

# 2021 Formulary

Priority Health Medicare Dual Eligible Special Needs Plan (D-SNP)

## List of covered drugs

*Please read:*

*This document contains information about the drugs we cover in this plan.*

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This formulary was approved on 10/19/2021. For more recent information or other questions, please contact Priority Health Medicare at toll-free 833.939.0983 or, for TTY users, 711, 8 a.m. to 8 p.m., seven days a week, or visit [prioritymedicare.com](http://prioritymedicare.com).

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

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Priority Health. When it refers to “plan” or “our plan,” it means Priority Health Medicare.

This document includes a list of the drugs (formulary) for our plan which is current as of December 1, 2021. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2022, and from time to time during the year.

## What is the Priority Health Medicare Formulary?

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

## Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Priority Health Medicare Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

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

**Changes that will not affect you if you are currently taking the drug:** Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of December 1, 2021. To get updated information about the drugs covered by Priority Health Medicare, please contact us. Our contact information appears on the front and back cover pages. If there are significant changes to the formulary, you may receive a letter in the mail outlining those changes.

## **How do I use the Formulary?**

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

### **Medical Condition**

The formulary begins on page 9. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents". If you know what your drug is used for, look for the category name in the list that begins on page 9. Then look under the category name for your drug.

### **Alphabetical Listing**

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

## **What are generic drugs?**

Priority Health Medicare covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

## Are there any restrictions on my coverage?

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

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Priority Health Medicare to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Priority Health Medicare formulary?" on page 6 for information about how to request an exception.

## What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Service and ask if your drug is covered.

If you learn that Priority Health Medicare does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Priority Health Medicare. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Priority Health Medicare.
- You can ask Priority Health Medicare to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the Priority Health Medicare Formulary?

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

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

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

You should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

## What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

Priority Health Medicare provides members experiencing a level of care change with a transition supply of at least 30 days of medication unless the prescription is written for fewer days.

## **For more information**

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

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

If you have general questions about Medicare prescription drug coverage, please call Medicare at 800.MEDICARE (800.633.4227) 24 hours a day, seven days a week. TTY users should call 877.486.2048. Or, visit *medicare.gov*.

# Priority Medicare D-SNP Formulary

The formulary that begins on page 9 provides coverage information about the drugs covered by Priority Health Medicare. If you have trouble finding your drug in the list, turn to the Index that begins on the page following the Drug List.

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

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

## List of Abbreviations

**B/D: Part B vs. Part D.** This drug requires prior authorization and may be covered differently under Medicare Part B (medical services) or D (prescription drug coverage) depending upon your circumstances. Information may need to be submitted by your doctor describing the use and setting of the drug to make the determination.

**EA: Each**

**GM: Grams**

**HI: Home Infusion.** This prescription drug may be covered under our medical benefit. For more information, call Customer Service at toll-free 833.939.0983, 8 a.m. to 8 p.m., seven days a week. TTY users should call 711.

**LA: Limited Availability.** This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Customer Service at toll-free 833.939.0983, 8 a.m. to 8 p.m., seven days a week. TTY users should call 711.

**ML: Milliliters**

**PA: Prior Authorization.** Priority Health Medicare requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Priority Health Medicare before you fill your prescriptions. If you don't get approval, Priority Health Medicare may not cover the drug.

**QL: Quantity Limit.** For certain drugs, Priority Health Medicare limits the amount of the drug that Priority Health Medicare will cover. For example, Priority Health Medicare provides 60 tablets per 30-day prescription of ENTRESTO. This may be in addition to a standard one-month or three-month supply.

**ST: Step Therapy.** In some cases, Priority Health Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Priority Health Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Priority Health Medicare will then cover Drug B.



Drug Name	Drug Tiers	Requirements/Limits
<b>Analgesics</b>		
<b>Nonsteroidal Anti-Inflammatory Drugs</b>		
CAMBIA	1	
<i>celecoxib oral</i>	1	
<i>diclofenac epolamine</i>	1	PA
<i>diclofenac potassium oral tablet 50 mg</i>	1	
<i>diclofenac sodium er</i>	1	
<i>diclofenac sodium external gel 1 %</i>	1	
<i>diclofenac sodium external gel 3 %</i>	1	
<i>diclofenac sodium external solution</i>	1	
<i>diclofenac sodium oral</i>	1	
<i>diclofenac sodium transdermal gel 1 %</i>	1	
<i>diclofenac sodium transdermal gel 3 %</i>	1	
<i>diclofenac sodium transdermal solution</i>	1	
<i>diclofenac-misoprostol oral tablet delayed release</i>	1	
<i>diflunisal oral</i>	1	
<i>etodolac oral</i>	1	
<i>fenoprofen calcium oral tablet</i>	1	
<i>flurbiprofen oral tablet 100 mg</i>	1	
<i>ibu oral tablet 600 mg, 800 mg</i>	1	
<i>ibuprofen oral suspension</i>	1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
<i>ketoprofen oral</i>	1	
<i>mefenamic acid oral</i>	1	QL (30 EA per 30 days)
<i>meloxicam oral tablet</i>	1	
<i>nabumetone oral</i>	1	
<i>naproxen oral tablet</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	
<i>oxaprozin</i>	1	
<i>piroxicam oral</i>	1	
<i>salsalate oral</i>	1	
<i>sulindac oral</i>	1	
ZIPSOR	1	
<b>Opioid Analgesics, Long-Acting</b>		
<i>buprenorphine transdermal</i>	1	QL (4 EA per 28 days)

**Tier 1** = Generic and Brand Drugs

\*= 30-day supply only

**B/D**-Part Bvs. Part D; **EA**-Each; **HI**-Home Infusion; **LA**-Limited Availability; **PA**-Prior Authorization; **QL**-Quantity Limits; **ST**-Step Therapy; **ML**-Milliliters; **GM**-Grams

Note: All drugs listed on the formulary are available via mail order. You can find information on what the abbreviations mean on page 8.

Drug Name	Drug Tiers	Requirements/Limits
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	1	QL (10 EA per 30 days)
<i>hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 12 mg, 16 mg, 8 mg</i>	1	QL (60 EA per 30 days)
<i>hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 32 mg</i>	1*	QL (60 EA per 30 days)
<i>hydromorphone hcl er oral tablet extended release 24 hour 12 mg, 16 mg, 8 mg</i>	1	QL (60 EA per 30 days)
<i>hydromorphone hcl er oral tablet extended release 24 hour 32 mg</i>	1*	QL (60 EA per 30 days)
<i>methadone hcl oral solution 10 mg/5ml</i>	1	QL (600 ML per 30 days)
<i>methadone hcl oral solution 5 mg/5ml</i>	1	QL (1200 ML per 30 days)
<i>methadone hcl oral tablet 10 mg</i>	1	QL (90 EA per 30 days)
<i>methadone hcl oral tablet 5 mg</i>	1	QL (120 EA per 30 days)
<i>morphine sulfate er oral tablet extended release 100 mg</i>	1	QL (60 EA per 30 days)
<i>morphine sulfate er oral tablet extended release 15 mg, 200 mg, 30 mg, 60 mg</i>	1	QL (120 EA per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 15 mg, 20 mg, 30 mg, 40 mg</i>	1	QL (90 EA per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 60 mg</i>	1	QL (60 EA per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 80 mg</i>	1*	QL (60 EA per 30 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG, 20 MG, 40 MG	1	QL (90 EA per 30 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 60 MG	1*	QL (90 EA per 30 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 80 MG	1*	QL (60 EA per 30 days)
<i>oxymorphone hcl er</i>	1	QL (90 EA per 30 days)
<i>tramadol hcl er oral tablet extended release 24 hour</i>	1	QL (30 EA per 30 days)
<b>Opioid Analgesics, Short-Acting</b>		
<i>acetaminophen-codeine #3</i>	1	QL (360 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	1	QL (360 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	1	QL (180 EA per 30 days)
<i>butorphanol tartrate nasal</i>	1	QL (10 ML per 28 days)

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Drug Name	Drug Tiers	Requirements/Limits
<i>codeine sulfate oral tablet 30 mg, 60 mg</i>	1	QL (180 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	1	QL (360 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle</i>	1*	PA; QL (120 EA per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	1	QL (5550 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	QL (360 EA per 30 days)
<i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i>	1	QL (150 EA per 30 days)
<i>hydromorphone hcl oral liquid</i>	1	QL (2400 ML per 30 days)
<i>hydromorphone hcl oral tablet</i>	1	QL (180 EA per 30 days)
<i>hydromorphone hcl pf injection solution 10 mg/ml, 50 mg/5ml</i>	1	QL (240 ML per 30 days)
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml</i>	1	QL (900 ML per 30 days)
<i>morphine sulfate oral solution</i>	1	QL (900 ML per 30 days)
<i>morphine sulfate oral tablet</i>	1	QL (180 EA per 30 days)
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	1	QL (180 ML per 30 days)
<i>oxycodone hcl oral solution</i>	1	QL (1200 ML per 30 days)
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	1	QL (180 EA per 30 days)
<i>oxycodone hcl oral tablet 5 mg</i>	1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	QL (360 EA per 30 days)
<i>oxycodone-aspirin oral tablet 4.8355-325 mg</i>	1	QL (360 EA per 30 days)
<i>oxymorphone hcl oral tablet 10 mg</i>	1	QL (360 EA per 30 days)
<i>oxymorphone hcl oral tablet 5 mg</i>	1	QL (180 EA per 30 days)
<i>tramadol hcl oral tablet 50 mg</i>	1	QL (240 EA per 30 days)
<i>tramadol-acetaminophen</i>	1	QL (240 EA per 30 days)
<b>Anesthetics</b>		
<b>Local Anesthetics</b>		
<i>lidocaine external ointment 5 %</i>	1	
<i>lidocaine external patch 5 %</i>	1	PA
<i>lidocaine hcl external solution</i>	1	
<i>lidocaine hcl urethral/mucosal</i>	1	
<i>lidocaine viscous hcl</i>	1	
<i>lidocaine-prilocaine external cream</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Anti-Addiction/Substance Abuse Treatment Agents</b>		
<b>Alcohol Deterrents/Anti-Craving</b>		
<i>acamprosate calcium</i>	1	
<i>disulfiram oral</i>	1	
<i>naltrexone hcl oral</i>	1	
<b>Opioid Dependence</b>		
<i>buprenorphine hcl sublingual</i>	1	QL (90 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1	QL (60 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	1	QL (90 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual</i>	1	QL (90 EA per 30 days)
<b>Opioid Reversal Agents</b>		
<i>naloxone hcl injection solution 0.4 mg/ml</i>	1	
<i>naloxone hcl injection solution cartridge</i>	1	
<i>naloxone hcl injection solution prefilled syringe</i>	1	
NARCAN	1	QL (2 EA per 30 days)
<b>Smoking Cessation Agents</b>		
APO-VARENICLINE	1	
<i>bupropion hcl er (smoking det)</i>	1	
CHANTIX STARTING MONTH PAK	1	
NICOTROL	1	
NICOTROL NS	1	
<i>varenicline tartrate</i>	1	
<b>Antibacterials</b>		
<b>Aminoglycosides</b>		
<i>amikacin sulfate injection solution 500 mg/2ml</i>	1	HI
ARIKAYCE	1*	PA; QL (235.2 ML per 28 days)
<i>gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%, 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%</i>	1	HI
<i>gentamicin sulfate external</i>	1	
<i>gentamicin sulfate injection solution 40 mg/ml</i>	1	
<i>neomycin sulfate oral</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>paromomycin sulfate oral</i>	1	
<i>streptomycin sulfate intramuscular</i>	1	
<i>tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml</i>	1	HI
<b>Antibacterials, Other</b>		
<i>aztreonam injection solution reconstituted 1 gm</i>	1	HI
CLEOCIN ORAL SOLUTION RECONSTITUTED	1	
CLEOCIN VAGINAL SUPPOSITORY	1	
<i>clindamycin hcl oral capsule 150 mg</i>	1	
<i>clindamycin hcl oral capsule 300 mg</i>	1	
<i>clindamycin palmitate hcl</i>	1	
<i>clindamycin phosphate external swab</i>	1	
<i>clindamycin phosphate in d5w</i>	1	
<i>clindamycin phosphate vaginal</i>	1	
<i>colistimethate sodium (cba)</i>	1	HI
DALVANCE	1*	
<i>daptomycin</i>	1*	HI
<i>firvanq</i>	1	
<i>fosfomycin tromethamine</i>	1	
<i>impavido</i>	1*	PA
<i>linezolid intravenous solution 600 mg/300ml</i>	1	
<i>linezolid oral suspension reconstituted</i>	1	
<i>linezolid oral tablet</i>	1	QL (56 EA per 28 days)
<i>methenamine hippurate</i>	1	
<i>metronidazole external</i>	1	
<i>metronidazole in nacl intravenous solution 5-0.79 mg/ml-%</i>	1	
<i>metronidazole oral tablet</i>	1	
<i>metronidazole vaginal</i>	1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	1	
<i>nitrofurantoin monohyd macro</i>	1	
SIVEXTRO ORAL	1*	PA; QL (6 EA per 30 days)
<i>tigecycline</i>	1	HI
<i>trimethoprim oral</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 500 mg</i>	1	HI
<i>vancomycin hcl intravenous solution reconstituted 1.5 gm</i>	1	
<i>vancomycin hcl oral capsule 125 mg</i>	1	
<i>vancomycin hcl oral capsule 250 mg</i>	1*	
XIFAXAN ORAL TABLET 200 MG	1	QL (30 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	1*	QL (60 EA per 30 days)
<b>Beta-Lactam, Cephalosporins</b>		
AVYCAZ	1*	
<i>cefaclor</i>	1	
<i>cefadroxil oral capsule</i>	1	
<i>cefadroxil oral suspension reconstituted</i>	1	
<i>cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 500 mg</i>	1	HI
<i>cefdinir</i>	1	
<i>cefepime hcl injection</i>	1	HI
<i>cefoxitin sodium injection</i>	1	
<i>cefoxitin sodium intravenous</i>	1	HI
<i>cefpodoxime proxetil</i>	1	
<i>cefprozil</i>	1	
<i>ceftazidime injection solution reconstituted 1 gm, 6 gm</i>	1	HI
<i>ceftazidime injection solution reconstituted 2 gm</i>	1	
<i>ceftazidime intravenous</i>	1	HI
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg</i>	1	HI
<i>ceftriaxone sodium intravenous solution reconstituted 10 gm</i>	1	HI
<i>cefuroxime axetil oral tablet</i>	1	
<i>cefuroxime sodium injection solution reconstituted 7.5 gm</i>	1	
<i>cefuroxime sodium injection solution reconstituted 750 mg</i>	1	HI
<i>cefuroxime sodium intravenous solution reconstituted 1.5 gm</i>	1	HI
<i>cephalexin oral capsule 250 mg, 500 mg</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>cephalexin oral suspension reconstituted</i>	1	
SUPRAX ORAL SUSPENSION RECONSTITUTED 500 MG/5ML	1	
SUPRAX ORAL TABLET CHEWABLE	1	
TEFLARO	1	
ZERBAXA	1*	
<b>Beta-Lactam, Penicillins</b>		
<i>amoxicillin oral capsule</i>	1	
<i>amoxicillin oral suspension reconstituted</i>	1	
<i>amoxicillin oral tablet</i>	1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	1	
<i>amoxicillin-pot clavulanate er</i>	1	
<i>amoxicillin-pot clavulanate oral</i>	1	
<i>ampicillin oral capsule 500 mg</i>	1	
<i>ampicillin sodium injection solution reconstituted 1 gm, 125 mg</i>	1	HI
<i>ampicillin sodium intravenous solution reconstituted 10 gm</i>	1	HI
<i>ampicillin-sulbactam sodium injection solution reconstituted 3 (2-1) gm</i>	1	HI
<i>ampicillin-sulbactam sodium intravenous solution reconstituted 15 (10-5) gm</i>	1	HI
BICILLIN C-R	1	
BICILLIN C-R 900/300	1	
BICILLIN L-A	1	
<i>dicloxacillin sodium</i>	1	
<i>nafcillin sodium injection solution reconstituted 1 gm, 2 gm</i>	1	
<i>nafcillin sodium intravenous solution reconstituted 10 gm</i>	1	
<i>oxacillin sodium in dextrose intravenous solution 1 gm/50ml</i>	1	HI
<i>oxacillin sodium injection solution reconstituted 1 gm</i>	1	
<i>oxacillin sodium intravenous</i>	1	
<i>penicillin g pot in dextrose intravenous solution 40000 unit/ml, 60000 unit/ml</i>	1	HI

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Drug Name	Drug Tiers	Requirements/Limits
<i>penicillin g potassium injection solution reconstituted 20000000 unit</i>	1	HI
<i>penicillin g potassium injection solution reconstituted 5000000 unit</i>	1	
<i>penicillin g procaine</i>	1	
<i>penicillin g sodium</i>	1	
<i>penicillin v potassium oral solution reconstituted</i>	1	
<i>penicillin v potassium oral tablet</i>	1	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm</i>	1	HI
<b>Carbapenems</b>		
<i>ertapenem sodium</i>	1	
<i>imipenem-cilastatin</i>	1	
<i>meropenem intravenous solution reconstituted 500 mg</i>	1	
<b>Macrolides</b>		
<i>azithromycin intravenous</i>	1	HI
<i>azithromycin oral packet</i>	1	
<i>azithromycin oral suspension reconstituted</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	
<i>clarithromycin er</i>	1	
<i>clarithromycin oral</i>	1	
DIFICID ORAL SUSPENSION RECONSTITUTED	1*	ST; QL (100 ML per 30 days)
DIFICID ORAL TABLET	1*	ST; QL (20 EA per 30 days)
ERY-TAB	1	
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	1	
ERYTHROCIN STEARATE ORAL TABLET 250 MG	1	
<i>erythromycin base oral</i>	1	
<i>erythromycin ethylsuccinate oral</i>	1	
<b>Quinolones</b>		
<i>ciprofloxacin hcl ophthalmic</i>	1	
<i>ciprofloxacin hcl oral tablet 100 mg, 750 mg</i>	1	

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<b>Drug Name</b>	<b>Drug Tiers</b>	<b>Requirements/Limits</b>
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg</i>	1	
<i>ciprofloxacin in d5w intravenous solution 200 mg/100ml</i>	1	
<i>levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml</i>	1	
<i>levofloxacin intravenous</i>	1	HI
<i>levofloxacin oral</i>	1	
<i>moxifloxacin hcl oral</i>	1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	1	
<b>Sulfonamides</b>		
<i>sulfacetamide sodium (acne)</i>	1	
<i>sulfadiazine oral</i>	1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1	
<b>Tetracyclines</b>		
<i>demeclocycline hcl oral</i>	1	
DOXY 100	1	B/D
<i>doxycycline hyclate oral capsule</i>	1	
<i>doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg</i>	1	
<i>doxycycline hyclate oral tablet delayed release 75 mg</i>	1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	1	
<i>doxycycline monohydrate oral capsule 75 mg</i>	1	
<i>doxycycline monohydrate oral suspension reconstituted</i>	1	
<i>doxycycline monohydrate oral tablet 150 mg, 50 mg, 75 mg</i>	1	
<i>minocycline hcl oral capsule</i>	1	
<i>tetracycline hcl oral</i>	1	
<b>Anticonvulsants</b>		
<b>Anticonvulsants, Other</b>		
BRIVIACT ORAL SOLUTION	1*	ST
BRIVIACT ORAL TABLET	1*	ST; QL (60 EA per 30 days)
DIACOMIT	1*	PA

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Drug Name	Drug Tiers	Requirements/Limits
EPIDIOLEX	1*	PA; QL (500 ML per 30 days)
<i>felbamate</i>	1	
FINTEPLA	1*	PA; QL (360 ML per 30 days)
FYCOMPA ORAL SUSPENSION	1*	
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	1*	QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG	1	QL (30 EA per 30 days)
<i>lamotrigine er</i>	1	
<i>lamotrigine oral kit 25 &amp; 50 &amp; 100 mg</i>	1	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg</i>	1	
<i>lamotrigine oral tablet 25 mg</i>	1	
<i>lamotrigine oral tablet chewable</i>	1	
<i>lamotrigine oral tablet dispersible</i>	1	
<i>lamotrigine starter kit-blue</i>	1	
<i>lamotrigine starter kit-green</i>	1	
<i>lamotrigine starter kit-orange</i>	1	
<i>levetiracetam er</i>	1	
<i>levetiracetam oral solution</i>	1	
<i>levetiracetam oral tablet 1000 mg, 750 mg</i>	1	
<i>levetiracetam oral tablet 250 mg, 500 mg</i>	1	
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 500 MG, 750 MG	1	QL (90 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG	1	QL (60 EA per 30 days)
<i>topiramate er</i>	1	ST
<i>topiramate oral capsule sprinkle</i>	1	
<i>topiramate oral tablet 100 mg, 200 mg</i>	1	
<i>topiramate oral tablet 25 mg, 50 mg</i>	1	
<i>valproic acid oral capsule</i>	1	
<i>valproic acid oral solution</i>	1	
XCOPRI (250 MG DAILY DOSE)	1*	QL (56 EA per 28 days)
XCOPRI (350 MG DAILY DOSE)	1*	QL (56 EA per 28 days)
XCOPRI ORAL TABLET 100 MG, 50 MG	1*	QL (30 EA per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	1*	QL (60 EA per 30 days)
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG	1	QL (28 EA per 28 days)

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Drug Name	Drug Tiers	Requirements/Limits
XCOPRI ORAL TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG	1*	QL (28 EA per 28 days)
<b>Calcium Channel Modifying Agents</b>		
CELONTIN	1	
<i>ethosuximide oral</i>	1	
<b>Gamma-Aminobutyric Acid (Gaba) Augmenting Agents</b>		
<i>clobazam oral suspension</i>	1*	PA; QL (480 ML per 30 days)
<i>clobazam oral tablet</i>	1	PA; QL (60 EA per 30 days)
<i>diazepam rectal</i>	1	
<i>gabapentin oral capsule</i>	1	
<i>gabapentin oral solution 250 mg/5ml</i>	1	
<i>gabapentin oral tablet</i>	1	
NAYZILAM	1	QL (10 EA per 30 days)
<i>phenobarbital oral elixir</i>	1	PA
<i>phenobarbital oral tablet</i>	1	PA
<i>primidone oral</i>	1	
SYMPAZAN	1*	PA; QL (60 EA per 30 days)
<i>tiagabine hcl</i>	1	
VALTOCO 10 MG DOSE	1	QL (10 EA per 30 days)
VALTOCO 15 MG DOSE	1	QL (20 EA per 30 days)
VALTOCO 20 MG DOSE	1	QL (20 EA per 30 days)
VALTOCO 5 MG DOSE	1	QL (10 EA per 30 days)
<i>vigabatrin</i>	1*	LA
<i>vigadrone</i>	1*	
<b>Sodium Channel Agents</b>		
APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	1*	ST; QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG	1*	ST; QL (60 EA per 30 days)
<i>carbamazepine er oral tablet extended release 12 hour</i>	1	
<i>carbamazepine oral</i>	1	
<i>epitol</i>	1	
<i>oxcarbazepine</i>	1	
PEGANONE	1	

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<b>Drug Name</b>	<b>Drug Tiers</b>	<b>Requirements/Limits</b>
<i>phenytoin oral suspension 125 mg/5ml</i>	1	
<i>phenytoin oral tablet chewable</i>	1	
<i>phenytoin sodium extended oral capsule 100 mg</i>	1	
<i>phenytoin sodium extended oral capsule 200 mg, 300 mg</i>	1	
<i>rufinamide</i>	1*	PA
VIMPAT ORAL SOLUTION	1	
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	1*	QL (60 EA per 30 days)
VIMPAT ORAL TABLET 50 MG	1	QL (60 EA per 30 days)
<i>zonisamide oral capsule 100 mg, 50 mg</i>	1	
<i>zonisamide oral capsule 25 mg</i>	1	
<b>Antidementia Agents</b>		
<b>Antidementia Agents, Other</b>		
<i>donepezil hcl oral tablet 10 mg, 5 mg</i>	1	
<i>donepezil hcl oral tablet dispersible</i>	1	
<i>ergoloid mesylates oral</i>	1	
<b>Cholinesterase Inhibitors</b>		
<i>donepezil hcl oral tablet 23 mg</i>	1	
<i>galantamine hydrobromide</i>	1	
<i>galantamine hydrobromide er</i>	1	
<i>rivastigmine</i>	1	QL (30 EA per 30 days)
<i>rivastigmine tartrate</i>	1	QL (60 EA per 30 days)
<b>N-Methyl-D-Aspartate (Nmda) Receptor Antagonist</b>		
<i>memantine hcl er</i>	1	QL (30 EA per 30 days)
<i>memantine hcl oral solution 2 mg/ml</i>	1	QL (300 ML per 30 days)
<i>memantine hcl oral tablet 10 mg, 5 mg</i>	1	QL (60 EA per 30 days)
<i>memantine hcl oral tablet 28 x 5 mg &amp; 21 x 10 mg</i>	1	QL (49 EA per 30 days)
<b>Antidepressants</b>		
<b>Antidepressants, Other</b>		
<i>bupropion hcl er (sr)</i>	1	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg</i>	1	
<i>bupropion hcl oral</i>	1	
<i>maprotiline hcl</i>	1	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	1	
<i>mirtazapine oral tablet 7.5 mg</i>	1	
<i>mirtazapine oral tablet dispersible</i>	1	
<b>Monoamine Oxidase Inhibitors</b>		
EMSAM	1*	ST
MARPLAN	1	QL (180 EA per 30 days)
<i>phenelzine sulfate oral</i>	1	
<i>tranylcypromine sulfate</i>	1	
<b>Ssris/Snrns (Selective Serotonin Reuptake Inhibitors/Serotonin And Norepinephrine Reuptake Inhibitor</b>		
<i>citalopram hydrobromide oral solution</i>	1	QL (600 ML per 30 days)
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg</i>	1	QL (45 EA per 30 days)
<i>citalopram hydrobromide oral tablet 40 mg</i>	1	QL (30 EA per 30 days)
<i>desvenlafaxine er</i>	1	ST; QL (30 EA per 30 days)
<i>desvenlafaxine succinate er</i>	1	QL (30 EA per 30 days)
DRIZALMA SPRINKLE	1	QL (60 EA per 30 days)
<i>escitalopram oxalate</i>	1	
FETZIMA	1	ST; QL (30 EA per 30 days)
FETZIMA TITRATION	1	ST; QL (30 EA per 30 days)
<i>fluoxetine hcl oral capsule</i>	1	
<i>fluoxetine hcl oral capsule delayed release</i>	1	
<i>fluoxetine hcl oral solution</i>	1	
<i>fluvoxamine maleate</i>	1	
<i>fluvoxamine maleate er</i>	1	
<i>nefazodone hcl</i>	1	
<i>paroxetine hcl oral suspension</i>	1	
<i>paroxetine hcl oral tablet</i>	1	
<i>paroxetine mesylate</i>	1	QL (30 EA per 30 days)
PAXIL ORAL SUSPENSION	1	
<i>sertraline hcl oral concentrate</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>sertraline hcl oral tablet</i>	1	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg</i>	1	
<i>trazodone hcl oral tablet 300 mg</i>	1	
TRINTELLIX	1	ST; QL (30 EA per 30 days)
<i>venlafaxine hcl</i>	1	
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 75 mg</i>	1	
<i>venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg</i>	1	
<i>venlafaxine hcl er oral tablet extended release 24 hour</i>	1	
VIIBRYD ORAL TABLET	1	ST; QL (30 EA per 30 days)
VIIBRYD STARTER PACK	1	ST; QL (30 EA per 30 days)
<b>Tricyclics</b>		
<i>amitriptyline hcl oral</i>	1	
<i>amoxapine</i>	1	
<i>clomipramine hcl oral</i>	1	
<i>desipramine hcl oral</i>	1	
<i>doxepin hcl oral capsule</i>	1	
<i>doxepin hcl oral concentrate</i>	1	
<i>imipramine hcl oral</i>	1	PA
<i>imipramine pamoate</i>	1	PA
<i>nortriptyline hcl oral capsule</i>	1	
<i>nortriptyline hcl oral solution</i>	1	
<i>protriptyline hcl</i>	1	
<i>trimipramine maleate oral</i>	1	PA
<b>Antiemetics</b>		
<b>Antiemetics, Other</b>		
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	1	
<i>prochlorperazine</i>	1	
<i>prochlorperazine maleate oral</i>	1	
<i>promethazine hcl oral tablet</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethegan rectal suppository 25 mg</i>	1	
<i>promethegan rectal suppository 50 mg</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>scopolamine</i>	1	
<b>Emetogenic Therapy Adjuncts</b>		
<i>aprepitant oral capsule</i>	1	B/D; QL (6 EA per 30 days)
<i>dronabinol</i>	1	B/D
<i>granisetron hcl oral</i>	1	B/D
<i>ondansetron</i>	1	B/D
<i>ondansetron hcl oral</i>	1	B/D
SANCUSO	1*	QL (4 EA per 28 days)
<b>Antifungals</b>		
<b>Antifungals</b>		
ABELCET	1	B/D
<i>amphotericin b intravenous</i>	1	B/D
ANCOBON	1*	
<i>casprofungin acetate</i>	1*	
<i>ciclopirox olamine external</i>	1	
<i>clotrimazole external cream</i>	1	
<i>clotrimazole external solution</i>	1	
<i>clotrimazole mouth/throat troche</i>	1	
CRESEMBA ORAL	1*	
<i>econazole nitrate external</i>	1	QL (90 GM per 30 days)
ERAXIS	1	
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%</i>	1	HI
<i>fluconazole oral</i>	1	
<i>flucytosine oral</i>	1*	
<i>griseofulvin microsize oral tablet</i>	1	
<i>griseofulvin ultramicrosize</i>	1	
<i>itraconazole oral capsule</i>	1	
<i>ketoconazole external cream</i>	1	QL (180 GM per 30 days)
<i>ketoconazole external shampoo 2 %</i>	1	QL (120 ML per 30 days)
<i>ketoconazole oral</i>	1	
<i>miconazole sodium intravenous solution reconstituted 100 mg</i>	1*	
<i>miconazole sodium intravenous solution reconstituted 50 mg</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>miconazole 3 vaginal suppository</i>	1	
NOXAFIL ORAL SUSPENSION	1*	
NYAMYC	1	QL (60 GM per 30 days)
<i>nystatin external cream</i>	1	
<i>nystatin external ointment</i>	1	
<i>nystatin external powder</i>	1	QL (480 GM per 30 days)
<i>nystatin mouth/throat</i>	1	
<i>nystatin oral tablet</i>	1	
NYSTOP	1	
<i>posaconazole</i>	1*	
<i>terbinafine hcl oral</i>	1	
<i>terconazole</i>	1	
<i>voriconazole intravenous</i>	1	
<i>voriconazole oral suspension reconstituted</i>	1*	
<i>voriconazole oral tablet 200 mg</i>	1*	
<i>voriconazole oral tablet 50 mg</i>	1	
<b>Antigout Agents</b>		
<b>Antigout Agents</b>		
<i>allopurinol oral</i>	1	
<i>colchicine oral</i>	1	
<i>colchicine-probenecid</i>	1	
COLCRYS	1	
<i>febuxostat</i>	1	
MITIGARE	1	
<i>probenecid oral</i>	1	
<b>Antimigraine Agents</b>		
<b>Ergot Alkaloids</b>		
<i>dihydroergotamine mesylate nasal</i>	1	QL (8 ML per 30 days)
<i>ergotamine-caffeine</i>	1	QL (40 EA per 30 days)
MIGERGOT	1	QL (20 EA per 28 days)
<b>Prophylactic</b>		
AIMOVIG	1	PA; QL (1 ML per 30 days)
AJOVY	1	PA; QL (1.5 ML per 30 days)
EMGALITY	1	PA
EMGALITY (300 MG DOSE)	1	PA; QL (3 ML per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
UBRELVY	1	PA; QL (10 EA per 30 days)
<b>Serotonin (5-Ht) Receptor Agonist</b>		
<i>eletriptan hydrobromide</i>	1	QL (12 EA per 30 days)
<i>naratriptan hcl</i>	1	QL (12 EA per 30 days)
REYVOW ORAL TABLET 100 MG	1	PA; QL (8 EA per 30 days)
REYVOW ORAL TABLET 50 MG	1	PA; QL (4 EA per 30 days)
<i>rizatriptan benzoate</i>	1	QL (12 EA per 30 days)
<i>sumatriptan nasal</i>	1	
<i>sumatriptan succinate oral</i>	1	QL (12 EA per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge</i>	1	QL (4 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	1	QL (4 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector</i>	1	QL (4 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution prefilled syringe 6 mg/0.5ml</i>	1	QL (4 ML per 30 days)
<i>zolmitriptan oral</i>	1	QL (12 EA per 30 days)
<b>Antimyasthenic Agents</b>		
<b>Parasympathomimetics</b>		
<i>guanidine hcl oral</i>	1	
<i>pyridostigmine bromide er</i>	1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	
<b>Antimycobacterials</b>		
<b>Antimycobacterials, Other</b>		
<i>dapsone oral</i>	1	
PRIFTIN	1	
<i>rifabutin</i>	1	
<b>Antituberculars</b>		
<i>ethambutol hcl oral</i>	1	
<i>isoniazid oral syrup</i>	1	
<i>isoniazid oral tablet</i>	1	
PASER	1	
PRETOMANID	1	PA; QL (30 EA per 30 days)
<i>pyrazinamide oral</i>	1	
RIFAMATE	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>rifampin intravenous</i>	1	
<i>rifampin oral</i>	1	
RIFATER	1	
SIRTURO	1*	
TRECTOR	1	
<b>Antineoplastics</b>		
<b>Alkylating Agents</b>		
<i>cyclophosphamide oral capsule</i>	1	B/D
CYCLOPHOSPHAMIDE ORAL TABLET	1	B/D
LEUKERAN	1*	
MATULANE	1*	PA
<i>melphalan</i>	1	
VALCHLOR	1*	PA; LA; QL (60 GM per 30 days)
<b>Antiandrogens</b>		
<i>abiraterone acetate oral tablet 250 mg</i>	1*	PA; QL (120 EA per 30 days)
<i>abiraterone acetate oral tablet 500 mg</i>	1*	PA; QL (60 EA per 30 days)
<i>bicalutamide</i>	1	
ERLEADA	1*	PA; QL (120 EA per 30 days)
<i>flutamide</i>	1	
NILANDRON	1*	
<i>nilutamide</i>	1*	
NUBEQA	1*	PA; QL (120 EA per 30 days)
<i>toremifene citrate</i>	1*	
XTANDI ORAL CAPSULE	1*	PA; LA; QL (120 EA per 30 days)
XTANDI ORAL TABLET 40 MG	1*	PA; LA; QL (120 EA per 30 days)
XTANDI ORAL TABLET 80 MG	1*	PA; LA; QL (60 EA per 30 days)
<b>Antiangiogenic Agents</b>		
POMALYST	1*	PA; LA; QL (21 EA per 28 days)
REVLIMID	1*	PA; LA; QL (30 EA per 30 days)
THALOMID	1*	PA
<b>Antiestrogens/Modifiers</b>		
EMCYT	1	
<i>raloxifene hcl</i>	1	
SOLTAMOX	1	
<i>tamoxifen citrate oral</i>	1	

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<b>Antimetabolites</b>		
DROXIA	1	
<i>hydroxyurea oral</i>	1	
INQOVI	1*	PA
ONUREG	1*	PA; QL (14 EA per 28 days)
PURIXAN	1*	
SIKLOS ORAL TABLET 100 MG	1	PA
SIKLOS ORAL TABLET 1000 MG	1*	PA
TABLOID	1*	
<b>Antineoplastics, Other</b>		
GAVRETO	1*	PA; QL (120 EA per 30 days)
IDHIFA	1*	PA; QL (30 EA per 30 days)
KISQALI FEMARA (400 MG DOSE)	1*	PA
KISQALI FEMARA (600 MG DOSE)	1*	PA
KISQALI FEMARA(200 MG DOSE)	1*	PA
LONSURF	1*	PA
LUMAKRAS	1*	PA; QL (240 EA per 30 days)
LYNPARZA ORAL TABLET 100 MG	1*	PA; QL (120 EA per 30 days)
LYNPARZA ORAL TABLET 150 MG	1*	PA
NINLARO	1*	QL (3 EA per 28 days)
ORGOVYX	1*	PA; QL (30 EA per 30 days)
RETEVMO	1*	PA; QL (120 EA per 30 days)
SYNRIBO	1*	PA
TUKYSA ORAL TABLET 150 MG	1*	PA; QL (120 EA per 30 days)
TUKYSA ORAL TABLET 50 MG	1*	PA; QL (60 EA per 30 days)
WELIREG	1*	PA; QL (90 EA per 30 days)
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	1*	PA; QL (20 EA per 28 days)
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	1*	PA; QL (8 EA per 28 days)
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	1*	PA; QL (8 EA per 28 days)
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	1*	PA; QL (4 EA per 28 days)
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	1*	PA; QL (16 EA per 28 days)

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Drug Name	Drug Tiers	Requirements/Limits
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	1*	PA; QL (8 EA per 28 days)
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	1*	PA; QL (12 EA per 28 days)
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	1*	PA; QL (4 EA per 28 days)
XPOVIO (60 MG TWICE WEEKLY)	1*	PA; QL (24 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	1*	PA; QL (16 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	1*	PA; QL (8 EA per 28 days)
XPOVIO (80 MG TWICE WEEKLY)	1*	PA; QL (32 EA per 28 days)
ZOLINZA	1*	PA
<b>Aromatase Inhibitors, 3Rd Generation</b>		
<i>anastrozole oral</i>	1	
<i>exemestane</i>	1	
<i>letrozole oral</i>	1	
<b>Molecular Target Inhibitors</b>		
AFINITOR DISPERZ ORAL TABLET SOLUBLE 3 MG, 5 MG	1*	PA
AFINITOR ORAL TABLET 10 MG, 2.5 MG	1*	PA
ALECENSA	1*	PA
ALUNBRIG	1*	PA
AYVAKIT	1*	PA; QL (30 EA per 30 days)
BALVERSA	1*	PA
BOSULIF ORAL TABLET 100 MG	1*	PA; QL (120 EA per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	1*	PA; QL (30 EA per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	1*	PA
BRUKINSA	1*	PA; QL (120 EA per 30 days)
CABOMETYX	1*	PA; QL (30 EA per 30 days)
CALQUENCE	1*	PA; QL (60 EA per 30 days)
CAPRELSA	1*	PA; LA
COMETRIQ (100 MG DAILY DOSE)	1*	PA; QL (56 EA per 28 days)
COMETRIQ (140 MG DAILY DOSE)	1*	PA; QL (112 EA per 28 days)
COMETRIQ (60 MG DAILY DOSE)	1*	PA; QL (84 EA per 28 days)
COPIKTRA	1*	PA; QL (60 EA per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
COTELLIC	1*	PA; LA
DAURISMO	1*	PA; QL (30 EA per 30 days)
ERIVEDGE	1*	PA; LA
<i>erlotinib hcl</i>	1*	PA
<i>everolimus oral tablet 10 mg</i>	1*	PA
<i>everolimus oral tablet soluble 3 mg, 5 mg</i>	1*	PA
FARYDAK	1*	PA
FOTIVDA	1*	PA; QL (30 EA per 30 days)
GILOTRIF	1*	PA; QL (30 EA per 30 days)
IBRANCE	1*	PA; QL (21 EA per 28 days)
ICLUSIG ORAL TABLET 10 MG	1*	PA; QL (30 EA per 30 days)
ICLUSIG ORAL TABLET 15 MG, 30 MG, 45 MG	1*	PA
<i>imatinib mesylate</i>	1*	PA
IMBRUVICA	1*	PA; QL (30 EA per 30 days)
INLYTA	1*	PA; LA
INREBIC	1*	PA; QL (120 EA per 30 days)
IRESSA	1*	PA
JAKAFI	1*	PA; LA
KISQALI (200 MG DOSE)	1*	PA; QL (63 EA per 28 days)
KISQALI (400 MG DOSE)	1*	PA; QL (63 EA per 28 days)
KISQALI (600 MG DOSE)	1*	PA; QL (63 EA per 28 days)
KOSELUGO	1*	PA
<i>lapatinib ditosylate</i>	1*	PA
LENVIMA (10 MG DAILY DOSE)	1*	PA; LA; QL (30 EA per 30 days)
LENVIMA (12 MG DAILY DOSE)	1*	PA; LA; QL (90 EA per 30 days)
LENVIMA (14 MG DAILY DOSE)	1*	PA; LA; QL (60 EA per 30 days)
LENVIMA (18 MG DAILY DOSE)	1*	PA; LA; QL (105 EA per 30 days)
LENVIMA (20 MG DAILY DOSE)	1*	PA; LA; QL (60 EA per 30 days)
LENVIMA (24 MG DAILY DOSE)	1*	PA; LA; QL (90 EA per 30 days)
LENVIMA (4 MG DAILY DOSE)	1*	PA; LA; QL (30 EA per 30 days)
LENVIMA (8 MG DAILY DOSE)	1*	PA; LA; QL (70 EA per 30 days)
LORBRENA	1*	PA
MEKINIST ORAL TABLET 0.5 MG	1*	PA; QL (90 EA per 30 days)
MEKINIST ORAL TABLET 2 MG	1*	PA; QL (30 EA per 30 days)
MEKTOVI	1*	PA

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Drug Name	Drug Tiers	Requirements/Limits
NERLYNX	1*	PA; QL (180 EA per 30 days)
NEXAVAR	1*	PA; LA
ODOMZO	1*	PA; LA; QL (30 EA per 30 days)
PEMAZYRE	1*	PA
PIQRAY (200 MG DAILY DOSE)	1*	PA; QL (28 EA per 28 days)
PIQRAY (250 MG DAILY DOSE)	1*	PA; QL (56 EA per 28 days)
PIQRAY (300 MG DAILY DOSE)	1*	PA; QL (56 EA per 28 days)
QINLOCK	1*	PA; QL (90 EA per 30 days)
ROZLYTREK	1*	PA; QL (90 EA per 30 days)
RUBRACA	1*	PA; QL (120 EA per 30 days)
RYDAPT	1*	PA
SPRYCEL	1*	PA
STIVARGA	1*	PA; LA; QL (84 EA per 28 days)
<i>sunitinib malate</i>	1*	PA
TABRECTA	1*	PA; QL (120 EA per 30 days)
TAFINLAR	1*	PA; QL (120 EA per 30 days)
TAGRISO	1*	PA; LA; QL (30 EA per 30 days)
TALZENNA	1*	PA; QL (30 EA per 30 days)
TASIGNA	1*	PA
TAZVERIK	1*	PA; QL (240 EA per 30 days)
TEPMETKO	1*	PA; QL (60 EA per 30 days)
TIBSOVO	1*	PA
TRUSELTIQ (100MG DAILY DOSE)	1*	PA; QL (21 EA per 28 days)
TRUSELTIQ (125MG DAILY DOSE)	1*	PA; QL (42 EA per 28 days)
TRUSELTIQ (50MG DAILY DOSE)	1*	PA; QL (42 EA per 28 days)
TRUSELTIQ (75MG DAILY DOSE)	1*	PA; QL (63 EA per 28 days)
TURALIO	1*	PA; QL (120 EA per 30 days)
UKONIQ	1*	PA; QL (120 EA per 30 days)
VENCLEXTA ORAL TABLET 10 MG	1	PA
VENCLEXTA ORAL TABLET 100 MG, 50 MG	1*	PA
VENCLEXTA STARTING PACK	1*	PA
VERZENIO	1*	PA
VITRAKVI ORAL CAPSULE 100 MG	1*	PA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	1*	PA; QL (90 EA per 30 days)
VITRAKVI ORAL SOLUTION	1*	PA; QL (300 ML per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
VIZIMPRO	1*	PA
VOTRIENT	1*	PA
XALKORI	1*	PA; LA; QL (60 EA per 30 days)
XOSPATA	1*	PA
ZEJULA	1*	PA; QL (90 EA per 30 days)
ZELBORAF	1*	PA; LA; QL (240 EA per 30 days)
ZYDELIG	1*	PA; QL (60 EA per 30 days)
ZYKADIA ORAL TABLET	1*	PA
<b>Retinoids</b>		
<i>bexarotene</i>	1*	
TARGRETIN	1*	PA
<i>tretinoin oral</i>	1*	PA
<b>Treatment Adjuncts</b>		
<i>leucovorin calcium oral</i>	1	
MESNEX ORAL	1*	
<b>Antiparasitics</b>		
<b>Anthelmintics</b>		
<i>albendazole oral</i>	1	
<i>ivermectin oral</i>	1	
<i>praziquantel oral</i>	1	
<b>Antiprotozoals</b>		
<i>atovaquone oral</i>	1*	
<i>atovaquone-proguanil hcl</i>	1	
<i>chloroquine phosphate oral</i>	1	
COARTEM	1	QL (24 EA per 30 days)
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	1	
KRINTAFEL	1	QL (8 EA per 365 days)
<i>mefloquine hcl</i>	1	
MEPRON	1*	
<i>nitazoxanide oral</i>	1*	
PENTAM	1	
<i>pentamidine isethionate inhalation</i>	1	PA
<i>pentamidine isethionate injection</i>	1	
<i>primaquine phosphate oral</i>	1	
<i>pyrimethamine oral</i>	1*	

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Drug Name	Drug Tiers	Requirements/Limits
<i>quinine sulfate oral</i>	1	
<b>Antiparkinson Agents</b>		
<b>Anticholinergics</b>		
<i>benztropine mesylate oral</i>	1	
<i>trihexyphenidyl hcl</i>	1	
<b>Antiparkinson Agents, Other</b>		
<i>amantadine hcl oral</i>	1	
<i>carbidopa-levodopa-entacapone</i>	1	
<i>entacapone</i>	1	
ONGENTYS ORAL CAPSULE 25 MG	1	ST; QL (30 EA per 30 days)
ONGENTYS ORAL CAPSULE 50 MG	1	ST
<i>tolcapone</i>	1*	
<b>Dopamine Agonists</b>		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE	1*	QL (60 ML per 30 days)
<i>bromocriptine mesylate oral</i>	1	
KYNMOBI	1*	QL (150 EA per 30 days)
NEUPRO	1	ST; QL (30 EA per 30 days)
<i>pramipexole dihydrochloride</i>	1	
<i>pramipexole dihydrochloride er</i>	1	
<i>ropinirole hcl er</i>	1	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<i>ropinirole hcl oral tablet 5 mg</i>	1	
<b>Dopamine Precursors And/Or L-Amino Acid Decarboxylase Inhibitors</b>		
<i>carbidopa oral</i>	1	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	1	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg</i>	1	
<i>carbidopa-levodopa oral tablet 25-250 mg</i>	1	
<i>carbidopa-levodopa oral tablet dispersible</i>	1	
<b>Monoamine Oxidase B (Mao-B) Inhibitors</b>		
<i>rasagiline mesylate oral</i>	1	
<i>selegiline hcl oral</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Antipsychotics</b>		
<b>1St Generation/Typical</b>		
ADASUVE	1*	PA
<i>chlorpromazine hcl injection solution 50 mg/2ml</i>	1	
<i>chlorpromazine hcl oral concentrate</i>	1	
<i>chlorpromazine hcl oral tablet</i>	1	
<i>fluphenazine decanoate injection</i>	1	
<i>fluphenazine hcl injection</i>	1	
<i>fluphenazine hcl oral</i>	1	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml, 50 mg/ml(1ml)</i>	1	
<i>haloperidol lactate</i>	1	
<i>haloperidol oral</i>	1	
<i>loxapine succinate oral</i>	1	
<i>molindone hcl</i>	1	
<i>perphenazine oral</i>	1	
<i>pimozide</i>	1	
<i>thioridazine hcl oral</i>	1	
<i>thiothixene oral</i>	1	
<i>trifluoperazine hcl oral</i>	1	
<b>2Nd Generation/Atypical</b>		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE	1*	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	1*	
<i>aripiprazole oral solution</i>	1	QL (750 ML per 30 days)
<i>aripiprazole oral tablet</i>	1	QL (30 EA per 30 days)
<i>aripiprazole oral tablet dispersible</i>	1*	QL (60 EA per 30 days)
ARISTADA	1*	
ARISTADA INITIO	1*	
<i>asenapine maleate</i>	1*	ST; QL (60 EA per 30 days)
CAPLYTA	1*	PA; QL (30 EA per 30 days)
FANAPT	1*	ST; QL (60 EA per 30 days)
FANAPT TITRATION PACK	1	ST

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Drug Name	Drug Tiers	Requirements/Limits
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML	1*	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML	1*	QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 78 MG/0.5ML	1*	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	1	
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1*	
LATUDA	1*	ST; QL (30 EA per 30 days)
NUPLAZID ORAL CAPSULE	1*	PA
NUPLAZID ORAL TABLET 10 MG	1*	PA
<i>olanzapine</i>	1	QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	1	ST; QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	1	ST; QL (60 EA per 30 days)
PERSERIS	1*	PA; QL (1 EA per 28 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 50 mg</i>	1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg</i>	1	QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	1	
<i>quetiapine fumarate oral tablet 25 mg</i>	1	
REXULTI	1*	ST; QL (30 EA per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG	1	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG	1*	
<i>risperidone</i>	1	
SECUADO	1*	ST; QL (30 EA per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
VRAYLAR ORAL CAPSULE	1*	ST
VRAYLAR ORAL CAPSULE THERAPY PACK	1	ST
<i>ziprasidone hcl</i>	1	QL (60 EA per 30 days)
<i>ziprasidone mesylate</i>	1	
ZYPREXA INTRAMUSCULAR	1	QL (30 EA per 30 days)
ZYPREXA RELPREVV	1*	
<b>Treatment-Resistant</b>		
<i>clozapine</i>	1	
VERSACLOZ	1*	
<b>Antispasticity Agents</b>		
<b>Antispasticity Agents</b>		
<i>baclofen oral tablet 10 mg, 20 mg</i>	1	
<i>baclofen oral tablet 5 mg</i>	1	
<i>dantrolene sodium oral</i>	1	
<i>tizanidine hcl oral tablet</i>	1	
<b>Antivirals</b>		
<b>Anti-Cytomegalovirus (Cmv) Agents</b>		
PREVYMIS ORAL	1*	PA
VALCYTE ORAL TABLET	1*	
<i>valganciclovir hcl oral tablet</i>	1*	
<b>Anti-Hepatitis B (Hbv) Agents</b>		
<i>adefovir dipivoxil</i>	1*	
BARACLUDE ORAL SOLUTION	1	QL (600 ML per 30 days)
<i>entecavir</i>	1	
EPIVIR HBV ORAL SOLUTION	1	
HEPSERA	1*	
<i>lamivudine oral solution</i>	1	
<i>lamivudine oral tablet</i>	1	
VEMLIDY	1*	
<b>Anti-Hepatitis C (Hcv) Agents</b>		
EPCLUSA	1*	PA
<i>ledipasvir-sofosbuvir</i>	1*	PA
MAVYRET	1*	PA; QL (84 EA per 28 days)
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5ML	1*	

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Drug Name	Drug Tiers	Requirements/Limits
<i>ribavirin oral capsule</i>	1	
<i>ribavirin oral tablet 200 mg</i>	1	
ZEPATIER	1*	PA
<b>Antitherpetic Agents</b>		
<i>acyclovir oral capsule</i>	1	
<i>acyclovir oral tablet</i>	1	
<i>acyclovir sodium intravenous solution</i>	1	B/D
<i>famciclovir oral</i>	1	
<i>valacyclovir hcl oral</i>	1	
<b>Anti-Hiv Agents, Integrase Inhibitors (Insti)</b>		
BIKTARVY	1*	QL (30 EA per 30 days)
DOVATO	1*	QL (30 EA per 30 days)
GENVOYA	1*	QL (30 EA per 30 days)
ISENTRESS HD	1*	
ISENTRESS ORAL PACKET	1	
ISENTRESS ORAL TABLET	1*	
ISENTRESS ORAL TABLET CHEWABLE 100 MG	1*	
ISENTRESS ORAL TABLET CHEWABLE 25 MG	1	
STRIBILD	1*	
SYMTUZA	1*	QL (30 EA per 30 days)
TIVICAY ORAL TABLET 10 MG	1	QL (30 EA per 30 days)
TIVICAY ORAL TABLET 25 MG	1*	QL (30 EA per 30 days)
TIVICAY ORAL TABLET 50 MG	1*	QL (60 EA per 30 days)
TIVICAY PD	1	QL (180 EA per 30 days)
<b>Anti-Hiv Agents, Non-Nucleoside Reverse Transcriptase Inhibitors (Nnrti)</b>		
COMPLERA	1*	QL (30 EA per 30 days)
EDURANT	1*	QL (30 EA per 30 days)
<i>efavirenz</i>	1	
<i>etravirine</i>	1*	
INTELENCE ORAL TABLET 25 MG	1	QL (120 EA per 30 days)
<i>nevirapine er oral tablet extended release 24 hour 100 mg</i>	1	QL (60 EA per 30 days)
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	1	QL (30 EA per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
<i>nevirapine oral suspension</i>	1	QL (1200 ML per 30 days)
<i>nevirapine oral tablet</i>	1	QL (60 EA per 30 days)
PIFELTRO	1*	QL (30 EA per 30 days)
VIRAMUNE ORAL SUSPENSION	1	QL (1200 ML per 30 days)
VIRAMUNE ORAL TABLET	1*	QL (60 EA per 30 days)
<b>Anti-Hiv Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors (Nrti)</b>		
<i>abacavir sulfate oral solution</i>	1	
<i>abacavir sulfate oral tablet</i>	1	
<i>abacavir sulfate-lamivudine</i>	1	
<i>abacavir-lamivudine-zidovudine</i>	1*	
CIMDUO	1*	QL (30 EA per 30 days)
DELSTRIGO	1*	QL (30 EA per 30 days)
DESCOVY	1*	
<i>didanosine oral capsule delayed release 200 mg, 250 mg, 400 mg</i>	1	
<i>efavirenz-emtricitab-tenofovir</i>	1*	
<i>efavirenz-lamivudine-tenofovir</i>	1*	QL (30 EA per 30 days)
<i>emtricitabine</i>	1	
<i>emtricitabine-tenofovir df</i>	1*	
EMTRIVA ORAL SOLUTION	1	
EPZICOM	1*	
JULUCA	1*	QL (30 EA per 30 days)
<i>lamivudine-zidovudine</i>	1	
ODEFSEY	1*	QL (30 EA per 30 days)
<i>stavudine oral capsule</i>	1	
TEMIXYS	1*	QL (30 EA per 30 days)
<i>tenofovir disoproxil fumarate</i>	1	
TRIZIVIR	1*	
VIREAD ORAL POWDER	1*	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1*	
<i>zidovudine</i>	1	
<b>Anti-Hiv Agents, Other</b>		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED	1*	

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Drug Name	Drug Tiers	Requirements/Limits
RUKOBIA	1*	QL (60 EA per 30 days)
SELZENTRY ORAL SOLUTION	1*	
SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG	1*	
SELZENTRY ORAL TABLET 25 MG	1	
TRIUMEQ	1*	QL (30 EA per 30 days)
TYBOST	1	QL (30 EA per 30 days)
<b>Anti-Hiv Agents, Protease Inhibitors</b>		
APTIVUS ORAL CAPSULE	1*	
APTIVUS ORAL SOLUTION	1	
<i>atazanavir sulfate</i>	1	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	1	
EVOTAZ	1*	QL (30 EA per 30 days)
<i>fosamprenavir calcium</i>	1*	
INVIRASE ORAL TABLET	1*	
KALETRA ORAL SOLUTION	1*	
LEXIVA ORAL SUSPENSION	1	
<i>lopinavir-ritonavir oral solution</i>	1*	
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	1	
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	1*	
NORVIR ORAL PACKET	1	
NORVIR ORAL SOLUTION	1	
PREZCOBIX	1*	QL (30 EA per 30 days)
PREZISTA ORAL SUSPENSION	1*	
PREZISTA ORAL TABLET 150 MG, 75 MG	1	
PREZISTA ORAL TABLET 600 MG, 800 MG	1*	
REYATAZ ORAL PACKET	1*	
RITONAVIR	1	
VIRACEPT ORAL TABLET	1*	
<b>Anti-Influenza Agents</b>		
<i>oseltamivir phosphate oral</i>	1	
RELENZA DISKHALER	1	
<i>rimantadine hcl</i>	1	
XOFLUZA (40 MG DOSE)	1	QL (4 EA per 365 days)

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Drug Name	Drug Tiers	Requirements/Limits
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG	1	QL (2 EA per 365 days)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 2 X 40 MG	1	QL (4 EA per 365 days)
<b>Anxiolytics</b>		
<b>Anxiolytics, Other</b>		
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 7.5 mg</i>	1	
<i>buspirone hcl oral tablet 5 mg</i>	1	
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	1	
<i>oxazepam</i>	1	
<b>Benzodiazepines</b>		
<i>alprazolam er</i>	1	
<i>alprazolam oral tablet</i>	1	
<i>chlordiazepoxide hcl</i>	1	
<i>clonazepam oral tablet</i>	1	
<i>clonazepam oral tablet dispersible</i>	1	
<i>clorazepate dipotassium</i>	1	
<i>diazepam oral concentrate</i>	1	
<i>diazepam oral solution 5 mg/5ml</i>	1	
<i>diazepam oral tablet</i>	1	
LORAZEPAM INTENSOL	1	
<i>lorazepam oral tablet</i>	1	
<b>Bipolar Agents</b>		
<b>Mood Stabilizers</b>		
<i>carbamazepine er oral capsule extended release 12 hour</i>	1	
<i>divalproex sodium er oral tablet extended release 24 hour</i>	1	
<i>divalproex sodium oral capsule delayed release sprinkle</i>	1	
<i>divalproex sodium oral tablet delayed release 125 mg</i>	1	
<i>divalproex sodium oral tablet delayed release 250 mg, 500 mg</i>	1	
<i>lithium</i>	1	
<i>lithium carbonate er</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>lithium carbonate oral</i>	1	
<b>Blood Glucose Regulators</b>		
<b>Antidiabetic Agents</b>		
<i>acarbose oral</i>	1	
ADLYXIN	1	
ADLYXIN STARTER PACK	1	
BYDUREON BCISE	1	QL (3.4 ML per 28 days)
BYDUREON SUBCUTANEOUS PEN-INJECTOR	1	QL (4 EA per 28 days)
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	
CYCLOSET	1	
FARXIGA	1	QL (30 EA per 30 days)
<i>glimepiride</i>	1	
<i>glipizide er</i>	1	
<i>glipizide oral</i>	1	
<i>glipizide-metformin hcl</i>	1	
GLYXAMBI	1	QL (30 EA per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML	1	QL (0.4 ML per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML	1	QL (0.8 ML per 30 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML	1	QL (0.4 ML per 30 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML	1	QL (0.8 ML per 30 days)
INVOKAMET	1	ST
INVOKAMET XR	1	ST; QL (60 EA per 30 days)
INVOKANA	1	ST; QL (30 EA per 30 days)
JANUMET	1	
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-500 MG	1	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG	1	QL (60 EA per 30 days)
JANUVIA	1	QL (30 EA per 30 days)
JARDIANCE	1	

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Drug Name	Drug Tiers	Requirements/Limits
JENTADUETO	1	QL (60 EA per 30 days)
JENTADUETO XR	1	QL (30 EA per 30 days)
KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	1	ST; QL (60 EA per 30 days)
KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG, 5-500 MG	1	ST; QL (30 EA per 30 days)
<i>metformin hcl er</i>	1	
<i>metformin hcl oral tablet</i>	1	
<i>miglitol</i>	1	
<i>nateglinide</i>	1	
ONGLYZA	1	ST
OZEMPIC (0.25 OR 0.5 MG/DOSE)	1	ST
OZEMPIC (1 MG/DOSE)	1	ST
<i>pioglitazone hcl</i>	1	
<i>pioglitazone hcl-glimepiride</i>	1	
<i>pioglitazone hcl-metformin hcl</i>	1	
QTERN ORAL TABLET 10-5 MG	1	QL (30 EA per 30 days)
<i>repaglinide</i>	1	
SEGLUROMET ORAL TABLET 2.5-1000 MG, 7.5-1000 MG, 7.5-500 MG	1	ST; QL (60 EA per 30 days)
SEGLUROMET ORAL TABLET 2.5-500 MG	1	ST; QL (120 EA per 30 days)
STEGLATRO	1	ST; QL (30 EA per 30 days)
STEGLUJAN	1	QL (30 EA per 30 days)
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR	1*	ST
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR	1*	ST; QL (12 ML per 30 days)
SYNJARDY	1	
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG	1	QL (30 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG	1	QL (60 EA per 30 days)
TRADJENTA	1	QL (30 EA per 30 days)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG	1	QL (30 EA per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG	1	QL (60 EA per 30 days)
TRULICITY	1	
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	ST
XIGDUO XR	1	
XULTOPHY	1	
<b>Glycemic Agents</b>		
BAQSIMI TWO PACK	1	QL (2 EA per 30 days)
<i>diazoxide oral</i>	1*	
GLUCAGEN HYPOKIT	1	
<i>glucagon emergency injection kit</i>	1	
GLUCAGON EMERGENCY INJECTION SOLUTION RECONSTITUTED	1	
KORLYM	1*	QL (120 EA per 30 days)
<b>Insulins</b>		
APIDRA	1	ST
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	ST
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML	1	
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML	1	
CVS GAUZE STERILE PAD 2"X2"	1	
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM	1	
FIASP	1	ST
FIASP FLEXTOUCH	1	ST
FIASP PENFILL	1	ST
HUMALOG	1	
HUMALOG JUNIOR KWIKPEN	1	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	
HUMALOG MIX 50/50	1	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR	1	

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Drug Name	Drug Tiers	Requirements/Limits
HUMALOG MIX 75/25	1	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN- INJECTOR	1	
HUMULIN 70/30	1	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR	1	
HUMULIN N	1	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR	1	
HUMULIN R	1	
HUMULIN R U-500 (CONCENTRATED)	1*	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1*	
<i>insulin asp prot &amp; asp flexpen</i>	1	ST
<i>insulin aspart</i>	1	ST
<i>insulin aspart flexpen</i>	1	ST
<i>insulin aspart penfill</i>	1	ST
<i>insulin aspart prot &amp; aspart</i>	1	ST
LANTUS	1	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	
LYUMJEV	1	
LYUMJEV KWIKPEN	1	
NOVOLIN 70/30	1	ST
NOVOLIN 70/30 FLEXPEN	1	ST
NOVOLIN N	1	ST
NOVOLIN N FLEXPEN	1	ST
NOVOLIN R	1	ST
NOVOLIN R FLEXPEN	1	ST
<i>preferred plus insulin syringe 28g x 1/2" 0.5 ml</i>	1	
RELI-ON INSULIN SYRINGE 29G 0.3 ML	1	
SOLIQUA	1	
TOUJEO MAX SOLOSTAR	1	
TOUJEO SOLOSTAR	1	
V-GO 20	1	

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Drug Name	Drug Tiers	Requirements/Limits
V-GO 30	1	
V-GO 40	1	
<b>Blood Products And Modifiers</b>		
<b>Anticoagulants</b>		
COUMADIN ORAL	1	
ELIQUIS	1	QL (74 EA per 30 days)
ELIQUIS DVT/PE STARTER PACK	1	QL (74 EA per 30 days)
<i>enoxaparin sodium injection</i>	1	
<i>enoxaparin sodium subcutaneous solution 100 mg/ml, 150 mg/ml</i>	1	QL (60 ML per 30 days)
<i>enoxaparin sodium subcutaneous solution 120 mg/0.8ml, 80 mg/0.8ml</i>	1	QL (48 ML per 30 days)
<i>enoxaparin sodium subcutaneous solution 30 mg/0.3ml</i>	1	QL (18 ML per 30 days)
<i>enoxaparin sodium subcutaneous solution 40 mg/0.4ml</i>	1	QL (24 ML per 30 days)
<i>enoxaparin sodium subcutaneous solution 60 mg/0.6ml</i>	1	QL (36 ML per 30 days)
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml</i>	1*	QL (24 ML per 30 days)
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	1	QL (15 ML per 30 days)
<i>fondaparinux sodium subcutaneous solution 5 mg/0.4ml</i>	1*	QL (12 ML per 30 days)
<i>fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml</i>	1*	QL (18 ML per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 7500 UNIT/0.3ML	1*	
FRAGMIN SUBCUTANEOUS SOLUTION 2500 UNIT/0.2ML, 5000 UNIT/0.2ML	1	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	1	HI
<i>jantoven</i>	1	
PRADAXA	1	QL (60 EA per 30 days)
SAVAYSA	1	QL (30 EA per 30 days)
<i>warfarin sodium oral</i>	1	
XARELTO ORAL TABLET 10 MG, 20 MG	1	QL (30 EA per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
XARELTO ORAL TABLET 15 MG, 2.5 MG	1	QL (60 EA per 30 days)
XARELTO STARTER PACK	1	
<b>Blood Products And Modifiers, Other</b>		
<i>anagrelide hcl</i>	1	
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	1*	B/D
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 25 MCG/ML	1	B/D
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML	1	B/D
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML	1*	B/D
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	1	B/D
FULPHILA	1*	
GRANIX	1*	
LEUKINE INJECTION SOLUTION RECONSTITUTED	1*	
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE	1*	PA
NYVEPRIA	1*	QL (1.2 ML per 28 days)
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML	1	B/D
PROCRIT INJECTION SOLUTION 20000 UNIT/ML, 40000 UNIT/ML	1*	B/D
PROCRIT INJECTION SOLUTION 4000 UNIT/ML	1	B/D
PROMACTA	1*	PA; LA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML	1	B/D
UDENYCA	1*	QL (1.2 ML per 28 days)
ZARXIO	1*	

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Drug Name	Drug Tiers	Requirements/Limits
ZIEXTENZO	1*	QL (1.2 ML per 28 days)
<b>Hemostasis Agents</b>		
<i>tranexamic acid oral</i>	1	
<b>Platelet Modifying Agents</b>		
<i>aspirin-dipyridamole er</i>	1	
BRILINTA	1	QL (60 EA per 30 days)
<i>cilostazol</i>	1	
<i>clopidogrel bisulfate oral tablet 75 mg</i>	1	
<i>prasugrel hcl</i>	1	
<b>Cardiovascular Agents</b>		
<b>Alpha-Adrenergic Agonists</b>		
<i>clonidine</i>	1	
<i>clonidine hcl oral</i>	1	
<i>droxidopa</i>	1*	PA
<i>midodrine hcl</i>	1	
<b>Alpha-Adrenergic Blocking Agents</b>		
<i>doxazosin mesylate oral</i>	1	
<i>prazosin hcl oral</i>	1	
<i>terazosin hcl oral</i>	1	
<b>Angiotensin II Receptor Antagonists</b>		
<i>candesartan cilexetil</i>	1	
<i>irbesartan</i>	1	
<i>losartan potassium oral</i>	1	
<i>olmesartan medoxomil oral</i>	1	
<i>telmisartan</i>	1	
<i>telmisartan-hctz oral tablet 80-12.5 mg</i>	1	
<i>valsartan</i>	1	
<b>Angiotensin-Converting Enzyme (Ace) Inhibitors</b>		
<i>benazepril hcl oral</i>	1	
<i>captopril oral</i>	1	
<i>enalapril maleate oral tablet</i>	1	
<i>fosinopril sodium</i>	1	
<i>lisinopril oral</i>	1	
<i>moexipril hcl</i>	1	

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<b>Drug Name</b>	<b>Drug Tiers</b>	<b>Requirements/Limits</b>
<i>perindopril erbumine</i>	1	
<i>quinapril hcl</i>	1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 5 mg</i>	1	
<i>ramipril oral capsule 2.5 mg</i>	1	
<i>trandolapril</i>	1	
<b>Antiarrhythmics</b>		
<i>amiodarone hcl oral tablet 200 mg</i>	1	
<i>disopyramide phosphate oral</i>	1	
<i>dofetilide</i>	1	
<i>flecainide acetate</i>	1	
<i>mexiletine hcl oral</i>	1	
MULTAQ	1	
<i>pacerone oral tablet 200 mg</i>	1	
<i>propafenone hcl</i>	1	
<i>propafenone hcl er</i>	1	
<i>quinidine gluconate er</i>	1	
<i>quinidine sulfate oral</i>	1	
RYTHMOL SR	1	
SORINE	1	
<i>sotalol hcl (af)</i>	1	
<i>sotalol hcl oral</i>	1	
<b>Beta-Adrenergic Blocking Agents</b>		
<i>acebutolol hcl oral</i>	1	
<i>atenolol oral</i>	1	
<i>betaxolol hcl oral</i>	1	
<i>bisoprolol fumarate oral</i>	1	
<i>carvedilol</i>	1	
<i>carvedilol phosphate er</i>	1	
INNOPRAN XL	1	
<i>labetalol hcl oral</i>	1	
<i>metoprolol succinate er</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 37.5 mg, 75 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	

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<b>Drug Name</b>	<b>Drug Tiers</b>	<b>Requirements/Limits</b>
<i>nebivolol hcl</i>	1	
<i>pindolol</i>	1	
<i>propranolol hcl er</i>	1	
<i>propranolol hcl oral</i>	1	
<i>timolol maleate oral</i>	1	
<b>Calcium Channel Blocking Agents, Dihydropyridines</b>		
<i>amlodipine besylate oral</i>	1	
<i>felodipine er</i>	1	
<i>isradipine</i>	1	
<i>nicardipine hcl oral</i>	1	
<i>nifedipine er</i>	1	
<i>nifedipine er osmotic release</i>	1	
<i>nimodipine oral</i>	1	
<b>Calcium Channel Blocking Agents, Nondihydropyridines</b>		
<i>cartia xt</i>	1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 360 mg, 420 mg</i>	1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour</i>	1	
<i>diltiazem hcl er oral capsule extended release 12 hour</i>	1	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg</i>	1	
<i>diltiazem hcl oral tablet 120 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl oral tablet 30 mg</i>	1	
<i>dilt-xr</i>	1	
<i>taztia xt</i>	1	
<i>verapamil hcl er</i>	1	
<i>verapamil hcl oral</i>	1	
<b>Cardiovascular Agents, Other</b>		
<i>acetazolamide oral</i>	1	
<i>aliskiren fumarate</i>	1	
<i>amiloride-hydrochlorothiazide</i>	1	
<i>amlodipine besy-benazepril hcl</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>amlodipine besylate-valsartan</i>	1	
<i>amlodipine-atorvastatin</i>	1	
<i>amlodipine-olmesartan</i>	1	
<i>amlodipine-valsartan-hctz</i>	1	
<i>atenolol-chlorthalidone</i>	1	
<i>benazepril-hydrochlorothiazide</i>	1	
BIDIL	1	
<i>bisoprolol-hydrochlorothiazide</i>	1	
<i>candesartan cilexetil-hctz</i>	1	
<i>captopril-hydrochlorothiazide</i>	1	
CORLANOR	1	
DIGITEK	1	
DIGOX	1	
<i>digoxin oral</i>	1	
<i>enalapril-hydrochlorothiazide</i>	1	
ENTRESTO	1	QL (60 EA per 30 days)
<i>fosinopril sodium-hctz</i>	1	
<i>irbesartan-hydrochlorothiazide</i>	1	
<i>lisinopril-hydrochlorothiazide</i>	1	
<i>losartan potassium-hctz</i>	1	
<i>metoprolol-hydrochlorothiazide</i>	1	
<i>metyrosine</i>	1	
NEXLETOL	1	PA; QL (30 EA per 30 days)
NEXLIZET	1	PA; QL (30 EA per 30 days)
<i>olmesartan medoxomil-hctz</i>	1	
<i>olmesartan-amlodipine-hctz</i>	1	
ORLADEYO	1*	PA; QL (30 EA per 30 days)
<i>pentoxifylline er</i>	1	
<i>propranolol-hctz</i>	1	
<i>quinapril-hydrochlorothiazide</i>	1	
<i>ranolazine er</i>	1	
<i>spironolactone-hctz</i>	1	
TEKTURNA HCT	1	
<i>telmisartan-amlodipine</i>	1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-25 mg</i>	1	

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<b>Drug Name</b>	<b>Drug Tiers</b>	<b>Requirements/Limits</b>
<i>trandolapril-verapamil hcl er</i>	1	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hctz oral tablet</i>	1	
<i>valsartan-hydrochlorothiazide</i>	1	
VECAMYL	1*	
VERQUVO	1	PA; QL (30 EA per 30 days)
<b>Diuretics, Loop</b>		
<i>bumetanide oral</i>	1	
<i>ethacrynic acid oral</i>	1	
<i>furosemide injection solution 10 mg/ml</i>	1	HI
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	1	
<i>furosemide oral tablet</i>	1	
<i>toremide oral tablet 10 mg, 20 mg</i>	1	
<i>toremide oral tablet 100 mg, 5 mg</i>	1	
<b>Diuretics, Potassium-Sparing</b>		
<i>amiloride hcl oral</i>	1	
<i>epplerenone</i>	1	
KERENDIA	1	PA; QL (30 EA per 30 days)
<i>spironolactone oral tablet 100 mg, 50 mg</i>	1	
<i>spironolactone oral tablet 25 mg</i>	1	
<i>triamterene oral</i>	1	
<b>Diuretics, Thiazide</b>		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>hydrochlorothiazide oral</i>	1	
<i>indapamide oral</i>	1	
<i>metolazone</i>	1	
<b>Dyslipidemics, Fibric Acid Derivatives</b>		
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	1	
<i>fenofibrate oral capsule 134 mg, 150 mg, 50 mg</i>	1	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	1	
<i>fenofibric acid oral capsule delayed release</i>	1	
<i>gemfibrozil oral</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Dyslipidemics, Hmg Coa Reductase Inhibitors</b>		
<i>atorvastatin calcium oral tablet 10 mg</i>	1	
<i>atorvastatin calcium oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>fluvastatin sodium</i>	1	
<i>fluvastatin sodium er</i>	1	
<i>lovastatin oral</i>	1	
<i>pravastatin sodium</i>	1	
<i>rosuvastatin calcium</i>	1	
<i>simvastatin oral tablet</i>	1	
<b>Dyslipidemics, Other</b>		
<i>cholestyramine light</i>	1	
<i>cholestyramine oral</i>	1	
<i>colesevelam hcl oral packet</i>	1	
<i>colesevelam hcl oral tablet</i>	1	
<i>colestipol hcl oral packet</i>	1	
<i>colestipol hcl oral tablet</i>	1	
EVKEEZA	1*	PA
<i>ezetimibe</i>	1	
<i>ezetimibe-simvastatin</i>	1	
<i>icosapent ethyl</i>	1	PA
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg</i>	1	
<i>niacin er (antihyperlipidemic) oral tablet extended release 500 mg, 750 mg</i>	1	
<i>omega-3-acid ethyl esters</i>	1	
<i>prevalite</i>	1	
REPATHA	1	PA; QL (2 ML per 28 days)
REPATHA PUSHTRONEX SYSTEM	1	PA; QL (3.5 ML per 30 days)
REPATHA SURECLICK	1	PA; QL (2 ML per 28 days)
VASCEPA ORAL CAPSULE 0.5 GM	1	PA
<b>Vasodilators, Direct-Acting Arterial/Venous</b>		
<i>isosorbide dinitrate oral tablet 10 mg, 30 mg, 5 mg</i>	1	
<i>isosorbide dinitrate oral tablet 20 mg</i>	1	
<i>isosorbide mononitrate</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>isosorbide mononitrate er</i>	1	
NITRO-BID	1	
<i>nitroglycerin sublingual</i>	1	
<i>nitroglycerin transdermal patch 24 hour</i>	1	
<i>nitroglycerin translingual solution</i>	1	
<i>nitrolingual</i>	1	
RECTIV	1	QL (30 GM per 30 days)
<b>Vasodilators, Direct-Acting Arterial</b>		
<i>hydralazine hcl oral</i>	1	
<i>minoxidil oral</i>	1	
<b>Central Nervous System Agents</b>		
<b>Attention Deficit Hyperactivity Disorder Agents, Amphetamines</b>		
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 25 mg, 5 mg</i>	1	QL (30 EA per 30 days)
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 30 mg</i>	1	QL (60 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 5 mg, 7.5 mg</i>	1	QL (120 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 20 mg</i>	1	QL (90 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 30 mg</i>	1	QL (60 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg</i>	1	QL (60 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	1	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg</i>	1	QL (180 EA per 30 days)
<i>dextroamphetamine sulfate oral tablet 5 mg</i>	1	QL (60 EA per 30 days)
VYVANSE	1	QL (30 EA per 30 days)
<b>Attention Deficit Hyperactivity Disorder Agents, Non-Amphetamines</b>		
<i>atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	1	QL (60 EA per 30 days)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	1	QL (30 EA per 30 days)
<i>clonidine hcl er</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
DAYTRANA	1	QL (30 EA per 30 days)
<i>dexmethylphenidate hcl</i>	1	QL (60 EA per 30 days)
<i>dexmethylphenidate hcl er</i>	1	QL (30 EA per 30 days)
<i>methylphenidate hcl er (cd)</i>	1	QL (30 EA per 30 days)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg</i>	1	QL (30 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	1	QL (90 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 18 mg, 36 mg, 54 mg, 72 mg</i>	1	QL (30 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 36 mg, 54 mg</i>	1	QL (30 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 24 hour 27 mg</i>	1	QL (60 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 27 mg</i>	1	QL (60 EA per 30 days)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	1	QL (1500 ML per 30 days)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	1	QL (3000 ML per 30 days)
<i>methylphenidate hcl oral tablet</i>	1	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet chewable</i>	1	
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG	1	PA; QL (30 EA per 30 days)
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 150 MG, 200 MG	1	PA; QL (60 EA per 30 days)
<b>Central Nervous System, Other</b>		
AUSTEDO ORAL TABLET 12 MG	1*	PA; QL (120 EA per 30 days)
AUSTEDO ORAL TABLET 6 MG	1*	PA; QL (240 EA per 30 days)
AUSTEDO ORAL TABLET 9 MG	1*	PA; QL (150 EA per 30 days)
EVRYSDI	1*	PA; QL (240 ML per 30 days)
FIRDAPSE	1*	PA; QL (240 EA per 30 days)
INGREZZA	1*	PA; QL (30 EA per 30 days)
NUEDEXTA	1*	PA; QL (60 EA per 30 days)
<i>riluzole</i>	1	
<i>tetrabenazine oral tablet 12.5 mg</i>	1*	PA; QL (90 EA per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	1*	PA; QL (120 EA per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
<b>Fibromyalgia Agents</b>		
<i>duloxetine hcl oral capsule delayed release particles 20 mg</i>	1	QL (180 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 30 mg</i>	1	QL (120 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	1	QL (30 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 60 mg</i>	1	QL (60 EA per 30 days)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	1	QL (90 EA per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	1	QL (60 EA per 30 days)
<i>pregabalin oral solution</i>	1	
<b>Multiple Sclerosis Agents</b>		
AUBAGIO	1*	
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT	1*	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT	1*	
<i>dalfampridine er</i>	1*	PA; QL (60 EA per 30 days)
<i>dimethyl fumarate oral</i>	1*	
<i>dimethyl fumarate starter pack</i>	1*	
GILENYA ORAL CAPSULE 0.5 MG	1*	
<i>glatiramer acetate</i>	1*	
GLATOPA	1*	
KESIMPTA	1*	
MAVENCLAD (10 TABS)	1*	PA; QL (40 EA per 365 days)
MAVENCLAD (4 TABS)	1*	PA; QL (20 EA per 365 days)
MAVENCLAD (5 TABS)	1*	PA; QL (20 EA per 365 days)
MAVENCLAD (6 TABS)	1*	PA; QL (24 EA per 365 days)
MAVENCLAD (7 TABS)	1*	PA; QL (28 EA per 365 days)
MAVENCLAD (8 TABS)	1*	PA; QL (20 EA per 365 days)
MAVENCLAD (9 TABS)	1*	PA; QL (20 EA per 365 days)
MAYZENT ORAL TABLET 0.25 MG	1*	QL (120 EA per 30 days)
MAYZENT ORAL TABLET 2 MG	1*	QL (30 EA per 30 days)
MAYZENT STARTER PACK	1*	
PLEGRIDY	1*	QL (1 ML per 28 days)

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Drug Name	Drug Tiers	Requirements/Limits
PLEGRIDY STARTER PACK	1*	QL (1 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR	1*	
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR	1*	
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	
ZEPOSIA	1*	QL (30 EA per 30 days)
ZEPOSIA 7-DAY STARTER PACK	1*	QL (14 EA per 365 days)
ZEPOSIA STARTER KIT	1*	QL (74 EA per 365 days)
<b>Dental And Oral Agents</b>		
<b>Dental And Oral Agents</b>		
<i>cevimeline hcl</i>	1	
<i>chlorhexidine gluconate mouth/throat</i>	1	
<i>denta 5000 plus</i>	1	
<i>pilocarpine hcl oral tablet 5 mg</i>	1	QL (180 EA per 30 days)
<i>pilocarpine hcl oral tablet 7.5 mg</i>	1	QL (120 EA per 30 days)
<i>sf</i>	1	
<i>sf 5000 plus</i>	1	
<i>triamcinolone acetonide mouth/throat</i>	1	
<b>Dermatological Agents</b>		
<b>Acne And Rosacea Agents</b>		
<i>acitretin</i>	1	
<i>adapalene external gel 0.1 %</i>	1	
<i>adapalene external gel 0.3 %</i>	1	
<i>amnesteam</i>	1	
<i>azelaic acid external</i>	1	
<i>beser external lotion</i>	1	
CLARAVIS	1	
<i>clindamycin phos-benzoyl perox external gel 1-5 %</i>	1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	1	
SORIATANE ORAL CAPSULE 10 MG, 25 MG	1*	

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<b>Drug Name</b>	<b>Drug Tiers</b>	<b>Requirements/Limits</b>
<i>tazarotene external cream</i>	1	
<i>tretinoin external cream</i>	1	
<i>tretinoin external gel 0.01 %, 0.025 %</i>	1	
<i>tretinoin external gel 0.05 %</i>	1	
<b><i>Dermatitis And Pruitus Agents</i></b>		
<i>ala-cort external cream 1 %</i>	1	
<i>alclometasone dipropionate</i>	1	
<i>ammonium lactate external</i>	1	
<i>betamethasone dipropionate aug external gel</i>	1	QL (50 GM per 30 days)
<i>betamethasone dipropionate aug external lotion</i>	1	QL (60 ML per 30 days)
<i>betamethasone dipropionate aug external ointment</i>	1	QL (50 GM per 30 days)
<i>betamethasone dipropionate external cream</i>	1	
<i>betamethasone dipropionate external lotion</i>	1	
<i>betamethasone valerate external cream</i>	1	
<i>betamethasone valerate external lotion</i>	1	QL (60 ML per 30 days)
<i>betamethasone valerate external ointment</i>	1	
<i>calcipotriene-betameth diprop external ointment</i>	1	
<i>clobetasol prop emollient base</i>	1	
<i>clobetasol propionate e</i>	1	QL (60 GM per 30 days)
<i>clobetasol propionate external cream</i>	1	QL (60 GM per 30 days)
<i>clobetasol propionate external gel</i>	1	
<i>clobetasol propionate external lotion</i>	1	QL (118 ML per 30 days)
<i>clobetasol propionate external ointment</i>	1	QL (60 GM per 30 days)
<i>clobetasol propionate external shampoo</i>	1	QL (118 ML per 30 days)
<i>clobetasol propionate external solution</i>	1	
<i>desonide external cream</i>	1	
<i>desonide external ointment</i>	1	
<i>desoximetasone external cream 0.25 %</i>	1	
<i>desoximetasone external ointment 0.25 %</i>	1	
<i>doxepin hcl external</i>	1	QL (90 GM per 365 days)
ENSTILAR	1*	
<i>fluocinolone acetonide external</i>	1	
<i>fluocinolone acetonide scalp</i>	1	
<i>fluocinonide emulsified base</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>fluocinonide external cream 0.05 %</i>	1	
<i>fluocinonide external gel</i>	1	
<i>fluocinonide external ointment</i>	1	
<i>fluocinonide external solution</i>	1	QL (60 ML per 30 days)
<i>fluticasone propionate external cream</i>	1	
<i>fluticasone propionate external ointment</i>	1	
<i>halobetasol propionate external cream</i>	1	QL (50 GM per 30 days)
<i>halobetasol propionate external ointment</i>	1	QL (50 GM per 30 days)
<i>hydrocortisone butyr lipo base</i>	1	
<i>hydrocortisone butyrate external cream</i>	1	
<i>hydrocortisone butyrate external ointment</i>	1	
<i>hydrocortisone butyrate external solution</i>	1	
<i>hydrocortisone external cream 1 %, 2.5 %</i>	1	
<i>hydrocortisone external lotion 2.5 %</i>	1	
<i>hydrocortisone external ointment 2.5 %</i>	1	
<i>hydrocortisone valerate external cream</i>	1	QL (120 GM per 30 days)
<i>hydrocortisone valerate external ointment</i>	1	
<i>mometasone furoate external</i>	1	
NOLIX EXTERNAL LOTION	1	
<i>pimecrolimus</i>	1	
<i>prednicarbate</i>	1	
<i>procto-med hc external</i>	1	
<i>procto-pak external</i>	1	
<i>proctosol hc external</i>	1	
PROCTOZONE-HC EXTERNAL	1	
<i>selenium sulfide external lotion</i>	1	
<i>tacrolimus external ointment</i>	1	QL (100 GM per 30 days)
<i>triamcinolone acetonide external cream</i>	1	
<i>triamcinolone acetonide external lotion</i>	1	
<i>triamcinolone acetonide external ointment</i>	1	
TRIDERM EXTERNAL CREAM 0.1 %	1	
XERESE	1	QL (5 GM per 30 days)
<b><i>Dermatological Agents, Other</i></b>		
<i>calcipotriene external cream</i>	1	QL (120 GM per 30 days)
<i>calcipotriene external ointment</i>	1	QL (120 GM per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
<i>calcipotriene external solution</i>	1	QL (120 ML per 30 days)
<i>calcitriol external</i>	1	ST
<i>clotrimazole-betamethasone</i>	1	
<i>fluorouracil external cream 5 %</i>	1	
<i>fluorouracil external solution</i>	1	
<i>global alcohol prep ease</i>	1	
<i>imiquimod external cream 3.75 %</i>	1*	
<i>imiquimod external cream 5 %</i>	1	
<i>imiquimod pump</i>	1*	
KLISYRI	1*	ST; QL (5 EA per 365 days)
<i>methoxsalen rapid</i>	1*	
<i>nystatin-triamcinolone</i>	1	
OTEZLA ORAL TABLET	1*	PA; QL (60 EA per 30 days)
OXSORALEN ULTRA	1*	
PANRETIN	1*	PA; QL (60 GM per 30 days)
PICATO	1*	ST
<i>podofilox external</i>	1	
SANTYL	1	QL (60 GM per 30 days)
<i>silver sulfadiazine external</i>	1	
ssd	1	
<b>Pediculicides/Scabicides</b>		
<i>ivermectin external cream</i>	1	
<i>ivermectin external lotion</i>	1	QL (117 GM per 14 days)
<i>lindane external shampoo</i>	1	
<i>permethrin external cream</i>	1	
<b>Topical Anti-Infectives</b>		
<i>acyclovir external ointment</i>	1	QL (30 GM per 30 days)
<i>ciclopirox external</i>	1	
<i>clindamycin phosphate external gel</i>	1	
<i>clindamycin phosphate external lotion</i>	1	
<i>clindamycin phosphate external solution</i>	1	QL (180 ML per 30 days)
<i>ery</i>	1	
<i>erythromycin external gel</i>	1	
<i>erythromycin external solution</i>	1	
<i>mupirocin calcium</i>	1	QL (60 GM per 30 days)

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Drug Name	Drug Tiers	Requirements/Limits
<i>mupirocin external</i>	1	QL (440 GM per 30 days)
SULFAMYLON EXTERNAL CREAM	1	
<b>Electrolytes/Minerals/Metals/Vitamins</b>		
<b>Electrolyte/Mineral Replacement</b>		
CARBAGLU	1*	PA; LA
DOJOLVI	1*	PA
<i>kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.45 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%</i>	1	
<i>kcl-lactated ringers-d5w</i>	1	
KLOR-CON 10	1	
KLOR-CON M10	1	
KLOR-CON M15	1	
KLOR-CON M20	1	
KLOR-CON ORAL TABLET EXTENDED RELEASE	1	
KLOR-CON SPRINKLE	1	
KLOR-CON/EF	1	
NORMOSOL-M IN D5W	1	
NORMOSOL-R	1	
<i>potassium chloride crys er</i>	1	
<i>potassium chloride er</i>	1	
<i>potassium chloride in dextrose intravenous solution 20-5 meq/l-%, 40-5 meq/l-%</i>	1	
<i>potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%, 40-0.9 meq/l-%</i>	1	
<i>potassium chloride intravenous solution 10 meq/100ml, 2 meq/ml, 20 meq/100ml, 40 meq/100ml</i>	1	HI
<i>potassium chloride oral packet</i>	1	
<i>potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	1	
<i>potassium citrate er</i>	1	
<i>sodium chloride intravenous solution 0.9 %</i>	1	HI
<i>sodium chloride irrigation solution 0.9 %</i>	1	
SUPREP BOWEL PREP KIT	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Electrolyte/Mineral/Metal Modifiers</b>		
CLINIMIX E/DEXTROSE (4.25/10)	1	B/D
<i>deferasirox oral tablet</i>	1*	
<i>deferasirox oral tablet soluble 125 mg</i>	1	
<i>deferasirox oral tablet soluble 250 mg, 500 mg</i>	1*	
<i>deferiprone</i>	1*	
<i>klor-con oral packet 20 meq</i>	1	
SAMSCA	1*	PA
<i>tolvaptan</i>	1*	PA
<i>trientine hcl</i>	1	
<b>Electrolytes/Minerals/Metals/Vitamins</b>		
AMINOSYN II INTRAVENOUS SOLUTION 15 %	1	B/D
AMINOSYN-PF	1	B/D
CLINIMIX E/DEXTROSE (2.75/5)	1	B/D
CLINIMIX E/DEXTROSE (4.25/5)	1	B/D
CLINIMIX E/DEXTROSE (5/15)	1	B/D
CLINIMIX E/DEXTROSE (5/20)	1	B/D
CLINIMIX/DEXTROSE (4.25/10)	1	B/D
CLINIMIX/DEXTROSE (4.25/5)	1	B/D
CLINIMIX/DEXTROSE (5/15)	1	B/D
CLINIMIX/DEXTROSE (5/20)	1	B/D
<i>dextrose intravenous solution 10 %, 5 %</i>	1	
<i>dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.225 %, 5-0.45 %, 5-0.9 %</i>	1	
INTRALIPID	1	B/D
<i>levocarnitine oral solution</i>	1	
<i>levocarnitine oral tablet</i>	1	
NEPHRAMINE	1	B/D
PREMASOL INTRAVENOUS SOLUTION 10 %	1	B/D
PROCALAMINE	1	B/D
TROPHAMINE	1	B/D
<b>Phosphate Binders</b>		
AURYXIA	1*	PA
<i>calcium acetate (phos binder)</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>lanthanum carbonate</i>	1*	
<i>sevelamer carbonate oral packet</i>	1*	
<i>sevelamer carbonate oral tablet</i>	1	
VELPHORO	1*	ST
<b>Potassium Binders</b>		
KIONEX ORAL SUSPENSION	1	
LOKELMA ORAL PACKET 10 GM	1	QL (90 EA per 30 days)
LOKELMA ORAL PACKET 5 GM	1	QL (30 EA per 30 days)
<i>sodium polystyrene sulfonate oral powder</i>	1	
SPS	1	
VELTASSA	1	QL (30 EA per 30 days)
<b>Gastrointestinal Agents</b>		
<b>Anti-Constipation Agents</b>		
AMITIZA	1	
<i>constulose</i>	1	
<i>enulose</i>	1	
<i>gavilyte-c</i>	1	
<i>gavilyte-g</i>	1	
<i>gavilyte-h</i>	1	
<i>gavilyte-n with flavor pack</i>	1	
<i>generlac</i>	1	
KRISTALOSE	1	
<i>lactulose oral packet</i>	1*	
<i>lactulose oral solution 10 gm/15ml</i>	1	
LINZESS	1	QL (30 EA per 30 days)
MOVANTI	1	ST; QL (30 EA per 30 days)
<i>peg 3350-kcl-na bicarb-nacl</i>	1	
<i>peg-3350/electrolytes</i>	1	
RELISTOR ORAL	1*	PA; QL (90 EA per 30 days)
RELISTOR SUBCUTANEOUS SOLUTION	1*	PA
<b>Anti-Diarrheal Agents</b>		
<i>alosetron hcl</i>	1*	
<i>diphenoxylate-atropine oral liquid</i>	1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	1	
<i>loperamide hcl oral capsule</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
XERMELO	1*	PA
<b>Antispasmodics, Gastrointestinal</b>		
CUVPOSA	1	
<i>dicyclomine hcl oral</i>	1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	
<i>methscopolamine bromide oral</i>	1	
<b>Gastrointestinal Agents, Other</b>		
<i>amoxicill-clarithro-lansopraz</i>	1	
GATTEX	1*	PA
<i>metoclopramide hcl oral solution 5 mg/5ml</i>	1	
<i>metoclopramide hcl oral tablet</i>	1	
<i>metoclopramide hcl oral tablet dispersible</i>	1	
MYALEPT	1*	PA
OCALIVA	1*	PA; QL (30 EA per 30 days)
<i>opium</i>	1	QL (118 ML per 30 days)
<i>ursodiol oral capsule 300 mg</i>	1	
<i>ursodiol oral tablet</i>	1	
<b>Histamine2 (H2) Receptor Antagonists</b>		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	1	
<i>cimetidine oral</i>	1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	
<i>nizatidine oral capsule</i>	1	
<b>Protectants</b>		
<i>misoprostol oral</i>	1	
<i>sucralfate oral suspension</i>	1	
<i>sucralfate oral tablet</i>	1	
<b>Proton Pump Inhibitors</b>		
<i>esomeprazole magnesium oral capsule delayed release</i>	1	
<i>lansoprazole oral capsule delayed release</i>	1	
<i>omeprazole oral capsule delayed release 10 mg, 40 mg</i>	1	
<i>omeprazole oral capsule delayed release 20 mg</i>	1	
<i>pantoprazole sodium oral tablet delayed release</i>	1	
<i>rabeprazole sodium oral tablet delayed release</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment</b>		
<i>Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment</i>		
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	1*	PA; LA
CERDELGA	1*	QL (60 EA per 30 days)
CHOLBAM	1*	PA
CREON	1	
<i>cromolyn sodium oral</i>	1	
CYSTADANE	1	LA
CYSTAGON	1	LA
GALAFOLD	1*	PA; QL (14 EA per 28 days)
GLASSIA	1*	PA; LA
KEVEYIS	1*	PA
<i>miglustat</i>	1*	
<i>nitisinone</i>	1*	
NULIBRY	1*	PA
ORFADIN ORAL CAPSULE 20 MG	1*	LA
ORFADIN ORAL SUSPENSION	1*	LA
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600- 6200 UNIT, 2600-8800 UNIT, 4200-14200 UNIT	1	ST
<i>pancreaze oral capsule delayed release particles 37000-97300 unit</i>	1	ST
PROCYSBI	1*	
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED	1*	PA; LA
RAVICTI	1*	PA
RUZURGI	1*	PA; QL (300 EA per 30 days)
<i>sapropterin dihydrochloride</i>	1*	
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	1*	
<i>sodium phenylbutyrate oral tablet</i>	1*	
SUCRAID	1*	LA
TEGSEDI	1*	PA; QL (6 ML per 28 days)
VIOKACE	1	ST

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Drug Name	Drug Tiers	Requirements/Limits
VISTOGARD	1*	QL (20 EA per 5 days)
VYNDAQEL	1*	PA; QL (120 EA per 30 days)
ZEMAIRA	1*	PA; LA
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT	1	ST
<b>Genitourinary Agents</b>		
<b>Antispasmodics, Urinary</b>		
<i>darifenacin hydrobromide er</i>	1	
<i>flavoxate hcl</i>	1	
GELNIQUE TRANSDERMAL GEL 10 %	1	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR	1	
<i>oxybutynin chloride er</i>	1	
<i>oxybutynin chloride oral</i>	1	
<i>solifenacin succinate</i>	1	
<i>tolterodine tartrate</i>	1	
<i>tolterodine tartrate er</i>	1	
TOVIAZ	1	
<i>tropium chloride</i>	1	
<i>tropium chloride er</i>	1	
<b>Benign Prostatic Hypertrophy Agents</b>		
<i>alfuzosin hcl er</i>	1	
<i>dutasteride oral</i>	1	
<i>dutasteride-tamsulosin hcl</i>	1	
<i>finasteride oral tablet 5 mg</i>	1	
<i>silodosin</i>	1	
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1	PA; QL (30 EA per 30 days)
<i>tamsulosin hcl</i>	1	
<b>Genitourinary Agents, Other</b>		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 50 mg</i>	1	
<i>bethanechol chloride oral tablet 5 mg</i>	1	
ELMIRON	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>methylergonovine maleate oral</i>	1	
<i>penicillamine oral tablet</i>	1	PA
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</b>		
ACTHAR	1*	PA
<i>betamethasone dipropionate aug external cream</i>	1	
<i>betamethasone dipropionate external ointment</i>	1	
<i>cortisone acetate oral</i>	1	
DEXAMETHASONE INTENSOL	1	
<i>dexamethasone oral elixir</i>	1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 4 mg</i>	1	
<i>dexamethasone oral tablet 1 mg, 1.5 mg, 2 mg, 6 mg</i>	1	
<i>dexamethasone oral tablet therapy pack</i>	1	
<i>dexamethasone sodium phosphate injection solution 120 mg/30ml</i>	1	
<i>fludrocortisone acetate oral</i>	1	
HEMADY	1*	PA; QL (30 EA per 30 days)
<i>hydrocortisone oral</i>	1	
ISTURISA ORAL TABLET 1 MG	1*	PA; QL (240 EA per 30 days)
ISTURISA ORAL TABLET 10 MG	1*	PA; QL (180 EA per 30 days)
ISTURISA ORAL TABLET 5 MG	1*	PA; QL (90 EA per 30 days)
<i>methylprednisolone oral</i>	1	
<i>prednisolone oral solution</i>	1	
<i>prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml</i>	1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 6.7 (5 base) mg/5ml</i>	1	
PREDNISON INTENSOL	1	
<i>prednisone oral solution</i>	1	
<i>prednisone oral tablet</i>	1	
<i>prednisone oral tablet therapy pack</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</b>		
<i>desmopressin ace spray refrig</i>	1	
<i>desmopressin acetate oral</i>	1	
GENOTROPIN	1*	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SOLUTION RECONSTITUTED 0.2 MG	1	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG	1*	PA
INCRELEX	1*	LA
NORDITROPIN FLEXPRO	1*	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG	1*	PA; LA
VYNDAMAX	1*	PA; QL (30 EA per 30 days)
ZORBTIVE	1*	PA; LA
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)</b>		
<b>Anabolic Steroids</b>		
ANADROL-50	1	
<i>oxandrolone oral</i>	1	
<b>Androgens</b>		
AVEED	1	PA
<i>danazol oral</i>	1	
<i>methyltestosterone oral</i>	1*	PA
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	
<i>testosterone enanthate intramuscular solution</i>	1	
<i>testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)</i>	1	PA
<i>testosterone transdermal solution</i>	1	PA

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Drug Name	Drug Tiers	Requirements/Limits
<b>Estrogens</b>		
ALTAVERA	1	
<i>alyacen 1/35</i>	1	
<i>amabelz</i>	1	
AMETHIA	1	
APRI	1	
ARANELLE	1	
AVIANE	1	
BALZIVA	1	
CAMRESE LO	1	
CAZIAN	1	
CRYSSELLE-28	1	
CYCLAFEM 1/35	1	
CYCLAFEM 7/7/7	1	
DEPO-ESTRADIOL	1	
<i>desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg</i>	1	
DIVIGEL TRANSDERMAL GEL 1 MG/GM	1	
<i>dotti</i>	1	
EMOQUETTE	1	
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	1	
<i>estarylla</i>	1	
<i>estradiol oral</i>	1	
<i>estradiol transdermal</i>	1	
<i>estradiol vaginal cream</i>	1	
<i>estradiol vaginal tablet</i>	1	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	1	
<i>estradiol-norethindrone acet</i>	1	
ESTRING	1	
<i>ethynodiol diac-eth estradiol</i>	1	
FALMINA	1	
FEMRING	1	
FEMYNOR	1	
FYAVOLV	1	

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Drug Name	Drug Tiers	Requirements/Limits
GIANVI	1	
ISIBLOOM	1	
JINTELI	1	
JUNEL 1.5/30	1	
JUNEL 1/20	1	
JUNEL FE 1.5/30	1	
JUNEL FE 1/20	1	
KARIVA	1	
KELNOR 1/35	1	
<i>kelnor 1/50</i>	1	
KURVELO	1	
LARIN FE 1.5/30	1	
LARIN FE 1/20	1	
LARISSIA	1	
LEENA	1	
LESSINA	1	
<i>levonorgest-eth est &amp; eth est</i>	1	
<i>levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg</i>	1	
<i>levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg</i>	1	
LEVORA 0.15/30 (28)	1	
LORYNA	1	
LOW-OGESTREL	1	
LUTERA	1	
<i>lyllana</i>	1	
<i>marlissa</i>	1	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	1	
MICROGESTIN 1.5/30	1	
MICROGESTIN 1/20	1	
MICROGESTIN FE 1.5/30	1	
MICROGESTIN FE 1/20	1	
MIMVEY	1	
NECON 0.5/35 (28)	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg</i>	1	
<i>norethindrone-eth estradiol</i>	1	
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg</i>	1	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1	
<i>norgestim-eth estrad triphasic</i>	1	
NORTREL 0.5/35 (28)	1	
NORTREL 1/35 (21)	1	
NORTREL 1/35 (28)	1	
NORTREL 7/7/7	1	
NUVARING	1	
<i>nymyo</i>	1	
OCELLA	1	
ORSYTHIA	1	
PIRMELLA 1/35	1	
PORTIA-28	1	
PREMARIN VAGINAL	1	
PREVIFEM	1	
RECLIPSEN	1	
SPRINTEC 28	1	
SRONYX	1	
<i>syeda</i>	1	
<i>tri-estarylla</i>	1	
TRI-LEGEST FE	1	
TRI-LO-ESTARYLLA	1	
TRI-LO-SPRINTEC	1	
<i>tri-nymyo</i>	1	
TRI-PREVIFEM	1	
TRI-SPRINTEC	1	
TRIVORA (28)	1	
<i>tri-vylibra</i>	1	
VELIVET	1	
<i>vylibra</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
XULANE	1	
YUVAFEM	1	
ZARAH	1	
ZOVIA 1/35E (28)	1	
<b>Progestins</b>		
CAMILA	1	
CRINONE VAGINAL GEL 8 %	1	PA
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE	1	
ERRIN	1	
<i>medroxyprogesterone acetate intramuscular</i>	1	
<i>medroxyprogesterone acetate oral</i>	1	
<i>megestrol acetate oral suspension 40 mg/ml</i>	1	
<i>megestrol acetate oral suspension 625 mg/5ml</i>	1	
<i>megestrol acetate oral tablet</i>	1	
NORA-BE	1	
<i>norethindrone acetate oral</i>	1	
<i>progesterone micronized oral</i>	1	
<i>progesterone oral</i>	1	
<b>Selective Estrogen Receptor Modifying Agents</b>		
<i>clomiphene citrate oral</i>	1	PA
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</b>		
<i>euthyrox</i>	1	
<i>levothyroxine sodium oral tablet</i>	1	
<i>levoxyl</i>	1	
<i>liothyronine sodium oral</i>	1	
SYNTHROID	1	
<i>unithroid</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Hormonal Agents, Suppressant (Adrenal)</b>		
<i>Hormonal Agents, Suppressant (Adrenal)</i>		
LYSODREN	1	
<b>Hormonal Agents, Suppressant (Pituitary)</b>		
<i>Hormonal Agents, Suppressant (Pituitary)</i>		
<i>cabergoline</i>	1	
ELIGARD	1	
FIRMAGON (240 MG DOSE)	1*	B/D
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG	1	B/D
<i>leuprolide acetate injection</i>	1	
LUPANETA PACK COMBINATION KIT 11.25 & 5 MG	1	QL (1 EA per 90 days)
LUPANETA PACK COMBINATION KIT 3.75 & 5 MG	1	QL (1 EA per 30 days)
LUPRON DEPOT (1-MONTH)	1*	
LUPRON DEPOT (3-MONTH)	1*	
LUPRON DEPOT (4-MONTH)	1*	
LUPRON DEPOT (6-MONTH)	1*	
LUPRON DEPOT-PED (1-MONTH)	1*	
LUPRON DEPOT-PED (3-MONTH)	1*	
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	1	
<i>octreotide acetate injection solution 1000 mcg/ml, 500 mcg/ml</i>	1*	
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml</i>	1	
<i>octreotide acetate subcutaneous solution prefilled syringe 500 mcg/ml</i>	1*	
SANDOSTATIN LAR DEPOT	1*	
SIGNIFOR	1*	PA
SOMATULINE DEPOT	1*	
SOMAVERT	1*	LA
SYNAREL	1*	
TRELSTAR MIXJECT	1*	B/D

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Drug Name	Drug Tiers	Requirements/Limits
<b>Hormonal Agents, Suppressant (Thyroid)</b>		
<b>Antithyroid Agents</b>		
<i>methimazole oral</i>	1	
<i>propylthiouracil oral</i>	1	
<b>Immunological Agents</b>		
<b>Angioedema Agents</b>		
BERINERT	1*	PA; LA
<i>icatibant acetate</i>	1*	PA
TAKHZYRO	1*	PA; LA
<b>Immunoglobulins</b>		
BIVIGAM INTRAVENOUS SOLUTION 5 GM/50ML	1*	PA
GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML	1*	PA
GAMMAGARD S/D LESS IGA	1*	PA
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML	1*	PA
PANZYGA	1*	PA
<b>Immunological Agents, Other</b>		
ARCALYST	1*	LA
COSENTYX (300 MG DOSE)	1*	PA
COSENTYX SENSOREADY (300 MG)	1*	PA
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	1*	PA
DUPIXENT	1*	PA
<i>leflunomide oral</i>	1	
ORENCIA CLICKJECT	1*	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	PA
RIDAURA	1	
RINVOQ	1*	PA; QL (30 EA per 30 days)
SKYRIZI	1*	PA; QL (2 ML per 84 days)
SKYRIZI (150 MG DOSE)	1*	PA; QL (2 EA per 84 days)
SKYRIZI PEN	1*	PA; QL (2 ML per 84 days)
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	1*	PA

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Drug Name	Drug Tiers	Requirements/Limits
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	PA
XELJANZ ORAL SOLUTION	1*	PA; QL (300 ML per 30 days)
XELJANZ ORAL TABLET	1*	PA; QL (60 EA per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG	1*	PA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED	1*	PA; LA
<b>Immunostimulants</b>		
ACTIMMUNE	1*	PA
INTRON A	1*	B/D
PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 180 MCG/0.5ML	1*	
PEGASYS PROCLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 180 MCG/0.5ML	1*	
PEGASYS SUBCUTANEOUS SOLUTION	1*	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG	1*	PA
<b>Immunosuppressants</b>		
ACTEMRA ACTPEN	1*	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	1*	PA; QL (3.6 ML per 28 days)
AFINITOR DISPERZ ORAL TABLET SOLUBLE 2 MG	1*	PA
ASTAGRAF XL	1	B/D
AZASAN	1	B/D
<i>azathioprine oral tablet 100 mg, 75 mg</i>	1	B/D
<i>azathioprine oral tablet 50 mg</i>	1	B/D
BENLYSTA SUBCUTANEOUS	1*	PA
CELLCEPT ORAL CAPSULE	1*	B/D
CELLCEPT ORAL SUSPENSION RECONSTITUTED	1	B/D
CELLCEPT ORAL TABLET	1*	B/D
<i>cyclosporine modified</i>	1	B/D

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Drug Name	Drug Tiers	Requirements/Limits
<i>cyclosporine oral capsule</i>	1	B/D
ENBREL MINI	1*	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	1*	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	PA
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED	1*	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR	1*	PA
ENSPRYNG	1*	PA; QL (1 ML per 30 days)
ENVARBUS XR	1	B/D
<i>everolimus oral tablet 0.25 mg</i>	1	B/D
<i>everolimus oral tablet 0.5 mg, 0.75 mg</i>	1*	B/D
<i>everolimus oral tablet 2.5 mg, 5 mg, 7.5 mg</i>	1*	PA
<i>everolimus oral tablet soluble 2 mg</i>	1*	PA
GENGRAF ORAL CAPSULE 100 MG, 25 MG	1	B/D
GENGRAF ORAL SOLUTION	1	B/D
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML	1*	PA
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	1*	PA; QL (2 EA per 28 days)
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	1*	PA
HUMIRA PEN-CD/UC/HS STARTER	1*	PA
HUMIRA PEN-PEDIATRIC UC START	1*	PA
HUMIRA PEN-PS/UV/ADOL HS START	1*	PA
HUMIRA PEN-PSOR/UVEIT STARTER	1*	PA
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT	1*	PA; QL (2 EA per 28 days)
LUPKYNIS	1*	PA
<i>mercaptopurine oral</i>	1	
<i>methotrexate oral</i>	1	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>methotrexate sodium injection solution reconstituted</i>	1	
<i>mycophenolate mofetil oral capsule</i>	1	B/D
<i>mycophenolate mofetil oral suspension reconstituted</i>	1*	B/D
<i>mycophenolate mofetil oral tablet</i>	1	B/D
<i>mycophenolate sodium</i>	1	B/D
MYFORTIC ORAL TABLET DELAYED RELEASE 180 MG	1	B/D
MYFORTIC ORAL TABLET DELAYED RELEASE 360 MG	1*	B/D
OTEZLA ORAL TABLET THERAPY PACK	1*	PA; QL (60 EA per 30 days)
PROGRAF ORAL PACKET	1	B/D
SANDIMMUNE ORAL SOLUTION	1	B/D
<i>sirolimus oral solution</i>	1*	B/D
<i>sirolimus oral tablet 0.5 mg</i>	1	B/D
<i>sirolimus oral tablet 1 mg</i>	1	B/D
<i>sirolimus oral tablet 2 mg</i>	1*	B/D
<i>tacrolimus oral</i>	1	B/D
TREXALL	1	B/D
XATMEP	1	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG	1*	PA
ZORTRESS ORAL TABLET 1 MG	1*	B/D
<b>Vaccines</b>		
ACTHIB	1	
ADACEL	1	
<i>bcg vaccine</i>	1	
BEXSERO	1	
BOOSTRIX	1	
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	1	
<i>diphtheria-tetanus toxoids dt</i>	1	
ENGERIX-B INJECTION	1	B/D
GARDASIL 9	1	
HAVRIX	1	

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HIBERIX INJECTION	1	
IMOVAX RABIES	1	
INFANRIX	1	
IPOL	1	
IXIARO	1	
KINRIX	1	
MENACTRA	1	
<i>menquadfi</i>	1	
MENVEO	1	
M-M-R II INJECTION	1	
PEDIARIX	1	
PEDVAX HIB INTRAMUSCULAR SUSPENSION	1	
PENTACEL	1	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	1	
QUADRACEL	1	
RABAVERT	1	
RECOMBIVAX HB	1	B/D
ROTARIX	1	
ROTATEQ ORAL SOLUTION	1	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	1	
TDVAX	1	
TENIVAC	1	
TRUMENBA	1	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
TYPHIM VI	1	
VAQTA	1	
VARIVAX	1	
VARIZIG INTRAMUSCULAR SOLUTION	1	
YF-VAX	1	
ZOSTAVAX SUBCUTANEOUS SUSPENSION RECONSTITUTED	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Inflammatory Bowel Disease Agents</b>		
<b>Aminosalicylates</b>		
<i>balsalazide disodium</i>	1	
<i>mesalamine er</i>	1	
<i>mesalamine oral capsule delayed release</i>	1	
<i>mesalamine oral tablet delayed release</i>	1	
<i>mesalamine rectal suppository</i>	1	
<i>sulfasalazine oral</i>	1	
<b>Glucocorticoids</b>		
<i>budesonide er oral tablet extended release 24 hour</i>	1*	QL (30 EA per 30 days)
<i>budesonide oral</i>	1	
EPIFOAM	1	
<i>hydrocortisone rectal enema</i>	1	
UCERIS ORAL	1*	QL (30 EA per 30 days)
UCERIS RECTAL	1	
<b>Metabolic Bone Disease Agents</b>		
<b>Metabolic Bone Disease Agents</b>		
<i>alendronate sodium oral solution</i>	1	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	1	
<i>calcitonin (salmon) nasal</i>	1	
<i>calcitriol oral</i>	1	
<i>cinacalcet hcl oral tablet 30 mg</i>	1	B/D
<i>cinacalcet hcl oral tablet 60 mg, 90 mg</i>	1*	B/D
<i>doxercalciferol oral</i>	1	B/D
EVENITY	1*	PA; QL (2.34 ML per 30 days)
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML	1*	PA
<i>ibandronate sodium oral</i>	1	
NATPARA	1*	PA
<i>paricalcitol oral capsule 1 mcg</i>	1	
<i>paricalcitol oral capsule 2 mcg, 4 mcg</i>	1	
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1	PA
RAYALDEE	1*	PA

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Drug Name	Drug Tiers	Requirements/Limits
<i>risedronate sodium oral tablet 150 mg</i>	1	QL (1 EA per 28 days)
<i>risedronate sodium oral tablet 30 mg</i>	1	QL (120 EA per 365 days)
<i>risedronate sodium oral tablet 35 mg</i>	1	QL (4 EA per 28 days)
<i>risedronate sodium oral tablet 5 mg</i>	1	QL (30 EA per 30 days)
<i>risedronate sodium oral tablet delayed release</i>	1	
TERIPARATIDE (RECOMBINANT)	1*	PA
TYMLOS	1*	PA; QL (1.56 ML per 30 days)
XGEVA	1*	PA
<b>Ophthalmic Agents</b>		
<b>Ophthalmic Prostaglandin And Prostanoid Analogs</b>		
<i>bimatoprost ophthalmic</i>	1	
<i>latanoprost ophthalmic</i>	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	1	ST
RHOPRESSA	1	
<i>travoprost (bak free)</i>	1	ST
<b>Ophthalmic Agents, Other</b>		
<i>atropine sulfate ophthalmic solution 1 %</i>	1	
<i>bacitra-neomycin-polymyxin-hc</i>	1	
BLEPHAMIDE	1	
BLEPHAMIDE S.O.P.	1	
CEQUA	1	QL (60 EA per 30 days)
CYSTADROPS	1*	PA; QL (20 ML per 30 days)
CYSTARAN	1*	QL (60 ML per 28 days)
<i>dorzolamide hcl-timolol mal</i>	1	
<i>dorzolamide hcl-timolol mal pf</i>	1	
LACRISERT	1	
<i>neomycin-polymyxin-dexameth ophthalmic ointment</i>	1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	1	
OXERVATE	1*	PA

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Drug Name	Drug Tiers	Requirements/Limits
<i>polymyxin b-trimethoprim</i>	1	
PRED-G	1	
PRED-G S.O.P.	1	
RESTASIS	1	QL (60 EA per 30 days)
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 %	1	QL (5.5 ML per 30 days)
ROCKLATAN	1	
<i>sulfacetamide-prednisolone ophthalmic solution</i>	1	
TOBRADEX OPHTHALMIC OINTMENT	1	
<i>tobramycin-dexamethasone</i>	1	
<b>Ophthalmic Anti-Allergy Agents</b>		
<i>azelastine hcl ophthalmic</i>	1	
<i>cromolyn sodium ophthalmic</i>	1	
<i>epinastine hcl</i>	1	
<i>olopatadine hcl ophthalmic</i>	1	
<b>Ophthalmic Anti-Infectives</b>		
AZASITE	1	
<i>bacitracin ophthalmic</i>	1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	1	
CILOXAN OPHTHALMIC OINTMENT	1	
<i>ciprofloxacin hcl ophthalmic</i>	1	
<i>erythromycin ophthalmic</i>	1	
<i>gatifloxacin ophthalmic</i>	1	
GENTAK OPHTHALMIC OINTMENT	1	
<i>gentamicin sulfate ophthalmic solution</i>	1	
<i>levofloxacin ophthalmic</i>	1	
<i>moxifloxacin hcl ophthalmic solution</i>	1	
NATACYN	1	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000</i>	1	
<i>ofloxacin ophthalmic</i>	1	
<i>sulfacetamide sodium ophthalmic</i>	1	
<i>tobramycin ophthalmic</i>	1	
TOBEX OPHTHALMIC OINTMENT	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>trifluridine ophthalmic</i>	1	
ZIRGAN	1	
<b>Ophthalmic Anti-Inflammatories</b>		
<i>bromfenac sodium (once-daily)</i>	1	
<i>dexamethasone sodium phosphate ophthalmic</i>	1	
<i>diclofenac sodium ophthalmic</i>	1	
<i>difluprednate</i>	1	ST
EYSUVIS	1	QL (33.2 ML per 365 days)
FLAREX	1	
<i>fluorometholone ophthalmic</i>	1	
<i>flurbiprofen sodium</i>	1	
FML	1	
FML FORTE	1	
<i>ketorolac tromethamine ophthalmic</i>	1	
LOTEMAX OPHTHALMIC OINTMENT	1	ST
LOTEMAX SM	1	ST
<i>loteprednol etabonate</i>	1	ST
MAXIDEX	1	
PRED MILD	1	
<i>prednisolone acetate ophthalmic</i>	1	
<i>prednisolone sodium phosphate ophthalmic</i>	1	
XIIDRA	1	QL (60 EA per 30 days)
<b>Ophthalmic Beta-Adrenergic Blocking Agents</b>		
<i>betaxolol hcl ophthalmic</i>	1	
<i>carteolol hcl</i>	1	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate ophthalmic gel forming solution</i>	1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	
<b>Ophthalmic Intraocular Pressure Lowering Agents, Other</b>		
<i>acetazolamide er</i>	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %	1	
<i>apraclonidine hcl</i>	1	
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	1	

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<i>brinzolamide</i>	1	
COMBIGAN	1	
<i>dorzolamide hcl ophthalmic</i>	1	
IOPIDINE OPHTHALMIC SOLUTION 1 %	1	
<i>methazolamide oral</i>	1	
PHOSPHOLINE IODIDE	1	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1	
SIMBRINZA	1	
<b>Otic Agents</b>		
<b>Otic Agents</b>		
<i>acetic acid otic</i>	1	
CIPRO HC	1	
<i>ciprofloxacin hcl otic</i>	1	
<i>ciprofloxacin-dexamethasone</i>	1	
<i>fluocinolone acetonide otic</i>	1	
<i>hydrocortisone-acetic acid</i>	1	
<i>neomycin-polymyxin-hc otic solution 1 %</i>	1	
<i>neomycin-polymyxin-hc otic suspension</i>	1	
<i>ofloxacin otic</i>	1	
<b>Respiratory Tract/Pulmonary Agents</b>		
<b>Antihistamines</b>		
<i>azelastine hcl nasal solution 0.1 %, 0.15 %</i>	1	
<i>cyproheptadine hcl oral tablet</i>	1	
<i>desloratadine oral tablet</i>	1	
<i>desloratadine oral tablet dispersible 2.5 mg</i>	1	
<i>hydroxyzine hcl oral tablet</i>	1	
<i>levocetirizine dihydrochloride oral</i>	1	
<i>olopatadine hcl nasal</i>	1	QL (30.5 GM per 30 days)
<b>Anti-Inflammatories, Inhaled Corticosteroids</b>		
ARNUITY ELLIPTA	1	
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1	B/D
<i>budesonide inhalation suspension 1 mg/2ml</i>	1	B/D
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	1	
<i>fluticasone propionate nasal</i>	1	

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Drug Name	Drug Tiers	Requirements/Limits
<i>mometasone furoate nasal</i>	1	
PULMICORT FLEXHALER	1	
QNASL	1	QL (10.6 GM per 30 days)
QVAR REDHALER	1	
<b>Antileukotrienes</b>		
<i>montelukast sodium oral</i>	1	
<i>zafirlukast</i>	1	
<i>zileuton er</i>	1*	QL (120 EA per 30 days)
<b>Bronchodilators, Anticholinergic</b>		
ATROVENT HFA	1	
INCRUSE ELLIPTA	1	
<i>ipratropium bromide inhalation</i>	1	B/D
<i>ipratropium bromide nasal</i>	1	
SPIRIVA HANDIHALER	1	
SPIRIVA RESPIMAT	1	QL (4 GM per 30 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACT	1	QL (1 EA per 30 days)
<b>Bronchodilators, Sympathomimetic</b>		
<i>albuterol sulfate er</i>	1	
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	1	
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml</i>	1	B/D
<i>albuterol sulfate oral</i>	1	
ARCAPTA NEOHALER	1	QL (30 EA per 30 days)
<i>arformoterol tartrate</i>	1*	B/D
BREO ELLIPTA	1	
DULERA	1	QL (13 GM per 30 days)
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	1	QL (4 EA 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	
<i>levalbuterol hcl inhalation</i>	1	B/D
<i>levalbuterol tartrate</i>	1	
<i>metaproterenol sulfate oral syrup</i>	1	

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PROAIR RESPICLICK	1	
SEREVENT DISKUS	1	
STRIVERDI RESPIMAT	1	QL (4 GM per 30 days)
SYMJEPI	1	QL (4 EA per 30 days)
<i>terbutaline sulfate oral</i>	1	
VENTOLIN HFA	1	
<b>Cystic Fibrosis Agents</b>		
CAYSTON	1*	PA; LA
KALYDECO ORAL PACKET	1*	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	1*	PA; QL (60 EA per 30 days)
ORKAMBI	1*	PA; QL (120 EA per 30 days)
PULMOZYME	1*	B/D
SYMDEKO	1*	PA; QL (60 EA per 30 days)
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	1*	B/D
TRIKAFTA	1*	PA; QL (84 EA per 28 days)
<b>Phosphodiesterase Inhibitors, Airways Disease</b>		
DALIRESP	1	PA; QL (30 EA per 30 days)
<i>theophylline er oral tablet extended release 12 hour 300 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour</i>	1	
<b>Pulmonary Antihypertensives</b>		
ADEMPAS	1*	PA; LA; QL (90 EA per 30 days)
<i>ambrisentan</i>	1*	LA
<i>bosentan</i>	1*	
OPSUMIT	1*	PA; LA; QL (30 EA per 30 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	1	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG, 5 MG	1*	PA
<i>sildenafil citrate oral tablet 20 mg</i>	1	PA
<i>tadalafil (pah)</i>	1*	PA
TRACLEER ORAL TABLET SOLUBLE	1*	LA; QL (112 EA per 28 days)
TYVASO	1*	B/D

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Drug Name	Drug Tiers	Requirements/Limits
TYVASO REFILL	1*	B/D
TYVASO STARTER	1*	B/D
UPTRAVI INTRAVENOUS	1*	PA; QL (60 EA per 30 days)
UPTRAVI ORAL TABLET	1*	PA; QL (60 EA per 30 days)
UPTRAVI ORAL TABLET THERAPY PACK	1*	PA
VENTAVIS	1*	B/D
<b>Pulmonary Fibrosis Agents</b>		
ESBRIET ORAL CAPSULE	1*	PA; QL (270 EA per 30 days)
<i>esbriet oral tablet 267 mg</i>	1*	PA; QL (270 EA per 30 days)
ESBRIET ORAL TABLET 801 MG	1*	PA; QL (90 EA per 30 days)
OFEV	1*	PA; LA; QL (60 EA per 30 days)
<b>Respiratory Tract Agents, Other</b>		
<i>acetylcysteine inhalation</i>	1	B/D
ADVAIR DISKUS	1	
ADVAIR HFA	1	
ANORO ELLIPTA	1	QL (60 EA per 30 days)
BEVESPI AEROSPHERE	1	
COMBIVENT RESPIMAT	1	
<i>cromolyn sodium inhalation</i>	1	B/D
FASENRA	1*	PA
FASENRA PEN	1*	PA
<i>ipratropium-albuterol</i>	1	B/D
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR	1*	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1*	PA
STIOLTO RESPIMAT	1	QL (4 GM per 30 days)
SYMBICORT	1	QL (10.2 GM per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH	1	
<i>trelegy ellipta inhalation aerosol powder breath activated 200-62.5-25 mcg/inh</i>	1	
UTIBRON NEOHALER	1	

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Drug Name	Drug Tiers	Requirements/Limits
<b>Skeletal Muscle Relaxants</b>		
<i>Skeletal Muscle Relaxants</i>		
<i>chlorzoxazone oral tablet 500 mg</i>	1	
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	1	
<i>methocarbamol oral</i>	1	
<i>orphenadrine citrate er</i>	1	
<b>Sleep Disorder Agents</b>		
<i>Sleep Promoting Agents</i>		
<i>estazolam</i>	1	
<i>eszopiclone</i>	1	QL (90 EA per 365 days)
<i>flurazepam hcl</i>	1	
HETLIOZ	1*	PA
<i>ramelteon</i>	1	
<i>temazepam oral capsule 15 mg, 30 mg</i>	1	
<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	1	
<i>triazolam</i>	1	QL (10 EA per 30 days)
<i>zaleplon</i>	1	QL (90 EA per 365 days)
<i>zolpidem tartrate er</i>	1	QL (90 EA per 365 days)
<i>zolpidem tartrate oral</i>	1	QL (90 EA per 365 days)
<b>Wakefulness Promoting Agents</b>		
<i>armodafinil</i>	1	PA; QL (30 EA per 30 days)
<i>modafinil</i>	1	QL (60 EA per 30 days)
XYREM	1*	PA; LA; QL (540 ML per 30 days)
XYWAV	1*	PA; QL (540 ML per 30 days)

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<i>brimonidine tartrate</i> .....	80	<i>cefazolin sodium</i> .....	14	CLINIMIX E/DEXTROSE (5/20).....	60
<i>brinzolamide</i> .....	81	<i>cefdinir</i> .....	14	CLINIMIX/DEXTROSE (4.25/10).....	60
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# Notice of Nondiscrimination and Language Assistance Services

Priority Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Priority Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Federal law requires that we provide you with this Notice of Nondiscrimination and Language assistance services.

## Free aids and services

Priority Health provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Priority Health provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Priority Health customer service by calling the number at the back of your membership ID card (TTY users call 711).

## To file a civil rights grievance

If you believe that Priority Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Priority Health Compliance Department  
Attention: Civil Rights Coordinator  
1231 East Beltline Ave NE  
Grand Rapids, MI 49525-4501  
Toll free: 866.807.1931 (TTY users call 711) Fax: 616.975.8850  
[PH-compliance@priorityhealth.com](mailto:PH-compliance@priorityhealth.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Priority Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov](http://ocrportal.hhs.gov) or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201  
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.389.6648 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.389.6648 (رقم هاتف الصم والبكم: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.389.6648 (TTY : 711)。

ملاحظة: إذا كنت تتحدث لغة غير اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.389.6648 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.389.6648 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.888.389.6648 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.389.6648 (TTY: 711)번으로 전화해 주십시오.

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৮৮.৩৮৯.৬৬৪৮ (TTY: ৭১১)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.888.389.6648 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.888.389.6648 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.888.389.6648 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.888.389.6648 (TTY:711) まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.389.6648 (телетайп: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1.888.389.6648 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.389.6648 (TTY: 711).



This formulary was approved on 10/19/2021. For more recent information or other questions, please contact Priority Health Medicare at toll-free 833.939.0983 or, for TTY users, 711, 8 a.m. – 8 p.m., seven days a week, or visit [prioritymedicare.com](http://prioritymedicare.com). The Formulary, may change at any time. You will receive notice when necessary.

The pharmacy network and/or provider network may change at any time. You will receive notice when necessary. Priority Health Medicare's pharmacy network offers limited access to pharmacies with preferred cost sharing in Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 833.939.0983, TTY users should call 711, or consult the online pharmacy directory at [prioritymedicare.com](http://prioritymedicare.com).

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