	1 or 1b*	PA; LD
<i>deferasirox oral packet</i>	1 or 1b*	PA; LD
<i>deferasirox oral tablet</i>	1 or 1b*	PA; LD
<i>deferasirox oral tablet soluble</i>	1 or 1b*	PA; LD
<i>deferiprone oral tablet</i>	1 or 1b*	PA; LD
FERRIPROX ORAL SOLUTION (<i>deferiprone</i>)	3	PA; LD
FERRIPROX TWICE-A-DAY ORAL TABLET (<i>deferiprone</i>)	3	PA; LD
*ANTIDOTES AND SPECIFIC ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
ACETADOTE INTRAVENOUS SOLUTION (<i>acetylcysteine</i>)	3	
<i>acetylcysteine intravenous solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDEXXA INTRAVENOUS SOLUTION RECONSTITUTED (<i>coag fact xa inactivated-zhzo</i>)	3	
BRIDION INTRAVENOUS SOLUTION (<i>sugammadex sodium</i>)	3	
CYANOKIT INTRAVENOUS SOLUTION RECONSTITUTED (<i>hydroxocobalamin</i>)	3	
<i>deferoxamine mesylate injection solution reconstituted</i>	1 or 1b*	LD
DESFERAL INJECTION SOLUTION RECONSTITUTED (<i>deferoxamine mesylate</i>)	3	LD
DIGIFAB INTRAVENOUS SOLUTION RECONSTITUTED (<i>digoxin immune fab</i>)	3	
<i>edetate calcium disodium injection solution</i>	3	
<i>fomepizole intravenous solution</i>	1 or 1b*	
<i>methylene blue (antidote) intravenous solution</i>	1 or 1b*	
<i>methylene blue intravenous solution</i>	1 or 1b*	
PRAXBIND INTRAVENOUS SOLUTION (<i>idarucizumab</i>)	3	
PROTOPAM CHLORIDE INTRAVENOUS SOLUTION RECONSTITUTED (<i>pralidoxime chloride</i>)	3	
PROVAYBLUE INTRAVENOUS SOLUTION (<i>methylene blue (antidote)</i>)	3	
RADIOGARDASE ORAL CAPSULE (<i>prussian blue insoluble</i>)	3	
SODIUM NITRITE INTRAVENOUS SOLUTION	3	
SODIUM THIOSULFATE INTRAVENOUS SOLUTION	1 or 1b*	
VISTOGARD ORAL PACKET (<i>uridine triacetate</i>)	3	PA; LD; QL (20 packets per 30 days)
*BENZODIAZEPINE ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
<i>flumazenil intravenous solution</i>	1 or 1b*	
*OPIOID ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
KLOXXADO NASAL LIQUID (<i>naloxone hcl</i>)	2	QL (6 nasal sprays per 3 monthss)
<i>nalmefene hcl injection solution</i>	3	QL (20 mL per 150 days)
<i>naloxone hcl injection solution</i>	1 or 1b*	QL (6 vial per 90 days)
<i>naloxone hcl injection solution cartridge</i>	1 or 1b*	QL (6 syringe per 90 days)
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml</i>	1 or 1b*	ST; QL (6 syringes per 3 months)
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	1 or 1b*	QL (6 syringe per 90 days)
<i>naloxone hcl nasal liquid</i>	1 or 1b*	QL (6 nasal sprays per 3 monthss)
<i>naltrexone hcl oral tablet</i>	1 or 1b*	
OPVEE NASAL SOLUTION (<i>nalmefene hcl</i>)	2	QL (3 cartons per 90 days)
REXTOVY NASAL LIQUID (<i>naloxone hcl</i>)	2	QL (6 nasal sprays per 3 monthss)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>naltrexone</i>)	3	LD; QL (1 vial per 28 days)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE (<i>naloxone hcl</i>)	2	QL (6 syringes per 3 monthss)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETICS - DRUGS FOR THE STOMACH		
*5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA		
ANZEMET ORAL TABLET (<i>dolasetron mesylate</i>)	3	LD; QL (5 tablets per 30 days)
<i>granisetron hcl intravenous solution</i>	1 or 1b*	LD
<i>granisetron hcl oral tablet</i>	1 or 1b*	LD; QL (10 tablets per 30 days)
<i>ondansetron hcl injection solution</i>	1 or 1b*	
<i>ondansetron hcl injection solution prefilled syringe</i>	1 or 1b*	LD
<i>ondansetron hcl oral solution</i>	1 or 1b*	LD; QL (8 mL per 1 day)
<i>ondansetron hcl oral tablet 24 mg</i>	1 or 1b*	LD; QL (8 tablet per 30 days)
<i>ondansetron hcl oral tablet 4 mg</i>	1 or 1b*	LD; QL (48 tablets per 30 days)
<i>ondansetron hcl oral tablet 8 mg</i>	1 or 1b*	LD; QL (24 tablets per 30 days)
<i>ondansetron oral tablet dispersible 16 mg</i>	1 or 1b*	QL (4 tablets per 30 days)
<i>ondansetron oral tablet dispersible 4 mg</i>	1 or 1b*	LD; QL (48 tablets per 30 days)
<i>ondansetron oral tablet dispersible 8 mg</i>	1 or 1b*	LD; QL (24 tablets per 30 days)
PALONOSETRON HCL INTRAVENOUS SOLUTION 0.25 MG/2ML	3	PA; LD
<i>palonosetron hcl intravenous solution 0.25 mg/5ml</i>	1 or 1b*	PA; LD
<i>palonosetron hcl intravenous solution prefilled syringe</i>	1 or 1b*	PA; LD
POSFREA INTRAVENOUS SOLUTION (<i>palonosetron hcl</i>)	3	PA; LD
SANCUSO TRANSDERMAL PATCH (<i>granisetron</i>)	3	LD; QL (4 patches per 28 days)
SUSTOL SUBCUTANEOUS PREFILLED SYRINGE (<i>granisetron</i>)	3	LD
*ANTIEMETIC COMBINATIONS*** - DRUGS FOR VOMITING AND NAUSEA		
AKYNZEO (READY-TO-USE) INTRAVENOUS SOLUTION (<i>fosnetupitant-palonosetron</i>)	3	PA; LD; QL (5 vials per 30 days)
AKYNZEO (TO-BE-DILUTED) INTRAVENOUS SOLUTION (<i>fosnetupitant-palonosetron</i>)	3	PA; LD; QL (5 vials per 30 days)
AKYNZEO INTRAVENOUS SOLUTION RECONSTITUTED (<i>fosnetupitant-palonosetron</i>)	3	PA; LD; QL (5 vials per 30 days)
AKYNZEO ORAL CAPSULE (<i>netupitant-palonosetron</i>)	3	LD; QL (5 capsules per 25 days)
BONJESTA ORAL TABLET EXTENDED RELEASE (<i>doxylamine-pyridoxine</i>)	3	PA; QL (4 tablet per 1 day)
<i>doxylamine-pyridoxine oral tablet delayed release</i>	1 or 1b*	PA; QL (4 tablet per 1 day)
*ANTIEMETICS - ANTICHOLINERGIC*** - DRUGS FOR VOMITING AND NAUSEA		
ANTIVERT ORAL TABLET (<i>meclizine hcl</i>)	3	
ANTIVERT ORAL TABLET CHEWABLE (<i>meclizine hcl</i>)	3	
DIMENHYDRINATE INJECTION SOLUTION	3	
<i>meclizine hcl oral tablet 25 mg</i>	1 or 1a*	
<i>meclizine hcl oral tablet 50 mg</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>scopolamine transdermal patch 72 hour</i>	1 or 1b*	
TIGAN INTRAMUSCULAR SOLUTION (<i>trimethobenzamide hcl</i>)	3	
<i>trimethobenzamide hcl oral capsule</i>	1 or 1b*	
*ANTIEMETICS - ANTIDOPAMINERGIC*** - DRUGS FOR VOMITING AND NAUSEA		
BARHEMSYS INTRAVENOUS SOLUTION (<i>amisulpride (antiemetic)</i>)	3	
*ANTIEMETICS - MISCELLANEOUS*** - DRUGS FOR VOMITING AND NAUSEA		
<i>dronabinol oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
MARINOL ORAL CAPSULE (<i>dronabinol</i>)	3	QL (4 capsules per 1 day)
SYNDROS ORAL SOLUTION (<i>dronabinol</i>)	3	QL (8 mL per 1 day)
*SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA		
APONVIE INTRAVENOUS EMULSION (<i>aprepitant</i>)	3	LD
<i>aprepitant oral</i>	1 or 1b*	LD; QL (15 capsules per 25 days)
<i>aprepitant oral capsule 125 mg</i>	1 or 1b*	LD; QL (5 capsules per 25 days)
<i>aprepitant oral capsule 40 mg</i>	1 or 1b*	LD; QL (1 capsule per 1 fill)
<i>aprepitant oral capsule 80 & 125 mg</i>	1 or 1b*	LD; QL (15 capsules per 25 days)
<i>aprepitant oral capsule 80 mg</i>	1 or 1b*	LD; QL (10 capsules per 25 days)
CINVANTI INTRAVENOUS EMULSION (<i>aprepitant</i>)	3	PA; QL (5 vials per 30 days)
EMEND ORAL SUSPENSION RECONSTITUTED (<i>aprepitant</i>)	3	QL (15 kit per 30 days)
<i>focinvez intravenous solution</i>	3	PA; QL (5 vials per 30 days)
<i>fosaprepitant dimeglumine intravenous solution reconstituted</i>	1 or 1b*	PA; LD; QL (5 vial per 30 days)
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK (<i>rolapitant hcl</i>)	3	QL (4 capsules per 28 days)
ANTIFUNGALS - DRUGS FOR INFECTIONS		
*ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)*** - DRUGS FOR FUNGUS		
CANCIDAS INTRAVENOUS SOLUTION RECONSTITUTED (<i>caspofungin acetate</i>)	3	QL (1 vial per 1 day)
CASPOFUNGIN ACETATE INTRAVENOUS SOLUTION RECONSTITUTED	3	QL (1 vial per 1 day)
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED (<i>anidulafungin</i>)	3	
MICAFUNGIN SODIUM INTRAVENOUS SOLUTION RECONSTITUTED	3	
<i>micafungin sodium-nacl intravenous solution</i>	3	
MYCAMINE INTRAVENOUS SOLUTION RECONSTITUTED (<i>micafungin sodium</i>)	3	
REZZAYO INTRAVENOUS SOLUTION RECONSTITUTED (<i>rezafungin acetate</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (TRITERPENOID)*** - ANTIBIOTICS		
BREXAFEMME ORAL TABLET (<i>ibrexafungerp citrate</i>)	3	PA; QL (4 tablets per 1 month)
*ANTIFUNGALS*** - DRUGS FOR FUNGUS		
ABELCET INTRAVENOUS SUSPENSION (<i>amphotericin b lipid</i>)	3	
AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED (<i>amphotericin b liposome</i>)	3	
<i>amphotericin b intravenous solution reconstituted</i>	1 or 1b*	
<i>amphotericin b liposome intravenous suspension reconstituted</i>	1 or 1b*	
ANCOBON ORAL CAPSULE (<i>flucytosine</i>)	3	PA
<i>flucytosine oral capsule</i>	1 or 1b*	PA
<i>griseofulvin microsize oral suspension</i>	1 or 1b*	
<i>griseofulvin microsize oral tablet</i>	1 or 1b*	
<i>griseofulvin ultramicrosize oral tablet</i>	1 or 1b*	
<i>nystatin oral tablet</i>	1 or 1b*	
<i>terbinafine hcl oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
*IMIDAZOLES*** - DRUGS FOR FUNGUS		
<i>ketoconazole oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*TETRAZOLES*** - DRUGS FOR FUNGUS		
VIVJOA ORAL CAPSULE THERAPY PACK (<i>oteseconazole</i>)	3	PA; QL (1 carton per 4 monthss)
*TRIAZOLES*** - DRUGS FOR FUNGUS		
CRESEMBA INTRAVENOUS SOLUTION RECONSTITUTED (<i>isavuconazonium sulfate</i>)	3	PA; QL (1 vial per 1 day)
CRESEMBA ORAL CAPSULE 186 MG (<i>isavuconazonium sulfate</i>)	3	PA; QL (2 capsules per 1 day)
CRESEMBA ORAL CAPSULE 74.5 MG (<i>isavuconazonium sulfate</i>)	3	PA; QL (5 capsules per 1 day)
DIFLUCAN ORAL SUSPENSION RECONSTITUTED (<i>fluconazole</i>)	3	QL (10 mL per 1 day)
DIFLUCAN ORAL TABLET 100 MG (<i>fluconazole</i>)	3	QL (4 tablet per 1 day)
DIFLUCAN ORAL TABLET 200 MG (<i>fluconazole</i>)	3	QL (2 tablets per 1 day)
FLUCONAZOLE IN SODIUM CHLORIDE INTRAVENOUS SOLUTION 100-0.9 MG/50ML-%	3	
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%</i>	1 or 1b*	
<i>fluconazole oral suspension reconstituted 10 mg/ml</i>	1 or 1b*	QL (40 mL per 1 day)
<i>fluconazole oral suspension reconstituted 40 mg/ml</i>	1 or 1b*	QL (10 mL per 1 day)
<i>fluconazole oral tablet 100 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>fluconazole oral tablet 150 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>fluconazole oral tablet 50 mg</i>	1 or 1b*	QL (8 tablet per 1 day)
<i>itraconazole oral capsule</i>	1 or 1b*	PA; QL (4.2 capsules per 1 day)
<i>itraconazole oral solution</i>	1 or 1b*	PA; QL (20 mL per 1 day)
NOXAFIL ORAL PACKET (<i>posaconazole</i>)	3	PA; QL (31 packet per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>posaconazole intravenous solution</i>	1 or 1b*	
<i>posaconazole oral suspension</i>	1 or 1b*	PA; QL (20 mL per 1 day)
<i>posaconazole oral tablet delayed release</i>	1 or 1b*	PA; QL (93 tablets per 30 days)
SPORANOX ORAL CAPSULE (<i>itraconazole</i>)	3	PA; QL (4.2 capsules per 1 day)
SPORANOX ORAL SOLUTION (<i>itraconazole</i>)	3	PA; QL (20 mL per 1 day)
TOLSURA ORAL CAPSULE	3	PA; QL (126 capsules per 30 days)
VFEND ORAL SUSPENSION RECONSTITUTED (<i>voriconazole</i>)	3	PA; QL (17.5 mL per 1 day)
VFEND ORAL TABLET (<i>voriconazole</i>)	3	PA; QL (6 tablets per 1 day)
<i>voriconazole oral suspension reconstituted</i>	1 or 1b*	PA; QL (17.5 mL per 1 day)
<i>voriconazole oral tablet 200 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>voriconazole oral tablet 50 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
ANTIHISTAMINES - DRUGS FOR THE LUNGS		
*ANTIHISTAMINES - ETHANOLAMINES*** - DRUGS FOR ALLERGIES		
<i>carbinoxamine maleate er oral suspension extended release</i>	1 or 1b*	ST; QL (40 mL per 1 day)
<i>carbinoxamine maleate oral solution</i>	1 or 1b*	ST
<i>carbinoxamine maleate oral tablet 4 mg</i>	1 or 1b*	ST
CLEMASTINE FUMARATE ORAL SYRUP	3	ST; QL (60 mL per 1 day)
<i>clemastine fumarate oral tablet</i>	1 or 1b*	ST; QL (3 tablets per 1 day)
<i>diphenhydramine hcl injection solution</i>	1 or 1b*	
<i>diphenhydramine hcl oral elixir</i>	1 or 1a*	QL (4 mL per 1 day)
*ANTIHISTAMINES - NON-SEDATING*** - DRUGS FOR ALLERGIES		
<i>cetirizine hcl oral solution</i>	1 or 1b*	BE; QL (10 mL per 1 day)
CLARINEX ORAL TABLET (<i>desloratadine</i>)	3	ST; QL (1 tablet per 1 day)
<i>desloratadine oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>desloratadine oral tablet dispersible</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>levocetirizine dihydrochloride oral solution</i>	1 or 1b*	BE; QL (10 mL per 1 day)
<i>levocetirizine dihydrochloride oral tablet</i>	1 or 1b*	BE; QL (1 tablet per 1 day)
QUZYTIR INTRAVENOUS SOLUTION (<i>cetirizine hcl</i>)	3	
*ANTIHISTAMINES - PHENOTHIAZINES*** - DRUGS FOR ALLERGIES		
PHENERGAN INJECTION SOLUTION (<i>promethazine hcl</i>)	3	
<i>promethazine hcl injection solution</i>	1 or 1a*	
<i>promethazine hcl oral solution</i>	1 or 1a*	QL (40 mL per 1 day)
<i>promethazine hcl oral tablet 12.5 mg, 25 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>promethazine hcl oral tablet 50 mg</i>	1 or 1a*	QL (1 tablet per 1 day)
<i>promethazine hcl rectal suppository</i>	1 or 1b*	QL (6 suppositories per 1 day)
<i>promethegan rectal suppository 12.5 mg, 25 mg</i>	1 or 1b*	QL (6 suppositories per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>promethegan rectal suppository 50 mg</i>	1 or 1b*	QL (1 suppository per 1 day)
*ANTIHISTAMINES - PIPERIDINES*** - DRUGS FOR ALLERGIES		
<i>cyproheptadine hcl oral syrup</i>	1 or 1b*	
<i>cyproheptadine hcl oral tablet</i>	1 or 1b*	
ANTIHYPERTENSIVES - DRUGS FOR THE HEART		
*ACL INHIB-INTestinal CHOLESTEROL ABSORPTION INHIB COMB*** - DRUGS FOR CHOLESTEROL		
NEXLIZET ORAL TABLET (<i>bempedoic acid-ezetimibe</i>)	3	PA; QL (1 tablet per 1 day)
*ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS*** - DRUGS FOR CHOLESTEROL		
NEXLETOL ORAL TABLET (<i>bempedoic acid</i>)	3	PA; QL (1 tablet per 1 day)
*ANGIOTENSIN-LIKE PROTEIN 3 (ANGPTL3) INHIBITORS*** - DRUGS FOR CHOLESTEROL		
EVKEEZA INTRAVENOUS SOLUTION (<i>evinacumab-dgnb</i>)	3	PA; LD
*ANTIHYPERTENSIVES - MISC.*** - DRUGS FOR CHOLESTEROL		
<i>icosapent ethyl oral capsule 0.5 gm</i>	1 or 1b*	PA; QL (8 capsules per 1 day)
<i>icosapent ethyl oral capsule 1 gm</i>	1 or 1b*	PA; QL (4 capsule per 1 day)
<i>omega-3-acid ethyl esters oral capsule</i>	1 or 1b*	PA; QL (4 capsule per 1 day)
VASCEPA ORAL CAPSULE 0.5 GM (<i>icosapent ethyl</i>)	2	PA; QL (8 capsules per 1 day)
VASCEPA ORAL CAPSULE 1 GM (<i>icosapent ethyl</i>)	2	PA; QL (4 capsule per 1 day)
*BILE ACID SEQUESTRANTS*** - DRUGS FOR CHOLESTEROL		
<i>cholestyramine light oral packet</i>	1 or 1b*	QL (24 grams per 1 day)
<i>cholestyramine light oral powder</i>	1 or 1b*	QL (30 grams per 1 day)
<i>cholestyramine oral packet</i>	1 or 1b*	QL (6 packets per 1 day)
<i>cholestyramine oral powder</i>	1 or 1b*	QL (54 gm per 1 day)
<i>colesevelam hcl oral packet</i>	3	QL (1 packet per 1 day)
<i>colesevelam hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
COLESTID ORAL GRANULES (<i>colestipol hcl</i>)	3	QL (45 grams per 1 day)
COLESTID ORAL TABLET (<i>colestipol hcl</i>)	3	QL (16 tablets per 1 day)
<i>colestipol hcl oral granules</i>	1 or 1b*	QL (45 grams per 1 day)
<i>colestipol hcl oral packet</i>	1 or 1b*	QL (30 grams per 1 day)
<i>colestipol hcl oral tablet</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>prevalite oral packet</i>	1 or 1b*	QL (24 grams per 1 day)
<i>prevalite oral powder</i>	1 or 1b*	QL (30 grams per 1 day)
QUESTRAN LIGHT ORAL POWDER (<i>cholestyramine light</i>)	3	QL (30 grams per 1 day)
QUESTRAN ORAL PACKET (<i>cholestyramine</i>)	3	QL (6 packets per 1 day)
QUESTRAN ORAL POWDER (<i>cholestyramine</i>)	3	QL (54 gm per 1 day)
*FIBRIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL		
<i>fenofibrate micronized oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fenofibrate oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	3	ST; QL (1 tablet per 1 day)
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fenofibric acid oral capsule delayed release</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>fenofibric acid oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
FIBRICOR ORAL TABLET (<i>fenofibric acid</i>)	3	ST; QL (1 tablet per 1 day)
<i>gemfibrozil oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
LIPOFEN ORAL CAPSULE (<i>fenofibrate</i>)	3	ST; QL (1 capsule per 1 day)
LOPID ORAL TABLET (<i>gemfibrozil</i>)	3	ST; QL (2 tablets per 1 day)
TRICOR ORAL TABLET (<i>fenofibrate</i>)	3	ST; QL (1 tablet per 1 day)
*HMG COA REDUCTASE INHIBITORS*** - DRUGS FOR CHOLESTEROL		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	1 or 1b*; \$0	DO
<i>atorvastatin calcium oral tablet 40 mg</i>	1 or 1b*	DO
<i>atorvastatin calcium oral tablet 80 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fluvastatin sodium oral capsule</i>	1 or 1b*; \$0	DO
<i>lovastatin oral tablet 10 mg, 20 mg</i>	1 or 1b*; \$0	DO
<i>lovastatin oral tablet 40 mg</i>	1 or 1b*; \$0	QL (2 tablets per 1 day)
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1 or 1b*; \$0	DO
<i>pravastatin sodium oral tablet 80 mg</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
<i>rosuvastatin calcium oral tablet 10 mg, 5 mg</i>	1 or 1b*; \$0	DO
<i>rosuvastatin calcium oral tablet 20 mg</i>	1 or 1b*	DO
<i>rosuvastatin calcium oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>simvastatin oral tablet 10 mg, 20 mg, 5 mg</i>	1 or 1b*; \$0	DO
<i>simvastatin oral tablet 40 mg</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
<i>simvastatin oral tablet 80 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
*INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB*** - DRUGS FOR CHOLESTEROL		
<i>ezetimibe-simvastatin oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
*INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS*** - DRUGS FOR CHOLESTEROL		
<i>ezetimibe oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
*MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN INHIBITORS*** - DRUGS FOR CHOLESTEROL		
JUXTAPID ORAL CAPSULE 10 MG, 5 MG (<i>lomitapide mesylate</i>)	3	PA; LD; DO
JUXTAPID ORAL CAPSULE 20 MG, 30 MG (<i>lomitapide mesylate</i>)	3	PA; LD; QL (2 capsules per 1 day)
*NICOTINIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL		
<i>niacin (antihyperlipidemic) oral tablet</i>	1 or 1b*	ST; QL (12 tablets per 1 day)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 750 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>niacin er (antihyperlipidemic) oral tablet extended release 500 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>niacor oral tablet</i>	1 or 1b*	ST; QL (12 tablets per 1 day)
*PCSK9 INHIBITORS*** - DRUGS FOR CHOLESTEROL		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE (<i>evolocumab</i>)	3	PA; QL (1 cartridge per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>evolocumab</i>)	3	PA; QL (2 syringe per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>evolocumab</i>)	3	PA; QL (2 syringe per 28 days)
*SMALL INTERFERING RNA (SIRNA) PCSK9 INHIBITORS*** - DRUGS FOR CHOLESTEROL		
LEQVIO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>inclisiran sodium</i>)	3	PA; LD; QL (1.5 mL per 180 days)
ANTIHYPERTENSIVES - DRUGS FOR THE HEART		
*ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-40 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>amlodipine besy-benazepril hcl oral capsule 2.5-10 mg</i>	1 or 1b*	DO
<i>amlodipine besy-benazepril hcl oral capsule 5-10 mg, 5-20 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
PRESTALIA ORAL TABLET 14-10 MG (<i>perindopril arg-amlodipine</i>)	3	QL (1 tablet per 1 day)
PRESTALIA ORAL TABLET 3.5-2.5 MG, 7-5 MG (<i>perindopril arg-amlodipine</i>)	3	DO
<i>trandolapril-verapamil hcl er oral tablet extended release</i>	1 or 1b*	QL (1 tablet per 1 day)
*ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE		
ACCURETIC ORAL TABLET 10-12.5 MG (<i>quinapril-hydrochlorothiazide</i>)	3	DO
ACCURETIC ORAL TABLET 20-12.5 MG (<i>quinapril-hydrochlorothiazide</i>)	3	QL (2 tablets per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 5-6.25 mg</i>	1 or 1b*	DO
<i>captopril-hydrochlorothiazide oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg</i>	1 or 1b*	DO
<i>fosinopril sodium-hctz oral tablet 20-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	DO
<i>lisinopril-hydrochlorothiazide oral tablet 20-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 20-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
LOTENSIN HCT ORAL TABLET 10-12.5 MG (<i>benazepril-hydrochlorothiazide</i>)	3	QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOTENSIN HCT ORAL TABLET 20-12.5 MG, 20-25 MG (<i>benazepril-hydrochlorothiazide</i>)	3	QL (1 tablet per 1 day)
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	DO
<i>quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
VASERETIC ORAL TABLET (<i>enalapril-hydrochlorothiazide</i>)	3	QL (2 tablets per 1 day)
ZESTORETIC ORAL TABLET 10-12.5 MG (<i>lisinopril-hydrochlorothiazide</i>)	3	DO
ZESTORETIC ORAL TABLET 20-12.5 MG (<i>lisinopril-hydrochlorothiazide</i>)	3	QL (4 tablets per 1 day)
ZESTORETIC ORAL TABLET 20-25 MG (<i>lisinopril-hydrochlorothiazide</i>)	3	QL (2 tablets per 1 day)
*ACE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>benazepril hcl oral tablet 10 mg, 5 mg</i>	1 or 1a*	DO
<i>benazepril hcl oral tablet 20 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>benazepril hcl oral tablet 40 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>captopril oral tablet 100 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>captopril oral tablet 12.5 mg, 25 mg</i>	1 or 1b*	DO
<i>captopril oral tablet 50 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>enalapril maleate oral solution</i>	1 or 1b*	QL (40 mg per 1 day)
<i>enalapril maleate oral tablet 10 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>enalapril maleate oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	DO
<i>enalapril maleate oral tablet 20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalaprilat intravenous solution</i>	1 or 1b*	
EPANED ORAL SOLUTION (<i>enalapril maleate</i>)	3	QL (40 mg per 1 day)
<i>fosinopril sodium oral tablet 10 mg</i>	1 or 1b*	DO
<i>fosinopril sodium oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>fosinopril sodium oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lisinopril oral tablet 10 mg, 20 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lisinopril oral tablet 2.5 mg, 5 mg</i>	1 or 1a*	DO
<i>lisinopril oral tablet 30 mg, 40 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
LOTENSIN ORAL TABLET 10 MG (<i>benazepril hcl</i>)	3	DO
LOTENSIN ORAL TABLET 20 MG (<i>benazepril hcl</i>)	3	QL (4 tablets per 1 day)
LOTENSIN ORAL TABLET 40 MG (<i>benazepril hcl</i>)	3	QL (2 tablets per 1 day)
<i>moexipril hcl oral tablet 15 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>moexipril hcl oral tablet 7.5 mg</i>	1 or 1b*	DO
<i>perindopril erbumine oral tablet 2 mg, 4 mg</i>	1 or 1b*	DO
<i>perindopril erbumine oral tablet 8 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
QBRELIS ORAL SOLUTION (<i>lisinopril</i>)	3	QL (40 mg per 1 day)
<i>quinapril hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	DO
<i>quinapril hcl oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>quinapril hcl oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>ramipril oral capsule 1.25 mg, 2.5 mg</i>	1 or 1b*	DO

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ramipril oral capsule 10 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>ramipril oral capsule 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>trandolapril oral tablet 1 mg, 2 mg</i>	1 or 1b*	DO
<i>trandolapril oral tablet 4 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*AGENTS FOR PHEOCHROMOCYTOMA*** - DRUGS FOR HIGH BLOOD PRESSURE		
DEMSEER ORAL CAPSULE (<i>metyrosine</i>)	3	PA; LD; QL (16 capsules per 1 day)
DIBENZYLINE ORAL CAPSULE (<i>phenoxybenzamine hcl</i>)	3	PA; QL (12 capsules per 1 day)
<i>metyrosine oral capsule</i>	1 or 1b*	PA; LD; QL (16 capsules per 1 day)
<i>phenoxybenzamine hcl oral capsule</i>	1 or 1b*	PA; QL (12 capsules per 1 day)
<i>phentolamine mesylate injection solution reconstituted</i>	1 or 1b*	
*ANGIOTENSIN II RECEPTOR ANTAG & CA CHANNEL BLOCKER COMB*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-320 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate-valsartan oral tablet 5-160 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-olmesartan oral tablet 5-20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>telmisartan-amlodipine oral tablet 40-10 mg, 80-10 mg, 80-5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan-amlodipine oral tablet 40-5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
EDARBYCLOR ORAL TABLET (<i>azilsartan-chlorthalidone</i>)	3	QL (1 tablet per 1 day)
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium-hctz oral tablet 50-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan medoxomil-hctz oral tablet 40-12.5 mg, 40-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>telmisartan-hctz oral tablet 80-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 80-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>valsartan-hydrochlorothiazide oral tablet 160-25 mg, 320-12.5 mg, 320-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>candesartan cilexetil oral tablet 16 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>candesartan cilexetil oral tablet 32 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>candesartan cilexetil oral tablet 4 mg, 8 mg</i>	1 or 1b*	DO
EDARBI ORAL TABLET 40 MG (<i>azilsartan medoxomil</i>)	3	DO

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EDARBI ORAL TABLET 80 MG (<i>azilsartan medoxomil</i>)	3	QL (1 tablet per 1 day)
<i>irbesartan oral tablet 150 mg, 75 mg</i>	1 or 1b*	DO
<i>irbesartan oral tablet 300 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium oral tablet 100 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium oral tablet 25 mg</i>	1 or 1b*	DO
<i>losartan potassium oral tablet 50 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan medoxomil oral tablet 20 mg, 5 mg</i>	1 or 1b*	DO
<i>olmesartan medoxomil oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan oral tablet 20 mg, 40 mg</i>	1 or 1b*	DO
<i>telmisartan oral tablet 80 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>valsartan oral solution</i>	1 or 1b*	PA; QL (80 mL per 1 day)
<i>valsartan oral tablet 160 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>valsartan oral tablet 320 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>valsartan oral tablet 40 mg, 80 mg</i>	1 or 1b*	DO
*ANGIOTENSIN II RECEPTOR ANT-CA CHANNEL BLOCKER-THIAZIDES*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-valsartan-hctz oral tablet 5-160-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan-amlodipine-hctz oral tablet 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*ANTIADRENERGICS - CENTRALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE		
CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY (<i>clonidine</i>)	3	QL (12 patches per 28 days)
CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY (<i>clonidine</i>)	3	QL (12 patches per 28 days)
CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY (<i>clonidine</i>)	3	QL (0.29 patches per 1 day)
<i>clonidine hcl oral tablet 0.1 mg</i>	1 or 1a*	DO
<i>clonidine hcl oral tablet 0.2 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>clonidine hcl oral tablet 0.3 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr</i>	1 or 1b*	QL (12 patches per 28 days)
<i>clonidine transdermal patch weekly 0.3 mg/24hr</i>	1 or 1b*	QL (0.29 patches per 1 day)
<i>guanfacine hcl oral tablet</i>	1 or 1b*	
<i>methyldopa oral tablet 250 mg</i>	1 or 1b*	DO
<i>methyldopa oral tablet 500 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
*ANTIADRENERGICS - PERIPHERALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG (<i>doxazosin mesylate</i>)	3	QL (1 tablet per 1 day)
CARDURA ORAL TABLET 8 MG (<i>doxazosin mesylate</i>)	3	QL (2 tablets per 1 day)
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg</i>	1 or 1b*	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxazosin mesylate oral tablet 8 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>prazosin hcl oral capsule</i>	1 or 1b*	
<i>terazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>terazosin hcl oral capsule 10 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
*ANTIHYPERTENSIVES - MISC.*** - DRUGS FOR HIGH BLOOD PRESSURE		
VECAMYL ORAL TABLET (<i>mecamylamine hcl</i>)	3	
*BETA BLOCKER & DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>atenolol-chlorthalidone oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>bisoprolol-hydrochlorothiazide oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 50-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metoprolol-hydrochlorothiazide oral tablet 100-50 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
TENORETIC 100 ORAL TABLET (<i>atenolol-chlorthalidone</i>)	3	QL (1 tablet per 1 day)
TENORETIC 50 ORAL TABLET (<i>atenolol-chlorthalidone</i>)	3	QL (1 tablet per 1 day)
*DIRECT RENIN INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>aliskiren fumarate oral tablet 150 mg</i>	1 or 1b*	DO
<i>aliskiren fumarate oral tablet 300 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>eplerenone oral tablet</i>	1 or 1b*	
INSPRA ORAL TABLET (<i>eplerenone</i>)	3	
*VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>hydralazine hcl injection solution</i>	1 or 1b*	
<i>hydralazine hcl oral tablet</i>	1 or 1b*	
<i>minoxidil oral tablet</i>	1 or 1b*	
NIPRIDE RTU INTRAVENOUS SOLUTION (<i>nitroprusside sodium-nacl</i>)	3	
<i>nitroprusside sodium intravenous solution</i>	1 or 1b*	
<i>nitroprusside sodium-nacl intravenous solution</i>	1 or 1b*	
<i>sodium nitroprusside intravenous solution</i>	1 or 1b*	
ANTI-INFECTIVE AGENTS - MISC. - DRUGS FOR INFECTIONS		
*ANTI-INFECTIVE AGENTS - MISC.*** - DRUGS FOR INFECTIONS		
FLAGYL ORAL CAPSULE (<i>metronidazole</i>)	3	
IMPAVIDO ORAL CAPSULE (<i>miltefosine</i>)	3	PA; QL (84 capsules per 1 fill)
METRONIDAZOLE INTRAVENOUS SOLUTION	3	
<i>metronidazole oral capsule</i>	1 or 1a*	
<i>metronidazole oral tablet</i>	1 or 1a*	
NEBUPENT INHALATION SOLUTION RECONSTITUTED (<i>pentamidine isethionate</i>)	3	LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENTAM INJECTION SOLUTION RECONSTITUTED (<i>pentamidine isethionate</i>)	3	LD
<i>pentamidine isethionate inhalation solution reconstituted</i>	1 or 1b*	LD
<i>pentamidine isethionate injection solution reconstituted</i>	1 or 1b*	LD
<i>tinidazole oral tablet 250 mg</i>	1 or 1b*	QL (5 tablets per 28 days)
<i>tinidazole oral tablet 500 mg</i>	1 or 1b*	QL (20 tablets per 1 fill)
TRIMETHOPRIM ORAL TABLET	1 or 1a*	
XIFAXAN ORAL TABLET 200 MG (<i>rifaximin</i>)	3	PA; QL (9 tablets per 1 fill)
XIFAXAN ORAL TABLET 550 MG (<i>rifaximin</i>)	3	PA; QL (126 tablet per 252 days)
*ANTI-INFECTIVE MISC. - COMBINATIONS*** - ANTIBIOTICS		
BACTRIM DS ORAL TABLET (<i>sulfamethoxazole-trimethoprim</i>)	3	
BACTRIM ORAL TABLET (<i>sulfamethoxazole-trimethoprim</i>)	3	
<i>sulfamethoxazole-trimethoprim intravenous solution</i>	1 or 1b*	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1 or 1a*	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1 or 1a*	
<i>sulfatrim pediatric oral suspension</i>	1 or 1a*	
*ANTIPROTOZOAL AGENTS*** - DRUGS FOR PARASITES		
<i>atovaquone oral suspension</i>	1 or 1b*	
LAMPIT ORAL TABLET (<i>nifurtimox</i>)	3	
MEPRON ORAL SUSPENSION (<i>atovaquone</i>)	3	
<i>nitazoxanide oral tablet</i>	1 or 1b*	QL (6 tablets per 1 fill)
*BETA-LACTAMASE INHIBITOR - COMBINATIONS** - DRUGS FOR INFECTIONS		
XACDURO INTRAVENOUS SOLUTION RECONSTITUTED (<i>sulbactam sod-durlobactam sod</i>)	3	
*CARBAPENEM COMBINATIONS*** - ANTIBIOTICS		
<i>imipenem-cilastatin intravenous solution reconstituted</i>	1 or 1b*	
PRIMAXIN IV INTRAVENOUS SOLUTION RECONSTITUTED (<i>imipenem-cilastatin</i>)	3	
RECARBRIO INTRAVENOUS SOLUTION RECONSTITUTED (<i>imipenem-cilastatin-relebactam</i>)	3	
VABOMERE INTRAVENOUS SOLUTION RECONSTITUTED (<i>meropenem-vaborbactam</i>)	3	
*CARBAPENEMS*** - ANTIBIOTICS		
<i>ertapenem sodium injection solution reconstituted</i>	1 or 1b*	
<i>meropenem intravenous solution reconstituted 1 gm, 500 mg</i>	1 or 1b*	
<i>meropenem intravenous solution reconstituted 2 gm</i>	3	
MEROPENEM-SODIUM CHLORIDE INTRAVENOUS SOLUTION RECONSTITUTED	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CHLORAMPHENICALS*** - ANTIBIOTICS		
<i>chloramphenicol sod succinate intravenous solution reconstituted</i>	1 or 1b*	
*CYCLIC LIPOPEPTIDES*** - ANTIBIOTICS		
DAPTOMYCIN INTRAVENOUS SOLUTION RECONSTITUTED	3	
<i>daptomycin-sodium chloride intravenous solution</i>	3	
*GLYCOPEPTIDES*** - ANTIBIOTICS		
DALVANCE INTRAVENOUS SOLUTION RECONSTITUTED (<i>dalbavancin hcl</i>)	3	
FIRVANQ ORAL SOLUTION RECONSTITUTED (<i>vancomycin hcl</i>)	3	PA; QL (1200 mL per 30 days)
KIMYRSA INTRAVENOUS SOLUTION RECONSTITUTED (<i>oritavancin diphosphate</i>)	3	
ORBACTIV INTRAVENOUS SOLUTION RECONSTITUTED (<i>oritavancin diphosphate</i>)	3	
VANCOGIN ORAL CAPSULE (<i>vancomycin hcl</i>)	3	PA; QL (240 capsules per 30 days)
<i>vancomycin hcl in dextrose intravenous solution 1.5-5 gm/300ml-%</i>	3	QL (600 mL per 1 day)
VANCOMYCIN HCL IN DEXTROSE INTRAVENOUS SOLUTION 1-5 GM/200ML-%	3	QL (400 mL per 1 day)
VANCOMYCIN HCL IN DEXTROSE INTRAVENOUS SOLUTION 500-5 MG/100ML-%	3	QL (200 mL per 1 day)
VANCOMYCIN HCL IN DEXTROSE INTRAVENOUS SOLUTION 750-5 MG/150ML-%	3	QL (300 mL per 1 day)
VANCOMYCIN HCL IN NACL INTRAVENOUS SOLUTION 1-0.9 GM/200ML-%	3	QL (400 mL per 1 day)
VANCOMYCIN HCL IN NACL INTRAVENOUS SOLUTION 500-0.9 MG/100ML-%	3	QL (2 vials per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1000 MG/200ML	3	QL (400 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1250 MG/250ML	3	QL (500 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1500 MG/300ML	3	QL (600 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 1750 MG/350ML	3	QL (700 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 2000 MG/400ML	3	QL (800 mL per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 500 MG/100ML	3	QL (2 vials per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION 750 MG/150ML	3	QL (300 mL per 1 day)
<i>vancomycin hcl intravenous solution reconstituted 1 gm, 1.75 gm, 2 gm, 500 mg</i>	3	QL (2 vials per 1 day)
VANCOMYCIN HCL INTRAVENOUS SOLUTION RECONSTITUTED 1.25 GM, 1.5 GM, 750 MG	3	QL (2 vials per 1 day)
<i>vancomycin hcl intravenous solution reconstituted 10 gm, 5 gm</i>	3	QL (1 vial per 30 days)
<i>vancomycin hcl intravenous solution reconstituted 100 gm</i>	1 or 1b*	QL (1 vial per 30 days)
<i>vancomycin hcl oral capsule</i>	1 or 1b*	PA; QL (240 capsules per 30 days)
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml</i>	1 or 1b*	PA; QL (1200 mL per 30 days)
VANCOMYCIN HCL ORAL SOLUTION RECONSTITUTED 250 MG/5ML	1 or 1b*	PA; QL (1200 mL per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIBATIV INTRAVENOUS SOLUTION RECONSTITUTED (<i>telavancin hcl</i>)	3	
*LEPROSTATICS*** - ANTIBIOTICS		
<i>dapsone oral tablet</i>	1 or 1b*	
*LINCOSAMIDES*** - ANTIBIOTICS		
CLEOCIN ORAL CAPSULE (<i>clindamycin hcl</i>)	3	
CLEOCIN ORAL SOLUTION RECONSTITUTED (<i>clindamycin palmitate hcl</i>)	3	
CLEOCIN PHOSPHATE INJECTION SOLUTION (<i>clindamycin phosphate</i>)	3	
<i>clindamycin hcl oral capsule</i>	1 or 1b*	
<i>clindamycin palmitate hcl oral solution reconstituted</i>	1 or 1b*	
<i>clindamycin phosphate in d5w intravenous solution</i>	1 or 1b*	
CLINDAMYCIN PHOSPHATE IN NACL INTRAVENOUS SOLUTION	3	
<i>clindamycin phosphate injection solution</i>	1 or 1b*	
LINCOCIN INJECTION SOLUTION (<i>lincomycin hcl</i>)	3	
<i>lincomycin hcl injection solution</i>	1 or 1b*	
*MONOBACTAMS*** - ANTIBIOTICS		
AZACTAM INJECTION SOLUTION RECONSTITUTED (<i>aztreonam</i>)	3	
<i>aztreonam injection solution reconstituted</i>	1 or 1b*	
CAYSTON INHALATION SOLUTION RECONSTITUTED (<i>aztreonam lysine</i>)	3	LD; QL (3 vials per 1 day)
*OXAZOLIDINONES*** - ANTIBIOTICS		
<i>linezolid in sodium chloride intravenous solution</i>	3	
<i>linezolid intravenous solution</i>	1 or 1b*	
<i>linezolid oral suspension reconstituted</i>	1 or 1b*	PA; QL (900 mL per 30 days)
<i>linezolid oral tablet</i>	1 or 1b*	PA; QL (28 tablet per 30 days)
SIVEXTRO INTRAVENOUS SOLUTION RECONSTITUTED (<i>tedizolid phosphate</i>)	3	
SIVEXTRO ORAL TABLET (<i>tedizolid phosphate</i>)	3	PA; QL (6 tablet per 30 days)
ZYVOX INTRAVENOUS SOLUTION (<i>linezolid</i>)	3	
ZYVOX ORAL SUSPENSION RECONSTITUTED (<i>linezolid</i>)	3	PA; QL (900 mL per 30 days)
ZYVOX ORAL TABLET (<i>linezolid</i>)	3	PA; QL (28 tablet per 30 days)
*POLYMYXINS*** - ANTIBIOTICS		
<i>colistimethate sodium (cba) injection solution reconstituted</i>	1 or 1b*	
COLY-MYCIN M INJECTION SOLUTION RECONSTITUTED (<i>colistimethate sodium</i>)	3	
<i>polymyxin b sulfate injection solution reconstituted</i>	1 or 1b*	
*URINARY ANTI-INFECTIVES*** - ANTIBIOTICS		
<i>fosfomycin tromethamine oral packet</i>	1 or 1b*	
HIPREX ORAL TABLET (<i>methenamine hippurate</i>)	3	
MACROBID ORAL CAPSULE (<i>nitrofurantoin monohyd macro</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACRODANTIN ORAL CAPSULE (<i>nitrofurantoin macrocrystal</i>)	3	
<i>methenamine hippurate oral tablet</i>	1 or 1b*	
<i>nitrofurantoin macrocrystal oral capsule</i>	1 or 1b*	
<i>nitrofurantoin monohyd macro oral capsule</i>	1 or 1b*	
<i>nitrofurantoin oral suspension 25 mg/5ml, 50 mg/10ml</i>	1 or 1b*	
<i>nitrofurantoin oral suspension 50 mg/5ml</i>	3	
ANTIMALARIALS - DRUGS FOR INFECTIONS		
*ANTIMALARIAL COMBINATIONS*** - DRUGS FOR PARASITES		
<i>atovaquone-proguanil hcl oral tablet</i>	1 or 1b*	
COARTEM ORAL TABLET (<i>artemether-lumefantrine</i>)	3	
MALARONE ORAL TABLET (<i>atovaquone-proguanil hcl</i>)	3	
*ANTIMALARIALS*** - DRUGS FOR PARASITES		
ARAKODA ORAL TABLET (<i>tafenoquine succinate</i>)	3	QL (64 tablets per 1 year)
ARTESUNATE INTRAVENOUS SOLUTION RECONSTITUTED	3	
<i>chloroquine phosphate oral tablet</i>	1 or 1a*	
DARAPRIM ORAL TABLET (<i>pyrimethamine</i>)	3	PA; QL (3 tablets per 1 day)
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 100 MG, 300 MG	1 or 1b*	QL (2 tablets per 1 day)
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 400 MG	1 or 1b*	QL (1 tablet per 1 day)
KRINTAFEL ORAL TABLET (<i>tafenoquine succinate</i>)	3	QL (2 tablets per 1 fill)
<i>mefloquine hcl oral tablet</i>	1 or 1b*	QL (5 tablets per 28 days)
PRIMAQUINE PHOSPHATE ORAL TABLET	3	
<i>pyrimethamine oral tablet</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
QUALAQUIN ORAL CAPSULE (<i>quinine sulfate</i>)	3	PA; QL (60 capsule per 30 days)
<i>quinine sulfate oral capsule</i>	1 or 1b*	PA; QL (60 capsule per 30 days)
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS FOR NERVES AND MUSCLES		
*ANTIMYASTHENIC/CHOLINERGIC AGENTS*** - DRUGS FOR NERVES AND MUSCLES		
BLOXIVERZ INTRAVENOUS SOLUTION (<i>neostigmine methylsulfate</i>)	3	
BLOXIVERZ INTRAVENOUS SOLUTION PREFILLED SYRINGE (<i>neostigmine methylsulfate</i>)	3	
FIRDAPSE ORAL TABLET (<i>amifampridine phosphate</i>)	3	PA; LD; QL (10 tablets per 1 day)
MESTINON ORAL SOLUTION (<i>pyridostigmine bromide</i>)	3	
MESTINON ORAL TABLET (<i>pyridostigmine bromide</i>)	3	
MESTINON ORAL TABLET EXTENDED RELEASE (<i>pyridostigmine bromide</i>)	3	
NEOSTIGMINE METHYLSULFATE INTRAVENOUS SOLUTION 10 MG/10ML, 5 MG/10ML	3	
<i>pyridostigmine bromide er oral tablet extended release</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pyridostigmine bromide oral solution</i>	1 or 1b*	
<i>pyridostigmine bromide oral tablet</i>	1 or 1b*	
REGONOL INTRAVENOUS SOLUTION (<i>pyridostigmine bromide</i>)	3	
ANTIMYCOBACTERIAL AGENTS - DRUGS FOR INFECTIONS		
*ANTIMYCOBACTERIAL AGENTS*** - ANTIBIOTICS		
<i>cycloserine oral capsule</i>	1 or 1b*	
<i>ethambutol hcl oral tablet</i>	1 or 1b*	
<i>isoniazid injection solution</i>	1 or 1a*	
<i>isoniazid oral syrup</i>	1 or 1a*	
<i>isoniazid oral tablet</i>	1 or 1a*	
PRETOMANID ORAL TABLET	3	
PRIFTIN ORAL TABLET (<i>rifapentine</i>)	2	
<i>pyrazinamide oral tablet</i>	1 or 1b*	
<i>rifabutin oral capsule</i>	1 or 1b*	
RIFADIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>rifampin</i>)	3	
<i>rifampin intravenous solution reconstituted</i>	1 or 1b*	
<i>rifampin oral capsule</i>	1 or 1b*	
SIRTURO ORAL TABLET (<i>bedaquiline fumarate</i>)	3	
TRECTOR ORAL TABLET (<i>ethionamide</i>)	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS FOR CANCER		
*ALKYLATING AGENTS*** - DRUGS FOR CANCER		
BELRAPZO INTRAVENOUS SOLUTION (<i>bendamustine hcl</i>)	3	PA; LD
<i>bendamustine hcl intravenous solution</i>	3	PA; LD
<i>bendamustine hcl intravenous solution reconstituted</i>	1 or 1b*	PA; LD
BENDEKA INTRAVENOUS SOLUTION (<i>bendamustine hcl</i>)	3	PA; LD
<i>busulfan intravenous solution</i>	1 or 1b*	LD
BUSULFEX INTRAVENOUS SOLUTION (<i>busulfan</i>)	3	LD
<i>carboplatin intravenous solution</i>	1 or 1b*	LD
<i>cisplatin intravenous solution</i>	1 or 1b*	LD
CISPLATIN INTRAVENOUS SOLUTION RECONSTITUTED	3	LD
MYLERAN ORAL TABLET (<i>busulfan</i>)	2; OC	LD; OC
<i>oxaliplatin intravenous solution</i>	1 or 1b*	LD
<i>oxaliplatin intravenous solution reconstituted</i>	1 or 1b*	LD
<i>paraplatin intravenous solution</i>	1 or 1b*	LD
TEPADINA INJECTION SOLUTION RECONSTITUTED (<i>thiotepa</i>)	3	LD
<i>thiotepa injection solution reconstituted</i>	1 or 1b*	LD
TREANDA INTRAVENOUS SOLUTION RECONSTITUTED (<i>bendamustine hcl</i>)	3	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>vivimusta intravenous solution</i>	3	PA; LD
ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED (<i>lurbinectedin</i>)	3	PA; LD
*ANDROGEN BIOSYNTHESIS INHIBITORS*** - DRUGS FOR CANCER		
<i>abiraterone acetate oral tablet 250 mg</i>	1 or 1b*; OC	PA; LD; QL (4 tablet per 1 day); OC
<i>abiraterone acetate oral tablet 500 mg</i>	1 or 1b*; OC	PA; LD; QL (2 tablets per 1 day); OC
*ANTIADRENALS*** - DRUGS FOR CANCER		
LYSODREN ORAL TABLET (<i>mitotane</i>)	2; OC	LD; QL (38 tablet per 1 day); OC
*ANTIANDROGENS*** - DRUGS FOR CANCER		
<i>bicalutamide oral tablet</i>	1 or 1b*; OC	LD; QL (1 tablet per 1 day); OC
CASODEX ORAL TABLET (<i>bicalutamide</i>)	3; OC	LD; QL (1 tablet per 1 day); OC
ERLEADA ORAL TABLET 240 MG (<i>apalutamide</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
ERLEADA ORAL TABLET 60 MG (<i>apalutamide</i>)	2; OC	PA; LD; QL (4 tablets per 1 day); OC
EULEXIN ORAL CAPSULE (<i>flutamide</i>)	3; OC	OC
<i>nilutamide oral tablet</i>	1 or 1b*; OC	LD; QL (1 tablet per 1 day); OC
NUBEQA ORAL TABLET (<i>darolutamide</i>)	2; OC	PA; LD; QL (4 tablets per 1 day); OC
XTANDI ORAL CAPSULE (<i>enzalutamide</i>)	2; OC	PA; LD; QL (4 capsules per 1 day); OC
XTANDI ORAL TABLET 40 MG (<i>enzalutamide</i>)	2; OC	PA; LD; QL (4 tablets per 1 day); OC
XTANDI ORAL TABLET 80 MG (<i>enzalutamide</i>)	2; OC	PA; LD; QL (2 tablets per 1 day); OC
*ANTIESTROGENS*** - DRUGS FOR CANCER		
FARESTON ORAL TABLET (<i>toremifene citrate</i>)	3; OC	LD; QL (1 tablet per 1 day); OC
SOLTAMOX ORAL SOLUTION (<i>tamoxifen citrate</i>)	2; OC; \$0	LD; OC
<i>tamoxifen citrate oral tablet</i>	1 or 1b*; OC; \$0	LD; OC
<i>toremifene citrate oral tablet</i>	1 or 1b*; OC	LD; QL (1 tablet per 1 day); OC
*ANTIMETABOLITES*** - DRUGS FOR CANCER		
ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED (<i>pemetrexed disodium</i>)	3	PA; LD
ARRANON INTRAVENOUS SOLUTION (<i>nelarabine</i>)	3	LD
<i>azacitidine injection suspension reconstituted</i>	1 or 1b*	PA; LD
<i>capecitabine oral tablet</i>	1 or 1b*; OC	PA; LD; OC
<i>cladribine intravenous solution</i>	1 or 1b*	LD
<i>clofarabine intravenous solution</i>	1 or 1b*	LD
<i>cytarabine (pf) injection solution</i>	1 or 1b*	LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cytarabine injection solution</i>	1 or 1b*	LD
<i>decitabine intravenous solution reconstituted</i>	1 or 1b*	LD
<i>floxuridine injection solution reconstituted</i>	1 or 1b*	LD
<i>fludarabine phosphate intravenous solution</i>	1 or 1b*	LD
<i>fludarabine phosphate intravenous solution reconstituted</i>	1 or 1b*	LD
<i>fluorouracil intravenous solution</i>	1 or 1b*	LD
FOLOTYN INTRAVENOUS SOLUTION (<i>pralatrexate</i>)	3	LD
GEMCITABINE HCL INTRAVENOUS SOLUTION	3	LD
<i>gemcitabine hcl intravenous solution reconstituted</i>	1 or 1b*	LD
JYLAMVO ORAL SOLUTION (<i>methotrexate</i>)	3; OC	PA; LD; OC
<i>mercaptopurine oral tablet</i>	1 or 1b*; OC	LD; OC
<i>methotrexate sodium (pf) injection solution</i>	1 or 1b*	LD
<i>methotrexate sodium injection solution</i>	1 or 1b*	LD
<i>methotrexate sodium injection solution reconstituted</i>	1 or 1b*	LD
<i>methotrexate sodium oral tablet</i>	1 or 1b*; OC	LD; OC
<i>nelarabine intravenous solution</i>	1 or 1b*	LD
ONUREG ORAL TABLET (<i>azacitidine</i>)	3; OC	PA; LD; QL (14 tablets per 28 days); OC
<i>pemetrexed dipotassium intravenous solution reconstituted</i>	3	PA
<i>pemetrexed disodium intravenous solution</i>	3	PA; LD
<i>pemetrexed disodium intravenous solution reconstituted</i>	1 or 1b*	PA; LD
<i>pemetrexed ditromethamine intravenous solution reconstituted</i>	3	PA; LD
<i>pemetrexed intravenous solution</i>	3	PA; LD
PEMFEXY INTRAVENOUS SOLUTION (<i>pemetrexed</i>)	3	PA; LD
PEMRYDI RTU INTRAVENOUS SOLUTION (<i>pemetrexed disodium</i>)	3	PA; LD
PURIXAN ORAL SUSPENSION (<i>mercaptopurine</i>)	3; OC	PA; LD; OC
TABLOID ORAL TABLET (<i>thioguanine</i>)	2; OC	LD; OC
TREXALL ORAL TABLET (<i>methotrexate sodium</i>)	2; OC	ST; LD; OC
VIDAZA INJECTION SUSPENSION RECONSTITUTED (<i>azacitidine</i>)	3	PA; LD
XATMEP ORAL SOLUTION (<i>methotrexate</i>)	3; OC	PA; LD; OC
*ANTINEOPLASTIC - AKT INHIBITORS*** - DRUGS FOR CANCER		
TRUQAP ORAL TABLET (<i>capivasertib</i>)	3; OC	PA; LD; QL (64 capsules per 28 days); OC
TRUQAP ORAL TABLET THERAPY PACK (<i>capivasertib</i>)	3; OC	PA; LD; QL (64 capsules per 28 days); OC
*ANTINEOPLASTIC - ALK INHIBITORS*** - DRUGS FOR CANCER		
ALECENSA ORAL CAPSULE (<i>alectinib hcl</i>)	2; OC	PA; LD; QL (8 capsule per 1 day); OC
ALUNBRIG ORAL TABLET 180 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALUNBRIG ORAL TABLET 30 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (6 tablets per 1 day); OC
ALUNBRIG ORAL TABLET 90 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (2 tablets per 1 day); OC
ALUNBRIG ORAL TABLET THERAPY PACK (<i>brigatinib</i>)	2; OC	PA; LD; QL (1 pack per 30 days); OC
LORBRENA ORAL TABLET 100 MG (<i>lorlatinib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
LORBRENA ORAL TABLET 25 MG (<i>lorlatinib</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
XALKORI ORAL CAPSULE (<i>crizotinib</i>)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
XALKORI ORAL CAPSULE SPRINKLE 150 MG (<i>crizotinib</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
XALKORI ORAL CAPSULE SPRINKLE 20 MG (<i>crizotinib</i>)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
XALKORI ORAL CAPSULE SPRINKLE 50 MG (<i>crizotinib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
ZYKADIA ORAL TABLET (<i>ceritinib</i>)	3; OC	PA; LD; QL (3 capsules per 1 day); OC
*ANTINEOPLASTIC - ANTIBODY COMBINATIONS*** - DRUGS FOR CANCER		
OPDUALAG INTRAVENOUS SOLUTION (<i>nivolumab-relatlimab-rmbw</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CCR4 ANTIBODIES*** - DRUGS FOR CANCER		
POTELIGEO INTRAVENOUS SOLUTION (<i>mogamulizumab-kpkc</i>)	3	LD
*ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES*** - DRUGS FOR CANCER		
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED (<i>tafasitamab-cxix</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CD19 ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
ZYNLONTA INTRAVENOUS SOLUTION RECONSTITUTED (<i>loncastuximab tesirine-lpyl</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES*** - DRUGS FOR CANCER		
ARZERRA INTRAVENOUS CONCENTRATE (<i>ofatumumab</i>)	3	PA; LD
GAZYVA INTRAVENOUS SOLUTION (<i>obinutuzumab</i>)	3	PA; LD
RIABNI INTRAVENOUS SOLUTION (<i>rituximab-arrx</i>)	3	PA; LD
RITUXAN INTRAVENOUS SOLUTION (<i>rituximab</i>)	3	PA; LD
RUXIENCE INTRAVENOUS SOLUTION (<i>rituximab-pvvr</i>)	3	PA; LD
TRUXIMA INTRAVENOUS SOLUTION (<i>rituximab-abbs</i>)	3	PA; LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTINEOPLASTIC - ANTI-CD22 ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
BESPONSA INTRAVENOUS SOLUTION RECONSTITUTED (<i>inotuzumab ozogamicin</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CD30 ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
ADCETRIS INTRAVENOUS SOLUTION RECONSTITUTED (<i>brentuximab vedotin</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED (<i>gemtuzumab ozogamicin</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES*** - DRUGS FOR CANCER		
DARZALEX INTRAVENOUS SOLUTION (<i>daratumumab</i>)	3	PA; LD
SARCLISA INTRAVENOUS SOLUTION (<i>isatuximab-irfc</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CD79B ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED (<i>polatuzumab vedotin-piiq</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-CLDN18.2 ANTIBODIES*** - DRUGS FOR CANCER		
VYLOY INTRAVENOUS SOLUTION RECONSTITUTED (<i>zolbetuximab-clzb</i>)	3	PA
*ANTINEOPLASTIC - ANTI-CTLA-4 ANTIBODIES*** - DRUGS FOR CANCER		
IMJUDO INTRAVENOUS SOLUTION (<i>tremelimumab-actl</i>)	3	PA; LD
YERVOY INTRAVENOUS SOLUTION (<i>ipilimumab</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-GD2 ANTIBODIES*** - DRUGS FOR CANCER		
DANYELZA INTRAVENOUS SOLUTION (<i>naxitamab-gqgk</i>)	3	PA; LD
UNITUXIN INTRAVENOUS SOLUTION (<i>dinutuximab</i>)	3	LD
*ANTINEOPLASTIC - ANTI-HER2 AGENTS*** - DRUGS FOR CANCER		
HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab</i>)	3	LD
HERZUMA INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab-pkrb</i>)	3	ST; LD
KANJINTI INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab-anns</i>)	3	LD
MARGENZA INTRAVENOUS SOLUTION (<i>margetuximab-cmkb</i>)	3	PA; LD
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab-dkst</i>)	3	ST; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONTRUZANT INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab-dttb</i>)	3	ST; LD
PERJETA INTRAVENOUS SOLUTION (<i>pertuzumab</i>)	3	PA; LD
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab-qyyp</i>)	3	ST; LD
TUKYSA ORAL TABLET (<i>tucatinib</i>)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
ZIIHERA INTRAVENOUS SOLUTION RECONSTITUTED (<i>zanidatamab-hrii</i>)	3	PA
*ANTINEOPLASTIC - ANTI-NECTIN-4 ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
PADCEV INTRAVENOUS SOLUTION RECONSTITUTED (<i>enfortumab vedotin-ejfv</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES*** - DRUGS FOR CANCER		
JEMPERLI INTRAVENOUS SOLUTION (<i>dostarlimab-gxly</i>)	3	PA; LD
KEYTRUDA INTRAVENOUS SOLUTION (<i>pembrolizumab</i>)	3	PA; LD
LIBTAYO INTRAVENOUS SOLUTION (<i>cemiplimab-rwlc</i>)	3	PA; LD
LOQTORZI INTRAVENOUS SOLUTION (<i>toripalimab-tpzi</i>)	3	PA; LD
OPDIVO INTRAVENOUS SOLUTION (<i>nivolumab</i>)	3	PA; LD
TEVIMBRA INTRAVENOUS SOLUTION (<i>tislelizumab-jsgr</i>)	3	PA; LD
ZYNYZ INTRAVENOUS SOLUTION (<i>retifanlimab-dlwr</i>)	3	PA; LD; QL (1 vial per 28 days)
*ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES*** - DRUGS FOR CANCER		
BAVENCIO INTRAVENOUS SOLUTION (<i>avelumab</i>)	3	PA; LD
IMFINZI INTRAVENOUS SOLUTION (<i>durvalumab</i>)	3	PA; LD
TECENTRIQ INTRAVENOUS SOLUTION (<i>atezolizumab</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES*** - DRUGS FOR CANCER		
EMPLICITI INTRAVENOUS SOLUTION RECONSTITUTED (<i>elotuzumab</i>)	3	PA; LD
*ANTINEOPLASTIC - ANTI-TF ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
TIVDAK INTRAVENOUS SOLUTION RECONSTITUTED (<i>tisotumab vedotin-tftv</i>)	3	PA; LD
*ANTINEOPLASTIC - BCL-2 INHIBITORS*** - DRUGS FOR CANCER		
VENCLEXTA ORAL TABLET 10 MG (<i>venetoclax</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
VENCLEXTA ORAL TABLET 100 MG (<i>venetoclax</i>)	3; OC	PA; LD; QL (6 tablet per 1 day); OC
VENCLEXTA ORAL TABLET 50 MG (<i>venetoclax</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK (<i>venetoclax</i>)	3; OC	PA; LD; QL (1 pack per 365 days); OC
*ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS*** - DRUGS FOR CANCER		
BOSULIF ORAL CAPSULE 100 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (4 capsules per 1 day); OC
BOSULIF ORAL CAPSULE 50 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (1 capsule per 1 day); OC
BOSULIF ORAL TABLET 100 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (4 tablet per 1 day); OC
BOSULIF ORAL TABLET 400 MG, 500 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
<i>dasatinib oral tablet</i>	1 or 1b*; OC	PA; LD; QL (1 tablet per 1 day); OC
<i>imatinib mesylate oral tablet</i>	1 or 1b*; OC	PA; LD; QL (2 tablets per 1 day); OC
TASIGNA ORAL CAPSULE (<i>nilotinib hcl</i>)	2; OC	PA; LD; QL (4 capsules per 1 day); OC
*ANTINEOPLASTIC - BISPECIFIC T-CELL ENGAGERS*** - DRUGS FOR CANCER		
BLINCYTO INTRAVENOUS SOLUTION RECONSTITUTED (<i>blinatumomab</i>)	3	PA; LD
COLUMVI INTRAVENOUS SOLUTION (<i>glofitamab-gxbm</i>)	3	PA; LD
ELREXFIO SUBCUTANEOUS SOLUTION (<i>elranatamab-bcmm</i>)	3	PA; LD
EPKINLY SUBCUTANEOUS SOLUTION (<i>epcoritamab-bysp</i>)	3	PA; LD
IMDELLTRA INTRAVENOUS SOLUTION RECONSTITUTED (<i>tarlatamab-dlle</i>)	3	PA; LD
KIMMTRAK INTRAVENOUS SOLUTION (<i>tebentafusp-tebn</i>)	3	PA; LD
LUNSUMIO INTRAVENOUS SOLUTION (<i>mosunetuzumab-axgb</i>)	3	PA; LD
TALVEY SUBCUTANEOUS SOLUTION (<i>talquetamab-tgvs</i>)	3	PA; LD
TECVAYLI SUBCUTANEOUS SOLUTION (<i>teclistamab-cqyv</i>)	3	PA; LD
*ANTINEOPLASTIC - BRAF KINASE INHIBITORS*** - DRUGS FOR CANCER		
BRAFTOVI ORAL CAPSULE (<i>encorafenib</i>)	3; OC	PA; LD; QL (6 capsules per 1 day); OC
OJEMDA ORAL SUSPENSION RECONSTITUTED (<i>tovorafenib</i>)	3; OC	PA; LD; QL (8 bottles per 28 days); OC
OJEMDA ORAL TABLET (<i>tovorafenib</i>)	3; OC	PA; LD; QL (24 tablets per 28 days); OC
TAFINLAR ORAL CAPSULE (<i>dabrafenib mesylate</i>)	3; OC	PA; LD; QL (4 capsule per 1 day); OC
TAFINLAR ORAL TABLET SOLUBLE (<i>dabrafenib mesylate</i>)	3; OC	PA; LD; QL (15 tablets per 1 day); OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZELBORAF ORAL TABLET (<i>vemurafenib</i>)	2; OC	PA; LD; QL (8 tablet per 1 day); OC
*ANTINEOPLASTIC - BTK INHIBITORS*** - DRUGS FOR CANCER		
BRUKINSA ORAL CAPSULE (<i>zanubrutinib</i>)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
CALQUENCE ORAL TABLET (<i>acalabrutinib maleate</i>)	2; OC	PA; LD; QL (2 capsules per 1 day); OC
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	2; OC	PA; LD; QL (3 capsule per 1 day); OC
IMBRUVICA ORAL CAPSULE 70 MG (<i>ibrutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
IMBRUVICA ORAL SUSPENSION (<i>ibrutinib</i>)	2; OC	PA; LD; QL (8 mL per 1 day); OC
IMBRUVICA ORAL TABLET (<i>ibrutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
JAYPIRCA ORAL TABLET 100 MG (<i>pirtobrutinib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
JAYPIRCA ORAL TABLET 50 MG (<i>pirtobrutinib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
*ANTINEOPLASTIC - EGFR INHIBITORS*** - DRUGS FOR CANCER		
ERBITUX INTRAVENOUS SOLUTION (<i>cetuximab</i>)	3	PA; LD
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	1 or 1b*; OC	PA; LD; QL (1 tablet per 1 day); OC
<i>erlotinib hcl oral tablet 25 mg</i>	1 or 1b*; OC	PA; LD; QL (3 tablets per 1 day); OC
<i>gefitinib oral tablet</i>	1 or 1b*; OC	PA; LD; QL (1 tablet per 1 day); OC
GILOTRIF ORAL TABLET (<i>afatinib dimaleate</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
IRESSA ORAL TABLET (<i>gefitinib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
LAZCLUZE ORAL TABLET 240 MG (<i>lazertinib mesylate</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
LAZCLUZE ORAL TABLET 80 MG (<i>lazertinib mesylate</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
PORTRAZZA INTRAVENOUS SOLUTION (<i>necitumumab</i>)	3	LD
TAGRISSE ORAL TABLET (<i>osimertinib mesylate</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
VECTIBIX INTRAVENOUS SOLUTION (<i>panitumumab</i>)	3	PA; LD
VIZIMPRO ORAL TABLET (<i>dacomitinib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTINEOPLASTIC - FGFR KINASE INHIBITORS*** - DRUGS FOR CANCER		
BALVERSA ORAL TABLET 3 MG (<i>erdafitinib</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
BALVERSA ORAL TABLET 4 MG (<i>erdafitinib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
BALVERSA ORAL TABLET 5 MG (<i>erdafitinib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>futibatinib</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>futibatinib</i>)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>futibatinib</i>)	3; OC	PA; LD; QL (5 tablets per 1 day); OC
PEMAZYRE ORAL TABLET 13.5 MG (<i>pemigatinib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
PEMAZYRE ORAL TABLET 4.5 MG, 9 MG (<i>pemigatinib</i>)	3; OC	PA; LD; QL (14 tablets per 21 days); OC
*ANTINEOPLASTIC - GAMMA SECRETASE INHIBITORS*** - DRUGS FOR CANCER		
OGSIVEO ORAL TABLET 100 MG, 150 MG (<i>nirogacestat hydrobromide</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
OGSIVEO ORAL TABLET 50 MG (<i>nirogacestat hydrobromide</i>)	3; OC	PA; LD; QL (6 tablets per 1 day); OC
*ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS*** - DRUGS FOR CANCER		
DAURISMO ORAL TABLET 100 MG (<i>glasdegib maleate</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
DAURISMO ORAL TABLET 25 MG (<i>glasdegib maleate</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
ERIVEDGE ORAL CAPSULE (<i>vismodegib</i>)	2; OC	PA; LD; QL (1 capsule per 1 day); OC
ODOMZO ORAL CAPSULE (<i>sonidegib phosphate</i>)	3; OC	PA; LD; QL (1 capsule per 1 day); OC
*ANTINEOPLASTIC - HIF-2-ALPHA INHIBITORS*** - DRUGS FOR CANCER		
WELIREG ORAL TABLET (<i>belzutifan</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
*ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS*** - DRUGS FOR CANCER		
BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED (<i>belinostat</i>)	3	PA; LD
ISTODAX INTRAVENOUS SOLUTION RECONSTITUTED (<i>romidepsin</i>)	3	PA; LD
<i>romidepsin intravenous solution reconstituted</i>	1 or 1b*	PA; LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZOLINZA ORAL CAPSULE (<i>vorinostat</i>)	2; OC	PA; LD; QL (4 capsule per 1 day); OC
*ANTINEOPLASTIC - HORMONAL AND RELATED AGENT COMBINATIONS*** - DRUGS FOR CANCER		
AKEEGA ORAL TABLET (<i>niraparib-abiraterone acetate</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
*ANTINEOPLASTIC - IMMUNOMODULATORS*** - DRUGS FOR CANCER		
POMALYST ORAL CAPSULE (<i>pomalidomide</i>)	3; OC	PA; LD; QL (21 capsules per 28 days); OC
*ANTINEOPLASTIC - KRAS INHIBITORS*** - DRUGS FOR CANCER		
KRAZATI ORAL TABLET (<i>adagrasib</i>)	3; OC	PA; LD; QL (6 tablets per 1 day); OC
LUMAKRAS ORAL TABLET 120 MG (<i>sotorasib</i>)	3; OC	PA; LD; QL (8 tablets per 1 day); OC
LUMAKRAS ORAL TABLET 240 MG (<i>sotorasib</i>)	3; OC	PA; QL (4 tablets per 1 day); OC
LUMAKRAS ORAL TABLET 320 MG (<i>sotorasib</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
*ANTINEOPLASTIC - MEK INHIBITORS*** - DRUGS FOR CANCER		
COTELLIC ORAL TABLET (<i>cobimetinib fumarate</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
KOSELUGO ORAL CAPSULE 10 MG (<i>selumetinib sulfate</i>)	3; OC	PA; LD; QL (8 capsules per 1 day); OC
KOSELUGO ORAL CAPSULE 25 MG (<i>selumetinib sulfate</i>)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
MEKINIST ORAL SOLUTION RECONSTITUTED (<i>trametinib dimethyl sulfoxide</i>)	3; OC	PA; LD; QL (40 mL per 1 day); OC
MEKINIST ORAL TABLET 0.5 MG (<i>trametinib dimethyl sulfoxide</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
MEKINIST ORAL TABLET 2 MG (<i>trametinib dimethyl sulfoxide</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
MEKTOVI ORAL TABLET (<i>binimetinib</i>)	3; OC	PA; LD; QL (6 tablets per 1 day); OC
*ANTINEOPLASTIC - MET INHIBITORS*** - DRUGS FOR CANCER		
TABRECTA ORAL TABLET (<i>capmatinib hcl</i>)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
TEPMETKO ORAL TABLET (<i>tepotinib hcl</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
*ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS*** - DRUGS FOR CANCER		
TAZVERIK ORAL TABLET (<i>tazemetostat hbr</i>)	3; OC	PA; LD; QL (8 tablets per 1 day); OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTINEOPLASTIC - MTOR KINASE INHIBITORS*** - DRUGS FOR CANCER		
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	1 or 1b*; OC	PA; LD; OC
<i>everolimus oral tablet soluble</i>	1 or 1b*; OC	PA; LD; OC
FYARRO INTRAVENOUS SUSPENSION RECONSTITUTED (<i>sirolimus protein-bound part</i>)	3	PA; LD
<i>temsirolimus intravenous solution</i>	1 or 1b*	PA; LD
TORISEL INTRAVENOUS SOLUTION (<i>temsirolimus</i>)	3	PA; LD
<i>everolimus</i> (Torpenz Oral Tablet)	1 or 1b*; OC	PA; LD; OC
*ANTINEOPLASTIC - MULTIKINASE INHIBITORS*** - DRUGS FOR CANCER		
CABOMETYX ORAL TABLET (<i>cabozantinib s-malate</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
CAPRELSA ORAL TABLET 100 MG (<i>vandetanib</i>)	2; OC	PA; LD; QL (3 tablet per 1 day); OC
CAPRELSA ORAL TABLET 300 MG (<i>vandetanib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
COMETRIQ (100 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	3; OC	PA; LD; QL (1 dose-pack per 56 days); OC
COMETRIQ (140 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	3; OC	PA; LD; QL (1 dose pack per 28 days); OC
COMETRIQ (60 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	3; OC	PA; LD; QL (1 dose pack per 28 days); OC
FOTIVDA ORAL CAPSULE (<i>tivozanib hcl</i>)	3; OC	PA; LD; QL (21 capsules per 28 days); OC
<i>lapatinib ditosylate oral tablet</i>	1 or 1b*; OC	PA; LD; QL (6 tablet per 1 day); OC
NERLYNX ORAL TABLET (<i>neratinib maleate</i>)	3; OC	PA; LD; QL (6 tablets per 1 day); OC
NEXAVAR ORAL TABLET (<i>sorafenib tosylate</i>)	3; OC	PA; LD; QL (4 tablet per 1 day); OC
<i>pazopanib hcl oral tablet</i>	1 or 1b*; OC	PA; LD; QL (4 tablet per 1 day); OC
QINLOCK ORAL TABLET (<i>ripretinib</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
RYDAPT ORAL CAPSULE (<i>midostaurin</i>)	3; OC	PA; LD; QL (8 capsules per 1 day); OC
<i>sorafenib tosylate oral tablet</i>	1 or 1b*; OC	PA; LD; QL (4 tablet per 1 day); OC
STIVARGA ORAL TABLET (<i>regorafenib</i>)	2; OC	PA; LD; QL (84 tablets per 28 days); OC
<i>sunitinib malate oral capsule</i>	1 or 1b*; OC	PA; LD; QL (1 capsule per 1 day); OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUTENT ORAL CAPSULE (<i>sunitinib malate</i>)	3; OC	PA; LD; QL (1 capsule per 1 day); OC
TURALIO ORAL CAPSULE (<i>pexidartinib hcl</i>)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
VANFLYTA ORAL TABLET (<i>quizartinib dihydrochloride</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
XOSPATA ORAL TABLET (<i>gilteritinib fumarate</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
*ANTINEOPLASTIC - MULTIPLE RECEPTOR ANTIBODIES*** - DRUGS FOR CANCER		
RYBREVA INTRAVENOUS SOLUTION (<i>amivantamab-vmjw</i>)	3	PA; LD
*ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS*** - DRUGS FOR CANCER		
AYVAKIT ORAL TABLET (<i>avapritinib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
*ANTINEOPLASTIC - PROTEASOME INHIBITORS*** - DRUGS FOR CANCER		
<i>bortezomib injection solution reconstituted 1 mg, 2.5 mg</i>	3	PA; LD
<i>bortezomib injection solution reconstituted 3.5 mg</i>	1 or 1b*	PA; LD
BORUZU INJECTION SOLUTION (<i>bortezomib</i>)	3	PA
KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED (<i>carfilzomib</i>)	3	PA; LD
NINLARO ORAL CAPSULE (<i>ixazomib citrate</i>)	3; OC	PA; LD; QL (3 capsule per 28 days); OC
VELCADE INJECTION SOLUTION RECONSTITUTED (<i>bortezomib</i>)	3	PA; LD
*ANTINEOPLASTIC - RET INHIBITORS*** - DRUGS FOR CANCER		
GAVRETO ORAL CAPSULE (<i>pralsetinib</i>)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG (<i>selpercatinib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
RETEVMO ORAL TABLET 40 MG (<i>selpercatinib</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
*ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS*** - DRUGS FOR CANCER		
AUGTYRO ORAL CAPSULE 160 MG (<i>reprotrectinib</i>)	3; OC	QL (2 capsules per 1 day); OC
AUGTYRO ORAL CAPSULE 40 MG (<i>reprotrectinib</i>)	3; OC	PA; LD; QL (8 capsules per 1 day); OC
ROZLYTREK ORAL CAPSULE 100 MG (<i>entrectinib</i>)	3; OC	PA; LD; QL (1 capsule per 1 day); OC
ROZLYTREK ORAL CAPSULE 200 MG (<i>entrectinib</i>)	3; OC	PA; LD; QL (3 capsules per 1 day); OC
ROZLYTREK ORAL PACKET (<i>entrectinib</i>)	3; OC	PA; LD; QL (12 packets per 1 day); OC
VITRAKVI ORAL CAPSULE 100 MG (<i>larotrectinib sulfate</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITRAKVI ORAL CAPSULE 25 MG (<i>larotrectinib sulfate</i>)	3; OC	PA; LD; QL (6 tablets per 1 day); OC
VITRAKVI ORAL SOLUTION (<i>larotrectinib sulfate</i>)	3; OC	PA; LD; QL (10 mL per 1 day); OC
*ANTINEOPLASTIC - XPO1 INHIBITORS*** - DRUGS FOR CANCER		
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (<i>selinexor</i>)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (<i>selinexor</i>)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK (<i>selinexor</i>)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (<i>selinexor</i>)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK (<i>selinexor</i>)	3; OC	PA; LD; QL (1 pack per 1 week); OC
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK (<i>selinexor</i>)	3; OC	PA; LD; QL (1 carton per 28 days); OC
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK (<i>selinexor</i>)	3; OC	PA; LD; QL (32 tablets per 28 weeks); OC
*ANTINEOPLASTIC ANTIBIOTICS*** - DRUGS FOR CANCER		
<i>adriamycin intravenous solution reconstituted</i>	1 or 1b*	LD
<i>bleomycin sulfate injection solution reconstituted</i>	1 or 1b*	LD
<i>dactinomycin intravenous solution reconstituted</i>	1 or 1b*	LD
DAUNORUBICIN HCL INTRAVENOUS SOLUTION	3	LD
DOXIL INTRAVENOUS SUSPENSION (<i>doxorubicin hcl liposomal</i>)	3	PA; LD
<i>doxorubicin hcl intravenous solution</i>	3	LD
<i>doxorubicin hcl intravenous solution reconstituted</i>	1 or 1b*	LD
<i>doxorubicin hcl liposomal intravenous suspension</i>	1 or 1b*	PA; LD
ELLENCE INTRAVENOUS SOLUTION (<i>epirubicin hcl</i>)	3	PA; LD
IDAMYCIN PFS INTRAVENOUS SOLUTION (<i>idarubicin hcl</i>)	3	LD
<i>idarubicin hcl intravenous solution</i>	1 or 1b*	LD
JELMYTO SOLUTION RECONSTITUTED (<i>mitomycin</i>)	3	PA; LD
<i>mitomycin intravenous solution reconstituted</i>	1 or 1b*	LD
<i>mitomycin intravesical solution prefilled syringe</i>	3	LD
<i>mitoxantrone hcl intravenous concentrate</i>	1 or 1b*	LD
<i>mutamycin intravenous solution reconstituted</i>	1 or 1b*	LD
<i>valrubicin intravesical solution</i>	1 or 1b*	LD
VALSTAR INTRAVESICAL SOLUTION (<i>valrubicin</i>)	3	LD
*ANTINEOPLASTIC -ANTIBODY FOR RADIOPHARMACEUTICAL THERAPY*** - DRUGS FOR CANCER		
ZEVALIN Y-90 INTRAVENOUS KIT (<i>ibritumomab tiuxetan for y-90</i>)	3	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTINEOPLASTIC ANTIBODY-DRUG COMPLEXES*** - DRUGS FOR CANCER		
ELAHERE INTRAVENOUS SOLUTION (<i>mirvetuximab soravtansine-gynx</i>)	3	PA; LD
ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED (<i>fam-trastuzumab deruxtec-nxki</i>)	3	PA; LD
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED (<i>ado-trastuzumab emtansine</i>)	3	PA; LD
*ANTINEOPLASTIC COMBINATIONS*** - DRUGS FOR CANCER		
DARZALEX FASPRO SUBCUTANEOUS SOLUTION (<i>daratumumab-hyaluronidase-fihj</i>)	3	PA; LD
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION (<i>trastuzumab-hyaluronidase-oysk</i>)	3	LD
INQOVI ORAL TABLET (<i>decitabine-cedazuridine</i>)	3; OC	PA; LD; QL (5 tablets per 28 days); OC
LONSURF ORAL TABLET (<i>trifluridine-tipiracil</i>)	3; OC	PA; LD; OC
PHESGO SUBCUTANEOUS SOLUTION (<i>pertuz-trastuz-hyaluron-zzxf</i>)	3	PA; LD
RITUXAN HYCELA SUBCUTANEOUS SOLUTION (<i>rituximab-hyaluronidase human</i>)	3	LD
TECENTRIQ HYBREZA SUBCUTANEOUS SOLUTION (<i>atezolizumab-hyaluronidas-tqjs</i>)	3	PA; LD
VYXEOS INTRAVENOUS SUSPENSION RECONSTITUTED (<i>daunorubicin-cytarabine lipo</i>)	3	LD
*ANTINEOPLASTIC ENZYMES*** - DRUGS FOR CANCER		
ASPARLAS INTRAVENOUS SOLUTION (<i>calaspargase pegol-mknl</i>)	3	PA; LD
ONCASPAR INJECTION SOLUTION (<i>pegaspargase</i>)	3	PA; LD
RYLAZE INTRAMUSCULAR SOLUTION (<i>asparaginase erwinia chry-rywn</i>)	3	PA; LD
*ANTINEOPLASTIC RADIOPHARMACEUTICALS*** - DRUGS FOR CANCER		
LUTATHERA INTRAVENOUS SOLUTION (<i>lutetium lu 177 dotatate</i>)	3	PA; LD
PLUVICTO INTRAVENOUS SOLUTION (<i>lutetium lu 177 vipivotide tet</i>)	3	PA; LD
STRONTIUM CHLORIDE SR-89 INTRAVENOUS SOLUTION	3	
XOFIGO INTRAVENOUS SOLUTION (<i>radium ra 223 dichloride</i>)	3	PA; LD
*ANTINEOPLASTICS - INTERLEUKINS & AGONISTS*** - DRUGS FOR CANCER		
ANKTIVA INTRAVESICAL SOLUTION (<i>nogapendekin alfa inbakic-pmln</i>)	3	PA; LD
ELZONRIS INTRAVENOUS SOLUTION (<i>tagraxofusp-erzs</i>)	3	PA; LD
PROLEUKIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>aldesleukin</i>)	3	PA; LD
*ANTINEOPLASTICS - PHOTOACTIVATED AGENTS*** - DRUGS FOR CANCER		
PHOTOFRIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>porfimer sodium</i>)	3	LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UVADEX EXTRACORPOREAL SOLUTION (<i>methoxsalen (photopheresis)</i>)	3	
*ANTINEOPLASTICS MISC.*** - DRUGS FOR CANCER		
ACTIMMUNE SUBCUTANEOUS SOLUTION (<i>interferon gamma-1b</i>)	3	PA; LD
<i>arsenic trioxide intravenous solution</i>	1 or 1b*	LD
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>ropeginterferon alfa-2b-njft</i>)	3	PA; LD; QL (2 mL per 28 days)
<i>dacarbazine intravenous solution reconstituted</i>	1 or 1b*	LD
HYDREA ORAL CAPSULE (<i>hydroxyurea</i>)	3; OC	LD; OC
<i>hydroxyurea oral capsule</i>	1 or 1b*; OC	LD; OC
MATULANE ORAL CAPSULE (<i>procarbazine hcl</i>)	2; OC	LD; OC
NIPENT INTRAVENOUS SOLUTION RECONSTITUTED (<i>pentostatin</i>)	3	LD
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED (<i>bcg live</i>)	3	LD
TRISENOX INTRAVENOUS SOLUTION (<i>arsenic trioxide</i>)	3	LD
*AROMATASE INHIBITORS*** - DRUGS FOR CANCER		
<i>anastrozole oral tablet</i>	1 or 1b*; OC; \$0	LD; QL (1 tablet per 1 day); OC
AROMASIN ORAL TABLET (<i>exemestane</i>)	3; OC	LD; QL (2 tablets per 1 day); OC
<i>exemestane oral tablet</i>	1 or 1b*; OC; \$0	LD; QL (2 tablets per 1 day); OC
FEMARA ORAL TABLET (<i>letrozole</i>)	3; OC	LD; QL (1 tablet per 1 day); OC
<i>letrozole oral tablet</i>	1 or 1b*; OC; \$0	LD; QL (1 tablet per 1 day); OC
*CARBOXYPEPTIDASE ENZYME AGENTS*** - DRUGS FOR CANCER		
VORAXAZE INTRAVENOUS SOLUTION RECONSTITUTED (<i>glucarpidase</i>)	3	LD
*CARDIAC PROTECTIVE AGENTS*** - DRUGS FOR CANCER		
<i>dexrazoxane hcl intravenous solution reconstituted</i>	1 or 1b*	LD
<i>dexrazoxane intravenous solution reconstituted</i>	1 or 1b*	LD
*CHEMOTHERAPY ADJUNCTS - HYPERURICEMIA AGENTS*** - DRUGS FOR CANCER		
ELITEK INTRAVENOUS SOLUTION RECONSTITUTED (<i>rasburicase</i>)	3	PA; LD
*CHEMOTHERAPY ADJUNCTS - KERATINOCYTE GROWTH FACTORS*** - DRUGS FOR CANCER		
KEPIVANCE INTRAVENOUS SOLUTION RECONSTITUTED (<i>palifermin</i>)	3	LD
*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS*** - DRUGS FOR CANCER		
IBRANCE ORAL CAPSULE (<i>palbociclib</i>)	2; OC	PA; LD; QL (21 capsules per 28 days); OC
IBRANCE ORAL TABLET 100 MG, 75 MG (<i>palbociclib</i>)	2; OC	PA; LD; QL (21 tablets per 28 days); OC
IBRANCE ORAL TABLET 125 MG (<i>palbociclib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	2; OC	PA; LD; QL (0.75 tablet per 1 day); OC
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	2; OC	PA; LD; QL (1.5 tablets per 1 day); OC
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	2; OC	PA; LD; QL (2.25 tablets per 1 day); OC
VERZENIO ORAL TABLET (<i>abemaciclib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
*ESTROGEN RECEPTOR ANTAGONIST*** - DRUGS FOR CANCER		
FASLODEX INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>fulvestrant</i>)	3	PA; LD
<i>fulvestrant intramuscular solution prefilled syringe</i>	1 or 1b*	PA; LD
*FOLIC ACID ANTAGONISTS RESCUE AGENTS*** - DRUGS FOR CANCER		
KHAPZORY INTRAVENOUS SOLUTION RECONSTITUTED (<i>levoleucovorin</i>)	3	PA; LD
<i>leucovorin calcium injection solution</i>	1 or 1b*	LD
<i>leucovorin calcium injection solution reconstituted</i>	1 or 1b*	LD
<i>leucovorin calcium oral tablet</i>	1 or 1b*	
<i>levoleucovorin calcium intravenous solution reconstituted</i>	1 or 1b*	PA; LD
<i>levoleucovorin calcium pf intravenous solution</i>	1 or 1b*	PA; LD
*GONADOTROPIN RELEASING HORMONE (GNRH) ANTAGONISTS*** - DRUGS FOR CANCER		
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>degarelix acetate</i>)	3	PA; LD; QL (2 units per 310 days)
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>degarelix acetate</i>)	3	PA; LD; QL (1 kit per 28 days)
ORGOVYX ORAL TABLET (<i>relugolix</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
*IMIDAZOTETRAZINES*** - DRUGS FOR CANCER		
TEMODAR INTRAVENOUS SOLUTION RECONSTITUTED (<i>temozolomide</i>)	2	PA; LD
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 250 mg</i>	1 or 1b*; OC	PA; LD; QL (2 capsules per 1 day); OC
<i>temozolomide oral capsule 20 mg</i>	1 or 1b*; OC	PA; LD; QL (4 capsule per 1 day); OC
<i>temozolomide oral capsule 5 mg</i>	1 or 1b*; OC	PA; LD; QL (3 capsule per 1 day); OC
*ISOCITRATE DEHYDROGENASE 1 & 2 (IDH1 & IDH2) INHIBITORS*** - DRUGS FOR CANCER		
VORANIGO ORAL TABLET 10 MG (<i>vorasidenib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
VORANIGO ORAL TABLET 40 MG (<i>vorasidenib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS*** - DRUGS FOR CANCER		
REZLIDHIA ORAL CAPSULE (<i>olutasidenib</i>)	3; OC	PA; LD; QL (2 capsules per 1 day); OC
TIBSOVO ORAL TABLET (<i>ivosidenib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
*ISOCITRATE DEHYDROGENASE-2 (IDH2) INHIBITORS*** - DRUGS FOR CANCER		
IDHIFA ORAL TABLET 100 MG (<i>enasidenib mesylate</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
IDHIFA ORAL TABLET 50 MG (<i>enasidenib mesylate</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
*JANUS ASSOCIATED KINASE (JAK) INHIBITORS*** - DRUGS FOR CANCER		
INREBIC ORAL CAPSULE (<i>fedratinib hcl</i>)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
JAKAFI ORAL TABLET (<i>ruxolitinib phosphate</i>)	2; OC	PA; LD; QL (2 tablets per 1 day); OC
OJJAARA ORAL TABLET (<i>momelotinib dihydrochloride</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
VONJO ORAL CAPSULE (<i>pacritinib citrate</i>)	3; OC	PA; LD; QL (4 capsules per 1 day); OC
*LHRH ANALOGS*** - DRUGS FOR CANCER		
CAMCEVI SUBCUTANEOUS PREFILLED SYRINGE (<i>leuprolide mesylate (6 month)</i>)	3	PA; LD; QL (1 syringe per 24 weekss)
ELIGARD SUBCUTANEOUS KIT 22.5 MG (<i>leuprolide acetate (3 month)</i>)	3	PA; LD; QL (1 syringe per 84 days)
ELIGARD SUBCUTANEOUS KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	3	PA; LD; QL (1 syringe per 112 days)
ELIGARD SUBCUTANEOUS KIT 45 MG (<i>leuprolide acetate (6 month)</i>)	3	PA; LD; QL (1 syringe per 168 days)
ELIGARD SUBCUTANEOUS KIT 7.5 MG (<i>leuprolide acetate (3 month) intramuscular injectable</i>)	3	PA; LD; QL (1 kit per 12 weeks)
<i>leuprolide acetate injection kit</i>	1 or 1b*	PA; LD
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG (<i>leuprolide acetate</i>)	3	PA; LD; QL (1 syringe kit per 28 days)
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 7.5 MG (<i>leuprolide acetate</i>)	3	PA; LD; QL (1 kit per 28 days)
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT (<i>leuprolide acetate (3 month)</i>)	3	PA; LD; QL (1 kit per 84 days)
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT (<i>leuprolide acetate (4 month)</i>)	3	PA; LD; QL (1 kit per 112 days)
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT (<i>leuprolide acetate (6 month)</i>)	3	PA; LD; QL (1 syringe kit per 168 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (<i>triptorelin pamoate</i>)	3	PA; LD; QL (1 vial per 84 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 22.5 MG (<i>triptorelin pamoate</i>)	3	PA; LD; QL (1 syringe per 168 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (<i>triptorelin pamoate</i>)	3	PA; LD; QL (1 kit per 28 days)
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG (<i>goserelin acetate</i>)	3	PA; LD; QL (1 EA per 84 days)
ZOLADEX SUBCUTANEOUS IMPLANT 3.6 MG (<i>goserelin acetate</i>)	3	PA; LD; QL (1 unit per 28 days)
*MITOTIC INHIBITORS*** - DRUGS FOR CANCER		
ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED (<i>paclitaxel protein-bound part</i>)	3	PA; LD
DOCETAXEL INTRAVENOUS CONCENTRATE	3	PA; LD
DOCETAXEL INTRAVENOUS SOLUTION	3	PA; LD
DOCIVYX INTRAVENOUS SOLUTION (<i>docetaxel</i>)	3	PA; LD
<i>eribulin mesylate intravenous solution</i>	1 or 1b*	PA; LD
ETOPOPHOS INTRAVENOUS SOLUTION RECONSTITUTED (<i>etoposide phosphate</i>)	3	LD
<i>etoposide intravenous solution</i>	1 or 1b*	LD
<i>etoposide oral capsule</i>	1 or 1b*; OC	LD; OC
HALAVEN INTRAVENOUS SOLUTION (<i>eribulin mesylate</i>)	3	PA; LD
IXEMPRA KIT INTRAVENOUS SOLUTION RECONSTITUTED (<i>ixabepilone</i>)	3	PA; LD
JEVTANA INTRAVENOUS SOLUTION (<i>cabazitaxel</i>)	3	PA; LD
<i>paclitaxel intravenous concentrate</i>	1 or 1b*	LD
PACLITAXEL PROTEIN-BOUND PART INTRAVENOUS SUSPENSION RECONSTITUTED	3	PA; LD
<i>vinblastine sulfate intravenous solution</i>	1 or 1b*	LD
<i>vincristine sulfate intravenous solution</i>	1 or 1b*	LD
<i>vinorelbine tartrate intravenous solution</i>	1 or 1b*	LD
*MYELOPROTECTIVE AGENTS*** - DRUGS FOR CANCER		
COSELA INTRAVENOUS SOLUTION RECONSTITUTED (<i>trilaciclib dihydrochloride</i>)	3	PA; LD
*NITROGEN MUSTARDS AND RELATED ANALOGUES*** - DRUGS FOR CANCER		
<i>cyclophosphamide injection solution reconstituted</i>	1 or 1b*	LD
<i>cyclophosphamide intravenous solution 1 gm/2ml, 1000 mg/10ml, 2 gm/4ml, 2000 mg/20ml, 500 mg/5ml, 500 mg/ml</i>	3	LD
CYCLOPHOSPHAMIDE INTRAVENOUS SOLUTION 1 GM/5ML, 2 GM/10ML, 500 MG/2.5ML	3	LD
<i>cyclophosphamide oral capsule</i>	1 or 1b*; OC	LD; OC
CYCLOPHOSPHAMIDE ORAL TABLET	3; OC	LD; OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVOMELA INTRAVENOUS SOLUTION RECONSTITUTED (<i>melfalan hcl</i>)	3	LD
HEPZATO W/50MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED (<i>melfalan hcl</i>)	3	LD
HEPZATO W/62MM CATHETER INTRA-ARTERIAL SOLUTION RECONSTITUTED (<i>melfalan hcl</i>)	3	LD
IFEX INTRAVENOUS SOLUTION RECONSTITUTED (<i>ifosfamide</i>)	3	LD
<i>ifosfamide intravenous solution</i>	1 or 1b*	LD
<i>ifosfamide intravenous solution reconstituted 1 gm</i>	1 or 1b*	LD
IFOSFAMIDE INTRAVENOUS SOLUTION RECONSTITUTED 3 GM	3	LD
LEUKERAN ORAL TABLET (<i>chlorambucil</i>)	2; OC	LD; OC
<i>melfalan hcl intravenous solution reconstituted</i>	1 or 1b*	LD
*NITROSOUREAS*** - DRUGS FOR CANCER		
<i>carmustine intravenous solution reconstituted</i>	1 or 1b*	LD
GLEOSTINE ORAL CAPSULE (<i>lomustine</i>)	3; OC	PA; LD; OC
GLIADEL WAFER IMPLANT WAFER (<i>carmustine in polifeprosan</i>)	3	
ZANOSAR INTRAVENOUS SOLUTION RECONSTITUTED (<i>streptozocin</i>)	3	LD
*OLIGONUCLEOTIDE TELOMERASE INHIBITORS*** - DRUGS FOR CANCER		
RYTELO INTRAVENOUS SOLUTION RECONSTITUTED (<i>imetelstat sodium</i>)	3	PA; LD
*ORNITHINE DECARBOXYLASE (ODC) INHIBITORS*** - DRUGS FOR CANCER		
IWILFIN ORAL TABLET (<i>eflornithine hcl</i>)	3; OC	PA; LD; QL (8 tablets per 1 day); OC
*OTOPROTECTIVE AGENTS*** - DRUGS FOR CANCER		
PEDMARK INTRAVENOUS SOLUTION (<i>sodium thiosulfate</i>)	3	PA; LD
*PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS*** - DRUGS FOR CANCER		
ALIQOPA INTRAVENOUS SOLUTION RECONSTITUTED (<i>copanlisib hcl</i>)	3	PA; LD
COPIKTRA ORAL CAPSULE (<i>duvelisib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
ITOVEBI ORAL TABLET 3 MG (<i>inavolisib</i>)	3; OC	PA; QL (1 tablet per 1 day); OC
ITOVEBI ORAL TABLET 9 MG (<i>inavolisib</i>)	3; OC	PA; QL (2 tablets per 1 day); OC
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>alpelisib</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>alpelisib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK (<i>alpelisib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYDELIG ORAL TABLET (<i>idelalisib</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
*POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS*** - DRUGS FOR CANCER		
LYNPARZA ORAL TABLET (<i>olaparib</i>)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
RUBRACA ORAL TABLET (<i>rucaparib camsylate</i>)	3; OC	PA; LD; QL (4 tablets per 1 day); OC
TALZENNA ORAL CAPSULE (<i>talazoparib tosylate</i>)	3; OC	PA; LD; QL (1 capsule per 1 day); OC
ZEJULA ORAL TABLET (<i>niraparib tosylate</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
*PROGESTINS-ANTINEOPLASTIC*** - DRUGS FOR CANCER		
<i>megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 800 mg/20ml</i>	1 or 1b*; OC	LD; OC
<i>megestrol acetate oral tablet</i>	1 or 1b*; OC	LD; OC
*RETINOIDS*** - DRUGS FOR CANCER		
<i>tretinoin oral capsule</i>	1 or 1b*; OC	LD; OC
*SELECTIVE ESTROGEN RECEPTOR DEGRADERS*** - DRUGS FOR CANCER		
ORSERDU ORAL TABLET 345 MG (<i>elacestrant hydrochloride</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
ORSERDU ORAL TABLET 86 MG (<i>elacestrant hydrochloride</i>)	3; OC	PA; LD; QL (3 tablets per 1 day); OC
*SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR CANCER		
<i>bexarotene oral capsule</i>	1 or 1b*; OC	PA; LD; QL (10 capsules per 1 day); OC
*TETRAHYDROISOQUINOLINES*** - DRUGS FOR CANCER		
YONDELIS INTRAVENOUS SOLUTION RECONSTITUTED (<i>trabectedin</i>)	3	LD
*TOPOISOMERASE I INHIBITORS - ANTIBODY-DRUG COMPLEX*** - DRUGS FOR CANCER		
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED (<i>sacituzumab govitecan-hziy</i>)	3	PA; LD
*TOPOISOMERASE I INHIBITORS*** - DRUGS FOR CANCER		
CAMPTOSAR INTRAVENOUS SOLUTION (<i>irinotecan hcl</i>)	3	LD
HYCANTIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>topotecan hcl</i>)	3	LD
HYCANTIN ORAL CAPSULE (<i>topotecan hcl</i>)	2; OC	PA; LD; OC
<i>irinotecan hcl intravenous solution</i>	1 or 1b*	LD
ONIVYDE INTRAVENOUS INJECTABLE (<i>irinotecan hcl liposome</i>)	3	LD
TOPOTECAN HCL INTRAVENOUS SOLUTION	3	LD
<i>topotecan hcl intravenous solution reconstituted</i>	1 or 1b*	LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*URINARY TRACT PROTECTIVE AGENTS*** - DRUGS FOR CANCER		
<i>mesna intravenous solution</i>	1 or 1b*	PA; LD
MESNEX INTRAVENOUS SOLUTION (<i>mesna</i>)	3	PA; LD
MESNEX ORAL TABLET (<i>mesna</i>)	2	PA; LD
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS*** - DRUGS FOR CANCER		
AVASTIN INTRAVENOUS SOLUTION (<i>bevacizumab</i>)	3	PA; LD
CYRAMZA INTRAVENOUS SOLUTION (<i>ramucirumab</i>)	3	PA; LD
FRUZAQLA ORAL CAPSULE 1 MG (<i>fruquintinib</i>)	3; OC	PA; LD; QL (84 capsules per 28 days); OC
FRUZAQLA ORAL CAPSULE 5 MG (<i>fruquintinib</i>)	3; OC	PA; LD; QL (21 capsules per 28 days); OC
INLYTA ORAL TABLET 1 MG (<i>axitinib</i>)	2; OC	PA; LD; QL (6 tablets per 1 day); OC
INLYTA ORAL TABLET 5 MG (<i>axitinib</i>)	2; OC	PA; LD; QL (4 tablet per 1 day); OC
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (30 capsules per 30 days); OC
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); OC
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (60 capsules per 30 days); OC
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); OC
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (60 capsules per 30 days); OC
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (90 capsules per 30 days); OC
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (30 capsules per 30 days); OC
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); OC
MVASI INTRAVENOUS SOLUTION (<i>bevacizumab-awwb</i>)	3	PA; LD
ZALTRAP INTRAVENOUS SOLUTION (<i>ziv-aflibercept</i>)	3	PA; LD
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ADENOSINE RECEPTOR ANTAGONIST*** - DRUGS FOR PARKINSON		
NOURIANZ ORAL TABLET (<i>istradefylline</i>)	3	PA; LD; QL (1 tablet per 1 day)
*ANTIPARKINSON ANTICHOLINERGICS*** - DRUGS FOR PARKINSON		
<i>benztropine mesylate injection solution</i>	1 or 1a*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>benztropine mesylate oral tablet</i>	1 or 1a*	
<i>trihexyphenidyl hcl oral solution</i>	1 or 1a*	
<i>trihexyphenidyl hcl oral tablet</i>	1 or 1a*	
*ANTIPARKINSON DOPAMINERGICS*** - DRUGS FOR PARKINSON		
<i>amantadine hcl oral capsule</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>amantadine hcl oral solution</i>	1 or 1b*	QL (40 mL per 1 day)
<i>amantadine hcl oral tablet</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>bromocriptine mesylate oral capsule</i>	1 or 1b*	
<i>bromocriptine mesylate oral tablet</i>	1 or 1b*	
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG (<i>amantadine hcl</i>)	3	PA; QL (2 capsules per 1 day)
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 68.5 MG (<i>amantadine hcl</i>)	3	PA; DO
INBRIJA INHALATION CAPSULE (<i>levodopa</i>)	3	PA; LD; QL (5 kits per 30 days)
OSMOLEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>amantadine hcl</i>)	3	PA; DO
PARLODEL ORAL CAPSULE (<i>bromocriptine mesylate</i>)	3	
PARLODEL ORAL TABLET (<i>bromocriptine mesylate</i>)	3	
*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS*** - DRUGS FOR PARKINSON		
AZILECT ORAL TABLET 0.5 MG (<i>rasagiline mesylate</i>)	3	QL (2 tablets per 1 day)
AZILECT ORAL TABLET 1 MG (<i>rasagiline mesylate</i>)	3	QL (1 tablet per 1 day)
<i>rasagiline mesylate oral tablet 0.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>rasagiline mesylate oral tablet 1 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>selegiline hcl oral capsule</i>	1 or 1b*	
<i>selegiline hcl oral tablet</i>	1 or 1b*	
XADAGO ORAL TABLET 100 MG (<i>safinamide mesylate</i>)	3	PA; QL (1 tablet per 1 day)
XADAGO ORAL TABLET 50 MG (<i>safinamide mesylate</i>)	3	PA; QL (2 tablets per 1 day)
ZELAPAR ORAL TABLET DISPERSIBLE (<i>selegiline hcl</i>)	3	PA; QL (2 tablets per 1 day)
*CENTRAL/PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON		
TASMAR ORAL TABLET (<i>tolcapone</i>)	3	PA; QL (6 tablet per 1 day)
<i>tolcapone oral tablet</i>	1 or 1b*	PA; QL (6 tablet per 1 day)
*DECARBOXYLASE INHIBITORS*** - DRUGS FOR PARKINSON		
<i>carbidopa oral tablet</i>	1 or 1b*	
LODOSYN ORAL TABLET (<i>carbidopa</i>)	3	
*LEVODOPA COMBINATIONS*** - DRUGS FOR PARKINSON		
<i>carbidopa-levodopa er oral tablet extended release</i>	1 or 1b*	
<i>carbidopa-levodopa oral tablet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbidopa-levodopa oral tablet dispersible</i>	1 or 1b*	
<i>carbidopa-levodopa-entacapone oral tablet</i>	1 or 1b*	
DHIVY ORAL TABLET (<i>carbidopa-levodopa</i>)	3	
DUOPA ENTERAL SUSPENSION (<i>carbidopa-levodopa</i>)	3	PA; LD
RYTARY ORAL CAPSULE EXTENDED RELEASE 23.75-95 MG, 48.75-195 MG (<i>carbidopa-levodopa</i>)	3	QL (12 capsules per 1 day)
RYTARY ORAL CAPSULE EXTENDED RELEASE 36.25-145 MG (<i>carbidopa-levodopa</i>)	3	QL (9 capsules per 1 day)
RYTARY ORAL CAPSULE EXTENDED RELEASE 61.25-245 MG (<i>carbidopa-levodopa</i>)	3	QL (10 capsules per 1 day)
SINEMET ORAL TABLET (<i>carbidopa-levodopa</i>)	3	
*NONERGOLINE DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR PARKINSON		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE (<i>apomorphine hcl</i>)	3	PA; LD; QL (2 mL per 1 day)
<i>apomorphine hcl subcutaneous solution cartridge</i>	1 or 1b*	PA; LD; QL (2 mL per 1 day)
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>pramipexole dihydrochloride</i>)	3	QL (1 tablet per 1 day)
NEUPRO TRANSDERMAL PATCH 24 HOUR (<i>rotigotine</i>)	3	QL (1 patch per 1 day)
<i>pramipexole dihydrochloride er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>pramipexole dihydrochloride oral tablet</i>	1 or 1b*	QL (3 tablet per 1 day)
<i>ropinirole hcl er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>ropinirole hcl oral tablet</i>	1 or 1b*	
*PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON		
<i>entacapone oral tablet</i>	1 or 1b*	QL (8 tablet per 1 day)
ONGENTYS ORAL CAPSULE 25 MG (<i>opicapone</i>)	3	PA; QL (1 tablet per 1 day)
ONGENTYS ORAL CAPSULE 50 MG (<i>opicapone</i>)	3	PA; QL (6 tablets per 1 day)
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTIMANIC AGENTS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>lithium carbonate er oral tablet extended release 300 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>lithium carbonate er oral tablet extended release 450 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lithium carbonate oral capsule 150 mg, 300 mg</i>	1 or 1a*	DO
<i>lithium carbonate oral capsule 600 mg</i>	1 or 1a*	QL (3 capsules per 1 day)
<i>lithium carbonate oral tablet</i>	1 or 1a*	DO
<i>lithium oral solution</i>	1 or 1b*	
*ANTIPSYCHOTICS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS		
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG (<i>lumateperone tosylate</i>)	3	ST; DO
CAPLYTA ORAL CAPSULE 42 MG (<i>lumateperone tosylate</i>)	3	ST; QL (1 capsule per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG (<i>carbamazepine (antipsychotic)</i>)	3	QL (8 capsules per 1 day)
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 300 MG (<i>carbamazepine (antipsychotic)</i>)	3	QL (5 capsules per 1 day)
GEODON INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>ziprasidone mesylate</i>)	3	AL; QL (6 vials per 28 days)
<i>lurasidone hcl oral tablet 120 mg</i>	1 or 1b*	AL
<i>lurasidone hcl oral tablet 20 mg, 40 mg</i>	1 or 1b*	DO; AL
<i>lurasidone hcl oral tablet 60 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
<i>lurasidone hcl oral tablet 80 mg</i>	1 or 1b*	AL; QL (2 tablets per 1 day)
NUPLAZID ORAL CAPSULE (<i>pimavanserin tartrate</i>)	3	PA; LD; QL (1 capsule per 1 day)
NUPLAZID ORAL TABLET (<i>pimavanserin tartrate</i>)	3	PA; LD; QL (1 tablet per 1 day)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG (<i>cariprazine hcl</i>)	3	ST; DO
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	3	ST; QL (1 capsule per 1 day)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg</i>	1 or 1b*	DO; AL
<i>ziprasidone hcl oral capsule 60 mg, 80 mg</i>	1 or 1b*	AL; QL (2 capsules per 1 day)
<i>ziprasidone mesylate intramuscular solution reconstituted</i>	1 or 1b*	AL; QL (6 vials per 28 days)
*BENZISOXAZOLES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG (<i>iloperidone</i>)	3	ST; DO
FANAPT ORAL TABLET 10 MG, 12 MG, 8 MG (<i>iloperidone</i>)	3	ST; QL (2 tablets per 1 day)
FANAPT TITRATION PACK ORAL TABLET (<i>iloperidone</i>)	3	ST; QL (1 pack per 1 year)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML (<i>paliperidone palmitate</i>)	3	AL; QL (3.5 mL per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML (<i>paliperidone palmitate</i>)	3	AL; QL (5 mL per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>paliperidone palmitate</i>)	3	AL; QL (1 syringe per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML (<i>paliperidone palmitate</i>)	3	AL; QL (0.88 mL per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML (<i>paliperidone palmitate</i>)	3	AL; QL (1.32 mL per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML (<i>paliperidone palmitate</i>)	3	AL; QL (1.75 mL per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML (<i>paliperidone palmitate</i>)	3	AL; QL (2.63 mL per 90 days)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg</i>	1 or 1b*	DO; AL
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	1 or 1b*	AL; QL (2 tablets per 1 day)
<i>paliperidone er oral tablet extended release 24 hour 9 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE (<i>risperidone</i>)	3	AL; QL (1 syringe per 30 days)
<i>risperidone microspheres er intramuscular suspension reconstituted er</i>	1 or 1b*	AL; QL (2 injections per 28 days)
<i>risperidone oral solution</i>	1 or 1b*	AL; QL (8 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>risperidone oral tablet 3 mg, 4 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>risperidone oral tablet dispersible 3 mg, 4 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
*BUTYROPHENONES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 100 MG/ML (<i>haloperidol decanoate</i>)	3	AL; QL (5 injections per 30 days)
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 50 MG/ML (<i>haloperidol decanoate</i>)	3	AL; QL (5 ampules per 30 days)
<i>haloperidol decanoate intramuscular solution 100 mg/ml</i>	1 or 1b*	AL; QL (5 injections per 30 days)
<i>haloperidol decanoate intramuscular solution 50 mg/ml</i>	1 or 1b*	AL; QL (5 ampules per 30 days)
<i>haloperidol lactate injection solution</i>	1 or 1b*	AL
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	1 or 1b*	AL; QL (30 mL per 1 day)
<i>haloperidol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>haloperidol oral tablet 10 mg, 20 mg, 5 mg</i>	1 or 1b*	AL; QL (3 tablets per 1 day)
*DIBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>clozapine oral tablet 100 mg</i>	1 or 1b*	AL; QL (9 tablets per 1 day)
<i>clozapine oral tablet 200 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>clozapine oral tablet 25 mg, 50 mg</i>	1 or 1b*	DO; AL
<i>clozapine oral tablet dispersible 100 mg</i>	1 or 1b*	AL; QL (9 tablets per 1 day)
<i>clozapine oral tablet dispersible 12.5 mg, 25 mg</i>	1 or 1b*	DO; AL
<i>clozapine oral tablet dispersible 150 mg</i>	1 or 1b*	AL; QL (6 tablets per 1 day)
<i>clozapine oral tablet dispersible 200 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
VERSACLOZ ORAL SUSPENSION (<i>clozapine</i>)	3	AL; QL (18 mL per 1 day)
*DIBENZO-OXEPINO PYRROLES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>asenapine maleate sublingual tablet sublingual 10 mg</i>	1 or 1b*	AL; QL (2 tablets per 1 day)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg, 5 mg</i>	1 or 1b*	DO; AL
SECUADO TRANSDERMAL PATCH 24 HOUR (<i>asenapine</i>)	3	ST; QL (1 patch per 1 day)
*DIBENZOTHIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	1 or 1b*	DO; AL
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	1 or 1b*	AL; QL (2 tablets per 1 day)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1 or 1b*	DO; AL
<i>quetiapine fumarate oral tablet 150 mg</i>	1 or 1b*	AL; QL (5 tablets per 1 day)
<i>quetiapine fumarate oral tablet 300 mg, 400 mg</i>	1 or 1b*	AL; QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*DIBENZOXAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>loxapine</i>)	3	AL
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg</i>	1 or 1b*	DO; AL
<i>loxapine succinate oral capsule 50 mg</i>	1 or 1b*	AL; QL (4 capsules per 1 day)
*DIHYDROINDOLONES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>molindone hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	DO; AL
<i>molindone hcl oral tablet 25 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
*PHENOTHIAZINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>chlorpromazine hcl injection solution</i>	1 or 1b*	AL
CHLORPROMAZINE HCL ORAL CONCENTRATE 100 MG/ML	1 or 1b*	AL; QL (8 mL per 1 day)
CHLORPROMAZINE HCL ORAL CONCENTRATE 30 MG/ML	1 or 1b*	AL; QL (26 mL per 1 day)
<i>chlorpromazine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1 or 1b*	DO; AL
<i>chlorpromazine hcl oral tablet 100 mg, 200 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>compro rectal suppository</i>	1 or 1b*	AL
<i>fluphenazine decanoate injection solution</i>	1 or 1b*	AL
<i>fluphenazine hcl injection solution</i>	1 or 1b*	AL
<i>fluphenazine hcl oral concentrate</i>	1 or 1b*	AL; QL (8 mL per 1 day)
<i>fluphenazine hcl oral elixir</i>	1 or 1b*	AL; QL (80 mL per 1 day)
<i>fluphenazine hcl oral tablet 1 mg, 2.5 mg, 5 mg</i>	1 or 1b*	DO; AL
<i>fluphenazine hcl oral tablet 10 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>perphenazine oral tablet 16 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
<i>perphenazine oral tablet 2 mg</i>	1 or 1b*	DO; AL
<i>perphenazine oral tablet 4 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>perphenazine oral tablet 8 mg</i>	1 or 1b*	AL; QL (3 tablets per 1 day)
<i>prochlorperazine edisylate injection solution</i>	1 or 1b*	AL
<i>prochlorperazine maleate oral tablet</i>	1 or 1a*	AL
<i>prochlorperazine rectal suppository</i>	1 or 1b*	AL
<i>thioridazine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1 or 1b*	DO; AL
<i>thioridazine hcl oral tablet 100 mg</i>	1 or 1b*	AL; QL (8 tablets per 1 day)
<i>trifluoperazine hcl oral tablet 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>trifluoperazine hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
*QUINOLINONE DERIVATIVES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE (<i>aripiprazole</i>)	3	AL; QL (1 injection per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER (<i>aripiprazole</i>)	3	AL; QL (1 injection per 30 days)
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 5 MG (<i>aripiprazole w/ sens-strip-pod</i>)	3	ST; DO
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET THERAPY PACK 20 MG, 30 MG (<i>aripiprazole w/ sens-strip-pod</i>)	3	ST; QL (1 tablet per 1 day)
ABILIFY MYCITE STARTER KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 5 MG (<i>aripiprazole w/ sens-strip-pod</i>)	3	ST; DO
ABILIFY MYCITE STARTER KIT ORAL TABLET THERAPY PACK 20 MG, 30 MG (<i>aripiprazole w/ sens-strip-pod</i>)	3	ST; QL (1 tablet per 1 day)
<i>aripiprazole oral solution</i>	1 or 1b*	AL; QL (30 mL per 1 day)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg</i>	1 or 1b*	DO; AL
<i>aripiprazole oral tablet 20 mg, 30 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
<i>aripiprazole oral tablet dispersible 10 mg</i>	1 or 1b*	AL; QL (3 tablets per 1 day)
<i>aripiprazole oral tablet dispersible 15 mg</i>	1 or 1b*	AL; QL (2 tablets per 1 day)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE (<i>aripiprazole lauroxil</i>)	3	AL; QL (1 syringe per 1 fill)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML (<i>aripiprazole lauroxil</i>)	3	AL; QL (1 kit per 60 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML (<i>aripiprazole lauroxil</i>)	3	AL; QL (1 kit per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG (<i>brexpiprazole</i>)	3	ST; DO
REXULTI ORAL TABLET 4 MG (<i>brexpiprazole</i>)	3	ST; QL (1 tablet per 1 day)
*THIENBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>olanzapine intramuscular solution reconstituted</i>	1 or 1b*	AL; QL (3 injections per 1 fill)
<i>olanzapine oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	1 or 1b*	DO; AL
<i>olanzapine oral tablet 15 mg, 20 mg</i>	1 or 1b*	AL; QL (1 tablets per 1 day)
<i>olanzapine oral tablet dispersible 10 mg, 5 mg</i>	1 or 1b*	DO; AL
<i>olanzapine oral tablet dispersible 15 mg</i>	1 or 1b*	AL; QL (1 tablets per 1 day)
<i>olanzapine oral tablet dispersible 20 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG (<i>olanzapine pamoate</i>)	3	AL; QL (2 injections per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG (<i>olanzapine pamoate</i>)	3	AL; QL (1 injections per 28 days)
*THIOXANTHENES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>thiothixene oral capsule 1 mg, 2 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>thiothixene oral capsule 10 mg</i>	1 or 1b*	PA; QL (6 capsules per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS & DISINFECTANTS - ANTISEPTICS AND DISINFECTANTS		
*ANTISEPTICS & DISINFECTANTS*** - ANTISEPTICS AND DISINFECTANTS		
<i>formaldehyde external solution 10 %</i>	1 or 1b*	
*CHLORINE ANTISEPTICS*** - ANTISEPTICS AND DISINFECTANTS		
BENZALKONIUM CHLORIDE EXTERNAL SOLUTION	3	
*IODINE ANTISEPTICS*** - ANTISEPTICS AND DISINFECTANTS		
LUGOLS STRONG IODINE EXTERNAL SOLUTION	3	
ANTIVIRALS - DRUGS FOR INFECTIONS		
*ANTIRETROVIRAL COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS		
<i>abacavir sulfate-lamivudine oral tablet</i>	1 or 1b*	LD; QL (1 tablet per 1 day)
BIKTARVY ORAL TABLET (<i>bictegravir-emtricitab-tenofovir</i>)	2	LD; QL (1 tablet per 1 day)
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML (<i>cabotegravir & rilpivirine</i>)	3	PA; LD; QL (1 kit per 30 days)
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML (<i>cabotegravir & rilpivirine</i>)	3	PA; LD; QL (1 kit per 60 days)
CIMDUO ORAL TABLET (<i>lamivudine-tenofovir</i>)	3	LD; QL (1 tablet per 1 day)
DELSTRIGO ORAL TABLET (<i>doravirin-lamivudin-tenofovir df</i>)	3	LD; QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	2	LD; QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	2; \$0	LD; QL (1 tablet per 1 day)
DOVATO ORAL TABLET (<i>dolutegravir-lamivudine</i>)	2	LD; QL (1 tablet per 1 day)
<i>efavirenz-emtricitab-tenofovir df oral tablet</i>	1 or 1b*	LD; QL (1 tablet per 1 day)
<i>efavirenz-lamivudine-tenofovir oral tablet</i>	1 or 1b*	LD; QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1 or 1b*	LD; QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1 or 1b*; \$0	LD; QL (1 tablet per 1 day)
EVOTAZ ORAL TABLET (<i>atazanavir-cobicistat</i>)	3	LD; QL (1 tablet per 1 day)
GENVOYA ORAL TABLET (<i>elviteg-cobic-emtricit-tenofaf</i>)	2	LD; QL (1 tablet per 1 day)
JULUCA ORAL TABLET (<i>dolutegravir-rilpivirine</i>)	3	PA; LD; QL (1 tablet per 1 day)
KALETRA ORAL SOLUTION (<i>lopinavir-ritonavir</i>)	3	LD; QL (16 mL per 1 day)
KALETRA ORAL TABLET 100-25 MG (<i>lopinavir-ritonavir</i>)	3	LD; QL (10 tablets per 1 day)
KALETRA ORAL TABLET 200-50 MG (<i>lopinavir-ritonavir</i>)	3	LD; QL (4 tablets per 1 day)
<i>lamivudine-zidovudine oral tablet</i>	1 or 1b*	LD; QL (2 tablets per 1 day)
<i>lopinavir-ritonavir oral solution</i>	1 or 1b*	LD; QL (16 mL per 1 day)
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	1 or 1b*	LD; QL (10 tablets per 1 day)
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	1 or 1b*	LD; QL (4 tablets per 1 day)
ODEFSEY ORAL TABLET (<i>emtricitab-rilpivir-tenofovir af</i>)	2	LD; QL (1 tablet per 1 day)
STRIBILD ORAL TABLET (<i>elviteg-cobic-emtricit-tenofdf</i>)	2	LD; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMTUZA ORAL TABLET (<i>darun-cobic-emtricit-tenofaf</i>)	2	LD; QL (1 tablet per 1 day)
TRIUMEQ ORAL TABLET (<i>abacavir-dolutegravir-lamivud</i>)	2	LD; QL (1 tablet per 1 day)
TRIUMEQ PD ORAL TABLET SOLUBLE	2	LD; QL (6 tablets per 1 day)
*ANTIRETROVIRALS - CAPSID INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
SUNLENCA ORAL TABLET THERAPY PACK (<i>lenacapavir sodium</i>)	3	PA; LD; QL (1 pack per 1 one time fill)
SUNLENCA SUBCUTANEOUS SOLUTION (<i>lenacapavir sodium</i>)	3	PA; LD; QL (1 kit per 24 weeks)
*ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)*** - DRUGS FOR VIRAL INFECTIONS		
<i>maraviroc oral tablet</i>	1 or 1b*	LD; QL (4 tablets per 1 day)
SELZENTRY ORAL SOLUTION (<i>maraviroc</i>)	3	LD; QL (62 mL per 1 day)
SELZENTRY ORAL TABLET (<i>maraviroc</i>)	3	LD; QL (4 tablets per 1 day)
*ANTIRETROVIRALS - CD4-DIRECTED POST-ATTACHMENT INHIBITOR*** - DRUGS FOR VIRAL INFECTIONS		
TROGARZO INTRAVENOUS SOLUTION (<i>ibalizumab-uiyk</i>)	3	PA; LD; QL (8 vials per 28 days)
*ANTIRETROVIRALS - FUSION INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>enfuvirtide</i>)	2	PA; LD; QL (2 vials per 1 day)
*ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR*** - DRUGS FOR VIRAL INFECTIONS		
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR (<i>fostemsavir tromethamine</i>)	3	PA; LD; QL (2 tablets per 1 day)
*ANTIRETROVIRALS - INTEGRASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE (<i>cabotegravir</i>)	3	LD; QL (1 vial per 2 monthss)
ISENTRESS HD ORAL TABLET (<i>raltegravir potassium</i>)	3	LD; QL (2 tablets per 1 day)
ISENTRESS ORAL PACKET (<i>raltegravir potassium</i>)	3	LD; QL (2 packets per 1 day)
ISENTRESS ORAL TABLET (<i>raltegravir potassium</i>)	3	LD; QL (4 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 100 MG (<i>raltegravir potassium</i>)	3	LD; QL (6 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 25 MG (<i>raltegravir potassium</i>)	3	LD; QL (24 tablets per 1 day)
TIVICAY ORAL TABLET (<i>dolutegravir sodium</i>)	3	LD; QL (2 tablets per 1 day)
TIVICAY PD ORAL TABLET SOLUBLE (<i>dolutegravir sodium</i>)	3	LD; QL (12 tablets per 1 day)
*ANTIRETROVIRALS - PROTEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
APTIVUS ORAL CAPSULE (<i>tipranavir</i>)	2	PA; LD; QL (4 capsules per 1 day)
<i>atazanavir sulfate oral capsule 150 mg, 200 mg</i>	1 or 1b*	LD; QL (2 capsules per 1 day)
<i>atazanavir sulfate oral capsule 300 mg</i>	1 or 1b*	LD; QL (1 capsule per 1 day)
<i>darunavir oral tablet 600 mg</i>	1 or 1b*	LD; QL (2 tablets per 1 day)
<i>darunavir oral tablet 800 mg</i>	1 or 1b*	LD; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fosamprenavir calcium oral tablet</i>	1 or 1b*	LD; QL (4 tablets per 1 day)
NORVIR ORAL PACKET (<i>ritonavir</i>)	3	LD; QL (12 packets per 1 day)
NORVIR ORAL TABLET (<i>ritonavir</i>)	3	LD; QL (12 tablets per 1 day)
PREZISTA ORAL SUSPENSION (<i>darunavir</i>)	2	LD; QL (14 mL per 1 day)
PREZISTA ORAL TABLET 150 MG (<i>darunavir</i>)	2	LD; QL (6 tablets per 1 day)
PREZISTA ORAL TABLET 75 MG (<i>darunavir</i>)	2	LD; QL (10 tablets per 1 day)
REYATAZ ORAL CAPSULE 200 MG (<i>atazanavir sulfate</i>)	3	LD; QL (2 capsules per 1 day)
REYATAZ ORAL CAPSULE 300 MG (<i>atazanavir sulfate</i>)	3	LD; QL (1 capsule per 1 day)
REYATAZ ORAL PACKET (<i>atazanavir sulfate</i>)	2	LD; QL (5 packets per 1 day)
<i>ritonavir oral tablet</i>	1 or 1b*	LD; QL (12 tablets per 1 day)
VIRACEPT ORAL TABLET 250 MG (<i>nelfinavir mesylate</i>)	2	LD; QL (10 tablets per 1 day)
VIRACEPT ORAL TABLET 625 MG (<i>nelfinavir mesylate</i>)	2	LD; QL (4 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
EDURANT ORAL TABLET (<i>rilpivirine hcl</i>)	2	PA; LD; QL (1 tablet per 1 day)
<i>efavirenz oral tablet</i>	1 or 1b*	LD; QL (1 tablet per 1 day)
<i>etravirine oral tablet 100 mg</i>	1 or 1b*	PA; LD; QL (4 tablets per 1 day)
<i>etravirine oral tablet 200 mg</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
INTELENCE ORAL TABLET 100 MG (<i>etravirine</i>)	3	PA; LD; QL (4 tablets per 1 day)
INTELENCE ORAL TABLET 200 MG (<i>etravirine</i>)	3	PA; LD; QL (2 tablets per 1 day)
INTELENCE ORAL TABLET 25 MG (<i>etravirine</i>)	2	PA; LD; QL (16 tablets per 1 day)
<i>nevirapine er oral tablet extended release 24 hour</i>	1 or 1b*	LD; QL (1 tablet per 1 day)
<i>nevirapine oral suspension</i>	1 or 1b*	LD; QL (40 mL per 1 day)
<i>nevirapine oral tablet</i>	1 or 1b*	LD; QL (2 tablets per 1 day)
PIFELTRO ORAL TABLET (<i>doravirine</i>)	3	LD; QL (1 tablet per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES*** - DRUGS FOR VIRAL INFECTIONS		
<i>abacavir sulfate oral solution</i>	1 or 1b*	LD; QL (32 mL per 1 day)
<i>abacavir sulfate oral tablet</i>	1 or 1b*	LD; QL (2 tablets per 1 day)
ZIAGEN ORAL SOLUTION (<i>abacavir sulfate</i>)	3	LD; QL (32 mL per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES*** - DRUGS FOR VIRAL INFECTIONS		
<i>emtricitabine oral capsule</i>	1 or 1b*; \$0	LD; QL (1 capsule per 1 day)
EMTRIVA ORAL CAPSULE (<i>emtricitabine</i>)	3	LD; QL (1 capsule per 1 day)
EMTRIVA ORAL SOLUTION (<i>emtricitabine</i>)	2	LD; QL (29 mL per 1 day)
EPIVIR ORAL SOLUTION (<i>lamivudine</i>)	3	LD; QL (32 mL per 1 day)
EPIVIR ORAL TABLET 150 MG (<i>lamivudine</i>)	3	PA; LD; QL (2 tablets per 1 day)
EPIVIR ORAL TABLET 300 MG (<i>lamivudine</i>)	3	PA; LD; QL (1 tablet per 1 day)
<i>lamivudine oral solution</i>	1 or 1b*	LD; QL (32 mL per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lamivudine oral tablet 150 mg</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
<i>lamivudine oral tablet 300 mg</i>	1 or 1b*	PA; LD; QL (1 tablet per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES*** - DRUGS FOR VIRAL INFECTIONS		
RETROVIR INTRAVENOUS SOLUTION (<i>zidovudine</i>)	2	LD
RETROVIR ORAL CAPSULE (<i>zidovudine</i>)	3	LD; QL (6 capsules per 1 day)
RETROVIR ORAL SYRUP (<i>zidovudine</i>)	3	LD; QL (64 mL per 1 day)
<i>zidovudine oral capsule</i>	1 or 1b*	LD; QL (6 capsules per 1 day)
<i>zidovudine oral syrup</i>	1 or 1b*	LD; QL (64 mL per 1 day)
<i>zidovudine oral tablet</i>	1 or 1b*	LD; QL (2 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>tenofovir disoproxil fumarate oral tablet</i>	1 or 1b*; \$0	LD; QL (1 tablet per 1 day)
VIREAD ORAL POWDER (<i>tenofovir disoproxil fumarate</i>)	2	LD; QL (8 grams per 1 day)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>tenofovir disoproxil fumarate</i>)	2	LD; QL (1 tablet per 1 day)
*ANTIRETROVIRALS ADJUVANTS*** - DRUGS FOR VIRAL INFECTIONS		
TYBOST ORAL TABLET (<i>cobicistat</i>)	3	LD; QL (1 tablet per 1 day)
*ANTIVIRAL COMBINATIONS*** - DRUGS FOR INFECTIONS		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK (<i>nirmatrelvir-ritonavir</i>)	3	QL (1 pack per 90 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK (<i>nirmatrelvir-ritonavir</i>)	3	QL (1 pack per 90 days)
*CMV AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>cidofovir intravenous solution</i>	1 or 1b*	LD
<i>foscarnet sodium intravenous solution</i>	1 or 1b*	LD
FOSCAVIR INTRAVENOUS SOLUTION (<i>foscarnet sodium</i>)	3	LD
GANCICLOVIR INTRAVENOUS SOLUTION	3	LD
GANCICLOVIR SODIUM INTRAVENOUS SOLUTION	3	LD
<i>ganciclovir sodium intravenous solution reconstituted</i>	1 or 1b*	LD
LIVTENCITY ORAL TABLET (<i>maribavir</i>)	3	PA; LD; QL (4 tablets per 1 day)
PREVYMIS INTRAVENOUS SOLUTION (<i>letermovir</i>)	3	PA; LD; QL (200 vials per 1 year)
PREVYMIS ORAL TABLET (<i>letermovir</i>)	3	PA; LD; QL (224 tablets per 1 year)
VALCYTE ORAL SOLUTION RECONSTITUTED (<i>valganciclovir hcl</i>)	3	LD
VALCYTE ORAL TABLET (<i>valganciclovir hcl</i>)	3	LD
<i>valganciclovir hcl oral solution reconstituted</i>	1 or 1b*	LD
<i>valganciclovir hcl oral tablet</i>	1 or 1b*	LD
*HEPATITIS B AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>adefovir dipivoxil oral tablet</i>	1 or 1b*	PA; LD; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BARACLUDE ORAL SOLUTION (<i>entecavir</i>)	2	PA; LD; QL (20 mL per 1 day)
<i>entecavir oral tablet</i>	1 or 1b*	PA; LD; QL (1 tablet per 1 day)
<i>lamivudine oral tablet 100 mg</i>	1 or 1b*	PA; LD; QL (1 tablet per 1 day)
VEMLIDY ORAL TABLET (<i>tenofovir alafenamide fumarate</i>)	3	PA; LD; QL (1 tablet per 1 day)
*HEPATITIS C AGENT - COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS		
EPCLUSA ORAL PACKET 150-37.5 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; LD; QL (1 packet per 1 day)
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; LD; QL (2 packets per 1 day)
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; LD; QL (2 tablets per 1 day)
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	3	PA; LD; QL (1 tablet per 1 day)
HARVONI ORAL PACKET 33.75-150 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; LD; QL (1 packet per 1 day)
HARVONI ORAL PACKET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; LD; QL (2 packets per 1 day)
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; LD; QL (2 tablets per 1 day)
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	3	PA; LD; QL (1 tablet per 1 day)
VOSEVI ORAL TABLET (<i>sofosbuv-velpatasv-voxilaprev</i>)	3	PA; LD; QL (1 tablet per 1 day)
*HEPATITIS C AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
PEGASYS SUBCUTANEOUS SOLUTION (<i>peginterferon alfa-2a</i>)	3	LD; QL (4 vials per 28 days)
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>peginterferon alfa-2a</i>)	3	LD; QL (4 syringes per 28 days)
<i>ribavirin oral capsule</i>	1 or 1b*	LD; QL (6 capsules per 1 day)
<i>ribavirin oral tablet</i>	1 or 1b*	LD; QL (6 tablets per 1 day)
*HERPES AGENTS - PURINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>acyclovir oral capsule</i>	1 or 1b*	
<i>acyclovir oral suspension</i>	1 or 1b*	
<i>acyclovir oral tablet</i>	1 or 1b*	
<i>acyclovir sodium intravenous solution</i>	1 or 1b*	
<i>valacyclovir hcl oral tablet 1 gm</i>	1 or 1b*	QL (30 tablets per 1 fill)
<i>valacyclovir hcl oral tablet 500 mg</i>	1 or 1b*	QL (60 tablets per 30 days)
*HERPES AGENTS - THYMIDINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>famciclovir oral tablet 125 mg, 250 mg</i>	1 or 1b*	QL (60 tablets per 1 fill)
<i>famciclovir oral tablet 500 mg</i>	1 or 1b*	QL (21 tablets per 1 fill)
*INFLUENZA AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>rimantadine hcl oral tablet</i>	1 or 1b*	
*MISC. ANTIVIRALS*** - DRUGS FOR VIRAL INFECTIONS		
LAGEVRIO ORAL CAPSULE (<i>molnupiravir</i>)	3	QL (40 capsules per 90 days)
TEMBEXA ORAL SUSPENSION (<i>brincidofovir</i>)	3	
TEMBEXA ORAL TABLET (<i>brincidofovir</i>)	3	
TPOXX INTRAVENOUS SOLUTION (<i>tecovirimat</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TPOXX ORAL CAPSULE (<i>tecovirimat</i>)	3	
*NEURAMINIDASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
<i>oseltamivir phosphate oral capsule 30 mg</i>	1 or 1b*	QL (20 capsule per 90 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	1 or 1b*	QL (10 capsule per 90 days)
<i>oseltamivir phosphate oral suspension reconstituted</i>	1 or 1b*	QL (180 mL per 90 days)
RAPIVAB INTRAVENOUS SOLUTION (<i>peramivir</i>)	3	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>zanamivir</i>)	2	QL (1 unit per 90 days)
TAMIFLU ORAL CAPSULE 30 MG (<i>oseltamivir phosphate</i>)	3	QL (20 capsule per 90 days)
TAMIFLU ORAL CAPSULE 45 MG, 75 MG (<i>oseltamivir phosphate</i>)	3	QL (10 capsule per 90 days)
TAMIFLU ORAL SUSPENSION RECONSTITUTED (<i>oseltamivir phosphate</i>)	3	QL (180 mL per 90 days)
*PA ENDONUCLEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK (<i>baloxavir marboxil</i>)	3	QL (1 dose pack per 90 days)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK (<i>baloxavir marboxil</i>)	3	QL (1 dose pack per 90 days)
*RSV AGENTS - NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>ribavirin inhalation solution reconstituted</i>	1 or 1b*	
VIRAZOLE INHALATION SOLUTION RECONSTITUTED (<i>ribavirin</i>)	3	
BETA BLOCKERS - DRUGS FOR THE HEART		
*ALPHA-BETA BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>carvedilol oral tablet 12.5 mg, 3.125 mg, 6.25 mg</i>	1 or 1b*	DO
<i>carvedilol oral tablet 25 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg</i>	1 or 1b*	DO
<i>carvedilol phosphate er oral capsule extended release 24 hour 20 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>carvedilol phosphate er oral capsule extended release 24 hour 40 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>carvedilol phosphate er oral capsule extended release 24 hour 80 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>labetalol hcl intravenous solution prefilled syringe 10 mg/2ml</i>	3	
<i>labetalol hcl oral tablet 100 mg</i>	1 or 1b*	DO
<i>labetalol hcl oral tablet 200 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>labetalol hcl oral tablet 300 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
*BETA BLOCKERS CARDIO-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>acebutolol hcl oral capsule</i>	1 or 1b*	
<i>atenolol oral tablet</i>	1 or 1a*	
<i>betaxolol hcl oral tablet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bisoprolol fumarate oral tablet</i>	1 or 1b*	
BREVIBLOC IN NA CL INTRAVENOUS SOLUTION (<i>esmolol hcl-sodium chloride</i>)	3	
BREVIBLOC INTRAVENOUS SOLUTION (<i>esmolol hcl</i>)	3	
BREVIBLOC PREMIXED DS INTRAVENOUS SOLUTION (<i>esmolol hcl-sodium chloride</i>)	3	
BREVIBLOC PREMIXED INTRAVENOUS SOLUTION (<i>esmolol hcl-sodium chloride</i>)	3	
<i>esmolol hcl intravenous solution 100 mg/10ml</i>	1 or 1b*	
ESMOLOL HCL INTRAVENOUS SOLUTION 2000 MG/100ML, 2500 MG/250ML	3	
<i>esmolol hcl-sodium chloride intravenous solution</i>	1 or 1b*	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE (<i>metoprolol succinate</i>)	3	
<i>metoprolol succinate er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>metoprolol tartrate intravenous solution</i>	1 or 1a*	
<i>metoprolol tartrate oral tablet</i>	1 or 1a*	
<i>nebivolol hcl oral tablet</i>	1 or 1b*	
*BETA BLOCKERS NON-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE		
HEMANGEOL ORAL SOLUTION (<i>propranolol hcl</i>)	3	
INDERAL XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR (<i>propranolol hcl sr beads</i>)	3	QL (1 capsule per 1 day)
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR (<i>propranolol hcl sr beads</i>)	3	QL (1 capsule per 1 day)
<i>nadolol oral tablet 20 mg, 40 mg</i>	1 or 1b*	DO
<i>nadolol oral tablet 80 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>pindolol oral tablet 10 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>pindolol oral tablet 5 mg</i>	1 or 1b*	DO
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 60 mg, 80 mg</i>	1 or 1b*	DO
<i>propranolol hcl er oral capsule extended release 24 hour 160 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>propranolol hcl intravenous solution</i>	1 or 1b*	
<i>propranolol hcl oral solution</i>	1 or 1b*	QL (80 mL per 1 day)
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg</i>	1 or 1b*	DO
<i>propranolol hcl oral tablet 80 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>sotalol hcl (af) oral tablet</i>	1 or 1b*	
SOTALOL HCL INTRAVENOUS SOLUTION	3	
<i>sotalol hcl oral tablet 120 mg, 80 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>sotalol hcl oral tablet 160 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>sotalol hcl oral tablet 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOTYLIZE ORAL SOLUTION (<i>sotalol hcl</i>)	3	
<i>timolol maleate oral tablet 10 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>timolol maleate oral tablet 20 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>timolol maleate oral tablet 5 mg</i>	1 or 1b*	DO
CALCIUM CHANNEL BLOCKERS - DRUGS FOR THE HEART		
*CALCIUM CHANNEL BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besylate oral tablet 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	DO
CARDENE IV INTRAVENOUS SOLUTION (<i>nicardipine hcl in nacl</i>)	3	
CARDIZEM ORAL TABLET 120 MG (<i>diltiazem hcl</i>)	3	QL (3 tablet per 1 day)
CARDIZEM ORAL TABLET 30 MG, 60 MG (<i>diltiazem hcl</i>)	3	DO
<i>cartia xt oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>cartia xt oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>cartia xt oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>cartia xt oral capsule extended release 24 hour 300 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
CLEVIPREX INTRAVENOUS EMULSION (<i>clevudipine</i>)	3	
CONJUPRI ORAL TABLET 2.5 MG (<i>levamlodipine maleate</i>)	3	ST; DO
CONJUPRI ORAL TABLET 5 MG (<i>levamlodipine maleate</i>)	3	ST; QL (1 tablet per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er beads oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg, 360 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er oral capsule extended release 12 hour 60 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er oral capsule extended release 12 hour 90 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>diltiazem hcl er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er oral tablet extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl intravenous solution</i>	1 or 1b*	
DILTIAZEM HCL INTRAVENOUS SOLUTION RECONSTITUTED	3	
<i>diltiazem hcl oral tablet 120 mg</i>	1 or 1b*	QL (3 tablet per 1 day)
<i>diltiazem hcl oral tablet 30 mg, 60 mg</i>	1 or 1b*	DO
<i>diltiazem hcl oral tablet 90 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>dilt-xr oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>dilt-xr oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>dilt-xr oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>felodipine er oral tablet extended release 24 hour 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>felodipine er oral tablet extended release 24 hour 2.5 mg, 5 mg</i>	1 or 1b*	DO
<i>isradipine oral capsule 2.5 mg</i>	1 or 1b*	DO
<i>isradipine oral capsule 5 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
KATERZIA ORAL SUSPENSION (<i>amlodipine benzoate</i>)	3	PA; QL (10 mL per 1 day)
<i>levamlodipine maleate oral tablet 2.5 mg</i>	1 or 1b*	ST; DO
<i>levamlodipine maleate oral tablet 5 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>matzim la oral tablet extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>matzim la oral tablet extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>matzim la oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
NICARDIPINE HCL IN NA CL INTRAVENOUS SOLUTION	3	
<i>nicardipine hcl intravenous solution</i>	3	
<i>nicardipine hcl oral capsule 20 mg</i>	1 or 1b*	QL (6 capsule per 1 day)
<i>nicardipine hcl oral capsule 30 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 60 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg</i>	1 or 1b*	DO
<i>nifedipine er osmotic release oral tablet extended release 24 hour 60 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 90 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>nifedipine oral capsule 10 mg</i>	1 or 1b*	DO
<i>nifedipine oral capsule 20 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>nimodipine oral capsule</i>	1 or 1b*	QL (12 capsule per 1 day)
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 8.5 mg</i>	1 or 1b*	DO
<i>nisoldipine er oral tablet extended release 24 hour 25.5 mg, 30 mg, 34 mg, 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
NORLIQVA ORAL SOLUTION (<i>amlodipine besylate</i>)	3	PA; QL (2 bottles per 30 days)
NYMALIZE ORAL SOLUTION (<i>nimodipine</i>)	3	QL (60 mL per 1 day)
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG (<i>nifedipine</i>)	3	DO
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 60 MG (<i>nifedipine</i>)	3	QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 90 MG (<i>nifedipine</i>)	3	QL (1 tablet per 1 day)
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 8.5 MG (<i>nisoldipine</i>)	3	DO
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 34 MG (<i>nisoldipine</i>)	3	QL (1 tablet per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>tiadylt er oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG (<i>diltiazem hcl er beads</i>)	3	DO
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 180 MG (<i>diltiazem hcl er beads</i>)	3	QL (3 capsules per 1 day)
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG (<i>diltiazem hcl er beads</i>)	3	QL (2 capsules per 1 day)
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 360 MG, 420 MG (<i>diltiazem hcl er beads</i>)	3	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg</i>	3	DO
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg</i>	1 or 1b*	DO
<i>verapamil hcl er oral capsule extended release 24 hour 200 mg, 300 mg, 360 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>verapamil hcl er oral tablet extended release 120 mg</i>	1 or 1b*	DO
<i>verapamil hcl er oral tablet extended release 180 mg, 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>verapamil hcl intravenous solution</i>	1 or 1b*	
<i>verapamil hcl oral tablet 120 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>verapamil hcl oral tablet 40 mg, 80 mg</i>	1 or 1b*	DO
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG (<i>verapamil hcl</i>)	3	DO
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG (<i>verapamil hcl</i>)	3	QL (2 capsules per 1 day)
VERELAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 360 MG (<i>verapamil hcl</i>)	3	QL (1 capsule per 1 day)
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (<i>verapamil hcl</i>)	3	DO
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG, 300 MG (<i>verapamil hcl</i>)	3	QL (1 capsule per 1 day)
CARDIOTONICS - DRUGS FOR THE HEART		
*CARDIAC GLYCOSIDES*** - DRUGS FOR THE HEART		
<i>digoxin injection solution</i>	1 or 1b*	
<i>digoxin oral solution</i>	1 or 1b*	QL (10 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>digoxin oral tablet 125 mcg, 62.5 mcg</i>	1 or 1b*	DO
<i>digoxin oral tablet 250 mcg</i>	1 or 1b*	QL (2 tablets per 1 day)
LANOXIN INJECTION SOLUTION (<i>digoxin</i>)	3	
LANOXIN PEDIATRIC INJECTION SOLUTION (<i>digoxin</i>)	2	
*INOTROPES*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>dobutamine hcl intravenous solution</i>	1 or 1b*	
DOBUTAMINE-DEXTROSE INTRAVENOUS SOLUTION	3	
DOPAMINE HCL INTRAVENOUS SOLUTION	3	
DOPAMINE-DEXTROSE INTRAVENOUS SOLUTION	3	
<i>milrinone lactate in dextrose intravenous solution</i>	1 or 1b*	
<i>milrinone lactate intravenous solution</i>	1 or 1b*	
CARDIOVASCULAR AGENTS - MISC. - DRUGS FOR THE HEART		
*CALCIUM CHANNEL BLOCKER & HMG COA REDUCTASE INHIBIT COMB*** - DRUGS FOR CHOLESTEROL		
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-80 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1 or 1b*	DO
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-80 MG (<i>amlodipine-atorvastatin</i>)	3	QL (1 tablet per 1 day)
CADUET ORAL TABLET 5-10 MG, 5-20 MG, 5-40 MG (<i>amlodipine-atorvastatin</i>)	3	DO
*CARDIAC MYOSIN INHIBITORS*** - DRUGS FOR THE HEART		
CAMZYOS ORAL CAPSULE (<i>mavacamten</i>)	3	PA; LD; QL (1 capsule per 1 day)
*NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB*** - DRUGS FOR HIGH BLOOD PRESSURE		
ENTRESTO ORAL CAPSULE SPRINKLE (<i>sacubitril-valsartan</i>)	3	QL (8 capsules per 1 day)
ENTRESTO ORAL TABLET (<i>sacubitril-valsartan</i>)	3	QL (6 tablets per 1 day)
*NITRATE & VASODILATOR COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
BIDIL ORAL TABLET (<i>isosorb dinitrate-hydralazine</i>)	3	QL (6 tablets per 1 day)
<i>isosorb dinitrate-hydralazine oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*PDE INHIBITOR-ENDOTHELIN RECEPTOR ANTAGONIST COMBINATIONS*** - DRUGS FOR CHOLESTEROL		
OPSYNVI ORAL TABLET (<i>macitentan-tadalafil</i>)	3	PA; LD; QL (1 tablet per 1 day)
*PROSTAGLANDIN - IMPOTENCE AGENTS*** - DRUGS FOR THE HEART		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT (<i>alprostadil vasodilator</i>)	3	PA
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED (<i>alprostadil vasodilator</i>)	3	PA
EDEX INTRACAVERNOSAL KIT (<i>alprostadil vasodilator</i>)	3	PA

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PROSTAGLANDIN VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>epoprostenol sodium intravenous solution reconstituted</i>	1 or 1b*	PA; LD
FLOLAN INTRAVENOUS SOLUTION RECONSTITUTED (<i>epoprostenol sodium</i>)	3	PA; LD
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>treprostinil diolamine</i>)	3	PA; LD; QL (1 pack per 28 days)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>treprostinil diolamine</i>)	3	PA; LD; QL (1 pack per 28 days)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>treprostinil diolamine</i>)	3	PA; LD; QL (1 pack per 28 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE (<i>treprostinil diolamine</i>)	3	PA; LD
REMODULIN INJECTION SOLUTION (<i>treprostinil</i>)	3	PA; LD
<i>treprostinil injection solution</i>	1 or 1b*	PA; LD
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER (<i>treprostinil</i>)	3	PA; LD; QL (1 kit per 28 days)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER (<i>treprostinil</i>)	3	PA; LD; QL (1 kit per 28 days)
TYVASO DPI TITRATION KIT INHALATION POWDER (<i>treprostinil</i>)	3	PA; LD; QL (1 kit per 1 lifetime)
TYVASO INHALATION SOLUTION (<i>treprostinil</i>)	3	PA; LD; QL (1 kit per 28 days)
TYVASO REFILL KIT INHALATION SOLUTION (<i>treprostinil</i>)	3	PA; LD; QL (1 kit per 28 days)
TYVASO STARTER KIT INHALATION SOLUTION (<i>treprostinil</i>)	3	PA; LD; QL (1 kit per 28 days)
VELETRI INTRAVENOUS SOLUTION RECONSTITUTED (<i>epoprostenol sodium</i>)	3	PA; LD
VENTAVIS INHALATION SOLUTION (<i>iloprost</i>)	3	PA; LD; QL (9 mL per 1 day)
*PULM HYPERTEN-SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)*** - DRUGS FOR HIGH BLOOD PRESSURE		
ADEMPAS ORAL TABLET (<i>riociguat</i>)	3	PA; LD; QL (3 tablets per 1 day)
*PULMONARY HYPERTENSION - ACTIVIN SIGNALING INHIBITOR*** - DRUGS FOR THE HEART		
WINREVAIR SUBCUTANEOUS KIT (<i>sotatercept-csrk</i>)	3	PA; LD; QL (1 kit per 21 days)
*PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>ambrisentan oral tablet</i>	1 or 1b*	PA; LD; QL (1 tablet per 1 day)
<i>bosentan oral tablet</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
OPSUMIT ORAL TABLET (<i>macitentan</i>)	3	PA; LD; QL (1 tablet per 1 day)
TRACLEER ORAL TABLET SOLUBLE (<i>bosentan</i>)	3	PA; LD; QL (2 tablets per 1 day)
*PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>alyq oral tablet</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
<i>sildenafil citrate intravenous solution</i>	1 or 1b*	PA; LD; QL (3 vial per 1 day)
<i>sildenafil citrate oral suspension reconstituted</i>	1 or 1b*	PA; LD; QL (24 mL per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sildenafil citrate oral tablet 20 mg</i>	1 or 1b*	PA; LD; QL (12 tablets per 1 day)
<i>tadalafil (pah) oral tablet</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
TADLIQ ORAL SUSPENSION (<i>tadalafil (pah)</i>)	3	PA; LD; QL (10 ml per 1 day)
*PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST*** - DRUGS FOR HIGH BLOOD PRESSURE		
UPTRAVI INTRAVENOUS SOLUTION RECONSTITUTED (<i>selexipag</i>)	3	PA; LD; QL (2 vials per 1 day)
UPTRAVI ORAL TABLET (<i>selexipag</i>)	3	PA; LD; QL (2 tablets per 1 day)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK (<i>selexipag</i>)	3	PA; LD; QL (1 pack per 365 days)
*SELECTIVE CGMP PHOSPHODIESTERASE TYPE 5 INHIBITORS*** - DRUGS FOR THE HEART		
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	1 or 1b*	PA
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1 or 1b*	PA
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; QL (30 tablets per 30 days)
<i>vardenafil hcl oral tablet dispersible</i>	1 or 1b*	PA
*SEPTAL AGENTS - ABLATION** - DRUGS FOR THE HEART		
ABLYSINOL INTRA-ARTERIAL SOLUTION (<i>dehydrated alcohol</i>)	3	
*SINUS NODE INHIBITORS** - DRUGS FOR HIGH BLOOD PRESSURE		
CORLANOR ORAL SOLUTION (<i>ivabradine hcl</i>)	3	PA; QL (4 ampules per 1 day)
<i>ivabradine hcl oral tablet</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
*TRANSTHYRETIN STABILIZERS*** - DRUGS FOR THE HEART		
VYNDAMAX ORAL CAPSULE (<i>tafamidis</i>)	3	PA; LD; QL (1 capsule per 1 day)
VYNDAQEL ORAL CAPSULE (<i>tafamidis meglumine (cardiac)</i>)	3	PA; LD; QL (4 capsules per 1 day)
*VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)*** - DRUGS FOR ANGINA		
VERQUVO ORAL TABLET 10 MG, 5 MG (<i>vericiguat</i>)	3	PA; QL (1 tablet per 1 day)
VERQUVO ORAL TABLET 2.5 MG (<i>vericiguat</i>)	3	PA; QL (1 tablets per 1 day)
CEPHALOSPORINS - DRUGS FOR INFECTIONS		
*CEPHALOSPORIN COMBINATIONS*** - ANTIBIOTICS		
AVYCAZ INTRAVENOUS SOLUTION RECONSTITUTED (<i>ceftazidime-avibactam</i>)	3	
ZERBAXA INTRAVENOUS SOLUTION RECONSTITUTED (<i>ceftolozane-tazobactam</i>)	3	
*CEPHALOSPORINS - 1ST GENERATION*** - ANTIBIOTICS		
<i>cefadroxil oral capsule</i>	1 or 1b*	
<i>cefadroxil oral suspension reconstituted</i>	1 or 1b*	
<i>cefadroxil oral tablet</i>	1 or 1b*	
<i>cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm, 3 gm, 500 mg</i>	1 or 1b*	
CEFAZOLIN SODIUM INJECTION SOLUTION RECONSTITUTED 100 GM, 300 GM	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefazolin sodium intravenous solution reconstituted 1 gm</i>	1 or 1b*	
<i>cefazolin sodium intravenous solution reconstituted 2 gm, 3 gm</i>	3	
CEFAZOLIN SODIUM-DEXTROSE INTRAVENOUS SOLUTION 1-4 GM/50ML-%, 2-4 GM/100ML-%	3	
<i>cefazolin sodium-dextrose intravenous solution 3-4 gm/150ml-%</i>	3	
CEFAZOLIN SODIUM-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	
<i>cephalexin oral capsule</i>	1 or 1a*	
<i>cephalexin oral suspension reconstituted</i>	1 or 1a*	
<i>cephalexin oral tablet</i>	1 or 1a*	
*CEPHALOSPORINS - 2ND GENERATION*** - ANTIBIOTICS		
CEFACLOR ER ORAL TABLET EXTENDED RELEASE 12 HOUR	3	
<i>cefaclor oral capsule</i>	1 or 1b*	
<i>cefaclor oral suspension reconstituted</i>	1 or 1b*	
CEFOTAN INJECTION SOLUTION RECONSTITUTED (<i>cefotetan disodium</i>)	3	
<i>cefotetan disodium injection solution reconstituted</i>	1 or 1b*	
<i>cefoxitin sodium intravenous solution reconstituted</i>	1 or 1b*	
CEFOXITIN SODIUM-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	
<i>cefprozil oral suspension reconstituted</i>	1 or 1b*	
<i>cefprozil oral tablet</i>	1 or 1b*	
<i>cefuroxime axetil oral tablet</i>	1 or 1b*	
<i>cefuroxime sodium injection solution reconstituted</i>	1 or 1b*	
<i>cefuroxime sodium intravenous solution reconstituted</i>	1 or 1b*	
*CEPHALOSPORINS - 3RD GENERATION*** - ANTIBIOTICS		
<i>cefdinir oral capsule</i>	1 or 1b*	
<i>cefdinir oral suspension reconstituted</i>	1 or 1b*	
<i>cefixime oral capsule</i>	1 or 1b*	
<i>cefixime oral suspension reconstituted</i>	1 or 1b*	
<i>cefotaxime sodium injection solution reconstituted</i>	3	
<i>cefpodoxime proxetil oral suspension reconstituted</i>	1 or 1b*	
<i>cefpodoxime proxetil oral tablet</i>	1 or 1b*	
<i>ceftazidime injection solution reconstituted</i>	1 or 1b*	
<i>ceftazidime intravenous solution reconstituted</i>	1 or 1b*	
<i>ceftriaxone sodium in dextrose intravenous solution</i>	1 or 1b*	QL (3000 mL per 30 days)
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 500 mg</i>	1 or 1b*	QL (60 vials per 30 fills)
CEFTRIAXONE SODIUM INJECTION SOLUTION RECONSTITUTED 100 GM	3	QL (1 vial per 30 days)
<i>ceftriaxone sodium injection solution reconstituted 250 mg</i>	1 or 1b*	QL (1 vial per 30 fills)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ceftriaxone sodium intravenous solution reconstituted 1 gm, 2 gm</i>	1 or 1b*	QL (60 vials per 30 days)
<i>ceftriaxone sodium intravenous solution reconstituted 10 gm</i>	1 or 1b*	QL (1 vial per 30 days)
CEFTRIAZONE SODIUM-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	QL (60 IV Bags per 30 days)
<i>tazicef injection solution reconstituted</i>	1 or 1b*	
TAZICEF INTRAVENOUS SOLUTION (<i>ceftazidime sodium in dextrose</i>)	3	
<i>tazicef intravenous solution reconstituted</i>	1 or 1b*	
*CEPHALOSPORINS - 4TH GENERATION*** - ANTIBIOTICS		
<i>cefepime hcl injection solution reconstituted</i>	1 or 1b*	
CEFEPIME HCL INTRAVENOUS SOLUTION	3	
CEFEPIME HCL INTRAVENOUS SOLUTION RECONSTITUTED 100 GM	3	
<i>cefepime hcl intravenous solution reconstituted 2 gm</i>	1 or 1b*	
CEFEPIME-DEXTROSE INTRAVENOUS SOLUTION RECONSTITUTED	3	
*CEPHALOSPORINS - 5TH GENERATION*** - ANTIBIOTICS		
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED (<i>ceftaroline fosamil</i>)	3	
*CEPHALOSPORINS - SIDEROPHORES*** - ANTIBIOTICS		
FETROJA INTRAVENOUS SOLUTION RECONSTITUTED (<i>cefiderocol sulfate tosylate</i>)	3	
CONTRACEPTIVES - DRUGS FOR WOMEN		
*BIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>azurette oral tablet</i>	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>kariva oral tablet</i>	1 or 1b*; \$0	
LO LOESTRIN FE ORAL TABLET (<i>norethin-eth estrad-fe biphas</i>)	2	\$0
<i>pimtreea oral tablet</i>	1 or 1b*; \$0	
<i>simliya oral tablet</i>	1 or 1b*; \$0	
<i>viorele oral tablet</i>	1 or 1b*; \$0	
<i>volnea oral tablet</i>	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>afirmelle oral tablet</i>	1 or 1a*; \$0	
<i>altavera oral tablet</i>	1 or 1a*; \$0	
<i>alyacen 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>apri oral tablet</i>	1 or 1a*; \$0	
<i>aubra eq oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 24 fe oral tablet</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aurovela fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>aviane oral tablet</i>	1 or 1a*; \$0	
<i>ayuna oral tablet</i>	1 or 1a*; \$0	
BALCOLTRA ORAL TABLET (<i>levonorgest-eth estrad-fe bisg</i>)	3	
<i>balziva oral tablet</i>	1 or 1a*; \$0	
BEYAZ ORAL TABLET (<i>drospiren-eth estrad-levomefol</i>)	3	
<i>blisovi 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>blisovi fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>blisovi fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>briellyn oral tablet</i>	1 or 1a*; \$0	
<i>charlotte 24 fe oral tablet chewable</i>	1 or 1a*; \$0	
<i>chateal eq oral tablet</i>	1 or 1a*; \$0	
<i>cryselle-28 oral tablet</i>	1 or 1a*; \$0	
<i>cyred eq oral tablet</i>	1 or 1a*; \$0	
<i>dasetta 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>delyla oral tablet</i>	1 or 1a*; \$0	
<i>drospiren-eth estrad-levomefol oral tablet</i>	1 or 1b*; \$0	
<i>drospirenone-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>elinest oral tablet</i>	1 or 1a*; \$0	
<i>enskyce oral tablet</i>	1 or 1a*; \$0	
<i>estarylla oral tablet</i>	1 or 1a*; \$0	
<i>ethynodiol diac-eth estradiol oral tablet</i>	1 or 1a*; \$0	
<i>falmina oral tablet</i>	1 or 1a*; \$0	
FEMLYV ORAL TABLET DISPERSIBLE (<i>norethindrone acet-ethinyl est</i>)	3	\$0
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable)	1 or 1a*; \$0	
<i>gemmily oral capsule</i>	1 or 1b*; \$0	
<i>hailey 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>hailey 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>hailey fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>hailey fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>isibloom oral tablet</i>	1 or 1a*; \$0	
<i>jasmiel oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad-fe bisg</i> (Joyeaux Oral Tablet)	1 or 1b*; \$0	
<i>juleber oral tablet</i>	1 or 1a*; \$0	
<i>junel 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>junel 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>junel fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 24 oral tablet</i>	1 or 1a*; \$0	
<i>kaitlib fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>kalliga oral tablet</i>	1 or 1a*; \$0	
<i>kelnor 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>kelnor 1/50 oral tablet</i>	1 or 1a*; \$0	
<i>kurvelo oral tablet</i>	1 or 1a*; \$0	
<i>larin 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>larin 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>larin 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>larin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>larin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>layolis fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>lessina oral tablet</i>	1 or 1a*; \$0	
<i>levonorgest-eth estradiol-iron oral tablet</i>	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	1 or 1a*; \$0	
<i>levora 0.15/30 (28) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin 1.5/30 (21) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin 1/20 (21) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>loestrin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>loryna oral tablet</i>	1 or 1b*; \$0	
<i>low-ogestrel oral tablet</i>	1 or 1a*; \$0	
<i>lo-zumandimine oral tablet</i>	1 or 1b*; \$0	
<i>lutera oral tablet</i>	1 or 1a*; \$0	
<i>marlissa oral tablet</i>	1 or 1a*; \$0	
<i>merzee oral capsule</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe (Mibelas 24 Fe Oral Tablet Chewable)</i>	1 or 1a*; \$0	
<i>microgestin 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>mili oral tablet</i>	1 or 1a*; \$0	
<i>mono-lynyah oral tablet</i>	1 or 1a*; \$0	
<i>necon 0.5/35 (28) oral tablet</i>	1 or 1a*; \$0	
NEXTSTELLIS ORAL TABLET (<i>drospirenone-estetrol</i>)	3	\$0
<i>nikki oral tablet</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe oral capsule</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe oral tablet</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe oral tablet chewable</i>	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est oral tablet</i>	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1 or 1a*; \$0	
<i>nortrel 0.5/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>nortrel 1/35 (21) oral tablet</i>	1 or 1a*; \$0	
<i>nortrel 1/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>nylia 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>ocella oral tablet</i>	1 or 1b*; \$0	
<i>philith oral tablet</i>	1 or 1a*; \$0	
<i>portia-28 oral tablet</i>	1 or 1a*; \$0	
<i>reclipsen oral tablet</i>	1 or 1a*; \$0	
SAFYRAL ORAL TABLET (<i>drospiren-eth estrad-levomefol</i>)	3	
<i>sprintec 28 oral tablet</i>	1 or 1a*; \$0	
<i>sronyx oral tablet</i>	1 or 1a*; \$0	
<i>syeda oral tablet</i>	1 or 1b*; \$0	
<i>tarina 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>tarina fe 1/20 eq oral tablet</i>	1 or 1a*; \$0	
<i>taysofy oral capsule</i>	1 or 1b*; \$0	
TAYTULLA ORAL CAPSULE (<i>norethin ace-eth estrad-fe</i>)	3	
<i>norgestrel-ethinyl estradiol</i> (Turqoz Oral Tablet)	1 or 1a*; \$0	
TYBLUME ORAL TABLET CHEWABLE (<i>levonorgestrel-ethinyl estrad</i>)	3	\$0
<i>tydemy oral tablet</i>	1 or 1b*; \$0	
<i>vestura oral tablet</i>	1 or 1b*; \$0	
<i>vienva oral tablet</i>	1 or 1a*; \$0	
<i>vyfemla oral tablet</i>	1 or 1a*; \$0	
<i>vylibra oral tablet</i>	1 or 1a*; \$0	
<i>wera oral tablet</i>	1 or 1a*; \$0	
<i>wymzya fe oral tablet chewable</i>	1 or 1b*; \$0	
YASMIN 28 ORAL TABLET (<i>drospirenone-ethinyl estradiol</i>)	3	
YAZ ORAL TABLET (<i>drospirenone-ethinyl estradiol</i>)	3	
<i>zovia 1/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>zumandimine oral tablet</i>	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - TRANSDERMAL*** - BIRTH CONTROL PILLS		
<i>norelgestromin-eth estradiol transdermal patch weekly</i>	1 or 1b*; \$0	
TWIRLA TRANSDERMAL PATCH WEEKLY (<i>levonorgestrel-eth estradiol</i>)	3	\$0
<i>xulane transdermal patch weekly</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zafemy transdermal patch weekly</i>	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - VAGINAL*** - BIRTH CONTROL PILLS		
ANNOVERA VAGINAL RING (<i>segesterone-ethinyl estradiol</i>)	3	\$0
<i>eluryng vaginal ring</i>	1 or 1b*; \$0	
<i>etonogestrel-ethinyl estradiol</i> (Enilloring Vaginal Ring)	1 or 1b*; \$0	
<i>etonogestrel-ethinyl estradiol vaginal ring</i>	1 or 1b*; \$0	
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring)	1 or 1b*; \$0	
NUVARING VAGINAL RING (<i>etonogestrel-ethinyl estradiol</i>)	3	
*CONTINUOUS CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>amethyst oral tablet</i>	1 or 1b*; \$0	
<i>dolishale oral tablet</i>	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad oral tablet 90-20 mcg</i>	1 or 1b*; \$0	
*COPPER CONTRACEPTIVES - IUD*** - BIRTH CONTROL PILLS		
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (<i>copper</i>)	3	
*EMERGENCY CONTRACEPTIVES*** - BIRTH CONTROL PILLS		
<i>aftera oral tablet</i>	1 or 1b*; \$0	
<i>afterpill oral tablet</i>	1 or 1b*; \$0	
CURAE ORAL TABLET (<i>levonorgestrel</i>)	1 or 1b*; \$0	
<i>econtra one-step oral tablet</i>	1 or 1b*; \$0	
ELLA ORAL TABLET (<i>ulipristal acetate</i>)	3; \$0	
HER STYLE ORAL TABLET (<i>levonorgestrel</i>)	1 or 1b*; \$0	
<i>levonorgestrel oral tablet</i>	1 or 1b*; \$0	
<i>my choice oral tablet</i>	1 or 1b*; \$0	
<i>my way oral tablet</i>	1 or 1b*; \$0	
<i>new day oral tablet</i>	1 or 1b*; \$0	
<i>opcicon one-step oral tablet</i>	1 or 1b*; \$0	
<i>option 2 oral tablet</i>	1 or 1b*; \$0	
<i>react oral tablet</i>	1 or 1b*; \$0	
<i>take action oral tablet</i>	1 or 1b*; \$0	
*EXTENDED-CYCLE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>ashlyna oral tablet</i>	1 or 1b*; \$0	
<i>camrese lo oral tablet</i>	1 or 1b*; \$0	
<i>camrese oral tablet</i>	1 or 1b*; \$0	
<i>daysee oral tablet</i>	1 or 1b*; \$0	
<i>iclevia oral tablet</i>	1 or 1b*; \$0	
<i>introvale oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>jaimiess oral tablet</i>	1 or 1b*; \$0	
<i>jolessa oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth est & eth est oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day oral tablet</i>	1 or 1b*; \$0	
<i>lojaimiess oral tablet</i>	1 or 1b*; \$0	
<i>rivelsa oral tablet</i>	1 or 1b*; \$0	
<i>setlakin oral tablet</i>	1 or 1b*; \$0	
<i>simpesse oral tablet</i>	1 or 1b*; \$0	
*FOUR PHASE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
NATAZIA ORAL TABLET (<i>estradiol valerate-dienogest</i>)	3	\$0
*PROGESTIN CONTRACEPTIVES - IMPLANTS*** - BIRTH CONTROL PILLS		
NEXPLANON SUBCUTANEOUS IMPLANT (<i>etonogestrel</i>)	3	LD
*PROGESTIN CONTRACEPTIVES - INJECTABLE*** - BIRTH CONTROL PILLS		
DEPO-PROVERA INTRAMUSCULAR SUSPENSION (<i>medroxyprogesterone acetate</i>)	3	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>medroxyprogesterone acetate</i>)	3	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (<i>medroxyprogesterone acetate</i>)	3; \$0	
<i>medroxyprogesterone acetate intramuscular suspension</i>	1 or 1b*; \$0	
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe</i>	1 or 1b*; \$0	
*PROGESTIN CONTRACEPTIVES - IUD*** - BIRTH CONTROL PILLS		
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE (<i>levonorgestrel</i>)	3	LD
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE (<i>levonorgestrel</i>)	3	LD
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE (<i>levonorgestrel</i>)	3	LD
SKYLA INTRAUTERINE INTRAUTERINE DEVICE (<i>levonorgestrel</i>)	3	LD
*PROGESTIN CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>camila oral tablet</i>	1 or 1b*; \$0	
<i>deblitane oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone</i> (Emzahh Oral Tablet)	1 or 1b*; \$0	
<i>errin oral tablet</i>	1 or 1b*; \$0	
<i>heather oral tablet</i>	1 or 1b*; \$0	
<i>incassia oral tablet</i>	1 or 1b*; \$0	
<i>jencycla oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lyleq oral tablet</i>	1 or 1b*; \$0	
<i>lyza oral tablet</i>	1 or 1b*; \$0	
<i>nora-be oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone oral tablet</i>	1 or 1b*; \$0	
<i>norlyroc oral tablet</i>	1 or 1b*; \$0	
OPILL ORAL TABLET (<i>norgestrel</i>)	2; \$0	
<i>sharobel oral tablet</i>	1 or 1b*; \$0	
SLYND ORAL TABLET (<i>drospirenone</i>)	3	\$0
*TRIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>alyacen 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>aranelle oral tablet</i>	1 or 1a*; \$0	
<i>dasetta 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>enpresse-28 oral tablet</i>	1 or 1a*; \$0	
<i>leena oral tablet</i>	1 or 1a*; \$0	
<i>levonest oral tablet</i>	1 or 1a*; \$0	
<i>levonorg-eth estrad triphasic oral tablet</i>	1 or 1a*; \$0	
<i>norethindron-ethinyl estrad-fe oral tablet</i>	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic oral tablet</i>	1 or 1b*; \$0	
<i>nortrel 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>nylia 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>tilia fe oral tablet</i>	1 or 1b*; \$0	
<i>tri-estarylla oral tablet</i>	1 or 1b*; \$0	
<i>tri-legest fe oral tablet</i>	1 or 1b*; \$0	
<i>tri-linyah oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-estarylla oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-marzia oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-mili oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-sprintec oral tablet</i>	1 or 1b*; \$0	
<i>tri-mili oral tablet</i>	1 or 1b*; \$0	
<i>tri-sprintec oral tablet</i>	1 or 1b*; \$0	
<i>trivora (28) oral tablet</i>	1 or 1a*; \$0	
<i>tri-vylibra lo oral tablet</i>	1 or 1b*; \$0	
<i>tri-vylibra oral tablet</i>	1 or 1b*; \$0	
<i>velivet oral tablet</i>	1 or 1a*; \$0	
CORTICOSTEROIDS - HORMONES		
*GLUCOCORTICOSTEROIDS*** - DRUGS FOR INFLAMMATION		
ALKINDI SPRINKLE ORAL CAPSULE SPRINKLE (<i>hydrocortisone</i>)	3	PA
<i>budesonide er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>budesonide oral capsule delayed release particles</i>	1 or 1b*	QL (3 capsule per 1 day)
CORTEF ORAL TABLET (<i>hydrocortisone</i>)	3	
DEPO-MEDROL INJECTION SUSPENSION (<i>methylprednisolone acetate</i>)	3	
DEXABLISS ORAL TABLET THERAPY PACK	3	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE (<i>dexamethasone</i>)	2	
<i>dexamethasone oral elixir</i>	1 or 1a*	
<i>dexamethasone oral solution</i>	1 or 1a*	
<i>dexamethasone oral tablet</i>	1 or 1a*	
<i>dexamethasone oral tablet therapy pack</i>	1 or 1b*	
<i>dexamethasone sod phos +rfid injection solution prefilled syringe</i>	1 or 1b*	
<i>dexamethasone sod phosphate pf injection solution</i>	1 or 1b*	
DEXAMETHASONE SOD PHOSPHATE PF INJECTION SOLUTION PREFILLED SYRINGE	1 or 1b*	
<i>dexamethasone sodium phosphate injection solution 100 mg/10ml, 120 mg/30ml, 20 mg/5ml</i>	1 or 1b*	
DEXAMETHASONE SODIUM PHOSPHATE INJECTION SOLUTION PREFILLED SYRINGE	1 or 1b*	
HEMADY ORAL TABLET (<i>dexamethasone</i>)	3	PA; QL (2 tablets per 1 day)
HEXATRIONE INTRA-ARTICULAR SUSPENSION (<i>triamcinolone hexacetonide</i>)	3	
<i>hidex 6-day oral tablet therapy pack</i>	1 or 1b*	
<i>hydrocortisone oral tablet</i>	1 or 1b*	
<i>hydrocortisone sod suc (pf) injection solution reconstituted</i>	1 or 1b*	
KENALOG-10 INJECTION SUSPENSION (<i>triamcinolone acetonide</i>)	3	
KENALOG-40 INJECTION SUSPENSION (<i>triamcinolone acetonide</i>)	3	
KENALOG-80 INJECTION SUSPENSION (<i>triamcinolone acetonide</i>)	3	
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (<i>methylprednisolone</i>)	3	
MEDROL ORAL TABLET 2 MG (<i>methylprednisolone</i>)	2	
MEDROL ORAL TABLET THERAPY PACK (<i>methylprednisolone</i>)	3	
<i>methylprednisolone oral tablet</i>	1 or 1a*	
<i>methylprednisolone oral tablet therapy pack</i>	1 or 1a*	
<i>methylprednisolone sodium succ injection solution reconstituted</i>	1 or 1b*	
ORAPRED ODT ORAL TABLET DISPERSIBLE 10 MG, 30 MG (<i>prednisolone sodium phosphate</i>)	3	QL (2 tablets per 1 day)
ORAPRED ODT ORAL TABLET DISPERSIBLE 15 MG (<i>prednisolone sodium phosphate</i>)	3	DO
PEDIAPRED ORAL SOLUTION (<i>prednisolone sodium phosphate</i>)	3	
<i>prednisolone oral solution</i>	1 or 1a*	
<i>prednisolone oral tablet</i>	1 or 1b*	
<i>prednisolone sodium phosphate oral solution</i>	1 or 1a*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg, 30 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>prednisolone sodium phosphate oral tablet dispersible 15 mg</i>	1 or 1a*	DO
PREDNISONO INTENSOL ORAL CONCENTRATE (<i>prednisone</i>)	3	
<i>prednisone oral solution</i>	1 or 1a*	
<i>prednisone oral tablet</i>	1 or 1a*	
<i>prednisone oral tablet therapy pack</i>	1 or 1a*	
SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED (<i>hydrocortisone sod succinate</i>)	3	
SOLU-MEDROL (PF) INJECTION SOLUTION RECONSTITUTED (<i>methylprednisolone sodium succ</i>)	3	
SOLU-MEDROL INJECTION SOLUTION RECONSTITUTED (<i>methylprednisolone sodium succ</i>)	3	
<i>taperdex 12-day oral tablet therapy pack</i>	1 or 1b*	
<i>taperdex 6-day oral tablet therapy pack</i>	1 or 1b*	
<i>taperdex 7-day oral tablet therapy pack</i>	1 or 1b*	
TARPEYO ORAL CAPSULE DELAYED RELEASE (<i>budesonide</i>)	3	PA; LD; QL (4 capsules per 1 day)
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>budesonide</i>)	3	QL (1 tablet per 1 day)
ZILRETTA INTRA-ARTICULAR SUSPENSION RECONSTITUTED ER (<i>triamcinolone acetonide</i>)	3	PA; LD; QL (1 injection per 1 knee)
*MINERALOCORTICOID*** - DRUGS FOR INFLAMMATION		
<i>fludrocortisone acetate oral tablet</i>	1 or 1b*	
*STEROID COMBINATIONS*** - DRUGS FOR INFLAMMATION		
CELESTONE SOLUSPAN INJECTION SUSPENSION (<i>betamethasone sod phos & acet</i>)	3	
COUGH/COLD/ALLERGY - DRUGS FOR THE LUNGS		
*ANTITUSSIVE - NONNARCOTIC*** - DRUGS FOR ALLERGIES		
<i>benzonatate oral capsule</i>	1 or 1b*	
*ANTITUSSIVE - OPIOID*** - DRUGS FOR COUGH AND COLD		
HYCODAN ORAL SOLUTION (<i>hydrocodone bit-homatrop mbr</i>)	3	AL; QL (150 mL per 5 days)
HYCODAN ORAL TABLET (<i>hydrocodone bit-homatrop mbr</i>)	3	PA; QL (30 tablets per 5 days)
<i>hydrocodone bit-homatrop mbr oral solution</i>	1 or 1a*	AL; QL (150 mL per 5 days)
<i>hydrocodone bit-homatrop mbr oral tablet</i>	1 or 1a*	PA; QL (30 tablets per 5 days)
<i>hydromet oral solution</i>	1 or 1a*	AL; QL (150 mL per 5 days)
*ANTITUSSIVE-EXPECTORANT*** - DRUGS FOR COUGH AND COLD		
CODITUSSIN AC ORAL LIQUID	3	AL
<i>g tussin ac oral solution</i>	1 or 1a*	AL; QL (120 mL per 1 fill)
<i>guaifenesin-codeine oral solution</i>	1 or 1a*	AL; QL (120 mL per 1 fill)
MAR-COF CG EXPECTORANT ORAL LIQUID (<i>guaifenesin-codeine</i>)	2	AL
<i>maxi-tuss ac oral solution</i>	1 or 1a*	AL; QL (120 mL per 1 fill)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NINJACOF-XG ORAL LIQUID (<i>guaifenesin-codeine</i>)	3	AL
*ANTITUSSIVE-EXPECTORANTS-DECONGESTANT*** - DRUGS FOR COUGH AND COLD		
CODITUSSIN DAC ORAL LIQUID	3	AL
TUSNEL C ORAL SYRUP (<i>pseudoephedrine-codeine-gg</i>)	2	PA; QL (200 mL per 5 days)
*DECONGESTANT & ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR (<i>desloratadine-pseudoephedrine</i>)	3	ST; QL (2 tablets per 1 day)
<i>promethazine vc oral syrup</i>	1 or 1b*	QL (2 fills per 30 days)
<i>promethazine-phenylephrine oral syrup</i>	1 or 1b*	QL (2 fills per 30 days)
*MISC. RESPIRATORY INHALANTS*** - DRUGS FOR ALLERGIES		
HYPERSAL INHALATION NEBULIZATION SOLUTION 7 % (<i>sodium chloride</i>)	3	
<i>sodium chloride</i> (Nebusal Inhalation Nebulization Solution 3 %)	1 or 1b*	
<i>sodium chloride</i> (Pulmosal Inhalation Nebulization Solution)	1 or 1b*	
<i>sodium chloride inhalation nebulization solution</i>	1 or 1b*	
*MUCOLYTICS*** - DRUGS FOR THE LUNGS		
<i>acetylcysteine inhalation solution</i>	1 or 1b*	
*NON-NARC ANTITUSSIVE-ANTIANTHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>promethazine-dm oral syrup</i>	1 or 1a*	QL (2 fills per 30 days)
*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIANTHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>pseudoeph-bromphen-dm oral syrup</i>	1 or 1b*	
*OPIOID ANTITUSSIVE-ANTIANTHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>hydrocod poli-chlorphe poli er oral suspension extended release</i>	1 or 1b*	AL; QL (120 mL per 1 fill)
<i>promethazine-codeine oral solution</i>	1 or 1a*	AL; QL (100 mL per 5 days)
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR (<i>chlorpheniramine-codeine</i>)	3	AL; QL (10 tablets per 5 days)
*OPIOID ANTITUSSIVE-DECONGESTANT-ANTIANTHISTAMINE*** - DRUGS FOR COUGH AND COLD		
MAXI-TUSS CD ORAL LIQUID	2	AL; QL (150 mL per 5 days)
POLY-TUSSIN AC ORAL LIQUID	2	AL; QL (300 mL per 5 days)
PRO-RED AC ORAL SYRUP (<i>phenyleph-dexchlorphen-codeine</i>)	3	PA
RYDEX ORAL LIQUID (<i>pseudoeph-bromphen-cod</i>)	2	AL; QL (450 mL per 5 days)
DERMATOLOGICALS - DRUGS FOR THE SKIN		
*ACNE ANTIBIOTICS*** - DRUGS FOR THE SKIN		
CLEOCIN-T EXTERNAL LOTION (<i>clindamycin phosphate</i>)	3	ST; QL (4 mL per 1 day)
<i>clindacin etz external swab</i>	1 or 1b*	QL (2 pads per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clindamycin phosphate</i> (Clindacin External Foam)	1 or 1b*	QL (100 grams per 30 days)
<i>clindacin-p external swab</i>	1 or 1b*	QL (2 pads per 1 day)
<i>clindamycin phosphate external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>clindamycin phosphate external gel</i>	1 or 1b*	QL (75 ml/gm per 30 days)
<i>clindamycin phosphate external lotion</i>	1 or 1b*	QL (4 mL per 1 day)
<i>clindamycin phosphate external solution</i>	1 or 1b*	QL (4 mL per 1 day)
<i>clindamycin phosphate external swab</i>	1 or 1b*	QL (2 pads per 1 day)
<i>dapsone external gel</i>	3	ST; QL (90 grams per 30 days)
<i>ery external pad</i>	1 or 1b*	QL (2 pads per 1 day)
ERYGEL EXTERNAL GEL (<i>erythromycin</i>)	3	QL (60 grams per 30 days)
<i>erythromycin external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>erythromycin external solution</i>	1 or 1b*	QL (60 mL per 30 days)
KLARON EXTERNAL LOTION (<i>sulfacetamide sodium (acne)</i>)	3	
<i>sulfacetamide sodium (acne) external lotion</i>	1 or 1b*	
*ACNE COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>adapalene-benzoyl peroxide external gel 0.3-2.5 %</i>	1 or 1b*	PA; QL (60 grams per 30 days)
<i>benzoyl peroxide-erythromycin external gel</i>	1 or 1b*	QL (46.6 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1 or 1b*	QL (45 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %</i>	1 or 1b*	QL (50 grams per 30 days)
<i>clindamycin-tretinoin external gel</i>	3	PA; QL (60 grams per 30 days)
<i>neuac external gel</i>	1 or 1b*	QL (45 grams per 30 days)
*ACNE PRODUCTS*** - DRUGS FOR THE SKIN		
ABSORICA LD ORAL CAPSULE (<i>isotretinoin micronized</i>)	3	PA
ABSORICA ORAL CAPSULE (<i>isotretinoin</i>)	3	PA
<i>accutane oral capsule</i>	2	PA
<i>adapalene external cream</i>	1 or 1b*	PA; QL (1.5 grams per 1 day)
<i>adapalene external gel</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>adapalene external pad</i>	1 or 1b*	PA; QL (1 swab per 1 day)
AKLIEF EXTERNAL CREAM (<i>trifarotene</i>)	3	ST; QL (1 pump per 30 days)
<i>amnestem oral capsule</i>	2	PA
ARAZLO EXTERNAL LOTION (<i>tazarotene</i>)	3	ST; QL (45 grams per 30 days)
<i>claravis oral capsule</i>	2	PA
<i>isotretinoin oral capsule</i>	2	PA
<i>tretinoin external cream</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>tretinoin external gel</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>tretinoin microsphere external gel 0.04 %, 0.1 %</i>	1 or 1b*	PA; QL (50 grams per 30 days)
<i>tretinoin microsphere pump external gel 0.04 %, 0.1 %</i>	1 or 1b*	PA; QL (50 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zenatane oral capsule</i>	2	PA
*AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS*** - DRUGS FOR THE SKIN		
VEREGEN EXTERNAL OINTMENT (<i>sinecatechins</i>)	3	ST; QL (30 grams per 28 days)
*AGENTS FOR FACIAL WRINKLES - RETINOIDS*** - DRUGS FOR THE SKIN		
RENOVA EXTERNAL CREAM (<i>tretinoin (facial wrinkles)</i>)	3	PA; QL (60 grams per 30 days)
RENOVA PUMP EXTERNAL CREAM (<i>tretinoin (facial wrinkles)</i>)	3	PA; QL (60 grams per 30 days)
*ANTIBIOTIC STEROID COMBINATIONS - TOPICAL*** - DRUGS FOR THE SKIN		
NEO-SYNALAR EXTERNAL CREAM (<i>neomycin-fluocinolone</i>)	3	
*ANTIBIOTICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>gentamicin sulfate external cream</i>	1 or 1b*	QL (30 grams per 1 fill)
<i>gentamicin sulfate external ointment</i>	1 or 1b*	QL (30 grams per 1 fill)
<i>mupirocin external ointment</i>	1 or 1b*	QL (30 grams per 1 fill)
*ANTIFUNGALS - TOPICAL COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>clotrimazole-betamethasone external cream</i>	1 or 1b*	QL (180 grams per 30 days)
<i>clotrimazole-betamethasone external lotion</i>	1 or 1b*	QL (120 mL per 30 days)
FUNGIMEZ EXTERNAL SOLUTION	3	
<i>miconazole-zinc oxide-petrolat external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>nystatin-triamcinolone external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin-triamcinolone external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
VUSION EXTERNAL OINTMENT (<i>miconazole-zinc oxide-petrolat</i>)	3	QL (50 grams per 30 days)
*ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>ciclodan external solution</i>	1 or 1b*	QL (7 mL per 30 days)
<i>ciclopirox external gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>ciclopirox external shampoo</i>	1 or 1b*	QL (120 mL per 30 days)
<i>ciclopirox external solution</i>	1 or 1b*	QL (7 mL per 30 days)
<i>ciclopirox olamine external cream</i>	1 or 1b*	QL (90 grams per 30 days)
<i>ciclopirox olamine external suspension</i>	1 or 1b*	QL (60 mL per 30 days)
<i>nystatin</i> (Klayesta External Powder)	1 or 1b*	QL (60 grams per 30 days)
<i>naftifine hcl external cream 1 %</i>	1 or 1b*	ST; QL (90 grams per 30 days)
<i>naftifine hcl external cream 2 %</i>	1 or 1b*	ST; QL (60 grams per 30 days)
<i>naftifine hcl external gel</i>	1 or 1b*	ST; QL (60 grams per 30 days)
NAFTIN EXTERNAL GEL (<i>naftifine hcl</i>)	3	ST; QL (60 grams per 30 days)
<i>nyamyc external powder</i>	1 or 1b*	QL (60 grams per 30 days)
<i>nystatin external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin external powder</i>	1 or 1b*	QL (60 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nystop external powder</i>	1 or 1b*	QL (60 grams per 30 days)
*ANTI-INFLAMMATORY AGENTS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>diclofenac sodium external gel 1 %</i>	1 or 1b*	BE; QL (1000 gm per 30 days)
*ANTINEOPLASTIC ALKYLATING AGENTS - TOPICAL*** - DRUGS FOR THE SKIN		
VALCHLOR EXTERNAL GEL (<i>mechlorethamine hcl (topical)</i>)	3	PA; LD; QL (1 tube per 30 days)
*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL*** - DRUGS FOR THE SKIN		
CARAC EXTERNAL CREAM (<i>fluorouracil</i>)	3	ST; QL (30 gm per 365 days)
EFUDEX EXTERNAL CREAM (<i>fluorouracil</i>)	3	ST; QL (40 gm per 365 days)
<i>fluorouracil external cream</i>	1 or 1b*	AL; QL (40 gm per 365 days)
<i>fluorouracil external solution</i>	1 or 1b*	AL; QL (10 mL per 365 days)
TOLAK EXTERNAL CREAM (<i>fluorouracil</i>)	3	ST; QL (40 gm per 365 days)
*ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S*** - DRUGS FOR THE SKIN		
<i>diclofenac sodium external gel 3 %</i>	1 or 1b*	PA; QL (300 grams per 1 year)
*ANTINEOPLASTIC RETINOIDS - TOPICAL*** - DRUGS FOR THE SKIN		
PANRETIN EXTERNAL GEL (<i>alitretinoin</i>)	3	LD
*ANTIPRURITICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>doxepin hcl external cream</i>	1 or 1b*	PA; QL (1 tube per 1 fill)
*ANTIPSORIATICS - SYSTEMIC*** - DRUGS FOR THE SKIN		
<i>acitretin oral capsule 10 mg, 17.5 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>acitretin oral capsule 25 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>secukinumab</i>)	3	PA; LD; QL (2 syringes per 28 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	3	PA; LD; QL (2 pens per 28 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	3	PA; LD; QL (1 pen per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>secukinumab</i>)	3	PA; LD; QL (1 syringe per 28 days)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	3	PA; LD; QL (1 pen per 28 days)
<i>methoxsalen rapid oral capsule</i>	1 or 1b*	LD
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>risankizumab-rzaa</i>)	3	PA; LD; QL (1 unit per 12 weeks)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>risankizumab-rzaa</i>)	3	PA; LD; QL (1 unit per 12 weeks)
SPEVIGO INTRAVENOUS SOLUTION (<i>spesolimab-sbzo</i>)	3	PA; LD; QL (2 vials per 1 year)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>spesolimab-sbzo</i>)	3	PA; LD; QL (2 syringes per 28 days)
STELARA SUBCUTANEOUS SOLUTION (<i>ustekinumab</i>)	3	PA; LD; QL (1 unit per 12 weeks)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (<i>ustekinumab</i>)	3	PA; LD; QL (1 unit per 12 weeks)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (<i>ustekinumab</i>)	3	PA; LD; QL (1 syringe per 12 weeks)
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>ixekizumab</i>)	3	PA; LD; QL (1 auto-injector per 28 days)
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>ixekizumab</i>)	3	PA; LD; QL (1 syringe per 28 days)
TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	3	PA; LD; QL (1 mL per 56 days)
TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	3	PA; LD; QL (1 pen/syringe per 28 Straight PA no ST embeddeds)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	3	PA; LD; QL (1 mL per 56 days)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (<i>guselkumab</i>)	3	PA; LD; QL (1 pen/syringe per 28 Straight PA no ST embeddeds)
*ANTIPSORIATICS*** - DRUGS FOR THE SKIN		
<i>calcipotriene external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external foam</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>calcitrene external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcitriol external ointment</i>	1 or 1b*	QL (800 grams per 28 days)
<i>tazarotene external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>tazarotene external gel</i>	1 or 1b*	QL (100 grams per 30 days)
TAZORAC EXTERNAL GEL (<i>tazarotene</i>)	3	QL (100 grams per 30 days)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3	PA; QL (60 grams per 30 days)
*ANTISEBORRHEIC PRODUCTS*** - DRUGS FOR THE SKIN		
<i>selenium sulfide external lotion</i>	1 or 1a*	QL (120 mL per 30 days)
*ANTIVIRAL TOPICAL COMBINATIONS*** - DRUGS FOR THE SKIN		
XERESE EXTERNAL CREAM (<i>acyclovir-hydrocortisone</i>)	3	PA; QL (5 gm per 30 days)
*ANTIVIRALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>acyclovir external cream</i>	1 or 1b*	PA; QL (5 gm per 30 days)
<i>acyclovir external ointment</i>	1 or 1b*	QL (30 gm per 30 days)
DENAVIR EXTERNAL CREAM (<i>penciclovir</i>)	3	PA; QL (5 gm per 30 days)
<i>penciclovir external cream</i>	1 or 1b*	PA; QL (5 gm per 30 days)
ZOVIRAX EXTERNAL OINTMENT (<i>acyclovir</i>)	3	QL (30 gm per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ATOPIC DERMATITIS - JANUS KINASE (JAK) INHIBITORS*** - DRUGS FOR THE SKIN		
OPZELURA EXTERNAL CREAM (<i>ruxolitinib phosphate</i>)	3	PA; QL (1 tube per 30 days)
*ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE SKIN		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>dupilumab</i>)	3	PA; LD
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>dupilumab</i>)	3	PA; LD
*BURN PRODUCTS*** - DRUGS FOR THE SKIN		
<i>mafenide acetate external packet</i>	1 or 1b*	
SILVADENE EXTERNAL CREAM (<i>silver sulfadiazine</i>)	3	
<i>silver sulfadiazine external cream</i>	1 or 1a*	
<i>ssd external cream</i>	1 or 1a*	
SULFAMYLON EXTERNAL CREAM (<i>mafenide acetate</i>)	3	
*CORTICOSTEROIDS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>ala-cort external cream</i>	1 or 1a*	QL (454 grams per 30 days)
<i>alclometasone dipropionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>alclometasone dipropionate external ointment</i>	1 or 1b*	QL (2 grams per 1 day)
<i>amcinonide external cream</i>	3	QL (2 grams per 1 day)
<i>betamethasone dipropionate aug external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate aug external gel</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate aug external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone dipropionate aug external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone dipropionate external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone dipropionate external ointment</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone valerate external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone valerate external foam</i>	3	ST; QL (100 grams per 30 days)
<i>betamethasone valerate external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone valerate external ointment</i>	1 or 1b*	QL (45 grams per 30 days)
<i>clobetasol propionate e external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate emulsion external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>clobetasol propionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external foam</i>	1 or 1b*	QL (100 mL per 30 days)
<i>clobetasol propionate external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external liquid</i>	1 or 1b*	QL (125 mL per 30 days)
<i>clobetasol propionate external lotion</i>	1 or 1b*	QL (118 mL per 30 days)
<i>clobetasol propionate external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external shampoo</i>	1 or 1b*	QL (3.94 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobetasol propionate external solution</i>	1 or 1b*	QL (50 mL per 30 days)
<i>clocortolone pivalate external cream</i>	3	ST; QL (90 grams per 30 days)
<i>clodan external shampoo</i>	1 or 1b*	QL (3.94 mL per 1 day)
<i>desonide external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>desonide external gel</i>	1 or 1b*	QL (2 grams per 1 day)
<i>desonide external lotion</i>	1 or 1b*	QL (118 mL per 30 days)
<i>desonide external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>desoximetasone external cream</i>	3	ST; QL (100 grams per 30 days)
<i>desoximetasone external gel</i>	3	ST; QL (60 grams per 30 days)
<i>desoximetasone external liquid</i>	3	ST; QL (100 mL per 30 days)
<i>desoximetasone external ointment</i>	3	ST; QL (100 grams per 30 days)
<i>diflorasone diacetate external cream</i>	3	ST; QL (60 grams per 30 days)
<i>diflorasone diacetate external ointment</i>	3	ST; QL (60 grams per 30 days)
<i>fluocinolone acetonide body external oil</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluocinolone acetonide external cream 0.01 %</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinolone acetonide external cream 0.025 %</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinolone acetonide external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinolone acetonide external solution</i>	1 or 1b*	QL (90 mL per 30 days)
<i>fluocinolone acetonide scalp external oil</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluocinonide emulsified base external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinonide external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>flurandrenolide external cream</i>	3	ST; QL (120 grams per 30 days)
<i>flurandrenolide external lotion</i>	3	ST; QL (120 mL per 30 days)
<i>fluticasone propionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluticasone propionate external lotion</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluticasone propionate external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>halcinonide external cream</i>	3	ST; QL (60 grams per 30 days)
<i>halobetasol propionate external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>halobetasol propionate external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>hydrocortisone butyrate external cream</i>	3	ST; QL (60 grams per 30 days)
<i>hydrocortisone butyrate external lotion</i>	3	ST; QL (3.94 mL per 1 day)
<i>hydrocortisone butyrate external ointment</i>	3	ST; QL (60 grams per 30 days)
<i>hydrocortisone butyrate external solution</i>	3	ST; QL (60 mL per 30 days)
<i>hydrocortisone external cream 2.5 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>hydrocortisone external lotion 2.5 %</i>	1 or 1a*	QL (118 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone external ointment 2.5 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>hydrocortisone valerate external cream</i>	3	ST; QL (60 grams per 30 days)
<i>hydrocortisone valerate external ointment</i>	3	ST; QL (60 grams per 30 days)
<i>mometasone furoate external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>mometasone furoate external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>mometasone furoate external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>tovet external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>triamcinolone acetonide external aerosol solution</i>	3	ST; QL (100 grams per 30 days)
<i>triamcinolone acetonide external cream</i>	1 or 1a*	QL (454 grams per 30 days)
<i>triamcinolone acetonide external lotion</i>	1 or 1a*	QL (60 mL per 30 days)
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>triamcinolone acetonide external ointment 0.05 %</i>	3	ST; QL (430 grams per 30 days)
<i>triamcinolone acetonide external ointment 0.5 %</i>	1 or 1a*	QL (30 grams per 30 days)
<i>triamcinolone in absorbase external ointment</i>	3	ST; QL (430 grams per 30 days)
<i>triderm external cream</i>	1 or 1a*	QL (454 grams per 30 days)
*DEPIGMENTING COMBINATIONS*** - DRUGS FOR THE SKIN		
TRI-LUMA EXTERNAL CREAM (<i>fluocin-hydroquinone-tretinoin</i>)	3	
*EMOLLIENT/KERATOLYTIC COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>xirun external gel</i>	3	
*ENZYMES - TOPICAL*** - DRUGS FOR THE SKIN		
NEXOBRID EXTERNAL GEL (<i>anacaulase-bcdb</i>)	3	PA; LD; QL (440 grams per 2 days)
SANTYL EXTERNAL OINTMENT (<i>collagenase</i>)	3	PA; QL (30 grams per 30 days)
*GLABELLAR LINES (FROWN LINES) AGENTS*** - DRUGS FOR THE SKIN		
BOTOX COSMETIC INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>onabotulinumtoxinA (cosmetic)</i>)	3	PA; LD
DAXXIFY INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>daxibotulinumtoxinA-lanm</i>)	3	PA; LD
JEUVEAU INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>prabotulinumtoxinA-xvfs (cosm)</i>)	3	
*IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>clotrimazole external cream</i>	1 or 1b*	QL (113 grams per 30 days)
<i>econazole nitrate external cream</i>	1 or 1b*	QL (85 grams per 30 days)
ECOZA EXTERNAL FOAM (<i>econazole nitrate</i>)	3	ST; QL (70 grams per 30 days)
ERTACZO EXTERNAL CREAM (<i>sertaconazole nitrate</i>)	3	ST; QL (60 grams per 30 days)
EXELDERM EXTERNAL CREAM (<i>sulconazole nitrate</i>)	3	ST; QL (60 grams per 30 days)
EXELDERM EXTERNAL SOLUTION (<i>sulconazole nitrate</i>)	3	ST; QL (60 mL per 30 days)
JUBLIA EXTERNAL SOLUTION (<i>efinaconazole</i>)	3	QL (8 mL per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ketoconazole external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>ketoconazole external foam</i>	3	QL (100 grams per 30 days)
<i>ketoconazole external shampoo</i>	1 or 1b*	QL (120 mL per 30 days)
<i>ketodan external foam</i>	3	QL (100 grams per 30 days)
<i>luliconazole external cream</i>	1 or 1b*	ST; QL (60 grams per 30 days)
LUZU EXTERNAL CREAM (<i>luliconazole</i>)	3	ST; QL (60 grams per 30 days)
<i>oxiconazole nitrate external cream</i>	3	ST; QL (90 grams per 30 days)
OXISTAT EXTERNAL LOTION (<i>oxiconazole nitrate</i>)	3	ST; QL (60 mL per 30 days)
<i>sulconazole nitrate external cream</i>	1 or 1b*	ST; QL (60 grams per 30 days)
<i>sulconazole nitrate external solution</i>	1 or 1b*	ST; QL (60 mL per 30 days)
*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL*** - DRUGS FOR THE SKIN		
<i>imiquimod external cream 3.75 %</i>	1 or 1b*	QL (28 units per 28 days)
<i>imiquimod external cream 5 %</i>	1 or 1b*	QL (48 packet per 365 days)
<i>imiquimod pump external cream</i>	1 or 1b*	ST; QL (1 pump bottle per 28 days)
ZYCLARA EXTERNAL CREAM (<i>imiquimod</i>)	3	ST; QL (28 units per 28 days)
ZYCLARA PUMP EXTERNAL CREAM 2.5 % (<i>imiquimod</i>)	3	ST; QL (1 pump bottle per 28 days)
ZYCLARA PUMP EXTERNAL CREAM 3.75 % (<i>imiquimod</i>)	3	ST; QL (1 bottle per 28 days)
*KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS*** - DRUGS FOR THE SKIN		
CONDYLOX EXTERNAL GEL (<i>podofilox</i>)	3	ST; QL (7 grams per 28 days)
<i>podofilox external gel</i>	1 or 1b*	QL (7 grams per 28 days)
<i>podofilox external solution</i>	1 or 1b*	QL (7 mL per 28 days)
YCANTH EXTERNAL SOLUTION (<i>cantharidin</i>)	3	PA; QL (8 applicators per 84 days)
*LINIMENTS*** - DRUGS FOR THE SKIN		
TURPENTINE EXTERNAL SPIRIT	3	
*LOCAL ANESTHETICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>dyclopro external solution</i>	3	
<i>glydo external prefilled syringe</i>	1 or 1b*	
<i>lidocaine external ointment 5 %</i>	1 or 1b*	
<i>lidocaine external patch 5 %</i>	1 or 1b*	PA; QL (3 patches per 1 day)
<i>lidocaine hcl external solution</i>	1 or 1b*	QL (10 mL per 1 day)
<i>lidocaine hcl urethral/mucosal external prefilled syringe</i>	1 or 1b*	
<i>lidocaine</i> (Tridacaine Ii External Patch)	1 or 1b*	PA; QL (3 patches per 1 day)
<i>lidocaine</i> (Tridacaine Iii External Patch)	1 or 1b*	PA; QL (3 patches per 1 day)
*MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL*** - DRUGS FOR THE SKIN		
HYFTOR EXTERNAL GEL (<i>sirolimus</i>)	3	PA; QL (1 tube per 30 days)
<i>pimecrolimus external cream</i>	1 or 1b*	ST; QL (100 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tacrolimus external ointment</i>	1 or 1b*	ST; QL (100 grams per 30 days)
*MELANOCORTIN RECEPTOR AGONISTS (UV PROTECTIVE)*** - DRUGS FOR THE SKIN		
SCENESSE SUBCUTANEOUS IMPLANT (<i>afamelanotide acetate</i>)	3	PA; LD; QL (1 implant per 2 monthss)
*MICROTUBULE INHIBITORS - TOPICAL*** - DRUGS FOR THE SKIN		
KLISYRI (250 MG) EXTERNAL OINTMENT (<i>tirbanibulin</i>)	3	
KLISYRI (350 MG) EXTERNAL OINTMENT (<i>tirbanibulin</i>)	3	
*MISC. DERMATOLOGICAL PRODUCTS*** - DRUGS FOR THE SKIN		
ILIDERM EXTERNAL EMULSION	3	
*MISC. TOPICAL*** - DRUGS FOR THE SKIN		
QBREXZA EXTERNAL PAD (<i>glycopyrronium tosylate</i>)	3	PA; QL (1 cloth per 1 day)
*OXABOROLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>tavaborole external solution</i>	1 or 1b*	ST; QL (1 bottle per 30 days)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL*** - DRUGS FOR THE SKIN		
EUCRISA EXTERNAL OINTMENT (<i>crisaborole</i>)	3	ST; QL (100 grams per 30 days)
*PHOTODYNAMIC THERAPY AGENTS - TOPICAL*** - DRUGS FOR THE SKIN		
AMELUZ EXTERNAL GEL (<i>aminolevulinic acid hcl</i>)	3	
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED (<i>aminolevulinic acid hcl</i>)	3	
*PROSTAGLANDINS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>bimatoprost external solution</i>	1 or 1b*	
LATISSE EXTERNAL SOLUTION (<i>bimatoprost</i>)	3	
*ROSACEA AGENTS*** - DRUGS FOR THE SKIN		
<i>azelaic acid external gel</i>	1 or 1b*	QL (50 grams per 30 days)
<i>brimonidine tartrate external gel</i>	1 or 1b*	QL (30 grams per 30 days)
FINACEA EXTERNAL FOAM (<i>azelaic acid</i>)	2	QL (1.67 grams per 1 day)
<i>ivermectin external cream</i>	1 or 1b*	QL (45 grams per 30 days)
METROCREAM EXTERNAL CREAM (<i>metronidazole</i>)	3	ST; QL (45 grams per 30 days)
<i>metronidazole external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>metronidazole external gel 0.75 %</i>	1 or 1b*	QL (45 grams per 30 days)
<i>metronidazole external gel 1 %</i>	1 or 1b*	QL (60 grams per 30 days)
<i>metronidazole external lotion</i>	1 or 1b*	QL (59 mL per 30 days)
MIRVASO EXTERNAL GEL (<i>brimonidine tartrate</i>)	3	QL (30 grams per 30 days)
RHOFADE EXTERNAL CREAM (<i>oxymetazoline hcl</i>)	3	QL (30 grams per 30 days)
SOOLANTRA EXTERNAL CREAM (<i>ivermectin</i>)	2	QL (45 grams per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZILXI EXTERNAL FOAM (<i>minocycline hcl micronized</i>)	2	QL (1 gram per 1 day)
*SCABICIDES & PEDICULICIDES*** - DRUGS FOR THE SKIN		
<i>crotan external lotion</i>	1 or 1b*	QL (60 grams per 30 days)
ELIMITE EXTERNAL CREAM (<i>permethrin</i>)	3	QL (120 grams per 30 days)
<i>malathion external lotion</i>	1 or 1b*	QL (4 mL per 1 day)
NATROBA EXTERNAL SUSPENSION (<i>spinosad</i>)	3	QL (120 mL per 7 days)
OVIDE EXTERNAL LOTION (<i>malathion</i>)	3	QL (4 mL per 1 day)
<i>permethrin external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>spinosad external suspension</i>	1 or 1b*	QL (120 mL per 7 days)
*SCAR TREATMENT PRODUCTS*** - DRUGS FOR THE SKIN		
COPASIL EXTERNAL GEL (<i>scar treatment products</i>)	3	
*SEBORRHEIC KERATOSIS PRODUCTS** - DRUGS FOR THE SKIN		
ESKATA EXTERNAL SOLUTION (<i>hydrogen peroxide</i>)	3	
*STEROID-LOCAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN		
EPIFOAM EXTERNAL FOAM (<i>pramoxine-hc</i>)	3	
PRAMOSONE EXTERNAL CREAM (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL LOTION (<i>pramoxine-hc</i>)	2	
*TAR PRODUCTS*** - DRUGS FOR THE SKIN		
<i>coal tar external solution</i>	1 or 1b*	
*TISSUE REPLACEMENTS*** - DRUGS FOR THE SKIN		
AMNIOFIX INJECTION SUSPENSION RECONSTITUTED (<i>amniotic membrane allograft</i>)	3	
AMNIOTEXT EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
AMPHENOL-40 INJECTION SUSPENSION RECONSTITUTED	3	
CYGNUS DUAL EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
EPICORD EXTERNAL SHEET 2 CM X 3 CM , 3 CM X 5 CM (<i>umbilical cord allograft</i>)	3	
EPIFIX EXTERNAL DISK (<i>amniotic membrane allograft</i>)	3	
EPIFIX EXTERNAL SHEET 2 CM X 2 CM , 2 CM X 3 CM , 2 CM X 4 CM , 3 CM X 3 CM , 3 CM X 5 CM , 3.5 CM X 3.5 CM , 4 CM X 3 CM , 4 CM X 4 CM , 4 CM X 6 CM , 5 CM X 5.5 CM , 5 CM X 6 CM , 7 CM X 7 CM (<i>amniotic membrane allograft</i>)	3	
EPIFIX MICRONIZED INJECTION SUSPENSION RECONSTITUTED (<i>amniotic membrane allograft</i>)	3	
KARDIAMEMBRANE EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
NEOX 100 EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
NEOX CORD 1K EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
PALINGEN FLOW INJECTION INJECTABLE (<i>amniotic memb-fluid allograft</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PALINGEN HYDROMEMBRANE EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
PALINGEN INOVFLO INJECTION INJECTABLE (<i>amniotic fluid allograft</i>)	3	
PALINGEN MEMBRANE EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
PALINGEN XPLUS HYDROMEMBRANE EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
PALINGEN XPLUS MEMBRANE EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
STRAVIX EXTERNAL SHEET (<i>amniotic membrane allograft</i>)	3	
TRUSKIN EXTERNAL SHEET 4 CM X 8 CM (<i>skin allograft (human)</i>)	3	
*TOPICAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>lidocaine-prilocaine external cream</i>	1 or 1b*	QL (30 grams per 30 days)
<i>lidocaine-prilocaine external kit</i>	1 or 1b*	QL (1 kit per 30 days)
VENIPUNCTURE PX1 PHLEBOTOMY EXTERNAL KIT (<i>lidocaine hcl-blood collection</i>)	3	
*TOPICAL SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR THE SKIN		
<i>bexarotene external gel</i>	1 or 1b*	PA; LD; QL (60 grams per 30 days)
TARGRETIN EXTERNAL GEL (<i>bexarotene</i>)	3	PA; LD; QL (60 grams per 30 days)
*TOPICAL STEROID COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>calcipotriene-betameth diprop external ointment</i>	2	ST; QL (400 grams per 28 days)
<i>calcipotriene-betameth diprop external suspension</i>	2	ST; QL (420 grams per 28 days)
DUOBRII EXTERNAL LOTION (<i>halobetasol prop-tazarotene</i>)	3	PA; QL (200 grams per 30 days)
ENSTILAR EXTERNAL FOAM (<i>calcipotriene-betameth diprop</i>)	3	QL (420 grams per 28 days)
TACLONEX EXTERNAL SUSPENSION (<i>calcipotriene-betameth diprop</i>)	3	ST; QL (420 grams per 28 days)
*TYPE II 5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE SKIN		
<i>finasteride oral tablet 1 mg</i>	1 or 1b*	
PROPECIA ORAL TABLET (<i>finasteride</i>)	3	
*WOUND CARE - GROWTH FACTOR AGENTS*** - DRUGS FOR THE SKIN		
REGRANEX EXTERNAL GEL (<i>becaplermin</i>)	3	QL (15 grams per 30 days)
*WOUND CLEANSERS/DECUBITUS ULCER THERAPY*** - DRUGS FOR THE SKIN		
LAVARE WOUND WASH EXTERNAL GEL	3	
*WOUND DRESSINGS*** - DRUGS FOR THE SKIN		
FILSUVEZ EXTERNAL GEL (<i>birch triterpenes</i>)	3	PA; LD
KENDALL HYDROGEL WOUND DRESS EXTERNAL (<i>hydroactive dressings</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAGNOSTIC PRODUCTS		
*DIAGNOSTIC TESTS***		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ACCU-CHEK GUIDE TEST IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ACCU-CHEK SMARTVIEW IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ACCUTREND GLUCOSE IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA BLUE TEST IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA TEST IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH VERIO IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
DIGESTIVE AIDS - DRUGS FOR THE STOMACH		
*DIGESTIVE ENZYMES*** - DRUGS FOR THE STOMACH		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES (<i>pancrelipase (lip-prot-amyl)</i>)	2	QL (25 capsules per 1 day)
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES (<i>pancrelipase (lip-prot-amyl)</i>)	3	ST; QL (25 capsules per 1 day)
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES (<i>pancrelipase (lip-prot-amyl)</i>)	3	ST; QL (25 capsules per 1 day)
SUCRAID ORAL SOLUTION (<i>sacrosidase</i>)	3	PA; LD; QL (360 mL per 30 days)
VIOKACE ORAL TABLET (<i>pancrelipase (lip-prot-amyl)</i>)	3	QL (25 tablets per 1 day)
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES (<i>pancrelipase (lip-prot-amyl)</i>)	2	QL (25 capsules per 1 day)
DIURETICS - DRUGS FOR THE HEART		
*CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>acetazolamide er oral capsule extended release 12 hour</i>	1 or 1b*	
<i>acetazolamide oral tablet</i>	1 or 1b*	
<i>acetazolamide sodium injection solution reconstituted</i>	1 or 1b*	
<i>dichlorphenamide oral tablet</i>	1 or 1b*	PA; LD; QL (4 tablet per 1 day)
<i>methazolamide oral tablet</i>	1 or 1b*	
<i>dichlorphenamide</i> (Ormalvi Oral Tablet)	1 or 1b*	PA; LD; QL (4 tablet per 1 day)
*DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amiloride-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>spironolactone-hctz oral tablet</i>	1 or 1b*	
<i>triamterene-hctz oral capsule</i>	1 or 1a*	
<i>triamterene-hctz oral tablet</i>	1 or 1a*	
*LOOP DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>bumetanide injection solution</i>	1 or 1b*	
<i>bumetanide oral tablet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BUMEX ORAL TABLET (<i>bumetanide</i>)	3	
EDECIN ORAL TABLET (<i>ethacrynic acid</i>)	3	
<i>ethacrynate sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>ethacrynic acid oral tablet</i>	1 or 1b*	
FUROSCIX SUBCUTANEOUS CARTRIDGE KIT (<i>furosemide</i>)	3	PA; LD; QL (6 kits per 30 days)
<i>furosemide injection solution</i>	1 or 1a*	
<i>furosemide oral solution</i>	1 or 1a*	
<i>furosemide oral tablet</i>	1 or 1a*	
LASIX ORAL TABLET (<i>furosemide</i>)	3	
<i>torseamide oral tablet</i>	1 or 1b*	
*OSMOTIC DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>mannitol intravenous solution</i>	1 or 1b*	
<i>osmitrol intravenous solution</i>	1 or 1b*	
*POTASSIUM SPARING DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
ALDACTONE ORAL TABLET (<i>spironolactone</i>)	3	
<i>amiloride hcl oral tablet</i>	1 or 1b*	
CAROSPIR ORAL SUSPENSION (<i>spironolactone</i>)	3	
<i>spironolactone oral suspension</i>	1 or 1b*	
<i>spironolactone oral tablet</i>	1 or 1a*	
<i>triamterene oral capsule</i>	1 or 1b*	
*THIAZIDES AND THIAZIDE-LIKE DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>chlorothiazide sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>chlorthalidone oral tablet</i>	1 or 1a*	
DIURIL ORAL SUSPENSION (<i>chlorothiazide</i>)	3	
<i>hydrochlorothiazide oral capsule</i>	1 or 1a*	
<i>hydrochlorothiazide oral tablet</i>	1 or 1a*	
<i>indapamide oral tablet</i>	1 or 1b*	
<i>metolazone oral tablet</i>	1 or 1b*	
THALITONE ORAL TABLET (<i>chlorthalidone</i>)	3	
ENDOCRINE AND METABOLIC AGENTS - MISC. - HORMONES		
*ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR WOMEN		
MIFEPREX ORAL TABLET (<i>mifepristone</i>)	3	\$0 for Fully insured members in California
<i>mifepristone oral tablet 200 mg</i>	1 or 1b*	\$0 for Fully insured members in California

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ACID SPHINGOMYELINASE DEFICIENCY (ASMD) - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
XENPOZYME INTRAVENOUS SOLUTION RECONSTITUTED (<i>olipudase alfa-rpcp</i>)	3	PA; LD
*ADENOSINE DEAMINASE SCID TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
REVCovi INTRAMUSCULAR SOLUTION (<i>elapegademase-lvlr</i>)	3	PA; LD
*ALPHA-MANNOSIDOSIS TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
LAMZEDE INTRAVENOUS SOLUTION RECONSTITUTED (<i>velmanase alfa-tycv</i>)	3	PA; LD
*BISPHOSPHONATES*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
ACTONEL ORAL TABLET 150 MG (<i>risedronate sodium</i>)	3	QL (0.04 tablets per 1 day)
ACTONEL ORAL TABLET 35 MG (<i>risedronate sodium</i>)	3	QL (4 tablets per 28 days)
<i>alendronate sodium oral solution</i>	1 or 1b*	QL (10.72 mg per 1 day)
<i>alendronate sodium oral tablet 10 mg, 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>alendronate sodium oral tablet 35 mg, 70 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
AELVIA ORAL TABLET DELAYED RELEASE (<i>risedronate sodium</i>)	3	QL (4 tablets per 28 days)
BINOSTO ORAL TABLET EFFERVESCENT (<i>alendronate sodium</i>)	3	QL (4 tablets per 28 days)
FOSAMAX ORAL TABLET (<i>alendronate sodium</i>)	3	QL (4 tablets per 28 days)
FOSAMAX PLUS D ORAL TABLET (<i>alendronate-cholecalciferol</i>)	2	QL (0.15 tablets per 1 day)
<i>ibandronate sodium intravenous solution</i>	1 or 1b*	LD
<i>ibandronate sodium oral tablet</i>	1 or 1b*	QL (1 tablet per 28 days)
<i>pamidronate disodium intravenous solution 30 mg/10ml, 90 mg/10ml</i>	1 or 1b*	LD
PAMIDRONATE DISODIUM INTRAVENOUS SOLUTION 6 MG/ML	3	LD
RECLAST INTRAVENOUS SOLUTION (<i>zoledronic acid</i>)	3	PA; LD; QL (100 mL per 375 days)
<i>risedronate sodium oral tablet 150 mg</i>	1 or 1b*	QL (0.04 tablets per 1 day)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>risedronate sodium oral tablet 35 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
<i>risedronate sodium oral tablet delayed release</i>	1 or 1b*	QL (4 tablets per 28 days)
<i>zoledronic acid intravenous concentrate</i>	1 or 1b*	PA; LD
ZOLEDRONIC ACID INTRAVENOUS SOLUTION 4 MG/100ML	3	PA; LD
<i>zoledronic acid intravenous solution 5 mg/100ml</i>	1 or 1b*	PA; LD; QL (100 mL per 375 days)
*CALCIMIMETIC AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
<i>cinacalcet hcl oral tablet 90 mg</i>	1 or 1b*	PA; LD; QL (4 tablets per 1 day)
PARSABIV INTRAVENOUS SOLUTION (<i>etelcalcetide hcl</i>)	3	PA; LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CALCITONINS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>calcitonin (salmon) injection solution</i>	1 or 1b*	LD
<i>calcitonin (salmon) nasal solution</i>	1 or 1b*	QL (0.13 mL per 1 day)
MIACALCIN INJECTION SOLUTION (<i>calcitonin (salmon)</i>)	3	LD
*CARNITINE REPLENISHER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
CARNITOR INTRAVENOUS SOLUTION (<i>levocarnitine</i>)	3	
CARNITOR ORAL SOLUTION (<i>levocarnitine</i>)	3	
CARNITOR ORAL TABLET (<i>levocarnitine</i>)	3	
CARNITOR SF ORAL SOLUTION (<i>levocarnitine</i>)	3	
<i>levocarnitine intravenous solution</i>	1 or 1b*	
<i>levocarnitine oral solution</i>	1 or 1b*	
<i>levocarnitine oral tablet</i>	1 or 1b*	
<i>levocarnitine sf oral solution</i>	1 or 1b*	
*CKD AGENT-SODIUM/HYDROGEN EXCHANGER 3 (NHE3) INHIBITOR*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
XPHOZAH ORAL TABLET (<i>tenapanor hcl (ckd)</i>)	3	PA; QL (2 tablets per 1 day)
*CORTICOTROPIN*** - HORMONES		
ACTHAR GEL SUBCUTANEOUS AUTO-INJECTOR (<i>corticotropin</i>)	3	PA; LD
ACTHAR INJECTION GEL (<i>corticotropin</i>)	3	PA; LD
CORTROPHIN INJECTION GEL (<i>corticotropin</i>)	3	PA; LD
*CORTISOL SYNTHESIS INHIBITORS*** - HORMONES		
ISTURISA ORAL TABLET (<i>osilodrostat phosphate</i>)	3	PA; LD; QL (4 tablets per 1 day)
*DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR WOMEN		
<i>cabergoline oral tablet</i>	1 or 1b*	QL (0.58 tablets per 1 day)
*FABRY DISEASE - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
ELFABRIO INTRAVENOUS SOLUTION (<i>pegunigalsidase alfa-iwxj</i>)	3	PA; LD
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED (<i>agalsidase beta</i>)	3	PA; LD
GALAFOLD ORAL CAPSULE (<i>migalastat hcl</i>)	3	PA; LD; QL (14 capsules per 30 days)
*GAA DEFICIENCY TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
LUMIZYME INTRAVENOUS SOLUTION RECONSTITUTED (<i>alglucosidase alfa</i>)	3	PA; LD
NEXVIAZYME INTRAVENOUS SOLUTION RECONSTITUTED (<i>avalglucosidase alfa-ngpt</i>)	3	PA; LD
OPFOLDA ORAL CAPSULE (<i>miglustat (gaa deficiency)</i>)	3	PA; LD; QL (8 capsules per 28 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POMBILITI INTRAVENOUS SOLUTION RECONSTITUTED (<i>cipaglucosidase alfa-atga</i>)	3	PA; LD
*GNRH/LHRH ANTAGONISTS*** - DRUGS FOR WOMEN		
<i>cetorelix acetate subcutaneous kit</i>	1 or 1b*	PA; LD
CETROTIDE SUBCUTANEOUS KIT (<i>cetorelix acetate</i>)	3	PA; LD
<i>fyremadel subcutaneous solution prefilled syringe</i>	1 or 1b*	PA; LD
GANIRELIX ACETATE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	3	PA; LD
ORLISSA ORAL TABLET 150 MG (<i>elagolix sodium</i>)	2	PA; QL (1 tablet per 1 day)
ORLISSA ORAL TABLET 200 MG (<i>elagolix sodium</i>)	2	PA; QL (2 tablets per 1 day)
*GROWTH HORMONE RECEPTOR ANTAGONISTS*** - DRUGS FOR GROWTH		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>pegvisomant</i>)	3	PA; LD; QL (1 vial per 1 day)
*GROWTH HORMONE RELEASING HORMONES (GHRH)*** - DRUGS FOR GROWTH		
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>tesamorelin acetate</i>)	3	PA; LD; QL (1 package per 30 days)
*GROWTH HORMONES*** - DRUGS FOR GROWTH		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (<i>somatropin</i>)	3	PA; LD; QL (1 syringe per 1 day)
GENOTROPIN SUBCUTANEOUS CARTRIDGE (<i>somatropin</i>)	3	PA; LD; QL (1 vial per 1 day)
HUMATROPE INJECTION CARTRIDGE 12 MG, 6 MG (<i>somatropin</i>)	3	PA; LD; QL (1 vial per 1 day)
HUMATROPE INJECTION CARTRIDGE 24 MG (<i>somatropin</i>)	3	PA; LD; QL (1 injection per 1 day)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG (<i>somatropin (non-refrigerated)</i>)	3	PA; LD; QL (1 vial per 1 day)
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 5 MG, 6 MG (<i>somatropin (non-refrigerated)</i>)	3	PA; LD; QL (1 solution per 1 day)
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 7.6 MG, 9.1 MG (<i>lonapegsomatropin-tcgd</i>)	3	PA; LD; QL (8 cartridges per 28 days)
SKYTROFA SUBCUTANEOUS CARTRIDGE 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG (<i>lonapegsomatropin-tcgd</i>)	3	PA; LD; QL (4 cartridges per 28 days)
*HEREDITARY OROTIC ACIDURIA TREATMENT - AGENTS** - DRUGS FOR MENOPAUSE AND BONE LOSS		
XURIDEN ORAL PACKET (<i>uridine triacetate</i>)	3	PA; LD; QL (4 packets per 1 day)
*HEREDITARY TYROSINEMIA TYPE 1 (HT-1) TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>nitisinone oral capsule</i>	1 or 1b*	PA; LD
NITYR ORAL TABLET (<i>nitisinone</i>)	3	PA; LD
ORFADIN ORAL CAPSULE (<i>nitisinone</i>)	3	PA; LD
ORFADIN ORAL SUSPENSION (<i>nitisinone</i>)	3	PA; LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*HOMOCYSTINURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>betaine oral powder</i>	1 or 1b*	LD
CYSTADANE ORAL POWDER (<i>betaine</i>)	3	LD
*HYPERAMMONEMIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>carglumic acid oral tablet soluble</i>	1 or 1b*	PA; LD
*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>calcitriol intravenous solution</i>	1 or 1b*	PA
<i>calcitriol oral capsule</i>	1 or 1b*	PA
<i>calcitriol oral solution</i>	1 or 1b*	PA
<i>doxercalciferol intravenous solution</i>	1 or 1b*	PA
<i>doxercalciferol oral capsule</i>	1 or 1b*	PA
HECTOROL INTRAVENOUS SOLUTION (<i>doxercalciferol</i>)	3	PA
<i>paricalcitol intravenous solution</i>	1 or 1b*	PA
<i>paricalcitol oral capsule</i>	1 or 1b*	PA
RAYALDEE ORAL CAPSULE EXTENDED RELEASE (<i>calcifediol</i>)	3	PA; QL (2 tablets per 1 day)
ZEMPLAR INTRAVENOUS SOLUTION (<i>paricalcitol</i>)	3	PA
ZEMPLAR ORAL CAPSULE (<i>paricalcitol</i>)	3	PA
*HYPOPHOSPHATASIA (HPP) AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
STRENSIQ SUBCUTANEOUS SOLUTION (<i>asfotase alfa</i>)	3	PA; LD
*INSULIN-LIKE GROWTH FACTOR-1 RECEPTOR INHIBITORS(IGF-1R)*** - DRUGS FOR THYROID		
TEPEZZA INTRAVENOUS SOLUTION RECONSTITUTED (<i>teprotumumab-trbw</i>)	3	PA; LD; QL (8 fills per 168 days)
*INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)*** - HORMONES		
INCRELEX SUBCUTANEOUS SOLUTION (<i>mecasermin</i>)	3	PA; LD
*LEPTIN ANALOGUES*** - HORMONES		
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>metreleptin</i>)	3	PA; LD; QL (1 vial per 1 day)
*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS*** - DRUGS FOR WOMEN		
FENSOLVI (6 MONTH) SUBCUTANEOUS KIT (<i>leuprolide acetate (6 month)</i>)	3	PA; LD; QL (1 kit per 24 weekss)
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG (<i>leuprolide acetate</i>)	3	PA; LD; QL (1 kit per 28 days)
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG (<i>leuprolide acetate</i>)	3	PA; LD; QL (1 syringe kit per 28 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (<i>leuprolide acetate (3 month)</i>)	3	PA; LD; QL (1 kit per 12 weekss)
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 30 MG (<i>leuprolide acetate (3 month)</i>)	3	PA; LD; QL (1 kit per 84 days)
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT (<i>leuprolide acetate (6 month)</i>)	3	PA; LD; QL (1 kit per 24 weekss)
SUPPRELIN LA SUBCUTANEOUS KIT (<i>histrelin acetate</i>)	3	PA; LD; QL (1 kit per 365 days)
SYNAREL NASAL SOLUTION (<i>nafarelin acetate</i>)	3	PA; LD; QL (5 bottle per 30 days)
TRIPTODUR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER (<i>triptorelin pamoate</i>)	3	PA; LD; QL (1 vial per 168 days)
*LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
KANUMA INTRAVENOUS SOLUTION (<i>sebelipase alfa</i>)	3	PA; LD
*MOLYBDENUM COFACTOR DEFICIENCY (MOCD) - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
NULIBRY INTRAVENOUS SOLUTION RECONSTITUTED (<i>fosdenopterin hydrobromide</i>)	3	PA; LD
*MUCOPOLYSACCHARIDOSIS I (MPS I) - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
ALDURAZYME INTRAVENOUS SOLUTION (<i>laronidase</i>)	3	PA; LD
*MUCOPOLYSACCHARIDOSIS II (MPS II) - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
ELAPRASE INTRAVENOUS SOLUTION (<i>idursulfase</i>)	3	PA; LD
*MUCOPOLYSACCHARIDOSIS IV (MPS IV) - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
VIMIZIM INTRAVENOUS SOLUTION (<i>elosulfase alfa</i>)	3	PA; LD
*MUCOPOLYSACCHARIDOSIS VI (MPS VI) - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
NAGLAZYME INTRAVENOUS SOLUTION (<i>galsulfase</i>)	3	PA; LD
*MUCOPOLYSACCHARIDOSIS VII (MPS VII) - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
MEPSEVII INTRAVENOUS SOLUTION (<i>vestronidase alfa-vjvk</i>)	3	PA; LD
*NATRIURETIC PEPTIDES*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>vosoritide</i>)	3	PA; LD; QL (1 vial per 1 day)
*NEUROKININ 3 (NK3) RECEPTOR ANTAGONISTS*** - HORMONES		
VEOZAH ORAL TABLET (<i>fezolinetant</i>)	3	PA; QL (1 tablet per 1 day)
*NON-STEROIDAL MINERALOCORTICOID RECEPTOR ANTAGONISTS*** - HORMONES		
KERENDIA ORAL TABLET (<i>finerenone</i>)	3	PA; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*OVULATION STIMULANTS-GONADOTROPINS*** - DRUGS FOR WOMEN		
CHORIONIC GONADOTROPIN INTRAMUSCULAR SOLUTION RECONSTITUTED	3	PA; LD
GONAL-F INJECTION SOLUTION RECONSTITUTED (<i>follitropin alfa</i>)	3	PA; LD
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>follitropin alfa</i>)	3	PA; LD
GONAL-F RFF SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>follitropin alfa</i>)	3	PA; LD
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>menotropins</i>)	3	PA; LD
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chorionic gonadotropin</i>)	2	PA; LD
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>choriogonadotropin alfa</i>)	3	PA; LD
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chorionic gonadotropin</i>)	3	PA; LD
*OVULATION STIMULANTS-SYNTHETIC*** - DRUGS FOR WOMEN		
<i>clomiphene citrate</i> (Clomid Oral Tablet)	1 or 1b*	PA
<i>clomiphene citrate oral tablet</i>	1 or 1b*	PA
*PARATHYROID HORMONE AND DERIVATIVES*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>teriparatide</i>)	3	LD; QL (1 pen per 28 days)
<i>teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml</i>	3	LD; QL (1 pen per 28 days)
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML	3	LD; QL (1 pen per 28 days)
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>abaloparatide</i>)	3	LD; QL (1 pen per 30 days)
*PHENYLKETONURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>sapropterin dihydrochloride</i> (Javygtor Oral Packet)	1 or 1b*	PA; LD
<i>sapropterin dihydrochloride</i> (Javygtor Oral Tablet)	1 or 1b*	PA; LD
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 2.5 MG/0.5ML (<i>pegvaliase-pqpz</i>)	3	PA; LD
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (<i>pegvaliase-pqpz</i>)	3	PA; LD; QL (1 syringe per 1 day)
<i>sapropterin dihydrochloride oral packet</i>	1 or 1b*	PA; LD
<i>sapropterin dihydrochloride oral tablet</i>	1 or 1b*	PA; LD
*RANK LIGAND (RANKL) INHIBITORS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>denosumab</i>)	3	PA; LD; QL (1 syringe per 180 days)
XGEVA SUBCUTANEOUS SOLUTION (<i>denosumab</i>)	3	PA; LD; QL (1 vial per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SCLEROSTIN INHIBITORS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
EVENITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>romosozumab-aqqg</i>)	3	PA; LD; QL (2 syringes per 30 days)
*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
EVISTA ORAL TABLET (<i>raloxifene hcl</i>)	3; \$0	QL (1 tablet per 1 day)
OSPHENA ORAL TABLET (<i>ospemifene</i>)	3	PA; QL (1 tablet per 1 day)
<i>raloxifene hcl oral tablet</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
*SELECTIVE VASOPRESSIN V2-RECEPTOR ANTAGONISTS*** - HORMONES		
JYNARQUE ORAL TABLET (<i>tolvaptan</i>)	3	PA; LD; QL (4 tablets per 1 day)
JYNARQUE ORAL TABLET THERAPY PACK (<i>tolvaptan</i>)	3	PA; LD; QL (1 carton per 28 days)
<i>tolvaptan oral tablet 15 mg</i>	1 or 1b*	PA; LD; QL (1 tablet per 1 day)
<i>tolvaptan oral tablet 30 mg</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
*SOMATOSTATIC AGENTS*** - DRUGS FOR GROWTH		
LANREOTIDE ACETATE SUBCUTANEOUS SOLUTION	3	PA; LD; QL (1 syringe/vial per 28 days)
MYCAPSSA ORAL CAPSULE DELAYED RELEASE (<i>octreotide acetate</i>)	3	PA; LD; QL (4 capsules per 1 day)
<i>octreotide acetate injection solution</i>	1 or 1b*	PA; LD
<i>octreotide acetate intramuscular kit 20 mg</i>	1 or 1b*	PA; LD; QL (2 kits per 28 days)
<i>octreotide acetate intramuscular kit 30 mg</i>	1 or 1b*	PA; LD; QL (1 kit per 28 days)
<i>octreotide acetate subcutaneous solution prefilled syringe</i>	1 or 1b*	PA; LD
SANDOSTATIN INJECTION SOLUTION (<i>octreotide acetate</i>)	3	PA; LD
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 30 MG (<i>octreotide acetate</i>)	3	PA; LD; QL (1 kit per 28 days)
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 20 MG (<i>octreotide acetate</i>)	3	PA; LD; QL (2 kits per 28 days)
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER (<i>pasireotide pamoate</i>)	3	PA; LD; QL (1 kit per 28 days)
SIGNIFOR SUBCUTANEOUS SOLUTION (<i>pasireotide diaspertate</i>)	3	PA; LD; QL (2 mL per 1 day)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION (<i>lanreotide acetate</i>)	3	PA; LD; QL (1 syringe/vial per 28 days)
*UREA CYCLE DISORDER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
AMMONUL INTRAVENOUS SOLUTION (<i>sod benz-sod phenylacet</i>)	3	
OLPRUVA (2 GM DOSE) ORAL THERAPY PACK (<i>sodium phenylbutyrate</i>)	3	PA; LD; QL (1 kit per 30 days)
OLPRUVA (3 GM DOSE) ORAL THERAPY PACK (<i>sodium phenylbutyrate</i>)	3	PA; LD; QL (1 kit per 30 days)
OLPRUVA (4 GM DOSE) ORAL THERAPY PACK (<i>sodium phenylbutyrate</i>)	3	PA; LD; QL (1 kit per 30 days)
OLPRUVA (5 GM DOSE) ORAL THERAPY PACK (<i>sodium phenylbutyrate</i>)	3	PA; LD; QL (1 kit per 30 days)
OLPRUVA (6 GM DOSE) ORAL THERAPY PACK (<i>sodium phenylbutyrate</i>)	3	PA; LD; QL (1 kit per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OLPRUVA (6.67 GM DOSE) ORAL THERAPY PACK (<i>sodium phenylbutyrate</i>)	3	PA; LD; QL (1 kit per 30 days)
PHEBURANE ORAL PELLETT (<i>sodium phenylbutyrate</i>)	3	PA; LD; QL (8 bottles per 30 days)
RAVICTI ORAL LIQUID (<i>glycerol phenylbutyrate</i>)	3	PA; LD; QL (17.5 mL per 1 day)
<i>sod benz-sod phenylacet intravenous solution</i>	1 or 1b*	
<i>sodium phenylbutyrate oral powder</i>	1 or 1b*	PA; LD; QL (25 GM per 1 day)
<i>sodium phenylbutyrate oral tablet</i>	1 or 1b*	PA; LD; QL (40 tablets per 1 day)
*VASOPRESSIN*** - HORMONES		
DDAVP INJECTION SOLUTION (<i>desmopressin acetate</i>)	3	LD
DDAVP ORAL TABLET 0.1 MG (<i>desmopressin acetate</i>)	3	LD; DO
DDAVP ORAL TABLET 0.2 MG (<i>desmopressin acetate</i>)	3	LD; QL (6 tablets per 1 day)
DDAVP PF INJECTION SOLUTION (<i>desmopressin acetate</i>)	3	LD
<i>desmopressin ace spray refrig nasal solution</i>	1 or 1b*	
<i>desmopressin acetate injection solution</i>	1 or 1b*	LD
DESMOPRESSIN ACETATE NASAL SOLUTION	3	LD; QL (5 mL per 30 days)
<i>desmopressin acetate oral tablet 0.1 mg</i>	1 or 1b*	LD; DO
<i>desmopressin acetate oral tablet 0.2 mg</i>	1 or 1b*	LD; QL (6 tablets per 1 day)
<i>desmopressin acetate pf injection solution</i>	1 or 1b*	LD
<i>desmopressin acetate spray nasal solution</i>	1 or 1b*	
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL (<i>desmopressin acetate</i>)	3	PA; LD; QL (1 tablet per 1 day)
TERLIVAZ INTRAVENOUS SOLUTION RECONSTITUTED (<i>terlipressin acetate</i>)	3	
<i>vasopressin +rfid intravenous solution</i>	1 or 1b*	
<i>vasopressin intravenous solution</i>	1 or 1b*	
<i>vasopressin-sodium chloride intravenous solution</i>	3	
VASOSTRICT INTRAVENOUS SOLUTION (<i>vasopressin</i>)	3	
*X-LINKED HYPOPHOSPHATEMIA (XLH) TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
CRYSVITA SUBCUTANEOUS SOLUTION 10 MG/ML (<i>burosumab-twza</i>)	3	PA; LD; QL (2 vials per 28 days)
CRYSVITA SUBCUTANEOUS SOLUTION 20 MG/ML (<i>burosumab-twza</i>)	3	PA; LD; QL (8 vials per 28 days)
CRYSVITA SUBCUTANEOUS SOLUTION 30 MG/ML (<i>burosumab-twza</i>)	3	PA; LD; QL (6 vials per 28 days)
ESTROGENS - HORMONES		
*ESTROGEN & PROGESTIN*** - DRUGS FOR WOMEN		
ACTIVELLA ORAL TABLET (<i>estradiol-norethindrone acet</i>)	3	
ANGELIQ ORAL TABLET (<i>drospirenone-estradiol</i>)	3	
BIJUVA ORAL CAPSULE (<i>estradiol-progesterone</i>)	2	QL (1 capsule per 1 day)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY (<i>estradiol-levonorgestrel</i>)	2	QL (4 patch per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY (<i>estradiol-norethindrone acet</i>)	2	QL (8 patch per 28 days)
<i>estradiol-norethindrone acet oral tablet</i>	1 or 1b*	
<i>fyavolv oral tablet</i>	1 or 1b*	
<i>jinteli oral tablet</i>	1 or 1b*	
<i>mimvey oral tablet</i>	1 or 1b*	
<i>norethindrone-eth estradiol oral tablet</i>	1 or 1b*	
PREMPHASE ORAL TABLET (<i>conj estrogen-medroxyprogesterone ace</i>)	2	
PREMPRO ORAL TABLET (<i>conj estrogen-medroxyprogesterone ace</i>)	2	
*ESTROGEN-PROGESTIN-GNRH ANTAGONIST*** - DRUGS FOR WOMAN		
MYFEMBREE ORAL TABLET (<i>relugolix-estradiol-norethind</i>)	3	PA; QL (1 tablet per 1 day)
ORIAHNN ORAL CAPSULE THERAPY PACK (<i>elagolix-estradiol-norethind</i>)	3	PA; QL (1 carton per 28 days)
*ESTROGENS*** - DRUGS FOR WOMEN		
ALORA TRANSDERMAL PATCH TWICE WEEKLY (<i>estradiol</i>)	3	QL (8 patch per 28 days)
CLIMARA TRANSDERMAL PATCH WEEKLY (<i>estradiol</i>)	3	QL (4 patches per 28 days)
DELESTROGEN INTRAMUSCULAR OIL (<i>estradiol valerate</i>)	3	
DEPO-ESTRADIOL INTRAMUSCULAR OIL (<i>estradiol cypionate</i>)	3	
DIVIGEL TRANSDERMAL GEL 0.25 MG/0.25GM, 0.5 MG/0.5GM, 0.75 MG/0.75GM, 1 MG/GM (<i>estradiol</i>)	3	QL (1 packet per 1 day)
DIVIGEL TRANSDERMAL GEL 1.25 MG/1.25GM (<i>estradiol</i>)	3	QL (30 packets per 30 days)
<i>dotti transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
ELESTRIN TRANSDERMAL GEL (<i>estradiol</i>)	3	QL (52 grams per 30 days)
<i>estradiol oral tablet</i>	1 or 1b*	
<i>estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm</i>	1 or 1b*	QL (1 packet per 1 day)
<i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i>	1 or 1b*	QL (50 grams per 30 days)
<i>estradiol transdermal gel 1.25 mg/1.25gm</i>	1 or 1b*	QL (30 packets per 30 days)
<i>estradiol transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
<i>estradiol transdermal patch weekly</i>	1 or 1b*	QL (4 patches per 28 days)
<i>estradiol valerate intramuscular oil</i>	1 or 1b*	
ESTROGEL TRANSDERMAL GEL (<i>estradiol</i>)	3	QL (50 grams per 30 days)
EVAMIST TRANSDERMAL SOLUTION (<i>estradiol</i>)	2	QL (16.2 mL per 30 days)
<i>lyllana transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
MENEST ORAL TABLET (<i>esterified estrogens</i>)	2	
MENOSTAR TRANSDERMAL PATCH WEEKLY (<i>estradiol</i>)	3	QL (4 patches per 28 days)
PREMARIN INJECTION SOLUTION RECONSTITUTED (<i>estrogens conjugated</i>)	2	
PREMARIN ORAL TABLET (<i>estrogens conjugated</i>)	2	QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MODULATOR COMB*** - DRUGS FOR WOMEN		
DUAVEE ORAL TABLET (<i>conj estrogens-bazedoxifene</i>)	3	PA; QL (1 tablet per 1 day)
FLUOROQUINOLONES - DRUGS FOR INFECTIONS		
*FLUOROQUINOLONES*** - ANTIBIOTICS		
BAXDELA INTRAVENOUS SOLUTION RECONSTITUTED (<i>delafloxacin meglumine</i>)	3	
BAXDELA ORAL TABLET (<i>delafloxacin meglumine</i>)	3	PA
CIPRO ORAL SUSPENSION RECONSTITUTED (<i>ciprofloxacin</i>)	3	
CIPRO ORAL TABLET (<i>ciprofloxacin hcl</i>)	3	
<i>ciprofloxacin hcl oral tablet</i>	1 or 1b*	
<i>ciprofloxacin in d5w intravenous solution</i>	1 or 1b*	
<i>levofloxacin in d5w intravenous solution</i>	1 or 1b*	
<i>levofloxacin intravenous solution</i>	1 or 1b*	QL (1 fill per 30 days)
<i>levofloxacin oral solution</i>	1 or 1b*	
<i>levofloxacin oral tablet</i>	1 or 1b*	
<i>moxifloxacin hcl in nacl intravenous solution</i>	1 or 1b*	
MOXIFLOXACIN HCL INTRAVENOUS SOLUTION	3	
<i>moxifloxacin hcl oral tablet</i>	1 or 1b*	
<i>ofloxacin oral tablet</i>	1 or 1b*	
GASTROINTESTINAL AGENTS - MISC. - DRUGS FOR THE STOMACH		
*BILE ACID SYNTHESIS DISORDER AGENTS*** - DRUGS FOR THE STOMACH		
CHOLBAM ORAL CAPSULE (<i>cholic acid</i>)	3	PA; LD; QL (4 capsule per 1 day)
*FARNESOID X RECEPTOR (FXR) AGONISTS*** - DRUGS FOR THE STOMACH		
OALIVA ORAL TABLET (<i>obeticholic acid</i>)	3	PA; LD; QL (1 tablet per 1 day)
*GALLSTONE SOLUBILIZING AGENTS*** - DRUGS FOR THE STOMACH		
URSO FORTE ORAL TABLET (<i>ursodiol</i>)	3	
<i>ursodiol oral capsule 300 mg</i>	1 or 1b*	
<i>ursodiol oral tablet</i>	1 or 1b*	
*GASTROINTESTINAL ANTIALLERGY AGENTS*** - DRUGS FOR THE STOMACH		
<i>cromolyn sodium oral concentrate</i>	1 or 1b*	
GASTROCROM ORAL CONCENTRATE (<i>cromolyn sodium</i>)	3	
*GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME		
<i>lubiprostone oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*GASTROINTESTINAL STIMULANTS*** - DRUGS FOR THE STOMACH		
GIMOTI NASAL SOLUTION (<i>metoclopramide hcl</i>)	3	PA; QL (1 bottle per 4 weekss)
<i>metoclopramide hcl injection solution</i>	1 or 1a*	
<i>metoclopramide hcl oral solution</i>	1 or 1a*	QL (60 mL per 1 day)
<i>metoclopramide hcl oral tablet 10 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>metoclopramide hcl oral tablet 5 mg</i>	1 or 1a*	QL (12 tablets per 1 day)
<i>metoclopramide hcl oral tablet dispersible</i>	1 or 1a*	ST; QL (12 tablets per 1 day)
REGLAN ORAL TABLET 10 MG (<i>metoclopramide hcl</i>)	3	QL (6 tablets per 1 day)
REGLAN ORAL TABLET 5 MG (<i>metoclopramide hcl</i>)	3	QL (12 tablets per 1 day)
*GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS*** - DRUGS FOR THE STOMACH		
GATTEX SUBCUTANEOUS KIT (<i>teduglutide (rdna)</i>)	3	PA; LD
*HEPATOTROPICS - THYROID HORMONE RECEPTOR-BETA AGONISTS*** - DRUGS FOR THE STOMACH		
REZDIFFRA ORAL TABLET (<i>resmetirom</i>)	3	PA; LD; QL (1 tablet per 1 day)
*IBS AGENT - GUANYLATE CYCLASE-C (GC-C) AGONISTS*** - DRUGS FOR CONSTIPATION		
LINZESS ORAL CAPSULE (<i>linaclotide</i>)	2	QL (1 capsule per 1 day)
*IBS AGENT - MU-OPIOID RECEPTOR AGONISTS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME		
VIBERZI ORAL TABLET (<i>eluxadoline</i>)	3	PA; QL (2 tablets per 1 day)
*IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME		
<i>alosetron hcl oral tablet</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
*ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS*** - DRUGS FOR THE STOMACH		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (<i>odevixibat</i>)	3	PA; LD; QL (30 pellets per 1 day)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (<i>odevixibat</i>)	3	PA; LD; QL (10 pellets per 1 day)
BYLVAY ORAL CAPSULE 1200 MCG (<i>odevixibat</i>)	3	PA; LD; QL (5 capsules per 1 day)
BYLVAY ORAL CAPSULE 400 MCG (<i>odevixibat</i>)	3	PA; LD; QL (15 capsules per 1 day)
LIVMARLI ORAL SOLUTION 19 MG/ML (<i>maralixibat chloride</i>)	3	PA; LD; QL (60 mL per 30 days)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (<i>maralixibat chloride</i>)	3	PA; LD; QL (90 mL per 30 days)
*INFLAMMATORY BOWEL AGENTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR (<i>mesalamine</i>)	3	ST; QL (4 capsule per 1 day)
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE (<i>sulfasalazine</i>)	3	QL (8 tablet per 1 day)
AZULFIDINE ORAL TABLET (<i>sulfasalazine</i>)	3	QL (8 tablet per 1 day)
<i>balsalazide disodium oral capsule</i>	1 or 1b*	QL (9 capsule per 1 day)
CANASA RECTAL SUPPOSITORY (<i>mesalamine</i>)	3	QL (1 suppository per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DELZICOL ORAL CAPSULE DELAYED RELEASE (<i>mesalamine</i>)	3	ST; QL (6 tablets per 1 day)
DIPENTUM ORAL CAPSULE (<i>olsalazine sodium</i>)	3	ST; QL (4 capsule per 1 day)
<i>mesalamine er oral capsule extended release</i>	1 or 1b*	QL (8 capsule per 1 day)
<i>mesalamine er oral capsule extended release 24 hour</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>mesalamine oral capsule delayed release</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>mesalamine oral tablet delayed release 1.2 gm</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>mesalamine oral tablet delayed release 800 mg</i>	1 or 1b*	QL (6 tablet per 1 day)
<i>mesalamine rectal enema</i>	1 or 1b*	QL (60 mL per 1 day)
<i>mesalamine rectal suppository</i>	1 or 1b*	QL (1 suppository per 1 day)
<i>mesalamine-cleanser rectal kit</i>	1 or 1b*	QL (1 kit per 30 days)
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG (<i>mesalamine</i>)	2	QL (16 capsule per 1 day)
PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG (<i>mesalamine</i>)	3	ST; QL (8 capsule per 1 day)
ROWASA RECTAL KIT (<i>mesalamine-cleanser</i>)	3	QL (1 kit per 30 days)
SFROWASA RECTAL ENEMA (<i>mesalamine</i>)	3	QL (60 mL per 1 day)
<i>sulfasalazine oral tablet</i>	1 or 1b*	QL (8 tablet per 1 day)
<i>sulfasalazine oral tablet delayed release</i>	1 or 1b*	QL (8 tablet per 1 day)
*INTEGRIN RECEPTOR ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED (<i>vedolizumab</i>)	3	PA; LD; QL (1 vial per 56 days)
*INTERLEUKIN ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
SKYRIZI INTRAVENOUS SOLUTION (<i>risankizumab-rzaa</i>)	3	PA; LD; QL (30 mL per 365 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE (<i>risankizumab-rzaa</i>)	3	PA; LD; QL (1 kit per 56 days)
STELARA INTRAVENOUS SOLUTION (<i>ustekinumab</i>)	3	PA; LD; QL (4 vial per 365 days)
*INTESTINAL ACIDIFIERS*** - DRUGS FOR THE STOMACH		
<i>enulose oral solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>generlac oral solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>lactulose encephalopathy oral solution</i>	1 or 1b*	QL (60 mL per 30 days)
*LIVE FECAL MICROBIOTA (HUMAN)** - DRUGS FOR THE STOMACH		
REBYOTA RECTAL SUSPENSION (<i>fecal microbiota, live-jslm</i>)	3	PA; LD; QL (1 carton per 1 lifetime)
VOWST ORAL CAPSULE (<i>fecal microb spores, live-brpk</i>)	3	PA; LD; QL (12 capsules per 1 lifetime)
*PERIPHERAL OPIOID RECEPTOR ANTAGONISTS*** - DRUGS FOR THE STOMACH		
<i>alvimopan oral capsule</i>	1 or 1b*	
MOVANTIK ORAL TABLET (<i>naloxegol oxalate</i>)	2	QL (1 tablet per 1 day)
RELISTOR ORAL TABLET (<i>methylnaltrexone bromide</i>)	3	ST; QL (3 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELISTOR SUBCUTANEOUS SOLUTION (<i>methylnaltrexone bromide</i>)	3	ST; QL (1 syringe per 1 day)
SYMPROIC ORAL TABLET (<i>naldemedine tosylate</i>)	3	ST; QL (1 tablet per 1 day)
*PHOSPHATE BINDER AGENTS*** - DRUGS FOR THE STOMACH		
AURYXIA ORAL TABLET (<i>ferric citrate</i>)	3	ST; QL (9 tablets per 1 day)
<i>calcium acetate (phos binder) oral capsule</i>	1 or 1b*	QL (12 capsules per 1 day)
<i>calcium acetate oral tablet 667 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
FOSRENOL ORAL PACKET (<i>lanthanum carbonate</i>)	3	ST; QL (3 stick packs per 1 day)
<i>lanthanum carbonate oral tablet chewable</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>sevelamer carbonate oral packet 0.8 gm</i>	1 or 1b*	QL (6 packets per 1 day)
<i>sevelamer carbonate oral packet 2.4 gm</i>	1 or 1b*	QL (3 packets per 1 day)
<i>sevelamer carbonate oral tablet</i>	1 or 1b*	QL (9 tablets per 1 day)
<i>sevelamer hcl oral tablet 400 mg</i>	1 or 1b*	QL (15 tablets per 1 day)
<i>sevelamer hcl oral tablet 800 mg</i>	1 or 1b*	QL (9 tablets per 1 day)
VELPHORO ORAL TABLET CHEWABLE (<i>sucroferric oxyhydroxide</i>)	3	ST; QL (3 tablets per 1 day)
*TRYPTOPHAN HYDROXYLASE INHIBITORS*** - DRUGS FOR DIARRHEA		
XERMELO ORAL TABLET (<i>telotristat etiprate</i>)	3	PA; LD; QL (3 tablets per 1 day)
*TUMOR NECROSIS FACTOR ALPHA BLOCKERS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED (<i>infliximab-axxq</i>)	3	PA; LD
INFLIXIMAB INTRAVENOUS SOLUTION RECONSTITUTED	3	PA; LD
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED (<i>infliximab</i>)	3	PA; LD
GENERAL ANESTHETICS - DRUGS FOR PAIN AND FEVER		
*ANESTHETICS - MISC.*** - DRUGS FOR SEDATION		
AMIDATE INTRAVENOUS SOLUTION (<i>etomidate</i>)	3	
ANESTHESIA S/I-40A INTRAVENOUS KIT	3	
ANESTHESIA S/I-40H INTRAVENOUS KIT	3	
ANESTHESIA S/I-40S INTRAVENOUS KIT	3	
DIPRIVAN INTRAVENOUS EMULSION (<i>propofol</i>)	3	
<i>etomidate intravenous solution</i>	1 or 1b*	
<i>fresenius propoven intravenous emulsion</i>	1 or 1b*	
KETALAR INJECTION SOLUTION (<i>ketamine hcl</i>)	3	
<i>ketamine hcl injection solution 100 mg/ml, 50 mg/ml</i>	1 or 1b*	
<i>propofol intravenous emulsion</i>	1 or 1b*	
*BARBITURATE ANESTHETICS*** - DRUGS FOR SEDATION		
BREVITAL SODIUM INJECTION SOLUTION RECONSTITUTED (<i>methohexital sodium</i>)	3	
*VOLATILE ANESTHETICS*** - DRUGS FOR SEDATION		
<i>desflurane inhalation solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORANE INHALATION SOLUTION (<i>isoflurane</i>)	3	
<i>isoflurane inhalation solution</i>	1 or 1b*	
<i>sevoflurane inhalation solution</i>	1 or 1b*	
SUPRANE INHALATION SOLUTION (<i>desflurane</i>)	3	
<i>terrell inhalation solution</i>	1 or 1b*	
ULTANE INHALATION SOLUTION (<i>sevoflurane</i>)	3	
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS FOR THE URINARY SYSTEM		
*5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE PROSTATE		
<i>dutasteride oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>finasteride oral tablet 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
PROSCAR ORAL TABLET (<i>finasteride</i>)	3	QL (1 tablet per 1 day)
*ALPHA 1-ADRENOCEPTOR ANTAGONISTS*** - DRUGS FOR THE PROSTATE		
<i>alfuzosin hcl er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>doxazosin mesylate</i>)	3	QL (1 tablet per 1 day)
<i>silodosin oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>tamsulosin hcl oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)
*ANTI-INFECTIVE GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>neomycin-polymyxin b gu irrigation solution</i>	1 or 1b*	
*CITRATES*** - DRUGS FOR INFECTIONS		
<i>potassium citrate er oral tablet extended release</i>	1 or 1b*	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE (<i>potassium citrate</i>)	3	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE (<i>potassium citrate</i>)	3	
*CYSTINOSIS AGENTS*** - DRUGS FOR THE URINARY SYSTEM		
CYSTAGON ORAL CAPSULE (<i>cysteamine bitartrate</i>)	3	PA; LD
PROCYSBI ORAL CAPSULE DELAYED RELEASE (<i>cysteamine bitartrate</i>)	3	PA; LD
PROCYSBI ORAL PACKET (<i>cysteamine bitartrate</i>)	3	PA; LD
*GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>acetic acid irrigation solution</i>	1 or 1b*	
<i>argyle sterile saline irrigation solution</i>	1 or 1b*	
<i>curity sterile saline irrigation solution</i>	1 or 1b*	
<i>glycine irrigation solution</i>	1 or 1b*	
<i>glycine urologic irrigation solution</i>	1 or 1b*	
RENACIDIN IRRIGATION SOLUTION (<i>citric ac-gluconolact-mg carb</i>)	3	
<i>sodium chloride irrigation solution</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SORBITOL IRRIGATION SOLUTION	3	
SORBITOL-MANNITOL IRRIGATION SOLUTION	3	
*IGAN AGENTS - ENDOTHELIN & ANGIOTENSIN II RECEPTOR ANTAG*** - DRUGS FOR THE URINARY SYSTEM		
FILSPARI ORAL TABLET (<i>sparsentan</i>)	3	PA; LD; QL (1 tablet per 1 day)
*INTERSTITIAL CYSTITIS AGENTS*** - DRUGS FOR THE URINARY SYSTEM		
ELMIRON ORAL CAPSULE (<i>pentosan polysulfate sodium</i>)	3	QL (3 capsules per 1 day)
RIMSO-50 INTRAVESICAL SOLUTION (<i>dimethyl sulfoxide</i>)	3	
*PHOSPHATES*** - DRUGS FOR INFECTIONS		
K-PHOS NO 2 ORAL TABLET (<i>pot & sod ac phosphates</i>)	3	
*PROSTATIC HYPERTROPHY AGENT COMBINATIONS*** - DRUGS FOR THE PROSTATE		
<i>dutasteride-tamsulosin hcl oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
*SMALL INTERFERING RIBONUCLEIC ACID AGENTS (SIRNA)*** - DRUGS FOR THE URINARY SYSTEM		
OXLUMO SUBCUTANEOUS SOLUTION (<i>lumasiran sodium</i>)	3	PA; LD
RIVFLOZA SUBCUTANEOUS SOLUTION (<i>nedosiran sodium</i>)	3	PA; LD; QL (2 syringes per 30 days)
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>nedosiran sodium</i>)	3	PA; LD; QL (1 syringe per 30 days)
*URINARY STONE AGENTS*** - DRUGS FOR THE URINARY SYSTEM		
LITHOSTAT ORAL TABLET (<i>acetohydroxamic acid</i>)	3	
<i>tiopronin oral tablet</i>	1 or 1b*	PA; LD; QL (10 tablet per 1 day)
<i>tiopronin oral tablet delayed release</i>	1 or 1b*	PA; LD; QL (10 tablet per 1 day)
*VESICoureTERAL REFLUX (VUR) AGENT COMBINATIONS*** - DRUGS FOR THE URINARY SYSTEM		
DEFLUX INJECTION PREFILLED SYRINGE (<i>dextranomer-hyaluronic acid</i>)	3	
GOUT AGENTS - DRUGS FOR PAIN AND FEVER		
*GOUT AGENT COMBINATIONS*** - GOUT DRUGS		
<i>colchicine-probenecid oral tablet</i>	1 or 1b*	
*GOUT AGENTS*** - GOUT DRUGS		
<i>allopurinol oral tablet 100 mg</i>	1 or 1a*	QL (8 tablets per 1 day)
<i>allopurinol oral tablet 300 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>allopurinol sodium intravenous solution reconstituted</i>	1 or 1b*	
ALOPRIM INTRAVENOUS SOLUTION RECONSTITUTED (<i>allopurinol sodium</i>)	3	
<i>colchicine oral tablet</i>	2	QL (2.3 tablet per 1 day)
<i>febuxostat oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLOPERBA ORAL SOLUTION (<i>colchicine</i>)	3	QL (300 mL per 30 days)
KRYSTEXXA INTRAVENOUS SOLUTION (<i>pegloticase</i>)	3	PA; LD; QL (0.08 mL per 1 day)
*URICOSURICS*** - GOUT DRUGS		
<i>probenecid oral tablet</i>	1 or 1b*	
HEMATOLOGICAL AGENTS - MISC. - DRUGS FOR THE BLOOD		
AGENTS FOR CONGENITAL THROMBOTIC THROMBOCYTOPENIC PURPURA - DRUGS FOR THE BLOOD		
<i>adzynma intravenous kit</i>	3	PA; LD
*AMINOLEVULINATE SYNTHASE 1-DIRECTED SIRNA*** - DRUGS FOR THE BLOOD		
GIVLAARI SUBCUTANEOUS SOLUTION (<i>givosiran sodium</i>)	3	PA; LD
*ANTIHEMOPHILIC PRODUCTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE BLOOD		
HEMLIBRA SUBCUTANEOUS SOLUTION (<i>emicizumab-kxwh</i>)	3	PA; LD
*ANTIHEMOPHILIC PRODUCTS*** - DRUGS TO PREVENT BLEEDING		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophil factor (rahf-pfm)</i>)	3	PA; LD
ADYNOVATE INTRAVENOUS SOLUTION RECONSTITUTED	3	PA; LD
AFSTYLA INTRAVENOUS KIT (<i>antihemophil fact single chain</i>)	3	PA; LD
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophilic factor-vwf</i>)	3	PA; LD
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor ix</i>)	3	PA; LD
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor ix (rfixfc)</i>)	3	PA; LD
ALTUVIIIIO INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihem fact fc-vwf-xten-ehil</i>)	3	PA; LD
BALFAXAR INTRAVENOUS SOLUTION RECONSTITUTED (<i>prothrombin complex human-lans</i>)	3	
BENEFIX INTRAVENOUS KIT (<i>coagulation factor ix (recomb)</i>)	3	PA; LD
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor x (human)</i>)	3	PA; LD
CORIFACT INTRAVENOUS KIT (<i>factor xiii concentrate human</i>)	3	PA; LD
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihem fact (bdd-rfviiiifc)</i>)	3	PA; LD
ESPEROCT INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemoph fact rcmb gpeg-exei</i>)	3	PA; LD
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED (<i>antiinhibitor coagulant cmlx</i>)	3	PA; LD
FIBRYGA INTRAVENOUS SOLUTION RECONSTITUTED (<i>fibrinogen concentrate (human)</i>)	3	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophilic factor</i>)	3	PA; LD
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophilic factor-vwf</i>)	3	PA; LD
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor ix (rix-fp)</i>)	3	PA; LD
IXINITY INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor ix (recomb)</i>)	3	PA; LD
JIVI INTRAVENOUS SOLUTION RECONSTITUTED (<i>ahf (bdd-rfviii peg-aucl)</i>)	3	PA; LD
KCENTRA INTRAVENOUS KIT (<i>prothrombin complex conc human</i>)	3	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophilic factor</i>)	3	PA; LD
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophilic factor</i>)	3	PA; LD
KOGENATE FS INTRAVENOUS KIT (<i>antihem factor recomb (rfviii)</i>)	3	PA; LD
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophil factor (rahf-pfm)</i>)	3	PA; LD
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihemophil fact bd truncated</i>)	3	PA; LD
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor viia recomb</i>)	3	PA; LD
NUWIQ INTRAVENOUS KIT (<i>antihem fact (bdd-rfviii,sim)</i>)	3	PA; LD
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihem fact (bdd-rfviii,sim)</i>)	3	PA; LD
<i>obizur intravenous solution reconstituted</i>	3	PA; LD
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED (<i>factor ix complex</i>)	3	PA; LD
REBINYN INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor ix glycopeg</i>)	3	PA; LD
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED (<i>antihem factor recomb (rfviii)</i>)	3	PA; LD
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED (<i>fibrinogen concentrate (human)</i>)	3	PA; LD
RIXUBIS INTRAVENOUS SOLUTION RECONSTITUTED	3	PA; LD
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor viia-jncw</i>)	3	PA; LD
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED (<i>coagulation factor xiii a-sub</i>)	3	PA; LD
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED (<i>von willebrand factor (recomb)</i>)	3	PA; LD
WILATE INTRAVENOUS KIT (<i>antihemophilic factor-vwf</i>)	3	PA; LD
XYNTHA INTRAVENOUS KIT (<i>antihem fact (bdd-rfviii,mor)</i>)	3	PA; LD
XYNTHA SOLOFUSE INTRAVENOUS KIT (<i>antihem fact (bdd-rfviii,mor)</i>)	3	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTI-VON WILLEBRAND FACTOR AGENTS*** - DRUGS FOR THE BLOOD		
CABLIVI INJECTION KIT (<i>caplacizumab-yhdp</i>)	3	PA; LD
*BRADYKININ B2 RECEPTOR ANTAGONISTS*** - DRUGS FOR THE BLOOD		
<i>icatibant acetate subcutaneous solution prefilled syringe</i>	1 or 1b*	PA; LD; QL (18 syringes per 30 days)
<i>sajazir subcutaneous solution prefilled syringe</i>	1 or 1b*	PA; LD; QL (18 syringes per 30 days)
*C1 ESTERASE INHIBITORS*** - DRUGS FOR THE BLOOD		
BERINERT INTRAVENOUS KIT (<i>c1 esterase inhibitor (human)</i>)	3	PA; LD; QL (24 kits per 30 days)
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED (<i>c1 esterase inhibitor (human)</i>)	3	PA; LD; QL (20 vials per 30 days)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (<i>c1 esterase inhibitor (human)</i>)	3	PA; LD; QL (24 vials per 28 days)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (<i>c1 esterase inhibitor (human)</i>)	3	PA; LD; QL (16 vials per 28 days)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED (<i>c1 esterase inhibitor (recomb)</i>)	3	PA; LD; QL (16 vials per 30 days)
*COMPLEMENT C1 INHIBITORS*** - DRUGS FOR THE BLOOD		
ENJAYMO INTRAVENOUS SOLUTION (<i>sutimlimab-jome</i>)	3	PA; LD; QL (6 vials per 2 weeks)
*COMPLEMENT C3 INHIBITORS*** - DRUGS FOR THE BLOOD		
EMPAVELI SUBCUTANEOUS SOLUTION (<i>pegcetacoplan</i>)	3	PA; LD; QL (200 mL per 30 days)
*COMPLEMENT C5 INHIBITORS*** - DRUGS FOR THE BLOOD		
PIASKY INJECTION SOLUTION (<i>crovalimab-akkz</i>)	3	PA; LD; QL (3 vials per 28 days)
SOLIRIS INTRAVENOUS SOLUTION (<i>eculizumab</i>)	3	PA; LD; QL (8 vials per 28 days)
ULTOMIRIS INTRAVENOUS SOLUTION (<i>ravulizumab-cwvz</i>)	3	PA; LD; QL (12 vials per 56 days)
VEOPOZ INJECTION SOLUTION (<i>pezelimab-bbfg</i>)	3	PA; LD; QL (2 vials per 1 week)
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>zilucoplan sodium</i>)	3	PA; LD; QL (1 syringe per 1 day)
*COMPLEMENT C5A INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>gohibic intravenous solution</i>	3	
*COMPLEMENT C5A RECEPTOR INHIBITORS*** - DRUGS FOR THE BLOOD		
TAVNEOS ORAL CAPSULE (<i>avacopan</i>)	3	PA; LD; QL (6 capsules per 1 day)
*COMPLEMENT FACTOR B INHIBITORS*** - DRUGS FOR THE BLOOD		
FABHALTA ORAL CAPSULE (<i>iptacopan hcl</i>)	3	PA; LD; QL (2 capsules per 1 day)
*COMPLEMENT FACTOR D INHIBITORS*** - DRUGS FOR THE BLOOD		
VOYDEYA ORAL TABLET (<i>danicopan</i>)	3	PA; LD; QL (6 tablets per 1 day)
VOYDEYA ORAL TABLET THERAPY PACK (<i>danicopan</i>)	3	PA; LD; QL (6 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*DIRECT-ACTING P2Y12 INHIBITORS*** - DRUGS FOR THE BLOOD		
BRILINTA ORAL TABLET (<i>ticagrelor</i>)	2	QL (2 tablets per 1 day)
KENGREAL INTRAVENOUS SOLUTION RECONSTITUTED (<i>cangrelor tetrasodium</i>)	3	
*GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS*** - DRUGS FOR THE BLOOD		
AGGRASTAT INTRAVENOUS CONCENTRATE (<i>tirofiban hcl</i>)	3	
AGGRASTAT INTRAVENOUS SOLUTION (<i>tirofiban hcl in nacl</i>)	3	
<i>eptifibatide intravenous solution</i>	1 or 1b*	
<i>tirofiban hcl in nacl intravenous solution</i>	1 or 1b*	
*HEMATORHEOLOGIC AGENTS*** - DRUGS FOR THE BLOOD		
<i>pentoxifylline er oral tablet extended release</i>	1 or 1b*	
*HEMIN*** - DRUGS FOR THE BLOOD		
PANHEMATIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>hemin</i>)	3	LD
*HUMAN PROTEIN C*** - DRUGS FOR THE BLOOD		
CEPROTIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>protein c concentrate (human)</i>)	3	LD
*PHOSPHODIESTERASE III INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>cilostazol oral tablet</i>	1 or 1b*	
*PLASMA EXPANDERS*** - DRUGS FOR THE BLOOD		
<i>hetastarch-nacl intravenous solution</i>	1 or 1b*	
HEXTEND INTRAVENOUS SOLUTION (<i>hetastarch-electrolytes</i>)	3	
<i>lmd in d5w intravenous solution</i>	1 or 1b*	
<i>lmd in nacl intravenous solution</i>	1 or 1b*	
*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE BLOOD		
TAKHZYRO SUBCUTANEOUS SOLUTION (<i>lanadelumab-flyo</i>)	3	PA; LD; QL (1 vial per 28 days)
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>lanadelumab-flyo</i>)	3	PA; LD; QL (1 syringe per 28 days)
*PLASMA KALLIKREIN INHIBITORS*** - DRUGS FOR THE BLOOD		
KALBITOR SUBCUTANEOUS SOLUTION (<i>ecallantide</i>)	3	PA; LD; QL (36 vials per 30 days)
ORLADEYO ORAL CAPSULE (<i>berotralstat hcl</i>)	3	PA; LD; QL (1 capsule per 1 day)
*PLASMA PROTEINS*** - DRUGS FOR THE BLOOD		
ALBUKED 25 INTRAVENOUS SOLUTION (<i>albumin human</i>)	3	
ALBUKED 5 INTRAVENOUS SOLUTION (<i>albumin human</i>)	3	
ALBUMIN HUMAN INTRAVENOUS SOLUTION	3	
ALBUMINEX INTRAVENOUS SOLUTION (<i>albumin human-kjda</i>)	3	
ALBUMIN-ZLB INTRAVENOUS SOLUTION	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALBURX INTRAVENOUS SOLUTION	3	
ALBUTEIN INTRAVENOUS SOLUTION (<i>albumin human</i>)	3	
FLEXBUMIN INTRAVENOUS SOLUTION (<i>albumin human</i>)	3	
KEDBUMIN INTRAVENOUS SOLUTION	3	
OCTAPLAS BLOOD GROUP A INTRAVENOUS SOLUTION (<i>plasma human</i>)	3	
OCTAPLAS BLOOD GROUP AB INTRAVENOUS SOLUTION (<i>plasma human</i>)	3	
OCTAPLAS BLOOD GROUP B INTRAVENOUS SOLUTION (<i>plasma human</i>)	3	
OCTAPLAS BLOOD GROUP O INTRAVENOUS SOLUTION (<i>plasma human</i>)	3	
RYPLAZIM INTRAVENOUS SOLUTION RECONSTITUTED (<i>plasminogen human-tvmh</i>)	3	PA; LD
THROMBATE III INTRAVENOUS SOLUTION RECONSTITUTED (<i>antithrombin iii (human)</i>)	3	
*PLATELET AGGREGATION INHIBITOR COMBINATIONS*** - DRUGS FOR THE BLOOD		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour</i>	1 or 1b*	QL (2 capsules per 1 day)
YOSPRALA ORAL TABLET DELAYED RELEASE (<i>aspirin-omeprazole</i>)	3	PA; QL (1 tablet per 1 day)
*PLATELET AGGREGATION INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>dipyridamole oral tablet</i>	1 or 1b*	
*PROTAMINE*** - DRUGS FOR THE BLOOD		
<i>protamine sulfate intravenous solution</i>	1 or 1b*	
*PROTEASE-ACTIVATED RECEPTOR-1 (PAR-1) ANTAGONISTS*** - DRUGS FOR THE BLOOD		
ZONTIVITY ORAL TABLET (<i>vorapaxar sulfate</i>)	3	PA; QL (1 tablet per 1 day)
*PYRUVATE KINASE ACTIVATORS*** - DRUGS FOR THE BLOOD		
PYRUKYND ORAL TABLET (<i>mitapivat sulfate</i>)	3	PA; LD; QL (2 tablets per 1 day)
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK (<i>mitapivat sulfate</i>)	3	PA; LD; QL (1 pack per 28 days)
*QUINAZOLINE AGENTS*** - DRUGS FOR THE BLOOD		
AGRYLIN ORAL CAPSULE (<i>anagrelide hcl</i>)	3	QL (20 capsules per 1 day)
<i>anagrelide hcl oral capsule 0.5 mg</i>	1 or 1b*	QL (20 capsules per 1 day)
<i>anagrelide hcl oral capsule 1 mg</i>	1 or 1b*	QL (10 capsules per 1 day)
*SPLEEN TYROSINE KINASE (SYK) INHIBITORS*** - DRUGS FOR THE BLOOD		
TAVALISSE ORAL TABLET (<i>fostamatinib disodium</i>)	3	PA; LD; QL (2 tablets per 1 day)
*THIENOPYRIDINE DERIVATIVES*** - DRUGS FOR THE BLOOD		
<i>clopidogrel bisulfate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>prasugrel hcl oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*THROMBOLYTIC AGENT - MISC*** - DRUGS FOR THE BLOOD		
DEFITELIO INTRAVENOUS SOLUTION (<i>defibrotide sodium</i>)	3	LD
*TISSUE PLASMINOGEN ACTIVATORS*** - DRUGS FOR THE BLOOD		
ACTIVASE INTRAVENOUS SOLUTION RECONSTITUTED (<i>alteplase</i>)	3	
CATHFLO ACTIVASE INJECTION SOLUTION RECONSTITUTED (<i>alteplase</i>)	3	
TNKASE INTRAVENOUS KIT (<i>tenecteplase</i>)	3	
HEMATOPOIETIC AGENTS - DRUGS FOR NUTRITION		
*AGENTS FOR GAUCHER DISEASE*** - DRUGS FOR NUTRITION		
CERDELGA ORAL CAPSULE (<i>eliglustat tartrate</i>)	2	PA; LD; QL (2 capsules per 1 day)
CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED (<i>imiglucerase</i>)	3	PA; LD
ELELYSO INTRAVENOUS SOLUTION RECONSTITUTED (<i>taliglucerase alfa</i>)	3	PA; LD
<i>miglustat oral capsule</i>	1 or 1b*	PA; LD; QL (3 capsules per 1 day)
VPRIV INTRAVENOUS SOLUTION RECONSTITUTED (<i>velaglucerase alfa</i>)	3	PA; LD
<i>miglustat</i> (Yargesa Oral Capsule)	1 or 1b*	PA; LD; QL (3 capsules per 1 day)
*AMINO ACIDS*** - DRUGS FOR NUTRITION		
<i>l-glutamine oral packet</i>	1 or 1b*	PA; LD
*COBALAMINS*** - DRUGS FOR NUTRITION		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1 or 1a*	
<i>dodex injection solution</i>	1 or 1a*	
<i>hydroxocobalamin acetate intramuscular solution</i>	1 or 1b*	
*CXCR4 RECEPTOR ANTAGONIST*** - DRUGS FOR NUTRITION		
APHEXDA SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>motixafortide acetate</i>)	3	PA; LD
MOZOBIL SUBCUTANEOUS SOLUTION (<i>plerixafor</i>)	3	PA; LD
<i>plerixafor subcutaneous solution</i>	1 or 1b*	PA; LD
XOLREMDI ORAL CAPSULE (<i>mavorixafor</i>)	3	PA; LD; QL (4 capsules per 1 day)
*CYTOTOXIC AGENTS*** - DRUGS FOR NUTRITION		
DROXIA ORAL CAPSULE (<i>hydroxyurea</i>)	2	
SIKLOS ORAL TABLET (<i>hydroxyurea</i>)	3	PA; LD
*ERYTHROID MATURATION AGENTS*** - DRUGS FOR NUTRITION		
REBLOZYL SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>luspatercept-aamt</i>)	3	PA; LD
*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)*** - DRUGS FOR NUTRITION		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION (<i>darbepoetin alfa</i>)	3	PA; LD; QL (4 vials per 28 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	3	PA; LD; QL (4 syringes per 28 days)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	3	PA; LD; QL (4 syringes per 30 days)
EPOGEN INJECTION SOLUTION (<i>epoetin alfa</i>)	3	PA; LD; QL (12 mL per 28 days)
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE (<i>methoxy peg-epoetin beta</i>)	3	PA; LD; QL (2 syringes per 28 days)
PROCRIT INJECTION SOLUTION (<i>epoetin alfa</i>)	3	PA; LD; QL (12 mL per 28 days)
RETACRIT INJECTION SOLUTION (<i>epoetin alfa-epbx</i>)	3	PA; LD; QL (12 mL per 28 days)
*FOLIC ACID/FOLATE COMBINATIONS*** - DRUGS FOR NUTRITION		
<i>foltabs 800 oral tablet</i>	1 or 1b*; \$0	
*FOLIC ACID/FOLATES*** - DRUGS FOR NUTRITION		
<i>cvs folic acid oral tablet</i>	1 or 1a*; \$0	
<i>fa-8 oral capsule</i>	1 or 1b*; \$0	
<i>folate oral tablet</i>	1 or 1a*; \$0	
<i>folic acid injection solution</i>	1 or 1a*	
<i>folic acid oral capsule 0.8 mg</i>	1 or 1b*; \$0	
<i>folic acid oral tablet 1 mg</i>	1 or 1a*	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	1 or 1a*; \$0	
<i>ft folic acid oral tablet</i>	1 or 1a*; \$0	
<i>gnp folic acid oral tablet</i>	1 or 1a*; \$0	
<i>kp folic acid oral tablet 800 mcg</i>	1 or 1a*; \$0	
<i>qc folic acid oral tablet</i>	1 or 1a*; \$0	
<i>ra folic acid oral tablet</i>	1 or 1a*; \$0	
<i>sm folic acid oral tablet</i>	1 or 1a*; \$0	
<i>true folic acid oral tablet 400 mcg</i>	1 or 1a*; \$0	
<i>yl folic acid oral tablet</i>	1 or 1a*; \$0	
*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)*** - DRUGS FOR NUTRITION		
GRANIX SUBCUTANEOUS SOLUTION (<i>tbo-filgrastim</i>)	3	PA; LD
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>tbo-filgrastim</i>)	3	PA; LD
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT (<i>pegfilgrastim</i>)	3	PA; LD; QL (2 injectors/kits per 28 days)
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim</i>)	3	PA; LD; QL (2 syringes per 28 days)
NEUPOGEN INJECTION SOLUTION (<i>filgrastim</i>)	3	PA; LD
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE (<i>filgrastim</i>)	3	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIVESTYM INJECTION SOLUTION (<i>filgrastim-aafi</i>)	3	PA; LD
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE (<i>filgrastim-aafi</i>)	3	PA; LD
RELEUKO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	3	PA; LD
ROLVEDON SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>eflapegrastim-xnst</i>)	3	PA; LD; QL (2 syringes per 28 days)
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim-cbqv</i>)	3	PA; LD; QL (2 syringes per 28 days)
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>pegfilgrastim-cbqv</i>)	3	PA; LD; QL (2 syringes per 28 days)
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim-cbqv</i>)	3	PA; LD; QL (2 syringes per 28 days)
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE (<i>filgrastim-sndz</i>)	3	PA; LD
*GRANULOCYTE/MACROPHAGE COLONY-STIMULATING FACTOR(GM-CSF)*** - DRUGS FOR NUTRITION		
LEUKINE INJECTION SOLUTION RECONSTITUTED (<i>sargramostim</i>)	3	PA; LD
*IRON*** - DRUGS FOR NUTRITION		
ACCRUFER ORAL CAPSULE (<i>ferric maltol</i>)	3	
FERAHEME INTRAVENOUS SOLUTION (<i>ferumoxytol</i>)	3	PA; LD; QL (2 vials per 6 days)
FERRLECIT INTRAVENOUS SOLUTION (<i>na ferric gluc cplx in sucrose</i>)	3	PA; LD; QL (16 vials per 8 weekss)
<i>ferumoxytol intravenous solution</i>	3	PA; LD; QL (2 vials per 6 days)
INFED INJECTION SOLUTION (<i>iron dextran</i>)	3	PA; LD
<i>na ferric gluc cplx in sucrose intravenous solution</i>	1 or 1b*	PA; LD; QL (16 vials per 8 weekss)
VENOFER INTRAVENOUS SOLUTION (<i>iron sucrose</i>)	3	PA; LD; QL (15 mL per 84 days)
*SELECTIN BLOCKERS*** - DRUGS FOR NUTRITION		
ADAKVEO INTRAVENOUS SOLUTION (<i>crizanlizumab-tmca</i>)	3	PA; LD
*THROMBOPOIETIN (TPO) RECEPTOR AGONISTS*** - DRUGS FOR NUTRITION		
DOPTELET ORAL TABLET (<i>avatrombopag maleate</i>)	3	PA; LD; QL (2 tablets per 1 day)
MULPLETA ORAL TABLET (<i>lusutrombopag</i>)	3	PA; LD; QL (1 tablet per 1 day)
NPLATE SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>romiplostim</i>)	3	PA; LD
PROMACTA ORAL PACKET 12.5 MG (<i>eltrombopag olamine</i>)	3	PA; LD; DO
PROMACTA ORAL PACKET 25 MG (<i>eltrombopag olamine</i>)	3	PA; LD; QL (3 dose-packs per 1 day)
PROMACTA ORAL TABLET 12.5 MG, 25 MG (<i>eltrombopag olamine</i>)	3	PA; LD; DO
PROMACTA ORAL TABLET 50 MG (<i>eltrombopag olamine</i>)	3	PA; LD; QL (3 tablets per 1 day)
PROMACTA ORAL TABLET 75 MG (<i>eltrombopag olamine</i>)	3	PA; LD; QL (1 tablet per 1 day)
HEMOSTATICS - DRUGS FOR THE BLOOD		
*HEMOSTATIC COMBINATIONS - TOPICAL*** - DRUGS TO PREVENT BLEEDING		
ARTISS EXTERNAL KIT (<i>fibrin sealant component</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTISS EXTERNAL SOLUTION (<i>fibrin sealant component</i>)	3	
THROMBI-GEL 10 EXTERNAL PAD (<i>thrombin-cmc-cacl-gelatin</i>)	3	
THROMBI-GEL 100 EXTERNAL PAD (<i>thrombin-cmc-cacl-gelatin</i>)	3	
THROMBI-GEL 40 EXTERNAL PAD (<i>thrombin-cmc-cacl-gelatin</i>)	3	
THROMBI-PAD EXTERNAL PAD (<i>thrombin-cmc-cacl</i>)	3	
TISSEEL EXTERNAL KIT (<i>fibrin sealant component</i>)	3	
TISSEEL EXTERNAL SOLUTION (<i>fibrin sealant component</i>)	3	
*HEMOSTATICS - SYSTEMIC*** - DRUGS TO PREVENT BLEEDING		
<i>aminocaproic acid intravenous solution</i>	1 or 1b*	
<i>aminocaproic acid oral solution</i>	1 or 1b*	QL (120 mL per 1 day)
<i>aminocaproic acid oral tablet 1000 mg</i>	1 or 1b*	
<i>aminocaproic acid oral tablet 500 mg</i>	1 or 1b*	QL (60 tablets per 1 day)
CYKLOKAPRON INTRAVENOUS SOLUTION (<i>tranexamic acid</i>)	3	
<i>tranexamic acid intravenous solution</i>	1 or 1b*	
<i>tranexamic acid oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
TRANEXAMIC ACID-NACL INTRAVENOUS SOLUTION	3	
*HEMOSTATICS - TOPICAL*** - DRUGS TO PREVENT BLEEDING		
ACTIFOAM COLLAGEN SPONGE EXTERNAL (<i>absorbable collagen hemostat</i>)	3	
AVITENE EXTERNAL PAD (<i>microfibrillar coll hemostat</i>)	3	
AVITENE FLOUR EXTERNAL POWDER (<i>microfibrillar coll hemostat</i>)	3	
ENDO AVITENE EXTERNAL (<i>absorbable collagen hemostat</i>)	3	
GELFILM EXTERNAL FILM (<i>gelatin absorbable</i>)	3	
GEL-FLOW NT EXTERNAL PREFILLED SYRINGE (<i>gelatin absorbable</i>)	3	
GELFOAM COMPRESSED SIZE 100 EXTERNAL (<i>gelatin absorbable</i>)	3	
GELFOAM DENTAL PACK SIZE 4 EXTERNAL (<i>gelatin absorbable</i>)	3	
GELFOAM MOUTH/THROAT POWDER (<i>gelatin absorbable</i>)	3	
GELFOAM SPONGE EXTERNAL (<i>gelatin absorbable</i>)	3	
GELFOAM SPONGE SIZE 100 EXTERNAL (<i>gelatin absorbable</i>)	3	
GELFOAM SPONGE SIZE 200 EXTERNAL (<i>gelatin absorbable</i>)	3	
GELFOAM SPONGE SIZE 50 EXTERNAL (<i>gelatin absorbable</i>)	3	
INSTAT EXTERNAL PAD (<i>absorbable collagen hemostat</i>)	3	
INTERCEED (TC7) EXTERNAL PAD (<i>oxidized cellulose</i>)	3	
INTERCEED EXTERNAL PAD (<i>oxidized cellulose</i>)	3	
RECOTHROM EXTERNAL SOLUTION RECONSTITUTED (<i>thrombin (recombinant)</i>)	3	
RECOTHROM SPRAY KIT EXTERNAL SOLUTION RECONSTITUTED (<i>thrombin (recombinant)</i>)	3	
SURGICEL FIBRILLAR EXTERNAL PAD (<i>oxidized cellulose</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURGICEL NU-KNIT EXTERNAL PAD (<i>oxidized cellulose</i>)	3	
SURGICEL SNOW 1"X2" EXTERNAL PAD (<i>oxidized cellulose</i>)	3	
SURGICEL SNOW 2"X4" EXTERNAL PAD (<i>oxidized cellulose</i>)	3	
SURGICEL SNOW 4"X4" EXTERNAL PAD (<i>oxidized cellulose</i>)	3	
SYRINGE AVITENE EXTERNAL (<i>absorbable collagen hemostat</i>)	3	
TACHOSIL EXTERNAL PATCH (<i>absorbable fibrin sealant</i>)	3	
THROMBIN-JMI EPISTAXIS EXTERNAL KIT (<i>thrombin</i>)	3	
THROMBIN-JMI EXTERNAL KIT (<i>thrombin</i>)	3	
THROMBIN-JMI EXTERNAL SOLUTION RECONSTITUTED (<i>thrombin</i>)	3	
THROMBOGEN EXTERNAL KIT (<i>thrombin</i>)	3	
THROMBOGEN EXTERNAL SOLUTION RECONSTITUTED (<i>thrombin</i>)	3	
ULTRAFOAM SPONGE 2X6.25X7CM EXTERNAL (<i>microfibrillar coll hemostat</i>)	3	
ULTRAFOAM SPONGE 8X12.5X1CM EXTERNAL (<i>microfibrillar coll hemostat</i>)	3	
ULTRAFOAM SPONGE 8X12.5X3CM EXTERNAL (<i>microfibrillar coll hemostat</i>)	3	
ULTRAFOAM SPONGE 8X25X1CM EXTERNAL (<i>microfibrillar coll hemostat</i>)	3	
ULTRAFOAM SPONGE 8X6.25X1CM EXTERNAL (<i>microfibrillar coll hemostat</i>)	3	
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*BARBITURATE HYPNOTICS*** - DRUGS FOR INSOMNIA		
<i>pentobarbital sodium injection solution</i>	1 or 1b*	
<i>phenobarbital oral elixir</i>	1 or 1b*	QL (100 mL per 1 day)
<i>phenobarbital oral tablet 100 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>phenobarbital oral tablet 15 mg, 16.2 mg, 30 mg, 32.4 mg</i>	1 or 1b*	DO
<i>phenobarbital sodium injection solution</i>	1 or 1b*	
SEZABY INTRAVENOUS SOLUTION RECONSTITUTED (<i>phenobarbital sodium</i>)	3	
*BENZODIAZEPINE HYPNOTICS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
BYFAVO INTRAVENOUS SOLUTION RECONSTITUTED (<i>remimazolam besylate</i>)	3	LD
<i>estazolam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>flurazepam hcl oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
HALCION ORAL TABLET (<i>triazolam</i>)	3	ST; QL (1 tablet per 1 day)
<i>midazolam hcl (pf) injection solution</i>	1 or 1b*	
<i>midazolam hcl injection solution</i>	1 or 1b*	
<i>midazolam hcl oral syrup</i>	1 or 1b*	QL (10 mL per 1 fill)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIDAZOLAM HCL-SODIUM CHLORIDE INTRAVENOUS SOLUTION 100-0.8 MG/100ML-%, 50-0.8 MG/50ML-%	3	
<i>midazolam-sodium chloride (pf) intravenous solution</i>	3	
<i>quazepam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
RESTORIL ORAL CAPSULE (<i>temazepam</i>)	3	ST; QL (1 capsule per 1 day)
<i>temazepam oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>triazolam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
*HYPNOTICS - TRICYCLIC AGENTS*** - DRUGS FOR INSOMNIA		
<i>doxepin hcl oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS*** - DRUGS FOR INSOMNIA		
EDLUAR SUBLINGUAL TABLET SUBLINGUAL (<i>zolpidem tartrate</i>)	3	ST; QL (1 tablet per 1 day)
<i>eszopiclone oral tablet 1 mg, 2 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>eszopiclone oral tablet 3 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
<i>zaleplon oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>zolpidem tartrate er oral tablet extended release</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zolpidem tartrate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zolpidem tartrate sublingual tablet sublingual</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
*OREXIN RECEPTOR ANTAGONISTS*** - DRUGS FOR INSOMNIA		
QUVIVIQ ORAL TABLET (<i>daridorexant hcl</i>)	3	ST; QL (1 tablet per 1 day)
*SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES*** - DRUGS FOR INSOMNIA		
<i>dexmedetomidine hcl in nacl intravenous solution</i>	1 or 1b*	
DEXMEDETOMIDINE HCL INTRAVENOUS SOLUTION 1000 MCG/10ML, 400 MCG/4ML	3	
<i>dexmedetomidine hcl intravenous solution 200 mcg/2ml</i>	1 or 1b*	
DEXMEDETOMIDINE HCL-DEXTROSE INTRAVENOUS SOLUTION	3	
IGALMI SUBLINGUAL FILM (<i>dexmedetomidine hcl</i>)	3	PA; QL (20 films per 30 days)
PRECEDEX INTRAVENOUS SOLUTION (<i>dexmedetomidine hcl in nacl</i>)	3	
*SELECTIVE MELATONIN RECEPTOR AGONISTS*** - DRUGS FOR INSOMNIA		
HETLIOZ LQ ORAL SUSPENSION (<i>tasimelteon</i>)	3	PA; LD; QL (5 mL per 1 day)
<i>ramelteon oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>tasimelteon oral capsule</i>	1 or 1b*	PA; LD; QL (1 capsule per 1 day)
LAXATIVES - DRUGS FOR THE STOMACH		
*BOWEL EVACUANT COMBINATIONS*** - DRUGS TO PREVENT CONSTIPATION		
CLENPIQ ORAL SOLUTION (<i>sod picosulfate-mag ox-cit acid</i>)	3	QL (350 mL per 30 days)
GAVILYTE-C ORAL SOLUTION RECONSTITUTED (<i>peg 3350-kcl-nabcb-nacl-nasulf</i>)	1 or 1a*; \$0	QL (1 bottle per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gavilyte-g oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg 3350-kcl-na bicarb-nacl</i> (Gavilyte-N With Flavor Pack Oral Solution Reconstituted)	1 or 1a*; \$0	QL (4000 grams per 30 days)
GOLYTELY ORAL SOLUTION RECONSTITUTED (<i>peg 3350-kcl-nabcb-nacl-nasulf</i>)	3	QL (4000 grams per 30 days)
MOVIPREP ORAL SOLUTION RECONSTITUTED (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	3	QL (1 gram per 30 days)
<i>na sulfate-k sulfate-mg sulf oral solution</i>	1 or 1b*; \$0	QL (1 kit per 30 days)
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg-3350/electrolytes oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted</i>	1 or 1b*; \$0	QL (1 gram per 30 days)
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted</i>	1 or 1b*; \$0	QL (1 gram per 30 days)
PEG-PREP ORAL KIT (<i>bisacodyl-peg-kcl-nabicar-nacl</i>)	3	QL (1 kit per 30 days)
PLENVU ORAL SOLUTION RECONSTITUTED (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	3	QL (1 gram per 30 days)
SUTAB ORAL TABLET (<i>sodium sulfate-mag sulfate-kcl</i>)	2	QL (24 tablets per 30 days)
*LAXATIVES - MISCELLANEOUS*** - DRUGS TO PREVENT CONSTIPATION		
<i>clearlax oral powder</i>	1 or 1b*; \$0	
<i>constulose oral solution</i>	1 or 1b*	QL (120 mL per 1 day)
<i>cvs purelax oral packet</i>	1 or 1b*; \$0	
<i>cvs purelax oral powder</i>	1 or 1b*; \$0	
<i>eq clearlax oral powder</i>	1 or 1b*; \$0	
<i>eq laxative oral packet</i>	1 or 1b*; \$0	
<i>eql clearlax oral powder</i>	1 or 1b*; \$0	
<i>ft clearlax oral powder</i>	1 or 1b*; \$0	
<i>gavilax oral powder</i>	1 or 1b*; \$0	
<i>gentlelax oral powder</i>	1 or 1b*; \$0	
<i>glycolax oral powder</i>	1 or 1b*; \$0	
<i>gnp clearlax oral packet</i>	1 or 1b*; \$0	
<i>gnp clearlax oral powder</i>	1 or 1b*; \$0	
<i>goodsense clearlax oral powder</i>	1 or 1b*; \$0	
<i>healthylax oral packet</i>	1 or 1b*; \$0	
<i>hm clearlax oral powder</i>	1 or 1b*; \$0	
<i>kls laxaclear oral powder</i>	1 or 1b*; \$0	
KRISTALOSE ORAL PACKET (<i>lactulose</i>)	3	ST; QL (2 packets per 1 day)
LACTULOSE ORAL PACKET	3	ST; QL (2 packets per 1 day)
<i>lactulose oral solution</i>	1 or 1b*	QL (120 mL per 1 day)
<i>mm clearlax oral powder</i>	1 or 1b*; \$0	
<i>peg 3350 oral packet</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>peg 3350 oral powder</i>	1 or 1b*; \$0	
<i>polyethylene glycol 3350 oral packet</i>	1 or 1b*; \$0	
<i>polyethylene glycol 3350 oral powder</i>	1 or 1b*; \$0	
<i>qc natura-lax oral powder</i>	1 or 1b*; \$0	
<i>ra laxative oral powder</i>	1 or 1b*; \$0	
<i>sb polyethylene glycol 3350 oral powder</i>	1 or 1b*; \$0	
<i>sm clearlax oral powder</i>	1 or 1b*; \$0	
<i>smooth lax oral packet</i>	1 or 1b*; \$0	
<i>smooth lax oral powder</i>	1 or 1b*; \$0	
<i>true laxative oral powder</i>	1 or 1b*; \$0	
*LUBRICANT LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION		
<i>mineral oil heavy oral oil</i>	1 or 1b*	
*SALINE LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION		
<i>citrate of magnesia oral solution</i>	1 or 1a*; \$0	
<i>citroma oral solution</i>	1 or 1a*; \$0	
<i>cvs magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>cvs milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>dulcolax milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>dulcolax oral suspension</i>	1 or 1b*; \$0	
<i>eq magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>eql magnesium citrate oral solution</i>	1 or 1a*; \$0	
FRESKARO MAGNESIUM CITRATE ORAL SOLUTION (<i>magnesium citrate</i>)	1 or 1a*; \$0	
<i>ft magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>ft milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>gentle laxative oral suspension</i>	1 or 1b*; \$0	
<i>gnp magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>gnp milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>goodsense magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>goodsense milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>hm milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>milk of magnesia oral suspension</i>	1 or 1b*; \$0	
ONELAX MAGNESIUM CITRATE ORAL SOLUTION (<i>magnesium citrate</i>)	1 or 1a*; \$0	
<i>phillips milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>qc magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>qc milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>ra magnesium citrate oral solution</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ra milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>sb magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>sb milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>sm milk of magnesia oral suspension</i>	1 or 1b*; \$0	
*STIMULANT LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION		
<i>alophen oral tablet delayed release</i>	1 or 1a*; \$0	
<i>bisacodyl ec oral tablet delayed release</i>	1 or 1a*; \$0	
<i>bisacodyl oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs c-lax laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs gentle laxative womens oral tablet delayed release</i>	1 or 1a*; \$0	
<i>eq gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>eql gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>eql laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ex-lax ultra oral tablet delayed release</i>	1 or 1a*; \$0	
FLEET STIMULANT ORAL TABLET DELAYED RELEASE (<i>bisacodyl</i>)	1 or 1a*; \$0	
<i>ft laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>gnp gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>gnp womens gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>goodsense bisacodyl ec oral tablet delayed release</i>	1 or 1a*; \$0	
<i>goodsense bisacodyl laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>kp bisacodyl oral tablet delayed release</i>	1 or 1a*; \$0	
<i>laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>qc gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>qc gentle laxative womens oral tablet delayed release</i>	1 or 1a*; \$0	
<i>qc laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ra laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ra womens laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sb bisacodyl laxative ec oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sb gentle lax-women oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sm gentle laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>womans laxative oral tablet delayed release</i>	1 or 1a*; \$0	
<i>womens laxative oral tablet delayed release</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS-PARENTERAL - DRUGS FOR PAIN AND FEVER		
*LOCAL ANESTHETIC & SYMPATHOMIMETIC*** - DRUGS FOR SEDATION		
<i>articadent dental injection solution cartridge</i>	3	
<i>bupivacaine-epinephrine (pf) injection solution</i>	1 or 1b*	
<i>bupivacaine-epinephrine injection solution</i>	1 or 1b*	
<i>lidocaine-epinephrine (pf) injection solution 1.5 %-1:200000</i>	1 or 1b*	
<i>lidocaine-epinephrine injection solution</i>	1 or 1b*	
MARCAINE/EPINEPHRINE INJECTION SOLUTION (<i>bupivacaine-epinephrine</i>)	3	
MARCAINE/EPINEPHRINE PF INJECTION SOLUTION (<i>bupivacaine-epinephrine</i>)	3	
ORABLOC INJECTION SOLUTION CARTRIDGE (<i>articaine-epinephrine</i>)	3	
<i>sensorcaine/epinephrine injection solution</i>	1 or 1b*	
<i>sensorcaine-mpf/epinephrine injection solution 0.25% -1:200000</i>	1 or 1b*	
<i>sensorcaine-mpf/epinephrine injection solution 0.5% -1:200000</i>	3	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (<i>bupivacaine-epinephrine</i>)	3	
XYLOCAINE/EPINEPHRINE INJECTION SOLUTION (<i>lidocaine-epinephrine</i>)	3	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION (<i>lidocaine-epinephrine</i>)	3	
*LOCAL ANESTHETICS - AMIDES*** - DRUGS FOR SEDATION		
BUPIVACAINE FISIOPHARMA INJECTION SOLUTION	3	
<i>bupivacaine hcl (pf) injection solution</i>	1 or 1b*	
<i>lidocaine hcl (pf) injection solution</i>	1 or 1b*	
<i>lidocaine hcl injection solution 0.5 %</i>	1 or 1b*	
MARCAINE INJECTION SOLUTION (<i>bupivacaine hcl</i>)	3	
MARCAINE PRESERVATIVE FREE INJECTION SOLUTION (<i>bupivacaine hcl</i>)	3	
MONOJECT BONE MARROW BIOPSY INJECTION KIT (<i>lidocaine hcl</i>)	3	
NAROPIN INJECTION SOLUTION (<i>ropivacaine hcl</i>)	3	
<i>polocaine injection solution</i>	1 or 1b*	
<i>polocaine-mpf injection solution</i>	1 or 1b*	
POSIMIR INJECTION SOLUTION (<i>bupivacaine</i>)	3	
<i>ropivacaine hcl injection solution 10 mg/ml, 5 mg/ml, 7.5 mg/ml</i>	1 or 1b*	
<i>sensorcaine injection solution</i>	1 or 1b*	
<i>sensorcaine-mpf injection solution</i>	1 or 1b*	
XARACOLL IMPLANT IMPLANT (<i>bupivacaine hcl</i>)	3	
XYLOCAINE INJECTION SOLUTION (<i>lidocaine hcl</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XYLOCAINE-MPF INJECTION SOLUTION (<i>lidocaine hcl</i>)	3	
*LOCAL ANESTHETICS - ESTERS*** - DRUGS FOR SEDATION		
<i>chlorprocaine hcl (pf) injection solution</i>	1 or 1b*	
NESACAINE INJECTION SOLUTION (<i>chlorprocaine hcl</i>)	3	
NESACAINE-MPF INJECTION SOLUTION (<i>chlorprocaine hcl</i>)	3	
MACROLIDES - DRUGS FOR INFECTIONS		
*AZITHROMYCIN*** - ANTIBIOTICS		
<i>azithromycin intravenous solution reconstituted</i>	1 or 1b*	
<i>azithromycin oral suspension reconstituted</i>	1 or 1b*	
<i>azithromycin oral tablet</i>	1 or 1b*	
ZITHROMAX INTRAVENOUS SOLUTION RECONSTITUTED (<i>azithromycin</i>)	3	
ZITHROMAX ORAL PACKET (<i>azithromycin</i>)	3	
ZITHROMAX ORAL SUSPENSION RECONSTITUTED (<i>azithromycin</i>)	3	
ZITHROMAX ORAL TABLET (<i>azithromycin</i>)	3	
ZITHROMAX TRI-PAK ORAL TABLET (<i>azithromycin</i>)	3	
ZITHROMAX Z-PAK ORAL TABLET (<i>azithromycin</i>)	3	
*CLARITHROMYCIN*** - ANTIBIOTICS		
<i>clarithromycin er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>clarithromycin oral suspension reconstituted</i>	1 or 1b*	
<i>clarithromycin oral tablet</i>	1 or 1b*	
*ERYTHROMYCINS*** - ANTIBIOTICS		
<i>e.e.s. 400 oral tablet</i>	1 or 1b*	
<i>ery-tab oral tablet delayed release</i>	1 or 1b*	
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED (<i>erythromycin lactobionate</i>)	3	
<i>erythromycin base oral capsule delayed release particles</i>	1 or 1b*	
<i>erythromycin base oral tablet</i>	1 or 1b*	
<i>erythromycin base oral tablet delayed release</i>	1 or 1b*	
<i>erythromycin ethylsuccinate oral suspension reconstituted</i>	1 or 1b*	
<i>erythromycin ethylsuccinate oral tablet</i>	1 or 1b*	
<i>erythromycin lactobionate intravenous solution reconstituted</i>	1 or 1b*	
<i>erythromycin oral tablet delayed release</i>	1 or 1b*	
*FIDAXOMICIN*** - ANTIBIOTICS		
DIFICID ORAL SUSPENSION RECONSTITUTED (<i>fidaxomicin</i>)	3	QL (1 bottle per 30 days)
DIFICID ORAL TABLET (<i>fidaxomicin</i>)	3	QL (20 tablets per 1 fill)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEDICAL DEVICES AND SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
*CERVICAL CAPS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
FEMCAP VAGINAL DEVICE (<i>cervical caps</i>)	2; \$0	
*CONDOMS - FEMALE*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
FC2 FEMALE CONDOM (<i>condoms - female</i>)	2; \$0	QL (12 units per 1 fill)
*CONDOMS - MALE*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
<i>aimsco lubricated</i>	2; \$0	
<i>condoms</i>	2; \$0	
DUREX EXTRA SENSITIVE THIN (<i>condoms latex lubricated</i>)	2; \$0	
DUREX EXTRA SENSITIVE THIN DEVICE (<i>condoms latex lubricated</i>)	2; \$0	
DUREX REALFEEL DEVICE (<i>condoms non-latex lubricated</i>)	2; \$0	
DUREX TROPICAL (<i>condoms latex lubricated</i>)	2; \$0	
FANTASY LUBRICATED (<i>condoms latex lubricated</i>)	2; \$0	
FANTASY LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	2; \$0	
KAMELEON LUBRICATED (<i>condoms latex lubricated</i>)	2; \$0	
<i>kimono</i>	2; \$0	
KIMONO COLORS DEVICE (<i>condoms latex lubricated</i>)	2; \$0	
KIMONO MAXX-LARGE FLARE (<i>condoms latex lubricated</i>)	2; \$0	
<i>kimono micro thin</i>	2; \$0	
<i>kimono micro thin plus</i>	2; \$0	
<i>kimono plus</i>	2; \$0	
<i>kimono ps</i>	2; \$0	
<i>kimono ps plus</i>	2; \$0	
<i>kimono sensation</i>	2; \$0	
<i>kimono sensation plus</i>	2; \$0	
KIMONO SPECIAL DEVICE (<i>condoms latex lubricated</i>)	2; \$0	
<i>maxx</i>	2; \$0	
<i>maxx plus</i>	2; \$0	
REALITY LATEX CONDOMS (<i>condoms latex lubricated</i>)	2; \$0	
REALITY LATEX/ULTRA TEXTURED DEVICE (<i>condoms latex lubricated</i>)	2; \$0	
REALITY LATEX/ULTRA THIN DEVICE (<i>condoms latex lubricated</i>)	2; \$0	
TROJAN ENZ (<i>condoms latex non-lubricated</i>)	2; \$0	
TROJAN MAGNUM (<i>condoms latex lubricated</i>)	2; \$0	
TROJAN ULTRA RIBBED LUBRICATED DEVICE (<i>condoms latex lubricated</i>)	2; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TROJAN ULTRA THIN (<i>condoms latex lubricated</i>)	2; \$0	
TROJAN ULTRA THIN/SPERMICIDAL (<i>condoms latex lubricated</i>)	2; \$0	
TROJAN-ENZ LUBRICATED (<i>condoms latex lubricated</i>)	2; \$0	
TROJAN-ENZ/SPERMICIDAL (<i>condoms latex lubricated</i>)	2; \$0	
<i>true cover device</i>	2; \$0	
TRUSTEX COLOR CONDOMS + LUBE (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX LUB/RIBBED/STUDED (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX LUB/SPERMICIDE EX ST (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX LUB/SPERMICIDE XL (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX LUBRICATED (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX LUBRICATED EX LARGE (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX LUBRICATED EXTRA ST (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX NATURAL CONDOMS + LUBE (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	2; \$0	
TRUSTEX RIA LUB/SPERMICIDE (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX RIA LUBRICATED (<i>condoms latex lubricated</i>)	2; \$0	
TRUSTEX RIA NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	2; \$0	
TRUSTEX-NONOXYNOL-9/RIB/STUD (<i>condoms latex lubricated</i>)	2; \$0	
*DENTAL DESENSITIZING PRODUCTS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
REMESENSE DENTAL (<i>dental desensitizing product</i>)	3	
*DENTIFRICES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
MI PASTE DENTAL PASTE (<i>dentifrices</i>)	3	
MI PASTE PLUS DENTAL PASTE (<i>dentifrices</i>)	3	
*DIAPHRAGMS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
CAYA VAGINAL DIAPHRAGM (<i>diaphragm arc-spring</i>)	2; \$0	
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (<i>diaphragms</i>)	3; \$0	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
*GLUCOSE MONITORING TEST SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
ACCU-CHEK FASTCLIX LANCET KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
ACCU-CHEK FASTCLIX LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ACCU-CHEK SAFE-T PRO LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ACCU-CHEK SOFTCLIX LANCET DEV KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
ACCU-CHEK SOFTCLIX LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ACTI-LANCE 28G	2	QL (204 lancets per 30 days)
ACTI-LANCE LITE LANCETS 28G	2	QL (204 lancets per 30 days)
ACTI-LANCE SPECIAL LANCETS 17G	2	QL (204 lancets per 30 days)
ACTI-LANCE UNIVERSAL 23G	2	QL (204 lancets per 30 days)
<i>adjustable lancing device</i>	2	
ADVANCED MOBILE LANCET	2	QL (204 lancets per 30 days)
ADVOCATE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ADVOCATE LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ADVOCATE LANCING DEVICE (<i>lancet devices</i>)	2	
ADVOCATE RAPID-SAFE LANCING (<i>lancet devices</i>)	2	
ADVOCATE SAFETY LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ADVOCATE SAFETY LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
AGAMATRIX ULTRA-THIN LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
AIMSCO TWIST LANCETS 32G	2	QL (204 lancets per 30 days)
AIMSCO TWIST LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
AQUALANCE LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ASSURE COMFORT LANCETS 28G	2	QL (204 lancets per 30 days)
ASSURE LANCE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ASSURE LANCE LANCETS 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ASSURE LANCE PLUS SAFETY 25G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ASSURE LANCE PLUS SAFETY 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ASSURE LANCE SAFETY LANCET 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
AURORA LANCET SUPER THIN 30G	2	QL (204 lancets per 30 days)
AURORA LANCET THIN 23G	2	QL (204 lancets per 30 days)
AUTO-LANCET (<i>lancet devices</i>)	2	
AUTO-LANCET MINI (<i>lancet devices</i>)	2	
AUTOLET II CLINISAFE KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUTOLET LANCING DEVICE (<i>lancet devices</i>)	2	
AUTOLET LITE CLINISAFE KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
AUTOLET LITE STARTER PACK KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
AUTOLET MINI (<i>lancet devices</i>)	2	
AUTOLET PLATFORMS (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
AUTOLET PLUS (<i>lancet devices</i>)	2	
BD MICROTAINER LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARDIOCOM LANCING DEVICE (<i>lancet devices</i>)	2	
<i>careone advanced lancings dev</i>	2	
CAREONE LANCET SUPER THIN 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CAREONE LANCET THIN 23G	2	QL (204 lancets per 30 days)
CARESENS LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARESENS LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARETOUCH LANCING/EJECTOR (<i>lancet devices</i>)	2	
CARETOUCH SAFETY LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARETOUCH SAFETY LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CARETOUCH TWIST MC LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CHOSEN LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CHOSEN LANCING DEVICE (<i>lancet devices</i>)	2	
CHOSEN SAFETY LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CLEANLET LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CLEVER CHEK LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CLEVER CHOICE COMFORT EZ (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CLEVER CHOICE LANCETS 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CLEVER CHOICE LANCETS 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CLEVER CHOICE LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
COAGUCHEK LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
COMFORT ASSURED LANCETS 28G	2	QL (204 lancets per 30 days)
COMFORT ASSURED LANCETS 33G	2	QL (204 lancets per 30 days)
COMFORT TOUCH LANCETS 31G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
COMFORT TOUCH PLUS LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
COMFORT TOUCH PLUS LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
COMFORT TOUCH TWIST LANCET 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
CVS LANCETS 21G	2	QL (204 lancets per 30 days)
CVS LANCETS MICRO THIN 33G	2	QL (204 lancets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CVS LANCETS ORIGINAL	2	QL (204 lancets per 30 days)
CVS LANCETS THIN 26G	2	QL (204 lancets per 30 days)
CVS LANCETS ULTRA THIN 30G	2	QL (204 lancets per 30 days)
CVS LANCETS ULTRA-THIN 30G	2	QL (204 lancets per 30 days)
<i>cvs lancing device</i>	2	
CVS ULTRA THIN LANCETS	2	QL (204 lancets per 30 days)
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (3 units per 30 days)
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	2	PA; QL (1 unit per 90 days)
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 receiver per 1 year)
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (3 sensors per 30 days)
DIATHRIVE LANCET ULTRA THIN 30 (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DIATHRIVE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DIATHRIVE LANCING DEVICE (<i>lancet devices</i>)	2	
DROPLET GENTEEL LANCING DEVICE (<i>lancet devices</i>)	2	
DROPLET LANCETS ULTRA THIN 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DROPLET LANCING DEVICE (<i>lancet devices</i>)	2	
DROPLET PERSONAL LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DRUG MART LANCETS THIN 26G	2	QL (204 lancets per 30 days)
DRUG MART ON-THE-GO LANCET 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DRUG MART UNILET LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DRUG MART UNILET LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DRUG MART UNILET LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY COMFORT LANCETS	2	QL (204 lancets per 30 days)
EASY COMFORT LANCETS TWIST TOP	2	QL (204 lancets per 30 days)
<i>easy mini eject lancing device</i>	2	
<i>easy mini lancing device</i>	2	
EASY TOUCH LANCETS 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 28G/TWIST (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 30G/TWIST (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 32G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 32G/TWIST (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCETS 33G/TWIST (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH LANCING DEVICE (<i>lancet devices</i>)	2	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SAFETY LANCETS 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH SAFETY LANCETS 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH SAFETY LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EASY TOUCH SAFETY LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EMBRACE LANCETS ULTRA THIN 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
<i>embrace lancing device/ejector</i>	2	
EMBRACE PRESSURE ACTIVATED 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EMBRACE PRESSURE ACTIVATED 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ENLITE GLUCOSE SENSOR (<i>continuous glucose sensor</i>)	3	PA
EQL COLOR LANCETS 21G	2	QL (204 lancets per 30 days)
EQL COLOR LANCETS MICRO 33G	2	QL (204 lancets per 30 days)
EQL SUPER THIN LANCETS 30G	2	QL (204 lancets per 30 days)
EQL THIN LANCETS 26G	2	QL (204 lancets per 30 days)
EVERSENSE 365 SENSOR/HOLDER (<i>continuous glucose sensor</i>)	3	QL (1 sensor per 1 year)
EVERSENSE 365 SMART TRANSMIT (<i>continuous glucose transmitter</i>)	3	QL (1 transmitter per 1 year)
EVERSENSE E3 SENSOR/HOLDER (<i>continuous glucose sensor</i>)	3	PA
EVERSENSE E3 SMART TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 unit per 365 days)
EVERSENSE SENSOR/HOLDER (<i>continuous glucose sensor</i>)	3	PA
EVERSENSE SMART TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 unit per 365 days)
E-Z JECT LANCET MICRO-THIN 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
E-Z JECT LANCET SUPER THIN 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
E-Z JECT LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
E-Z JECT LANCETS 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
E-Z JECT LANCETS THIN 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
EZ-LETS LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
FIFTY50 SAFETY SEAL LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
FIFTY50 UNILET LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
FINGERSTIX LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
FORA LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
FORA LANCING DEVICE (<i>lancet devices</i>)	2	
FREESTYLE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 units per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 kits per 30 days)
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 reader per 1 year)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 units per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 sensors per 30 days)
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 1 year)
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 sensors per 28 days)
FREESTYLE LIBRE READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
FREESTYLE UNISTICK II LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
GENTEEL BUTTERFLY TOUCH LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
GENTEEL CONTACT TIPS (BLUE) (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL CONTACT TIPS (CLEAR) (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL CONTACT TIPS (GREEN) (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL CONTACT TIPS (ORANGE) (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL CONTACT TIPS (RAINBOW) (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL CONTACT TIPS (VIOLET) (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL CONTACT TIPS (YELLOW) (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL LANCING KIT (BLUE) KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL NOZZLES (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
GENTEEL PLUS LANCING (BLACK) (<i>lancet devices</i>)	2	
GENTEEL PLUS LANCING (PURPLE) (<i>lancet devices</i>)	2	
GENTEEL PLUS LANCING (WHITE) (<i>lancet devices</i>)	2	
GENTEEL PLUS LANCING DEV(BLUE) (<i>lancet devices</i>)	2	
GENTEEL PLUS LANCING DEV(PINK) (<i>lancet devices</i>)	2	
GLOBAL INJECT EASE LANCETS 28G	2	QL (204 lancets per 30 days)
GLOBAL INJECT EASE LANCETS 30G	2	QL (204 lancets per 30 days)
<i>global lancings device</i>	2	
GLUCOCOM LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
GLUCOCOM LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
GLUCOCOM LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
GNP LANCETS 21G	2	QL (204 lancets per 30 days)
GNP LANCETS THIN 26G	2	QL (204 lancets per 30 days)
GNP LANCING SYSTEM DEVICE (<i>lancet devices</i>)	2	
GNP STERILE LANCETS 28G	2	QL (204 lancets per 30 days)
GNP STERILE LANCETS 30G	2	QL (204 lancets per 30 days)
GNP STERILE LANCETS 33G	2	QL (204 lancets per 30 days)
GOJJI LANCING DEVICE/CLEAR CAP (<i>lancet devices</i>)	2	
GOJJI STERILE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
GOODSENSE COLOR LANCETS 33G	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 26G UNIV	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 30G	2	QL (204 lancets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GOODSENSE LANCETS 30G UNIV	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 33G	2	QL (204 lancets per 30 days)
GOODSENSE LANCETS 33G UNIV	2	QL (204 lancets per 30 days)
<i>goodsense lancing device</i>	2	
GUARDIAN 4 GLUCOSE SENSOR (<i>continuous glucose sensor</i>)	3	PA; QL (5 sensors per 30 days)
GUARDIAN 4 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (1 unit per 1 year)
GUARDIAN CONNECT TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA; QL (2 units per 1 year)
GUARDIAN LINK 3 TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA
GUARDIAN REAL-TIME REPLACE PED DEVICE (<i>continuous glucose receiver</i>)	3	PA; QL (1 unit per 365 days)
GUARDIAN SENSOR (3) (<i>continuous glucose sensor</i>)	3	PA; QL (5 sensors per 30 days)
GUARDIAN SENSOR 3	3	PA; QL (5 sensors per 30 days)
HAEMOLANCE (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HAEMOLANCE LOW FLOW LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS HIGH FLOW (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS LOW FLOW (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS MAX FLOW (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HAEMOLANCE PLUS PEDIATRIC FLOW (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HEALTH CARE LANCING DEVICE (<i>lancet devices</i>)	2	
<i>h-e-b incontrol adv lancing</i>	2	
H-E-B INCONTROL LANCETS 28G	2	QL (204 lancets per 30 days)
H-E-B INCONTROL LANCETS 30G	2	QL (204 lancets per 30 days)
H-E-B INCONTROL LANCETS 33G	2	QL (204 lancets per 30 days)
HYPOLANCE AST LANCING KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
HY-VEE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
HY-VEE THIN LANCETS	2	QL (204 lancets per 30 days)
IHEALTH LANCING DEVICE (<i>lancet devices</i>)	2	
IN TOUCH LANCING DEVICE (<i>lancet devices</i>)	2	
IN TOUCH STERILE LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
KINNEY LANCETS	2	QL (204 lancets per 30 days)
KINNEY THIN LANCETS	2	QL (204 lancets per 30 days)
KROGER AUTOLET LANCING DEVICE (<i>lancet devices</i>)	2	
KROGER HEALTHPRO LANCET 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
KROGER LANCETS	2	QL (204 lancets per 30 days)
KROGER LANCETS 21G	2	QL (204 lancets per 30 days)
KROGER LANCETS MICRO THIN 33G	2	QL (204 lancets per 30 days)
KROGER LANCETS SUPER THIN	2	QL (204 lancets per 30 days)
KROGER LANCETS THIN	2	QL (204 lancets per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KROGER LANCETS THIN 26G	2	QL (204 lancets per 30 days)
KROGER LANCETS ULTRATHIN 30G	2	QL (204 lancets per 30 days)
<i>kroger lancing device</i>	2	
<i>lancet device</i>	2	
<i>lancet device with ejector</i>	2	
LANCETS	2	QL (204 lancets per 30 days)
LANCETS 30G	2	QL (204 lancets per 30 days)
LANCETS 33G	2	QL (204 lancets per 30 days)
LANCETS MICRO THIN 33G	2	QL (204 lancets per 30 days)
LANCETS SUPER THIN (<i>lancets</i>)	2	QL (204 lancets per 30 days)
LANCETS SUPER THIN 28G	2	QL (204 lancets per 30 days)
LANCETS THIN	2	QL (204 lancets per 30 days)
LANCETS ULTRA THIN (<i>lancets</i>)	2	QL (204 lancets per 30 days)
LANCETS ULTRA THIN 30G	2	QL (204 lancets per 30 days)
<i>lancing device</i>	2	
LANZO (<i>lancet devices</i>)	2	
<i>leader advanced lancing device</i>	2	
LIBERTY MEDICAL LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
LIBERTY MINI LANCING DEVICE (<i>lancet devices</i>)	2	
LITE TOUCH LANCETS	2	QL (204 lancets per 30 days)
LITE TOUCH LANCING PEN (<i>lancet devices</i>)	2	
LITETOUCH LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
LIVE BETTER LANCET SUPER THIN	2	QL (204 lancets per 30 days)
LONGS LANCETS STANDARD	2	QL (204 lancets per 30 days)
LONGS LANCETS THIN	2	QL (204 lancets per 30 days)
LONGS LANCETS ULTRA THIN	2	QL (204 lancets per 30 days)
MEDICHOICE SAFETY LANCET	2	QL (204 lancets per 30 days)
MEDICHOICE SAFETY LANCET EXTRA	2	QL (204 lancets per 30 days)
MEDICHOICE SAFETY LANCET NORM	2	QL (204 lancets per 30 days)
MEDLANCE PLUS EXTRA 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS LITE 25G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS SPECIAL 0.8MM (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS SUPERLITE 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEDLANCE PLUS UNIVERSAL 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEIJER LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEIJER LANCETS THIN (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEIJER LANCETS UNIVERSAL 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEIJER LANCETS UNIVERSAL 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEIJER LANCETS UNIVERSAL 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MEIJER SUPER THIN LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MICROLET LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MICROLET NEXT LANCING DEVICE (<i>lancet devices</i>)	2	
<i>mini lancing device</i>	2	
MINILINK REAL-TIME TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA
MINIMED 630G GUARDIAN PRESS (<i>continuous glucose transmitter</i>)	3	PA
MM LANCING DEVICE (<i>lancet devices</i>)	2	
MM TWIST LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MONOLET LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MONOLET OPD LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
MONOLETTOR SAFETY LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
<i>multi-lancet device</i>	2	
MULTI-LANCET DEVICE 2 KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
MYGLUCOHEALTH LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
NOVA SAFETY LANCETS 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
NOVA SAFETY LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
NOVA SUREFLEX LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
NOVA SUREFLEX LANCING DEVICE (<i>lancet devices</i>)	2	
ONETOUCH DELICA PLUS LANCET30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ONETOUCH DELICA PLUS LANCET33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ONETOUCH DELICA PLUS LANCING (<i>lancet devices</i>)	2	
ONETOUCH DELICA SAFETY LANCING (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ONETOUCH ULTRASOFT 2 LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PARADIGM REAL-TIME TRANSMITTER (<i>continuous glucose transmitter</i>)	3	PA
PERFECT LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PERFECT LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PERFECT POINT SAFETY LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PHARMACIST CHOICE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PHARMACY COUNTER LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PIP LANCETS 28G	2	QL (204 lancets per 30 days)
PIP LANCETS 30G	2	QL (204 lancets per 30 days)
PREFERRED PLUS LANCETS COLORED	2	QL (204 lancets per 30 days)
PREFERRED PLUS LANCETS THIN	2	QL (204 lancets per 30 days)
PRO COMFORT LANCETS 30G	2	QL (204 lancets per 30 days)
PRO COMFORT LANCETS 31G	2	QL (204 lancets per 30 days)
<i>pro comfort safety lancets 30g</i>	2	QL (204 lancets per 30 days)
PRODIGY LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRODIGY LANCING DEVICE (<i>lancet devices</i>)	2	
PRODIGY SAFETY LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PRODIGY TWIST TOP LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
PURE COMFORT LANCETS 30G	2	QL (204 lancets per 30 days)
<i>px advanced lancing device</i>	2	
PX LANCETS MICROTHIN 33G	2	QL (204 lancets per 30 days)
PX LANCETS ULTRA THIN 28G	2	QL (204 lancets per 30 days)
<i>qc advanced lancing device</i>	2	
QC LANCETS SUPER THIN 30G	2	QL (204 lancets per 30 days)
QC LANCETS ULTRA THIN	2	QL (204 lancets per 30 days)
QC UNILET LANCETS 28G	2	QL (204 lancets per 30 days)
QC UNILET LANCETS MICRO THIN	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS THIN 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS THIN 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RA E-ZJECT LANCETS ULTRA THIN (<i>lancets</i>)	2	QL (204 lancets per 30 days)
READYLANCE SAFETY LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
REALITY LANCETS	2	QL (204 lancets per 30 days)
REALITY TRIGGER LANCETS	2	QL (204 lancets per 30 days)
RELION LANCET DEVICES 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RELION LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RELION LANCETS MICRO-THIN 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RELION LANCETS THIN 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RELION LANCETS ULTRA-THIN 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RELION LANCING DEVICE (<i>lancet devices</i>)	2	
RELION LANCING DEVICE KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
RELION ULTRA THIN LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RELION ULTRA THIN PLUS LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
REXALL LANCETS ULTRA THIN 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
RIGHTEST ALTERNATE SITE ADAPT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
RIGHTEST GD500 LANCING DEVICE (<i>lancet devices</i>)	2	
RIGHTEST GL300 LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SAFETY LANCET 30G/PRESSURE ACT	2	QL (204 lancets per 30 days)
SAFETY LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SAFETY LANCETS 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SAFETY LANCETS 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SAFETY LANCETS 28G	2	QL (204 lancets per 30 days)
<i>saps health plus lancets</i>	2	QL (204 lancets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SAPS HEALTH TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
SAPS TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
SAPSCARE TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
SB LANCETS THIN	2	QL (204 lancets per 30 days)
SB LANCETS ULTRA THIN	2	QL (204 lancets per 30 days)
<i>select-lite device/lancets kit</i>	2	QL (200 units per 30 days)
<i>select-lite lancing device</i>	2	
SIMPLE DIAGNOSTICS LANCING DEV (<i>lancet devices</i>)	2	
SINGLE-LET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SM LANCETS 33G	2	QL (204 lancets per 30 days)
SM TRUEDRAW LANCING DEVICE (<i>lancet devices</i>)	2	
SMART DIABETES VANTAGE LANCING (<i>lancet devices</i>)	2	
SMART SENSE COLOR LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SMART SENSE STANDARD LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SMART SENSE SUPER THIN LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SMART SENSE THIN LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SMARTEST LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SOLUS V2 LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SOLUS V2 LANCING DEVICE (<i>lancet devices</i>)	2	
SOLUS V2 TWIST LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
STERILANCE TL (<i>lancets</i>)	2	QL (204 lancets per 30 days)
SUPER THIN LANCETS	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 18G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 21G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 23G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 28G	2	QL (204 lancets per 30 days)
SURE COMFORT LANCETS 30G	2	QL (204 lancets per 30 days)
<i>sure comfort lancing pen</i>	2	
SURELITE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TECHLITE AST LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TECHLITE LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TECHLITE LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TGT LANCET MICRO THIN 33G	2	QL (204 lancets per 30 days)
TGT LANCET THIN 26G	2	QL (204 lancets per 30 days)
TGT LANCET ULTRA THIN 30G	2	QL (204 lancets per 30 days)
<i>tgt lancing device</i>	2	
<i>today's health lancing device</i>	2	
TODAYS HEALTH THIN LANCETS 28G	2	QL (204 lancets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TODAYS HEALTH THIN LANCETS 30G	2	QL (204 lancets per 30 days)
TOPCARE LANCETS MICRO-THIN 33G	2	QL (204 lancets per 30 days)
TRAVEL LANCETS ADVANCED 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
<i>true comfort safety lancets</i>	2	QL (204 lancets per 30 days)
TRUE COMFORT TWIST TOP LANCETS	2	QL (204 lancets per 30 days)
TRUEDRAW LANCING DEVICE (<i>lancet devices</i>)	2	
TRUEPLUS LANCETS 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TRUEPLUS LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TRUEPLUS LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TRUEPLUS LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
TRUEPLUS SAFETY LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
<i>twist top lancets 30g</i>	2	QL (204 lancets per 30 days)
ULTI-LANCE AUTOMATIC (<i>lancet devices</i>)	2	
ULTILET CLASSIC LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ULTILET LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ULTILET SAFETY LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ULTILET SAFETY LANCETS 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ULTRA THIN LANCETS 31G	2	QL (204 lancets per 30 days)
ULTRA-CARE LANCETS 30G	2	QL (204 lancets per 30 days)
ULTRA-THIN II AUTO LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ULTRA-THIN II LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET COMFORTOUCH LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET EXCELITE (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET EXCELITE II (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET G.P. LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET G.P. SUPERLITE LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET GP 28 ULTRA THIN (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET MICRO-THIN 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET SUPERLITE LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET SUPER-THIN 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNILET ULTRA-THIN 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK 1 (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 2 (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 2 COMFORT (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 2 EXTRA (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 2 NEONATAL (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 2 NORMAL (<i>lancets</i>)	2	QL (200 units per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNISTIK 2 SUPER (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 3 (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 3 COMFORT (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 3 EXTRA (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 3 GENTLE (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK 3 NEONATAL (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK 3 NORMAL (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK CZT COMFORT (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK CZT NORMAL (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK NORMAL (<i>lancets</i>)	2	QL (200 units per 30 days)
UNISTIK PRO SAFETY LANCET (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK SAFETY LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK SAFETY LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNISTIK TOUCH SAFETY LANC 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNIVERSAL 1 LANCETS THIN 26G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNIVERSAL 1 LANCETS THIN 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
UNIVERSAL 1 LANCETS ULTRA THIN (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VALUE PLUS LANCET STANDARD 21G	2	QL (204 lancets per 30 days)
VALUE PLUS LANCETS SUPER THIN	2	QL (204 lancets per 30 days)
VALUE PLUS LANCETS THIN 26G	2	QL (204 lancets per 30 days)
<i>value plus lancing device</i>	2	
VERIFINE SAFE LANCET MINI 21G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VERIFINE SAFE LANCET MINI 23G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VERIFINE SAFE LANCET MINI 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VERIFINE SAFE LANCET MINI 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VERIFINE UNIVERSAL LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VERIFINE UNIVERSAL LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VERIFINE UNIVERSAL LANCETS 33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VIVAGUARD LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VIVAGUARD LANCETS 30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
VIVAGUARD LANCING DEVICE (<i>lancet devices</i>)	2	
VIVAGUARD SAFETY LANCETS 28G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
WALGREENS LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
WALGREENS LANCETS MICRO THIN	2	QL (204 lancets per 30 days)
WALGREENS LANCETS SUPER THIN	2	QL (204 lancets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WALGREENS THIN LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
WALGREENS ULTRA THIN LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ZEV RX TWIST TOP LANCETS 30G	2	QL (204 lancets per 30 days)
*INSULIN ADMINISTRATION SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD 5 LIBRE2 PLUS G6 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 years)
OMNIPOD 5 LIBRE2 PLUS G6 PODS (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD CLASSIC PODS (GEN 3) (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PDM (GEN 4) KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PODS (GEN 4) (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
*NEEDLES & SYRINGES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
1ST TIER UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
1ST TIER UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
<i>aq insulin syringe</i>	3	ST; QL (200 syringes per 30 days)
<i>aqinject pen needle</i>	3	ST; QL (200 needles per 30 days)
ASSURE ID DUO PRO PEN NEEDLES (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
ASSURE ID PRO PEN NEEDLES (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
ASSURE ID SAFETY PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
<i>aum insulin safety pen needle</i>	3	ST; QL (200 needles per 30 days)
AUM MINI INSULIN PEN NEEDLE	3	ST; QL (200 needles per 30 days)
<i>aum pen needle</i>	3	ST; QL (200 needles per 30 days)
AUM READYGARD DUO PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
AUM SAFETY PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
AURORA PEN NEEDLES	3	ST; QL (200 needles per 30 days)
BD AUTOSHIELD DUO (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD INSULIN SYR ULTRAFINE II (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE HALF-UNIT (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE MICROFINE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U/F (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U/F 1/2UNIT (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U-500 (<i>insulin syringe/needle u-500</i>)	2	QL (200 syringes per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD INSULIN SYRINGE ULTRAFINE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD PEN NEEDLE MICRO U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE MINI U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE NANO 2ND GEN (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE NANO U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE ORIGINAL U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE SHORT U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD SAFETYGLIDE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD VEO INSULIN SYR U/F 1/2UNIT (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD VEO INSULIN SYRINGE U/F (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
CAREFINE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
CAREONE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
CAREONE UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
CARETOUCH INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
CARETOUCH PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
CLEVER CHOICE COMFORT EZ 29G X 12MM , 33G X 4 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
CLICKFINE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
COMFORT ASSIST INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML (<i>insulin syringe-needle u-100</i>)	3	QL (200 syringes per 30 days)
COMFORT EZ MICRO PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PRO PEN NEEDLES 31G X 5 MM (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
COMFORT EZ SHORT PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
COMFORT TOUCH INSULIN PEN NEED (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
DIATHRIVE PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 15/64" 0.3 ML, 30G X 15/64" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML (<i>insulin syringe-needle u-100</i>)	3	QL (200 syringes per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DROPLET MICRON (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
DROPLET PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
DROPSAFE SAFETY PEN NEEDLES	3	ST; QL (200 needles per 30 days)
DROPSAFE SAFETY SYRINGE/NEEDLE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 needles per 30 days)
DRUG MART UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
DRUG MART UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
EASY COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML, 32G X 5/16" 0.5 ML, 32G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
<i>easy comfort insulin syringe 31g x 1/2" 0.3 ml, 31g x 5/16" 0.3 ml</i>	3	ST; QL (200 syringes per 30 days)
EASY COMFORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
EASY GLIDE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
EASY TOUCH FLIPLOCK INSULIN SY (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SAFETY SYR (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML (<i>insulin syringe-needle u-100</i>)	3	QL (200 syringes per 30 days)
EASY TOUCH PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
EASY TOUCH SAFETY PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 1 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
EMBRACE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
EQL INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
FIFTY50 PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
FIFTY50 SUPERIOR COMFORT SYR (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
GLOBAL EASE INJECT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GLOBAL EASY GLIDE INSULIN SYR	3	ST; QL (200 syringes per 30 days)
GLOBAL EASY GLIDE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GLOBAL INJECT EASE INSULIN SYR	3	ST; QL (200 syringes per 30 days)
GLOBAL INSULIN SYRINGES	3	ST; QL (200 syringes per 30 days)
GLUCOPRO INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
GNP CLICKFINE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GNP INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 28GX1/2"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 29GX1/2"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 30GX5/16"	3	ST; QL (200 syringes per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GNP INSULIN SYRINGES 31GX5/16"	3	ST; QL (200 syringes per 30 days)
GNP ULTICARE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GNP ULTIGUARD SAFEPAK NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
GNP ULTRA COM INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
GOODSENSE CLICKFINE PEN NEEDLE	3	ST; QL (200 needles per 30 days)
GOODSENSE PEN NEEDLE PENFINE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
HEALTHWISE INSULIN SYR/NEEDLE	3	ST; QL (200 syringes per 30 days)
HEALTHWISE MICRON PEN NEEDLES	3	ST; QL (200 needles per 30 days)
HEALTHWISE SHORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
H-E-B INCONTROL PEN NEEDLES	3	ST; QL (200 needles per 30 days)
H-E-B INCONTROL UNIFINE PENTIP (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
HM ULTICARE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
HM ULTICARE MINI PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
HM ULTICARE SHORT PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
INCONTROL ULTICARE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml, 27g x 1/2" 1 ml, 28g x 1/2" 0.5 ml, 28g x 1/2" 1 ml, 30g x 1/2" 1 ml</i>	3	ST; QL (200 syringes per 30 days)
INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 1/4" 0.3 ML, 31G X 1/4" 0.5 ML, 31G X 1/4" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
INSUPEN PEN NEEDLES	3	ST; QL (200 needles per 30 days)
KINRAY INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
KMART VALU INSULIN SYRINGE 29G	3	ST; QL (200 syringes per 30 days)
KMART VALU INSULIN SYRINGE 30G	3	ST; QL (200 syringes per 30 days)
KROGER INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
KROGER PEN NEEDLES	3	ST; QL (200 needles per 30 days)
LEADER INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
LEADER UNIFINE PENTIPS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
LEADER UNIFINE PENTIPS PLUS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
LITETOUCH INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
LITETOUCH PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
LONGS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
MAGELLAN INSULIN SAFETY SYR (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
MARATHON MEDICAL PENTIPS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
MAXICOMFORT II PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
MAXI-COMFORT INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
MAXI-COMFORT SAFETY PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
MAXICOMFORT SYR 27G X 1/2" (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEDIC INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
MEDICINE SHOPPE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
MEIJER PEN NEEDLES	3	ST; QL (200 needles per 30 days)
MICRODOT PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
MM INSULIN SYRINGE/NEEDLE	3	ST; QL (200 syringes per 30 days)
MM PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
MONOJECT INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
MONOJECT ULTRA COMFORT SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
MS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
NOVOFINE PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
NOVOFINE PLUS PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
PC UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
<i>pen needle/5-bevel tip</i>	3	ST; QL (200 needles per 30 days)
PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PEN NEEDLES 5/16"	3	ST; QL (200 needles per 30 days)
PENTIPS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
PENTIPS GENERIC PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
<i>pip pen needles 31g x 5mm</i>	3	ST; QL (200 needles per 30 days)
<i>pip pen needles 32g x 4mm</i>	3	ST; QL (200 needles per 30 days)
PRECISION SURE-DOSE SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
PREFERRED PLUS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
PREFERRED PLUS UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
PREVENT DROPSAFE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
PREVENT SAFETY PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
PRO COMFORT INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
PRO COMFORT PEN NEEDLES 32G X 4 MM , 32G X 5 MM , 32G X 6 MM	3	ST; QL (200 needles per 30 days)
PRODIGY INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
PURE COMFORT PEN NEEDLE	3	ST; QL (200 needles per 30 days)
<i>pure comfort safety pen needle</i>	3	QL (200 needles per 30 days)
PX EXTRA SHORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PX INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
PX MINI PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PX PEN NEEDLE	3	ST; QL (200 needles per 30 days)
QC PEN NEEDLES	3	ST; QL (200 needles per 30 days)
QC UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
RA INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
RA PEN NEEDLES	3	ST; QL (200 needles per 30 days)
<i>raya sure pen needle</i>	3	ST; QL (200 needles per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REALITY INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
RELION INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
RELION MINI PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
RELION PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
RELION SHORT PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
<i>safety pen needles</i>	3	ST; QL (200 needles per 30 days)
SB INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
SECURES SAFE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
SECURES SAFE SAFETY PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
SURE COMFORT INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
SURE COMFORT PEN NEEDLES 29G X 12.7MM , 30G X 8 MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM	3	ST; QL (200 needles per 30 days)
<i>sure comfort pen needles 31g x 6 mm</i>	3	ST; QL (200 needles per 30 days)
TECHLITE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
TECHLITE PEN NEEDLES 29G X 12MM , 31G X 5 MM (<i>insulin pen needle</i>)	3	
TECHLITE PEN NEEDLES 31G X 8 MM , 32G X 6 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
TECHLITE PLUS PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
TODAYS HEALTH PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TODAYS HEALTH SHORT PEN NEEDLE	3	ST; QL (200 needles per 30 days)
TOPCARE CLICKFINE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TOPCARE ULTRA COMFORT INS SYR	3	ST; QL (200 syringes per 30 days)
<i>true comfort insulin syringe 30g x 1/2" 0.5 ml, 30g x 1/2" 1 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 32g x 5/16" 1 ml</i>	3	ST; QL (200 syringes per 30 days)
TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
TRUE COMFORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TRUE COMFORT PRO INSULIN SYR	3	ST; QL (200 syringes per 30 days)
TRUE COMFORT PRO PEN NEEDLES	3	ST; QL (200 needles per 30 days)
TRUEPLUS 5-BEVEL PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
TRUEPLUS INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
TRUEPLUS PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTICARE INSULIN SAFETY SYR (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTICARE INSULIN SYR 1/2 UNIT (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTICARE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTICARE MICRO PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTICARE MINI PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTICARE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTICARE SHORT PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTIGUARD SAFEPAK PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTIGUARD SAFEPAK SYR/NEEDLE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTILET PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTRA COMFORT INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
ULTRA FLO INSULIN PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTRA FLO INSULIN SYR 1/2 UNIT (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTRA FLO INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTRA THIN PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTRACARE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
ULTRACARE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II INS SYR SHORT (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTRA-THIN II INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTRA-THIN II MINI PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II PEN NEEDLE SHORT (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE PENTIPS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE PENTIPS PLUS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
UNIFINE PROTECT PEN NEEDLE 30G X 8 MM , 32G X 4 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE SAFECONTROL PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE ULTRA PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
VALUE HEALTH INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
VANISHPOINT INSULIN SYRINGE 29G X 1/2" 1 ML, 29G X 5/16" 1 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML, 30G X 3/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	QL (200 syringes per 30 days)
VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
VERIFINE INSULIN PEN NEEDLE 31G X 5 MM (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
VERIFINE INSULIN SYRINGE 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	QL (200 syringes per 30 days)
VERIFINE PLUS PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
VP INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
WEGMANS UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
ZEV RX INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
ZEV RX PEN NEEDLES	3	ST; QL (200 needles per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIGRAINE PRODUCTS - DRUGS FOR THE NERVOUS SYSTEM		
*CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAG (CGRP)*** - DRUGS FOR MIGRAINE HEADACHES		
NURTEC ORAL TABLET DISPERSIBLE (<i>rimegepant sulfate</i>)	2	PA; QL (8 tablets per 30 days)
QULIPTA ORAL TABLET (<i>atogepant</i>)	2	PA; QL (1 tablet per 1 day)
UBRELVY ORAL TABLET (<i>ubrogepant</i>)	2	ST; QL (16 tablets per 30 days)
*CGRP RECEPTOR ANTAGONISTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR MIGRAINE HEADACHES		
AIMOVIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>erenumab-aooe</i>)	3	PA; QL (1 autoinjector per 28 days)
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>fremanezumab-vfrm</i>)	3	PA; QL (3 syringes per 90 days)
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>fremanezumab-vfrm</i>)	3	PA; QL (3 syringes per 90 days)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>galcanezumab-gnlm</i>)	3	PA; QL (3 syringes per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>galcanezumab-gnlm</i>)	3	PA; QL (1 pen per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>galcanezumab-gnlm</i>)	3	PA; QL (1 syringe per 28 days)
*ERGOT COMBINATIONS*** - DRUGS FOR MIGRAINE HEADACHES		
<i>ergotamine-caffeine oral tablet</i>	1 or 1b*	
<i>migergot rectal suppository</i>	1 or 1b*	
*MIGRAINE PRODUCTS*** - DRUGS FOR MIGRAINE HEADACHES		
<i>dihydroergotamine mesylate injection solution</i>	1 or 1b*	PA; QL (24 mL per 28 days)
*SELECTIVE SEROTONIN AGONISTS 5-HT(1)*** - DRUGS FOR MIGRAINE HEADACHES		
<i>almotriptan malate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>eletriptan hydrobromide oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>frovatriptan succinate oral tablet</i>	1 or 1b*	ST; QL (9 tablets per 30 days)
<i>naratriptan hcl oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>rizatriptan benzoate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>rizatriptan benzoate oral tablet dispersible</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>sumatriptan nasal solution</i>	1 or 1b*	QL (6 nasal inhalers per 30 days)
<i>sumatriptan succinate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge</i>	1 or 1b*	QL (6 cartridges per 30 days)
<i>sumatriptan succinate subcutaneous solution</i>	1 or 1b*	QL (5 vials per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml</i>	1 or 1b*	QL (6 syringes (2 ML) per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	1 or 1b*	QL (6 cartridges per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zolmitriptan nasal solution</i>	1 or 1b*	ST; QL (6 nasal inhalers per 30 days)
<i>zolmitriptan oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>zolmitriptan oral tablet dispersible</i>	1 or 1b*	QL (9 tablets per 30 days)
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION		
*BICARBONATES*** - DRUGS FOR NUTRITION		
SODIUM ACETATE INTRAVENOUS SOLUTION 2 MEQ/ML	3	
<i>sodium acetate intravenous solution 4 meq/ml</i>	1 or 1b*	
<i>sodium bicarbonate intravenous solution 4.2 %, 7.5 %</i>	1 or 1b*	
THAM INTRAVENOUS SOLUTION (<i>tromethamine</i>)	3	
*CALCIUM COMBINATIONS*** - DRUGS FOR NUTRITION		
CALCIUM GLUCONATE-NACL INTRAVENOUS SOLUTION 1-0.675 GM/50ML-%, 1-0.8 GM/100ML-%, 2-0.675 GM/100ML-%	3	
*CALCIUM*** - DRUGS FOR NUTRITION		
CALCIUM GLUCONATE INTRAVENOUS SOLUTION	3	
*ELECTROLYTES & DEXTROSE*** - DRUGS FOR NUTRITION		
DEXTROSE 5%/ELECTROLYTE #48 INTRAVENOUS SOLUTION	3	
<i>dextrose in lactated ringers intravenous solution</i>	1 or 1b*	
DEXTROSE-SODIUM CHLORIDE INTRAVENOUS SOLUTION 10-0.2 %, 5-0.225 %, 5-0.3 %	3	
<i>dextrose-sodium chloride intravenous solution 10-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.45 %, 5-0.9 %</i>	1 or 1b*	
<i>dextrose-sodium chloride intravenous solution 2.5-0.45 %</i>	3	
IONOSOL-MB IN D5W INTRAVENOUS SOLUTION (<i>electrolyte-mb in dextrose</i>)	3	
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION (<i>electrolyte-p in dextrose</i>)	3	
<i>kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%</i>	1 or 1b*	
KCL IN DEXTROSE-NACL INTRAVENOUS SOLUTION 20-5-0.225 MEQ/L-%-%, 40-5-0.9 MEQ/L-%-%	3	
KCL-LACTATED RINGERS-D5W INTRAVENOUS SOLUTION	3	
NORMOSOL-M IN D5W INTRAVENOUS SOLUTION (<i>electrolyte-m in dextrose</i>)	3	
NORMOSOL-R IN D5W INTRAVENOUS SOLUTION (<i>electrolyte-r in dextrose</i>)	3	
<i>potassium cl in dextrose 5% intravenous solution</i>	1 or 1b*	
*ELECTROLYTES PARENTERAL*** - DRUGS FOR NUTRITION		
ISOLYTE-S INTRAVENOUS SOLUTION (<i>electrolyte-s</i>)	3	
ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION (<i>electrolyte-s (ph 7.4)</i>)	3	
KCL (0.149%) IN NACL INTRAVENOUS SOLUTION 20-0.45 MEQ/L-%	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>kcl (0.149%) in nacl intravenous solution 20-0.9 meq/l-%</i>	1 or 1b*	
KCL (0.298%) IN NACL INTRAVENOUS SOLUTION	1 or 1b*	
<i>lactated ringers intravenous solution</i>	1 or 1b*	
<i>multiple electro type 1 ph 5.5 intravenous solution</i>	1 or 1b*	
<i>multiple electro type 1 ph 7.4 intravenous solution</i>	1 or 1b*	
NORMOSOL-R INTRAVENOUS SOLUTION (<i>electrolyte-r</i>)	3	
NORMOSOL-R PH 7.4 INTRAVENOUS SOLUTION (<i>electrolyte-r (ph 7.4)</i>)	3	
PLASMA-LYTE A INTRAVENOUS SOLUTION (<i>electrolyte-a</i>)	3	
POTASSIUM CHLORIDE IN NACL INTRAVENOUS SOLUTION 20-0.45 MEQ/L-%, 40-0.9 MEQ/L-%	3	
<i>potassium chloride in nacl intravenous solution 20-0.9 meq/l-%</i>	3	
<i>ringers intravenous solution</i>	1 or 1b*	
TPN ELECTROLYTES INTRAVENOUS CONCENTRATE (<i>parenteral electrolytes</i>)	3	
*FLUORIDE COMBINATIONS*** - DRUGS FOR NUTRITION		
FLORIVA ORAL LIQUID (<i>sodium fluoride-vitamin d</i>)	3	
*FLUORIDE*** - DRUGS FOR NUTRITION		
<i>sodium fluoride oral solution</i>	1 or 1a*; \$0	
<i>sodium fluoride oral tablet</i>	1 or 1a*; \$0	
<i>sodium fluoride oral tablet chewable</i>	1 or 1a*; \$0	
*MAGNESIUM*** - DRUGS FOR NUTRITION		
MAGNESIUM SULFATE IN D5W INTRAVENOUS SOLUTION	3	
MAGNESIUM SULFATE INJECTION SOLUTION	1 or 1b*	
MAGNESIUM SULFATE INTRAVENOUS SOLUTION	3	
*MANGANESE*** - DRUGS FOR NUTRITION		
<i>manganese chloride intravenous solution</i>	1 or 1b*	
*PHOSPHATE*** - DRUGS FOR NUTRITION		
GLYCOPHOS INTRAVENOUS SOLUTION (<i>sodium glycerophosphate</i>)	3	
K-PHOS ORAL TABLET (<i>potassium phosphate monobasic</i>)	2	
K-PHOS-NEUTRAL ORAL TABLET (<i>k phos mono-sod phos di & mono</i>)	3	
<i>phospha 250 neutral oral tablet</i>	1 or 1b*	
<i>phosphorous oral tablet</i>	1 or 1b*	
<i>phospho-trin 250 neutral oral tablet</i>	1 or 1b*	
<i>phospho-trin k500 oral tablet</i>	1 or 1b*	
POTASSIUM PHOSPHATES INTRAVENOUS SOLUTION 15 MMOLE/5ML, 150 MMOLE/50ML	3	
<i>potassium phosphates intravenous solution 45 mmole/15ml</i>	1 or 1b*	
<i>potassium phosphates(66 meq k) intravenous solution</i>	3	
POTASSIUM PHOSPHATES(71 MEQ K) INTRAVENOUS SOLUTION	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium phosphates intravenous solution</i>	1 or 1b*	
<i>wes-phos 250 neutral oral tablet</i>	1 or 1b*	
*POTASSIUM*** - DRUGS FOR NUTRITION		
<i>klor-con 10 oral tablet extended release</i>	1 or 1b*	
<i>klor-con m10 oral tablet extended release</i>	1 or 1a*	
<i>klor-con m15 oral tablet extended release</i>	1 or 1a*	
<i>klor-con m20 oral tablet extended release</i>	1 or 1a*	
<i>klor-con oral packet</i>	1 or 1b*	
<i>klor-con oral tablet extended release</i>	1 or 1b*	
K-TAB ORAL TABLET EXTENDED RELEASE (<i>potassium chloride</i>)	3	
POTASSIUM ACETATE INTRAVENOUS SOLUTION	3	
<i>potassium chloride crys er oral tablet extended release</i>	1 or 1a*	
<i>potassium chloride er oral capsule extended release</i>	1 or 1b*	
<i>potassium chloride er oral tablet extended release</i>	1 or 1b*	
POTASSIUM CHLORIDE INTRAVENOUS SOLUTION 10 MEQ/100ML, 10 MEQ/50ML, 20 MEQ/100ML, 20 MEQ/50ML, 40 MEQ/100ML	3	
<i>potassium chloride intravenous solution 2 meq/ml</i>	1 or 1b*	
<i>potassium chloride oral packet</i>	1 or 1b*	
<i>potassium chloride oral solution</i>	1 or 1b*	
*SODIUM*** - DRUGS FOR NUTRITION		
<i>aquastat intravenous solution</i>	1 or 1b*	
<i>sodium chloride flush</i> (Aquastat Sfr Intravenous Solution)	1 or 1b*	
<i>bd posiflush intravenous solution</i>	1 or 1b*	
<i>sodium chloride flush</i> (Bd Posiflush Safescrub Intravenous Solution)	1 or 1b*	
<i>monoject flush syringe intravenous solution</i>	1 or 1b*	
<i>monoject sodium chloride flush intravenous solution</i>	1 or 1b*	
<i>normal saline flush intravenous solution</i>	1 or 1b*	
<i>saline flush intravenous solution</i>	1 or 1b*	
<i>sodium chloride (pf) injection solution</i>	1 or 1b*	
<i>sodium chloride injection solution</i>	1 or 1b*	
<i>sodium chloride intravenous solution 0.45 %, 3 %, 5 %</i>	1 or 1b*	
*TRACE MINERAL COMBINATIONS*** - DRUGS FOR NUTRITION		
MULTITRACE-4 PEDIATRIC INTRAVENOUS SOLUTION (<i>trace minerals cr-cu-mn-zn</i>)	3	
MULTRYS INTRAVENOUS SOLUTION (<i>trace minerals cu-mn-se-zn</i>)	3	
THE LIQUILIFT TRACE INTRAVENOUS KIT (<i>trace minerals cr-cu-mn-se-zn</i>)	3	
TRALEMENT INTRAVENOUS SOLUTION (<i>trace minerals cu-mn-se-zn</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*TRACE MINERALS*** - DRUGS FOR NUTRITION		
<i>chromic chloride intravenous solution</i>	1 or 1b*	
<i>cupric chloride intravenous solution</i>	3	
SELENIOS ACID INTRAVENOUS SOLUTION 12 MCG/2ML, 60 MCG/ML	3	
SELENIOS ACID INTRAVENOUS SOLUTION 40 MCG/ML	1 or 1b*	
*ZINC*** - DRUGS FOR NUTRITION		
GALZIN ORAL CAPSULE (<i>zinc acetate (oral)</i>)	3	
<i>zinc chloride intravenous solution</i>	3	
<i>zinc sulfate intravenous solution</i>	1 or 1b*	
MISCELLANEOUS THERAPEUTIC CLASSES - VITAMINS AND MINERALS		
*ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME AGENT*** - VITAMINS AND MINERALS		
JOENJA ORAL TABLET (<i>leniolisib phosphate</i>)	3; OC	PA; LD; QL (2 tablets per 1 day); OC
*ANTILEPTOTICS*** - VITAMINS AND MINERALS		
THALOMID ORAL CAPSULE (<i>thalidomide</i>)	2; OC	PA; LD; QL (1 capsule per 1 day); OC
*B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS*** - VITAMINS AND MINERALS		
BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED (<i>belimumab</i>)	3	PA; LD
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>belimumab</i>)	3	PA; LD; QL (4 autoinjectors per 28 days)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>belimumab</i>)	3	PA; LD; QL (4 pens per 28 days)
*CHELATING AGENTS*** - VITAMINS AND MINERALS		
DEPEN TITRATABS ORAL TABLET (<i>penicillamine</i>)	3	PA; LD; QL (8 tablets per 1 day)
<i>penicillamine oral tablet</i>	1 or 1b*	PA; LD; QL (8 tablets per 1 day)
<i>trientine hcl oral capsule 250 mg</i>	1 or 1b*	PA; LD; QL (8 capsules per 1 day)
*CONTINUOUS RENAL REPLACEMENT THERAPY (CRRT) SOLUTIONS*** - VITAMINS AND MINERALS		
PHOXILLUM B22K4/0 EXTRACORPOREAL SOLUTION	3	
PHOXILLUM BK4/2.5 EXTRACORPOREAL SOLUTION	3	
PRISMASOL B22GK 4/0 EXTRACORPOREAL SOLUTION (<i>bicarb-dextrose-k (crrt)</i>)	3	
PRISMASOL BGK 0/2.5 EXTRACORPOREAL SOLUTION (<i>bicarb-dextrose-ca (crrt)</i>)	3	
PRISMASOL BGK 2/0 EXTRACORPOREAL SOLUTION (<i>bicarb-dextrose-k (crrt)</i>)	3	
PRISMASOL BGK 2/3.5 EXTRACORPOREAL SOLUTION (<i>bicarb-dextrose-k-ca (crrt)</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRISMASOL BGK 4/0/1.2 EXTRACORPOREAL SOLUTION (<i>bicarb-dextrose-k-mg (crrt)</i>)	3	
PRISMASOL BGK 4/2.5 EXTRACORPOREAL SOLUTION (<i>bicarb-dextrose-k-ca (crrt)</i>)	3	
PRISMASOL BK 0/0/1.2 EXTRACORPOREAL SOLUTION (<i>bicarb-mg (crrt)</i>)	3	
*CYCLOSPORINE ANALOGS*** - VITAMINS AND MINERALS		
<i>cyclosporine modified oral capsule</i>	1 or 1b*	LD
<i>cyclosporine modified oral solution</i>	1 or 1b*	LD
<i>cyclosporine oral capsule</i>	1 or 1b*	LD
<i>gengraf oral capsule</i>	1 or 1b*	LD
<i>gengraf oral solution</i>	1 or 1b*	LD
LUPKYNIS ORAL CAPSULE (<i>voclosporin</i>)	3	PA; LD; QL (6 capsules per 1 day)
NEORAL ORAL CAPSULE (<i>cyclosporine modified</i>)	3	LD
NEORAL ORAL SOLUTION (<i>cyclosporine modified</i>)	3	LD
SANDIMMUNE INTRAVENOUS SOLUTION (<i>cyclosporine</i>)	3	LD
SANDIMMUNE ORAL CAPSULE (<i>cyclosporine</i>)	3	LD
*ENZYMES*** - VITAMINS AND MINERALS		
AMPHADASE INJECTION SOLUTION (<i>hyaluronidase bovine</i>)	3	
HYLENEX INJECTION SOLUTION (<i>hyaluronidase human</i>)	3	
XIAFLEX INJECTION SOLUTION RECONSTITUTED (<i>collagenase clostrid histolyt</i>)	3	PA; LD
*FARNESYLTRANSFERASE INHIBITORS*** - VITAMINS AND MINERALS		
ZOKINVY ORAL CAPSULE (<i>lonafarnib</i>)	3	PA; LD; QL (4 capsules per 1 day)
*FECAL INCONTINENCE BULKING AGENT - COMBINATIONS*** - VITAMINS AND MINERALS		
SOLESTA INJECTION GEL (<i>dextranomer-sodium hyaluronate</i>)	3	LD
*IMMUNE GLOBULIN IMMUNOSUPPRESSANTS*** - VITAMINS AND MINERALS		
ATGAM INTRAVENOUS SOLUTION (<i>lymphocyte,anti-thymo imm glob</i>)	3	LD
THYMOGLOBULIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>anti-thymocyte glob (rabbit)</i>)	3	LD
*IMMUNOMODULATORS - COMBINATIONS*** - VITAMINS AND MINERALS		
VYVGART HYTRULO SUBCUTANEOUS SOLUTION (<i>efgartigimod alfa-hyalur-qvfc</i>)	3	PA; LD; QL (4 vials per 50 days)
*IMMUNOMODULATORS FOR MYELOYDYSPLASTIC SYNDROMES*** - VITAMINS AND MINERALS		
<i>lenalidomide oral capsule</i>	1 or 1b*; OC	PA; LD; QL (1 capsule per 1 day); OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REVLIMID ORAL CAPSULE (<i>lenalidomide</i>)	2; OC	PA; LD; QL (1 capsule per 1 day); OC
*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS**** - VITAMINS AND MINERALS		
CELLCEPT INTRAVENOUS INTRAVENOUS SOLUTION RECONSTITUTED (<i>mycophenolate mofetil hcl</i>)	3	LD
CELLCEPT ORAL CAPSULE (<i>mycophenolate mofetil</i>)	3	ST; LD
CELLCEPT ORAL SUSPENSION RECONSTITUTED (<i>mycophenolate mofetil</i>)	3	ST; LD
CELLCEPT ORAL TABLET (<i>mycophenolate mofetil</i>)	3	ST; LD
<i>mycophenolate mofetil hcl intravenous solution reconstituted</i>	1 or 1b*	LD
<i>mycophenolate mofetil intravenous solution reconstituted</i>	1 or 1b*	LD
<i>mycophenolate mofetil oral capsule</i>	1 or 1b*	LD
<i>mycophenolate mofetil oral suspension reconstituted</i>	1 or 1b*	LD
<i>mycophenolate mofetil oral tablet</i>	1 or 1b*	LD
<i>mycophenolate sodium oral tablet delayed release</i>	1 or 1b*	LD
<i>mycophenolic acid oral tablet delayed release</i>	1 or 1b*	LD
MYFORTIC ORAL TABLET DELAYED RELEASE (<i>mycophenolate sodium</i>)	3	LD
MYHIBBIN ORAL SUSPENSION (<i>mycophenolate mofetil</i>)	3	ST; LD
*INTERLEUKIN-6 (IL-6) ANTAGONISTS**** - VITAMINS AND MINERALS		
SYLVANT INTRAVENOUS SOLUTION RECONSTITUTED (<i>siltuximab</i>)	3	PA; LD
*IRRIGATION SOLUTIONS**** - VITAMINS AND MINERALS		
<i>argyle sterile water irrigation solution</i>	1 or 1b*	
<i>lactated ringers irrigation solution</i>	1 or 1b*	
<i>physiolyte irrigation solution</i>	1 or 1b*	
<i>physiosol irrigation irrigation solution</i>	1 or 1b*	
<i>ringers irrigation irrigation solution</i>	1 or 1b*	
<i>sterile water for irrigation irrigation solution</i>	1 or 1b*	
<i>tis-u-sol irrigation solution</i>	1 or 1b*	
<i>water for irrigation, sterile irrigation solution</i>	1 or 1b*	
*MACROLIDE IMMUNOSUPPRESSANTS**** - VITAMINS AND MINERALS		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR (<i>tacrolimus</i>)	3	LD
ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>tacrolimus</i>)	3	LD
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	1 or 1b*	LD
PROGRAF INTRAVENOUS SOLUTION (<i>tacrolimus</i>)	2	LD
PROGRAF ORAL CAPSULE (<i>tacrolimus</i>)	3	LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGRAF ORAL PACKET (<i>tacrolimus</i>)	3	LD
RAPAMUNE ORAL SOLUTION (<i>sirolimus</i>)	3	LD
RAPAMUNE ORAL TABLET (<i>sirolimus</i>)	3	LD
<i>sirolimus oral solution</i>	1 or 1b*	LD
<i>sirolimus oral tablet</i>	1 or 1b*	LD
<i>tacrolimus oral capsule</i>	1 or 1b*	LD
ZORTRESS ORAL TABLET (<i>everolimus</i>)	3	LD
*MONOCLONAL ANTIBODIES*** - VITAMINS AND MINERALS		
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>satralizumab-mwge</i>)	3	PA; LD; QL (1 syringe per 28 days)
GAMIFANT INTRAVENOUS SOLUTION (<i>emapalumab-lzsg</i>)	3	PA; LD
SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED (<i>basiliximab</i>)	3	LD
UPLIZNA INTRAVENOUS SOLUTION (<i>inebilizumab-cdon</i>)	3	PA; LD; QL (30 mL per 180 days)
*NEONATAL FC RECEPTOR (FCRN) ANTAGONISTS*** - VITAMINS AND MINERALS		
RYSTIGGO SUBCUTANEOUS SOLUTION 280 MG/2ML (<i>rozanolixizumab-noli</i>)	3	PA; LD; QL (18 vials per 63 days)
RYSTIGGO SUBCUTANEOUS SOLUTION 420 MG/3ML, 560 MG/4ML, 840 MG/6ML (<i>rozanolixizumab-noli</i>)	3	PA; LD; QL (6 vials per 63 days)
VYVGART INTRAVENOUS SOLUTION (<i>efgartigimod alfa-fcab</i>)	3	PA; LD; QL (12 vials per 50 days)
*PIK3CA-RELATED OVERGROWTH SPECTRUM AGENTS - PI3K INHIB*** - VITAMINS AND MINERALS		
VIJOICE ORAL PACKET (<i>alpelisib</i>)	3	PA; LD; QL (1 packet per 1 day)
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 50 MG (<i>alpelisib</i>)	3	PA; LD; QL (1 tablet per 1 day)
VIJOICE ORAL TABLET THERAPY PACK 200 & 50 MG (<i>alpelisib</i>)	3	PA; LD; QL (2 tablets per 1 day)
*POTASSIUM REMOVING AGENTS*** - VITAMINS AND MINERALS		
LOKELMA ORAL PACKET 10 GM (<i>sodium zirconium cyclosilicate</i>)	3	QL (34 packets per 30 days)
LOKELMA ORAL PACKET 5 GM (<i>sodium zirconium cyclosilicate</i>)	3	QL (3 packets per 1 day)
<i>sodium polystyrene sulfonate oral powder</i>	1 or 1b*	
<i>sps (sodium polystyrene sulf) rectal suspension</i>	1 or 1b*	
VELTASSA ORAL PACKET 1 GM (<i>patiromer sorbitex calcium</i>)	3	QL (8 packets per 1 day)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM (<i>patiromer sorbitex calcium</i>)	3	QL (1 packet per 1 day)
VELTASSA ORAL PACKET 8.4 GM (<i>patiromer sorbitex calcium</i>)	3	QL (3 packets per 1 day)
*PROSTAGLANDINS*** - VITAMINS AND MINERALS		
PROSTIN VR INJECTION SOLUTION (<i>alprostadil</i>)	3	
*PURINE ANALOGS*** - VITAMINS AND MINERALS		
<i>azasan oral tablet</i>	1 or 1b*	LD
<i>azathioprine oral tablet</i>	1 or 1b*	LD

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZATHIOPRINE SODIUM INJECTION SOLUTION RECONSTITUTED	3	LD
IMURAN ORAL TABLET (<i>azathioprine</i>)	3	LD
*ROCK INHIBITORS*** - VITAMINS AND MINERALS		
REZUROCK ORAL TABLET (<i>belumosudil mesylate</i>)	3; OC	PA; LD; QL (1 tablet per 1 day); OC
*SCLEROSING AGENTS*** - VITAMINS AND MINERALS		
ASCLERA INTRAVENOUS SOLUTION (<i>polidocanol</i>)	3	
ETHAMOLIN INTRAVENOUS SOLUTION (<i>ethanolamine oleate</i>)	3	
<i>sodium tetradecyl sulfate intravenous solution</i>	1 or 1b*	
SOTRADECOL INTRAVENOUS SOLUTION 1 % (<i>sodium tetradecyl sulfate</i>)	1 or 1b*	
<i>sotradecol intravenous solution 3 %</i>	1 or 1b*	
VARITHENA INTRAVENOUS FOAM (<i>polidocanol</i>)	3	
*SELECTIVE T-CELL COSTIMULATION BLOCKERS*** - VITAMINS AND MINERALS		
NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED (<i>belatacept</i>)	3	PA; LD
*TYPE I INTERFERON (IFN) RECEPTOR ANTAGONISTS*** - VITAMINS AND MINERALS		
SAPHNELO INTRAVENOUS SOLUTION (<i>anifrolumab-fnia</i>)	3	PA; LD; QL (1 vial per 28 days)
*UREMIC PRURITUS AGENTS*** - VITAMINS AND MINERALS		
KORSUVA INTRAVENOUS SOLUTION (<i>difelikefalin acetate</i>)	3	PA
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT		
*ANESTHETICS TOPICAL ORAL*** - DRUGS FOR THE MOUTH AND THROAT		
<i>lidocaine hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
<i>lidocaine viscous hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
*ANTI-INFECTIVES - THROAT*** - DRUGS FOR THE MOUTH AND THROAT		
<i>clotrimazole mouth/throat troche</i>	1 or 1b*	QL (5 tablet per 1 day)
<i>nystatin mouth/throat suspension</i>	3	QL (24 mL per 1 day)
ORAVIG BUCCAL TABLET (<i>miconazole</i>)	3	
*ANTISEPTICS - MOUTH/THROAT*** - DRUGS FOR THE MOUTH AND THROAT		
<i>chlorhexidine gluconate mouth/throat solution</i>	1 or 1a*	QL (480 mL per 30 days)
PERIDEX MOUTH/THROAT SOLUTION (<i>chlorhexidine gluconate</i>)	3	QL (480 mL per 30 days)
<i>perigard mouth/throat solution</i>	1 or 1a*	QL (480 mL per 30 days)
*DENTAL PRODUCTS - COMBINATIONS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>denta 5000 plus sensitive dental gel</i>	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDEX SENSITIVITY RELIEF DENTAL GEL (<i>sod fluoride-potassium nitrate</i>)	3	
PREVIDENT 5000 ENAMEL PROTECT DENTAL GEL (<i>sod fluoride-potassium nitrate</i>)	3	
PREVIDENT 5000 SENSITIVE DENTAL GEL (<i>sod fluoride-potassium nitrate</i>)	3	
<i>sodium fluoride 5000 enamel dental gel</i>	1 or 1b*	
<i>sodium fluoride 5000 sensitive dental gel</i>	1 or 1b*	
*FLUORIDE DENTAL PRODUCTS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>clinpro 5000 dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>denta 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>dentagel dental gel</i>	1 or 1a*	QL (100 grams per 30 days)
<i>easygel dental gel</i>	1 or 1b*	
<i>fluoridex daily renewal mouth/throat concentrate</i>	1 or 1b*	
<i>fluoridex dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>fluoridex enhanced whitening dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>fraiche 5000 dental dental gel</i>	1 or 1b*	QL (100 grams per 30 days)
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE (<i>sodium fluoride</i>)	3	QL (3.77 grams per 1 day)
PREVIDENT 5000 DRY MOUTH DENTAL GEL (<i>sodium fluoride</i>)	3	QL (100 grams per 30 days)
PREVIDENT 5000 KIDS DENTAL PASTE (<i>sodium fluoride</i>)	3	QL (3.7 grams per 1 day)
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE (<i>sodium fluoride</i>)	3	QL (3.77 grams per 1 day)
PREVIDENT 5000 PLUS DENTAL CREAM (<i>sodium fluoride</i>)	3	QL (3.4 grams per 1 day)
PREVIDENT DENTAL GEL (<i>sodium fluoride</i>)	3	QL (100 grams per 30 days)
PREVIDENT MOUTH/THROAT SOLUTION (<i>sodium fluoride</i>)	3	
<i>sf 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sf dental gel</i>	1 or 1a*	QL (100 grams per 30 days)
<i>sodium fluoride 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride 5000 ppm dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride 5000 ppm dental gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>sodium fluoride 5000 ppm dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>sodium fluoride dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride mouth/throat solution</i>	1 or 1a*	
*SALIVA STIMULANTS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>cevimeline hcl oral capsule</i>	1 or 1b*	
EVOXAC ORAL CAPSULE (<i>cevimeline hcl</i>)	3	
<i>pilocarpine hcl oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
SALAGEN ORAL TABLET (<i>pilocarpine hcl</i>)	3	QL (4 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*STEROIDS - MOUTH/THROAT/DENTAL*** - DRUGS FOR THE MOUTH AND THROAT		
<i>triamcinolone acetonide</i> (Kourzeq Mouth/Throat Paste)	1 or 1b*	
<i>oralone mouth/throat paste</i>	1 or 1b*	
<i>triamcinolone acetonide mouth/throat paste</i>	1 or 1b*	
MULTIVITAMINS - DRUGS FOR NUTRITION		
*B-COMPLEX VITAMINS*** - DRUGS FOR NUTRITION		
<i>b complex-b12 oral tablet</i>	1 or 1b*; \$0	
<i>b-complex plus b-12 oral tablet</i>	1 or 1b*; \$0	
<i>b-complex/b-12 oral tablet</i>	1 or 1b*; \$0	
<i>ra b-complex oral tablet</i>	1 or 1b*; \$0	
<i>ra b-complex with b-12 oral tablet</i>	1 or 1b*; \$0	
<i>vitamin b complex oral tablet</i>	1 or 1b*; \$0	
<i>vitamin b complex w/b-12 oral tablet</i>	1 or 1b*; \$0	
<i>vitamin-b complex oral tablet</i>	1 or 1b*; \$0	
*B-COMPLEX W/ C & CALCIUM*** - DRUGS FOR NUTRITION		
<i>gnp b-complex plus vitamin c oral tablet</i>	1 or 1b*; \$0	
<i>qc b-complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
*B-COMPLEX W/ C & FOLIC ACID*** - DRUGS FOR NUTRITION		
<i>b complex-c-folic acid oral tablet</i>	1 or 1b*; \$0	
<i>b-complex balanced oral tablet</i>	1 or 1b*; \$0	
<i>b-complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
<i>b-complex-c (w/folic acid) oral tablet</i>	1 or 1b*; \$0	
<i>dialyvite 800 oral tablet</i>	1 or 1b*; \$0	
<i>eql super b complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
FULL SPECTRUM B/VITAMIN C ORAL TABLET	1 or 1b*; \$0	
<i>kp b complex-c oral tablet</i>	1 or 1b*; \$0	
<i>nephro vitamins oral tablet</i>	1 or 1b*; \$0	
NEPHRO-VITE ORAL TABLET (<i>b complex-c-folic acid</i>)	1 or 1b*; \$0	
<i>renal vitamin oral tablet</i>	1 or 1b*; \$0	
<i>rena-vite oral tablet</i>	1 or 1b*; \$0	
<i>sm b super vitamin complex oral tablet</i>	1 or 1b*; \$0	
SM B-COMPLEX/VITAMIN C ORAL TABLET	2; \$0	
<i>stress formula (folic acid) oral tablet</i>	1 or 1b*; \$0	
<i>super b complex/fa/vit c oral tablet</i>	1 or 1b*; \$0	
<i>super b-complex/vit c/fa oral tablet</i>	1 or 1b*; \$0	
*B-COMPLEX W/ C*** - DRUGS FOR NUTRITION		
<i>allbee/c oral tablet</i>	1 or 1b*; \$0	
<i>b complex-c oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>b-complex-c oral tablet</i>	1 or 1b*; \$0	
<i>better b complex oral tablet</i>	1 or 1b*; \$0	
<i>cvs b complex plus c oral tablet</i>	1 or 1b*; \$0	
<i>cvs super b complex/c oral tablet</i>	1 or 1b*; \$0	
<i>sm super b complex/c oral tablet</i>	1 or 1b*; \$0	
<i>sm vitamin b complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
<i>super b complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
<i>super b-complex + vitamin c oral tablet</i>	1 or 1b*; \$0	
*B-COMPLEX W/ C-BIOTIN-E & FOLIC ACID*** - DRUGS FOR NUTRITION		
B COMPLEX-C-BIOTIN-E-FA ORAL TABLET	2; \$0	
*B-COMPLEX W/ FOLIC ACID*** - DRUGS FOR NUTRITION		
<i>b complex formula 1 (w/ fa) oral tablet</i>	1 or 1b*; \$0	
<i>b-complex (folic acid) oral tablet</i>	1 or 1b*; \$0	
<i>b-complex/electrolytes oral tablet</i>	1 or 1b*; \$0	
<i>big 100 oral tablet</i>	1 or 1b*; \$0	
<i>kobee oral tablet</i>	1 or 1b*; \$0	
<i>sm balanced b-100 oral tablet</i>	1 or 1b*; \$0	
<i>sm balanced b-50 oral tablet</i>	1 or 1b*; \$0	
*B-COMPLEX W/BIOTIN & FOLIC ACID*** - DRUGS FOR NUTRITION		
<i>b complex 100 tr oral tablet extended release</i>	1 or 1b*; \$0	
<i>b-100 b-complex oral tablet</i>	1 or 1b*; \$0	
<i>b-100 complex cr oral tablet extended release</i>	1 or 1b*; \$0	
<i>b-100 tr oral tablet extended release</i>	1 or 1b*; \$0	
<i>b-50 complex oral tablet</i>	1 or 1b*; \$0	
<i>balance b-50 oral tablet</i>	1 or 1b*; \$0	
<i>balanced b complex oral tablet</i>	1 or 1b*; \$0	
<i>balanced b-100 oral tablet</i>	1 or 1b*; \$0	
<i>balanced b-100 oral tablet extended release</i>	1 or 1b*; \$0	
<i>balanced b-50/fa oral tablet</i>	1 or 1b*; \$0	
<i>b-compleet-100 oral tablet</i>	1 or 1b*; \$0	
<i>b-compleet-50 oral tablet</i>	1 or 1b*; \$0	
<i>b-complex oral tablet</i>	1 or 1b*; \$0	
<i>big 100 (biotin) oral tablet</i>	1 or 1b*; \$0	
<i>complex b-100 oral tablet extended release</i>	1 or 1b*; \$0	
<i>complex b-50 prolonged release oral tablet extended release</i>	1 or 1b*; \$0	
<i>endur-b oral tablet extended release</i>	1 or 1b*; \$0	
<i>eql b complex 50 oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eql b-100 complex oral tablet extended release</i>	1 or 1b*; \$0	
<i>ft b-100 complex pr oral tablet extended release</i>	1 or 1b*; \$0	
<i>gnp b-100 complex oral tablet extended release</i>	1 or 1b*; \$0	
<i>gnp b-50 complex oral tablet extended release</i>	1 or 1b*; \$0	
<i>qc b50 prolonged release oral tablet extended release</i>	1 or 1b*; \$0	
<i>quin b strong b-25 oral tablet</i>	1 or 1b*; \$0	
<i>ra balanced b-100 cr oral tablet extended release</i>	1 or 1b*; \$0	
<i>ra balanced b-100 oral tablet</i>	1 or 1b*; \$0	
<i>ra balanced b-50 oral tablet</i>	1 or 1b*; \$0	
<i>ra balanced b-50 tr oral tablet extended release</i>	1 or 1b*; \$0	
<i>sm b100 complex oral tablet</i>	1 or 1b*; \$0	
<i>sm b-complex oral tablet</i>	1 or 1b*; \$0	
<i>super b-complex oral tablet</i>	1 or 1b*; \$0	
<i>super dec b-100 oral tablet</i>	1 or 1b*; \$0	
<i>super quints b-50 oral tablet</i>	1 or 1b*; \$0	
<i>yl balanced b-100 oral tablet</i>	1 or 1b*; \$0	
*MULTIPLE VITAMINS W/ IRON*** - DRUGS FOR NUTRITION		
<i>daily vite multivitamin/iron oral tablet</i>	1 or 1b*; \$0	
<i>multiple vitamins/iron oral tablet</i>	1 or 1b*; \$0	
<i>multivitamin plus iron adult oral tablet</i>	1 or 1b*; \$0	
<i>multi-vitamin/iron oral tablet</i>	1 or 1b*; \$0	
<i>nat-rul daily-vite+iron oral tablet</i>	1 or 1b*; \$0	
<i>one daily multivitamin/iron oral tablet</i>	1 or 1b*; \$0	
<i>one-daily multi-vitamin/iron oral tablet</i>	1 or 1b*; \$0	
<i>one-daily/iron oral tablet</i>	1 or 1b*; \$0	
<i>qc daily multivitamins/iron oral tablet</i>	1 or 1b*; \$0	
<i>sm multiple vitamins/iron oral tablet</i>	1 or 1b*; \$0	
<i>stress b complex/iron oral tablet</i>	1 or 1b*; \$0	
<i>stress formula/iron oral tablet</i>	1 or 1b*; \$0	
<i>tab-a-vite/iron oral tablet</i>	1 or 1b*; \$0	
TAB-A-VITE/IRON/BETA CAROTENE ORAL TABLET (<i>multiple vitamins-iron</i>)	2; \$0	
*MULTIPLE VITAMINS W/ MINERALS & CALCIUM-FOLIC ACID*** - DRUGS FOR NUTRITION		
FOLGARD OS ORAL TABLET (<i>multiple vit-min-calcium-fa</i>)	3	
*MULTIPLE VITAMINS W/ MINERALS & FLUORIDE-IRON-FOLIC ACID*** - DRUGS FOR NUTRITION		
QUFLORA FE ORAL TABLET CHEWABLE (<i>multi vit-min-fluoride-fe-fa</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*MULTIVITAMINS*** - DRUGS FOR NUTRITION		
<i>anti-oxidant oral tablet</i>	1 or 1b*; \$0	
<i>daily multiple vitamins oral tablet</i>	1 or 1b*; \$0	
<i>daily value multivitamin oral tablet</i>	1 or 1b*; \$0	
<i>daily vitamins oral tablet</i>	1 or 1b*; \$0	
<i>daily vite oral tablet</i>	1 or 1b*; \$0	
<i>daily vites oral tablet</i>	1 or 1b*; \$0	
<i>daily-vite multivitamin oral tablet</i>	1 or 1b*; \$0	
<i>daily-vite oral tablet</i>	1 or 1b*; \$0	
ESTROFACTORS ORAL TABLET (<i>multiple vitamin</i>)	2; \$0	
<i>gnp essential one daily oral tablet</i>	1 or 1b*; \$0	
<i>healthy hair/skin/nails oral tablet</i>	1 or 1b*; \$0	
HIGH POTENCY MULTIVITAMIN ORAL TABLET	2; \$0	
INFUVITE ADULT INTRAVENOUS SOLUTION (<i>multiple vitamin</i>)	3	
<i>multi vitamin oral tablet</i>	2; \$0	
MULTI VITAMIN W/D-3 ORAL TABLET	2; \$0	
<i>multiple vitamin-folic acid oral tablet</i>	1 or 1b*; \$0	
<i>multiple vitamins essential oral tablet</i>	1 or 1b*; \$0	
<i>multiple vitamins oral tablet</i>	1 or 1b*; \$0	
<i>multivitamin adult oral tablet</i>	2; \$0	
<i>multivitamin iron-free oral tablet</i>	1 or 1b*; \$0	
MULTIVITAMIN ORAL TABLET	2; \$0	
<i>multi-vitamin oral tablet</i>	1 or 1b*; \$0	
NEOMULTIVITE ORAL TABLET (<i>multiple vitamin</i>)	2; \$0	
<i>novite oral capsule</i>	1 or 1b*	
OMNICAP ORAL TABLET	2; \$0	
<i>once daily oral tablet</i>	1 or 1b*; \$0	
<i>one daily essential oral tablet</i>	2; \$0	
<i>one daily essentials oral tablet</i>	2; \$0	
<i>one daily multivitamin adult oral tablet</i>	1 or 1b*; \$0	
<i>one daily oral tablet</i>	1 or 1b*; \$0	
ONE VITE DAILY MULTIVITAMIN ORAL TABLET (<i>multiple vitamin</i>)	2; \$0	
<i>one-daily multi vitamins oral tablet</i>	1 or 1b*; \$0	
<i>one-daily multi-vitamin oral tablet</i>	1 or 1b*; \$0	
<i>qc essentials oral tablet</i>	1 or 1b*; \$0	
QUINTABS ORAL TABLET	2; \$0	
<i>sm multiple vitamins essential oral tablet</i>	1 or 1b*; \$0	
<i>stress formula oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>stress formula/zinc/energy oral tablet</i>	2; \$0	
<i>stresstabs energy oral tablet</i>	1 or 1b*; \$0	
<i>tab-a-vite oral tablet</i>	1 or 1b*; \$0	
<i>tab-a-vite/beta carotene oral tablet</i>	1 or 1b*; \$0	
THERA ORAL TABLET (<i>multiple vitamin</i>)	2; \$0	
<i>thera-tabs oral tablet</i>	1 or 1b*; \$0	
THEREMS ORAL TABLET (<i>multiple vitamin</i>)	2; \$0	
<i>tm-daily vite oral tablet</i>	2; \$0	
<i>true daily vite oral tablet</i>	1 or 1b*; \$0	
<i>true multivitamin oral tablet</i>	2; \$0	
<i>vit e-vit c-beta carotene oral tablet</i>	1 or 1b*; \$0	
<i>vitalee oral tablet</i>	1 or 1b*; \$0	
VITLIPID N ADULT INTRAVENOUS EMULSION (<i>multiple vitamin</i>)	3	
*PED MULTI VITAMINS W/FL & FE*** - DRUGS FOR NUTRITION		
<i>multi-vitamin/fluoride/iron oral solution</i>	1 or 1b*	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE (<i>ped multivitamins-fl-iron</i>)	3	
QUFLORA FE PEDIATRIC ORAL LIQUID (<i>ped multivitamins-fl-iron</i>)	3	
*PED MV W/ FLUORIDE*** - DRUGS FOR NUTRITION		
DAVIMET-FLUORIDE ORAL TABLET CHEWABLE (<i>pediatric multivitamins-fl</i>)	3	
FLORAFOL PEDIATRIC ORAL TABLET CHEWABLE (<i>pediatric multivitamins-fl</i>)	3	
FLORIVA PLUS ORAL SOLUTION (<i>pediatric multivitamins-fl</i>)	3	
<i>multivitamin w/fluoride oral tablet chewable</i>	1 or 1b*; \$0	
<i>multivitamin/fluoride oral solution</i>	2	
<i>multi-vitamin/fluoride oral solution</i>	1 or 1b*; \$0	
<i>multivitamin/fluoride oral tablet chewable</i>	2; \$0	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE (<i>pediatric multivitamins-fl</i>)	3	
POLY-VI-FLOR ORAL SUSPENSION (<i>pediatric multivitamins-fl</i>)	3	
POLY-VI-FLOR ORAL TABLET CHEWABLE (<i>pediatric multivitamins-fl</i>)	3	
QUFLORA PEDIATRIC ORAL SOLUTION (<i>pediatric multivitamins-fl</i>)	3	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE (<i>pediatric multivitamins-fl</i>)	3	
*PED VITAMINS ACD & FA W/ FLUORIDE*** - DRUGS FOR NUTRITION		
TRI-VI-FLOR ORAL SUSPENSION (<i>ped vit a-c-d-methylfolate-fl</i>)	3	
TRI-VI-FLOORO ORAL SUSPENSION	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PED VITAMINS ACD W/ FLUORIDE*** - DRUGS FOR NUTRITION		
<i>tri-vite/fluoride oral solution</i>	1 or 1b*; \$0	
*PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE*** - DRUGS FOR NUTRITION		
FLORIVA ORAL TABLET CHEWABLE (<i>ped multiple vit-minerals-fl</i>)	3	
*PEDIATRIC MULTIPLE VITAMINS*** - DRUGS FOR NUTRITION		
INFUVITE PEDIATRIC INTRAVENOUS SOLUTION (<i>pediatric multiple vitamins</i>)	3	
VITALIPID N INFANT INTRAVENOUS EMULSION (<i>pediatric multiple vitamins</i>)	3	
VITLIPID N INFANT INTRAVENOUS EMULSION (<i>pediatric multiple vitamins</i>)	3	
*PRENATAL MV & MIN W/FE-FA*** - DRUGS FOR NUTRITION		
ATABEX EC ORAL TABLET DELAYED RELEASE (<i>prenatal vit-dss-fe cbn-fa</i>)	2	QL (1 tablet per 1 day)
ATABEX OB ORAL TABLET (<i>prenatal vit w/ fe bisg-fa</i>)	2	QL (1 tablet per 1 day)
AZESCO ORAL TABLET	3	ST; QL (2 tablets per 1 day)
CITRANATAL B-CALM ORAL (<i>prenat w/o a fecbnfeglu-fa & b6</i>)	2	QL (3 tablets per 1 day)
CLASSIC PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
C-NATE DHA ORAL CAPSULE	2	QL (1 capsule per 1 day)
COMPLETENATE ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)
CO-NATAL FA ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
CONCEPT DHA ORAL CAPSULE (<i>prenat-fefum-fepo-fa-omega 3</i>)	2	QL (1 capsule per 1 day)
CONCEPT OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
CVS PRENATAL ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
<i>elite-ob oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
ENBRACE HR ORAL CAPSULE (<i>prenat vit-fe gly cys-fa-omega</i>)	3	ST; QL (1 capsule per 1 day)
EQL PRENATAL FORMULA ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
FOLIVANE-OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
<i>ft prenatal oral tablet</i>	2; \$0	QL (1 tablet per 1 day)
GNP PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
<i>inatal gt oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
JENLIVA PRENATAL/POSTNATAL ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
KOSHER PRENATAL PLUS IRON ORAL TABLET	3	ST; QL (1 tablet per 1 day)
KP PRENATAL MULTIVITAMINS ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
KPN PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
MASONATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
M-NATAL PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
MULTI PRENATAL ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
<i>natal pnv oral tablet</i>	3	ST; QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NATALVIT ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
NEEVO DHA ORAL CAPSULE (<i>prenat w/oa-fefum-methf-omegas</i>)	3	ST; QL (1 capsule per 1 day)
NEONATAL COMPLETE ORAL TABLET	3	ST; QL (1 tablet per 1 day)
NEONATAL PLUS ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	QL (1 tablet per 1 day)
<i>neonatal prenatal oral tablet</i>	2; \$0	QL (1 tablet per 1 day)
NEONATAL VITAMIN ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2; \$0	ST; QL (1 tablet per 1 day)
NESTABS DHA ORAL (<i>prenat-w/oa-fe bisgly-fa-omega</i>)	3	ST; QL (2 tablets per 1 day)
NESTABS ORAL TABLET (<i>prenat-fe bisgly-fa-w/o vit a</i>)	3	ST; QL (2 tablets per 1 day)
NIVA-PLUS ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
OB COMPLETE ONE ORAL CAPSULE (<i>prenat-fecbn-feasppl-fa-fish</i>)	3	ST; QL (1 capsule per 1 day)
OB COMPLETE ORAL TABLET (<i>prenatal vit-iron carbonyl-fa</i>)	3	ST; QL (1 tablet per 1 day)
OB COMPLETE PETITE ORAL CAPSULE (<i>prenat-fecbn-feasppl-fa-omega</i>)	3	ST; QL (1 capsule per 1 day)
OB COMPLETE PREMIER ORAL TABLET (<i>prenatal-fe cbn-fe asp gly-fa</i>)	3	ST; QL (1 tablet per 1 day)
OB COMPLETE/DHA ORAL CAPSULE (<i>prenat-fecbn-feasppl-fa-omega</i>)	3	ST; QL (1 capsule per 1 day)
ONE VITE WOMENS ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
ONE VITE WOMENS PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
<i>pnv prenatal plus multivitamin+dha oral</i>	2	QL (2 units per 1 day)
PNV TABS 20-1 ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PNV-OMEGA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
<i>pnv-select oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
PREGENNA ORAL TABLET	3	ST; QL (1 tablet per 1 day)
PRENA1 PEARL ORAL CAPSULE EXTENDED RELEASE	3	ST; QL (1 capsule per 1 day)
PRENATAL (W/IRON & FA) ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET 29-1 MG	2	QL (1 tablet per 1 day)
<i>prenatal 19 oral tablet chewable</i>	1 or 1a*	QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET CHEWABLE 29-1 MG	2	QL (1 tablet per 1 day)
PRENATAL COMPLETE ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
PRENATAL FORTE ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
PRENATAL ONE DAILY ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 27-0.8 MG	2; \$0	ST; QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 27-1 MG	2	QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 28-0.8 MG	2; \$0	QL (1 tablet per 1 day)
PRENATAL PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL PLUS VITAMIN/MINERAL ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL VITAMIN AND MINERAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
<i>prenatal vitamins oral tablet 27-0.8 mg</i>	2; \$0	QL (1 tablet per 1 day)
PRENATAL VITAMINS ORAL TABLET 28-0.8 MG	2; \$0	QL (1 tablet per 1 day)
PRENATAL/IRON ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL/IRON ORAL TABLET 28-0.8 MG	2; \$0	QL (1 tablet per 1 day)
PRENATAL-U ORAL CAPSULE (<i>prenatal w/o a vit-fe fum-fa</i>)	2	QL (1 capsule per 1 day)
PRENATE ELITE ORAL TABLET (<i>prenatal-feaspgly-methylfol-fa</i>)	3	ST; QL (1 tablet per 1 day)
PRENATRIX ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	ST; QL (1 tablet per 1 day)
PRENATRYL ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	ST; QL (1 tablet per 1 day)
PRIMACARE ORAL CAPSULE (<i>pren-fe-meth-fa-omeg w/o a</i>)	3	ST; QL (1 capsule per 1 day)
PROVIDA OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
QC PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
RA PRENATAL FORMULA ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
RA PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
RELNATE DHA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
SELECT-OB ORAL TABLET CHEWABLE 29-0.6-0.4 MG (<i>prenat vit-fepoly-methylfol-fa</i>)	3	ST; QL (1 tablet per 1 day)
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (<i>prenatal vit-fe psac cmplx-fa</i>)	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)
SM ONE DAILY PRENATAL ORAL	2; \$0	QL (1 EA per 1 day)
SM PRENATAL VITAMINS ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
TARON-C DHA ORAL CAPSULE (<i>prenat-fefum-fepo-fa-omega 3</i>)	2	QL (1 capsule per 1 day)
THRIVITE RX ORAL TABLET	2	ST; QL (1 tablet per 1 day)
TRICARE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
TRINATAL RX 1 ORAL TABLET	2	QL (1 tablet per 1 day)
<i>trinate oral tablet</i>	1 or 1a*	QL (1 tablet per 1 day)
VINATE DHA RF ORAL CAPSULE (<i>prenat w/oa-fefum-methf-omegas</i>)	3	ST; QL (1 capsule per 1 day)
VITAFOL GUMMIES ORAL TABLET CHEWABLE (<i>prenatal vit-fe phos-fa-omega</i>)	2	QL (3 gummies per 1 day)
VITAFOL-OB ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	ST; QL (1 tablet per 1 day)
VITAPEARL ORAL CAPSULE EXTENDED RELEASE (<i>prenat-fefum-fered-fa-dha w/oa</i>)	3	ST; QL (1 capsule per 1 day)
VITATHELY WITH GINGER ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	3	ST; QL (1 tablet per 1 day)
VIVA DHA ORAL CAPSULE (<i>prenatal vit-fe fum-fa-omega</i>)	3	ST; QL (1 capsule per 1 day)
WESTAB PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
ZALVIT ORAL TABLET	3	ST; QL (2 tablets per 1 day)
ZIPHEX ORAL TABLET	3	ST; QL (2 tablets per 1 day)
*PRENATAL MV & MIN W/FE-FA-CA-OMEGA 3 FISH OIL*** - DRUGS FOR NUTRITION		
COMPLETE NATAL DHA ORAL	2	QL (2 units per 1 day)
<i>wesnatal dha complete oral</i>	2	QL (2 units per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PRENATAL MV & MIN W/FE-FA-DHA*** - DRUGS FOR NUTRITION		
CITRANATAL 90 DHA ORAL (<i>prenat w/o a-febgl-dss-fa-dha</i>)	3	ST; QL (2 tablets per 1 day)
CITRANATAL ASSURE ORAL (<i>prenat w/o a-febgl-dss-fa-dha</i>)	3	ST; QL (2 units per 1 day)
CITRANATAL HARMONY ORAL CAPSULE (<i>prenat-fefmcb-dss-fa-dha w/o a</i>)	3	ST; QL (1 capsule per 1 day)
CITRANATAL MEDLEY ORAL CAPSULE (<i>prenat-fech-fefum-fa-dha w/o a</i>)	3	ST; QL (1 capsule per 1 day)
ENFAMIL EXPECTA ORAL (<i>prenatal mv-min-fe fum-fa-dha</i>)	2; \$0	QL (2 tablets per 1 day)
NESTABS ONE ORAL CAPSULE (<i>prenat-fe-methylfol-dha w/o a</i>)	3	ST; QL (1 capsule per 1 day)
<i>pnv-dha oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
PNV-DHA+DOCUSATE ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
PREGEN DHA ORAL CAPSULE	3	ST; QL (1 tablet per 1 day)
<i>prena 1 true oral</i>	2	
PRENAISSANCE ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
PRENAISSANCE PLUS ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
PRENATAL MULTIVITAMIN + DHA ORAL (<i>prenatal mv-min-fe fum-fa-dha</i>)	2; \$0	QL (2 tablets per 1 day)
PRENATE DHA ORAL CAPSULE (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	ST; QL (1 capsule per 1 day)
PRENATE ENHANCE ORAL CAPSULE (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	ST; QL (1 capsule per 1 day)
PRENATE ESSENTIAL ORAL CAPSULE (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	ST; QL (1 capsule per 1 day)
PRENATE MINI ORAL CAPSULE (<i>prenat-fechn-feasp-meth-fa-dha</i>)	3	ST; QL (1 capsule per 1 day)
PRENATE PIXIE ORAL CAPSULE (<i>prenat-feasp-meth-fa-dha w/o a</i>)	3	ST; QL (1 capsule per 1 day)
PRENATE RESTORE ORAL CAPSULE (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	ST; QL (1 capsule per 1 day)
SELECT-OB+DHA ORAL (<i>prenatal vit-fepoly-fa-dha</i>)	3	ST; QL (2 units per 1 day)
TRISTART DHA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
VITAFOL FE+ ORAL CAPSULE (<i>prenat-fe poly-methfol-fa-dha</i>)	3	ST; QL (2 capsules per 1 day)
VITAFOL ULTRA ORAL CAPSULE (<i>prenat-fe poly-methfol-fa-dha</i>)	3	ST; QL (1 capsule per 1 day)
VITAFOL-OB+DHA ORAL (<i>prenatal mv-min-fe fum-fa-dha</i>)	3	ST; QL (2 units per 1 day)
VITAFOL-ONE ORAL CAPSULE (<i>prenatal vit-fepoly-fa-dha</i>)	3	ST; QL (1 capsule per 1 day)
VITAMEDMD ONE RX/QUATREFOLIC ORAL CAPSULE (<i>prenat w/o a-fe-methfol-fa-dha</i>)	3	ST; QL (1 capsule per 1 day)
VITATRUE ORAL (<i>prenat-fechel-fa-dha w/o vit a</i>)	3	ST; QL (2 tablets per 1 day)
WESTGEL DHA ORAL CAPSULE	3	ST; QL (1 capsule per 1 day)
*PRENATAL MV & MINERALS W/FA WITHOUT IRON*** - DRUGS FOR NUTRITION		
PRENATE ORAL TABLET CHEWABLE (<i>prenat mv-min-methylfolate-fa</i>)	3	ST; QL (1 tablet per 1 day)
*PRENATAL VITAMINS*** - DRUGS FOR NUTRITION		
PREMESISRX ORAL TABLET (<i>prenatal ca-b6-b12-fa-ginger</i>)	3	ST; QL (1 tablet per 1 day)
<i>prena1 oral tablet chewable</i>	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATE AM ORAL TABLET (<i>prenatal ca-b6-b12-fa-ginger</i>)	3	ST; QL (1 tablet per 1 day)
*VITAMINS W/ LIPOTROPICS*** - DRUGS FOR NUTRITION		
ACTIFLOVIT EAR HEALTH ORAL TABLET (<i>vitamins-lipotropics</i>)	2; \$0	
<i>b complex (lipotropics) oral tablet</i>	1 or 1b*; \$0	
<i>b complex formula 1 (lipotrop) oral tablet</i>	1 or 1b*; \$0	
<i>balance b-100 oral tablet</i>	1 or 1b*; \$0	
<i>balanced b-50 complex oral tablet</i>	1 or 1b*; \$0	
COMPLEX B-100-INOSITOL ORAL TABLET EXTENDED RELEASE	2; \$0	
<i>cvs balanced b50 oral tablet</i>	1 or 1b*; \$0	
<i>cvs inner ear plus oral tablet</i>	1 or 1b*; \$0	
<i>ear health formula oral tablet</i>	1 or 1b*; \$0	
<i>ear health plus oral tablet</i>	1 or 1b*; \$0	
FLAVOVIT EAR HEALTH ORAL TABLET (<i>vitamins-lipotropics</i>)	1 or 1b*; \$0	
<i>lipo flavonoid plus oral tablet</i>	1 or 1b*; \$0	
<i>lipoflavovit oral tablet</i>	1 or 1b*; \$0	
LIPOTRIAD ORAL TABLET (<i>vitamins-lipotropics</i>)	2; \$0	
<i>mega multiple/chelated mineral oral tablet</i>	1 or 1b*; \$0	
<i>nat-rul b-50 oral tablet</i>	1 or 1b*; \$0	
<i>risanoid plus oral tablet</i>	1 or 1b*; \$0	
<i>ultra b-100 complex oral tablet</i>	1 or 1b*; \$0	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
*CENTRAL MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
<i>baclofen oral tablet 10 mg, 5 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>baclofen oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carisoprodol oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 375 mg, 750 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>cyclobenzaprine hcl oral tablet 10 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>cyclobenzaprine hcl oral tablet 5 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>methocarbamol injection solution</i>	1 or 1b*	
<i>methocarbamol oral tablet 500 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>methocarbamol oral tablet 750 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>orphenadrine citrate er oral tablet extended release 12 hour</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>orphenadrine citrate injection solution</i>	1 or 1b*	
ROBAXIN INJECTION SOLUTION (<i>methocarbamol</i>)	3	
<i>tizanidine hcl oral capsule 6 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>tizanidine hcl oral tablet 2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tizanidine hcl oral tablet 4 mg</i>	1 or 1b*	QL (9 tablets per 1 day)
ZANAFLEX ORAL CAPSULE 6 MG (<i>tizanidine hcl</i>)	3	ST; QL (6 capsules per 1 day)
ZANAFLEX ORAL TABLET (<i>tizanidine hcl</i>)	3	ST; QL (9 tablets per 1 day)
*DIRECT MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
DANTRIUM INTRAVENOUS SOLUTION RECONSTITUTED (<i>dantrolene sodium</i>)	3	
DANTRIUM ORAL CAPSULE (<i>dantrolene sodium</i>)	3	
<i>dantrolene sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>dantrolene sodium oral capsule</i>	1 or 1b*	
<i>revonto intravenous solution reconstituted</i>	1 or 1b*	
RYANODEX INTRAVENOUS SUSPENSION RECONSTITUTED (<i>dantrolene sodium</i>)	3	
*MUSCLE RELAXANT COMBINATIONS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
<i>norgesic oral tablet</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
ORPHENADRINE-ASPIRIN-CAFFEINE ORAL TABLET	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>orphengesic forte oral tablet</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
*RETINOIC ACID RECEPTOR GAMMA SELECTIVE AGONISTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
SOHONOS ORAL CAPSULE 1 MG (<i>palovarotene</i>)	3	PA; LD; QL (4 capsules per 1 day)
SOHONOS ORAL CAPSULE 1.5 MG (<i>palovarotene</i>)	3	PA; LD; QL (2 capsules per 1 day)
SOHONOS ORAL CAPSULE 10 MG (<i>palovarotene</i>)	3	PA; LD; QL (14 capsules per 365 days)
SOHONOS ORAL CAPSULE 2.5 MG, 5 MG (<i>palovarotene</i>)	3	PA; LD; QL (1 capsule per 1 day)
*VISCOSUPPLEMENTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE (<i>cross-linked hyaluronate</i>)	3	PA; LD
GELSYN-3 INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
HYALGAN INTRA-ARTICULAR SOLUTION (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
HYALGAN INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
HYMOVIS INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hyaluronan</i>)	3	PA; LD
MONOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hyaluronan</i>)	3	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hyaluronan</i>)	3	PA; LD
SUPARTZ FX INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
SYNOJOYNT INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hylan g-f 20</i>)	3	PA; LD
SYNVISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hylan g-f 20</i>)	3	PA; LD
TRILURON INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate (viscosup)</i>)	3	PA; LD
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE		
*ANTIHISTAMINE-STEROID*** - ALLERGY		
<i>azelastine-fluticasone nasal suspension</i>	3	QL (1 bottle per 30 days)
DYMISTA NASAL SUSPENSION (<i>azelastine-fluticasone</i>)	3	QL (1 bottle per 30 days)
*NASAL ANESTHETICS*** - ALLERGY		
COCAINE HCL NASAL SOLUTION	3	
GOPRELTO NASAL SOLUTION	3	
NUMBRINO NASAL SOLUTION (<i>cocaine hcl (nasal anesthetic)</i>)	3	
*NASAL ANTICHOLINERGICS*** - ALLERGY		
<i>ipratropium bromide nasal solution 0.03 %</i>	1 or 1b*	QL (2 bottles per 30 days)
<i>ipratropium bromide nasal solution 0.06 %</i>	1 or 1b*	QL (1 mL per 1 day)
*NASAL ANTIHISTAMINES*** - ALLERGY		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	1 or 1b*	QL (1 package per 25 days)
<i>azelastine hcl nasal solution 0.15 %</i>	1 or 1b*	QL (1 bottle per 25 days)
<i>olopatadine hcl nasal solution</i>	1 or 1b*	QL (1 bottle per 30 days)
*NASAL STEROIDS*** - ALLERGY		
<i>flunisolide nasal solution</i>	3	ST; QL (3 inhalers per 30 days)
<i>fluticasone propionate nasal suspension</i>	1 or 1a*	BE; QL (1 bottle per 30 days)
<i>mometasone furoate nasal suspension</i>	3	ST; BE; QL (1 bottle per 30 days)
PROPEL MINI NASAL IMPLANT (<i>mometasone furoate</i>)	3	
PROPEL MINI SDS NASAL IMPLANT (<i>mometasone furoate</i>)	3	
PROPEL NASAL IMPLANT (<i>mometasone furoate</i>)	3	
NEUROMUSCULAR AGENTS - DRUGS FOR NERVES AND MUSCLES		
*ALS AGENTS - MISCELLANEOUS*** - DRUGS FOR NERVES AND MUSCLES		
RADICAVA ORS ORAL SUSPENSION (<i>edaravone</i>)	3	PA; LD; QL (1 kit per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RADICAVA ORS STARTER KIT ORAL SUSPENSION (<i>edaravone</i>)	3	PA; LD; QL (1 starter kit per 1 lifetime)
*BENZATHIAZOLES*** - DRUGS FOR NERVES AND MUSCLES		
<i>riluzole oral tablet</i>	1 or 1b*	PA; LD; QL (4 tablets per 1 day)
TEGLUTIK ORAL SUSPENSION (<i>riluzole</i>)	3	PA; LD; QL (40 mL per 1 day)
*DEPOLARIZING MUSCLE RELAXANTS*** - DRUGS FOR NERVES AND MUSCLES		
ANECTINE INJECTION SOLUTION (<i>succinylcholine chloride</i>)	3	
QUELICIN INJECTION SOLUTION (<i>succinylcholine chloride</i>)	3	
SUCCINYLCHOLINE CHLORIDE INJECTION SOLUTION PREFILLED SYRINGE 100 MG/5ML	3	
*FRIEDRICH'S ATAXIA AGENTS - NRF2 PATHWAY ACTIVATORS*** - DRUGS FOR NERVES AND MUSCLES		
SKYCLARYS ORAL CAPSULE (<i>omaveloxolone</i>)	3	PA; LD; QL (3 capsules per 1 day)
*MUSCULAR DYSTROPHY - GENE THERAPY AGENTS*** - DRUGS FOR NERVES AND MUSCLES		
AMONDYS 45 INTRAVENOUS SOLUTION	3	PA; LD
EXONDYS 51 INTRAVENOUS SOLUTION (<i>eteplirsen</i>)	3	PA; LD
VILTEPSO INTRAVENOUS SOLUTION (<i>viltolarsen</i>)	3	PA; LD
VYONDYS 53 INTRAVENOUS SOLUTION (<i>golodirsen</i>)	3	PA; LD
*MUSCULAR DYSTROPHY - HISTONE DEACETYLASE INHIBITORS** - DRUGS FOR NERVES AND MUSCLES		
DUVYZAT ORAL SUSPENSION (<i>givinostat hcl</i>)	3	PA; LD; QL (12 mL per 1 day)
*NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS*** - DRUGS FOR NERVES AND MUSCLES		
BOTOX INJECTION SOLUTION RECONSTITUTED (<i>onabotulinumtoxinA</i>)	3	PA; LD
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>abobotulinumtoxinA</i>)	3	PA; LD
MYOBLOC INTRAMUSCULAR SOLUTION (<i>rimabotulinumtoxinB</i>)	3	PA; LD
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>incobotulinumtoxinA</i>)	3	PA; LD
*NONDEPOLARIZING MUSCLE RELAXANTS*** - DRUGS FOR NERVES AND MUSCLES		
<i>atracurium besylate intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate (pf) intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate intravenous solution</i>	1 or 1b*	
<i>rocuronium bromide intravenous solution</i>	1 or 1b*	
<i>vecuronium bromide intravenous solution reconstituted</i>	1 or 1b*	
*RETT SYNDROME AGENTS - GLYCINE-PROLINE-GLUTAMATE ANALOGS*** - DRUGS FOR NERVES AND MUSCLES		
DAYBUE ORAL SOLUTION (<i>trofinetide</i>)	3	PA; LD; QL (120 mL per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SPINAL MUSCULAR ATROPHY-SMN2 SPLICING MODIFIERS*** - DRUGS FOR NERVES AND MUSCLES		
EVRYSDI ORAL SOLUTION RECONSTITUTED (<i>risdiplam</i>)	3	PA; LD; QL (5 mg per 1 day)
NUTRIENTS - DRUGS FOR NUTRITION		
*AMINO ACID MIXTURES*** - DRUGS FOR NUTRITION		
AMINOSYN II INTRAVENOUS SOLUTION 10 % (<i>amino acid infusion</i>)	3	
<i>aminosyn ii intravenous solution 15 %</i>	1 or 1b*	
AMINOSYN-PF 7% INTRAVENOUS SOLUTION (<i>amino acid infusion</i>)	3	
AMINOSYN-PF INTRAVENOUS SOLUTION (<i>amino acid infusion</i>)	3	
CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION (<i>amino acid elect-calc in d5w</i>)	3	
CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION (<i>amino acid elect-calc in d10w</i>)	3	
CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION (<i>amino acid elect-calc in d5w</i>)	3	
CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION (<i>amino acid elect-calc in d15w</i>)	3	
CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION (<i>amino acid elect-calc in d20w</i>)	3	
CLINIMIX E/DEXTROSE (8/10) INTRAVENOUS SOLUTION	3	
CLINIMIX E/DEXTROSE (8/14) INTRAVENOUS SOLUTION	3	
CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION (<i>amino acid infusion in d10w</i>)	3	
CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION (<i>amino acid infusion in d5w</i>)	3	
CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION (<i>amino acid infusion in d15w</i>)	3	
CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION (<i>amino acid infusion in d20w</i>)	3	
CLINIMIX/DEXTROSE (6/5) INTRAVENOUS SOLUTION	3	
CLINIMIX/DEXTROSE (8/10) INTRAVENOUS SOLUTION	3	
CLINIMIX/DEXTROSE (8/14) INTRAVENOUS SOLUTION	3	
<i>clinisol sf intravenous solution</i>	1 or 1b*	
<i>plenamine intravenous solution</i>	1 or 1b*	
PREMASOL INTRAVENOUS SOLUTION (<i>amino acid infusion</i>)	3	
PROSOL INTRAVENOUS SOLUTION (<i>amino acid infusion</i>)	3	
TRAVASOL INTRAVENOUS SOLUTION (<i>amino acid infusion</i>)	3	
TROPHAMINE INTRAVENOUS SOLUTION (<i>amino acid infusion</i>)	3	
*AMINO ACIDS-SINGLE*** - DRUGS FOR NUTRITION		
ELCYS INTRAVENOUS SOLUTION (<i>cysteine hcl</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CARBOHYDRATES*** - DRUGS FOR NUTRITION		
<i>dextrose intravenous solution 10 %, 5 %, 70 %</i>	1 or 1b*	
DEXTROSE INTRAVENOUS SOLUTION 20 %, 30 %, 40 %	3	
*LIPIDS*** - DRUGS FOR NUTRITION		
CLINOLIPID INTRAVENOUS EMULSION (<i>fat emuls plant base(soy/oliv)</i>)	3	
DOJOLVI ORAL LIQUID (<i>triheptanoin</i>)	3	PA; LD; QL (2 bottles per 30 days)
INTRALIPID INTRAVENOUS EMULSION (<i>fat emulsion plant based (soy)</i>)	3	
NUTRILIPID INTRAVENOUS EMULSION (<i>fat emulsion plant based (soy)</i>)	3	
OMEGAVEN INTRAVENOUS EMULSION (<i>fish oil triglyceride based</i>)	3	
SMOFLIPID INTRAVENOUS EMULSION (<i>fat emul fish oil/plant based</i>)	3	
*PROTEIN-CARBOHYDRATE-LIPID WITH ELECTROLYTE COMBINATIONS*** - DRUGS FOR NUTRITION		
KABIVEN INTRAVENOUS EMULSION (<i>amino ac-dext-lipid-electrolyt</i>)	3	
PERIKABIVEN INTRAVENOUS EMULSION (<i>amino ac-dext-lipid-electrolyt</i>)	3	
OPHTHALMIC AGENTS - DRUGS FOR THE EYE		
*ALPHA ADRENERGIC AGONIST & CARBONIC ANHYDRASE INHIB COMB*** - DRUGS FOR GLAUCOMA		
SIMBRINZA OPHTHALMIC SUSPENSION (<i>brinzolamide-brimonidine</i>)	2	QL (8 mL per 30 days)
*BETA-BLOCKERS - OPHTHALMIC COMBINATIONS*** - DRUGS FOR GLAUCOMA		
<i>brimonidine tartrate-timolol ophthalmic solution</i>	1 or 1b*	QL (15 mL per 30 days)
<i>dorzolamide hcl-timolol mal ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
<i>dorzolamide hcl-timolol mal pf ophthalmic solution</i>	1 or 1b*	QL (60 units per 30 days)
*BETA-BLOCKERS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA		
<i>betaxolol hcl ophthalmic solution</i>	1 or 1b*	QL (0.5 mL per 1 day)
BETIMOL OPHTHALMIC SOLUTION (<i>timolol hemihydrate</i>)	3	QL (15 mL per 30 days)
BETOPTIC-S OPHTHALMIC SUSPENSION (<i>betaxolol hcl</i>)	2	QL (15 mL per 30 days)
<i>carteolol hcl ophthalmic solution</i>	1 or 1a*	
<i>levobunolol hcl ophthalmic solution</i>	1 or 1b*	
<i>timolol hemihydrate ophthalmic solution</i>	1 or 1b*	QL (15 mL per 30 days)
<i>timolol maleate (once-daily) ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>timolol maleate ocudose ophthalmic solution</i>	1 or 1b*	QL (20 mL per 30 days)
<i>timolol maleate ophthalmic gel forming solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>timolol maleate ophthalmic solution</i>	1 or 1b*	QL (20 mL per 30 days)
<i>timolol maleate pf ophthalmic solution 0.25 %</i>	1 or 1b*	QL (18 mL per 30 days)
<i>timolol maleate pf ophthalmic solution 0.5 %</i>	1 or 1b*	QL (20 mL per 30 days)
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 % (<i>timolol maleate</i>)	3	QL (18 mL per 30 days)
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	3	QL (20 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CYCLOPLEGIC MYDRIATIC COMBINATIONS*** - DRUGS FOR THE EYE		
CYCLOMYDRIL OPHTHALMIC SOLUTION (<i>cyclopentolate-phenylephrine</i>)	3	
MYDCOMBI OPHTHALMIC SOLUTION CARTRIDGE (<i>tropicamide-phenylephrine</i>)	3	
*CYCLOPLEGIC MYDRIATICS*** - DRUGS FOR THE EYE		
ATROPINE SULFATE OPHTHALMIC SOLUTION 1 %	3	QL (20 mL per 30 days)
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 2 % (<i>cyclopentolate hcl</i>)	3	
CYCLOGYL OPHTHALMIC SOLUTION 1 % (<i>cyclopentolate hcl</i>)	3	QL (15 mL per 30 days)
<i>cyclopentolate hcl ophthalmic solution</i>	1 or 1b*	QL (15 mL per 30 days)
MYDRIACYL OPHTHALMIC SOLUTION (<i>tropicamide</i>)	3	
<i>phenylephrine hcl ophthalmic solution</i>	1 or 1b*	
<i>tropicamide ophthalmic solution</i>	1 or 1b*	
*LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
XIIDRA OPHTHALMIC SOLUTION (<i>lifitegrast</i>)	2	PA; QL (2 vial per 1 day)
*MIOTICS - CHOLINESTERASE INHIBITORS*** - DRUGS FOR GLAUCOMA		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED (<i>echothiophate iodide</i>)	3	QL (5 mL per 30 days)
*MIOTICS - DIRECT ACTING*** - DRUGS FOR GLAUCOMA		
MIOCHOL-E INTRAOCULAR SOLUTION RECONSTITUTED (<i>acetylcholine chloride</i>)	3	
MIOSTAT INTRAOCULAR SOLUTION (<i>carbachol</i>)	3	
<i>pilocarpine hcl ophthalmic solution</i>	1 or 1b*	
*OPHTHALMIC - MULTIPLE RECEPTOR ANGIOGENESIS INHIBITORS*** - DRUGS FOR THE EYE		
VABYSMO INTRAVITREAL SOLUTION (<i>faricimab-svoa</i>)	3	PA; LD
VABYSMO INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>faricimab-svoa</i>)	3	PA; LD
*OPHTHALMIC ANTIALLERGIC*** - DRUGS FOR ITCHY EYE		
<i>azelastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 24 days)
<i>cromolyn sodium ophthalmic solution</i>	1 or 1a*	QL (2 bottles per 30 days)
<i>epinastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 30 days)
*OPHTHALMIC ANTIBIOTICS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
AZASITE OPHTHALMIC SOLUTION (<i>azithromycin</i>)	3	QL (2.5 mL per 30 days)
<i>bacitracin ophthalmic ointment</i>	1 or 1b*	QL (7 grams per 30 days)
BESIVANCE OPHTHALMIC SUSPENSION (<i>besifloxacin hcl</i>)	3	QL (5 mL per 30 days)
CILOXAN OPHTHALMIC OINTMENT (<i>ciprofloxacin hcl</i>)	3	QL (3.5 grams per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ciprofloxacin hcl ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>erythromycin ophthalmic ointment</i>	3	QL (3.5 grams per 30 days)
<i>gatifloxacin ophthalmic solution</i>	1 or 1b*	QL (2.5 mL per 30 days)
<i>gentamicin sulfate ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>levofloxacin ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>mitomycin intraocular solution prefilled syringe</i>	3	
MITOSOL OPHTHALMIC KIT (<i>mitomycin</i>)	3	
<i>moxifloxacin hcl (2x day) ophthalmic solution</i>	1 or 1b*	QL (3 mL per 30 days)
<i>moxifloxacin hcl ophthalmic solution</i>	1 or 1b*	QL (3 mL per 30 days)
OCUFLOX OPHTHALMIC SOLUTION (<i>ofloxacin</i>)	3	QL (10 mL per 30 days)
<i>ofloxacin ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>tobramycin ophthalmic solution</i>	1 or 1a*	QL (20 mL per 30 days)
TOBREX OPHTHALMIC OINTMENT (<i>tobramycin</i>)	3	QL (3.5 grams per 30 days)
VIGAMOX OPHTHALMIC SOLUTION (<i>moxifloxacin hcl</i>)	3	QL (3 mL per 30 days)
*OPHTHALMIC ANTIFUNGAL*** - DRUGS FOR THE EYE		
NATACYN OPHTHALMIC SUSPENSION (<i>natamycin</i>)	3	QL (15 mL per 30 days)
*OPHTHALMIC ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitracin-polymyxin b ophthalmic ointment</i>	1 or 1a*	QL (3.5 grams per 30 days)
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>neomycin-polymyxin-gramicidin ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
<i>neo-polycin ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>polycin ophthalmic ointment</i>	1 or 1a*	QL (3.5 grams per 30 days)
<i>polymyxin b-trimethoprim ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
*OPHTHALMIC ANTISEPTICS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION (<i>povidone-iodine</i>)	3	
*OPHTHALMIC ANTIVIRALS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>trifluridine ophthalmic solution</i>	1 or 1b*	QL (7.5 mL per 30 days)
ZIRGAN OPHTHALMIC GEL (<i>ganciclovir</i>)	3	QL (5 gram per 7 days)
*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR GLAUCOMA		
<i>brinzolamide ophthalmic suspension</i>	1 or 1b*	QL (15 mL per 30 days)
<i>dorzolamide hcl ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
*OPHTHALMIC COMPLEMENT C3 INHIBITORS*** - DRUGS FOR THE EYE		
SYFOVRE INTRAVITREAL SOLUTION (<i>pegcetacoplan (ophthalmic)</i>)	3	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*OPHTHALMIC COMPLEMENT C5 INHIBITORS*** - DRUGS FOR THE EYE		
IZERVAY INTRAVITREAL SOLUTION (<i>avacincaptad pegol</i>)	3	PA; LD
*OPHTHALMIC DIAGNOSTIC PRODUCTS*** - DRUGS FOR THE EYE		
<i>ak-fluor intravenous solution 10 %</i>	1 or 1b*	
<i>ak-fluor intravenous solution 25 %</i>	3	
<i>altafluor benox ophthalmic solution</i>	1 or 1b*	
<i>fluorescein intravenous solution</i>	1 or 1b*	
FLUORESCIN SODIUM/BENOXINATE OPHTHALMIC SOLUTION	3	
<i>fluorescein-benoxinate ophthalmic solution</i>	1 or 1b*	
FLUORESCITE INTRAVENOUS SOLUTION (<i>fluorescein sodium</i>)	3	
FLURA-SAFE OPHTHALMIC SOLUTION (<i>fluorexon-benoxinate</i>)	3	
*OPHTHALMIC ECTOPARASITICIDE** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
XDEMVIY OPHTHALMIC SOLUTION (<i>lotilaner</i>)	3	PA; QL (1 bottle per 1 fill)
*OPHTHALMIC IMMUNOMODULATORS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>cyclosporine ophthalmic emulsion</i>	1 or 1b*	PA; QL (2 vials per 1 day)
RESTASIS MULTIDOSE OPHTHALMIC EMULSION (<i>cyclosporine</i>)	2	PA; QL (1 bottle per 28 days)
RESTASIS OPHTHALMIC EMULSION (<i>cyclosporine</i>)	2	PA; QL (2 vials per 1 day)
VERKAZIA OPHTHALMIC EMULSION (<i>cyclosporine</i>)	3	PA; QL (120 vials per 30 days)
*OPHTHALMIC IRRIGATION SOLUTIONS*** - DRUGS FOR THE EYE		
BSS INTRAOCULAR SOLUTION (<i>ophth irr soln-intraocular</i>)	3	
BSS PLUS INTRAOCULAR SOLUTION (<i>ophth irr soln-intraocular</i>)	3	
*OPHTHALMIC KINASE INHIBITORS - COMBINATIONS*** - DRUGS FOR GLAUCOMA		
ROCKLATAN OPHTHALMIC SOLUTION (<i>netarsudil-latanoprost</i>)	3	QL (2.5 mL per 30 days)
*OPHTHALMIC LOCAL ANESTHETICS*** - DRUGS FOR THE EYE		
AKTEN OPHTHALMIC GEL (<i>lidocaine hcl</i>)	3	
ALCAINE OPHTHALMIC SOLUTION (<i>proparacaine hcl</i>)	3	
IHEEZO OPHTHALMIC GEL (<i>chloroprocaine hcl</i>)	3	
<i>proparacaine hcl ophthalmic solution</i>	1 or 1b*	
<i>tetracaine hcl ophthalmic solution</i>	1 or 1b*	
*OPHTHALMIC NERVE GROWTH FACTORS*** - DRUGS FOR THE EYE		
OXERVATE OPHTHALMIC SOLUTION (<i>cenegermin-bkbj</i>)	3	PA; LD; QL (2 vials per 1 day)
*OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
ACULAR LS OPHTHALMIC SOLUTION (<i>ketorolac tromethamine</i>)	3	QL (5 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACULAR OPHTHALMIC SOLUTION (<i>ketorolac tromethamine</i>)	3	QL (10 mL per 30 days)
ACUVAIL OPHTHALMIC SOLUTION (<i>ketorolac tromethamine</i>)	3	QL (1 box per 30 days)
<i>bromfenac sodium (once-daily) ophthalmic solution</i>	1 or 1b*	QL (1.7 mL per 30 days)
<i>bromfenac sodium ophthalmic solution 0.07 %</i>	1 or 1b*	QL (3 mL per 30 days)
<i>bromfenac sodium ophthalmic solution 0.075 %</i>	1 or 1b*	QL (5 mL per 30 days)
BROMSITE OPHTHALMIC SOLUTION (<i>bromfenac sodium</i>)	3	QL (5 mL per 30 days)
<i>diclofenac sodium ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>flurbiprofen sodium ophthalmic solution</i>	1 or 1b*	QL (2.5 mL per 30 days)
ILEVRO OPHTHALMIC SUSPENSION (<i>nepafenac</i>)	2	QL (3 mL per 30 days)
<i>ketorolac tromethamine ophthalmic solution 0.4 %</i>	1 or 1b*	QL (5 mL per 30 days)
<i>ketorolac tromethamine ophthalmic solution 0.5 %</i>	1 or 1b*	QL (10 mL per 30 days)
NEVANAC OPHTHALMIC SUSPENSION (<i>nepafenac</i>)	3	QL (3 mL per 30 days)
*OPHTHALMIC PHOTODYNAMIC THERAPY AGENTS*** - DRUGS FOR THE EYE		
VISUDYNE INTRAVENOUS SOLUTION RECONSTITUTED (<i>verteporfin</i>)	3	LD; QL (1 fill per 30 days)
*OPHTHALMIC PHOTOENHANCER COMBINATIONS*** - DRUGS FOR THE EYE		
PHOTREXA-PHOTREXA VISCOUS KIT OPHTHALMIC SOLUTION PREFILLED SYRINGE (<i>riboflav5 & riboflav5-dextran</i>)	3	
*OPHTHALMIC RHO KINASE INHIBITORS*** - DRUGS FOR GLAUCOMA		
RHOPRESSA OPHTHALMIC SOLUTION (<i>netarsudil dimesylate</i>)	3	QL (2.5 mL per 30 days)
*OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR GLAUCOMA		
ALPHAGAN P OPHTHALMIC SOLUTION (<i>brimonidine tartrate</i>)	3	QL (30 mL per 30 days)
<i>apraclonidine hcl ophthalmic solution</i>	1 or 1b*	
<i>brimonidine tartrate ophthalmic solution</i>	1 or 1b*	QL (30 mL per 30 days)
IOPIDINE OPHTHALMIC SOLUTION (<i>apraclonidine hcl</i>)	3	
*OPHTHALMIC STEROID COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment</i>	1 or 1b*	QL (7 mL per 30 days)
MAXITROL OPHTHALMIC OINTMENT (<i>neomycin-polymyxin-dexameth</i>)	3	QL (7 mL per 30 days)
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (<i>neomycin-polymyxin-dexameth</i>)	3	QL (20 mL per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic ointment</i>	1 or 1a*	QL (7 mL per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	1 or 1a*	QL (20 mL per 30 days)
<i>neomycin-polymyxin-hc ophthalmic suspension</i>	1 or 1b*	
<i>neo-polycin hc ophthalmic ointment</i>	1 or 1b*	QL (7 mL per 30 days)
<i>sulfacetamide-prednisolone ophthalmic solution</i>	1 or 1a*	QL (15 mL per 30 days)
TOBRADEX OPHTHALMIC OINTMENT (<i>tobramycin-dexamethasone</i>)	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOBRADEX ST OPHTHALMIC SUSPENSION (<i>tobramycin-dexamethasone</i>)	3	QL (10 mL per 30 days)
<i>tobramycin-dexamethasone ophthalmic suspension</i>	1 or 1b*	QL (10 mL per 30 days)
ZYLET OPHTHALMIC SUSPENSION (<i>loteprednol-tobramycin</i>)	2	QL (20 mL per 30 days)
*OPHTHALMIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>dexamethasone sodium phosphate ophthalmic solution</i>	1 or 1b*	
DEXTENZA OPHTHALMIC INSERT (<i>dexamethasone</i>)	3	
DEXYCU INTRAOCULAR SUSPENSION (<i>dexamethasone</i>)	3	
<i>difluprednate ophthalmic emulsion</i>	1 or 1b*	QL (10 mL per 30 days)
DUREZOL OPHTHALMIC EMULSION (<i>difluprednate</i>)	3	QL (10 mL per 30 days)
FLAREX OPHTHALMIC SUSPENSION (<i>fluorometholone acetate</i>)	3	
<i>fluorometholone ophthalmic suspension</i>	1 or 1b*	
FML FORTE OPHTHALMIC SUSPENSION (<i>fluorometholone</i>)	3	
FML LIQUIFILM OPHTHALMIC SUSPENSION (<i>fluorometholone</i>)	3	
ILUVIEN INTRAVITREAL IMPLANT (<i>fluocinolone acetonide</i>)	3	PA; LD
INVELTYS OPHTHALMIC SUSPENSION (<i>loteprednol etabonate</i>)	3	QL (5.6 mL per 30 days)
LOTEMAX OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	3	QL (10 grams per 30 days)
LOTEMAX OPHTHALMIC OINTMENT (<i>loteprednol etabonate</i>)	3	QL (7 grams per 30 days)
LOTEMAX OPHTHALMIC SUSPENSION (<i>loteprednol etabonate</i>)	3	QL (30 mL per 30 days)
LOTEMAX SM OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	3	QL (10 grams per 30 days)
<i>loteprednol etabonate ophthalmic gel</i>	1 or 1b*	QL (10 grams per 30 days)
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	1 or 1b*	QL (30 mL per 30 days)
MAXIDEX OPHTHALMIC SUSPENSION (<i>dexamethasone</i>)	3	
OZURDEX INTRAVITREAL IMPLANT (<i>dexamethasone</i>)	3	PA; LD
PRED MILD OPHTHALMIC SUSPENSION (<i>prednisolone acetate</i>)	3	
<i>prednisolone acetate ophthalmic suspension</i>	1 or 1b*	QL (20 mL per 30 days)
PREDNISOLONE SODIUM PHOSPHATE OPHTHALMIC SOLUTION	3	QL (20 mL per 30 days)
RETISERT INTRAVITREAL IMPLANT (<i>fluocinolone acetonide</i>)	3	PA; LD
TRIESENCE INTRAOCULAR SUSPENSION (<i>triamcinolone acetonide</i>)	3	
XIPERE INTRAOCULAR SUSPENSION (<i>triamcinolone acetonide</i>)	3	PA; LD
YUTIQ INTRAVITREAL IMPLANT (<i>fluocinolone acetonide</i>)	3	PA; LD
*OPHTHALMIC SULFONAMIDES*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>sulfacetamide sodium ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>sulfacetamide sodium ophthalmic solution</i>	1 or 1b*	QL (15 mL per 30 days)
*OPHTHALMIC SURGICAL AIDS - COMBINATIONS*** - DRUGS FOR THE EYE		
DISCOVISC INTRAOCULAR SOLUTION (<i>na chondroit sulf-na hyaluron</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUOVISC INTRAOCULAR KIT 0.4-0.35 ML, 0.55-0.5 ML (<i>na hyalur & na chond-na hyalur</i>)	3	
OMIDRIA INTRAOCULAR SOLUTION (<i>phenylephrine-ketorolac</i>)	3	
VISCOAT INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>na chondroit sulf-na hyaluron</i>)	3	
*OPHTHALMIC SURGICAL AIDS*** - DRUGS FOR THE EYE		
AMVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate</i>)	3	LD
CELLUGEL INTRAOCULAR SOLUTION (<i>hypromellose</i>)	3	
HEALON DUET PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate</i>)	3	LD
HEALON GV PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate</i>)	3	LD
HEALON PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate</i>)	3	LD
HEALON5 PRO INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate</i>)	3	LD
PROVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate</i>)	3	LD
TISSUEBLUE INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>brilliant blue g</i>)	3	
TOTALVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>sodium hyaluronate</i>)	3	
VISIONBLUE INTRAOCULAR SOLUTION PREFILLED SYRINGE (<i>trypan blue</i>)	3	
*OPHTHALMICS - BLEPHAROPTOSIS AGENTS** - DRUGS FOR THE EYE		
UPNEEQ OPHTHALMIC SOLUTION (<i>oxymetazoline hcl</i>)	3	PA; QL (30 containers per 30 days)
*OPHTHALMICS - CYSTINOSIS AGENTS** - DRUGS FOR THE EYE		
CYSTADROPS OPHTHALMIC SOLUTION (<i>cysteamine hcl</i>)	3	PA; QL (4 bottles per 28 days)
CYSTARAN OPHTHALMIC SOLUTION (<i>cysteamine hcl</i>)	3	PA; LD; QL (60 mL per 28 days)
*PROSTAGLANDINS - OPHTHALMIC**** - DRUGS FOR GLAUCOMA		
<i>bimatoprost ophthalmic solution</i>	1 or 1b*	
DURYSTA INTRAOCULAR IMPLANT (<i>bimatoprost</i>)	3	PA; LD; QL (2 applicators per 1 lifetime)
IYUZEH OPHTHALMIC SOLUTION (<i>latanoprost</i>)	3	QL (30 units per 30 days)
<i>latanoprost ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
LUMIGAN OPHTHALMIC SOLUTION (<i>bimatoprost</i>)	2	QL (7.5 mL per 30 days)
<i>tafluprost (pf) ophthalmic solution</i>	1 or 1b*	QL (9 mL per 30 days)
<i>travoprost (bak free) ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
VYZULTA OPHTHALMIC SOLUTION (<i>latanoprostene bunod</i>)	3	QL (5 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XELPROS OPHTHALMIC EMULSION (<i>latanoprost</i>)	3	QL (5 mL per 30 days)
ZIOPTAN OPHTHALMIC SOLUTION (<i>tafluprost</i>)	3	QL (9 mL per 30 days)
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS*** - DRUGS FOR THE EYE		
BEOVU INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>brolocizumab-dbl</i>)	3	PA; LD
BYOOVIZ INTRAVITREAL SOLUTION (<i>ranibizumab-nuna</i>)	3	PA; LD
CIMERLI INTRAVITREAL SOLUTION (<i>ranibizumab-eqrn</i>)	3	PA; LD
EYLEA HD INTRAVITREAL SOLUTION (<i>aflibercept</i>)	3	PA; LD
EYLEA INTRAVITREAL SOLUTION (<i>aflibercept</i>)	3	PA; LD
EYLEA INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>aflibercept</i>)	3	PA; LD
LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>ranibizumab</i>)	3	PA; LD
PAVBLU INTRAVITREAL SOLUTION (<i>aflibercept-ayyh</i>)	3	PA
PAVBLU INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>aflibercept-ayyh</i>)	3	PA
SUSVIMO (IMPLANT 1ST FILL) INTRAVITREAL SOLUTION (<i>ranibizumab</i>)	3	LD
SUSVIMO (IMPLANT REFILL) INTRAVITREAL SOLUTION (<i>ranibizumab</i>)	3	LD
OTIC AGENTS - DRUGS FOR THE EAR		
*OTIC AGENTS - MISCELLANEOUS*** - WAX REMOVAL		
<i>acetic acid otic solution</i>	1 or 1b*	
*OTIC ANALGESIC COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
PRAMOTIC OTIC LIQUID (<i>pramoxine-chloroxylenol</i>)	3	
*OTIC ANTI-INFECTIVES*** - ANTIBIOTICS		
CETRAXAL OTIC SOLUTION (<i>ciprofloxacin hcl</i>)	3	QL (28 containers per 1 fill)
<i>ciprofloxacin hcl otic solution</i>	1 or 1b*	QL (28 containers per 1 fill)
<i>ofloxacin otic solution</i>	1 or 1b*	QL (10 mL per 1 fill)
*OTIC STEROID-ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>ciprofloxacin-dexamethasone otic suspension</i>	1 or 1b*	QL (7.5 mL per 1 fill)
<i>ciprofloxacin-fluocinolone pf otic solution</i>	1 or 1b*	QL (28 vials per 1 fill)
CORTISPORIN-TC OTIC SUSPENSION (<i>neomycin-colist-hc-thonzonium</i>)	3	
<i>neomycin-polymyxin-hc otic solution</i>	1 or 1b*	
<i>neomycin-polymyxin-hc otic suspension</i>	1 or 1b*	QL (15 mL per 30 days)
OTOVEL OTIC SOLUTION (<i>ciprofloxacin-fluocinolone</i>)	3	QL (28 vials per 1 fill)
*OTIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
DERMOTIC OTIC OIL (<i>fluocinolone acetonide</i>)	3	
<i>flac otic oil</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluocinolone acetonide otic oil</i>	1 or 1b*	
<i>hydrocortisone-acetic acid otic solution</i>	1 or 1b*	QL (10 mL per 1 fill)
OXYTOCICS - HORMONES		
*ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS*** - DRUGS FOR WOMEN		
<i>carboprost tromethamine intramuscular solution</i>	1 or 1b*	
<i>carboprost tromethamine intramuscular solution prefilled syringe</i>	3	
CERVIDIL VAGINAL INSERT (<i>dinoprostone</i>)	3	
HEMABATE INTRAMUSCULAR SOLUTION (<i>carboprost tromethamine</i>)	3	
PREPIDIL VAGINAL GEL (<i>dinoprostone</i>)	3	
*OXYTOCICS*** - DRUGS FOR WOMEN		
<i>methergine oral tablet</i>	1 or 1b*	
<i>methylergonovine maleate injection solution</i>	1 or 1b*	
<i>methylergonovine maleate oral tablet</i>	1 or 1b*	
<i>oxytocin injection solution</i>	1 or 1b*	
PITOCIN INJECTION SOLUTION (<i>oxytocin</i>)	3	
PASSIVE IMMUNIZING AND TREATMENT AGENTS - BIOLOGICAL AGENTS		
*ANTITOXINS-ANTIVENINS*** - BIOLOGICAL AGENTS		
ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED (<i>centruroides (scorpion) im fab</i>)	3	
ANAVIP INTRAVENOUS SOLUTION RECONSTITUTED (<i>crotalidae immune fab (equine)</i>)	3	
ANTIVENIN LATRODECTUS MACTANS INJECTION KIT	3	
ANTIVENIN MICRURUS FULVIUS INTRAVENOUS SOLUTION RECONSTITUTED	3	
CROFAB INTRAVENOUS SOLUTION RECONSTITUTED (<i>crotalidae polyval immune fab</i>)	3	
*ANTIVIRAL MONOCLONAL ANTIBODIES*** - BIOLOGICAL AGENTS		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>nirsevimab-alip</i>)	3; \$0	PA; LD; QL (2 syringe per 180 days)
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 50 MG/0.5ML (<i>nirsevimab-alip</i>)	3; \$0	PA; LD; QL (1 syringe per 1 lifetime)
PEMGARDA INTRAVENOUS SOLUTION (<i>pemivibart</i>)	3	
SYNAGIS INTRAMUSCULAR SOLUTION (<i>palivizumab</i>)	3	PA; LD
*BACTERIAL MONOCLONAL ANTIBODIES*** - BIOLOGICAL AGENTS		
ZINPLAVA INTRAVENOUS SOLUTION (<i>bezlotoxumab</i>)	3	PA
*IMMUNE SERUMS*** - BIOLOGICAL AGENTS		
BABYBIG INTRAVENOUS SOLUTION RECONSTITUTED (<i>botulism immune globulin human</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CNJ-016 INTRAVENOUS SOLUTION (<i>vaccinia immune globulin human</i>)	3	
CUTAQUIG SUBCUTANEOUS SOLUTION (<i>immune globulin (human)-hipp</i>)	3	PA; LD
CYTOGAM INTRAVENOUS SOLUTION (<i>cytomegalovirus immune glob</i>)	3	LD
GAMASTAN INTRAMUSCULAR INJECTABLE (<i>immune globulin (human)</i>)	3	PA; LD
GAMUNEX-C INJECTION SOLUTION (<i>immune globulin (human)</i>)	3	PA; LD
HEPAGAM B INJECTION SOLUTION (<i>hepatitis b immune globulin</i>)	3	LD
HIZENTRA SUBCUTANEOUS SOLUTION (<i>immune globulin (human)</i>)	3	PA; LD
HIZENTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>immune globulin (human)</i>)	3	PA; LD
HYPERHEP B INTRAMUSCULAR SOLUTION (<i>hepatitis b immune globulin</i>)	3	LD
HYPERHEP B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>hepatitis b immune globulin</i>)	3	LD
HYPERRAB INJECTION SOLUTION (<i>rabies immune globulin</i>)	3	LD
HYPERRHO S/D INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>rho d immune globulin</i>)	3	LD; QL (2 fills per 365 days)
HYPERTET INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>tetanus immune globulin</i>)	3	
IMOGAM RABIES-HT INJECTION SOLUTION (<i>rabies immune globulin</i>)	3	LD
KEDRAB INJECTION SOLUTION	3	LD
MICRHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>rho d immune globulin</i>)	3	LD; QL (2 fills per 365 days)
NABI-HB INTRAMUSCULAR SOLUTION (<i>hepatitis b immune globulin</i>)	3	LD
OCTAGAM INTRAVENOUS SOLUTION (<i>immune globulin (human)</i>)	3	PA; LD
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>rho d immune globulin</i>)	3	LD; QL (2 fills per 365 days)
RHOPHYLAC INJECTION SOLUTION PREFILLED SYRINGE (<i>rho d immune globulin</i>)	3	LD; QL (2 fills per 365 days)
VARIZIG INTRAMUSCULAR SOLUTION (<i>varicella-zoster immune glob</i>)	3	LD
WINRHO SDF INJECTION SOLUTION (<i>rho d immune globulin</i>)	3	LD; QL (2 fills per 365 days)
XEMBIFY SUBCUTANEOUS SOLUTION (<i>immune globulin (human)-klhw</i>)	3	PA; LD
PENICILLINS - DRUGS FOR INFECTIONS		
*AMINOPENICILLINS*** - ANTIBIOTICS		
<i>amoxicillin oral capsule</i>	1 or 1a*	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml</i>	1 or 1a*	
<i>amoxicillin oral suspension reconstituted 400 mg/5ml</i>	3	
<i>amoxicillin oral tablet</i>	1 or 1a*	
<i>amoxicillin oral tablet chewable</i>	1 or 1a*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ampicillin oral capsule</i>	1 or 1a*	
<i>ampicillin sodium injection solution reconstituted</i>	1 or 1b*	
<i>ampicillin sodium intravenous solution reconstituted</i>	1 or 1b*	
*NATURAL PENICILLINS*** - ANTIBIOTICS		
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>penicillin g benzathine</i>)	3	
EXTENCILLINE INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>penicillin g benzathine</i>)	3	
LENTOCILIN INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>penicillin g benzathine</i>)	3	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS SOLUTION	3	
<i>penicillin g potassium injection solution reconstituted</i>	1 or 1b*	
<i>penicillin g sodium injection solution reconstituted</i>	1 or 1b*	
<i>penicillin v potassium oral solution reconstituted</i>	1 or 1b*	
<i>penicillin v potassium oral tablet</i>	1 or 1b*	
<i>pfizerpen injection solution reconstituted</i>	1 or 1b*	
*PENICILLIN COMBINATIONS*** - ANTIBIOTICS		
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral suspension reconstituted</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral tablet</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral tablet chewable</i>	1 or 1b*	
<i>ampicillin-sulbactam sodium injection solution reconstituted</i>	1 or 1b*	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted</i>	1 or 1b*	
AUGMENTIN ES-600 ORAL SUSPENSION RECONSTITUTED (<i>amoxicillin-pot clavulanate</i>)	3	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED (<i>amoxicillin-pot clavulanate</i>)	2	
AUGMENTIN ORAL TABLET (<i>amoxicillin-pot clavulanate</i>)	3	
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION (<i>penicillin g benzathine & proc</i>)	3	
BICILLIN C-R INTRAMUSCULAR SUSPENSION (<i>penicillin g benzathine & proc</i>)	3	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted</i>	1 or 1b*	
UNASYN INJECTION SOLUTION RECONSTITUTED (<i>ampicillin-sulbactam sodium</i>)	3	
UNASYN INTRAVENOUS SOLUTION RECONSTITUTED (<i>ampicillin-sulbactam sodium</i>)	3	
ZOSYN INTRAVENOUS SOLUTION (<i>piperacillin-tazobactam in dex</i>)	3	
*PENICILLINASE-RESISTANT PENICILLINS*** - ANTIBIOTICS		
<i>dicloxacillin sodium oral capsule</i>	1 or 1b*	
NAFCILLIN SODIUM IN DEXTROSE INTRAVENOUS SOLUTION	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nafcillin sodium injection solution reconstituted</i>	1 or 1b*	
<i>nafcillin sodium intravenous solution reconstituted</i>	1 or 1b*	
OXACILLIN SODIUM IN DEXTROSE INTRAVENOUS SOLUTION	3	
<i>oxacillin sodium injection solution reconstituted</i>	1 or 1b*	
<i>oxacillin sodium intravenous solution reconstituted</i>	1 or 1b*	
PROGESTINS - HORMONES		
*PROGESTINS*** - DRUGS FOR WOMEN		
<i>norethindrone acetate</i> (Gallifrey Oral Tablet)	1 or 1b*	
<i>medroxyprogesterone acetate oral tablet</i>	1 or 1a*	QL (1 tablet per 1 day)
<i>megestrol acetate oral suspension 625 mg/5ml</i>	1 or 1b*	
<i>norethindrone acetate oral tablet</i>	1 or 1b*	
<i>progesterone intramuscular oil</i>	1 or 1b*	
<i>progesterone oral capsule 100 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>progesterone oral capsule 200 mg</i>	1 or 1b*	QL (2 capsule per 1 day)
PROVERA ORAL TABLET (<i>medroxyprogesterone acetate</i>)	3	QL (1 tablet per 1 day)
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS FOR THE NERVOUS SYSTEM		
*AGENTS FOR OPIOID WITHDRAWAL*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>lofexidine hcl oral tablet</i>	1 or 1b*	QL (16 tablets per 1 day)
*ALCOHOL DETERRENTS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>acamprosate calcium oral tablet delayed release</i>	1 or 1b*	QL (6 tablet per 1 day)
<i>disulfiram oral tablet</i>	1 or 1b*	
*ANTI-CATAPLECTIC AGENTS*** - DRUGS FOR SLEEP DISORDER		
<i>sodium oxybate oral solution</i>	3	PA; LD; QL (18 mL per 1 day)
XYREM ORAL SOLUTION (<i>sodium oxybate</i>)	3	PA; LD; QL (18 mL per 1 day)
*ANTIDEMENTIA AGENT COMBINATIONS*** - DRUGS FOR ALZHEIMER'S DISEASE		
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR (<i>memantine hcl-donepezil hcl</i>)	2	QL (1 capsule per 1 day)
*ANTISENSE OLIGONUCLEOTIDE (ASO) INHIBITOR AGENTS*** - DRUGS FOR THE NERVOUS SYSTEM		
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>eplontersen sodium</i>)	3	PA; LD; QL (1 autoinjector per 28 days)
*BENZODIAZEPINES & TRICYCLIC AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>chlordiazepoxide-amitriptyline oral tablet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CHOLINOMIMETICS - ACHE INHIBITORS*** - DRUGS FOR ALZHEIMER'S DISEASE		
ARICEPT ORAL TABLET 10 MG, 23 MG (<i>donepezil hcl</i>)	3	QL (1 tablet per 1 day)
ARICEPT ORAL TABLET 5 MG (<i>donepezil hcl</i>)	3	DO
<i>donepezil hcl oral tablet 10 mg, 23 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>donepezil hcl oral tablet 5 mg</i>	1 or 1b*	DO
<i>donepezil hcl oral tablet dispersible</i>	1 or 1b*	QL (1 tablet per 1 day)
EXELON TRANSDERMAL PATCH 24 HOUR 13.3 MG/24HR, 9.5 MG/24HR (<i>rivastigmine</i>)	3	ST; QL (1 patch per 1 day)
EXELON TRANSDERMAL PATCH 24 HOUR 4.6 MG/24HR (<i>rivastigmine</i>)	3	ST; QL (1 gram per 1 day)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 8 mg</i>	1 or 1b*	DO
<i>galantamine hydrobromide oral solution</i>	1 or 1b*	QL (6 mL per 1 day)
<i>galantamine hydrobromide oral tablet 12 mg, 8 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>galantamine hydrobromide oral tablet 4 mg</i>	1 or 1b*	DO
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg</i>	1 or 1b*	DO
<i>rivastigmine tartrate oral capsule 4.5 mg, 6 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 9.5 mg/24hr</i>	1 or 1b*	QL (1 patch per 1 day)
<i>rivastigmine transdermal patch 24 hour 4.6 mg/24hr</i>	1 or 1b*	QL (1 gram per 1 day)
*FIBROMYALGIA AGENT - SNRIS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
SAVELLA ORAL TABLET (<i>milnacipran hcl</i>)	2	QL (2 tablets per 1 day)
SAVELLA TITRATION PACK ORAL (<i>milnacipran hcl</i>)	2	QL (1 pack per 365 days)
*MELANOCORTIN RECEPTOR AGONISTS*** - DRUGS FOR THE NERVOUS SYSTEM		
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>bremelanotide acetate</i>)	3	PA; QL (4 autoinjectors per 30 days)
*MOVEMENT DISORDER DRUG THERAPY*** - DRUGS FOR THE NERVOUS SYSTEM		
AUSTEDO ORAL TABLET (<i>deutetrabenazine</i>)	3	PA; LD; QL (4 tablets per 1 day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 24 MG, 6 MG (<i>deutetrabenazine</i>)	3	PA; LD; QL (2 tablets per 1 day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG (<i>deutetrabenazine</i>)	3	PA; LD; QL (1 tablet per 1 day)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>deutetrabenazine</i>)	3	PA; LD; QL (2 kits per 1 year)
INGREZZA ORAL CAPSULE 40 MG (<i>valbenazine tosylate</i>)	3	PA; LD; DO
INGREZZA ORAL CAPSULE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	3	PA; LD; QL (1 capsule per 1 day)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG (<i>valbenazine tosylate</i>)	3	PA; LD; DO
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	3	PA; LD; QL (1 capsule per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INGREZZA ORAL CAPSULE THERAPY PACK (<i>valbenazine tosylate</i>)	3	PA; LD; QL (1 pack per 1 one-time fill)
<i>tetrabenazine oral tablet 12.5 mg</i>	1 or 1b*	PA; LD; QL (8 tablets per 1 day)
<i>tetrabenazine oral tablet 25 mg</i>	1 or 1b*	PA; LD; QL (4 tablets per 1 day)
*MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>teriflunomide oral tablet</i>	1 or 1b*	PA; LD; QL (1 tablet per 1 day)
*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES*** - DRUGS FOR MULTIPLE SCLEROSIS		
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	3	PA; LD; QL (2 packs per 46 weekss)
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	3	PA; LD; QL (2 packs per 46 weekss)
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	3	PA; LD; QL (2 packs per 46 weekss)
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	3	PA; LD; QL (2 packs per 46 weekss)
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	3	PA; LD; QL (2 packs per 46 weekss)
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	3	PA; LD; QL (2 packs per 46 weekss)
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	3	PA; LD; QL (2 packs per 46 weekss)
*MULTIPLE SCLEROSIS AGENTS - INTERFERONS*** - DRUGS FOR MULTIPLE SCLEROSIS		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (<i>interferon beta-1a</i>)	3	PA; LD; QL (4 kits per 28 days)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (<i>interferon beta-1a</i>)	3	PA; LD; QL (4 kits per 28 days)
BETASERON SUBCUTANEOUS KIT (<i>interferon beta-1b</i>)	3	PA; LD; QL (15 kits per 30 days)
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	3	PA; LD; QL (2 syringes per 28 days)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>peginterferon beta-1a</i>)	3	PA; LD; QL (1 ML per 28 days)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	3	PA; LD; QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>peginterferon beta-1a</i>)	3	PA; LD; QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	3	PA; LD; QL (1 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>interferon beta-1a</i>)	3	PA; LD; QL (12 ML per 28 days)
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>interferon beta-1a</i>)	3	PA; LD; QL (4.2 ML per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>interferon beta-1a</i>)	3	PA; LD; QL (12 syringes per 28 days)
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>interferon beta-1a</i>)	3	PA; LD; QL (1 pack per 1 fill)
*MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR MULTIPLE SCLEROSIS		
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>ofatumumab</i>)	3	PA; LD; QL (1 syringe per 28 days)
LEMTRADA INTRAVENOUS SOLUTION (<i>alemtuzumab</i>)	3	PA; LD; QL (3 vials per 365 days)
TYSABRI INTRAVENOUS CONCENTRATE (<i>natalizumab</i>)	3	PA; LD; QL (1 vial per 28 days)
*MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	1 or 1b*	PA; LD; QL (14 capsules per 365 days)
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1 or 1b*	PA; LD; QL (2 capsules per 1 day)
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack</i>	1 or 1b*	PA; LD; QL (1 kit per 365 days)
VUMERITY ORAL CAPSULE DELAYED RELEASE (<i>diroximel fumarate</i>)	3	PA; LD; QL (4 capsules per 1 day)
*MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS*** - DRUGS FOR MULTIPLE SCLEROSIS		
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HOUR (<i>dalfampridine</i>)	3	PA; LD; QL (2 tablets per 1 day)
<i>dalfampridine er oral tablet extended release 12 hour</i>	1 or 1b*	PA; LD; QL (2 tablets per 1 day)
*MULTIPLE SCLEROSIS AGENTS*** - DRUGS FOR MULTIPLE SCLEROSIS		
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (<i>glatiramer acetate</i>)	3	PA; LD; QL (12 syringe per 28 days)
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml</i>	3	PA; LD; QL (1 syringe per 1 day)
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	3	PA; LD; QL (12 syringe per 28 days)
<i>glatopa subcutaneous solution prefilled syringe 20 mg/ml</i>	3	PA; LD; QL (1 syringe per 1 day)
<i>glatopa subcutaneous solution prefilled syringe 40 mg/ml</i>	3	PA; LD; QL (12 syringe per 28 days)
*N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS*** - DRUGS FOR ALZHEIMER'S DISEASE		
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 7 mg</i>	1 or 1b*	DO
<i>memantine hcl er oral capsule extended release 24 hour 21 mg, 28 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>memantine hcl oral solution</i>	1 or 1b*	QL (10 mL per 1 day)
<i>memantine hcl oral tablet 10 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg</i>	1 or 1b*	QL (1 tablet per 6 months)
<i>memantine hcl oral tablet 5 mg</i>	1 or 1b*	DO
NAMENDA TITRATION PAK ORAL TABLET (<i>memantine hcl</i>)	3	QL (1 tablet per 6 months)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PHENOTHIAZINES & TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION		
<i>perphenazine-amitriptyline oral tablet</i>	1 or 1b*	AL
*POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>gabapentin (once-daily) oral tablet</i>	1 or 1b*	PA; DO
GRALISE ORAL TABLET 300 MG (<i>gabapentin (once-daily)</i>)	3	PA; DO
GRALISE ORAL TABLET 450 MG (<i>gabapentin (once-daily)</i>)	2	PA; DO
GRALISE ORAL TABLET 600 MG (<i>gabapentin (once-daily)</i>)	3	PA; QL (3 tablets per 1 day)
GRALISE ORAL TABLET 750 MG, 900 MG (<i>gabapentin (once-daily)</i>)	2	PA; QL (2 tablets per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 165 MG, 82.5 MG (<i>pregabalin</i>)	3	PA; DO
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 330 MG (<i>pregabalin</i>)	3	PA; QL (2 tablets per 1 day)
<i>pregabalin er oral tablet extended release 24 hour 165 mg, 82.5 mg</i>	1 or 1b*	PA; DO
<i>pregabalin er oral tablet extended release 24 hour 330 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
*PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS - SSRIS*** - DRUGS FOR DEPRESSION		
<i>fluoxetine hcl (pmd) oral tablet 10 mg</i>	1 or 1b*	DO
<i>fluoxetine hcl (pmd) oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
*PSEUDOBULBAR AFFECT AGENT COMBINATIONS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
NUEDEXTA ORAL CAPSULE (<i>dextromethorphan-quinidine</i>)	3	PA; QL (2 capsules per 1 day)
*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>ergoloid mesylates oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>pimozide oral tablet 1 mg</i>	1 or 1b*	AL; QL (10 tablets per 1 day)
<i>pimozide oral tablet 2 mg</i>	1 or 1b*	AL; QL (5 tablets per 1 day)
*SEROTONIN 1A RECEPT AGONIST/SEROTONIN 2A RECEPT ANTAG*** - DRUGS FOR THE NERVOUS SYSTEM		
ADDYI ORAL TABLET (<i>flibanserin</i>)	3	PA; QL (1 tablet per 1 day)
*SMALL INTERFERING RIBONUCLEIC ACID (SIRNA) AGENTS*** - DRUGS FOR THE NERVOUS SYSTEM		
AMVUTTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>vutrisiran sodium</i>)	3	PA; LD; QL (1 syringe per 90 days)
ONPATTRO INTRAVENOUS SOLUTION (<i>patisiran sodium</i>)	3	PA; LD; QL (0.72 mL per 1 day)
*SMOKING DETERRENTS*** - DRUGS FOR DEPRESSION		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour</i>	1 or 1b*; \$0	QL (2 tablets per 1 day)
<i>cvs nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>cvs nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>cvs nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>cvs nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>eq nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>eq nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>eq nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>eq nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>eq nicotine step 3 transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>eq nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>ft nicotine mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ft nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>ft nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ft nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>gnp nicotine mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>gnp nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>gnp nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>gnp nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>gnp nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>goodsense nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>goodsense nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>habitrol transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>hm nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>hm nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>kls quit2 mouth/throat gum</i>	1 or 1b*; \$0	
<i>kls quit2 mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>kls quit4 mouth/throat gum</i>	1 or 1b*; \$0	
<i>kls quit4 mouth/throat lozenge</i>	1 or 1b*; \$0	
NICODERM CQ TRANSDERMAL PATCH 24 HOUR (<i>nicotine</i>)	2; \$0	
NICORETTE MINI MOUTH/THROAT LOZENGE (<i>nicotine polacrilex</i>)	2; \$0	
NICORETTE MOUTH/THROAT GUM (<i>nicotine polacrilex</i>)	2; \$0	
NICORETTE MOUTH/THROAT LOZENGE (<i>nicotine polacrilex</i>)	2; \$0	
NICORETTE STARTER KIT MOUTH/THROAT GUM (<i>nicotine polacrilex</i>)	2; \$0	
<i>nicotine mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>nicotine polacrilex mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>nicotine step 1 transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>nicotine step 2 transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>nicotine step 3 transdermal patch 24 hour</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NICOTINE TRANSDERMAL KIT	2; \$0	
<i>nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
NICOTROL INHALATION INHALER (<i>nicotine</i>)	3; \$0	QL (16 cartridges per 1 day)
NICOTROL NS NASAL SOLUTION (<i>nicotine</i>)	3; \$0	QL (4 mL per 1 day)
<i>qc nicotine transdermal system transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>ra mini nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ra nicotine gum mouth/throat gum</i>	1 or 1b*; \$0	
<i>ra nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>ra nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ra nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>sm nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>sm nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>sm nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>sm nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>sm nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>thrive mouth/throat gum</i>	1 or 1b*; \$0	
<i>varenicline tartrate (starter) oral tablet therapy pack</i>	1 or 1b*; \$0	QL (53 dose pack per 365 days)
<i>varenicline tartrate oral tablet 0.5 mg</i>	1 or 1b*; \$0	QL (2 tablets per 1 day)
<i>varenicline tartrate oral tablet 1 mg</i>	1 or 1b*; \$0	QL (2 tablet per 1 day)
<i>varenicline tartrate(continue) oral tablet</i>	1 or 1b*; \$0	QL (2 tablet per 1 day)
*SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>fingolimod hcl oral capsule</i>	1 or 1b*	PA; LD; QL (1 capsule per 1 day)
GILENYA ORAL CAPSULE 0.25 MG (<i>fingolimod hcl</i>)	3	PA; LD; QL (1 capsule per 1 day)
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	3	PA; LD; QL (4 tablets per 1 day)
MAYZENT ORAL TABLET 1 MG, 2 MG (<i>siponimod fumarate</i>)	3	PA; LD; QL (1 tablet per 1 day)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; LD; QL (1 pack per 1 one time fill)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	3	PA; LD; QL (1 pack per 1 fill)
PONVORY ORAL TABLET (<i>ponesimod</i>)	3	PA; LD; QL (1 tablet per 1 day)
PONVORY STARTER PACK ORAL TABLET THERAPY PACK (<i>ponesimod</i>)	3	PA; LD; QL (1 pack per 1 one time fill)
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK (<i>ozanimod hcl</i>)	3	PA; LD; QL (1 pack per 1 fill)
ZEPOSIA ORAL CAPSULE (<i>ozanimod hcl</i>)	3	PA; LD; QL (1 capsule per 1 day)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK (<i>ozanimod hcl</i>)	3	PA; LD; QL (1 pack per 1 fill)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*THIENBENZODIAZEPINES & OPIOID ANTAGONISTS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
LYBALVI ORAL TABLET (<i>olanzapine-samidorphan</i>)	3	ST; QL (1 tablet per 1 day)
*THIENBENZODIAZEPINES & SSRIS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg</i>	1 or 1b*	AL; QL (1 capsule per 1 day)
<i>olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg</i>	1 or 1b*	DO; AL
SYMBYAX ORAL CAPSULE (<i>olanzapine-fluoxetine hcl</i>)	3	DO; AL
*VASOMOTOR SYMPTOM AGENTS - SSRIS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>paroxetine mesylate oral capsule</i>	1 or 1b*	
RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS		
*ALPHA-PROTEINASE INHIBITOR (HUMAN)*** - DRUGS FOR ASTHMA/COPD		
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED (<i>alpha1-proteinase inhibitor</i>)	3	PA; LD
GLASSIA INTRAVENOUS SOLUTION (<i>alpha1-proteinase inhibitor</i>)	3	PA; LD
PROLASTIN-C INTRAVENOUS SOLUTION (<i>alpha1-proteinase inhibitor</i>)	3	PA; LD
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED (<i>alpha1-proteinase inhibitor</i>)	3	PA; LD
*CFTR POTENTIATORS*** - DRUGS FOR CYSTIC FIBROSIS		
KALYDECO ORAL PACKET (<i>ivacaftor</i>)	3	PA; LD; QL (2 packets per 1 day)
KALYDECO ORAL TABLET (<i>ivacaftor</i>)	3	PA; LD; QL (2 tablets per 1 day)
*CYSTIC FIBROSIS AGENT - COMBINATIONS*** - DRUGS FOR CYSTIC FIBROSIS		
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (<i>lumacaftor-ivacaftor</i>)	3	PA; LD; QL (2 packets per 1 day)
ORKAMBI ORAL PACKET 75-94 MG (<i>lumacaftor-ivacaftor</i>)	3	PA; LD; QL (2 units per 1 day)
ORKAMBI ORAL TABLET (<i>lumacaftor-ivacaftor</i>)	3	PA; LD; QL (4 tablet per 1 day)
SYMDEKO ORAL TABLET THERAPY PACK (<i>tezacaftor-ivacaftor</i>)	3	PA; LD; QL (1 carton per 28 days)
TRIKAFTA ORAL TABLET THERAPY PACK (<i>elexacaftor-tezacaftor-ivacaft</i>)	3	PA; LD; QL (1 carton per 28 days)
TRIKAFTA ORAL THERAPY PACK (<i>elexacaftor-tezacaftor-ivacaft</i>)	3	PA; LD; QL (1 carton per 28 days)
*CYSTIC FIBROSIS AGENTS - MISCELLANEOUS*** - DRUGS FOR CYSTIC FIBROSIS		
BRONCHITOL INHALATION CAPSULE (<i>mannitol (cystic fibrosis)</i>)	3	PA; LD; QL (560 tablets per 28 days)
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE (<i>mannitol (cystic fibrosis)</i>)	3	PA; LD; QL (1 test per 1 fill)
*HYDROLYTIC ENZYMES*** - DRUGS FOR THE LUNGS		
PULMOZYME INHALATION SOLUTION (<i>dornase alfa</i>)	3	PA; LD; QL (150 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS*** - DRUGS FOR THE LUNGS		
OFEV ORAL CAPSULE (<i>nintedanib esylate</i>)	3	PA; LD; QL (2 capsules per 1 day)
*PULMONARY FIBROSIS AGENTS*** - DRUGS FOR THE LUNGS		
<i>pirfenidone oral capsule</i>	1 or 1b*	PA; LD; QL (9 capsule per 1 day)
<i>pirfenidone oral tablet 267 mg</i>	1 or 1b*	PA; LD; QL (9 tablets per 1 day)
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	1 or 1b*	PA; LD; QL (3 tablets per 1 day)
SULFONAMIDES - DRUGS FOR INFECTIONS		
*SULFONAMIDES*** - ANTIBIOTICS		
<i>sulfadiazine oral tablet</i>	1 or 1b*	
TETRACYCLINES - DRUGS FOR INFECTIONS		
*AMINOMETHYLCYCLINES*** - ANTIBIOTICS		
NUZYRA INTRAVENOUS SOLUTION RECONSTITUTED (<i>omadacycline tosylate</i>)	3	
NUZYRA ORAL TABLET (<i>omadacycline tosylate</i>)	3	PA; QL (30 tablets per 30 days)
*FLUOROCYCLINES*** - ANTIBIOTICS		
XERAVA INTRAVENOUS SOLUTION RECONSTITUTED (<i>eravacycline dihydrochloride</i>)	3	
*GLYCYLCYCLINES*** - ANTIBIOTICS		
TIGECYCLINE INTRAVENOUS SOLUTION RECONSTITUTED	3	
TYGACIL INTRAVENOUS SOLUTION RECONSTITUTED (<i>tigecycline</i>)	3	
*TETRACYCLINES*** - ANTIBIOTICS		
<i>demeclocycline hcl oral tablet</i>	1 or 1b*	
<i>doxy 100 intravenous solution reconstituted</i>	1 or 1b*	QL (2 vials per 1 day)
<i>doxycycline hyclate intravenous solution reconstituted</i>	1 or 1b*	QL (2 vials per 1 day)
<i>doxycycline hyclate oral capsule 100 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxycycline hyclate oral capsule 50 mg</i>	1 or 1b*	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg, 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxycycline monohydrate oral capsule 150 mg</i>	3	ST; QL (1 capsule per 1 day)
<i>doxycycline monohydrate oral suspension reconstituted</i>	1 or 1b*	QL (600 mL per 30 days)
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral tablet 150 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
MINOCIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>minocycline hcl</i>)	3	
<i>minocycline hcl oral capsule 100 mg, 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>minocycline hcl oral capsule 50 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>minocycline hcl oral tablet 100 mg, 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>minocycline hcl oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>mondoxylene nl oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tetracycline hcl oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
THYROID AGENTS - HORMONES		
*ANTITHYROID AGENTS - RADIOPHARMACEUTICALS*** - DRUGS FOR THYROID		
SODIUM IODIDE I-131 ORAL SOLUTION	3	
*ANTITHYROID AGENTS*** - DRUGS FOR THYROID		
<i>methimazole oral tablet</i>	1 or 1a*	
<i>propylthiouracil oral tablet</i>	1 or 1b*	
*THYROID HORMONES*** - DRUGS FOR THYROID		
ADTHYZA ORAL TABLET (<i>thyroid</i>)	3	
ARMOUR THYROID ORAL TABLET (<i>thyroid</i>)	3	
CYTOMEL ORAL TABLET (<i>liothyronine sodium</i>)	3	
<i>euthyrox oral tablet</i>	1 or 1b*	
<i>levo-t oral tablet</i>	1 or 1b*	
LEVOTHYROXINE SODIUM INTRAVENOUS SOLUTION 100 MCG/5ML, 200 MCG/5ML, 500 MCG/5ML	3	
<i>levothyroxine sodium intravenous solution 100 mcg/ml</i>	3	
LEVOTHYROXINE SODIUM INTRAVENOUS SOLUTION RECONSTITUTED	3	
<i>levothyroxine sodium oral capsule</i>	1 or 1b*	
<i>levothyroxine sodium oral tablet</i>	1 or 1a*	
<i>levoxyl oral tablet</i>	1 or 1a*	
<i>liothyronine sodium intravenous solution</i>	1 or 1b*	
<i>liothyronine sodium oral tablet</i>	1 or 1b*	
<i>niva thyroid oral tablet</i>	3	
<i>np thyroid oral tablet</i>	1 or 1a*	
SYNTHROID ORAL TABLET (<i>levothyroxine sodium</i>)	3	
THYQUIDITY ORAL SOLUTION (<i>levothyroxine sodium</i>)	3	
<i>thyroid oral tablet</i>	3	
TIROSINT ORAL CAPSULE (<i>levothyroxine sodium</i>)	3	
TIROSINT-SOL ORAL SOLUTION (<i>levothyroxine sodium</i>)	3	
<i>unithroid oral tablet</i>	1 or 1a*	
TOXOIDS - BIOLOGICAL AGENTS		
*TOXOID COMBINATIONS*** - VACCINES		
ADACEL INTRAMUSCULAR SUSPENSION (<i>tetanus-diphth-acell pertussis</i>)	3; \$0	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>tetanus-diphth-acell pertussis</i>)	3; \$0	
DAPTACEL INTRAMUSCULAR SUSPENSION (<i>diphth-acell pertussis-tetanus</i>)	3; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFANRIX INTRAMUSCULAR SUSPENSION (<i>diphth-acell pertussis-tetanus</i>)	3; \$0	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv vaccine</i>)	3; \$0	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	3; \$0	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	3; \$0	
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	3; \$0	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv vaccine</i>)	3; \$0	
TDVAX INTRAMUSCULAR SUSPENSION (<i>tetanus-diphtheria toxoids td</i>)	3; \$0	
TENIVAC INTRAMUSCULAR INJECTABLE (<i>tetanus-diphtheria toxoids td</i>)	3; \$0	
TETANUS-DIPHThERIA TOXOIDS TD INTRAMUSCULAR SUSPENSION	3; \$0	
VAXELIS INTRAMUSCULAR SUSPENSION (<i>dtap-ipv-hib-hepatitis b recomb</i>)	3	
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recomb</i>)	3	
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR THE STOMACH		
*ANTICHOLINERGIC COMBINATIONS*** - DRUGS FOR STOMACH CRAMPS		
<i>chlordiazepoxide-clidinium oral capsule</i>	1 or 1b*	
LIBRAX ORAL CAPSULE (<i>chlordiazepoxide-clidinium</i>)	3	
*ANTISPASMODICS*** - DRUGS FOR STOMACH CRAMPS		
BENTYL INTRAMUSCULAR SOLUTION (<i>dicyclomine hcl</i>)	3	
<i>dicyclomine hcl intramuscular solution</i>	1 or 1b*	
<i>dicyclomine hcl oral capsule</i>	1 or 1a*	
<i>dicyclomine hcl oral solution</i>	1 or 1a*	
<i>dicyclomine hcl oral tablet</i>	1 or 1a*	
*BELLADONNA ALKALOIDS*** - DRUGS FOR STOMACH CRAMPS		
ATROPINE SULFATE INJECTION SOLUTION	3	
ATROPINE SULFATE INJECTION SOLUTION PREFILLED SYRINGE 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML	3	
ATROPINE SULFATE INTRAVENOUS SOLUTION	3	
*H-2 ANTAGONISTS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>cimetidine hcl oral solution</i>	1 or 1b*	QL (90 mL per 1 day)
<i>cimetidine oral tablet 300 mg, 400 mg</i>	1 or 1b*	QL (4 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cimetidine oral tablet 800 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>famotidine (pf) intravenous solution</i>	1 or 1b*	
<i>famotidine intravenous solution</i>	1 or 1b*	
<i>famotidine oral suspension reconstituted</i>	1 or 1b*	QL (5 mL per 1 day)
<i>famotidine oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>famotidine premixed intravenous solution</i>	1 or 1b*	
<i>nizatidine oral capsule 150 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>nizatidine oral capsule 300 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
PEPCID ORAL TABLET 20 MG (<i>famotidine</i>)	3	QL (4 tablets per 1 day)
PEPCID ORAL TABLET 40 MG (<i>famotidine</i>)	3	QL (2 tablets per 1 day)
*MISC. ANTI-ULCER*** - DRUGS FOR ULCERS AND STOMACH ACID		
CARAFATE ORAL SUSPENSION (<i>sucralfate</i>)	3	
CARAFATE ORAL TABLET (<i>sucralfate</i>)	3	
<i>sucralfate oral suspension</i>	1 or 1b*	
<i>sucralfate oral tablet</i>	1 or 1b*	
*PROTON PUMP INHIBITORS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>esomeprazole magnesium oral capsule delayed release</i>	1 or 1b*	
<i>esomeprazole magnesium oral packet</i>	1 or 1b*	
<i>esomeprazole sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>lansoprazole oral capsule delayed release 15 mg</i>	1 or 1b*	ST; BE; QL (1 capsule per 1 day)
<i>lansoprazole oral capsule delayed release 30 mg</i>	1 or 1b*	
NEXIUM I.V. INTRAVENOUS SOLUTION RECONSTITUTED (<i>esomeprazole sodium</i>)	3	
<i>omeprazole oral capsule delayed release</i>	1 or 1b*	
<i>pantoprazole sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>pantoprazole sodium oral tablet delayed release</i>	1 or 1b*	
<i>pantoprazole sodium-nacl intravenous solution</i>	3	
PROTONIX INTRAVENOUS SOLUTION RECONSTITUTED (<i>pantoprazole sodium</i>)	3	
*QUATERNARY ANTICHOLINERGICS*** - DRUGS FOR STOMACH CRAMPS		
CUVPOSA ORAL SOLUTION (<i>glycopyrrolate</i>)	3	
GLYCATE ORAL TABLET (<i>glycopyrrolate</i>)	3	PA
<i>glycopyrrolate injection solution</i>	1 or 1b*	
<i>glycopyrrolate oral solution</i>	1 or 1b*	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1 or 1b*	
GLYCOPYRROLATE ORAL TABLET 1.5 MG	3	PA

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLYCOPYRROLATE PF INJECTION SOLUTION PREFILLED SYRINGE 0.2 MG/ML, 0.4 MG/2ML	1 or 1b*	
<i>glycopyrrolate pf injection solution prefilled syringe 0.6 mg/3ml</i>	3	
GLYRX-PF INJECTION SOLUTION (<i>glycopyrrolate</i>)	3	
GLYRX-PF INJECTION SOLUTION PREFILLED SYRINGE (<i>glycopyrrolate</i>)	3	
<i>methscopolamine bromide oral tablet</i>	1 or 1b*	
ROBINUL ORAL TABLET (<i>glycopyrrolate</i>)	3	
ROBINUL-FORTE ORAL TABLET (<i>glycopyrrolate</i>)	3	
*ULCER ANTI-INFECTIVE W/ BISMUTH COMBINATIONS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>bis subcit-metronid-tetracyc oral capsule</i>	1 or 1b*	ST; QL (1 pack per 1 fill)
<i>bismuth/metronidaz/tetracyclin oral capsule</i>	1 or 1b*	ST; QL (1 pack per 1 fill)
HELIDAC THERAPY ORAL (<i>metronid-tetracyc-bis subsal</i>)	3	ST; QL (1 pack per 1 fill)
PYLERA ORAL CAPSULE (<i>bis subcit-metronid-tetracyc</i>)	3	ST; QL (1 pack per 1 fill)
*ULCER ANTI-INFECTIVE W/ PROTON PUMP INHIBITORS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>amoxicill-clarithro-lansopraz oral therapy pack</i>	1 or 1b*	ST; QL (1 pack per 1 fill)
OMECLAMOX-PAK ORAL (<i>amoxicill-clarithro-omeprazole</i>)	3	ST; QL (1 pack per 1 fill)
TALICIA ORAL CAPSULE DELAYED RELEASE (<i>amoxicill-rifabutin-omeprazole</i>)	3	ST; QL (1 pack per 1 fill)
*ULCER DRUGS - PROSTAGLANDINS*** - DRUGS FOR ULCERS AND STOMACH ACID		
CYTOTEC ORAL TABLET (<i>misoprostol</i>)	3	\$0 for Fully insured members in California
<i>misoprostol oral tablet</i>	1 or 1a*	\$0 for Fully insured members in California
URINARY ANTISPASMODICS - DRUGS FOR THE URINARY SYSTEM		
*URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)*** - DRUGS FOR THE BLADDER		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fesoterodine fumarate er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>oxybutynin chloride er oral tablet extended release 24 hour 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>oxybutynin chloride oral solution</i>	1 or 1b*	QL (20 mL per 1 day)
<i>oxybutynin chloride oral tablet 2.5 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>oxybutynin chloride oral tablet 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>solifenacin succinate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>tolterodine tartrate er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>tolterodine tartrate oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>trosipium chloride er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>trosipium chloride oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS*** - DRUGS FOR THE BLADDER		
<i>mirabegron er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER (<i>mirabegron</i>)	3	ST; QL (3 bottles per 30 days)
*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS*** - DRUGS FOR THE BLADDER		
<i>bethanechol chloride oral tablet</i>	1 or 1b*	
*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS*** - DRUGS FOR THE BLADDER		
<i>flavoxate hcl oral tablet</i>	1 or 1b*	
VACCINES - BIOLOGICAL AGENTS		
*BACTERIAL VACCINES*** - VACCINES		
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	3; \$0	
BCG VACCINE INJECTION SOLUTION RECONSTITUTED	3; \$0	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>meningococcal b recomb omv adj</i>)	3; \$0	
BIOTHRAX INTRAMUSCULAR SUSPENSION (<i>anthrax vaccine adsorbed</i>)	3	
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>pneumococcal 21-valent conjuga</i>)	3; \$0	
HIBERIX INJECTION SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	3; \$0	
MENQUADFI INTRAMUSCULAR SOLUTION (<i>mening acy&w-135 tetanus conj</i>)	3; \$0	
MENVEO INTRAMUSCULAR SOLUTION (<i>meningococcal a c y&w-135 olig</i>)	3; \$0	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>meningococcal a c y&w-135 olig</i>)	3; \$0	
PEDVAX HIB INTRAMUSCULAR SUSPENSION (<i>haemophilus b polysac conj vac</i>)	3; \$0	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>mening acyw(tet conj)-b(rcmb)</i>)	3; \$0	
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE (<i>pneumococcal vac polyvalent</i>)	2; \$0	
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>pneumococcal 20-val conj vacc</i>)	2; \$0	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>meningococcal b vac (recomb)</i>)	3; \$0	
TYPHIM VI INTRAMUSCULAR SOLUTION (<i>typhoid vi polysaccharide vacc</i>)	3	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>typhoid vi polysaccharide vacc</i>)	3	
VAXCHORA ORAL SUSPENSION RECONSTITUTED (<i>cholera vac live attenuated</i>)	3	
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>pneumococcal 15-val conj vacc</i>)	2; \$0	
VIVOTIF ORAL CAPSULE DELAYED RELEASE (<i>typhoid vaccine</i>)	2	
*VIRAL VACCINE COMBINATIONS*** - VACCINES		
M-M-R II INJECTION SOLUTION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	3; \$0	
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	3; \$0	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles-mumps-rubella-varicell</i>)	3; \$0	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>hepatitis a-hep b recomb vac</i>)	3; \$0	
*VIRAL VACCINES*** - VACCINES		
ABRYSSVO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>rsv pre-fusion f a&b vac rcmb</i>)	3; \$0	QL (1 injection per 1 lifetime)
ACAM2000 INJECTION SOLUTION RECONSTITUTED (<i>smallpox vaccine</i>)	3; \$0	
AFLURIA INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	2; \$0	QL (1 mL per 1 one-time fill)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rsvpref3 vac recomb adjuvanted</i>)	3; \$0	PA; AL; QL (1 injection per 1 lifetime)
AUDENZ INTRAMUSCULAR EMULSION (<i>influenza a (h5n1) subunit adj</i>)	2; \$0	
AUDENZ INTRAMUSCULAR PREFILLED SYRINGE (<i>influenza a (h5n1) subunit adj</i>)	2; \$0	
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
DENG VAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>dengue virus vaccine live tetr</i>)	3	
ENGERIX-B INJECTION SUSPENSION (<i>hepatitis b vac recombinant</i>)	3; \$0	
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE (<i>hepatitis b vac recombinant</i>)	3; \$0	
ERVEBO INTRAMUSCULAR SUSPENSION (<i>ebola zaire virus vaccine live</i>)	3	
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza vac a&b surf ant adj</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>influenza vac recombinant ha</i>)	2; \$0	QL (1 fill per 180 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUCELVAX INTRAMUSCULAR SUSPENSION (<i>influenza vac tiss-cult subunt</i>)	2; \$0	QL (1 fill per 180 days)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza vac tiss-cult subunt</i>)	2; \$0	QL (1 fill per 180 days)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUMIST NASAL LIQUID (<i>influenza virus vaccine live</i>)	2; \$0	QL (1 fill per 180 days)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza vac split high-dose</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUZONE INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
GARDASIL 9 INTRAMUSCULAR SUSPENSION (<i>hvp 9-valent recomb vaccine</i>)	2; \$0	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>hvp 9-valent recomb vaccine</i>)	2; \$0	
HAVRIX INTRAMUSCULAR SUSPENSION (<i>hepatitis a vaccine</i>)	3; \$0	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>hepatitis b vac recomb adj</i>)	3; \$0	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rabies virus vaccine, hdc</i>)	3	
IPOP INJECTION INJECTABLE (<i>poliovirus vaccine inactivated</i>)	3; \$0	
IXCHIQ INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chikungunya virus vaccine live</i>)	3	
IXIARO INTRAMUSCULAR SUSPENSION (<i>japanese encephalitis vac inac</i>)	3	
JYNNEOS SUBCUTANEOUS SUSPENSION (<i>smallpox & monkeypox vac, live</i>)	3; \$0	
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>rsv mrna pre-f virus vaccine</i>)	3; \$0	AL; QL (1 syringe per 1 lifetime)
<i>novavax covid-19 vaccine intramuscular suspension prefilled syringe</i>	2; \$0	
PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
<i>pfizer covid-19 vac-tris 6m-4y intramuscular suspension</i>	2; \$0	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rabies vaccine, pcec</i>)	3	
RECOMBIVAX HB INJECTION SUSPENSION (<i>hepatitis b vac recombinant</i>)	3; \$0	
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE (<i>hepatitis b vac recombinant</i>)	3; \$0	
ROTARIX ORAL SUSPENSION (<i>rotavirus vaccine live oral</i>)	3; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROTATEQ ORAL SOLUTION (<i>rotavirus vac live pentavalent</i>)	3; \$0	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>zoster vac recomb adjuvanted</i>)	3; \$0	
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
STAMARIL INJECTION SUSPENSION RECONSTITUTED	3	
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>tick-borne encephalitis vacc</i>)	3	
VAQTA INTRAMUSCULAR SUSPENSION (<i>hepatitis a vaccine</i>)	3; \$0	
VARIVAX INJECTION SUSPENSION RECONSTITUTED (<i>varicella virus vaccine live</i>)	3; \$0	
YF-VAX SUBCUTANEOUS INJECTABLE (<i>yellow fever vaccine</i>)	3	
VAGINAL AND RELATED PRODUCTS - DRUGS FOR WOMEN		
*IMIDAZOLE-RELATED ANTIFUNGALS*** - DRUGS FOR INFECTIONS		
GYNAZOLE-1 VAGINAL CREAM (<i>butoconazole nitrate (1 dose)</i>)	3	
<i>miconazole 3 vaginal suppository</i>	1 or 1b*	
<i>terconazole vaginal cream 0.4 %</i>	1 or 1b*	QL (90 grams per 30 days)
<i>terconazole vaginal cream 0.8 %</i>	1 or 1b*	QL (40 grams per 30 days)
<i>terconazole vaginal suppository</i>	1 or 1b*	QL (6 suppositories per 30 days)
*MISCELLANEOUS VAGINAL PRODUCTS**** - DRUGS FOR WOMEN		
INTRAROSA VAGINAL INSERT (<i>prasterone</i>)	3	ST; QL (1 insert per 1 day)
*SPERMICIDES**** - BIRTH CONTROL PILLS		
ENCARE VAGINAL SUPPOSITORY (<i>nonoxynol-9</i>)	2; \$0	
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL (<i>nonoxynol-9</i>)	2; \$0	
TODAY SPONGE VAGINAL (<i>nonoxynol-9</i>)	2; \$0	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM (<i>nonoxynol-9</i>)	2; \$0	
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL (<i>nonoxynol-9</i>)	2; \$0	
*VAGINAL ANTI-INFECTIVES*** - DRUGS FOR INFECTIONS		
CLEOCIN VAGINAL CREAM (<i>clindamycin phosphate</i>)	3	
CLEOCIN VAGINAL SUPPOSITORY (<i>clindamycin phosphate</i>)	2	
<i>clindamycin phosphate vaginal cream</i>	1 or 1b*	
CLINDESSE VAGINAL CREAM (<i>clindamycin phosphate (1 dose)</i>)	3	
<i>metronidazole vaginal gel</i>	1 or 1b*	
NUVESSA VAGINAL GEL (<i>metronidazole</i>)	3	
VANAZOLE VAGINAL GEL (<i>metronidazole</i>)	1 or 1b*	
XACIATO VAGINAL GEL (<i>clindamycin phosphate</i>)	3	PA; QL (1 applicator per 1 fill)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*VAGINAL CONTRACEPTIVE PH MODULATOR - COMBINATIONS*** - DRUGS FOR WOMEN		
PHEXXI VAGINAL GEL (<i>lactic ac-citric ac-pot bitart</i>)	3	\$0
*VAGINAL ESTROGENS*** - DRUGS FOR WOMEN		
<i>estradiol vaginal cream</i>	1 or 1b*	QL (42.5 grams per 30 days)
<i>estradiol vaginal tablet</i>	1 or 1b*	QL (18 tablet per 28 days)
ESTRING VAGINAL RING (<i>estradiol</i>)	3	QL (1 ring per 90 days)
FEMRING VAGINAL RING (<i>estradiol acetate</i>)	3	QL (1 ring per 90 days)
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG (<i>estradiol</i>)	3	QL (18 inserts per 28 days)
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 4 MCG (<i>estradiol</i>)	3	QL (18 packs per 28 days)
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG (<i>estradiol</i>)	3	QL (18 inserts per 28 days)
IMVEXXY STARTER PACK VAGINAL INSERT 4 MCG (<i>estradiol</i>)	3	QL (18 packs per 28 days)
PREMARIN VAGINAL CREAM (<i>estrogens, conjugated</i>)	2	QL (1 gm per 1 day)
<i>yuvafem vaginal tablet</i>	1 or 1b*	QL (18 tablet per 28 days)
*VAGINAL PROGESTINS*** - DRUGS FOR WOMEN		
CRINONE VAGINAL GEL 4 % (<i>progesterone</i>)	3	LD
CRINONE VAGINAL GEL 8 % (<i>progesterone</i>)	3	PA; LD; QL (1 applicator per 1 day)
ENDOMETRIN VAGINAL INSERT (<i>progesterone</i>)	3	PA
VASOPRESSORS - DRUGS FOR THE HEART		
*ANAPHYLAXIS THERAPY AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
ADRENALIN INJECTION SOLUTION (<i>epinephrine</i>)	3	
<i>epinephrine (anaphylaxis) injection solution</i>	1 or 1b*	
<i>epinephrine injection solution auto-injector</i>	1 or 1b*	QL (2 pens per 1 fill)
EPINEPHRINESNAP INJECTION KIT (<i>epinephrine</i>)	3	
*NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>droxidopa oral capsule 100 mg</i>	1 or 1b*	PA; LD; QL (3 capsules per 1 day)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	1 or 1b*	PA; LD; QL (6 capsules per 1 day)
*VASOPRESSORS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
ADRENALIN-NACL INTRAVENOUS SOLUTION (<i>epinephrine-nacl</i>)	3	
AKOVAZ INTRAVENOUS SOLUTION (<i>ephedrine sulfatate (pressors)</i>)	3	
AKOVAZ INTRAVENOUS SOLUTION PREFILLED SYRINGE (<i>ephedrine sulfatate (pressors)</i>)	3	
BIORPHEN INTRAVENOUS SOLUTION (<i>phenylephrine hcl (pressors)</i>)	3	
EMERPHED INTRAVENOUS SOLUTION (<i>ephedrine sulfatate (pressors)</i>)	3	
EMERPHED INTRAVENOUS SOLUTION PREFILLED SYRINGE (<i>ephedrine sulfatate (pressors)</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EPHEDRINE SULFATE (PRESSORS) INTRAVENOUS SOLUTION	3	
<i>epinephrine injection solution 10 mg/10ml</i>	3	
EPINEPHRINE INTRAVENOUS SOLUTION PREFILLED SYRINGE 1 MG/10ML	3	
EPINEPHRINE PF INJECTION SOLUTION	3	
GIAPREZA INTRAVENOUS SOLUTION (<i>angiotensin ii acetate</i>)	3	
IMMPHENTIV INTRAVENOUS SOLUTION (<i>phenylephrine hcl (pressors)</i>)	3	
LEVOPHED INTRAVENOUS SOLUTION (<i>norepinephrine bitartrate</i>)	3	
<i>midodrine hcl oral tablet</i>	1 or 1b*	
PHENYLEPHRINE HCL (PRESSORS) INTRAVENOUS SOLUTION 10 MG/ML	3	
<i>phenylephrine hcl (pressors) intravenous solution prefilled syringe 5 mg/50ml</i>	3	
REZIPRES INTRAVENOUS SOLUTION (<i>ephedrine hcl</i>)	3	
VAZCULEP INTRAVENOUS SOLUTION (<i>phenylephrine hcl (pressors)</i>)	3	
VITAMINS - DRUGS FOR NUTRITION		
*VITAMIN A*** - DRUGS FOR NUTRITION		
AQUASOL A INTRAMUSCULAR SOLUTION (<i>vitamin a</i>)	3	
*VITAMIN B-1*** - DRUGS FOR NUTRITION		
<i>thiamine hcl injection solution</i>	1 or 1b*	
*VITAMIN C*** - DRUGS FOR NUTRITION		
ASCOR INTRAVENOUS SOLUTION (<i>ascorbic acid</i>)	3	
*VITAMIN D*** - DRUGS FOR NUTRITION		
DRISDOL ORAL CAPSULE (<i>ergocalciferol</i>)	3	
<i>ergocalciferol oral capsule</i>	1 or 1a*	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i>	1 or 1a*	
*VITAMIN K*** - DRUGS FOR NUTRITION		
<i>phytonadione injection solution</i>	1 or 1b*	
<i>phytonadione oral tablet</i>	1 or 1b*	
<i>vitamin k1 injection solution</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with the highest cost share **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Index

1ST TIER UNIFINE PENTIPS	171	ADACEL	222	ALBUKED 25	144
1ST TIER UNIFINE PENTIPS PLUS	171	ADAKVEO	148	ALBUKED 5	144
<i>abacavir sulfate</i>	91	<i>adalimumab-adbm (2 pen)</i>	16	ALBUMIN HUMAN	144
<i>abacavir sulfate-lamivudine</i>	89	<i>adalimumab-adbm (2 syringe)</i>	16	ALBUMINEX	144
ABELCET	49	<i>adalimumab-adbm(cd/uc/hs strt)</i>	16	ALBUMIN-ZLB	144
ABILIFY MAINTENA	87, 88	<i>adalimumab-adbm(ps/uv starter)</i>	16	ALBURX	145
ABILIFY MYCITE MAINTENANCE KIT	88	<i>adapalene</i>	113	ALBUTEIN	145
ABILIFY MYCITE STARTER KIT	88	<i>adapalene-benzoyl peroxide</i>	113	<i>albuterol sulfate</i>	29
<i>abiraterone acetate</i>	63	ADASUVE	87	ALBUTEROL SULFATE	29
ABLYSINOL	101	ADCETRIS	66	<i>albuterol sulfate hfa</i>	29
ABRAXANE	79	ADDYI	217	ALCAINE	205
ABRYSVO	227	<i>adefovir dipivoxil</i>	92	<i>alclometasone dipropionate</i>	117
ABSORICA	113	ADEMPAS	100	ALDACTONE	125
ABSORICA LD	113	<i>adenosine</i>	27	ALDURAZYME	130
ACAM2000	227	ADIPEX-P	12	ALECENSA	64
<i>acamprosate calcium</i>	213	<i>adjustable lancing device</i>	159	<i>alendronate sodium</i>	126
<i>acarbose</i>	40	ADRENALIN	230	<i>alfuzosin hcl er</i>	139
ACCOLATE	30	ADRENALIN-NACL	230	ALIMTA	63
ACCRUFER	148	<i>adriamycin</i>	74	ALIQOPA	80
ACCU-CHEK AVIVA PLUS	124	ADTHYZA	222	<i>aliskiren fumarate</i>	57
ACCU-CHEK FASTCLIX LANCET	159	ADVANCED MOBILE LANCET	159	ALKINDI SPRINKLE	109
ACCU-CHEK FASTCLIX LANCETS	159	ADVATE	141	<i>allbee/c</i>	188
ACCU-CHEK GUIDE TEST	124	ADVOCATE INSULIN PEN NEEDLE	171	<i>allopurinol</i>	140
ACCU-CHEK SAFE-T PRO LANCETS	159	ADVOCATE INSULIN PEN NEEDLES	171	<i>allopurinol sodium</i>	140
ACCU-CHEK SMARTVIEW	124	ADVOCATE INSULIN SYRINGE	171	<i>almotriptan malate</i>	178
ACCU-CHEK SOFTCLIX LANCET DEV	159	ADVOCATE LANCETS	159	<i>alogliptin benzoate</i>	41
ACCU-CHEK SOFTCLIX LANCETS	159	ADVOCATE LANCETS 30G	159	<i>alogliptin-metformin hcl</i>	41
ACCURETIC	53	ADVOCATE LANCING DEVICE	159	<i>alogliptin-pioglitazone</i>	41
<i>accutane</i>	113	ADVOCATE RAPID-SAFE LANCING	159	<i>alophen</i>	154
ACCUTREND GLUCOSE	124	ADVOCATE SAFETY LANCETS	159	ALOPRIM	140
<i>acebutolol hcl</i>	94	ADVOCATE SAFETY LANCETS 26G	159	ALORA	134
ACETADOTE	45	ADYNOVATE	141	<i>aloksetron hcl</i>	136
<i>acetaminophen</i>	18	<i>adzynma</i>	141	ALPHAGAN P	206
<i>acetaminophen-codeine</i>	20	<i>afirmelle</i>	103	ALPHANATE	141
<i>acetazolamide</i>	124	AFLURIA	227	ALPHANINE SD	141
<i>acetazolamide er</i>	124	AFLURIA PRESERVATIVE FREE	227	<i>alprazolam</i>	26
<i>acetazolamide sodium</i>	124	AFSTYLA	141	<i>alprazolam er</i>	26
<i>acetic acid</i>	139, 209	<i>aftera</i>	107	ALPRAZOLAM INTENSOL	26
<i>acetylcysteine</i>	45, 112	<i>afterpill</i>	107	<i>alprazolam xr</i>	26
<i>acitretin</i>	115	AGAMATRIX ULTRA-THIN LANCETS	159	ALPROLIX	141
ACTHAR	127	AGGRASTAT	144	<i>altafluor benox</i>	205
ACTHAR GEL	127	AGRYLIN	145	<i>altavera</i>	103
ACTHIB	226	AIMOVIG	178	ALTUVIIIIO	141
ACTIFLOVIT EAR HEALTH	197	<i>aimSCO lubricated</i>	157	ALUNBRIG	64, 65
ACTIFOAM COLLAGEN SPONGE	149	AIMSCO TWIST LANCETS 32G	159	<i>alvimopan</i>	137
ACTI-LANCE 28G	159	AIMSCO TWIST LANCETS 33G	159	<i>alyacen 1/35</i>	103
ACTI-LANCE LITE LANCETS 28G	159	AJOVY	178	<i>alyacen 7/7/7</i>	109
ACTI-LANCE SPECIAL LANCETS 17G	159	AKEEGA	71	<i>alyq</i>	100
ACTI-LANCE UNIVERSAL 23G	159	<i>ak-fluor</i>	205	<i>amantadine hcl</i>	83
ACTIMMUNE	76	AKLIEF	113	AMBISOME	49
ACTIVASE	146	AKOVAZ	230	<i>ambrisentan</i>	100
ACTIVELLA	133	AKTEN	205	<i>amcinonide</i>	117
ACTONEL	126	AKYNZEO	47	AMELUZ	121
ACULAR	206	AKYNZEO (READY-TO-USE)	47	<i>amethyst</i>	107
ACULAR LS	205	AKYNZEO (TO-BE-DILUTED)	47	AMIDATE	138
ACUVAIL	206	<i>ala-cort</i>	117	<i>amikacin sulfate</i>	15
<i>acyclovir</i>	93, 116	<i>albendazole</i>	25	<i>amiloride hcl</i>	125
<i>acyclovir sodium</i>	93			<i>amiloride-hydrochlorothiazide</i>	124

AMINOSYN-PF	201	APONVIE	48	ASSURE ID DUO PRO PEN	
AMINOSYN-PF 7%	201	<i>apraclonidine hcl</i>	206	NEEDLES	171
<i>amiodarone hcl</i>	27	<i>aprepitant</i>	48	ASSURE ID PRO PEN NEEDLES	171
<i>amitriptyline hcl</i>	39	APRETUDE	90	ASSURE ID SAFETY PEN	
<i>amlodipine besy-benazepril hcl</i>	53	<i>apri</i>	103	NEEDLES	171
<i>amlodipine besylate</i>	96	APRISO	136	ASSURE LANCE LANCETS	159
<i>amlodipine besylate-valsartan</i>	55	APTIOM	33	ASSURE LANCE LANCETS 21G	159
<i>amlodipine-atorvastatin</i>	99	APTIVUS	90	ASSURE LANCE PLUS SAFETY	
<i>amlodipine-valsartan-hctz</i>	56	<i>aq insulin syringe</i>	171	25G	159
AMMONUL	132	<i>aqinject pen needle</i>	171	ASSURE LANCE PLUS SAFETY	
<i>amnesteem</i>	113	AQUALANCE LANCETS 30G	159	30G	159
AMNIOFIX	122	AQUASOL A	231	ASSURE LANCE SAFETY LANCET	
AMNIOTEXT	122	<i>aquastat</i>	181	28G	159
AMONDYS 45	200	Aquastat Sfr	181	ASTAGRAF XL	184
<i>amoxapine</i>	39	ARAKODA	61	ATABEX EC	193
<i>amoxicill-clarithro-lansopraz</i>	225	ARALAST NP	220	ATABEX OB	193
<i>amoxicillin</i>	211	<i>aranelle</i>	109	<i>atazanavir sulfate</i>	90
<i>amoxicillin-pot clavulanate</i>	212	ARANESP (ALBUMIN FREE) ...	146, 147	ATELVIA	126
<i>amoxicillin-pot clavulanate er</i>	212	ARAVA	18	<i>atenolol</i>	94
AMPHADASE	183	ARAZLO	113	<i>atenolol-chlorthalidone</i>	57
AMPHENOL-40	122	ARCALYST	16	ATGAM	183
<i>amphetamine sulfate</i>	11	AREXVY	227	<i>atomoxetine hcl</i>	11
<i>amphetamine-dextroamphet er</i>	11	<i>arformoterol tartrate</i>	29	<i>atorvastatin calcium</i>	52
<i>amphetamine-dextroamphetamine</i>	11	ARGATROBAN	32	<i>atovaquone</i>	58
<i>amphet-dextroamphet 3-bead er</i>	11	ARGATROBAN IN SODIUM		<i>atovaquone-proguanil hcl</i>	61
<i>amphotericin b</i>	49	CHLORIDE	32	<i>atracurium besylate</i>	200
<i>amphotericin b liposome</i>	49	<i>argyle sterile saline</i>	139	ATROPINE SULFATE	203, 223
<i>ampicillin</i>	212	<i>argyle sterile water</i>	184	ATROVENT HFA	29
<i>ampicillin sodium</i>	212	ARICEPT	214	<i>abra eq</i>	103
<i>ampicillin-sulbactam sodium</i>	212	ARIKAYCE	15	AUDENZ	227
AMPYRA	216	<i>aripiprazole</i>	88	AUGMENTIN	212
AMVISC	208	ARISTADA	88	AUGMENTIN ES-600	212
AMVUTTRA	217	ARISTADA INITIO	88	AUGTYRO	73
<i>anagrelide hcl</i>	145	ARIXTRA	32	<i>aum insulin safety pen needle</i>	171
ANALPRAM-HC	25	<i>armodafinil</i>	13	AUM MINI INSULIN PEN NEEDLE	171
ANAPROX DS	17	ARMOUR THYROID	222	<i>aum pen needle</i>	171
ANASCORP	210	ARNUITY ELLIPTA	30	AUM READYGARD DUO PEN	
<i>anastrozole</i>	76	AROMASIN	76	NEEDLE	171
ANAVIP	210	ARRANON	63	AUM SAFETY PEN NEEDLE	171
ANCOBON	49	<i>arsenic trioxide</i>	76	AURORA LANCET SUPER THIN	
ANDEXXA	46	ARTESUNATE	61	30G	159
ANECTINE	200	<i>articadent dental</i>	155	AURORA LANCET THIN 23G	159
ANESTHESIA S/I-40A	138	ARTISS	148, 149	AURORA PEN NEEDLES	171
ANESTHESIA S/I-40H	138	ARZERRA	65	<i>aurovela 1.5/30</i>	103
ANESTHESIA S/I-40S	138	ASCLERA	186	<i>aurovela 1/20</i>	103
ANGELIQ	133	<i>ascomp-codeine</i>	20	<i>aurovela 24 fe</i>	103
ANGIOMAX	32	ASCOR	231	<i>aurovela fe 1.5/30</i>	104
ANKTIVA	75	<i>asenapine maleate</i>	86	<i>aurovela fe 1/20</i>	104
ANNOVERA	107	<i>ashlyna</i>	107	AURYXIA	138
ANORO ELLIPTA	28	ASPARLAS	75	AUSTEDO	214
<i>anti-oxidant</i>	191	<i>aspirin</i>	19	AUSTEDO XR	214
ANTIVENIN LATRODECTUS		<i>aspirin 81</i>	19	AUSTEDO XR PATIENT	
MACTANS	210	<i>aspirin adult low dose</i>	19	TITRATION	214
ANTIVENIN MICRURUS FULVIUS	210	<i>aspirin adult low strength</i>	19	AUTO-LANCET	159
ANTIVERT	47	<i>aspirin childrens</i>	19	AUTO-LANCET MINI	159
ANUSOL-HC	25	<i>aspirin ec adult low dose</i>	19	AUTOLET II CLINISAFE	159
ANZEMET	47	<i>aspirin ec low dose</i>	19	AUTOLET LANCING DEVICE	160
APADAZ	23	<i>aspirin ec low strength</i>	19	AUTOLET LITE CLINISAFE	160
<i>apap-caff-dihydrocodeine</i>	20	<i>aspirin low dose</i>	19	AUTOLET LITE STARTER PACK ...	160
APHEXDA	146	<i>aspirin regimen</i>	19	AUTOLET MINI	160
APOKYN	84	<i>aspirin-dipyridamole er</i>	145	AUTOLET PLATFORMS	160
<i>apomorphine hcl</i>	84	ASPRUZYO SPRINKLE	25	AUTOLET PLUS	160
		ASSURE COMFORT LANCETS 28G	159	AVASTIN	82

<i>aviane</i>	104	<i>bayer aspirin ec low dose</i>	19	BESPONSA.....	66
AVITENE.....	149	<i>bayer low dose</i>	19	BESREMI.....	76
AVITENE FLOUR.....	149	BCG VACCINE.....	226	BETADINE OPHTHALMIC PREP...	204
AVONEX PEN.....	215	<i>b-compleet-100</i>	189	<i>betaine</i>	129
AVONEX PREFILLED.....	215	<i>b-compleet-50</i>	189	<i>betamethasone dipropionate</i>	117
AVSOLA.....	138	<i>b-complex</i>	189	<i>betamethasone dipropionate aug</i>	117
AVYCAZ.....	101	<i>b-complex (folic acid)</i>	189	<i>betamethasone valerate</i>	117
<i>ayuna</i>	104	<i>b-complex balanced</i>	188	BETASERON.....	215
AYVAKIT.....	73	<i>b-complex plus b-12</i>	188	<i>betaxolol hcl</i>	94, 202
<i>azacitidine</i>	63	<i>b-complex/b-12</i>	188	<i>bethanechol chloride</i>	226
AZACTAM.....	60	<i>b-complex/electrolytes</i>	189	BETHKIS.....	15
<i>azasan</i>	185	<i>b-complex/vitamin c</i>	188	BETIMOL.....	202
AZASITE.....	203	<i>b-complex-c</i>	189	BETOPTIC-S.....	202
<i>azathioprine</i>	185	<i>b-complex-c (w/folic acid)</i>	188	<i>better b complex</i>	189
AZATHIOPRINE SODIUM.....	186	BD AUTOSHIELD DUO.....	171	<i>bexarotene</i>	81, 123
<i>azelaic acid</i>	121	<i>bd heparin posiflush</i>	32	BEXSERO.....	226
<i>azelastine hcl</i>	199, 203	BD INSULIN SYR ULTRAFINE II.....	171	BEYAZ.....	104
<i>azelastine-fluticasone</i>	199	BD INSULIN SYRINGE.....	171	BEYFORTUS.....	210
AZESCO.....	193	BD INSULIN SYRINGE HALF-UNIT.....	171	<i>bicalutamide</i>	63
AZILECT.....	83	BD INSULIN SYRINGE.....	171	BICILLIN C-R.....	212
<i>azithromycin</i>	156	BD INSULIN SYRINGE.....	171	BICILLIN C-R 900/300.....	212
<i>aztreonam</i>	60	MICROFINE.....	171	BICILLIN L-A.....	212
AZULFIDINE.....	136	BD INSULIN SYRINGE U/F.....	171	BIDIL.....	99
AZULFIDINE EN-TABS.....	136	BD INSULIN SYRINGE U/F 1/2UNIT.....	171	<i>big 100</i>	189
<i>azurette</i>	103	BD INSULIN SYRINGE U-500.....	171	<i>big 100 (biotin)</i>	189
<i>b complex (lipotropics)</i>	197	BD INSULIN SYRINGE.....	171	BIJUVA.....	133
<i>b complex 100 tr</i>	189	ULTRAFINE.....	172	BIKTARVY.....	89
<i>b complex formula 1 (lipotrop)</i>	197	BD MICROTAINER LANCETS.....	160	BILTRICIDE.....	25
<i>b complex formula 1 (w/ fa)</i>	189	BD PEN NEEDLE MICRO U/F.....	172	<i>bimatoprost</i>	121, 208
<i>b complex-b12</i>	188	BD PEN NEEDLE MINI U/F.....	172	BINOSTO.....	126
<i>b complex-c</i>	188	BD PEN NEEDLE NANO 2ND GEN.....	172	BIORPHEN.....	230
B COMPLEX-C-BIOTIN-E-FA.....	189	BD PEN NEEDLE NANO U/F.....	172	BIOTHRAX.....	226
<i>b complex-c-folic acid</i>	188	BD PEN NEEDLE ORIGINAL U/F.....	172	<i>bis subcit-metronid-tetracyc</i>	225
<i>b-100 b-complex</i>	189	BD PEN NEEDLE SHORT U/F.....	172	<i>bisacodyl</i>	154
<i>b-100 complex cr</i>	189	<i>bd posiflush</i>	181	<i>bisacodyl ec</i>	154
<i>b-100 tr</i>	189	Bd Posiflush Safescrub.....	181	<i>bismuth/metronidaz/tetracyclin</i>	225
<i>b-50 complex</i>	189	BD SAFETYGLIDE INSULIN.....	172	<i>bisoprolol fumarate</i>	95
BABYBIG.....	210	SYRINGE.....	172	<i>bisoprolol-hydrochlorothiazide</i>	57
<i>bac</i>	18	BD VEO INSULIN SYR U/F 1/2UNIT.....	172	<i>bivalirudin trifluoroacetate</i>	32
<i>bacitracin</i>	203	.....	172	<i>bleomycin sulfate</i>	74
<i>bacitracin-polymyxin b</i>	204	BD VEO INSULIN SYRINGE U/F.....	172	BLINCYTO.....	68
<i>bacitra-neomycin-polymyxin-hc</i>	206	BELBUCA.....	23	<i>blisovi 24 fe</i>	104
<i>baclofen</i>	197	BELEODAQ.....	70	<i>blisovi fe 1.5/30</i>	104
BACTRIM.....	58	BELRAPZO.....	62	<i>blisovi fe 1/20</i>	104
BACTRIM DS.....	58	<i>benazepril hcl</i>	54	BLOXIVERZ.....	61
<i>balance b-100</i>	197	<i>benazepril-hydrochlorothiazide</i>	53	BONJESTA.....	47
<i>balance b-50</i>	189	<i>bendamustine hcl</i>	62	BOOSTRIX.....	222
<i>balanced b complex</i>	189	BENDEKA.....	62	<i>bortezomib</i>	73
<i>balanced b-100</i>	189	BENEFIX.....	141	BORUZU.....	73
<i>balanced b-50 complex</i>	197	BENLYSTA.....	182	<i>bosentan</i>	100
<i>balanced b-50/fa</i>	189	BENTYL.....	223	BOSULIF.....	68
BALCOLTRA.....	104	BENZALKONIUM CHLORIDE.....	89	BOTOX.....	200
BALFAXAR.....	141	BENZHYDROCODONE-.....	23	BOTOX COSMETIC.....	119
<i>balsalazide disodium</i>	136	ACETAMINOPHEN.....	23	BRAFTOVI.....	68
BALVERSA.....	70	BENZNIDAZOLE.....	25	BREO ELLIPTA.....	28
<i>balziva</i>	104	<i>benzonatate</i>	111	BREVILOC.....	95
BANZEL.....	33	<i>benzoyl peroxide-erythromycin</i>	113	BREVILOC IN NAACL.....	95
BAQSIMI ONE PACK.....	40	<i>benzphetamine hcl</i>	12	BREVILOC PREMIXED.....	95
BAQSIMI TWO PACK.....	40	<i>benztropine mesylate</i>	82, 83	BREVILOC PREMIXED DS.....	95
BARACLUDGE.....	93	BEOVU.....	209	BREVITAL SODIUM.....	138
BARHEMSYS.....	48	BERINERT.....	143	BREXAFEMME.....	49
BAVENCIO.....	67	BESIVANCE.....	203	Breyna.....	28
BAXDELA.....	135			BREZTRI AEROSPHERE.....	28

BRIDION.....	46	CALDOLOR.....	17	CARNITOR SF.....	127
<i>briellyn</i>	104	CALQUENCE.....	69	CAROSPIR.....	125
BRILINTA.....	144	CAMCEVI.....	78	<i>carteolol hcl</i>	202
<i>brimonidine tartrate</i>	121, 206	<i>camila</i>	108	<i>cartia xt</i>	96
<i>brimonidine tartrate-timolol</i>	202	CAMPTOSAR.....	81	<i>carvedilol</i>	94
<i>brinzolamide</i>	204	<i>camrese</i>	107	<i>carvedilol phosphate er</i>	94
BRIVIACT.....	33	<i>camrese lo</i>	107	CASODEX.....	63
BRIXADI.....	23	CAMZYOS.....	99	CASPOFUNGIN ACETATE.....	48
BRIXADI (WEEKLY).....	23	CANASA.....	136	CATAPRES-TTS-1.....	56
<i>bromfenac sodium</i>	206	CANCIDAS.....	48	CATAPRES-TTS-2.....	56
<i>bromfenac sodium (once-daily)</i>	206	<i>candesartan cilexetil</i>	55	CATAPRES-TTS-3.....	56
<i>bromocriptine mesylate</i>	83	<i>candesartan cilexetil-hctz</i>	55	CATHFLO ACTIVASE.....	146
BROMSITE.....	206	<i>capecitabine</i>	63	CAVERJECT.....	99
BRONCHITOL.....	220	CAPLYTA.....	84	CAVERJECT IMPULSE.....	99
BRONCHITOL TOLERANCE TEST.....	220	CAPRELSA.....	72	CAYA.....	158
BROVANA.....	29	<i>captopril</i>	54	CAYSTON.....	60
BRUKINSA.....	69	<i>captopril-hydrochlorothiazide</i>	53	<i>cefaclor</i>	102
BSS.....	205	CAPVAXIVE.....	226	CEFACLOR ER.....	102
BSS PLUS.....	205	CARAC.....	115	<i>cefadroxil</i>	101
<i>budesonide</i>	24, 30, 110	CARAFATE.....	224	<i>cefazolin sodium</i>	101, 102
<i>budesonide er</i>	109	<i>carbamazepine</i>	33, 34	CEFAZOLIN SODIUM.....	101
<i>budesonide-formoterol fumarate</i>	28	<i>carbamazepine er</i>	33	CEFAZOLIN SODIUM-DEXTROSE.....	102
<i>bumetanide</i>	124	<i>carbidopa</i>	83	<i>cefazolin sodium-dextrose</i>	102
BUMEX.....	125	<i>carbidopa-levodopa</i>	83, 84	<i>cefdinir</i>	102
BUPIVACAINE FISIOPHARMA.....	155	<i>carbidopa-levodopa er</i>	83	<i>cefepime hcl</i>	103
<i>bupivacaine hcl (pf)</i>	155	<i>carbidopa-levodopa-entacapone</i>	84	CEFEPIME HCL.....	103
<i>bupivacaine-epinephrine</i>	155	<i>carbinoxamine maleate</i>	50	CEFEPIME-DEXTROSE.....	103
<i>bupivacaine-epinephrine (pf)</i>	155	<i>carbinoxamine maleate er</i>	50	<i>cefixime</i>	102
<i>buprenorphine</i>	23	<i>carboplatin</i>	62	CEFOTAN.....	102
<i>buprenorphine hcl</i>	23	<i>carboprost tromethamine</i>	210	<i>cefotaxime sodium</i>	102
<i>buprenorphine hcl-naloxone hcl</i>	23	CARDENE IV.....	96	<i>cefotetan disodium</i>	102
<i>bupropion hcl</i>	37	CARDIOM LANCING DEVICE.....	160	<i>cefoxitin sodium</i>	102
<i>bupropion hcl er (smoking det)</i>	217	CARDIZEM.....	96	CEFOXITIN SODIUM-DEXTROSE.....	102
<i>bupropion hcl er (sr)</i>	37	CARDURA.....	56	<i>cefpodoxime proxetil</i>	102
<i>bupropion hcl er (xl)</i>	37	CARDURA XL.....	139	<i>cefprozil</i>	102
<i>buspironone hcl</i>	26	CAREFINE PEN NEEDLES.....	172	<i>ceftazidime</i>	102
<i>busulfan</i>	62	<i>careone advanced lancing dev</i>	160	<i>ceftriaxone sodium</i>	102, 103
BUSULFEX.....	62	CAREONE INSULIN SYRINGE.....	172	CEFTRIAXONE SODIUM.....	102
<i>butalbital-acetaminophen</i>	18	CAREONE LANCET SUPER THIN.....	172	<i>ceftriaxone sodium in dextrose</i>	102
<i>butalbital-apap-caff-cod</i>	20	30G.....	160	CEFTRIAXONE SODIUM-DEXTROSE.....	103
<i>butalbital-apap-caffeine</i>	18, 19	CAREONE LANCET THIN 23G.....	160	<i>cefuroxime axetil</i>	102
<i>butalbital-asa-caff-codeine</i>	20	CAREONE UNIFINE PENTIPS PLUS.....	172	<i>cefuroxime sodium</i>	102
<i>butalbital-aspirin-caffeine</i>	19	CARESENS LANCETS.....	160	<i>celecoxib</i>	16
<i>butorphanol tartrate</i>	23	CARESENS LANCETS 30G.....	160	CELESTONE SOLUSPAN.....	111
BYFAVO.....	150	CARETOUCH INSULIN SYRINGE.....	172	CELLCEPT.....	184
BYLVAY.....	136	CARETOUCH LANCING/EJECTOR.....	160	CELLCEPT INTRAVENOUS.....	184
BYLVAY (PELLETS).....	136	CARETOUCH PEN NEEDLES.....	172	CELLUGEL.....	208
BYOOVIZ.....	209	CARETOUCH SAFETY LANCETS.....	160	CELONTIN.....	36
CABENUVA.....	89	CARETOUCH SAFETY LANCETS.....	160	<i>cephalexin</i>	102
<i>cabergoline</i>	127	26G.....	160	CEPROTIN.....	144
CABLIVI.....	143	CARETOUCH TWIST LANCETS.....	160	CERDELGA.....	146
CABOMETYX.....	72	28G.....	160	CEREBYX.....	36
CADUET.....	99	CARETOUCH TWIST LANCETS.....	160	CEREZYME.....	146
<i>caffeine citrate</i>	12	30G.....	160	CERVIDIL.....	210
<i>calcipotriene</i>	116	CARETOUCH TWIST LANCETS.....	160	<i>cetirizine hcl</i>	50
<i>calcipotriene-betameth diprop</i>	123	33G.....	160	CETRALAXAL.....	209
<i>calcitonin (salmon)</i>	127	CARETOUCH TWIST MC.....	160	<i>cetrolrelax acetate</i>	128
<i>calcitrene</i>	116	LANCETS 30G.....	160	CETROTIDE.....	128
<i>calcitriol</i>	116, 129	<i>carglumic acid</i>	129	<i>cevimeline hcl</i>	187
<i>calcium acetate</i>	138	<i>carisoprodol</i>	197	<i>charlotte 24 fe</i>	104
<i>calcium acetate (phos binder)</i>	138	<i>carmustine</i>	80	<i>chateal eq</i>	104
CALCIUM GLUCONATE.....	179	CARNITOR.....	127	CHEMET.....	45
CALCIUM GLUCONATE-NACL.....	179				

<i>childrens aspirin</i>	19	CLENPIQ	151	CNJ-016.....	211
<i>chloramphenicol sod succinate</i>	59	CLEOCIN	60, 229	COAGADEX	141
<i>chlordiazepoxide hcl</i>	26	CLEOCIN PHOSPHATE	60	COAGUCHEK LANCETS	160
<i>chlordiazepoxide-amitriptyline</i>	213	CLEOCIN-T	112	<i>coal tar</i>	122
<i>chlordiazepoxide-clidinium</i>	223	CLEVER CHEK LANCETS	160	COARTEM	61
<i>chlorhexidine gluconate</i>	186	CLEVER CHOICE COMFORT EZ	160, 172	COCAINE HCL	199
<i>chloroprocaine hcl (pf)</i>	156	CLEVER CHOICE LANCETS 21G	160	CODEINE SULFATE	21
<i>chloroquine phosphate</i>	61	CLEVER CHOICE LANCETS 23G	160	<i>codeine sulfate</i>	21
<i>chlorothiazide sodium</i>	125	CLEVER CHOICE LANCETS 28G	160	CODITUSSIN AC	111
<i>chlorpromazine hcl</i>	87	CLEVIPREX	96	CODITUSSIN DAC	112
CHLORPROMAZINE HCL	87	CLICKFINE PEN NEEDLES	172	<i>colchicine</i>	140
<i>chlorthalidone</i>	125	CLIMARA	134	<i>colchicine-probenecid</i>	140
<i>chlorzoxazone</i>	197	CLIMARA PRO	133	<i>colesevelam hcl</i>	51
CHOLBAM	135	Clindacin	113	COLESTID	51
<i>cholestyramine</i>	51	<i>clindacin etz</i>	112	<i>colestipol hcl</i>	51
<i>cholestyramine light</i>	51	<i>clindacin-p</i>	113	<i>colistimethate sodium (cba)</i>	60
CHORIONIC GONADOTROPIN	131	<i>clindamycin hcl</i>	60	COLUMVI	68
CHOSEN LANCETS 30G	160	<i>clindamycin palmitate hcl</i>	60	COLY-MYCIN M	60
CHOSEN LANCING DEVICE	160	<i>clindamycin phos-benzoyl perox</i>	113	COMBIPATCH	134
CHOSEN SAFETY LANCETS 28G	160	<i>clindamycin phosphate</i>	60, 113, 229	COMBIVENT RESPIMAT	28
<i>chromic chloride</i>	182	<i>clindamycin phosphate in d5w</i>	60	COMBOGESIC	16
<i>ciclodan</i>	114	CLINDAMYCIN PHOSPHATE IN	60	COMETRIQ (100 MG DAILY DOSE)	72
<i>ciclopirox</i>	114	NACL	60	COMETRIQ (140 MG DAILY DOSE)	72
<i>ciclopirox olamine</i>	114	<i>clindamycin-tretinoin</i>	113	COMETRIQ (60 MG DAILY DOSE)	72
<i>cidofovir</i>	92	CLINDESSE	229	COMFORT ASSIST INSULIN	172
<i>cilostazol</i>	144	CLINIMIX E/DEXTROSE (2.75/5)	201	SYRINGE	172
CILOXAN	203	CLINIMIX E/DEXTROSE (4.25/10)	201	COMFORT ASSURED LANCETS	160
CIMDUO	89	CLINIMIX E/DEXTROSE (4.25/5)	201	28G	160
CIMERLI	209	CLINIMIX E/DEXTROSE (5/15)	201	COMFORT ASSURED LANCETS	160
<i>cimetidine</i>	223, 224	CLINIMIX E/DEXTROSE (5/20)	201	33G	160
<i>cimetidine hcl</i>	223	CLINIMIX E/DEXTROSE (8/10)	201	COMFORT EZ INSULIN SYRINGE	172
<i>cinacalcet hcl</i>	126	CLINIMIX E/DEXTROSE (8/14)	201	COMFORT EZ MICRO PEN	172
CINQAIR	30	CLINIMIX E/DEXTROSE (4.25/10)	201	NEEDLES	172
CINRYZE	143	CLINIMIX/DEXTROSE (4.25/5)	201	COMFORT EZ PEN NEEDLES	172
CINVANTI	48	CLINIMIX/DEXTROSE (5/15)	201	COMFORT EZ PRO PEN NEEDLES	172
CIPRO	135	CLINIMIX/DEXTROSE (5/20)	201	COMFORT EZ SHORT PEN	172
<i>ciprofloxacin hcl</i>	135, 204, 209	CLINIMIX/DEXTROSE (6/5)	201	NEEDLES	172
<i>ciprofloxacin in d5w</i>	135	CLINIMIX/DEXTROSE (8/10)	201	COMFORT TOUCH INSULIN PEN	172
<i>ciprofloxacin-dexamethasone</i>	209	CLINIMIX/DEXTROSE (8/14)	201	NEED	172
<i>ciprofloxacin-fluocinolone pf</i>	209	<i>clinisol sf</i>	201	COMFORT TOUCH LANCETS 31G	160
<i>cisatracurium besylate</i>	200	CLINOLIPID	202	COMFORT TOUCH PLUS	160
<i>cisatracurium besylate (pf)</i>	200	<i>clinpro 5000</i>	187	LANCETS 28G	160
<i>cisplatin</i>	62	<i>clobazam</i>	33	COMFORT TOUCH PLUS	160
CISPLATIN	62	<i>clobetasol propionate</i>	117, 118	LANCETS 30G	160
<i>citalopram hydrobromide</i>	38	<i>clobetasol propionate e</i>	117	COMFORT TOUCH TWIST	160
CITRANATAL 90 DHA	196	<i>clobetasol propionate emulsion</i>	117	LANCET 30G	160
CITRANATAL ASSURE	196	<i>clocortolone pivalate</i>	118	COMIRNATY	227
CITRANATAL B-CALM	193	<i>clodan</i>	118	COMPLETE NATAL DHA	195
CITRANATAL HARMONY	196	<i>clofarabine</i>	63	COMPLETENATE	193
CITRANATAL MEDLEY	196	Clomid	131	<i>complex b-100</i>	189
<i>citrate of magnesia</i>	153	<i>clomiphene citrate</i>	131	COMPLEX B-100-INOSITOL	197
<i>citroma</i>	153	<i>clomipramine hcl</i>	39	<i>complex b-50 prolonged release</i>	189
<i>cladribine</i>	63	<i>clonazepam</i>	33	<i>compro</i>	87
<i>claravis</i>	113	<i>clonidine</i>	56	CO-NATAL FA	193
CLARINEX	50	<i>clonidine hcl</i>	56	CONCEPT DHA	193
CLARINEX-D 12 HOUR	112	<i>clonidine hcl er</i>	11	CONCEPT OB	193
<i>clarithromycin</i>	156	<i>clopidogrel bisulfate</i>	145	<i>condoms</i>	157
<i>clarithromycin er</i>	156	<i>clorazepate dipotassium</i>	26	CONDYLOX	120
CLASSIC PRENATAL	193	<i>clotrimazole</i>	119, 186	CONJUPRI	96
CLEANLET LANCETS 28G	160	<i>clotrimazole-betamethasone</i>	114	<i>constulose</i>	152
<i>clearlax</i>	152	<i>clozapine</i>	86	COPASIL	122
CLEMASTINE FUMARATE	50	C-NATE DHA	193	COPAXONE	216
<i>clemastine fumarate</i>	50			COPIKTRA	80

CORIFACT.....	141	CYCLOPHOSPHAMIDE.....	79	<i>deferiprone</i>	45
CORLANOR.....	101	<i>cycloserine</i>	62	<i>deferoxamine mesylate</i>	46
CORTEF.....	110	CYCLOSET.....	41	DEFITELIO.....	146
CORTENEMA.....	24	<i>cyclosporine</i>	183, 205	DEFLUX.....	140
CORTIFOAM.....	25	<i>cyclosporine modified</i>	183	DELESTROGEN.....	134
CORTISPORIN-TC.....	209	CYGNUS DUAL.....	122	DELSTRIGO.....	89
CORTROPHIN.....	127	CYKLOKAPRON.....	149	<i>delyla</i>	104
CORVERT.....	27	<i>cyproheptadine hcl</i>	51	DELZICOL.....	137
COSELA.....	79	CYRAMZA.....	82	<i>demeclocycline hcl</i>	221
COSENTYX.....	115	<i>cyred eq</i>	104	DEMEROL.....	21
COSENTYX (300 MG DOSE).....	115	CYSTADANE.....	129	DEMSEER.....	55
COSENTYX SENSOREADY (300		CYSTADROPS.....	208	DENAVIR.....	116
MG).....	115	CYSTAGON.....	139	DENGVAZIA.....	227
COSENTYX SENSOREADY PEN.....	115	CYSTARAN.....	208	<i>denta 5000 plus</i>	187
COSENTYX UNOREADY.....	115	<i>cytarabine</i>	64	<i>denta 5000 plus sensitive</i>	186
COTELLIC.....	71	<i>cytarabine (pf)</i>	63	<i>dentagel</i>	187
CREON.....	124	CYTOGAM.....	211	DEPEN TITRATABS.....	182
CRESEMBA.....	49	CYTOMEL.....	222	DEPO-ESTRADIOL.....	134
CRINONE.....	230	CYTOTEC.....	225	DEPO-MEDROL.....	110
CROFAB.....	210	<i>dacarbazine</i>	76	DEPO-PROVERA.....	108
<i>cromolyn sodium</i>	28, 135, 203	<i>dactinomycin</i>	74	DEPO-SUBQ PROVERA 104.....	108
<i>crotan</i>	122	<i>daily multiple vitamins</i>	191	DEPO-TESTOSTERONE.....	24
<i>cryselle-28</i>	104	<i>daily value multivitamin</i>	191	DERMOTIC.....	209
CRYSVITA.....	133	<i>daily vitamins</i>	191	DESCOVY.....	89
<i>cupric chloride</i>	182	<i>daily vite</i>	191	DESFERAL.....	46
CURAE.....	107	<i>daily vite multivitamin/iron</i>	190	<i>desflurane</i>	138
<i>curity sterile saline</i>	139	<i>daily vites</i>	191	<i>desipramine hcl</i>	39
CUTAQUIG.....	211	<i>daily-vite</i>	191	<i>desloratadine</i>	50
CUVPOSA.....	224	<i>daily-vite multivitamin</i>	191	<i>desmopressin ace spray refrig</i>	133
<i>cvs aspirin adult low dose</i>	19	<i>dalfampridine er</i>	216	<i>desmopressin acetate</i>	133
<i>cvs aspirin adult low strength</i>	19	DALIRESP.....	30	DESMOPRESSIN ACETATE.....	133
<i>cvs aspirin ec</i>	19	DALVANCE.....	59	<i>desmopressin acetate pf</i>	133
<i>cvs aspirin low dose</i>	19	<i>danazol</i>	24	<i>desmopressin acetate spray</i>	133
<i>cvs aspirin low strength</i>	19	DANTRIUM.....	198	<i>desogestrel-ethinyl estradiol</i>	103
<i>cvs b complex plus c</i>	189	<i>dantrolene sodium</i>	198	<i>desonide</i>	118
<i>cvs balanced b50</i>	197	DANYELZA.....	66	<i>desoximetasone</i>	118
<i>cvs c-lax laxative</i>	154	<i>dapagliflozin pro-metformin er</i>	43	DESVENLAFAXINE ER.....	38, 39
<i>cvs folic acid</i>	147	<i>dapagliflozin propanediol</i>	43	<i>desvenlafaxine succinate er</i>	39
<i>cvs gentle laxative</i>	154	<i>dapsone</i>	60, 113	DEXABLISS.....	110
<i>cvs gentle laxative womens</i>	154	DAPTACEL.....	222	<i>dexamethasone</i>	110
<i>cvs inner ear plus</i>	197	DAPTOMYCIN.....	59	DEXAMETHASONE INTENSOL.....	110
CVS LANCETS 21G.....	160	<i>daptomycin-sodium chloride</i>	59	<i>dexamethasone sod phos +rfid</i>	110
CVS LANCETS MICRO THIN 33G.....	160	DARAPRIM.....	61	<i>dexamethasone sod phosphate pf</i>	110
CVS LANCETS ORIGINAL.....	161	<i>darifenacin hydrobromide er</i>	225	DEXAMETHASONE SOD	
CVS LANCETS THIN 26G.....	161	<i>darunavir</i>	90	PHOSPHATE PF.....	110
CVS LANCETS ULTRA THIN 30G.....	161	DARZALEX.....	66	<i>dexamethasone sodium phosphate</i>	
CVS LANCETS ULTRA-THIN 30G.....	161	<i>dasatinib</i>	68	.....	110, 207
<i>cvs lancing device</i>	161	<i>dasetta 1/35</i>	104	DEXAMETHASONE SODIUM	
<i>cvs magnesium citrate</i>	153	<i>dasetta 7/7/7</i>	109	PHOSPHATE.....	110
<i>cvs milk of magnesia</i>	153	DAUNORUBICIN HCL.....	74	DEXCOM G6 RECEIVER.....	161
<i>cvs nicotine</i>	217, 218	DAURISMO.....	70	DEXCOM G6 SENSOR.....	161
<i>cvs nicotine polacrilex</i>	217, 218	DAVIMET-FLUORIDE.....	192	DEXCOM G6 TRANSMITTER.....	161
CVS PRENATAL.....	193	DAXXIFY.....	119	DEXCOM G7 RECEIVER.....	161
<i>cvs purelax</i>	152	DAYBUE.....	200	DEXCOM G7 SENSOR.....	161
<i>cvs super b complex/c</i>	189	DAYPRO.....	17	DEXMEDETOMIDINE HCL.....	151
CVS ULTRA THIN LANCETS.....	161	<i>daysee</i>	107	<i>dexmedetomidine hcl</i>	151
<i>cyanocobalamin</i>	146	DDAVP.....	133	<i>dexmedetomidine hcl in nacl</i>	151
CYANOKIT.....	46	DDAVP PF.....	133	DEXMEDETOMIDINE HCL-	
<i>cyclobenzaprine hcl</i>	197	<i>deblitane</i>	108	DEXTROSE.....	151
CYCLOGYL.....	203	<i>decitabine</i>	64	<i>dexmethylphenidate hcl</i>	13
CYCLOMYDRIL.....	203	<i>deferasirox</i>	45	<i>dexmethylphenidate hcl er</i>	13
<i>cyclopentolate hcl</i>	203	<i>deferasirox granules</i>	45	<i>dextrazoxane</i>	76
<i>cyclophosphamide</i>	79			<i>dextrazoxane hcl</i>	76

DEXTENZA	207	<i>divalproex sodium er</i>	37	DSUVIA	21
<i>dextroamphetamine sulfate</i>	11	DIVIGEL	134	DUAVEE	135
<i>dextroamphetamine sulfate er</i>	11	<i>dobutamine hcl</i>	99	DUETACT	44
<i>dextrose</i>	202	DOBUTAMINE-DEXTROSE	99	<i>dulcolax</i>	153
DEXTROSE	202	DOCETAXEL	79	<i>dulcolax milk of magnesia</i>	153
DEXTROSE 5%/ELECTROLYTE #48	179	DOCIVYX	79	<i>duloxetine hcl</i>	39
<i>dextrose in lactated ringers</i>	179	<i>dodex</i>	146	DUOBRII	123
DEXTROSE-SODIUM CHLORIDE	179	<i>dofetilide</i>	27	DUOPA	84
<i>dextrose-sodium chloride</i>	179	DOJOLVI	202	DUOVISC	208
DEXYCU	207	<i>dolishale</i>	107	DUPIXENT	117
DHIVY	84	<i>donepezil hcl</i>	214	<i>duramorph</i>	21
DIACOMIT	34	DOPAMINE HCL	99	DUREX EXTRA SENSITIVE THIN ..	157
<i>dialyvite 800</i>	188	DOPAMINE-DEXTROSE	99	DUREX REALFEEL	157
DIATHRIVE LANCET ULTRA THIN 30	161	DOPRAM	12	DUREX TROPICAL	157
DIATHRIVE LANCETS	161	DOPTLET	148	DUREZOL	207
DIATHRIVE LANCING DEVICE	161	<i>dorzolamide hcl</i>	204	DUROLANE	198
DIATHRIVE PEN NEEDLE	172	<i>dorzolamide hcl-timolol mal</i>	202	DURYSTA	208
<i>diazepam</i>	26, 33	<i>dorzolamide hcl-timolol mal pf</i>	202	<i>dutasteride</i>	139
<i>diazepam intensol</i>	26	<i>dotti</i>	134	<i>dutasteride-tamsulosin hcl</i>	140
<i>diazoxide</i>	40	DOVATO	89	DUVYZAT	200
DIBENZYLINE	55	<i>doxazosin mesylate</i>	56, 57	<i>dyclopro</i>	120
<i>dichlorphenamide</i>	124	<i>doxepin hcl</i>	39, 115, 151	DYMISTA	199
<i>diclofenac potassium</i>	17	<i>doxercalciferol</i>	129	DYSPORT	200
<i>diclofenac sodium</i>	17, 115, 206	DOXIL	74	<i>e.e.s. 400</i>	156
<i>diclofenac sodium er</i>	17	<i>doxorubicin hcl</i>	74	<i>ear health formula</i>	197
<i>diclofenac-misoprostol</i>	17	<i>doxorubicin hcl liposomal</i>	74	<i>ear health plus</i>	197
<i>dicloxacillin sodium</i>	212	<i>doxy 100</i>	221	EASY COMFORT INSULIN SYRINGE	173
<i>dicyclomine hcl</i>	223	<i>doxycycline hyclate</i>	221	<i>easy comfort insulin syringe</i>	173
<i>diethylpropion hcl</i>	12	<i>doxycycline monohydrate</i>	221	EASY COMFORT LANCETS	161
<i>diethylpropion hcl er</i>	12	<i>doxylamine-pyridoxine</i>	47	EASY COMFORT LANCETS TWIST TOP	161
DIFICID	156	DRISDOL	231	EASY COMFORT PEN NEEDLES ..	173
<i>diflorasone diacetate</i>	118	<i>dronabinol</i>	48	EASY GLIDE PEN NEEDLES	173
DIFLUCAN	49	<i>droperidol</i>	26	<i>easy mini eject lancing device</i>	161
<i>diflunisal</i>	19	DROPLET GENTEEL LANCING DEVICE	161	<i>easy mini lancing device</i>	161
<i>difluprednate</i>	207	DROPLET INSULIN SYRINGE	172	EASY TOUCH FLIPLOCK INSULIN SY	173
DIGIFAB	46	DROPLET LANCETS ULTRA THIN 30G	161	EASY TOUCH INSULIN SAFETY SYR	173
<i>digoxin</i>	98, 99	DROPLET LANCING DEVICE	161	EASY TOUCH INSULIN SYRINGE ..	173
<i>dihydroergotamine mesylate</i>	178	DROPLET MICRON	173	EASY TOUCH LANCETS 21G	161
DILANTIN	36	DROPLET PEN NEEDLES	173	EASY TOUCH LANCETS 23G	161
DILANTIN INFATABS	36	DROPLET PERSONAL LANCETS 30G	161	EASY TOUCH LANCETS 26G	161
DILANTIN-125	36	DROPSAFE SAFETY PEN NEEDLES	173	EASY TOUCH LANCETS 28G	161
DILAUDID	21	DROPSAFE SAFETY SYRINGE/NEEDLE	173	EASY TOUCH LANCETS 28G/TWIST	161
<i>diltiazem hcl</i>	97	<i>drospiren-eth estrad-levomefol</i>	104	EASY TOUCH LANCETS 30G	161
DILTIAZEM HCL	97	<i>drospirenone-ethinyl estradiol</i>	104	EASY TOUCH LANCETS 30G/TWIST	161
<i>diltiazem hcl er</i>	96	DROXIA	146	EASY TOUCH LANCETS 32G	161
<i>diltiazem hcl er beads</i>	96	<i>droxidopa</i>	230	EASY TOUCH LANCETS 32G/TWIST	161
<i>diltiazem hcl er coated beads</i>	96	DRUG MART LANCETS THIN 26G ..	161	EASY TOUCH LANCETS 33G/TWIST	161
<i>dilt-xr</i>	97	DRUG MART ON-THE-GO LANCET 30G	161	EASY TOUCH LANCETS 33G/TWIST	161
DIMENHYDRINATE	47	DRUG MART UNIFINE PENTIPS ..	173	EASY TOUCH LANCING DEVICE ..	161
<i>dimethyl fumarate</i>	216	DRUG MART UNIFINE PENTIPS PLUS	173	EASY TOUCH PEN NEEDLES	173
<i>dimethyl fumarate starter pack</i>	216	DRUG MART UNILET LANCETS 28G	161	EASY TOUCH SAFETY LANCETS 21G	162
DIPENTUM	137	DRUG MART UNILET LANCETS 30G	161	EASY TOUCH SAFETY LANCETS 23G	162
<i>diphenhydramine hcl</i>	50	DRUG MART UNILET LANCETS 33G	161	EASY TOUCH SAFETY LANCETS 26G	162
<i>diphenoxylate-atropine</i>	45				
DIPRIVAN	138				
<i>dipyridamole</i>	145				
DISCOVISC	207				
<i>disopyramide phosphate</i>	27				
<i>disulfiram</i>	213				
DIURIL	125				
<i>divalproex sodium</i>	37				

EASY TOUCH SAFETY LANCETS 28G.....	162	<i>emtricitabine-tenofovir df</i>	89	<i>eq nicotine step 3</i>	218
EASY TOUCH SAFETY PEN		EMTRIVA.....	91	<i>eq aspirin low dose</i>	19
NEEDLES.....	173	EMVERM.....	25	<i>eq b complex 50</i>	189
EASY TOUCH SHEATHLOCK SYRINGE.....	173	Emzahh.....	108	<i>eq b-100 complex</i>	190
<i>easygel</i>	187	<i>enalapril maleate</i>	54	<i>eq clearlax</i>	152
<i>ec-naproxen</i>	17	<i>enalaprilat</i>	54	EQL COLOR LANCETS 21G.....	162
<i>econazole nitrate</i>	119	<i>enalapril-hydrochlorothiazide</i>	53	EQL COLOR LANCETS MICRO 33G.....	162
<i>econtra one-step</i>	107	ENBRACE HR.....	193	<i>eq gentle laxative</i>	154
<i>ecotrin low strength</i>	19	ENBREL.....	18	EQL INSULIN SYRINGE.....	173
ECOZA.....	119	ENBREL MINI.....	18	<i>eq laxative</i>	154
EDARBI.....	55, 56	ENBREL SURECLICK.....	18	<i>eq magnesium citrate</i>	153
EDARBYCLOR.....	55	ENCARE.....	229	EQL PRENATAL FORMULA.....	193
EDECRIN.....	125	ENDO AVITENE.....	149	<i>eq super b complex/vitamin c</i>	188
<i>edetate calcium disodium</i>	46	<i>endocet</i>	23	EQL SUPER THIN LANCETS 30G...	162
EDEX.....	99	ENDOMETRIN.....	230	EQL THIN LANCETS 26G.....	162
EDLUAR.....	151	<i>endur-b</i>	189	EQUETRO.....	85
EDURANT.....	91	ENFAMIL EXPECTA.....	196	ERAXIS.....	48
<i>efavirenz</i>	91	ENGERIX-B.....	227	ERBITUX.....	69
<i>efavirenz-emtricitab-tenofo df</i>	89	ENHERTU.....	75	<i>ergocalciferol</i>	231
<i>efavirenz-lamivudine-tenofovir</i>	89	Enilloring.....	107	<i>ergoloid mesylates</i>	217
EFUDEX.....	115	ENJAYMO.....	143	<i>ergotamine-caffeine</i>	178
EGRIFTA SV.....	128	ENLITE GLUCOSE SENSOR.....	162	<i>eribulin mesylate</i>	79
ELAHERE.....	75	<i>enoxaparin sodium</i>	32	ERIVEDGE.....	70
ELAPRASE.....	130	<i>enpresse-28</i>	109	ERLEADA.....	63
ELCYS.....	201	<i>enskyce</i>	104	<i>erlotinib hcl</i>	69
ELELYSO.....	146	ENSPRYNG.....	185	<i>errin</i>	108
ELEPSIA XR.....	34	ENSTILAR.....	123	ERTACZO.....	119
ELESTRIN.....	134	<i>entacapone</i>	84	<i>ertapenem sodium</i>	58
<i>eletriptan hydrobromide</i>	178	<i>entecavir</i>	93	ERVEBO.....	227
ELFABRIO.....	127	ENTRESTO.....	99	<i>ery</i>	113
ELIGARD.....	78	ENTYVIO.....	137	ERYGEL.....	113
ELIMITE.....	122	<i>enulose</i>	137	<i>ery-tab</i>	156
<i>elimest</i>	104	ENVARSUS XR.....	184	ERYTHROCIN LACTOBIONATE...	156
ELIQUIS.....	31	EPANED.....	54	<i>erythromycin</i>	113, 156, 204
ELIQUIS DVT/PE STARTER PACK...	31	EPCLUSA.....	93	<i>erythromycin base</i>	156
ELITEK.....	76	EPHEDRINE SULFATE (PRESSORS).....	231	<i>erythromycin ethylsuccinate</i>	156
<i>elite-ob</i>	193	EPICORD.....	122	<i>erythromycin lactobionate</i>	156
ELIXOPHYLLIN.....	31	EPIDIOLEX.....	34	<i>escitalopram oxalate</i>	38
ELLA.....	107	EPIFIX.....	122	ESKATA.....	122
ELLENCE.....	74	EPIFIX MICRONIZED.....	122	<i>esmolol hcl</i>	95
ELMIRON.....	140	EPIFOAM.....	122	ESMOLOL HCL.....	95
ELOCTATE.....	141	<i>epinastine hcl</i>	203	<i>esmolol hcl-sodium chloride</i>	95
ELREXFIO.....	68	<i>epinephrine</i>	230, 231	<i>esomeprazole magnesium</i>	224
<i>eluryng</i>	107	EPINEPHRINE.....	231	<i>esomeprazole sodium</i>	224
ELZONRIS.....	75	<i>epinephrine (anaphylaxis)</i>	230	ESPEROCT.....	141
EMBRACE LANCETS ULTRA THIN 30G.....	162	EPINEPHRINE PF.....	231	<i>estarylla</i>	104
<i>embrace lancng device/ejector</i>	162	EPINEPHRINESNAP.....	230	<i>estazolam</i>	150
EMBRACE PEN NEEDLES.....	173	<i>epitol</i>	34	<i>estradiol</i>	134, 230
EMBRACE PRESSURE ACTIVATED 21G.....	162	EPIVIR.....	91	<i>estradiol valerate</i>	134
EMBRACE PRESSURE ACTIVATED 28G.....	162	EPKINLY.....	68	<i>estradiol-norethindrone acet</i>	134
EMEND.....	48	<i>eplerenone</i>	57	ESTRING.....	230
EMERPHED.....	230	EPOGEN.....	147	ESTROFACTORS.....	191
EMGALITY.....	178	<i>epoprostenol sodium</i>	100	ESTROGEL.....	134
EMGALITY (300 MG DOSE).....	178	<i>eptifibatide</i>	144	<i>eszopiclone</i>	151
EMPAVELI.....	143	<i>eq aspirin adult low dose</i>	19	<i>ethacrynate sodium</i>	125
EMPLICITI.....	67	<i>eq aspirin low dose</i>	19	<i>ethacrynic acid</i>	125
EMSAM.....	37	<i>eq clearlax</i>	152	<i>ethambutol hcl</i>	62
<i>emtricitabine</i>	91	<i>eq gentle laxative</i>	154	ETHAMOLIN.....	186
		<i>eq laxative</i>	152	<i>ethosuximide</i>	36
		<i>eq magnesium citrate</i>	153	<i>ethynodiol diac-eth estradiol</i>	104
		<i>eq nicotine</i>	218	<i>etodolac</i>	17
		<i>eq nicotine polacrilex</i>	218	<i>etodolac er</i>	17

<i>etomidate</i>	138	FARXIGA	43	<i>floxuridine</i>	64
<i>etonogestrel-ethinyl estradiol</i>	107	FASENRA	30	FLUAD	227
ETOPOPHOS	79	FASENRA PEN	30	FLUARIX	227
<i>etoposide</i>	79	FASLODEX	77	FLUBLOK	227
<i>etravirine</i>	91	FC2 FEMALE CONDOM	157	FLUCELVAX	228
EUCRISA	121	<i>febuxostat</i>	140	<i>fluconazole</i>	49
EUFLEXXA	198	FEIBA	141	FLUCONAZOLE IN SODIUM	
EULEXIN	63	<i>felbamate</i>	36	CHLORIDE	49
<i>euthyrox</i>	222	<i>felodipine er</i>	97	<i>fluconazole in sodium chloride</i>	49
EVAMIST	134	FEMARA	76	<i>flucytosine</i>	49
EVENITY	132	FEMCAP	157	<i>fludarabine phosphate</i>	64
<i>everolimus</i>	72, 184	FEMLYV	104	<i>fludrocortisone acetate</i>	111
EVERSENSE 365 SENSOR/HOLDER		FEMRING	230	FLULAVAL	228
.....	162	<i>fenofibrate</i>	52	<i>flumazenil</i>	46
EVERSENSE 365 SMART		<i>fenofibrate micronized</i>	51	FLUMIST	228
TRANSMIT	162	<i>fenofibric acid</i>	52	<i>flunisolide</i>	199
EVERSENSE E3 SENSOR/HOLDER	162	FENSOLVI (6 MONTH)	129	<i>fluocinolone acetonide</i>	118, 210
EVERSENSE E3 SMART		<i>fentanyl</i>	21	<i>fluocinolone acetonide body</i>	118
TRANSMITTER	162	<i>fentanyl citrate</i>	21	<i>fluocinolone acetonide scalp</i>	118
EVERSENSE SENSOR/HOLDER	162	FENTANYL CITRATE (PF)	21	<i>fluocinonide</i>	118
EVERSENSE SMART		<i>fentanyl citrate (pf)</i>	21	<i>fluocinonide emulsified base</i>	118
TRANSMITTER	162	<i>fentanyl citrate pf</i>	21	<i>fluorescein</i>	205
EVISTA	132	FENTANYL CITRATE PF	21	FLUORESCENIN	
EVKEEZA	51	FERAHEME	148	SODIUM/BENOXINATE	205
EVOMELA	80	FERRIPROX	45	<i>fluorescein-benoxinate</i>	205
EVOTAZ	89	FERRIPROX TWICE-A-DAY	45	FLUORESCITE	205
EVOXAC	187	FERRLECIT	148	<i>fluoridex</i>	187
EVRYSDI	201	<i>ferumoxytol</i>	148	<i>fluoridex daily renewal</i>	187
EXELDERM	119	<i>fesoterodine fumarate er</i>	225	<i>fluoridex enhanced whitening</i>	187
EXELON	214	FETROJA	103	FLUORIDEX SENSITIVITY RELIEF	187
<i>exemestane</i>	76	FETZIMA	39	<i>flurametholone</i>	207
<i>ex-lax ultra</i>	154	FETZIMA TITRATION	39	<i>flurouracil</i>	64, 115
EXONDYS 51	200	FIBRICOR	52	<i>fluoxetine hcl</i>	38
EXTENCILLINE	212	FIBRYGA	141	FLUOXETINE HCL	38
EYLEA	209	FIFTY50 PEN NEEDLES	173	<i>fluoxetine hcl (pmd)</i>	217
EYLEA HD	209	FIFTY50 SAFETY SEAL LANCETS	162	<i>fluphenazine decanoate</i>	87
E-Z JECT LANCET MICRO-THIN		FIFTY50 SUPERIOR COMFORT		<i>fluphenazine hcl</i>	87
33G	162	SYR	173	<i>flurandrenolide</i>	118
E-Z JECT LANCET SUPER THIN		FIFTY50 UNILET LANCETS 33G	162	FLURA-SAFE	205
30G	162	FILSPARI	140	<i>flurazepam hcl</i>	150
E-Z JECT LANCETS	162	FILSUVEZ	123	<i>flurbiprofen</i>	17
E-Z JECT LANCETS 21G	162	FINACEA	121	<i>flurbiprofen sodium</i>	206
E-Z JECT LANCETS THIN 26G	162	<i>finasteride</i>	123, 139	<i>fluticasone furoate-vilanterol</i>	28
<i>ezetimibe</i>	52	FINGERSTIX LANCETS	162	<i>fluticasone propionate</i>	118, 199
<i>ezetimibe-simvastatin</i>	52	<i>fingolimod hcl</i>	219	<i>fluticasone propionate diskus</i>	30
EZ-LETS LANCETS 21G	162	FINTEPLA	34	<i>fluticasone propionate hfa</i>	30, 31
EZ-LETS LANCETS 26G	162	Finzala	104	<i>fluticasone-salmeterol</i>	28
EZ-LETS LANCETS 28G	162	FIRDAPSE	61	<i>fluvastatin sodium</i>	52
EZ-LETS LANCETS 30G	162	FIRMAGON	77	<i>fluvoxamine maleate</i>	38
<i>fa-8</i>	147	FIRMAGON (240 MG DOSE)	77	<i>fluvoxamine maleate er</i>	38
FABHALTA	143	FIRVANQ	59	FLUZONE	228
FABRAZYME	127	<i>flac</i>	209	FLUZONE HIGH-DOSE	228
<i>falmina</i>	104	FLAGYL	57	FML FORTE	207
<i>famciclovir</i>	93	FLAREX	207	FML LIQUIFILM	207
<i>famotidine</i>	224	FLAVOVIT EAR HEALTH	197	<i>focinvez</i>	48
<i>famotidine (pf)</i>	224	<i>flavoxate hcl</i>	226	<i>folate</i>	147
<i>famotidine premixed</i>	224	<i>flecainide acetate</i>	27	FOLGARD OS	190
FANAPT	85	FLEET STIMULANT	154	<i>folic acid</i>	147
FANAPT TITRATION PACK	85	FLEXBUMIN	145	FOLIVANE-OB	193
FANTASY LUBRICATED	157	FLOLAN	100	FOLOTYN	64
FANTASY		FLORAFOL PEDIATRIC	192	<i>foltabs 800</i>	147
LUBRICATED/SPERMICIDE	157	FLORIVA	180, 193	<i>fomepizole</i>	46
FARESTON	63	FLORIVA PLUS	192	<i>fondaparinux sodium</i>	32

FORA LANCETS	162	<i>gabapentin</i>	34	GENTEEL NOZZLES	163
FORA LANCING DEVICE	162	<i>gabapentin (once-daily)</i>	217	GENTEEL PLUS LANCING	
FORANE	139	GALAFOLD	127	(BLACK)	163
<i>formaldehyde</i>	89	<i>galantamine hydrobromide</i>	214	GENTEEL PLUS LANCING	
<i>formoterol fumarate</i>	29	<i>galantamine hydrobromide er</i>	214	(PURPLE)	163
FORTEO	131	Gallifrey	213	GENTEEL PLUS LANCING	
FOSAMAX	126	GALZIN	182	(WHITE)	163
FOSAMAX PLUS D	126	GAMASTAN	211	GENTEEL PLUS LANCING	
<i>fosamprenavir calcium</i>	91	GAMIFANT	185	DEV (BLUE)	163
<i>fosaprepitant dimeglumine</i>	48	GAMUNEX-C	211	GENTEEL PLUS LANCING	
<i>foscarnet sodium</i>	92	GANCICLOVIR	92	DEV (PINK)	163
FOSCAVIR	92	GANCICLOVIR SODIUM	92	<i>gentle laxative</i>	153, 154
<i>fosfomycin tromethamine</i>	60	<i>ganciclovir sodium</i>	92	<i>gentlelax</i>	152
<i>fosinopril sodium</i>	54	GANIRELIX ACETATE	128	GENVOYA	89
<i>fosinopril sodium-hctz</i>	53	GARDASIL 9	228	GEODON	85
<i>fosphenytoin sodium</i>	36	GASTROCROM	135	GIAPREZA	231
FOSRENOL	138	<i>gatifloxacin</i>	204	GILENYA	219
FOTIVDA	72	GATTEX	136	GILOTRIF	69
FRAGMIN	32	<i>gavilax</i>	152	GIMOTI	136
<i>fraiche 5000 dental</i>	187	GAVILYTE-C	151	GIVLAARI	141
FREESTYLE LANCETS	162	<i>gavilyte-g</i>	152	GLASSIA	220
FREESTYLE LIBRE 14 DAY		Gavilyte-N With Flavor Pack	152	<i>glatiramer acetate</i>	216
READER	162	GAVRETO	73	<i>glatopa</i>	216
FREESTYLE LIBRE 14 DAY		GAZYVA	65	GLEOSTINE	80
SENSOR	162	<i>gefitinib</i>	69	GLIADEL WAFER	80
FREESTYLE LIBRE 2 PLUS		GELFILM	149	<i>glimepiride</i>	44
SENSOR	162	GEL-FLOW NT	149	<i>glipizide</i>	44
FREESTYLE LIBRE 2 READER	162	GELFOAM	149	<i>glipizide er</i>	44
FREESTYLE LIBRE 2 SENSOR	163	GELFOAM COMPRESSED SIZE 100		<i>glipizide xl</i>	44
FREESTYLE LIBRE 3 PLUS		.....	149	<i>glipizide-metformin hcl</i>	44
SENSOR	163	GELFOAM DENTAL PACK SIZE 4	149	GLOBAL EASE INJECT PEN	
FREESTYLE LIBRE 3 READER	163	GELFOAM SPONGE	149	NEEDLES	173
FREESTYLE LIBRE 3 SENSOR	163	GELFOAM SPONGE SIZE 100	149	GLOBAL EASY GLIDE INSULIN	
FREESTYLE LIBRE READER	163	GELFOAM SPONGE SIZE 200	149	SYR	173
FREESTYLE UNISTICK II		GELFOAM SPONGE SIZE 50	149	GLOBAL EASY GLIDE PEN	
LANCETS	163	GEL-ONE	198	NEEDLES	173
<i>fresenius propoven</i>	138	GELSYN-3	198	GLOBAL INJECT EASE INSULIN	
FRESKARO MAGNESIUM		GEMCITABINE HCL	64	SYR	173
CITRATE	153	<i>gemcitabine hcl</i>	64	GLOBAL INJECT EASE LANCETS	
<i>frovatriptan succinate</i>	178	<i>gemfibrozil</i>	52	28G	163
FRUZAQLA	82	<i>gemmily</i>	104	GLOBAL INJECT EASE LANCETS	
<i>ft aspirin</i>	19	<i>generlac</i>	137	30G	163
<i>ft aspirin low dose</i>	19	<i>gengraf</i>	183	GLOBAL INSULIN SYRINGES	173
<i>ft b-100 complex pr</i>	190	GENOTROPIN	128	<i>global lancing device</i>	163
<i>ft clearlax</i>	152	GENOTROPIN MINIQUICK	128	GLOPERBA	141
<i>ft folic acid</i>	147	<i>gentamicin in saline</i>	15	GLUCAGON EMERGENCY	40
<i>ft laxative</i>	154	<i>gentamicin sulfate</i>	15, 114, 204	GLUCOCOM LANCETS 28G	163
<i>ft magnesium citrate</i>	153	GENTEEL BUTTERFLY TOUCH		GLUCOCOM LANCETS 30G	163
<i>ft milk of magnesia</i>	153	LANCET	163	GLUCOCOM LANCETS 33G	163
<i>ft nicotine</i>	218	GENTEEL CONTACT TIPS (BLUE)	163	GLUCOPRO INSULIN SYRINGE	173
<i>ft nicotine mini</i>	218	GENTEEL CONTACT TIPS		<i>glyburide</i>	44
<i>ft prenatal</i>	193	(CLEAR)	163	<i>glyburide micronized</i>	44
FULL SPECTRUM B/VITAMIN C	188	GENTEEL CONTACT TIPS		<i>glyburide-metformin</i>	44
<i>fulvestrant</i>	77	(GREEN)	163	GLYCATE	224
FUNGIMEZ	114	GENTEEL CONTACT TIPS		<i>glycine</i>	139
FUROSCIX	125	(ORANGE)	163	<i>glycine urologic</i>	139
<i>furosemide</i>	125	GENTEEL CONTACT TIPS		<i>glycolax</i>	152
FUZEON	90	(RAINBOW)	163	GLYCOPHOS	180
FYARRO	72	GENTEEL CONTACT TIPS		<i>glycopyrrolate</i>	224
<i>fyavolv</i>	134	(VIOLET)	163	GLYCOPYRROLATE	224
FYCOMPA	33	GENTEEL CONTACT TIPS		GLYCOPYRROLATE PF	225
<i>fyremadel</i>	128	(YELLOW)	163	<i>glycopyrrolate pf</i>	225
<i>g tussin ac</i>	111	GENTEEL LANCING KIT (BLUE)	163	<i>glydo</i>	120

GLYRX-PF.....	225	GOODSENSE LANCETS 33G UNIV	164	HEALTHWISE INSULIN	
GLYXAMBI.....	43	<i>goodsense lancing device</i>	164	SYR/NEEDLE.....	174
<i>gnp adult aspirin low strength</i>	19	<i>goodsense magnesium citrate</i>	153	HEALTHWISE MICRON PEN	
<i>gnp aspirin</i>	19	<i>goodsense milk of magnesia</i>	153	NEEDLES.....	174
<i>gnp aspirin low dose</i>	19	<i>goodsense nicotine</i>	218	HEALTHWISE SHORT PEN	
<i>gnp b-100 complex</i>	190	GOODSENSE PEN NEEDLE		NEEDLES.....	174
<i>gnp b-50 complex</i>	190	PENFINE.....	174	<i>healthy hair/skin/nails</i>	191
<i>gnp b-complex plus vitamin c</i>	188	GOPRELTO.....	199	<i>healthylax</i>	152
<i>gnp clearlax</i>	152	GRALISE.....	217	<i>heather</i>	108
GNP CLICKFINE PEN NEEDLES	173	<i>granisetron hcl</i>	47	<i>h-e-b aspirin</i>	20
<i>gnp essential one daily</i>	191	GRANIX.....	147	<i>h-e-b incontrol adv lancing</i>	164
<i>gnp folic acid</i>	147	GRASTEK.....	14	H-E-B INCONTROL LANCETS 28G	164
<i>gnp gentle laxative</i>	154	<i>griseofulvin microsize</i>	49	H-E-B INCONTROL LANCETS 30G	164
GNP INSULIN SYRINGE.....	173	<i>griseofulvin ultramicrosize</i>	49	H-E-B INCONTROL LANCETS 33G	164
GNP INSULIN SYRINGES.....	173	<i>guaifenesin-codeine</i>	111	H-E-B INCONTROL PEN NEEDLES	174
GNP INSULIN SYRINGES 28GX1/2"		<i>guanfacine hcl</i>	56	H-E-B INCONTROL UNIFINE	
.....	173	<i>guanfacine hcl er</i>	11	PENTIP.....	174
GNP INSULIN SYRINGES 29GX1/2"		GUARDIAN 4 GLUCOSE SENSOR	164	HECTOROL.....	129
.....	173	GUARDIAN 4 TRANSMITTER	164	HELIDAC THERAPY.....	225
GNP INSULIN SYRINGES		GUARDIAN CONNECT		HEMABATE.....	210
30GX5/16".....	173	TRANSMITTER.....	164	HEMADY.....	110
GNP INSULIN SYRINGES		GUARDIAN LINK 3		HEMANGEOL.....	95
31GX5/16".....	174	TRANSMITTER.....	164	HEMLIBRA.....	141
GNP LANCETS 21G.....	163	GUARDIAN REAL-TIME REPLACE		HEMOPIL M.....	142
GNP LANCETS THIN 26G.....	163	PED.....	164	HEPAGAM B.....	211
GNP LANCING SYSTEM DEVICE	163	GUARDIAN SENSOR (3).....	164	<i>heparin (porcine) in nacl</i>	32
<i>gnp magnesium citrate</i>	153	GUARDIAN SENSOR 3.....	164	HEPARIN (PORCINE) IN NACL	32
<i>gnp milk of magnesia</i>	153	GVOKE HYOPEN 1-PACK.....	40	<i>heparin na (pork) lock flsh pf</i>	32
<i>gnp nicotine</i>	218	GVOKE HYOPEN 2-PACK.....	40	HEPARIN SOD (PORCINE) IN D5W	32
<i>gnp nicotine mini</i>	218	GVOKE KIT.....	41	<i>heparin sod (porcine) in d5w</i>	32
<i>gnp nicotine polacrilex</i>	218	GVOKE PFS.....	41	<i>heparin sod (pork) lock flush</i>	32
GNP PRENATAL.....	193	GYNAZOLE-1.....	229	<i>heparin sodium (porcine)</i>	32
GNP STERILE LANCETS 28G.....	163	<i>habitrol</i>	218	HEPARIN SODIUM (PORCINE)	32
GNP STERILE LANCETS 30G.....	163	HAEGARDA.....	143	<i>heparin sodium (porcine) pf</i>	32
GNP STERILE LANCETS 33G.....	163	HAEMOLANCE.....	164	HEPARIN SODIUM (PORCINE) PF	32
GNP ULTICARE PEN NEEDLES	174	HAEMOLANCE LOW FLOW		HEPLISAV-B.....	228
GNP ULTIGUARD SAFEPAK		LANCETS.....	164	HEPZATO W/50MM CATHETER	80
NEEDLE.....	174	HAEMOLANCE PLUS.....	164	HEPZATO W/62MM CATHETER	80
GNP ULTRA COM INSULIN		HAEMOLANCE PLUS HIGH FLOW	164	HER STYLE.....	107
SYRINGE.....	174	HAEMOLANCE PLUS LOW FLOW	164	HERCEPTIN.....	66
<i>gnp womens gentle laxative</i>	154	HAEMOLANCE PLUS MAX FLOW	164	HERCEPTIN HYLECTA.....	75
GOCOVRI.....	83	HAEMOLANCE PLUS PEDIATRIC		HERZUMA.....	66
<i>gohibic</i>	143	FLOW.....	164	<i>hetastarch-nacl</i>	144
GOJJI LANCING DEVICE/CLEAR		<i>hailey 1.5/30</i>	104	HETLIOZ LQ.....	151
CAP.....	163	<i>hailey 24 fe</i>	104	HEXATRIONE.....	110
GOJJI STERILE LANCETS.....	163	<i>hailey fe 1.5/30</i>	104	HEXTEND.....	144
GOLYTELY.....	152	<i>hailey fe 1/20</i>	104	HIBERIX.....	226
GONAL-F.....	131	HALAVEN.....	79	<i>hidex 6-day</i>	110
GONAL-F RFF.....	131	<i>halcinonide</i>	118	HIGH POTENCY MULTIVITAMIN	191
GONAL-F RFF REDIJECT.....	131	HALCION.....	150	HIPREX.....	60
<i>goodsense aspirin</i>	20	HALDOL DECANOATE.....	86	HIZENTRA.....	211
<i>goodsense aspirin low dose</i>	19	<i>halobetasol propionate</i>	118	<i>hm clearlax</i>	152
<i>goodsense bisacodyl ec</i>	154	Haloette.....	107	<i>hm milk of magnesia</i>	153
<i>goodsense bisacodyl laxative</i>	154	<i>haloperidol</i>	86	<i>hm nicotine polacrilex</i>	218
<i>goodsense clearlax</i>	152	<i>haloperidol decanoate</i>	86	HM ULTICARE INSULIN SYRINGE	174
GOODSENSE CLICKFINE PEN		<i>haloperidol lactate</i>	86	HM ULTICARE MINI PEN	
NEEDLE.....	174	HARVONI.....	93	NEEDLES.....	174
GOODSENSE COLOR LANCETS		HAVRIX.....	228	HM ULTICARE SHORT PEN	
33G.....	163	HEALON DUET PRO.....	208	NEEDLES.....	174
GOODSENSE LANCETS 26G UNIV	163	HEALON GV PRO.....	208	HUMALOG.....	41
GOODSENSE LANCETS 30G.....	163	HEALON PRO.....	208	HUMALOG JUNIOR KWIKPEN	41
GOODSENSE LANCETS 30G UNIV	164	HEALON5 PRO.....	208	HUMALOG KWIKPEN.....	41
GOODSENSE LANCETS 33G.....	164	HEALTH CARE LANCING DEVICE	164	HUMALOG MIX 50/50 KWIKPEN	41

HUMALOG MIX 75/25	41	<i>ibuprofen lysine</i>	17	INSPRA	57
HUMALOG MIX 75/25 KWIKPEN	41	<i>ibutilide fumarate</i>	27	INSTAT	149
HUMATE-P	142	<i>icatibant acetate</i>	143	INSULIN LISPRO	42
HUMATIN	15	<i>iclevia</i>	107	INSULIN LISPRO (1 UNIT DIAL)	42
HUMATROPE	128	<i>icosapent ethyl</i>	51	INSULIN LISPRO JUNIOR	
HUMIRA (2 PEN)	16	IDAMYCIN PFS	74	KWIKPEN	42
HUMIRA (2 SYRINGE)	16	<i>idarubicin hcl</i>	74	INSULIN LISPRO PROT & LISPRO	42
HUMIRA-CD/UC/HS STARTER	16	IDELVION	142	INSULIN SYRINGE	174
HUMIRA-PSORIASIS/UVEIT		IDHIFA	78	<i>insulin syringe-needle u-100</i>	174
STARTER	16	IFEX	80	INSULIN SYRINGE-NEEDLE U-100	174
HUMULIN 70/30	41	<i>ifosfamide</i>	80	INSUPEN PEN NEEDLES	174
HUMULIN 70/30 KWIKPEN	41	IFOSFAMIDE	80	INTELENCE	91
HUMULIN N	42	IGALMI	151	INTERCEED	149
HUMULIN N KWIKPEN	42	IHEALTH LANCING DEVICE	164	INTERCEED (TC7)	149
HUMULIN R	42	IHEEZO	205	INTRALIPID	202
HUMULIN R U-500		ILARIS	16	INTRAROSA	229
(CONCENTRATED)	42	ILEVRO	206	<i>introvale</i>	107
HUMULIN R U-500 KWIKPEN	42	ILIDERM	121	INVEGA HAFYERA	85
HYALGAN	198	ILUVIEN	207	INVEGA SUSTENNA	85
HYCAMTIN	81	<i>imatinib mesylate</i>	68	INVEGA TRINZA	85
HYCODAN	111	IMBRUVICA	69	INVELTYS	207
<i>hydralazine hcl</i>	57	IMCIVREE	13	IONOSOL-MB IN D5W	179
HYDREA	76	IMDELLTRA	68	IOPIDINE	206
<i>hydrochlorothiazide</i>	125	IMFINZI	67	IPOL	228
<i>hydrocod poli-chlorphe poli er</i>	112	<i>imipenem-cilastatin</i>	58	<i>ipratropium bromide</i>	29, 199
<i>hydrocodone bitartrate er</i>	21	<i>imipramine hcl</i>	39	<i>ipratropium-albuterol</i>	28
<i>hydrocodone bit-homatrop mbr</i>	111	<i>imipramine pamoate</i>	39	<i>irbesartan</i>	56
<i>hydrocodone-acetaminophen</i>	20	<i>iniquimod</i>	120	<i>irbesartan-hydrochlorothiazide</i>	55
<i>hydrocodone-ibuprofen</i>	21	<i>iniquimod pump</i>	120	IRESSA	69
<i>hydrocortisone</i>	25, 110, 118, 119	IMJUDO	66	<i>irinotecan hcl</i>	81
<i>hydrocortisone (perianal)</i>	25	IMMPHENTIV	231	ISENTRESS	90
<i>hydrocortisone ace-pramoxine</i>	25	IMOGAM RABIES-HT	211	ISENTRESS HD	90
<i>hydrocortisone butyrate</i>	118	IMOVAX RABIES	228	<i>isibloom</i>	104
<i>hydrocortisone sod suc (pf)</i>	110	IMPAVIDO	57	<i>isoflurane</i>	139
<i>hydrocortisone valerate</i>	119	IMURAN	186	ISOLYTE-P IN D5W	179
<i>hydrocortisone-acetic acid</i>	210	IMVEXXY MAINTENANCE PACK	230	ISOLYTE-S	179
<i>hydromet</i>	111	IMVEXXY STARTER PACK	230	ISOLYTE-S PH 7.4	179
<i>hydromorphone hcl</i>	21	IN TOUCH LANCING DEVICE	164	<i>isoniazid</i>	62
<i>hydromorphone hcl er</i>	21	IN TOUCH STERILE LANCETS 30G	164	<i>isoproterenol hcl</i>	29
HYDROMORPHONE HCL PF	21		164	ISORDIL TITRADOSE	25
<i>hydromorphone hcl pf</i>	21	<i>inatal gt</i>	193	<i>isosorb dinitrate-hydralazine</i>	99
<i>hydroxocobalamin acetate</i>	146	INBRIJA	83	<i>isosorbide dinitrate</i>	25
HYDROXYCHLOROQUINE		<i>incassia</i>	108	<i>isosorbide mononitrate</i>	25
SULFATE	61	INCONTROL ULTICARE PEN		<i>isosorbide mononitrate er</i>	25
<i>hydroxychloroquine sulfate</i>	61	NEEDLES	174	<i>isotretinoin</i>	113
<i>hydroxyurea</i>	76	INCRELEX	129	<i>isradipine</i>	97
<i>hydroxyzine hcl</i>	26	<i>indapamide</i>	125	ISTODAX	70
<i>hydroxyzine pamoate</i>	26	INDERAL XL	95	ISTURISA	127
HYFTOR	120	<i>indomethacin</i>	17	ITOVEBI	80
HYLENEX	183	<i>indomethacin er</i>	17	<i>itraconazole</i>	49
HYMOVIS	198	<i>indomethacin sodium</i>	17	<i>ivabradine hcl</i>	101
HYPERHEP B	211	INFANRIX	223	<i>ivermectin</i>	25, 121
HYPERRAB	211	INFED	148	IWILFIN	80
HYPERRHO S/D	211	INFLIXIMAB	138	IXCHIQ	228
HYPERSAL	112	INFUMORPH 200	21	IXEMPRA KIT	79
HYPERTET	211	INFUMORPH 500	21	IXIARO	228
HYPOLANCE AST LANCING	164	INFUVITE ADULT	191	IXINITY	142
HY-VEE LANCETS	164	INFUVITE PEDIATRIC	193	IYUZEH	208
HY-VEE THIN LANCETS	164	INGREZZA	214, 215	IZERVAY	205
<i>ibandronate sodium</i>	126	INLYTA	82	<i>jaimiess</i>	108
IBRANCE	76	INNOPRAN XL	95	JAKAFI	78
<i>ibu</i>	17	INQOVI	75	<i>jantoven</i>	31
<i>ibuprofen</i>	17	INREBIC	78	JANUMET	41

JANUMET XR.....	41	KESIMPTA.....	216	K-PHOS NO 2.....	140
JANUVIA.....	41	KETALAR.....	138	K-PHOS-NEUTRAL.....	180
JARDIANCE.....	43	<i>ketamine hcl</i>	138	KPN PRENATAL.....	193
<i>jasmiel</i>	104	<i>ketocozazole</i>	49, 120	KRAZATI.....	71
JATENZO.....	24	<i>ketodan</i>	120	KRINTAFEL.....	61
Javygtor.....	131	<i>ketoprofen er</i>	17	KRISTALOSE.....	152
JAYPIRCA.....	69	<i>ketorolac tromethamine</i>	17, 206	KROGER AUTOLET LANCING DEVICE.....	164
JELMYTO.....	74	KETOROLAC TROMETHAMINE.....	17	KROGER HEALTHPRO LANCET 26G.....	164
JEMPERLI.....	67	KEYTRUDA.....	67	KROGER INSULIN SYRINGE.....	174
<i>jencycla</i>	108	KHAPZORY.....	77	KROGER LANCETS.....	164
JENLIVA PRENATAL/POSTNATAL.....	193	KIMMTRAK.....	68	KROGER LANCETS 21G.....	164
JEUVEAU.....	119	<i>kimono</i>	157	KROGER LANCETS MICRO THIN 33G.....	164
JEVTANA.....	79	KIMONO COLORS.....	157	KROGER LANCETS SUPER THIN... 164	
<i>jinteli</i>	134	KIMONO MAXX-LARGE FLARE.....	157	KROGER LANCETS THIN.....	164
JIVI.....	142	<i>kimono micro thin</i>	157	KROGER LANCETS THIN 26G.....	165
JOENJA.....	182	<i>kimono micro thin plus</i>	157	KROGER LANCETS ULTRATHIN 30G.....	165
<i>jolessa</i>	108	<i>kimono plus</i>	157	<i>croger lancsing device</i>	165
Joyeaux.....	104	<i>kimono ps</i>	157	KROGER PEN NEEDLES.....	174
JUBLIA.....	119	<i>kimono ps plus</i>	157	KRYSTEXXA.....	141
<i>juleber</i>	104	<i>kimono sensation</i>	157	K-TAB.....	181
JULUCA.....	89	<i>kimono sensation plus</i>	157	<i>kurvelo</i>	105
<i>junel 1.5/30</i>	104	KIMONO SPECIAL.....	157	KYLEENA.....	108
<i>junel 1/20</i>	104	KIMYRSA.....	59	KYPROLIS.....	73
<i>junel fe 1.5/30</i>	104	KINNEY LANCETS.....	164	<i>labetalol hcl</i>	94
<i>junel fe 1/20</i>	105	KINNEY THIN LANCETS.....	164	<i>lacosamide</i>	34
<i>junel fe 24</i>	105	KINRAY INSULIN SYRINGE.....	174	<i>lactated ringers</i>	180, 184
JUXTAPID.....	52	KINRIX.....	223	LACTULOSE.....	152
JYLAMVO.....	64	KISQALI (200 MG DOSE).....	77	<i>lactulose encephalopathy</i>	137
JYNARQUE.....	132	KISQALI (400 MG DOSE).....	77	LAGEVRIO.....	93
JYNNEOS.....	228	KISQALI (600 MG DOSE).....	77	<i>lamivudine</i>	91, 92, 93
KABIVEN.....	202	KLARON.....	113	<i>lamivudine-zidovudine</i>	89
KADCYLA.....	75	Klayesta.....	114	<i>lamotrigine</i>	34
<i>kaitlib fe</i>	105	KLISYRI (250 MG).....	121	<i>lamotrigine er</i>	34
KALBITOR.....	144	KLISYRI (350 MG).....	121	<i>lamotrigine starter kit-blue</i>	34
KALETRA.....	89	<i>klor-con</i>	181	<i>lamotrigine starter kit-green</i>	34
<i>kalliga</i>	105	<i>klor-con 10</i>	181	<i>lamotrigine starter kit-orange</i>	34
KALYDECO.....	220	<i>klor-con m10</i>	181	LAMPIT.....	58
KAMELEON LUBRICATED.....	157	<i>klor-con m15</i>	181	LAMZEDE.....	126
KANJINTI.....	66	<i>klor-con m20</i>	181	<i>lancet device</i>	165
KANUMA.....	130	KLOXXADO.....	46	<i>lancet device with ejector</i>	165
KAPSPARGO SPRINKLE.....	95	<i>kls aspirin low dose</i>	20	LANCETS.....	165
KARDIAMEMBRANE.....	122	<i>kls laxaclear</i>	152	LANCETS 30G.....	165
<i>kariva</i>	103	<i>kls quit2</i>	218	LANCETS 33G.....	165
KATERZIA.....	97	<i>kls quit4</i>	218	LANCETS MICRO THIN 33G.....	165
KCENTRA.....	142	KMART VALU INSULIN SYRINGE 29G.....	174	LANCETS SUPER THIN.....	165
KCL (0.149%) IN NACL.....	179	KMART VALU INSULIN SYRINGE 30G.....	174	LANCETS SUPER THIN 28G.....	165
<i>kcl (0.149%) in nacl</i>	180	KOATE.....	142	LANCETS THIN.....	165
KCL (0.298%) IN NACL.....	180	KOATE-DVI.....	142	LANCETS ULTRA THIN.....	165
<i>kcl in dextrose-nacl</i>	179	<i>kobee</i>	189	LANCETS ULTRA THIN 30G.....	165
KCL IN DEXTROSE-NACL.....	179	KOGENATE FS.....	142	<i>lancing device</i>	165
KCL-LACTATED RINGERS-D5W... 179		KORSUVA.....	186	LANOXIN.....	99
KEDBUMIN.....	145	KOSELUGO.....	71	LANOXIN PEDIATRIC.....	99
KEDRAB.....	211	KOSHER PRENATAL PLUS IRON... 193		LANREOTIDE ACETATE.....	132
<i>kelnor 1/35</i>	105	Kourzeq.....	188	<i>lansoprazole</i>	224
<i>kelnor 1/50</i>	105	KOVALTRY.....	142	<i>lanthanum carbonate</i>	138
KENALOG-10.....	110	<i>kp aspirin</i>	20	LANTUS.....	42
KENALOG-40.....	110	<i>kp b complex-c</i>	188	LANTUS SOLOSTAR.....	42
KENALOG-80.....	110	<i>kp bisacodyl</i>	154	LANZO.....	165
KENDALL HYDROGEL WOUND DRESS.....	123	<i>kp folic acid</i>	147		
KENGREAL.....	144	KP PRENATAL MULTIVITAMINS... 193			
KEPIVANCE.....	76	K-PHOS.....	180		
KERENDIA.....	130				

<i>lapatinib ditosylate</i>	72	LEVOTHYROXINE SODIUM.....	222	LONGS INSULIN SYRINGE.....	174
<i>larin 1.5/30</i>	105	<i>levothyroxine sodium</i>	222	LONGS LANCETS STANDARD.....	165
<i>larin 1/20</i>	105	<i>levoxyl</i>	222	LONGS LANCETS THIN.....	165
<i>larin 24 fe</i>	105	LEVULAN KERASTICK.....	121	LONGS LANCETS ULTRA THIN.....	165
<i>larin fe 1.5/30</i>	105	<i>l-glutamine</i>	146	LONSURF.....	75
<i>larin fe 1/20</i>	105	LIBERTY MEDICAL LANCETS.....	165	<i>loperamide hcl</i>	45
LASIX.....	125	LIBERTY MINI LANCING DEVICE.....	165	LOPID.....	52
<i>latanoprost</i>	208	LIBRAX.....	223	<i>lopinavir-ritonavir</i>	89
LATISSE.....	121	LIBTAYO.....	67	LOQTORZI.....	67
LAVARE WOUND WASH.....	123	<i>lidocaine</i>	120	<i>lorazepam</i>	26
<i>laxative</i>	154	<i>lidocaine hcl</i>	120, 155, 186	<i>lorazepam intensol</i>	26
<i>layolis fe</i>	105	<i>lidocaine hcl (cardiac)</i>	27	LORBRENA.....	65
LAZCLUZE.....	69	LIDOCAINE HCL (CARDIAC) PF.....	27	<i>loryna</i>	105
<i>leader advanced lancing device</i>	165	<i>lidocaine hcl (cardiac) pf</i>	27	<i>losartan potassium</i>	56
LEADER INSULIN SYRINGE.....	174	<i>lidocaine hcl (pf)</i>	155	<i>losartan potassium-hctz</i>	55
LEADER UNIFINE PENTIPS.....	174	<i>lidocaine hcl urethral/mucosal</i>	120	LOTEMAX.....	207
LEADER UNIFINE PENTIPS PLUS.....	174	<i>lidocaine in d5w</i>	27	LOTEMAX SM.....	207
<i>leena</i>	109	<i>lidocaine viscous hcl</i>	186	LOTENSIN.....	54
<i>leflunomide</i>	18	<i>lidocaine-viscous hcl</i>	186	LOTENSIN HCT.....	53, 54
LEMTRADA.....	216	<i>lidocaine-epinephrine</i>	155	<i>loteprednol etabonate</i>	207
<i>lenalidomide</i>	183	<i>lidocaine-epinephrine (pf)</i>	155	<i>lovastatin</i>	52
LENTOCILIN.....	212	<i>lidocaine-prilocaine</i>	123	<i>low-ogestrel</i>	105
LENVIMA (10 MG DAILY DOSE).....	82	LILETTA (52 MG).....	108	<i>loxapine succinate</i>	87
LENVIMA (12 MG DAILY DOSE).....	82	LINCOCIN.....	60	<i>lo-zumandimine</i>	105
LENVIMA (14 MG DAILY DOSE).....	82	<i>lincomycin hcl</i>	60	<i>lubiprostone</i>	135
LENVIMA (18 MG DAILY DOSE).....	82	<i>linezolid</i>	60	LUCENTIS.....	209
LENVIMA (20 MG DAILY DOSE).....	82	<i>linezolid in sodium chloride</i>	60	LUGOLS STRONG IODINE.....	89
LENVIMA (24 MG DAILY DOSE).....	82	LINZESS.....	136	<i>luliconazole</i>	120
LENVIMA (4 MG DAILY DOSE).....	82	<i>liothyronine sodium</i>	222	LUMAKRAS.....	71
LENVIMA (8 MG DAILY DOSE).....	82	<i>lipo flavonoid plus</i>	197	LUMIGAN.....	208
LEQVIO.....	53	LIPOFEN.....	52	LUMIZYME.....	127
<i>lessina</i>	105	<i>lipoflavovit</i>	197	LUNSUNIO.....	68
<i>letrozole</i>	76	LIPOTRIAD.....	197	LUPKYNIS.....	183
<i>leucovorin calcium</i>	77	<i>liraglutide</i>	42	LUPRON DEPOT (1-MONTH).....	78
LEUKERAN.....	80	<i>lisdexamfetamine dimesylate</i>	11	LUPRON DEPOT (3-MONTH).....	78
LEUKINE.....	148	<i>lisinopril</i>	54	LUPRON DEPOT (4-MONTH).....	78
<i>leuprolide acetate</i>	78	<i>lisinopril-hydrochlorothiazide</i>	53	LUPRON DEPOT (6-MONTH).....	78
<i>leuprolide acetate (3 month)</i>	78	LITE TOUCH LANCETS.....	165	LUPRON DEPOT-PED (1-MONTH).....	129
<i>levalbuterol hcl</i>	29	LITE TOUCH LANCING PEN.....	165	LUPRON DEPOT-PED (3-MONTH).....	130
<i>levalbuterol tartrate</i>	29	LITETOUCH INSULIN SYRINGE.....	174	LUPRON DEPOT-PED (6-MONTH).....	130
<i>levamlodipine maleate</i>	97	LITETOUCH LANCETS.....	165	<i>lurasidone hcl</i>	85
<i>levetiracetam</i>	34	LITETOUCH PEN NEEDLES.....	174	LUTATHERA.....	75
<i>levetiracetam er</i>	34	<i>lithium</i>	84	<i>lutera</i>	105
LEVETIRACETAM IN NAACL.....	34	<i>lithium carbonate</i>	84	LUZU.....	120
<i>levobunolol hcl</i>	202	<i>lithium carbonate er</i>	84	LYBALVI.....	220
<i>levocarnitine</i>	127	LITHOSTAT.....	140	<i>lyleq</i>	109
<i>levocarnitine sf</i>	127	LIVE BETTER LANCET SUPER.....	165	<i>lyllana</i>	134
<i>levocetirizine dihydrochloride</i>	50	THIN.....	165	LYNPARZA.....	81
<i>levofloxacin</i>	135, 204	LIVMARLI.....	136	LYRICA CR.....	217
<i>levofloxacin in d5w</i>	135	LIVTENCITY.....	92	LYSODREN.....	63
<i>levoleucovorin calcium</i>	77	<i>lmd in d5w</i>	144	LYTGOBI (12 MG DAILY DOSE).....	70
<i>levoleucovorin calcium pf</i>	77	<i>lmd in nacl</i>	144	LYTGOBI (16 MG DAILY DOSE).....	70
<i>levonest</i>	109	LO LOESTRIN FE.....	103	LYTGOBI (20 MG DAILY DOSE).....	70
<i>levonorgest-eth est & eth est</i>	108	LODINE.....	17	LYUMJEV.....	42
<i>levonorgest-eth estrad 91-day</i>	108	LODOSYN.....	83	LYUMJEV KWIKPEN.....	42
<i>levonorgest-eth estradiol-iron</i>	105	<i>loestrin 1.5/30 (21)</i>	105	<i>lyza</i>	109
<i>levonorgestrel</i>	107	<i>loestrin 1/20 (21)</i>	105	MACROBID.....	60
<i>levonorgestrel-ethinyl estrad</i>	105, 107	<i>loestrin fe 1.5/30</i>	105	MACRODANTIN.....	61
<i>levonorg-eth estrad triphasic</i>	109	<i>loestrin fe 1/20</i>	105	<i>mafenide acetate</i>	117
LEVOPHED.....	231	<i>lofexidine hcl</i>	213	MAGELLAN INSULIN SAFETY.....	174
<i>levora 0.15/30 (28)</i>	105	<i>lojaimiess</i>	108	SYR.....	153
<i>levorphanol tartrate</i>	21	LOKELMA.....	185	<i>magnesium citrate</i>	153
<i>levo-t</i>	222	LOMAIRA.....	12	MAGNESIUM SULFATE.....	180
		LOMOTIL.....	45		

MAGNESIUM SULFATE IN D5W	180	MEIJER LANCETS	165	METHYLPHENIDATE HCL ER	
MALARONE	61	MEIJER LANCETS THIN	165	(OSM)	13
<i>malathion</i>	122	MEIJER LANCETS UNIVERSAL		<i>methylphenidate hcl er (xr)</i>	13
<i>manganese chloride</i>	180	21G	165	<i>methylprednisolone</i>	110
<i>mannitol</i>	125	MEIJER LANCETS UNIVERSAL		<i>methylprednisolone sodium succ</i>	110
MARATHON MEDICAL PENTIPS ...	174	30G	165	<i>metoclopramide hcl</i>	136
<i>maraviroc</i>	90	MEIJER LANCETS UNIVERSAL		<i>metolazone</i>	125
MARCAINE	155	33G	166	<i>metoprolol succinate er</i>	95
MARCAINE PRESERVATIVE FREE	155	MEIJER PEN NEEDLES	175	<i>metoprolol tartrate</i>	95
MARCAINE/EPINEPHRINE	155	MEIJER SUPER THIN LANCETS	166	<i>metoprolol-hydrochlorothiazide</i>	57
MARCAINE/EPINEPHRINE PF	155	MEKINIST	71	METROCREAM	121
MAR-COF CG EXPECTORANT	111	MEKTOVI	71	METRONIDAZOLE	57
MARGENZA	66	<i>meloxicam</i>	17	<i>metronidazole</i>	57, 121, 229
MARINOL	48	<i>melphalan hcl</i>	80	<i>metyrosine</i>	55
<i>marlissa</i>	105	<i>memantine hcl</i>	216	<i>mexiletine hcl</i>	27
MARPLAN	37	<i>memantine hcl er</i>	216	MI PASTE	158
MASONATAL	193	MENEST	134	MI PASTE PLUS	158
MATULANE	76	MENOPUR	131	MIACALCIN	127
<i>matzim la</i>	97	MENOSTAR	134	Mibelas 24 Fe	105
MAVENCLAD (10 TABS)	215	MENQUADFI	226	MICAFUNGIN SODIUM	48
MAVENCLAD (4 TABS)	215	MENVEO	226	<i>micafungin sodium-nacl</i>	48
MAVENCLAD (5 TABS)	215	<i>meperidine hcl</i>	21	<i>miconazole 3</i>	229
MAVENCLAD (6 TABS)	215	<i>meprobamate</i>	26	<i>miconazole-zinc oxide-petrolat</i>	114
MAVENCLAD (7 TABS)	215	MEPRON	58	MICRHOGAM ULTRA-FILTERED	
MAVENCLAD (8 TABS)	215	MEPSEVII	130	PLUS	211
MAVENCLAD (9 TABS)	215	<i>mercaptopurine</i>	64	MICRODOT PEN NEEDLE	175
MAXICOMFORT II PEN NEEDLE ...	174	<i>meropenem</i>	58	<i>microgestin 1.5/30</i>	105
MAXI-COMFORT INSULIN		MEROPENEM-SODIUM CHLORIDE	58	<i>microgestin 1/20</i>	105
SYRINGE	174	<i>merzee</i>	105	<i>microgestin fe 1.5/30</i>	105
MAXI-COMFORT SAFETY PEN		<i>mesalamine</i>	137	<i>microgestin fe 1/20</i>	105
NEEDLE	174	<i>mesalamine er</i>	137	MICROLET LANCETS	166
MAXICOMFORT SYR 27G X 1/2" ...	174	<i>mesalamine-cleanser</i>	137	MICROLET NEXT LANCING	
MAXIDEX	207	<i>mesna</i>	82	DEVICE	166
MAXITROL	206	MESNEX	82	<i>midazolam hcl</i>	150
<i>maxi-tuss ac</i>	111	MESTINON	61	<i>midazolam hcl (pf)</i>	150
MAXI-TUSS CD	112	<i>metformin hcl</i>	40	MIDAZOLAM HCL-SODIUM	
<i>maxx</i>	157	<i>metformin hcl er</i>	40	CHLORIDE	151
<i>maxx plus</i>	157	METHADONE HCL	21	<i>midazolam-sodium chloride (pf)</i>	151
MAYZENT	219	<i>methadone hcl</i>	22	<i>midodrine hcl</i>	231
MAYZENT STARTER PACK	219	<i>methadone hcl intensol</i>	21	MIFEPREX	125
<i>meclizine hcl</i>	47	METHADOSE	22	<i>mifepristone</i>	43, 125
<i>meclofenamate sodium</i>	17	<i>methadose</i>	22	<i>migergot</i>	178
MEDIC INSULIN SYRINGE	175	METHADOSE SUGAR-FREE	22	<i>miglitol</i>	40
MEDICHOICE SAFETY LANCET ...	165	<i>methazolamide</i>	124	<i>miglustat</i>	146
MEDICHOICE SAFETY LANCET		<i>methenamine hippurate</i>	61	<i>mili</i>	105
EXTRA	165	<i>methergine</i>	210	<i>milk of magnesia</i>	153
MEDICHOICE SAFETY LANCET		<i>methimazole</i>	222	<i>milrinone lactate</i>	99
NORM	165	<i>methocarbamol</i>	197	<i>milrinone lactate in dextrose</i>	99
MEDICINE SHOPPE PEN NEEDLES	175	<i>methotrexate sodium</i>	64	<i>mimvey</i>	134
MEDLANCE PLUS EXTRA 21G	165	<i>methotrexate sodium (pf)</i>	64	<i>mineral oil heavy</i>	153
MEDLANCE PLUS LITE 25G	165	<i>methoxsalen rapid</i>	115	<i>mini lancing device</i>	166
MEDLANCE PLUS SPECIAL 0.8MM		<i>methscopolamine bromide</i>	225	MINILINK REAL-TIME	
.....	165	<i>methsuximide</i>	37	TRANSMITTER	166
MEDLANCE PLUS SUPERLITE 30G		<i>methylidopa</i>	56	MINIMED 630G GUARDIAN PRESS	
.....	165	<i>methylene blue</i>	46	.....	166
MEDLANCE PLUS UNIVERSAL		<i>methylene blue (antidote)</i>	46	MINOCIN	221
21G	165	<i>methylergonovine maleate</i>	210	<i>minocycline hcl</i>	221
MEDROL	110	<i>methylphenidate</i>	14	<i>minoxidil</i>	57
<i>medroxyprogesterone acetate</i>	108, 213	<i>methylphenidate hcl</i>	14	MIOCHOL-E	203
<i>mefenamic acid</i>	17	<i>methylphenidate hcl er</i>	13, 14	MIOSTAT	203
<i>mefloquine hcl</i>	61	<i>methylphenidate hcl er (cd)</i>	13	<i>mirabegron er</i>	226
<i>mega multiple/chelated mineral</i>	197	<i>methylphenidate hcl er (la)</i>	13	MIRAPEX ER	84
<i>megestrol acetate</i>	81, 213	<i>methylphenidate hcl er (osm)</i>	13	MIRCERA	147

MIRENA (52 MG).....	108	<i>multiple electro type 1 ph 7.4</i>	180	<i>naratriptan hcl</i>	178
<i>mirtazapine</i>	37	<i>multiple vitamin-folic acid</i>	191	NARDIL.....	37
MIRVASO.....	121	<i>multiple vitamins</i>	191	NAROPIN.....	155
<i>misoprostol</i>	225	<i>multiple vitamins essential</i>	191	NATACYN.....	204
<i>mitigo</i>	22	<i>multiple vitamins/iron</i>	190	<i>natal pnv</i>	193
<i>mitomycin</i>	74, 204	MULTITRACE-4 PEDIATRIC.....	181	NATALVIT.....	194
MITOSOL.....	204	MULTIVITAMIN.....	191	NATAZIA.....	108
<i>mitoxantrone hcl</i>	74	<i>multi-vitamin</i>	191	<i>nateglinide</i>	43
<i>mm aspirin</i>	20	<i>multivitamin adult</i>	191	NATESTO.....	24
<i>mm clearlax</i>	152	<i>multivitamin iron-free</i>	191	NATROBA.....	122
MM INSULIN SYRINGE/NEEDLE... 175		<i>multivitamin plus iron adult</i>	190	<i>nat-rul b-50</i>	197
MM LANCING DEVICE.....	166	<i>multivitamin w/fluoride</i>	192	<i>nat-rul daily-vite+iron</i>	190
MM PEN NEEDLES.....	175	<i>multivitamin/fluoride</i>	192	NAYZILAM.....	33
MM TWIST LANCETS.....	166	<i>multi-vitamin/fluoride</i>	192	<i>neбивolol hcl</i>	95
M-M-R II.....	227	<i>multi-vitamin/fluoride/iron</i>	192	NEBUPENT.....	57
M-NATAL PLUS.....	193	<i>multi-vitamin/iron</i>	190	Nebusal.....	112
<i>modafinil</i>	14	MULTI-VIT-FLOR.....	192	<i>necon 0.5/35 (28)</i>	105
MODERNA COVID-19 VAC 6M-11Y		MULTRYS.....	181	NEEVO DHA.....	194
.....	228	<i>mupirocin</i>	114	<i>nefazodone hcl</i>	38
<i>moexipril hcl</i>	54	<i>mutamycin</i>	74	<i>nelarabine</i>	64
<i>molindone hcl</i>	87	MVASI.....	82	NEOMULTIVITE.....	191
<i>mometasone furoate</i>	119, 199	<i>my choice</i>	107	<i>neomycin sulfate</i>	15
<i>mondoxylene nl</i>	221	<i>my way</i>	107	<i>neomycin-bacitracin zn-polymyx</i>	204
MONJUVI.....	65	MYALEPT.....	129	<i>neomycin-polymyxin b gu</i>	139
MONOJECT BONE MARROW		MYCAMINE.....	48	<i>neomycin-polymyxin-dexameth</i>	206
BIOPSY.....	155	MYCAPSSA.....	132	<i>neomycin-polymyxin-gramicidin</i>	204
<i>monoject flush syringe</i>	181	<i>mycophenolate mofetil</i>	184	<i>neomycin-polymyxin-hc</i>	206, 209
MONOJECT INSULIN SYRINGE.....	175	<i>mycophenolate mofetil hcl</i>	184	NEONATAL COMPLETE.....	194
<i>monoject sodium chloride flush</i>	181	<i>mycophenolate sodium</i>	184	NEONATAL PLUS.....	194
MONOJECT ULTRA COMFORT		<i>mycophenolic acid</i>	184	<i>neonatal prenatal</i>	194
SYRINGE.....	175	MYDCOMBI.....	203	NEONATAL VITAMIN.....	194
MONOLET LANCETS.....	166	MYDRIACYL.....	203	<i>neo-polycin</i>	204
MONOLET OPD LANCETS.....	166	MYFEMBREE.....	134	<i>neo-polycin hc</i>	206
MONOLETTOR SAFETY LANCETS	166	MYFORTIC.....	184	NEOPROFEN.....	18
<i>mono-lynyah</i>	105	MYGLUCOHEALTH LANCETS 30G		NEORAL.....	183
MONOVISC.....	198	.....	166	NEOSTIGMINE METHYLSULFATE.	61
<i>montelukast sodium</i>	30	MYHIBBIN.....	184	NEO-SYNALAR.....	114
MORPHINE SULFATE.....	22	MYLERAN.....	62	NEOX 100.....	122
<i>morphine sulfate</i>	22	MYLOTARG.....	66	NEOX CORD 1K.....	122
<i>morphine sulfate (concentrate)</i>	22	MYOBLOC.....	200	<i>nephro vitamins</i>	188
<i>morphine sulfate (pf)</i>	22	MYRBETRIQ.....	226	NEPHRO-VITE.....	188
MORPHINE SULFATE (PF).....	22	MYTESI.....	45	NERLYNX.....	72
<i>morphine sulfate er</i>	22	MYXREDLIN.....	42	NESACAINE.....	156
<i>morphine sulfate er beads</i>	22	<i>na ferric gluc cplx in sucrose</i>	148	NESACAINE-MPF.....	156
MOTOFEN.....	45	<i>na sulfate-k sulfate-mg sulf</i>	152	NESTABS.....	194
MOUNJARO.....	42	NABI-HB.....	211	NESTABS DHA.....	194
MOVANTIK.....	137	<i>nabumetone</i>	17	NESTABS ONE.....	196
MOVIPREP.....	152	<i>nadolol</i>	95	<i>neucac</i>	113
MOXIFLOXACIN HCL.....	135	<i>nafacillin sodium</i>	213	NEULASTA.....	147
<i>moxifloxacin hcl</i>	135, 204	NAFCILLIN SODIUM IN		NEULASTA ONPRO.....	147
<i>moxifloxacin hcl (2x day)</i>	204	DEXTROSE.....	212	NEUPOGEN.....	147
<i>moxifloxacin hcl in nacl</i>	135	<i>naftifine hcl</i>	114	NEUPRO.....	84
MOZOBIL.....	146	NAFTIN.....	114	NEVANAC.....	206
MRESVIA.....	228	NAGLAZYME.....	130	<i>nevirapine</i>	91
MS INSULIN SYRINGE.....	175	<i>nalbuphine hcl</i>	23	<i>nevirapine er</i>	91
MULPLETA.....	148	<i>nalmefene hcl</i>	46	<i>new day</i>	107
MULTAQ.....	27	<i>naloxone hcl</i>	46	NEXAVAR.....	72
MULTI PRENATAL.....	193	<i>naltrexone hcl</i>	46	NEXIUM I.V.....	224
<i>multi vitamin</i>	191	NAMENDA TITRATION PAK.....	216	NEXLETOL.....	51
MULTI VITAMIN W/D-3.....	191	NAMZARIC.....	213	NEXLIZET.....	51
<i>multi-lancet device</i>	166	<i>naproxen</i>	18	NEXOBRID.....	119
MULTI-LANCET DEVICE 2.....	166	<i>naproxen dr</i>	18	NEXPLANON.....	108
<i>multiple electro type 1 ph 5.5</i>	180	<i>naproxen sodium</i>	18	NEXTERONE.....	27

NEXTSTELLIS	105	<i>norgestimate-eth estradiol</i>	106	OCTAGAM	211
NEXVIAZYME	127	<i>norgestim-eth estrad triphasic</i>	109	OCTAPLAS BLOOD GROUP A	145
<i>niacin (antihyperlipidemic)</i>	52	NORLIQVA	97	OCTAPLAS BLOOD GROUP AB	145
<i>niacin er (antihyperlipidemic)</i>	52, 53	<i>norlyroc</i>	109	OCTAPLAS BLOOD GROUP B	145
<i>niacor</i>	53	<i>normal saline flush</i>	181	OCTAPLAS BLOOD GROUP O	145
<i>nicardipine hcl</i>	97	NORMOSOL-M IN D5W	179	<i>octreotide acetate</i>	132
NICARDIPINE HCL IN NACL	97	NORMOSOL-R	180	OCUFLOX	204
NICODERM CQ	218	NORMOSOL-R IN D5W	179	ODACTRA	14
NICORETTE	218	NORMOSOL-R PH 7.4	180	ODEFSEY	89
NICORETTE MINI	218	NORPACE	27	ODOMZO	70
NICORETTE STARTER KIT	218	NORPACE CR	27	OFEV	221
NICOTINE	219	NORPRAMIN	39	<i>ofloxacin</i>	135, 204, 209
<i>nicotine</i>	219	<i>nortrel 0.5/35 (28)</i>	106	OGIVRI	66
<i>nicotine mini</i>	218	<i>nortrel 1/35 (21)</i>	106	OGSIVEO	70
<i>nicotine polacrilex</i>	218	<i>nortrel 1/35 (28)</i>	106	OHTUVAYRE	30
<i>nicotine polacrilex mini</i>	218	<i>nortrel 7/7/7</i>	109	OJEMDA	68
<i>nicotine step 1</i>	218	<i>nortriptyline hcl</i>	40	OJJAARA	78
<i>nicotine step 2</i>	218	NORVIR	91	<i>olanzapine</i>	88
<i>nicotine step 3</i>	218	NOURIANZ	82	<i>olanzapine-fluoxetine hcl</i>	220
NICOTROL	219	NOVA SAFETY LANCETS 23G	166	OLINVYK	22
NICOTROL NS	219	NOVA SAFETY LANCETS 28G	166	<i>olmesartan medoxomil</i>	56
<i>nifedipine</i>	97	NOVA SUREFLEX LANCETS	166	<i>olmesartan medoxomil-hctz</i>	55
<i>nifedipine er</i>	97	NOVA SUREFLEX LANCING		<i>olmesartan-amlodipine-hctz</i>	56
<i>nifedipine er osmotic release</i>	97	DEVICE	166	<i>olopatadine hcl</i>	199
<i>nikki</i>	105	NOVAREL	131	OLPRUVA (2 GM DOSE)	132
<i>nilutamide</i>	63	<i>novavax covid-19 vaccine</i>	228	OLPRUVA (3 GM DOSE)	132
<i>nimodipine</i>	97	<i>novite</i>	191	OLPRUVA (4 GM DOSE)	132
NINJACOF-XG	112	NOVOEIGHT	142	OLPRUVA (5 GM DOSE)	132
NINLARO	73	NOVOFINE PEN NEEDLE	175	OLPRUVA (6 GM DOSE)	132
NIPENT	76	NOVOFINE PLUS PEN NEEDLE	175	OLPRUVA (6.67 GM DOSE)	133
NIPRIDE RTU	57	NOVOSEVEN RT	142	OMECLAMOX-PAK	225
<i>nisoldipine er</i>	97	NOXAFIL	49	<i>omega-3-acid ethyl esters</i>	51
<i>nitazoxanide</i>	58	<i>np thyroid</i>	222	OMEGAVEN	202
NITHIODOTE	45	NPLATE	148	<i>omeprazole</i>	224
<i>nitisinone</i>	128	NUBEQA	63	OMIDRIA	208
NITRO-BID	25	NUCALA	30	OMNICAP	191
NITRO-DUR	25, 26	NUCYNTA	22	OMNIFLEX DIAPHRAGM	158
<i>nitrofurantoin</i>	61	NUEDEXTA	217	OMNIPOD 5 DEXG7G6 INTRO GEN	
<i>nitrofurantoin macrocrystal</i>	61	NULIBRY	130	5	171
<i>nitrofurantoin monohyd macro</i>	61	NULOJIX	186	OMNIPOD 5 DEXG7G6 PODS GEN	
<i>nitroglycerin</i>	25, 26	NUMBRINO	199	5	171
NITROGLYCERIN	26	NUPLAZID	85	OMNIPOD 5 LIBRE2 PLUS G6	171
<i>nitroglycerin in d5w</i>	26	NURTEC	178	OMNIPOD 5 LIBRE2 PLUS G6	
NITROLINGUAL	26	NUTRILIPID	202	PODS	171
<i>nitroprusside sodium</i>	57	NUVARING	107	OMNIPOD CLASSIC PODS (GEN 3)	171
<i>nitroprusside sodium-nacl</i>	57	NUVESSA	229	OMNIPOD DASH INTRO (GEN 4)	171
NITROSTAT	26	NUWIQ	142	OMNIPOD DASH PDM (GEN 4)	171
NITYR	128	NUZYRA	221	OMNIPOD DASH PODS (GEN 4)	171
<i>niva thyroid</i>	222	<i>nyamyc</i>	114	ONCASPAR	75
NIVA-PLUS	194	<i>nylia 1/35</i>	106	<i>once daily</i>	191
NIVESTYM	148	<i>nylia 7/7/7</i>	109	<i>ondansetron</i>	47
<i>nizatidine</i>	224	NYMALIZE	97	<i>ondansetron hcl</i>	47
NOCDURNA	133	<i>nystatin</i>	49, 114, 186	<i>one daily</i>	191
<i>nora-be</i>	109	<i>nystatin-triamcinolone</i>	114	<i>one daily essential</i>	191
<i>norelgestromin-eth estradiol</i>	106	<i>nystop</i>	115	<i>one daily essentials</i>	191
<i>norethin ace-eth estrad-fe</i>	105, 106	OB COMPLETE	194	<i>one daily multivitamin adult</i>	191
<i>norethindrone</i>	109	OB COMPLETE ONE	194	<i>one daily multivitamin/iron</i>	190
<i>norethindrone acetate</i>	213	OB COMPLETE PETITE	194	ONE VITE DAILY MULTIVITAMIN	191
<i>norethindrone acet-ethinyl est</i>	106	OB COMPLETE PREMIER	194	ONE VITE WOMENS	194
<i>norethindrone-eth estradiol</i>	134	OB COMPLETE/DHA	194	ONE VITE WOMENS PLUS	194
<i>norethindron-ethinyl estrad-fe</i>	109	<i>obizur</i>	142	<i>one-daily multi vitamins</i>	191
<i>norethin-eth estradiol-fe</i>	106	OCALIVA	135	<i>one-daily multi-vitamin</i>	191
<i>norgesic</i>	198	<i>ocella</i>	106	<i>one-daily multi-vitamin/iron</i>	190

<i>one-daily/iron</i>	190	OTOVEL	209	<i>pamidronate disodium</i>	126
ONELAX MAGNESIUM CITRATE ..	153	OTREXUP	15	PAMIDRONATE DISODIUM	126
ONETOUCH DELICA PLUS		OVIDE	122	PANCREAZE	124
LANCET30G	166	OVIDREL	131	PANHEMATIN	144
ONETOUCH DELICA PLUS		<i>oxacillin sodium</i>	213	PANRETIN	115
LANCET33G	166	OXACILLIN SODIUM IN		<i>pantoprazole sodium</i>	224
ONETOUCH DELICA PLUS		DEXTROSE	213	<i>pantoprazole sodium-nacl</i> ..	224
LANCING	166	<i>oxaliplatin</i>	62	PARADIGM REAL-TIME	
ONETOUCH DELICA SAFETY		<i>oxaprozin</i>	18	TRANSMITTER	166
LANCING	166	<i>oxazepam</i>	27	PARAGARD INTRAUTERINE	
ONETOUCH ULTRA	124	<i>oxcarbazepine</i>	35	COPPER	107
ONETOUCH ULTRA BLUE TEST ...	124	<i>oxcarbazepine er</i>	34, 35	<i>paraplatin</i>	62
ONETOUCH ULTRA TEST	124	OXERVATE	205	<i>paricalcitol</i>	129
ONETOUCH ULTRASOFT 2		<i>oxiconazole nitrate</i>	120	PARLODEL	83
LANCETS	166	OXISTAT	120	PARNATE	37
ONETOUCH VERIO	124	OXLUMO	140	<i>paroxetine hcl</i>	38
ONGENTYS	84	<i>oxybutynin chloride</i>	225	<i>paroxetine hcl er</i>	38
ONIVYDE	81	<i>oxybutynin chloride er</i>	225	<i>paroxetine mesylate</i>	220
ONPATTRO	217	<i>oxycodone hcl</i>	22	PARSABIV	126
ONTRUZANT	67	OXYCODONE-ACETAMINOPHEN ..	23	PAVBLU	209
ONUREG	64	<i>oxycodone-acetaminophen</i>	23	PAXIL	38
<i>opcicon one-step</i>	107	<i>oxymorphone hcl</i>	22	PAXLOVID (150/100)	92
OPDIVO	67	<i>oxymorphone hcl er</i>	22	PAXLOVID (300/100)	92
OPDUALAG	65	<i>oxytocin</i>	210	<i>pazopanib hcl</i>	72
OPFOLDA	127	OZEMPIC (0.25 OR 0.5 MG/DOSE) ...	42	PC UNIFINE PENTIPS	175
OPILL	109	OZEMPIC (1 MG/DOSE)	42	PEDIAPRED	110
OPSUMIT	100	OZEMPIC (2 MG/DOSE)	43	PEDIARIX	223
OPSYNVI	99	OZURDEX	207	PEDMARK	80
<i>option 2</i>	107	<i>pacerone</i>	27	PEDVAX HIB	226
OPTIONS GYNOL II		<i>paclitaxel</i>	79	<i>peg 3350</i>	152, 153
CONTRACEPTIVE	229	PACLITAXEL PROTEIN-BOUND		<i>peg 3350-kcl-na bicarb-nacl</i> ..	152
OPVEE	46	PART	79	<i>peg-3350/electrolytes</i>	152
OPZELURA	117	PADCEV	67	<i>peg-3350/electrolytes/ascorbat</i> ..	152
ORABLOC	155	PALFORZIA (12 MG DAILY DOSE) ..	14	PEGASYS	93
ORALAIR	14	PALFORZIA (120 MG DAILY		<i>peg-kcl-nacl-nasulf-na asc-c</i> ..	152
<i>oralone</i>	188	DOSE)	14	PEG-PREP	152
ORAPRED ODT	110	PALFORZIA (160 MG DAILY		PEMAZYRE	70
ORAVIG	186	DOSE)	14	<i>pemetrexed</i>	64
ORBACTIV	59	PALFORZIA (20 MG DAILY DOSE) ..	14	<i>pemetrexed dipotassium</i>	64
ORENITRAM	100	PALFORZIA (200 MG DAILY		<i>pemetrexed disodium</i>	64
ORENITRAM MONTH 1	100	DOSE)	14	<i>pemetrexed ditromethamine</i> ..	64
ORENITRAM MONTH 2	100	PALFORZIA (240 MG DAILY		PEMFEXY	64
ORENITRAM MONTH 3	100	DOSE)	14	PEMGARDA	210
ORFADIN	128	PALFORZIA (3 MG DAILY DOSE) ...	14	PEMRYDI RTU	64
ORGOVYX	77	PALFORZIA (300 MG		<i>pen needle/5-bevel tip</i>	175
ORIAHNN	134	MAINTENANCE)	14	PEN NEEDLES	175
ORLISSA	128	PALFORZIA (300 MG TITRATION) ..	14	PEN NEEDLES 5/16"	175
ORKAMBI	220	PALFORZIA (40 MG DAILY DOSE) ..	14	PENBRAYA	226
ORLADEYO	144	PALFORZIA (6 MG DAILY DOSE) ...	14	<i>penciclovir</i>	116
<i>orlistat</i>	13	PALFORZIA (80 MG DAILY DOSE) ..	14	<i>penicillamine</i>	182
Ormalvi	124	PALFORZIA INITIAL ESCALATION	14	PENICILLIN G POT IN DEXTROSE	212
<i>orphenadrine citrate</i>	197	PALINGEN FLOW	122	<i>penicillin g potassium</i>	212
<i>orphenadrine citrate er</i>	197	PALINGEN HYDROMEMBRANE	123	<i>penicillin g sodium</i>	212
ORPHENADRINE-ASPIRIN-		PALINGEN INOVOFLO	123	<i>penicillin v potassium</i>	212
CAFFEINE	198	PALINGEN MEMBRANE	123	PENTACEL	223
<i>orphengesic forte</i>	198	PALINGEN XPLUS		PENTAM	58
ORSERDU	81	HYDROMEMBRANE	123	<i>pentamidine isethionate</i>	58
ORTHOVISC	199	PALINGEN XPLUS MEMBRANE	123	PENTASA	137
<i>oseltamivir phosphate</i>	94	<i>paliperidone er</i>	85	<i>pentazocine-naloxone hcl</i>	23
<i>osmitrol</i>	125	PALONOSETRON HCL	47	PENTIPS	175
OSMOLEX ER	83	<i>palonosetron hcl</i>	47	PENTIPS GENERIC PEN NEEDLES	175
OSPHENA	132	PALYNZIQ	131	<i>pentobarbital sodium</i>	150
OTEZLA	18	PAMELOR	40	<i>pentoxifylline er</i>	144

PEPCID	224	<i>pimozide</i>	217	POTASSIUM PHOSPHATES(71	
PERFECT LANCETS 28G	166	<i>pimtree</i>	103	MEQ K)	180
PERFECT LANCETS 30G	166	<i>pindolol</i>	95	POTELIGEO	65
PERFECT POINT SAFETY		<i>pioglitazone hcl</i>	45	<i>pramipexole dihydrochloride</i>	84
LANCETS	166	<i>pioglitazone hcl-glimepiride</i>	44	<i>pramipexole dihydrochloride er</i>	84
PERFOROMIST	29	<i>pioglitazone hcl-metformin hcl</i>	45	PRAMOSONE	122
PERIDEX	186	PIP LANCETS 28G	166	PRAMOTIC	209
PERIKABIVEN	202	PIP LANCETS 30G	166	<i>prasugrel hcl</i>	145
<i>perindopril erbumine</i>	54	<i>pip pen needles 31g x 5mm</i>	175	<i>pravastatin sodium</i>	52
<i>periogard</i>	186	<i>pip pen needles 32g x 4mm</i>	175	PRAXBIND	46
PERJETA	67	<i>piperacillin sod-tazobactam so</i>	212	<i>praziquantel</i>	25
<i>permethrin</i>	122	PIQRAY (200 MG DAILY DOSE)	80	<i>prazosin hcl</i>	57
<i>perphenazine</i>	87	PIQRAY (250 MG DAILY DOSE)	80	PRECEDEX	151
<i>perphenazine-amitriptyline</i>	217	PIQRAY (300 MG DAILY DOSE)	80	PRECISION SURE-DOSE SYRINGE	175
PERSERIS	85	<i>pirfenidone</i>	221	PRED MILD	207
PERTZYE	124	<i>piroxicam</i>	18	<i>prednisolone</i>	110
PFIZER COVID-19 VAC-TRIS 5-11Y		PITOCIN	210	<i>prednisolone acetate</i>	207
.....	228	PLASMA-LYTE A	180	<i>prednisolone sodium phosphate</i> ..	110, 111
<i>pfizer covid-19 vac-tris 6m-4y</i>	228	PLEGRIDY	215	PREDNISOLONE SODIUM	
<i>pfizerpen</i>	212	PLEGRIDY STARTER PACK	215	PHOSPHATE	207
PHARMACIST CHOICE LANCETS	166	<i>plenamine</i>	201	<i>prednisone</i>	111
PHARMACY COUNTER LANCETS	166	PLENVU	152	PREDNISONE INTENSOL	111
PHEBURANE	133	<i>plerixafor</i>	146	PREFERRED PLUS INSULIN	
<i>phendimetrazine tartrate</i>	12	PLUVICTO	75	SYRINGE	175
PHENDIMETRAZINE TARTRATE		PNEUMOVAX 23	226	PREFERRED PLUS LANCETS	
ER	12	<i>pnv prenatal plus multivit+dha</i>	194	COLOR	166
<i>phenelzine sulfate</i>	37	PNV TABS 20-1	194	PREFERRED PLUS LANCETS THIN	
PHENERGAN	50	<i>pnv-dha</i>	196	.....	166
<i>phenobarbital</i>	150	PNV-DHA+DOCUSATE	196	PREFERRED PLUS UNIFINE	
<i>phenobarbital sodium</i>	150	PNV-OMEGA	194	PENTIPS	175
<i>phenoxybenzamine hcl</i>	55	<i>pnv-select</i>	194	<i>pregabalin</i>	35
<i>phentermine hcl</i>	12	<i>podofilox</i>	120	<i>pregabalin er</i>	217
<i>phentolamine mesylate</i>	55	POLIVY	66	PREGEN DHA	196
<i>phenylephrine hcl</i>	203	<i>polocaine</i>	155	PREGENNA	194
PHENYLEPHRINE HCL		<i>polocaine-mpf</i>	155	PREGNYL	131
(PRESSORS)	231	<i>polycin</i>	204	PREMARIN	134, 230
<i>phenylephrine hcl (pressors)</i>	231	<i>polyethylene glycol 3350</i>	153	PREMASOL	201
PHENYTEK	36	<i>polymyxin b sulfate</i>	60	PREMESISRX	196
<i>phenytoin</i>	36	<i>polymyxin b-trimethoprim</i>	204	PREMPHASE	134
<i>phenytoin infatabs</i>	36	POLY-TUSSIN AC	112	PREMPRO	134
<i>phenytoin sodium</i>	36	POLY-VI-FLOR	192	<i>prena 1 true</i>	196
<i>phenytoin sodium extended</i>	36	POLY-VI-FLOR/IRON	192	<i>prena1</i>	196
PHESGO	75	POMALYST	71	PRENA1 PEARL	194
PHEXXI	230	POMBILITI	128	PRENAISSANCE	196
<i>philith</i>	106	PONVORY	219	PRENAISSANCE PLUS	196
<i>phillips milk of magnesia</i>	153	PONVORY STARTER PACK	219	PRENATAL	194
<i>phospha 250 neutral</i>	180	<i>portia-28</i>	106	PRENATAL (W/IRON & FA)	194
PHOSPHOLINE IODIDE	203	PORTRAZZA	69	PRENATAL 19	194
<i>phosphorous</i>	180	<i>posaconazole</i>	50	<i>prenatal 19</i>	194
<i>phospho-trin 250 neutral</i>	180	POSFREA	47	PRENATAL COMPLETE	194
<i>phospho-trin k500</i>	180	POSIMIR	155	PRENATAL FORTE	194
PHOTOFRIN	75	POTASSIUM ACETATE	181	PRENATAL MULTIVITAMIN +	
PHOTREXA-PHOTREXA VISCOUS		POTASSIUM CHLORIDE	181	DHA	196
KIT	206	<i>potassium chloride</i>	181	PRENATAL ONE DAILY	194
PHOXILLUM B22K4/0	182	<i>potassium chloride crys er</i>	181	PRENATAL PLUS	194
PHOXILLUM BK4/2.5	182	<i>potassium chloride er</i>	181	PRENATAL PLUS	
<i>physiolyte</i>	184	POTASSIUM CHLORIDE IN NACL	180	VITAMIN/MINERAL	194
<i>physiosol irrigation</i>	184	<i>potassium chloride in nacl</i>	180	PRENATAL VITAMIN AND	
<i>phytonadione</i>	231	<i>potassium citrate er</i>	139	MINERAL	194
PIASKY	143	<i>potassium cl in dextrose 5%</i>	179	<i>prenatal vitamins</i>	194
PIFELTRO	91	POTASSIUM PHOSPHATES	180	PRENATAL VITAMINS	194
<i>pilocarpine hcl</i>	187, 203	<i>potassium phosphates</i>	180	PRENATAL/IRON	194, 195
<i>pimecrolimus</i>	120	<i>potassium phosphates(66 meq k)</i>	180	PRENATAL-U	195

PRENATE.....	196	<i>proctosol hc</i>	25	<i>pyridostigmine bromide</i>	62
PRENATE AM.....	197	<i>proctozone-hc</i>	25	<i>pyridostigmine bromide er</i>	61
PRENATE DHA.....	196	PROCYSBI.....	139	<i>pyrimethamine</i>	61
PRENATE ELITE.....	195	PRODIGY INSULIN SYRINGE.....	175	PYRUKYND.....	145
PRENATE ENHANCE.....	196	PRODIGY LANCETS 28G.....	166	PYRUKYND TAPER PACK.....	145
PRENATE ESSENTIAL.....	196	PRODIGY LANCING DEVICE.....	167	QBRELIS.....	54
PRENATE MINI.....	196	PRODIGY SAFETY LANCETS 26G.....	167	QBREXZA.....	121
PRENATE PIXIE.....	196	PRODIGY TWIST TOP LANCETS		<i>qc advanced lancng device</i>	167
PRENATE RESTORE.....	196	28G.....	167	<i>qc aspirin low dose</i>	20
PRENATRIX.....	195	PROFILNINE.....	142	<i>qc b50 prolonged release</i>	190
PRENATRYL.....	195	<i>progesterone</i>	213	<i>qc b-complex/vitamin c</i>	188
PREPIDIL.....	210	PROGLYCEM.....	41	<i>qc childrens aspirin</i>	20
PRESTALIA.....	53	PROGRAF.....	184, 185	<i>qc daily multivitamins/iron</i>	190
PRETOMANID.....	62	PROLASTIN-C.....	220	<i>qc essentials</i>	191
<i>prevalite</i>	51	PROLEUKIN.....	75	<i>qc folic acid</i>	147
PREVDUO.....	45	PROLIA.....	131	<i>qc gentle laxative</i>	154
PREVENT DROPSAFE PEN		PROMACTA.....	148	<i>qc gentle laxative womens</i>	154
NEEDLES.....	175	<i>promethazine hcl</i>	50	QC LANCETS SUPER THIN 30G.....	167
PREVENT SAFETY PEN NEEDLES.....	175	<i>promethazine vc</i>	112	QC LANCETS ULTRA THIN.....	167
PREVIDENT.....	187	<i>promethazine-codeine</i>	112	<i>qc laxative</i>	154
PREVIDENT 5000 BOOSTER PLUS.....	187	<i>promethazine-dm</i>	112	<i>qc magnesium citrate</i>	153
PREVIDENT 5000 DRY MOUTH.....	187	<i>promethazine-phenylephrine</i>	112	<i>qc milk of magnesia</i>	153
PREVIDENT 5000 ENAMEL		<i>promethegan</i>	50, 51	<i>qc natura-lax</i>	153
PROTECT.....	187	<i>propafenone hcl</i>	27	<i>qc nicotine transdermal system</i>	219
PREVIDENT 5000 KIDS.....	187	<i>propafenone hcl er</i>	27	QC PEN NEEDLES.....	175
PREVIDENT 5000 ORTHO		<i>proparacaine hcl</i>	205	QC PRENATAL.....	195
DEFENSE.....	187	PROPECIA.....	123	QC UNIFINE PENTIPS.....	175
PREVIDENT 5000 PLUS.....	187	PROPEL.....	199	QC UNILET LANCETS 28G.....	167
PREVIDENT 5000 SENSITIVE.....	187	PROPEL MINI.....	199	QC UNILET LANCETS MICRO	
PREVNAR 20.....	226	PROPEL MINI SDS.....	199	THIN.....	167
PREVYMIS.....	92	<i>propofol</i>	138	QDOLO.....	22
PREZISTA.....	91	<i>propranolol hcl</i>	95	QINLOCK.....	72
PRIFTIN.....	62	<i>propranolol hcl er</i>	95	QUADRACEL.....	223
PRIMACARE.....	195	<i>propylthiouracil</i>	222	QUALAQUIN.....	61
PRIMAQUINE PHOSPHATE.....	61	PROQUAD.....	227	<i>quazepam</i>	151
PRIMAXIN IV.....	58	PRO-RED AC.....	112	QUDEXY XR.....	35
<i>primidone</i>	35	PROSCAR.....	139	QUELICIN.....	200
PRIORIX.....	227	PROSOL.....	201	QUESTRAN.....	51
PRISMASOL B22GK 4/0.....	182	PROSTIN VR.....	185	QUESTRAN LIGHT.....	51
PRISMASOL BGK 0/2.5.....	182	<i>protamine sulfate</i>	145	<i>quetiapine fumarate</i>	86
PRISMASOL BGK 2/0.....	182	PROTONIX.....	224	<i>quetiapine fumarate er</i>	86
PRISMASOL BGK 2/3.5.....	182	PROTOPAM CHLORIDE.....	46	QUFLORA FE.....	190
PRISMASOL BGK 4/0/1.2.....	183	<i>protriptyline hcl</i>	40	QUFLORA FE PEDIATRIC.....	192
PRISMASOL BGK 4/2.5.....	183	PROVAYBLUE.....	46	QUFLORA PEDIATRIC.....	192
PRISMASOL BK 0/0/1.2.....	183	PROVERA.....	213	<i>quin b strong b-25</i>	190
PRO COMFORT INSULIN SYRINGE		PROVIDA OB.....	195	<i>quinapril hcl</i>	54
.....	175	PROVISC.....	208	<i>quinapril-hydrochlorothiazide</i>	54
PRO COMFORT LANCETS 30G.....	166	<i>pseudoeph-bromphen-dm</i>	112	<i>quinidine gluconate er</i>	27
PRO COMFORT LANCETS 31G.....	166	Pulmosal.....	112	<i>quinidine sulfate</i>	27
PRO COMFORT PEN NEEDLES.....	175	PULMOZYME.....	220	<i>quinine sulfate</i>	61
<i>pro comfort safety lancets 30g</i>	166	PURE COMFORT LANCETS 30G.....	167	QUINTABS.....	191
PROAIR RESPICLICK.....	29	PURE COMFORT PEN NEEDLE.....	175	QULIPTA.....	178
<i>probenecid</i>	141	<i>pure comfort safety pen needle</i>	175	QUVIVIQ.....	151
<i>procainamide hcl</i>	27	PURIXAN.....	64	QUZYTIR.....	50
PROCARDIA XL.....	97, 98	<i>px advanced lancng device</i>	167	QVAR REDIHALER.....	31
<i>procentra</i>	11	PX EXTRA SHORT PEN NEEDLES.....	175	<i>ra aspirin adult low dose</i>	20
<i>prochlorperazine</i>	87	PX INSULIN SYRINGE.....	175	<i>ra aspirin adult low strength</i>	20
<i>prochlorperazine edisylate</i>	87	PX LANCETS MICROTHIN 33G.....	167	<i>ra aspirin childrens</i>	20
<i>prochlorperazine maleate</i>	87	PX LANCETS ULTRA THIN 28G.....	167	<i>ra aspirin ec</i>	20
PROCRIT.....	147	PX MINI PEN NEEDLES.....	175	<i>ra aspirin ec adult low st</i>	20
PROCTOCORT.....	25	PX PEN NEEDLE.....	175	<i>ra balanced b-100</i>	190
PROCTOFOAM HC.....	25	PYLERA.....	225	<i>ra balanced b-100 cr</i>	190
<i>procto-med hc</i>	25	<i>pyrazinamide</i>	62	<i>ra balanced b-50</i>	190

<i>ra balanced b-50 tr</i>	190	REGONOL.....	62	RIASTAP.....	142
<i>ra b-complex</i>	188	REGRANEX.....	123	<i>ribavirin</i>	93, 94
<i>ra b-complex with b-12</i>	188	RELENZA DISKHALER.....	94	RIDAURA.....	16
RA E-ZJECT LANCETS 28G.....	167	RELEUKO.....	148	<i>rifabutin</i>	62
RA E-ZJECT LANCETS THIN 26G.....	167	RELION INSULIN SYRINGE.....	176	RIFADIN.....	62
RA E-ZJECT LANCETS THIN 28G.....	167	RELION LANCET DEVICES 30G.....	167	<i>rifampin</i>	62
RA E-ZJECT LANCETS ULTRA THIN.....	167	RELION LANCETS.....	167	RIGHTEST ALTERNATE SITE ADAPT.....	167
<i>ra folic acid</i>	147	RELION LANCETS MICRO-THIN 33G.....	167	RIGHTEST GD500 LANCING DEVICE.....	167
RA INSULIN SYRINGE.....	175	RELION LANCETS THIN 26G.....	167	RIGHTEST GL300 LANCETS.....	167
<i>ra laxative</i>	153, 154	RELION LANCETS ULTRA-THIN 30G.....	167	<i>riluzole</i>	200
<i>ra magnesium citrate</i>	153	RELION LANCING DEVICE.....	167	<i>rimantadine hcl</i>	93
<i>ra milk of magnesia</i>	154	RELION MINI PEN NEEDLES.....	176	RIMSO-50.....	140
<i>ra mini nicotine</i>	219	RELION PEN NEEDLES.....	176	<i>ringers</i>	180
<i>ra nicotine</i>	219	RELION SHORT PEN NEEDLES.....	176	<i>ringers irrigation</i>	184
<i>ra nicotine gum</i>	219	RELION ULTRA THIN LANCETS 30G.....	167	RINVOQ.....	15
<i>ra nicotine polacrilex</i>	219	RELION ULTRA THIN PLUS LANCETS.....	167	RINVOQ LQ.....	15
RA PEN NEEDLES.....	175	RELISTOR.....	137, 138	RIOMET.....	40
RA PRENATAL.....	195	RELNATE DHA.....	195	<i>risanoid plus</i>	197
RA PRENATAL FORMULA.....	195	REMERON.....	37	<i>risedronate sodium</i>	126
<i>ra womens laxative</i>	154	REMERON SOLTAB.....	37	<i>risperidone</i>	85, 86
RABAVERT.....	228	REMESENSE.....	158	<i>risperidone microspheres er</i>	85
RADICAVA ORS.....	199	REMICADE.....	138	<i>ritonavir</i>	91
RADICAVA ORS STARTER KIT.....	200	<i>remifentanyl hcl</i>	22	RITUXAN.....	65
RADIOGARDASE.....	46	REMODULIN.....	100	RITUXAN HYCELA.....	75
RAGWITEK.....	14	RENACIDIN.....	139	<i>rivastigmine</i>	214
<i>raloxifene hcl</i>	132	<i>renal vitamin</i>	188	<i>rivastigmine tartrate</i>	214
<i>ramelteon</i>	151	<i>rena-vite</i>	188	<i>rivelsa</i>	108
<i>ramipril</i>	54, 55	RENOVA.....	114	RIVFLOZA.....	140
<i>ranolazine er</i>	25	RENOVA PUMP.....	114	RIXUBIS.....	142
RAPAMUNE.....	185	<i>repaglinide</i>	43	<i>rizatriptan benzoate</i>	178
RAPIVAB.....	94	REPATHA.....	53	ROBAXIN.....	197
<i>rasagiline mesylate</i>	83	REPATHA PUSHTRONEX SYSTEM.....	53	ROBINUL.....	225
RASUVO.....	15	REPATHA SURECLICK.....	53	ROBINUL-FORTE.....	225
RAVICTI.....	133	RESTASIS.....	205	ROCKLATAN.....	205
<i>raya sure pen needle</i>	175	RESTASIS MULTIDOSE.....	205	<i>rocuronium bromide</i>	200
RAYALDEE.....	129	RESTORIL.....	151	<i>roflumilast</i>	30
<i>react</i>	107	RETACRIT.....	147	ROLVEDON.....	148
READYLANCE SAFETY LANCETS.....	167	RETEVMO.....	73	<i>romidepsin</i>	70
REALITY INSULIN SYRINGE.....	176	RETISERT.....	207	<i>ropinirole hcl</i>	84
REALITY LANCETS.....	167	RETROVIR.....	92	<i>ropinirole hcl er</i>	84
REALITY LATEX CONDOMS.....	157	REVCovi.....	126	<i>ropivacaine hcl</i>	155
REALITY LATEX/ULTRA TEXTURED.....	157	REVLIMID.....	184	<i>rosuvastatin calcium</i>	52
REALITY LATEX/ULTRA THIN.....	157	<i>revonto</i>	198	ROTARIX.....	228
REALITY TRIGGER LANCETS.....	167	REXALL LANCETS ULTRA THIN 30G.....	167	ROTATEQ.....	229
REBIF.....	216	REXTOVY.....	46	ROWASA.....	137
REBIF REBIDOSE.....	215	REXULTI.....	88	<i>rowepra</i>	35
REBIF REBIDOSE TITRATION PACK.....	215	REYATAZ.....	91	ROXICODONE.....	22
REBIF TITRATION PACK.....	216	REZDIFFRA.....	136	ROXYBOND.....	22
REBINYN.....	142	REZIPRES.....	231	ROZLYTREK.....	73
REBLOZYL.....	146	REZLIDHIA.....	78	RUBRACA.....	81
REBYOTA.....	137	REZUROCK.....	186	RUCONEST.....	143
RECARBRIO.....	58	REZZAYO.....	48	<i>rufinamide</i>	35
RECLAST.....	126	RHOFADE.....	121	RUKOBIA.....	90
<i>reclipsen</i>	106	RHOGAM ULTRA-FILTERED PLUS.....	211	RUXIENCE.....	65
RECOMBINATE.....	142	.....	211	RYANODEX.....	198
RECOMBIVAX HB.....	228	RHOPHYLAC.....	211	RYBELSUS.....	43
RECOTHROM.....	149	RHOPRESSA.....	206	RYBREVANT.....	73
RECOTHROM SPRAY KIT.....	149	RIABNI.....	65	RYDAPT.....	72
RECTIV.....	25			RYDEX.....	112
REGLAN.....	136			RYLAZE.....	75
				RYPLAZIM.....	145

RYSTIGGO.....	185	<i>sertraline hcl</i>	38	SMART DIABETES VANTAGE	
RYTARY.....	84	<i>setlakin</i>	108	LANCING.....	168
RYTELO.....	80	<i>sevelamer carbonate</i>	138	SMART SENSE COLOR LANCETS	
SAFETY LANCET 30G/PRESSURE		<i>sevelamer hcl</i>	138	33G.....	168
ACT.....	167	SEVENFACT.....	142	SMART SENSE STANDARD	
SAFETY LANCETS.....	167	<i>sevoflurane</i>	139	LANCETS.....	168
SAFETY LANCETS 21G.....	167	SEZABY.....	150	SMART SENSE SUPER THIN	
SAFETY LANCETS 23G.....	167	<i>sf</i>	187	LANCETS.....	168
SAFETY LANCETS 28G.....	167	<i>sf 5000 plus</i>	187	SMART SENSE THIN LANCETS	
<i>safety pen needles</i>	176	SFROWASA.....	137	26G.....	168
SAFYRAL.....	106	<i>sharobel</i>	109	SMARTEST LANCETS 28G.....	168
<i>sajazir</i>	143	SHINGRIX.....	229	SMOFLIPID.....	202
SALAGEN.....	187	SIGNIFOR.....	132	<i>smooth lax</i>	153
<i>saline flush</i>	181	SIGNIFOR LAR.....	132	<i>sod benz-sod phenylacet</i>	133
SANCUSO.....	47	SIKLOS.....	146	SODIUM ACETATE.....	179
SANDIMMUNE.....	183	<i>sildenafil citrate</i>	100, 101	<i>sodium acetate</i>	179
SANDOSTATIN.....	132	<i>silodosin</i>	139	<i>sodium bicarbonate</i>	179
SANDOSTATIN LAR DEPOT.....	132	SILVADENE.....	117	<i>sodium chloride</i>	112, 139, 181
SANTYL.....	119	<i>silver sulfadiazine</i>	117	<i>sodium chloride (pf)</i>	181
SAPHNELO.....	186	SIMBRINZA.....	202	<i>sodium fluoride</i>	180, 187
<i>sapropterin dihydrochloride</i>	131	<i>simliya</i>	103	<i>sodium fluoride 5000 enamel</i>	187
<i>saps health plus lancets</i>	167	<i>simpesse</i>	108	<i>sodium fluoride 5000 plus</i>	187
SAPS HEALTH TWIST TOP		SIMPLE DIAGNOSTICS LANCING		<i>sodium fluoride 5000 ppm</i>	187
LANCETS.....	168	DEV.....	168	<i>sodium fluoride 5000 sensitive</i>	187
SAPS TWIST TOP LANCETS.....	168	SIMPONI.....	16	SODIUM IODIDE I-131.....	222
SAPSCARE TWIST TOP LANCETS.....	168	SIMPONI ARIA.....	16	SODIUM NITRITE.....	46
SARCLISA.....	66	SIMULECT.....	185	<i>sodium nitroprusside</i>	57
SAVELLA.....	214	<i>simvastatin</i>	52	<i>sodium oxybate</i>	213
SAVELLA TITRATION PACK.....	214	SINEMET.....	84	<i>sodium phenylbutyrate</i>	133
SAXENDA.....	12	SINGLE-LET.....	168	<i>sodium phosphates</i>	181
<i>sb bisacodyl laxative ec</i>	154	<i>sirolimus</i>	185	<i>sodium polystyrene sulfonate</i>	185
<i>sb childrens aspirin</i>	20	SIRTURO.....	62	<i>sodium tetradecyl sulfate</i>	186
<i>sb gentle lax-women</i>	154	SIVEXTRO.....	60	SODIUM THIOSULFATE.....	46
SB INSULIN SYRINGE.....	176	SKYCLARYS.....	200	SOHONOS.....	198
SB LANCETS THIN.....	168	SKYLA.....	108	SOLESTA.....	183
SB LANCETS ULTRA THIN.....	168	SKYRIZI.....	115, 137	<i>solifenacin succinate</i>	225
<i>sb low dose asa ec</i>	20	SKYRIZI PEN.....	115	SOLIQUA.....	43
<i>sb magnesium citrate</i>	154	SKYTROFA.....	128	SOLIRIS.....	143
<i>sb milk of magnesia</i>	154	SLYND.....	109	SOLOSEC.....	15
<i>sb polyethylene glycol 3350</i>	153	<i>sm aspirin adult low strength</i>	20	SOLTAMOX.....	63
SCENESSE.....	121	<i>sm aspirin ec low strength</i>	20	SOLU-CORTEF.....	111
<i>scopolamine</i>	48	<i>sm aspirin low dose</i>	20	SOLU-MEDROL.....	111
SECUADO.....	86	<i>sm b super vitamin complex</i>	188	SOLU-MEDROL (PF).....	111
SECURESAFE INSULIN SYRINGE.....	176	<i>sm b100 complex</i>	190	SOLUS V2 LANCETS 28G.....	168
SECURESAFE SAFETY PEN		<i>sm balanced b-100</i>	189	SOLUS V2 LANCING DEVICE.....	168
NEEDLES.....	176	<i>sm balanced b-50</i>	189	SOLUS V2 TWIST LANCETS 30G...	168
<i>select-lite device/lancets</i>	168	<i>sm b-complex</i>	190	SOMATULINE DEPOT.....	132
<i>select-lite lancing device</i>	168	SM B-COMPLEX/VITAMIN C.....	188	SOMAVERT.....	128
SELECT-OB.....	195	<i>sm clearlax</i>	153	SOOLANTRA.....	121
SELECT-OB+DHA.....	196	<i>sm folic acid</i>	147	<i>sorafenib tosylate</i>	72
<i>selegiline hcl</i>	83	<i>sm gentle laxative</i>	154	SORBITOL.....	140
SELENIOS ACID.....	182	SM LANCETS 33G.....	168	SORBITOL-MANNITOL.....	140
<i>selenium sulfide</i>	116	<i>sm milk of magnesia</i>	154	SOTALOL HCL.....	95
SELZENTRY.....	90	<i>sm multiple vitamins essential</i>	191	<i>sotalol hcl</i>	95
SE-NATAL 19.....	195	<i>sm multiple vitamins/iron</i>	190	<i>sotalol hcl (af)</i>	95
<i>sensorcaine</i>	155	<i>sm nicotine</i>	219	SOTRADECOL.....	186
<i>sensorcaine/epinephrine</i>	155	<i>sm nicotine polacrilex</i>	219	<i>sotradecol</i>	186
<i>sensorcaine-mpf</i>	155	SM ONE DAILY PRENATAL.....	195	SOTYLIZE.....	96
<i>sensorcaine-mpf/epinephrine</i>	155	SM PRENATAL VITAMINS.....	195	SPEVIGO.....	115, 116
SENSORCAINE-MPF/EPINEPHRINE		<i>sm super b complex/c</i>	189	SPIKEVAX.....	229
.....	155	SM TRUEDRAW LANCING		<i>spinosad</i>	122
SEREVENT DISKUS.....	29	DEVICE.....	168	SPIRIVA HANDIHALER.....	29
SEROSTIM.....	128	<i>sm vitamin b complex/vitamin c</i>	189	SPIRIVA RESPIMAT.....	29

<i>spironolactone</i>	125	<i>super dec b-100</i>	190	<i>take action</i>	107
<i>spironolactone-hctz</i>	124	<i>super quints b-50</i>	190	TAKHZYRO	144
SPORANOX	50	SUPER THIN LANCETS	168	TALICIA	225
SPRAVATO (56 MG DOSE)	38	SUPPRELIN LA	130	TALTZ	116
SPRAVATO (84 MG DOSE)	38	SUPRANE	139	TALVEY	68
<i>sprintec 28</i>	106	SURE COMFORT INSULIN		TALZENNA	81
SPRITAM	35	SYRINGE	176	TAMIFLU	94
<i>sps (sodium polystyrene sulf)</i>	185	SURE COMFORT LANCETS 18G	168	<i>tamoxifen citrate</i>	63
<i>sronyx</i>	106	SURE COMFORT LANCETS 21G	168	<i>tamsulosin hcl</i>	139
<i>ssd</i>	117	SURE COMFORT LANCETS 23G	168	<i>taperdex 12-day</i>	111
<i>st joseph aspirin</i>	20	SURE COMFORT LANCETS 28G	168	<i>taperdex 6-day</i>	111
<i>st joseph low dose</i>	20	SURE COMFORT LANCETS 30G	168	<i>taperdex 7-day</i>	111
STAMARIL	229	<i>sure comfort lancng pen</i>	168	TARGETIN	123
STELARA	116, 137	SURE COMFORT PEN NEEDLES	176	<i>tarina 24 fe</i>	106
STERILANCE TL	168	<i>sure comfort pen needles</i>	176	<i>tarina fe 1/20 eq</i>	106
<i>sterile water for irrigation</i>	184	<i>surebiotic probiotic support</i>	45	TARON-C DHA	195
STIOLTO RESPIMAT	28	SURELITE LANCETS	168	TARPEYO	111
STIVARGA	72	SURGICEL FIBRILLAR	149	TASIGNA	68
STRAVIX	123	SURGICEL NU-KNIT	150	<i>tasimelteon</i>	151
STRENSIQ	129	SURGICEL SNOW 1"X2"	150	TASMAR	83
<i>streptomycin sulfate</i>	15	SURGICEL SNOW 2"X4"	150	<i>tavaborole</i>	121
<i>stress b complex/iron</i>	190	SURGICEL SNOW 4"X4"	150	TAVALISSE	145
<i>stress formula</i>	191	SUSTOL	47	TAVNEOS	143
<i>stress formula (folic acid)</i>	188	SUSVIMO (IMPLANT 1ST FILL)	209	<i>taysofy</i>	106
<i>stress formula/iron</i>	190	SUSVIMO (IMPLANT REFILL)	209	TAYTULLA	106
<i>stress formula/zinc/energy</i>	192	SUTAB	152	<i>tazarotene</i>	116
<i>stresstabs energy</i>	192	SUTENT	73	<i>tazicef</i>	103
STRIBILD	89	<i>syeda</i>	106	TAZICEF	103
STRIVERDI RESPIMAT	29	SYFOVRE	204	TAZORAC	116
STROMECTOL	25	SYLVANT	184	TAZVERIK	71
STRONTIUM CHLORIDE SR-89	75	SYMBYAX	220	TDVAX	223
SUBLOCADE	23	SYMDEKO	220	TECENTRIQ	67
<i>subvenite</i>	35	SYMLINPEN 120	40	TECENTRIQ HYBREZA	75
<i>subvenite starter kit-blue</i>	35	SYMLINPEN 60	40	TECHLITE AST LANCETS	168
<i>subvenite starter kit-green</i>	35	SYMPAZAN	33	TECHLITE INSULIN SYRINGE	176
<i>subvenite starter kit-orange</i>	35	SYMPROIC	138	TECHLITE LANCETS	168
SUCCINYLCHOLINE CHLORIDE	200	SYMTUZA	90	TECHLITE LANCETS 26G	168
SUCRAID	124	SYNAGIS	210	TECHLITE PEN NEEDLES	176
<i>sucralfate</i>	224	SYNAREL	130	TECHLITE PLUS PEN NEEDLES	176
SUFENTANIL CITRATE	23	SYNDROS	48	TECVAYLI	68
SULAR	98	SYNJARDY	43	TEFLARO	103
<i>sulconazole nitrate</i>	120	SYNJARDY XR	44	TEGLUTIK	200
<i>sulfacetamide sodium</i>	207	SYNOJOYNT	199	<i>telmisartan</i>	56
<i>sulfacetamide sodium (acne)</i>	113	SYNTHROID	222	<i>telmisartan-amlodipine</i>	55
<i>sulfacetamide-prednisolone</i>	206	SYNVISC	199	<i>telmisartan-hctz</i>	55
<i>sulfadiazine</i>	221	SYNVISC ONE	199	<i>temazepam</i>	151
<i>sulfamethoxazole-trimethoprim</i>	58	SYRINGE AVITENE	150	TEMBEXA	93
SULFAMYLON	117	<i>tab-a-vite</i>	192	TEMODAR	77
<i>sulfasalazine</i>	137	<i>tab-a-vite/beta carotene</i>	192	<i>temozolomide</i>	77
<i>sulfatrim pediatric</i>	58	<i>tab-a-vite/iron</i>	190	<i>temsirolimus</i>	72
<i>sulindac</i>	18	TAB-A-VITE/IRON/BETA		<i>tencon</i>	19
<i>sumatriptan</i>	178	CAROTENE	190	TENIVAC	223
<i>sumatriptan succinate</i>	178	TABLOID	64	<i>tenofovir disoproxil fumarate</i>	92
<i>sumatriptan succinate refill</i>	178	TABRECTA	71	TENORETIC 100	57
<i>sunitinib malate</i>	72	TACHOSIL	150	TENORETIC 50	57
SUNLENCA	90	TACLONEX	123	TEPADINA	62
SUNOSI	12	<i>tacrolimus</i>	121, 185	TEPEZZA	129
SUPARTZ FX	199	<i>tadalafil</i>	101	TEPMETKO	71
<i>super b complex/fa/vit c</i>	188	<i>tadalafil (pah)</i>	101	<i>terazosin hcl</i>	57
<i>super b complex/vitamin c</i>	189	TADLIQ	101	<i>terbinafine hcl</i>	49
<i>super b-complex</i>	190	TAFINLAR	68	<i>terbutaline sulfate</i>	29
<i>super b-complex + vitamin c</i>	189	<i>tafluprost (pf)</i>	208	<i>terconazole</i>	229
<i>super b-complex/vit c/fa</i>	188	TAGRISSO	69	<i>teriflunomide</i>	215

<i>teriparatide</i>	131	<i>tiotropium bromide monohydrate</i>	29	<i>trandolapril</i>	55
TERIPARATIDE	131	<i>tirofiban hcl in nacl</i>	144	<i>trandolapril-verapamil hcl er</i>	53
TERLIVAZ	133	TIROSINT	222	<i>tranexamic acid</i>	149
<i>terrell</i>	139	TIROSINT-SOL	222	TRANEXAMIC ACID-NACL	149
TESTOPEL	24	TISSEEL	149	<i>tranylecypromine sulfate</i>	37
<i>testosterone</i>	24	TISSUEBLUE	208	TRAVASOL	201
<i>testosterone cypionate</i>	24	<i>tis-u-sol</i>	184	TRAVEL LANCETS ADVANCED	
<i>testosterone enanthate</i>	24	TIVDAK	67	28G	169
TETANUS-DIPHThERIA TOXOIDS		TIVICAY	90	<i>travoprost (bak free)</i>	208
TD	223	TIVICAY PD	90	TRAZIMERA	67
<i>tetrabenazine</i>	215	<i>tizanidine hcl</i>	197, 198	<i>trazodone hcl</i>	38
<i>tetracaine hcl</i>	205	<i>tm-daily vite</i>	192	TREANDA	62
<i>tetracycline hcl</i>	222	TNKASE	146	TRECTOR	62
TEVIMBRA	67	TOBI PODHALER	15	TRELEGY ELLIPTA	28
TEZSPIRE	31	TOBRADEX	206	TRELSTAR MIXJECT	79
TGT LANCET MICRO THIN 33G	168	TOBRADEX ST	207	TREMFYA	116
TGT LANCET THIN 26G	168	<i>tobramycin</i>	15, 204	<i>treprostinil</i>	100
TGT LANCET ULTRA THIN 30G	168	<i>tobramycin sulfate</i>	15	TRESIBA	42
<i>tgt lancing device</i>	168	<i>tobramycin-dexamethasone</i>	207	TRESIBA FLEXTOUCH	42
THALITONE	125	TOBREX	204	<i>tretinoin</i>	81, 113
THALOMID	182	TODAY SPONGE	229	<i>tretinoin microsphere</i>	113
THAM	179	<i>today's health lancing device</i>	168	<i>tretinoin microsphere pump</i>	113
THE LIQUILIFT TRACE	181	TODAYS HEALTH PEN NEEDLES	176	TRETTEN	142
THEO-24	31	TODAYS HEALTH SHORT PEN		TREXALL	64
<i>theophylline</i>	31	NEEDLE	176	<i>trezix</i>	20
<i>theophylline er</i>	31	TODAYS HEALTH THIN LANCETS		<i>triamcinolone acetonide</i>	119, 188
THERA	192	28G	168	<i>triamcinolone in absorbase</i>	119
<i>thera-tabs</i>	192	TODAYS HEALTH THIN LANCETS		<i>triamterene</i>	125
THEREMS	192	30G	169	<i>triamterene-hctz</i>	124
<i>thiamine hcl</i>	231	TOLAK	115	<i>triazolam</i>	151
<i>thioridazine hcl</i>	87	<i>tolcapone</i>	83	TRICARE	195
<i>thiotepa</i>	62	<i>tolmetin sodium</i>	18	TRICOR	52
<i>thiothixene</i>	88	TOLSURA	50	Tridacaine Ii	120
<i>thrive</i>	219	<i>tolterodine tartrate</i>	225	Tridacaine Iii	120
THRIVITE RX	195	<i>tolterodine tartrate er</i>	225	<i>triderm</i>	119
THROMBATE III	145	<i>tolvaptan</i>	132	<i>trientine hcl</i>	182
THROMBI-GEL 10	149	TOPCARE CLICKFINE PEN		TRIESENCE	207
THROMBI-GEL 100	149	NEEDLES	176	<i>tri-estarylla</i>	109
THROMBI-GEL 40	149	TOPCARE LANCETS MICRO-THIN		<i>trifluoperazine hcl</i>	87
THROMBIN-JMI	150	33G	169	<i>trifluridine</i>	204
THROMBIN-JMI EPISTAXIS	150	TOPCARE ULTRA COMFORT INS		<i>trihexyphenidyl hcl</i>	83
THROMBI-PAD	149	SYR	176	TRIJARDY XR	43
THROMBOGEN	150	<i>topiramate</i>	35	TRIKAFTA	220
THYMOGLOBULIN	183	<i>topiramate er</i>	35	<i>tri-legest fe</i>	109
THYQUIDITY	222	TOPOTECAN HCL	81	<i>tri-linyah</i>	109
<i>thyroid</i>	222	<i>topotecan hcl</i>	81	<i>tri-lo-estarylla</i>	109
<i>tiadylt er</i>	98	<i>toremifene citrate</i>	63	<i>tri-lo-marzia</i>	109
<i>tiagabine hcl</i>	36	TORISEL	72	<i>tri-lo-mili</i>	109
TIAZAC	98	Torpenz	72	<i>tri-lo-sprintec</i>	109
TIBSOVO	78	<i>torse mide</i>	125	TRI-LUMA	119
TICE BCG	76	TOTALVISC	208	TRILURON	199
TICOVAC	229	TOUJEO MAX SOLOSTAR	42	<i>trimethobenzamide hcl</i>	48
TIGAN	48	TOUJEO SOLOSTAR	42	TRIMETHOPRIM	58
TIGECYCLINE	221	<i>tovet</i>	119	<i>tri-mili</i>	109
<i>tilia fe</i>	109	TPN ELECTROLYTES	180	<i>trimipramine maleate</i>	40
<i>timolol hemihydrate</i>	202	TPOXX	93, 94	TRINATAL RX 1	195
<i>timolol maleate</i>	96, 202	TRACLEER	100	<i>trinate</i>	195
<i>timolol maleate (once-daily)</i>	202	TRALEMENT	181	TRINTELLIX	38
<i>timolol maleate ocudose</i>	202	TRAMADOL HCL	23	TRIPTODUR	130
<i>timolol maleate pf</i>	202	<i>tramadol hcl</i>	23	TRISENOX	76
TIMOPTIC OCUDOSE	202	<i>tramadol hcl (er biphasic)</i>	23	<i>tri-sprintec</i>	109
<i>tinidazole</i>	58	<i>tramadol hcl er</i>	23	TRISTART DHA	196
<i>tiopronin</i>	140	<i>tramadol-acetaminophen</i>	24	TRIUMEQ	90

TRIUMEQ PD.....	90	TRUSTEX LUBRICATED EXTRA		ULTRA FLO INSULIN PEN	
TRI-VI-FLOR.....	192	ST.....	158	NEEDLES.....	177
TRI-VI-FLORO.....	192	TRUSTEX		ULTRA FLO INSULIN SYR 1/2	
<i>tri-vite/fluoride</i>	193	LUBRICATED/SPERMICIDE.....	158	UNIT.....	177
<i>trivora (28)</i>	109	TRUSTEX NATURAL CONDOMS +		ULTRA FLO INSULIN SYRINGE.....	177
<i>tri-vylibra</i>	109	LUBE.....	158	ULTRA THIN LANCETS 31G.....	169
<i>tri-vylibra lo</i>	109	TRUSTEX NON-LUBRICATED.....	158	ULTRA THIN PEN NEEDLES.....	177
TRODELVY.....	81	TRUSTEX RIA LUB/SPERMICIDE..	158	ULTRACARE INSULIN SYRINGE..	177
TROGARZO.....	90	TRUSTEX RIA LUBRICATED.....	158	ULTRA-CARE LANCETS 30G.....	169
TROJAN ENZ.....	157	TRUSTEX RIA NON-LUBRICATED	158	ULTRACARE PEN NEEDLES.....	177
TROJAN MAGNUM.....	157	TRUSTEX-NONOXYNOL-		ULTRAFOAM SPONGE	
TROJAN ULTRA RIBBED		9/RIB/STUD.....	158	2X6.25X7CM.....	150
LUBRICATED.....	157	TRUXIMA.....	65	ULTRAFOAM SPONGE	
TROJAN ULTRA THIN.....	158	TUKYSA.....	67	8X12.5X1CM.....	150
TROJAN ULTRA		TURALIO.....	73	ULTRAFOAM SPONGE	
THIN/SPERMICIDAL.....	158	TURPENTINE.....	120	8X12.5X3CM.....	150
TROJAN-ENZ LUBRICATED.....	158	Turqoz.....	106	ULTRAFOAM SPONGE 8X25X1CM	150
TROJAN-ENZ/SPERMICIDAL.....	158	TUSNEL C.....	112	ULTRAFOAM SPONGE	
TROPHAMINE.....	201	TUXARIN ER.....	112	8X6.25X1CM.....	150
<i>tropicamide</i>	203	TWINRIX.....	227	ULTRA-THIN II AUTO LANCET....	169
<i>tropium chloride</i>	226	TWIRLA.....	106	ULTRA-THIN II INS SYR SHORT....	177
<i>tropium chloride er</i>	226	<i>twist top lancets 30g</i>	169	ULTRA-THIN II INSULIN SYRINGE	
<i>true comfort insulin syringe</i>	176	TYBLUME.....	106	.....	177
TRUE COMFORT INSULIN		TYBOST.....	92	ULTRA-THIN II LANCETS.....	169
SYRINGE.....	176	<i>tydemy</i>	106	ULTRA-THIN II MINI PEN NEEDLE	
TRUE COMFORT PEN NEEDLES....	176	TYGACIL.....	221	.....	177
TRUE COMFORT PRO INSULIN		TYMLOS.....	131	ULTRA-THIN II PEN NEEDLE	
SYR.....	176	TYPHIM VI.....	226, 227	SHORT.....	177
TRUE COMFORT PRO PEN		TYSABRI.....	216	ULTRA-THIN II PEN NEEDLES.....	177
NEEDLES.....	176	TYVASO.....	100	UNASYN.....	212
<i>true comfort safety lancets</i>	169	TYVASO DPI INSTITUTIONAL KIT	100	UNIFINE PENTIPS.....	177
TRUE COMFORT TWIST TOP		TYVASO DPI MAINTENANCE KIT	100	UNIFINE PENTIPS PLUS.....	177
LANCETS.....	169	TYVASO DPI TITRATION KIT.....	100	UNIFINE PROTECT PEN NEEDLE..	177
<i>true cover</i>	158	TYVASO REFILL KIT.....	100	UNIFINE SAFECONTROL PEN	
<i>true daily vite</i>	192	TYVASO STARTER KIT.....	100	NEEDLE.....	177
<i>true folic acid</i>	147	TZIELD.....	40	UNIFINE ULTRA PEN NEEDLE.....	177
<i>true laxative</i>	153	UBRELVY.....	178	UNILET COMFORTOUCH LANCET	
<i>true multivitamin</i>	192	UCERIS.....	111	.....	169
TRUEDRAW LANCING DEVICE.....	169	UDENYCA.....	148	UNILET EXCELITE.....	169
TRUEPLUS 5-BEVEL PEN		UDENYCA ONBODY.....	148	UNILET EXCELITE II.....	169
NEEDLES.....	176	ULTANE.....	139	UNILET G.P. LANCET.....	169
TRUEPLUS INSULIN SYRINGE.....	176	ULTICARE INSULIN SAFETY SYR	176	UNILET G.P. SUPERLITE LANCET..	169
TRUEPLUS LANCETS 26G.....	169	ULTICARE INSULIN SYR 1/2 UNIT	176	UNILET GP 28 ULTRA THIN.....	169
TRUEPLUS LANCETS 28G.....	169	ULTICARE INSULIN SYRINGE.....	176	UNILET LANCET.....	169
TRUEPLUS LANCETS 30G.....	169	ULTICARE MICRO PEN NEEDLES..	176	UNILET MICRO-THIN 33G.....	169
TRUEPLUS LANCETS 33G.....	169	ULTICARE MINI PEN NEEDLES....	176	UNILET SUPERLITE LANCET.....	169
TRUEPLUS PEN NEEDLES.....	176	ULTICARE PEN NEEDLES.....	176	UNILET SUPER-THIN 30G.....	169
TRUEPLUS SAFETY LANCETS 28G		ULTICARE SHORT PEN NEEDLES..	176	UNILET ULTRA-THIN 28G.....	169
.....	169	ULTIGUARD SAFEPACK PEN		UNISTIK 1.....	169
TRULICITY.....	43	NEEDLE.....	177	UNISTIK 2.....	169
TRUMENBA.....	226	ULTIGUARD SAFEPACK		UNISTIK 2 COMFORT.....	169
TRUQAP.....	64	SYR/NEEDLE.....	177	UNISTIK 2 EXTRA.....	169
TRUSKIN.....	123	ULTI-LANCE AUTOMATIC.....	169	UNISTIK 2 NEONATAL.....	169
TRUSTEX COLOR CONDOMS +		ULTILET CLASSIC LANCETS.....	169	UNISTIK 2 NORMAL.....	169
LUBE.....	158	ULTILET LANCETS.....	169	UNISTIK 2 SUPER.....	170
TRUSTEX LUB/RIBBED/STUDDED	158	ULTILET PEN NEEDLE.....	177	UNISTIK 3.....	170
TRUSTEX LUB/SPERMICIDE EX		ULTILET SAFETY LANCETS.....	169	UNISTIK 3 COMFORT.....	170
ST.....	158	ULTILET SAFETY LANCETS 23G...169		UNISTIK 3 EXTRA.....	170
TRUSTEX LUB/SPERMICIDE XL....	158	ULTIVA.....	23	UNISTIK 3 GENTLE.....	170
TRUSTEX LUBRICATED.....	158	ULTOMIRIS.....	143	UNISTIK 3 NEONATAL.....	170
TRUSTEX LUBRICATED EX		<i>ultra b-100 complex</i>	197	UNISTIK 3 NORMAL.....	170
LARGE.....	158	ULTRA COMFORT INSULIN		UNISTIK CZT COMFORT.....	170
		SYRINGE.....	177	UNISTIK CZT NORMAL.....	170

UNISTIK NORMAL.....	170	<i>varденаfil hcl</i>	101	VERZENIO.....	77
UNISTIK PRO SAFETY LANCET....	170	<i>varenicline tartrate</i>	219	<i>vestura</i>	106
UNISTIK SAFETY LANCETS 28G... 170		<i>varenicline tartrate (starter)</i>	219	VFEND.....	50
UNISTIK SAFETY LANCETS 30G... 170		<i>varenicline tartrate(continue)</i>	219	VIBATIV.....	60
UNISTIK TOUCH SAFETY LANC		VARITHENA.....	186	VIBERZI.....	136
21G.....	170	VARIVAX.....	229	VIDAZA.....	64
UNISTIK TOUCH SAFETY LANC		VARIZIG.....	211	<i>vienna</i>	106
23G.....	170	VARUBI (180 MG DOSE).....	48	<i>vigabatrin</i>	36
UNISTIK TOUCH SAFETY LANC		VASCEPA.....	51	<i>vigadrone</i>	36
28G.....	170	VASERETIC.....	54	Vigadrone.....	36
UNISTIK TOUCH SAFETY LANC		<i>vasopressin</i>	133	VIGAFYDE.....	36
30G.....	170	<i>vasopressin +rfid</i>	133	VIGAMOX.....	204
<i>unithroid</i>	222	<i>vasopressin-sodium chloride</i>	133	Vigpoder.....	36
UNITUXIN.....	66	VASOSTRICT.....	133	VIJOICE.....	185
UNIVERSAL 1 LANCETS THIN 26G		VAXCHORA.....	227	<i>vilazodone hcl</i>	38
.....	170	VAXELIS.....	223	VILTEPSO.....	200
UNIVERSAL 1 LANCETS THIN 33G		VAXNEUVANCE.....	227	VIMIZIM.....	130
.....	170	VAZCULEP.....	231	VINATE DHA RF.....	195
UNIVERSAL 1 LANCETS ULTRA		VCF VAGINAL CONTRACEPTIVE.....	229	<i>vinblastine sulfate</i>	79
THIN.....	170	VECAMYL.....	57	<i>vincristine sulfate</i>	79
UPLIZNA.....	185	VECTIBIX.....	69	<i>vinorelbine tartrate</i>	79
UPNEEQ.....	208	<i>vecuronium bromide</i>	200	VIOKACE.....	124
UPTRAVI.....	101	VELCADE.....	73	<i>viorele</i>	103
UPTRAVI TITRATION.....	101	VELETRI.....	100	VIRACEPT.....	91
UROCIT-K 10.....	139	<i>velivet</i>	109	VIRAZOLE.....	94
UROCIT-K 15.....	139	VELPHORO.....	138	VIREAD.....	92
URSO FORTE.....	135	VELTASSA.....	185	VISCOAT.....	208
<i>ursodiol</i>	135	VEMLIDY.....	93	VISIONBLUE.....	208
UVADEX.....	76	VENCLEXTA.....	67	VISTOGARD.....	46
VABOMERE.....	58	VENCLEXTA STARTING PACK.....	68	VISUDYNE.....	206
VABYSMO.....	203	VENIPUNCTURE PX1		<i>vit e-vit c-beta carotene</i>	192
<i>valacyclovir hcl</i>	93	PHLEBOTOMY.....	123	VITAFOL FE+.....	196
VALCHLOR.....	115	<i>venlafaxine hcl</i>	39	VITAFOL GUMMIES.....	195
VALCYTE.....	92	<i>venlafaxine hcl er</i>	39	VITAFOL ULTRA.....	196
<i>valganciclovir hcl</i>	92	VENOFER.....	148	VITAFOL-OB.....	195
<i>valproate sodium</i>	37	VENTAVIS.....	100	VITAFOL-OB+DHA.....	196
<i>valproic acid</i>	37	VEOPOZ.....	143	VITAFOL-ONE.....	196
<i>valrubicin</i>	74	VEOZAH.....	130	<i>vitalee</i>	192
<i>valsartan</i>	56	<i>verapamil hcl</i>	98	VITALIPID N INFANT.....	193
<i>valsartan-hydrochlorothiazide</i>	55	<i>verapamil hcl er</i>	98	VITAMEDMD ONE	
VALSTAR.....	74	VEREGEN.....	114	RX/QUATREFOLIC.....	196
VALTOCO 10 MG DOSE.....	33	VERELAN.....	98	<i>vitamin b complex</i>	188
VALTOCO 15 MG DOSE.....	33	VERELAN PM.....	98	<i>vitamin b complex w/b-12</i>	188
VALTOCO 20 MG DOSE.....	33	VERIFINE INSULIN PEN NEEDLE..	177	<i>vitamin d (ergocalciferol)</i>	231
VALTOCO 5 MG DOSE.....	33	VERIFINE INSULIN SYRINGE.....	177	<i>vitamin k1</i>	231
VALUE HEALTH INSULIN		VERIFINE PLUS PEN NEEDLE.....	177	<i>vitamin-b complex</i>	188
SYRINGE.....	177	VERIFINE SAFE LANCET MINI 21G		VITAPEARL.....	195
VALUE PLUS LANCET		.....	170	VITATHELY WITH GINGER.....	195
STANDARD 21G.....	170	VERIFINE SAFE LANCET MINI 23G		VITATRUE.....	196
VALUE PLUS LANCETS SUPER		.....	170	VITLIPID N ADULT.....	192
THIN.....	170	VERIFINE SAFE LANCET MINI 28G		VITLIPID N INFANT.....	193
VALUE PLUS LANCETS THIN 26G		.....	170	VITRAKVI.....	73, 74
<i>value plus lancng device</i>	170	VERIFINE SAFE LANCET MINI 30G		VIVA DHA.....	195
VANCOCIN.....	59	.....	170	VIVAGUARD LANCETS.....	170
VANCOMYCIN HCL.....	59	VERIFINE UNIVERSAL LANCETS		VIVAGUARD LANCETS 30G.....	170
<i>vancomycin hcl</i>	59	28G.....	170	VIVAGUARD LANCING DEVICE... 170	
<i>vancomycin hcl in dextrose</i>	59	VERIFINE UNIVERSAL LANCETS		VIVAGUARD SAFETY LANCETS	
VANCOMYCIN HCL IN DEXTROSE		30G.....	170	28G.....	170
VANCOMYCIN HCL IN NAACL.....	59	VERIFINE UNIVERSAL LANCETS		<i>vivimusta</i>	63
VANDAZOLE.....	229	33G.....	170	VIVITROL.....	46
VANFLYTA.....	73	VERKAZIA.....	205	VIVJOA.....	49
VANISHPOINT INSULIN SYRINGE		VERQUVO.....	101	VIVOTIF.....	227
VAQTA.....	229	VERSACLOZ.....	86	VIZIMPRO.....	69

<i>volnea</i>	103	XACDURO.....	58	YOSPRALA.....	145
VONJO.....	78	XACIATO.....	229	YUPELRI.....	29
VONVENDI.....	142	XADAGO.....	83	YUTIQ.....	207
VORANIGO.....	77	XALKORI.....	65	<i>yuvafem</i>	230
VORAXAZE.....	76	XARACOLL.....	155	<i>zafemy</i>	107
<i>voriconazole</i>	50	XARELTO.....	31	<i>zafirlukast</i>	30
VOSEVI.....	93	XARELTO STARTER PACK.....	31	<i>zaleplon</i>	151
VOWST.....	137	XATMEP.....	64	ZALTRAP.....	82
VOXZOGO.....	130	XCOPRI.....	36	ZALVIT.....	195
VOYDEYA.....	143	XCOPRI (250 MG DAILY DOSE).....	36	ZANAFLEX.....	198
VP INSULIN SYRINGE.....	177	XCOPRI (350 MG DAILY DOSE).....	36	ZANOSAR.....	80
VPRIV.....	146	XDEMVY.....	205	ZARXIO.....	148
VRAYLAR.....	85	XELJANZ.....	15	ZEGALOGUE.....	41
VUMERITY.....	216	XELJANZ XR.....	15	ZEJULA.....	81
VUSION.....	114	XELPROS.....	209	ZELAPAR.....	83
<i>vyfemla</i>	106	XEMBIFY.....	211	ZELBORAF.....	69
VYLEESI.....	214	XENPOZYME.....	126	ZEMAIRA.....	220
<i>vylibra</i>	106	XEOMIN.....	200	ZEMDRI.....	15
VYLOY.....	66	XERAVA.....	221	ZEMPLAR.....	129
VYNDAMAX.....	101	XERESE.....	116	<i>zenatane</i>	114
VYNDAQEL.....	101	XERMELO.....	138	ZENPEP.....	124
VYONDYS 53.....	200	XGEVA.....	131	<i>zenzedi</i>	12
VYVANSE.....	12	XIAFLEX.....	183	ZEPBOUND.....	12
VYVGART.....	185	XIFAXAN.....	58	ZEPOSIA.....	219
VYVGART HYTRULO.....	183	XIGDUO XR.....	44	ZEPOSIA 7-DAY STARTER PACK..	219
VYXEOS.....	75	XIIDRA.....	203	ZEPOSIA STARTER KIT.....	219
VYZULTA.....	208	XIPERE.....	207	ZEPZELCA.....	63
WAINUA.....	213	<i>xirun</i>	119	ZERBAXA.....	101
WAKIX.....	13	XOFIGO.....	75	ZESTORETIC.....	54
WALGREENS LANCETS.....	170	XOFLUZA (40 MG DOSE).....	94	ZEVALIN Y-90.....	74
WALGREENS LANCETS MICRO		XOFLUZA (80 MG DOSE).....	94	ZEVRX INSULIN SYRINGE.....	177
THIN.....	170	XOLAIR.....	28	ZEVRX PEN NEEDLES.....	177
WALGREENS LANCETS SUPER		XOLREMDI.....	146	ZEVRX TWIST TOP LANCETS 30G	171
THIN.....	170	XOSPATA.....	73	ZIAGEN.....	91
WALGREENS THIN LANCETS.....	171	XPHOZAH.....	127	<i>zidovudine</i>	92
WALGREENS ULTRA THIN		XPROVIO (100 MG ONCE WEEKLY)..	74	ZIIHERA.....	67
LANCETS.....	171	XPROVIO (40 MG ONCE WEEKLY)....	74	ZILBRYSQ.....	143
<i>warfarin sodium</i>	31	XPROVIO (40 MG TWICE WEEKLY)..	74	ZILRETTA.....	111
<i>water for irrigation, sterile</i>	184	XPROVIO (60 MG ONCE WEEKLY)....	74	ZILXI.....	122
WEGMANS UNIFINE PENTIPS		XPROVIO (60 MG TWICE WEEKLY)..	74	ZIMHI.....	46
PLUS.....	177	XPROVIO (80 MG ONCE WEEKLY)....	74	<i>zinc chloride</i>	182
WEGOVI.....	12	XPROVIO (80 MG TWICE WEEKLY)..	74	<i>zinc sulfate</i>	182
WELIREG.....	70	XTANDI.....	63	ZINPLAVA.....	210
<i>wera</i>	106	<i>xulane</i>	106	ZIOPTAN.....	209
<i>wesnatal dha complete</i>	195	XULTOPHY.....	43	ZIPHEX.....	195
<i>wes-phos 250 neutral</i>	181	XURIDEN.....	128	<i>ziprasidone hcl</i>	85
WESTAB PLUS.....	195	XYLOCAINE.....	155	<i>ziprasidone mesylate</i>	85
WESTGEL DHA.....	196	XYLOCAINE/EPINEPHRINE.....	155	ZIRGAN.....	204
WIDE-SEAL DIAPHRAGM 60.....	158	XYLOCAINE-MPF.....	156	ZITHROMAX.....	156
WIDE-SEAL DIAPHRAGM 65.....	158	XYLOCAINE-MPF/EPINEPHRINE..	155	ZITHROMAX TRI-PAK.....	156
WIDE-SEAL DIAPHRAGM 70.....	158	XYNTHA.....	142	ZITHROMAX Z-PAK.....	156
WIDE-SEAL DIAPHRAGM 75.....	158	XYNTHA SOLOFUSE.....	142	ZOKINVY.....	183
WIDE-SEAL DIAPHRAGM 80.....	158	XYOSTED.....	24	ZOLADEX.....	79
WIDE-SEAL DIAPHRAGM 85.....	159	XYREM.....	213	<i>zoledronic acid</i>	126
WIDE-SEAL DIAPHRAGM 90.....	159	Yargesa.....	146	ZOLEDRONIC ACID.....	126
WIDE-SEAL DIAPHRAGM 95.....	159	YASMIN 28.....	106	ZOLINZA.....	71
WILATE.....	142	YAZ.....	106	<i>zolmitriptan</i>	179
WINREVAIR.....	100	YCANTH.....	120	<i>zolpidem tartrate</i>	151
WINRHO SDF.....	211	YERVOY.....	66	<i>zolpidem tartrate er</i>	151
<i>wixela inhub</i>	28	YF-VAX.....	229	<i>zonisamide</i>	35
<i>womans laxative</i>	154	<i>yl balanced b-100</i>	190	ZONTIVITY.....	145
<i>womens laxative</i>	154	<i>yl folic acid</i>	147	ZORTRESS.....	185
<i>wymzya fe</i>	106	YONDELIS.....	81	ZORYVE.....	116

ZOSYN.....	212
<i>zovia 1/35 (28)</i>	106
ZOVIRAX.....	116
ZTALMY.....	35
ZUBSOLV.....	24
ZULRESSO.....	37
<i>zumandimine</i>	106
ZURZUVAE.....	37
ZYCLARA.....	120
ZYCLARA PUMP.....	120
ZYDELIG.....	81
ZYKADIA.....	65
ZYLET.....	207
ZYNLONTA.....	65
ZYNYZ.....	67
ZYPREXA RELPREVV.....	88
ZYVOX.....	60

For information about your pharmacy benefit, log in at [anthem.com/ca](https://www.anthem.com/ca).

You'll find the most up-to-date drug list and details about your benefits.

If you still have questions, we're here. Just call the Member Services number on your ID card.

Speech and hearing impaired (TDD/TTY) users

Call 1-800-221-6915, Monday through Friday, 8:30 a.m. to 5 p.m.ET.



Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

Armenian

Ձեր իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo

Bee ná ahoót'í t'áá ni nizaad k'ehjí níká a'doowó t'áá jík'e. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí béésh bee hane'í bikáá' áá jì' hodiílnih. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí béésh bee hane'í bikáá' áá jì' hodiílnih. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.