

2020 Comprehensive Formulary

(LIST OF COVERED DRUGS)



PLEASE READ: This document contains information about the drugs we cover in these plans.

Gateway Health Medicare Assured DiamondSM (HMO SNP)

Gateway Health Medicare Assured RubySM (HMO SNP)

This formulary is current as of December 11, 2020. For more recent information or other questions, please contact Gateway Health Member Services toll-free at **1-800-685-5209**

(TTY 711)

Our business hours are 8 a.m. - 8 p.m., 7 days a week from October 1 through March 31.

From April 1 through September 30 our business hours are 8 a.m. - 8 p.m.,

Monday through Friday. Or visit us at **GatewayHealthPlan.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 Gateway HealthSM. When it refers to “plan” or “our plan,” it means Gateway Health Medicare Assured DiamondSM and Gateway Health Medicare Assured RubySM.

This document includes a list of the drugs (formulary) for our plan which is current as of December 11, 2020. 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, 2020, and from time to time during the year.

What is the Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby Formulary?

A formulary is a list of covered drugs selected by Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby 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. Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Gateway Health Medicare Assured Diamond or Gateway Health Medicare Assured Ruby 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?

Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 coverage year except when a new, less expensive generic drug becomes available, when new information about the safety or effectiveness of a drug is released, or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.) Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. Below are changes to the drug list that will also affect members currently taking a drug:

- **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 the steps you may take to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Gateway

Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby 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 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 Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 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.

The enclosed formulary is current as of December 11, 2020. To get updated information about the drugs covered by Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby, please contact us. Our contact information appears on the front and back cover pages. In the event we make changes to our formulary throughout the year, a Formulary Update Notice will be provided detailing date of change, drug affected, description and reason for change.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 3. 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 Drugs”. If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 79. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby 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:** Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby may not cover the drug.
- **Quantity Limits:** For certain drugs, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby limits the amount of the drug that we will cover. For example, we provide 60 tablets per prescription for a 30 day supply of metformin 1000 mg tablets. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan 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 3. You can also get more information about the restrictions applied to specific covered drugs by visiting our Website. We have posted on line documents that explain our prior authorization restriction and step therapy restriction. 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 Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby 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 Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby formulary?" on page iv. for information about how to request an exception.

What if my drug is not on the Formulary?

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

If you learn that Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Gateway Health Medicare Assured Diamond or Gateway Health Medicare Assured Ruby.
- You can ask us 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 Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby Formulary?

You can ask Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby 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 cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit 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, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug 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.

For more information

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

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

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

Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby Formulary

The formulary that begins on page 3 provides coverage information about some of the drugs covered by our plan. If you have trouble finding your drug in this list, turn to the Index that begins on page 79.

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

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

Plan Name	Drug Tier	Member Cost Share
Gateway Health Medicare Assured Diamond	Tier 1 – Preferred Generic Drugs	All drugs – *\$0.00
	Tier 2 – Generic Drugs	All drugs – \$0.00, \$1.30, or \$3.60
	Tier 3 – Preferred Brand Drugs	Generic drugs – \$0.00, \$1.30, or \$3.60 Brand drugs – \$0.00, \$3.90, or \$8.95
	Tier 4 – Non-Preferred Drugs	Generic drugs – \$0.00, \$1.30, \$3.60 Brand drugs – \$0.00, \$3.90, or \$8.95
	Tier 5 – Specialty Tier Drugs	Generic drugs – \$0.00, \$1.30, or \$3.60 Brand drugs – \$0.00, \$3.90,, or \$8.95
Gateway Health Medicare Assured Ruby	Tier 1 – Preferred Generic Drugs	All drugs – *\$0.00
	Tier 2 – Generic Drugs	All drugs – \$0.00, \$1.30, \$3.60, or or 15% of the cost
	Tier 3 – Preferred Brand Drugs	Generic drugs – \$0.00, \$1.30, \$3.60 or 15% of the cost Brand drugs – \$0.00, \$3.90, or \$8.95 or 15% of the cost
	Tier 4 – Non-Preferred Drugs	Generic drugs – \$0.00, \$1.30, \$3.60 or 15% of the cost Brand drugs – \$0.00, \$3.90, \$8.95 or 15% of the cost
	Tier 5 – Specialty Tier Drugs	Generic drugs – \$0.00, \$1.30, \$3.60 or 15% of the cost Brand drugs – \$0.00, \$3.90, \$8.95 or 15% of the cost

*The member will pay a \$0 copay during the initial coverage stage and should refer to their LIS Rider for copay amounts beyond this stage.

Drug Table Notes

The following table lists the notes as they appear in the formulary.

Italics = Generic drugs

UPPERCASE = Brand name drugs

Drug Tier

1= Preferred Generic

2= Generic

3= Preferred Brand

4= Non-Preferred Drug

5= Specialty Tier

***** = Not available at mail-order.

30DS = For certain kinds of drugs, you may only fill up to a 30-day supply.

B/D = This drug may be covered under Medicare B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

PA = Prior Authorization

ST = Step Therapy

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		Requirements/Limits * = For certain kinds of drugs, you can use the plan's network mail-order services. The drugs that are not available through the plan's mail-order service are marked with an asterisk in our drug list. 30DS = For certain kinds of drugs, you may only fill up to a 30 Day Supply B/D = This drug may be covered under Medicare Part B or D PA = Prior Authorization PA (NS) = Prior Authorization for New Starts Only QL = Quantity Limit ST = Step Therapy ST (NS) = Step Therapy for New Starts Only
		Drug Tier 1 = Preferred Generic 2 = Generic 3 = Preferred Brand 4 = Non-Preferred Drug 5 = Specialty Tier
italics = Generic drugs		
UPPERCASE = Brand name drugs		
Drug Name	Drug Tier	Requirements/Limits
Antihistamine Drugs		
Antihistamine Drugs		
<i>Cetirizine HCl Oral Solution 1 MG/ML</i>	2	
<i>Cyproheptadine HCl Oral</i>	2	PA
<i>Levocetirizine Dihydrochloride Oral</i>	2	
<i>Promethazine HCl Oral Syrup</i>	2	PA
<i>Promethazine HCl Oral Tablet</i>	2	PA
Anti-Infective Agents		
Aminoglycosides		
<i>Amikacin Sulfate Injection Solution 1 GM/4ML, 500 MG/2ML</i>	4	
<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-%, 2-0.9 MG/ML-%</i>	2	
<i>Gentamicin Sulfate Injection</i>	2	
<i>Neomycin Sulfate Oral</i>	2	
<i>Paromomycin Sulfate Oral</i>	4	
<i>Tobramycin Inhalation Nebulization Solution 300 MG/5ML</i>	5	B/D; *; 30DS; *Not available at mail-order; QL (280 ML per 28 days)
<i>Tobramycin Sulfate Injection</i>	2	

Drug Name	Drug Tier	Requirements/Limits
Anthelmintics		
<i>Albendazole Oral</i>	4	
<i>Ivermectin Oral</i>	2	
<i>Praziquantel Oral</i>	4	
Antibacterials, Miscellaneous		
<i>Clindamycin HCl Oral Capsule 150 MG, 300 MG</i>	1	QL (120 EA per 30 days)
<i>Clindamycin HCl Oral Capsule 75 MG</i>	1	
<i>Clindamycin Palmitate HCl</i>	2	
<i>Clindamycin Phosphate Injection Solution 300 MG/2ML, 600 MG/4ML, 900 MG/6ML</i>	2	
<i>Clindamycin Phosphate Intravenous Solution 600 MG/4ML</i>	2	
<i>Colistimethate Sodium (CBA)</i>	2	
<i>Dapsone Oral</i>	3	
<i>DAPTOmycin</i>	5	30DS
<i>Ertapenem Sodium</i>	3	
<i>Linezolid in Sodium Chloride</i>	5	PA; 30DS
<i>Linezolid Intravenous Solution 600 MG/300ML</i>	5	PA; 30DS
<i>Linezolid Oral Suspension Reconstituted</i>	5	PA; 30DS
<i>Linezolid Oral Tablet</i>	4	PA; 30DS; QL (60 EA per 30 days)
<i>Vancomycin HCl Intravenous Solution 1000 MG/200ML, 1500 MG/300ML, 2000 MG/400ML</i>	2	
<i>Vancomycin HCl Intravenous Solution Reconstituted 1 GM, 1.25 GM, 1.5 GM, 10 GM, 100 GM, 250 MG, 5 GM, 500 MG, 750 MG</i>	2	
<i>Vancomycin HCl Oral Capsule 125 MG</i>	4	QL (120 EA per 30 days)
<i>Vancomycin HCl Oral Capsule 250 MG</i>	5	30DS; QL (240 EA per 30 days)
Antifungals		
<i>ABELCET</i>	5	B/D; 30DS
<i>AMBISOME</i>	5	B/D; 30DS
<i>Caspofungin Acetate</i>	5	30DS
<i>Fluconazole in Sodium Chloride Intravenous Solution 200-0.9 MG/100ML-%, 400-0.9 MG/200ML-%</i>	2	
<i>Fluconazole Oral</i>	1	
<i>Flucytosine Oral</i>	5	PA; 30DS
<i>Griseofulvin Microsize Oral</i>	2	
<i>Griseofulvin Ultramicrosize</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Itraconazole Oral Capsule</i>	2	QL (120 EA per 30 days)
<i>Itraconazole Oral Solution</i>	2	
<i>Ketoconazole Oral</i>	2	QL (60 EA per 30 days)
NOXAFIL ORAL SUSPENSION	5	PA; 30DS; QL (630 ML per 30 days)
<i>Nystatin Mouth/Throat</i>	2	
<i>Nystatin Oral Tablet</i>	1	
SPORANOX ORAL SOLUTION	3	
<i>Terbinafine HCl Oral</i>	1	QL (30 EA per 30 days)
<i>Voriconazole Intravenous</i>	5	PA; 30DS
<i>Voriconazole Oral Suspension Reconstituted</i>	5	PA; 30DS; QL (300 ML per 30 days)
<i>Voriconazole Oral Tablet 200 MG</i>	5	PA; 30DS; QL (60 EA per 30 days)
<i>Voriconazole Oral Tablet 50 MG</i>	5	PA; 30DS; QL (120 EA per 30 days)
Antimalarials		
<i>Atovaquone Oral</i>	5	30DS
<i>Atovaquone-Proguanil HCl</i>	2	
<i>Chloroquine Phosphate Oral</i>	2	
DARAPRIM	3	
<i>Hydroxychloroquine Sulfate Oral</i>	2	
<i>Mefloquine HCl</i>	2	
<i>Primaquine Phosphate Oral</i>	2	
<i>Pyrimethamine Oral</i>	2	
<i>QuiNINE Sulfate Oral</i>	2	
Antiprotozoals, Miscellaneous		
ALINIA	5	30DS
<i>MetroNIDAZOLE in NaCl Intravenous Solution 500-0.74 MG/100ML-%, 500-0.79 MG/100ML-%</i>	2	
<i>metroNIDAZOLE Intravenous</i>	2	
<i>metroNIDAZOLE Oral Tablet</i>	1	
PENTAM	4	
<i>Pentamidine Isethionate Inhalation</i>	2	B/D
<i>Pentamidine Isethionate Injection</i>	4	
Antiretrovirals		
<i>Abacavir Sulfate</i>	2	
<i>Abacavir Sulfate-lamiVUDine</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Abacavir-Lamivudine-Zidovudine</i>	5	30DS
APTIVUS	5	30DS
<i>Atazanavir Sulfate</i>	5	30DS
BIKTARVY	5	30DS
CIMDUO	5	30DS
COMPLERA	5	30DS
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	3	
DELSTRIGO	5	30DS
DESCOVY	5	30DS
<i>Didanosine Oral Capsule Delayed Release 200 MG, 250 MG, 400 MG</i>	2	
DOVATO	5	30DS
EDURANT	5	30DS
<i>Efavirenz</i>	2	
<i>Efavirenz-Emtricitab-Tenofovir</i>	5	30DS
<i>Efavirenz-lamiVUDine-Tenofovir</i>	4	
<i>Emtricitabine</i>	3	
<i>Emtricitabine-Tenofovir DF</i>	5	30DS
EMTRIVA ORAL SOLUTION	3	
EPCLUSA ORAL TABLET 200-50 MG	5	PA; 30DS; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	3	
EVOTAZ	5	30DS; QL (30 EA per 30 days)
<i>Fosamprenavir Calcium</i>	5	30DS
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED	5	*; 30DS; *Not available at mail-order
GENVOYA	5	30DS
INTELENCE ORAL TABLET 100 MG	5	30DS; QL (120 EA per 30 days)
INTELENCE ORAL TABLET 200 MG	5	30DS; QL (60 EA per 30 days)
INTELENCE ORAL TABLET 25 MG	3	QL (120 EA per 30 days)
INVIRASE ORAL TABLET	5	30DS
ISENTRESS HD	3	QL (60 EA per 30 days)
ISENTRESS ORAL PACKET	3	
ISENTRESS ORAL TABLET	5	30DS; QL (60 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 100 MG	5	30DS
ISENTRESS ORAL TABLET CHEWABLE 25 MG	3	
JULUCA	5	30DS

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
KALETRA ORAL TABLET 100-25 MG	4	
KALETRA ORAL TABLET 200-50 MG	5	30DS
<i>LamiVUDine</i>	2	
<i>lamiVUDine-Zidovudine</i>	2	
LEXIVA ORAL SUSPENSION	3	
<i>Lopinavir-Ritonavir</i>	2	
<i>Nevirapine</i>	2	
<i>Nevirapine ER</i>	2	
NORVIR ORAL PACKET	4	
NORVIR ORAL SOLUTION	4	
ODEFSEY	5	30DS
PIFELTRO	5	30DS
PREZCOBIX	5	30DS; QL (30 EA per 30 days)
PREZISTA ORAL SUSPENSION	5	30DS; QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	5	30DS; QL (240 EA per 30 days)
PREZISTA ORAL TABLET 600 MG	5	30DS; QL (60 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	3	QL (480 EA per 30 days)
PREZISTA ORAL TABLET 800 MG	5	30DS; QL (30 EA per 30 days)
REYATAZ ORAL PACKET	5	30DS
<i>Ritonavir</i>	2	
<i>Rukobia</i>	5	30DS; QL (60 EA per 30 days)
SELZENTRY ORAL SOLUTION	3	QL (1800 ML per 30 days)
SELZENTRY ORAL TABLET 150 MG, 75 MG	5	30DS; QL (60 EA per 30 days)
SELZENTRY ORAL TABLET 25 MG	3	QL (120 EA per 30 days)
SELZENTRY ORAL TABLET 300 MG	5	30DS; QL (120 EA per 30 days)
<i>Stavudine Oral Capsule</i>	2	
STRIBILD	5	30DS
SYMTUZA	5	*; 30DS; Not available at mail-order; QL (30 EA per 30 days)
<i>Tenofovir Disoproxil Fumarate</i>	2	
TIVICAY ORAL TABLET 10 MG	3	QL (30 EA per 30 days)
TIVICAY ORAL TABLET 25 MG	5	30DS; QL (30 EA per 30 days)
TIVICAY ORAL TABLET 50 MG	5	30DS; QL (60 EA per 30 days)
TIVICAY PD	5	30DS; QL (180 EA per 30 days)
TRIUMEQ	5	30DS
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG	5	30DS
VIRACEPT ORAL TABLET	5	30DS

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
VIRAMUNE ORAL SUSPENSION	4	
VIREAD ORAL POWDER	5	30DS
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	30DS
<i>Zidovudine</i>	2	
Antituberculosis Agents		
<i>Ethambutol HCl Oral</i>	2	
<i>Isoniazid Oral</i>	1	
PASER	4	
PRIFTIN	4	
<i>Pyrazinamide Oral</i>	2	
<i>Rifabutin</i>	4	
<i>Rifampin Intravenous</i>	2	
<i>rifAMPin Oral</i>	2	
TRECTOR	3	
Antivirals		
<i>Acyclovir Oral</i>	2	
<i>Acyclovir Sodium Intravenous Solution</i>	2	B/D
<i>Adefovir Dipivoxil</i>	5	30DS; QL (30 EA per 30 days)
BARACLUDE ORAL SOLUTION	5	PA (NS); 30DS; QL (600 ML per 30 days)
<i>Entecavir</i>	5	PA (NS); 30DS; QL (30 EA per 30 days)
EPCLUSA ORAL TABLET 400-100 MG	5	PA; *; 30DS; *Not available at mail-order; QL (28 EA per 28 days)
<i>Famciclovir Oral</i>	2	
HARVONI ORAL PACKET 33.75-150 MG	5	PA; *; 30DS; *Not available at mail-order; QL (28 EA per 28 days)
HARVONI ORAL PACKET 45-200 MG	5	PA; *; 30DS; *Not available at mail-order; QL (56 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	5	PA; *; 30DS; *Not available at mail-order; QL (28 EA per 28 days)
INTRON A INJECTION SOLUTION 10000000 UNIT/ML	4	*; *Not available at mail-order
INTRON A INJECTION SOLUTION 6000000 UNIT/ML	5	*; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
INTRON A INJECTION SOLUTION RECONSTITUTED	5	*; 30DS; *Not available at mail-order
MAVYRET	5	PA; *; 30DS; *Not available at mail-order; QL (90 EA per 30 days)
<i>Oseltamivir Phosphate Oral Capsule 30 MG</i>	3	QL (84 EA per 180 days)
<i>Oseltamivir Phosphate Oral Capsule 45 MG, 75 MG</i>	3	QL (42 EA per 180 days)
<i>Oseltamivir Phosphate Oral Suspension Reconstituted</i>	3	QL (525 ML per 180 days)
PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 180 MCG/0.5ML	5	PA; *; 30DS; *Not available at mail-order
PEGASYS SUBCUTANEOUS SOLUTION	5	PA; *; 30DS; *Not available at mail-order
RELENZA DISKHALER	3	
RIBASPHERE ORAL TABLET 200 MG	2	*; *Not available at mail-order
RIBASPHERE ORAL TABLET 400 MG	5	*; 30DS; *Not available at mail-order
RIBASPHERE RIBAPAK ORAL TABLET 400 MG	5	*; 30DS; *Not available at mail-order
RIBASPHERE RIBAPAK ORAL TABLET THERAPY PACK 200 & 400 MG	5	*; 30DS; *Not available at mail-order
RIBATAB (800 MG PACK)	5	30DS
<i>Ribavirin Oral Capsule</i>	2	*; *Not available at mail-order
<i>Ribavirin Oral Tablet 200 MG</i>	2	*; *Not available at mail-order
<i>riMANTAdine HCl</i>	2	
SYNAGIS	5	PA; *; 30DS; *Not available at mail-order
<i>ValACYclovir HCl Oral</i>	2	
<i>ValGANciclovir HCl</i>	5	30DS
VOSEVI	5	PA; *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
ZEPATIER	5	PA; *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
Cephalosporins		
<i>Cefaclor ER</i>	2	
<i>Cefaclor Oral Capsule</i>	2	
<i>Cefadroxil Oral Capsule</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Cefadroxil Oral Suspension Reconstituted 250 MG/5ML</i>	2	
<i>Cefadroxil Oral Suspension Reconstituted 500 MG/5ML</i>	3	
<i>Cefadroxil Oral Tablet</i>	2	
<i>CeFAZolin Sodium Injection Solution Reconstituted 1 GM, 10 GM, 20 GM, 500 MG</i>	2	
<i>CeFAZolin Sodium Intravenous Solution Reconstituted</i>	2	
<i>CeFAZolin Sodium-Dextrose Intravenous Solution 1-4 GM/50ML-%</i>	2	
<i>CeFAZolin Sodium-Dextrose Intravenous Solution Reconstituted 1-4 GM-%(50ML)</i>	2	
<i>Cefdinir</i>	2	
<i>Cefepime HCl Injection</i>	2	
<i>Cefepime HCl Intravenous Solution</i>	2	
<i>Cefepime-Dextrose Intravenous Solution Reconstituted 1-5 GM-%(50ML), 2-5 GM-%(50ML)</i>	2	
<i>Cefixime Oral Suspension Reconstituted</i>	2	
<i>Cefpodoxime Proxetil</i>	2	
<i>Cefprozil</i>	2	
<i>CefTAZidime and Dextrose Intravenous Solution Reconstituted 1-5 GM-%(50ML), 2-5 GM-%(50ML)</i>	2	
<i>CefTAZidime Injection Solution Reconstituted 1 GM, 2 GM, 6 GM</i>	2	
<i>CefTRIAxone Sodium in Dextrose</i>	2	
<i>CefTRIAxone Sodium Injection</i>	2	
<i>CefTRIAxone Sodium Intravenous</i>	2	
<i>Cefuroxime Axetil Oral Tablet</i>	2	
<i>Cefuroxime Sodium Injection Solution Reconstituted 7.5 GM, 750 MG</i>	2	
<i>Cefuroxime Sodium Intravenous Solution Reconstituted 1.5 GM</i>	2	
<i>Cephalexin Oral Capsule 250 MG, 500 MG</i>	1	
<i>Cephalexin Oral Suspension Reconstituted</i>	1	
<i>Cephalexin Oral Tablet</i>	1	
TAZICEF INJECTION	2	
TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
TEFLARO	5	PA; 30DS
Macrolides		
<i>Azithromycin Intravenous</i>	2	
<i>Azithromycin Oral Suspension Reconstituted</i>	2	
<i>Azithromycin Oral Tablet 250 MG, 500 MG, 600 MG</i>	2	
<i>Clarithromycin ER</i>	2	
<i>Clarithromycin Oral</i>	2	
ERY-TAB	4	
ERYTHROCIN STEARATE ORAL TABLET 250 MG	4	
<i>Erythromycin Base Oral Tablet</i>	2	
<i>Erythromycin Base Oral Tablet Delayed Release</i>	2	
<i>Erythromycin Ethylsuccinate Oral Suspension Reconstituted 200 MG/5ML</i>	2	
<i>Erythromycin Ethylsuccinate Oral Tablet</i>	4	
Miscellaneous B-Lactam Antibiotics		
<i>Aztreonam</i>	1	
CAYSTON	5	PA; 30DS
<i>CefOXitin Sodium</i>	2	
<i>CefOXitin Sodium-Dextrose Intravenous Solution Reconstituted 1-4 GM-%(50ML), 2-2.2 GM-%(50ML)</i>	2	
<i>Imipenem-Cilastatin</i>	2	
<i>Meropenem Intravenous Solution Reconstituted 1 GM</i>	2	QL (90 EA per 30 days)
<i>Meropenem Intravenous Solution Reconstituted 500 MG</i>	2	
<i>Meropenem-Sodium Chloride Intravenous Solution Reconstituted 1 GM/50ML, 500 MG/50ML</i>	2	
Penicillins		
<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>	2	
<i>Amoxicillin-Pot Clavulanate Oral</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Ampicillin Oral Capsule 500 MG</i>	1	
<i>Ampicillin Sodium Injection Solution Reconstituted 1 GM, 125 MG, 250 MG, 500 MG</i>	2	
<i>Ampicillin Sodium Intravenous Solution Reconstituted 1 GM, 10 GM</i>	2	
<i>Ampicillin-Sulbactam Sodium</i>	2	
BACTOCILL IN DEXTROSE	2	
BICILLIN L-A	4	
<i>Dicloxacillin Sodium</i>	1	
<i>Oxacillin Sodium in Dextrose</i>	2	
<i>Oxacillin Sodium Injection Solution Reconstituted 1 GM, 2 GM</i>	2	
<i>Oxacillin Sodium Injection Solution Reconstituted 10 GM</i>	5	30DS
<i>Oxacillin Sodium Intravenous</i>	5	30DS
<i>Penicillin G Potassium</i>	2	
<i>Penicillin V Potassium</i>	1	
PFIZERPEN	2	
<i>Piperacillin Sod-Tazobactam So</i>	2	
ZOSYN INTRAVENOUS SOLUTION	4	
Quinolones		
<i>Ciprofloxacin HCl Oral Tablet 100 MG, 250 MG, 500 MG</i>	1	
<i>Ciprofloxacin HCl Oral Tablet 750 MG</i>	1	QL (60 EA per 30 days)
<i>Ciprofloxacin in D5W Intravenous Solution 200 MG/100ML</i>	4	
<i>Ciprofloxacin Oral Suspension Reconstituted 250 MG/5ML (5%)</i>	1	
<i>LevoFLOXacin Intravenous</i>	2	
<i>LevoFLOXacin Oral Solution</i>	2	
<i>Levofloxacin Oral Tablet</i>	1	
<i>Moxifloxacin HCl in NaCl</i>	2	
<i>Moxifloxacin HCl Intravenous</i>	2	
<i>Moxifloxacin HCl Oral</i>	2	
<i>Ofloxacin Oral Tablet 400 MG</i>	2	
Sulfonamides (Systemic)		
<i>SulfADIAZINE Oral</i>	2	
<i>Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Sulfamethoxazole-Trimethoprim Oral Tablet</i>	1	
<i>SulfaSALazine Oral</i>	2	
Tetracyclines		
<i>Demeclocycline HCl Oral</i>	2	
DOXY 100	2	B/D
<i>Doxycycline Hyclate Oral Capsule</i>	1	QL (60 EA per 30 days)
<i>Doxycycline Hyclate Oral Tablet 100 MG</i>	1	QL (60 EA per 30 days)
<i>Doxycycline Hyclate Oral Tablet 20 MG</i>	1	
<i>Doxycycline Monohydrate Oral Capsule 100 MG, 150 MG</i>	2	
<i>Doxycycline Monohydrate Oral Capsule 50 MG, 75 MG</i>	1	
<i>Doxycycline Monohydrate Oral Suspension Reconstituted</i>	1	
<i>Doxycycline Monohydrate Oral Tablet 100 MG, 50 MG, 75 MG</i>	1	
<i>Doxycycline Monohydrate Oral Tablet 150 MG</i>	2	
<i>Minocycline HCl Oral Capsule</i>	1	
<i>Minocycline HCl Oral Tablet 75 MG</i>	1	
<i>Tetracycline HCl Oral Capsule 250 MG</i>	2	QL (120 EA per 30 days)
<i>Tetracycline HCl Oral Capsule 500 MG</i>	2	
<i>Tigecycline</i>	2	
TYGACIL	4	
VIBRAMYCIN ORAL SYRUP	3	
Urinary Anti-Infectives		
<i>Methenamine Hippurate</i>	2	
<i>Nitrofurantoin</i>	2	PA; QL (1800 ML per 365 days)
<i>Nitrofurantoin Macrocrystal Oral</i>	2	PA; QL (90 EA per 365 days)
<i>Nitrofurantoin Monohyd Macro</i>	2	PA; QL (90 EA per 365 days)
<i>Trimethoprim Oral</i>	1	
Anti-Infectives		
Anti-Infectives - Miscellaneous		
<i>Clindamycin Phosphate Injection Solution 9 GM/60ML, 9000 MG/60ML</i>	2	
<i>Clindamycin Phosphate Intravenous Solution 300 MG/2ML, 900 MG/6ML</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
Penicillins		
<i>Ampicillin Sodium Injection Solution Reconstituted 2 GM</i>	2	
<i>Ampicillin Sodium Intravenous Solution Reconstituted 2 GM</i>	2	
Antineoplastic Agents		
Antineoplastic Agents		
<i>Abiraterone Acetate</i>	5	PA (NS); *; 30DS; Not available at mail-order
AFINITOR DISPERZ	5	PA (NS); *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
AFINITOR ORAL TABLET 10 MG	5	PA (NS); *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
ALECENSA	5	PA (NS); *; 30DS; *Not available at mail-order
ALUNBRIG	5	PA (NS); *; 30DS; *Not available at mail-order
<i>Anastrozole Oral</i>	2	QL (30 EA per 30 days)
AYVAKIT	5	PA (NS); 30DS; QL (30 EA per 30 days)
BALVERSA	5	PA (NS); 30DS
<i>Bexarotene</i>	5	*; 30DS; *Not available at mail-order
<i>Bicalutamide</i>	2	
BOSULIF	5	PA (NS); *; 30DS; *Not available at mail-order
BRAFTOVI ORAL CAPSULE 75 MG	5	PA (NS); *; 30DS; Not available at mail-order; QL (180 EA per 30 days)
BRUKINSA	5	PA (NS); 30DS; QL (120 EA per 30 days)
CABOMETYX	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
CALQUENCE	5	PA (NS); 30DS
CAPRELSA ORAL TABLET 100 MG	5	PA (NS); LA; 30DS; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA (NS); LA; 30DS; QL (30 EA per 30 days)
COMETRIQ (100 MG DAILY DOSE)	5	PA (NS); 30DS

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
COMETRIQ (140 MG DAILY DOSE)	5	PA (NS); 30DS
COMETRIQ (60 MG DAILY DOSE)	5	PA (NS); 30DS
COPIKTRA	5	PA (NS); 30DS; QL (60 EA per 30 days)
COTELLIC	5	PA (NS); *; 30DS; *Not available at mail-order
<i>Cyclophosphamide Oral Capsule</i>	2	B/D
DARZALEX FASPRO	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (60 ML per 28 days)
DAURISMO ORAL TABLET 100 MG	5	PA (NS); *; 30DS; Not available at mail-order; QL (30 EA per 30 days)
DAURISMO ORAL TABLET 25 MG	5	PA (NS); *; 30DS; Not available at mail-order; QL (60 EA per 30 days)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	4	B/D
DROXIA	3	
ELIGARD	4	*; *Not available at mail-order
EMCYT	3	
ERIVEDGE	5	PA (NS); *; 30DS; *Not available at mail-order
ERLEADA	5	PA (NS); *; 30DS; *Not available at mail-order
<i>Erlotinib HCl Oral Tablet 100 MG, 150 MG</i>	5	PA (NS); *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
<i>Erlotinib HCl Oral Tablet 25 MG</i>	5	PA (NS); *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
<i>Everolimus Oral Tablet 2.5 MG, 5 MG</i>	5	PA (NS); *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
<i>Everolimus Oral Tablet 7.5 MG</i>	5	PA (NS); *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
<i>Exemestane</i>	2	
FARYDAK ORAL CAPSULE 10 MG, 20 MG	5	PA (NS); *; 30DS; *Not available at mail-order
FIRMAGON (240 MG DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG	5	PA (NS); *; 30DS; *Not available at mail-order
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG	4	PA (NS); *; *Not available at mail-order
<i>Flutamide</i>	2	
GAVRETO	5	PA (NS); 30DS; QL (120 EA per 30 days)
GILOTRIF	5	PA (NS); LA; 30DS; QL (30 EA per 30 days)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	4	
<i>Hydroxyurea Oral</i>	2	
IBRANCE	5	PA (NS); *; 30DS; *Not available at mail-order; QL (21 EA per 28 days)
ICLUSIG	5	PA (NS); 30DS
IDHIFA	5	PA (NS); *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
<i>Imatinib Mesylate</i>	5	PA (NS); *; 30DS; *Not available at mail-order
IMBRUVICA ORAL CAPSULE 140 MG	5	PA (NS); LA; 30DS; QL (120 EA per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5	PA (NS); 30DS; QL (240 EA per 30 days)
IMBRUVICA ORAL TABLET 140 MG	5	PA (NS); 30DS; QL (120 EA per 30 days)
IMBRUVICA ORAL TABLET 280 MG	5	PA (NS); 30DS; QL (60 EA per 30 days)
IMBRUVICA ORAL TABLET 420 MG, 560 MG	5	PA (NS); 30DS; QL (30 EA per 30 days)
INLYTA	5	PA (NS); *; LA; 30DS; *Not available at mail-order
INQOVI	5	PA (NS); LA; 30DS; *Not available at mail-order; QL (5 EA per 28 days)
INREBIC	5	PA (NS); *; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
IRESSA	5	PA (NS); *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
JAKAFI	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
KISQALI (200 MG DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
KISQALI (400 MG DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
KISQALI (600 MG DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
KISQALI FEMARA (400 MG DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
KISQALI FEMARA (600 MG DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
KISQALI FEMARA(200 MG DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
KOSELUGO ORAL CAPSULE 10 MG	5	PA (NS); 30DS; QL (240 EA per 30 days)
KOSELUGO ORAL CAPSULE 25 MG	5	PA (NS); 30DS; QL (120 EA per 30 days)
<i>Lapatinib Ditosylate</i>	5	PA (NS); LA; 30DS; *Not available at mail-order; QL (180 EA per 30 days)
LENVIMA (10 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
LENVIMA (12 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
LENVIMA (14 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
LENVIMA (18 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
LENVIMA (20 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
LENVIMA (24 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
LENVIMA (4 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
LENVIMA (8 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order
<i>Letrozole Oral</i>	2	
LEUKERAN	5	30DS
<i>Leuprolide Acetate Injection</i>	2	PA (NS); *; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
LONSURF	5	PA (NS); *; 30DS; *Not available at mail-order
LORBRENA ORAL TABLET 100 MG	5	PA (NS); 30DS; QL (30 EA per 30 days)
LORBRENA ORAL TABLET 25 MG	5	PA (NS); 30DS; QL (90 EA per 30 days)
LUPANETA PACK	4	PA; *; *Not available at mail-order
LUPRON DEPOT (1-MONTH)	5	PA (NS); *; 30DS; *Not available at mail-order
LUPRON DEPOT (3-MONTH)	5	PA (NS); *; 30DS; *Not available at mail-order
LUPRON DEPOT (4-MONTH)	5	PA (NS); *; 30DS; *Not available at mail-order
LUPRON DEPOT (6-MONTH)	5	PA (NS); *; 30DS; *Not available at mail-order
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG	5	PA (NS); *; 30DS; *Not available at mail-order
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG	5	PA (NS); *; 30DS; Not available at mail-order
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED)	5	PA (NS); *; 30DS; Not available at mail-order
LYNPARZA ORAL TABLET	5	PA (NS); 30DS
LYSODREN	3	
MATULANE	5	LA; 30DS
<i>Megestrol Acetate Oral Suspension 40 MG/ML, 625 MG/5ML</i>	2	PA (NS)
<i>Megestrol Acetate Oral Tablet 20 MG</i>	1	PA (NS)
<i>Megestrol Acetate Oral Tablet 40 MG</i>	2	PA (NS)
MEKINIST ORAL TABLET 0.5 MG	5	PA (NS); *; 30DS; *Not available at mail-order
MEKINIST ORAL TABLET 2 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
MEKTOVI	5	PA (NS); *; 30DS; Not available at mail-order; QL (180 EA per 30 days)
<i>Mercaptopurine Oral</i>	2	
<i>Methotrexate Oral</i>	3	B/D
<i>Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 250 MG/10ML, 50 MG/2ML</i>	2	B/D
<i>Methotrexate Sodium Injection Solution 250 MG/10ML</i>	2	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Methotrexate Sodium Injection Solution 50 MG/2ML</i>	2	
<i>Methotrexate Sodium Injection Solution Reconstituted</i>	2	B/D
NERLYNX	5	PA (NS); *; 30DS; *Not available at mail-order
NEXAVAR	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
<i>Nilutamide</i>	5	30DS
NINLARO	5	PA (NS); *; 30DS; *Not available at mail-order
NUBEQA	5	PA (NS); *; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
ODOMZO	5	PA (NS); *; 30DS; *Not available at mail-order
ONUREG	5	PA (NS); LA; 30DS; *Not available at mail-order; QL (14 EA per 28 days)
PEMAZYRE	5	PA (NS); 30DS; QL (21 EA per 28 days)
PHESGO	5	PA (NS); LA; 30DS; *Not available at mail-order
PIQRAY (200 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order; QL (28 EA per 28 days)
PIQRAY (250 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order; QL (56 EA per 28 days)
PIQRAY (300 MG DAILY DOSE)	5	PA (NS); *; 30DS; *Not available at mail-order; QL (56 EA per 28 days)
POMALYST	5	PA (NS); *; 30DS; *Not available at mail-order; QL (21 EA per 28 days)
PURIXAN	5	*; 30DS; *Not available at mail-order
QINLOCK	5	PA (NS); 30DS; QL (90 EA per 30 days)
RETEVMO ORAL CAPSULE 40 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (180 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
RETEVMO ORAL CAPSULE 80 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
REVLIMID	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
RITUXAN INTRAVENOUS SOLUTION	5	PA (NS); *; 30DS; *Not available at mail-order
ROZLYTREK ORAL CAPSULE 100 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (150 EA per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (90 EA per 30 days)
RUBRACA	5	PA (NS); *; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
RYDAPT	5	PA (NS); *; 30DS; *Not available at mail-order
SOLTAMOX	5	30DS
SPRYCEL	5	PA (NS); *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
STIVARGA	5	PA (NS); *; 30DS; *Not available at mail-order
SUTENT	5	PA (NS); *; 30DS; *Not available at mail-order; QL (28 EA per 28 days)
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG	5	PA (NS); LA; 30DS; *Not available at mail-order
SYLVANT INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5	PA (NS); *; 30DS; *Not available at mail-order
SYNRIBO	5	PA (NS); 30DS
TABLOID	4	
TABRECTA	5	PA (NS); *; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
TAFINLAR ORAL CAPSULE 50 MG	5	PA (NS); *; 30DS; *Not available at mail-order
TAFINLAR ORAL CAPSULE 75 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
TAGRISSE	5	PA (NS); *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG	5	PA (NS); *; 30DS; Not available at mail-order; QL (90 EA per 30 days)
TALZENNA ORAL CAPSULE 1 MG	5	PA (NS); *; 30DS; Not available at mail-order; QL (30 EA per 30 days)
<i>Tamoxifen Citrate Oral</i>	1	
TASIGNA ORAL CAPSULE 150 MG, 50 MG	5	PA (NS); *; 30DS; *Not available at mail-order
TASIGNA ORAL CAPSULE 200 MG	5	PA (NS); *; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
TAZVERIK	5	PA (NS); 30DS; QL (240 EA per 30 days)
<i>Temsirolimus</i>	5	B/D; *; 30DS; Not available at mail-order
TIBSOVO	5	PA (NS); *; 30DS; Not available at mail-order; QL (60 EA per 30 days)
<i>Toremifene Citrate</i>	5	30DS
TRELSTAR MIXJECT	5	PA (NS); *; 30DS; *Not available at mail-order
<i>Tretinoin Oral</i>	5	30DS
TREXALL	4	B/D
TUKYSA ORAL TABLET 150 MG	5	PA (NS); 30DS; QL (120 EA per 30 days)
TUKYSA ORAL TABLET 50 MG	5	PA (NS); 30DS; QL (300 EA per 30 days)
TURALIO	5	PA (NS); 30DS; QL (120 EA per 30 days)
VALCHLOR	5	PA (NS); 30DS
VENCLEXTA ORAL TABLET 10 MG	4	LA
VENCLEXTA ORAL TABLET 100 MG, 50 MG	5	LA; 30DS
VENCLEXTA STARTING PACK	5	LA; 30DS
VERZENIO ORAL TABLET 100 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
VERZENIO ORAL TABLET 150 MG, 200 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
VERZENIO ORAL TABLET 50 MG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (180 EA per 30 days)
VITRAKVI	5	PA (NS); *; 30DS; Not available at mail-order
VIZIMPRO	5	PA (NS); *; 30DS; Not available at mail-order; QL (30 EA per 30 days)
VOTRIENT	5	*; LA; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
XALKORI	5	PA (NS); *; 30DS; *Not available at mail-order
XATMEP	4	PA (NS)
XOSPATA	5	PA (NS); 30DS; QL (90 EA per 30 days)
XPOVIO (100 MG ONCE WEEKLY)	5	PA (NS); 30DS; QL (32 EA per 28 days)
XPOVIO (40 MG ONCE WEEKLY)	5	PA (NS); 30DS; QL (8 EA per 28 days)
XPOVIO (40 MG TWICE WEEKLY)	5	PA (NS); 30DS; QL (16 EA per 28 days)
XPOVIO (60 MG ONCE WEEKLY)	5	PA (NS); 30DS; QL (32 EA per 28 days)
XPOVIO (60 MG TWICE WEEKLY)	5	PA (NS); 30DS; QL (24 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY)	5	PA (NS); 30DS; QL (32 EA per 28 days)
XPOVIO (80 MG TWICE WEEKLY)	5	PA (NS); 30DS; QL (32 EA per 28 days)
XTANDI	5	PA (NS); *; 30DS; *Not available at mail-order
YONSA	5	PA (NS); 30DS; QL (120 EA per 30 days)
ZEJULA	5	PA (NS); 30DS
ZELBORAF	5	PA (NS); *; 30DS; *Not available at mail-order
ZOLINZA	5	PA (NS); *; 30DS; *Not available at mail-order; QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
ZYDELIG	5	PA (NS); *; LA; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
ZYKADIA ORAL TABLET	5	PA (NS); *; 30DS; *Not available at mail-order
ZYTIGA ORAL TABLET 500 MG	5	PA (NS); *; 30DS; *Not available at mail-order
Autonomic Drugs		
Antimuscarinics/Antispasmodics		
ATROVENT HFA	3	QL (25.8 GM per 30 days)
<i>Dicyclomine HCl Oral Capsule</i>	1	PA
<i>Dicyclomine HCl Oral Solution</i>	2	PA
<i>Dicyclomine HCl Oral Tablet</i>	1	PA
<i>Ipratropium Bromide Inhalation</i>	2	B/D; QL (300 ML per 30 days)
<i>Methscopolamine Bromide Oral</i>	2	PA
Autonomic Drugs, Miscellaneous		
CHANTIX	3	QL (336 EA per 168 days)
CHANTIX CONTINUING MONTH PAK	3	QL (336 EA per 168 days)
CHANTIX STARTING MONTH PAK	3	
NICOTROL	4	
NICOTROL NS	3	
Beta-Adrenergic Agonists		
<i>Albuterol Sulfate ER</i>	1	
<i>Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT</i>	2	QL (17 GM per 30 days)
<i>Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (NDA020503)</i>	2	QL (13.4 GM per 30 days)
<i>Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (NDA020983)</i>	2	QL (36 GM per 30 days)
<i>Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, 0.63 MG/3ML, 1.25 MG/3ML</i>	1	B/D; QL (360 ML per 30 days)
<i>Albuterol Sulfate Inhalation Nebulization Solution (5 MG/ML) 0.5%</i>	1	B/D; QL (120 ML per 30 days)
<i>Albuterol Sulfate Inhalation Nebulization Solution 2.5 MG/0.5ML</i>	1	B/D; QL (120 EA per 30 days)
<i>Albuterol Sulfate Oral</i>	1	
COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
<i>Ipratropium-Albuterol</i>	2	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Metaproterenol Sulfate Oral Syrup</i>	2	
SEREVENT DISKUS	3	QL (60 EA per 30 days)
<i>Terbutaline Sulfate Oral</i>	2	
Parasympathomimetic (Cholinergic Agents)		
<i>Bethanechol Chloride Oral</i>	2	
<i>Cevimeline HCl</i>	2	
<i>Donepezil HCl</i>	2	QL (30 EA per 30 days)
<i>Galantamine Hydrobromide ER</i>	2	QL (30 EA per 30 days)
<i>Galantamine Hydrobromide Oral Tablet</i>	2	QL (60 EA per 30 days)
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK	4	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR	4	QL (30 EA per 30 days)
<i>Pilocarpine HCl Oral</i>	4	
<i>Pyridostigmine Bromide ER</i>	2	
<i>Pyridostigmine Bromide Oral Solution</i>	3	
<i>Pyridostigmine Bromide Oral Tablet</i>	2	
<i>Rivastigmine</i>	2	QL (30 EA per 30 days)
<i>Rivastigmine Tartrate</i>	2	QL (60 EA per 30 days)
Skeletal Muscle Relaxants		
<i>Chlorzoxazone Oral Tablet 500 MG</i>	4	PA
<i>Cyclobenzaprine HCl Oral Tablet 10 MG, 5 MG</i>	4	PA; QL (90 EA per 30 days)
<i>Dantrolene Sodium Oral</i>	2	
<i>Methocarbamol Oral</i>	1	PA
<i>Orphenadrine Citrate ER</i>	2	PA
<i>tiZANidine HCl Oral</i>	2	
Sympatholytic Adrenergic Blocking Agents		
<i>Alfuzosin HCl ER</i>	2	QL (30 EA per 30 days)
<i>Dihydroergotamine Mesylate Nasal</i>	5	PA; 30DS; QL (8 ML per 28 days)
<i>Tamsulosin HCl</i>	2	
Blood Formation, Coagulation, And Thrombosis		
Anticoagulants		
COUMADIN ORAL	3	
ELIQUIS DVT/PE STARTER PACK	3	
ELIQUIS ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
ELIQUIS ORAL TABLET 5 MG	3	QL (90 EA per 30 days)
<i>Enoxaparin Sodium Subcutaneous</i>	2	
<i>Fondaparinux Sodium Subcutaneous Solution 10 MG/0.8ML, 5 MG/0.4ML, 7.5 MG/0.6ML</i>	5	30DS
<i>Fondaparinux Sodium Subcutaneous Solution 2.5 MG/0.5ML</i>	2	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNIT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML, 95000 UNIT/3.8ML	4	
<i>Heparin Sodium (Porcine) Injection Solution 1000 UNIT/ML, 10000 UNIT/ML, 20000 UNIT/ML, 5000 UNIT/ML</i>	2	B/D
<i>Heparin Sodium (Porcine) PF Injection Solution 5000 UNIT/0.5ML</i>	2	
JANTOVEN	1	
PRADAXA	4	QL (60 EA per 30 days)
<i>Warfarin Sodium Oral</i>	1	
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (60 EA per 30 days)
XARELTO STARTER PACK	3	QL (51 EA per 30 days)
Hematopoietic Agents		
FULPHILA	5	PA; 30DS
LEUKINE INJECTION SOLUTION RECONSTITUTED	5	*; 30DS; *Not available at mail-order
LEUKINE INTRAVENOUS	5	*; 30DS; *Not available at mail-order
MOZOBIL	5	PA; *; 30DS; *Not available at mail-order; QL (9.6 ML per 30 days)
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML	5	PA; *; 30DS; *Not available at mail-order
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE	5	PA; *; 30DS; *Not available at mail-order
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	3	PA; *; *Not available at mail-order
PROCRIT INJECTION SOLUTION 20000 UNIT/ML, 40000 UNIT/ML	5	PA; *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
PROMACTA ORAL PACKET 12.5 MG	5	PA; *; LA; 30DS; *Not available at mail-order; QL (360 EA per 30 days)
PROMACTA ORAL PACKET 25 MG	5	PA; *; LA; 30DS; *Not available at mail-order; QL (180 EA per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG	5	PA; *; LA; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
PROMACTA ORAL TABLET 75 MG	5	PA; *; LA; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
UDENYCA	5	PA; 30DS
ZIEXTENZO	5	PA; *; 30DS; *Not available at mail-order
Platelet-Aggregation Inhibitors		
BRILINTA	3	
<i>Cilostazol</i>	2	
<i>Clopidogrel Bisulfate Oral</i>	1	
Cardiovascular Drugs		
Alpha-Adrenergic Blocking Agents		
<i>Doxazosin Mesylate Oral</i>	1	
<i>Prazosin HCl Oral</i>	1	
<i>Terazosin HCl Oral</i>	1	
Antiarrhythmic Agents		
<i>Amiodarone HCl Oral Tablet 100 MG, 400 MG</i>	4	
<i>Amiodarone HCl Oral Tablet 200 MG</i>	1	
<i>Dofetilide</i>	2	*; *Not available at mail-order
<i>Flecainide Acetate</i>	2	
<i>Mexiletine HCl Oral</i>	2	
MULTAQ	3	
<i>Propafenone HCl</i>	2	
<i>Propafenone HCl ER</i>	2	
<i>quinidine Gluconate ER</i>	2	
<i>quinidine Sulfate Oral</i>	2	
Antilipemic Agents		
<i>Atorvastatin Calcium Oral</i>	1	
<i>Cholestyramine Light</i>	2	
<i>Cholestyramine Oral</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Colestipol HCl Oral Granules</i>	4	
<i>Colestipol HCl Oral Packet</i>	4	
<i>Colestipol HCl Oral Tablet</i>	3	
<i>Ezetimibe</i>	2	QL (30 EA per 30 days)
<i>Fenofibrate Micronized</i>	2	
<i>Fenofibrate Oral Tablet 145 MG, 160 MG, 48 MG, 54 MG</i>	2	
<i>Fenofibric Acid Oral Capsule Delayed Release</i>	4	
<i>Gemfibrozil Oral</i>	1	
<i>Lovastatin</i>	1	
<i>Niacin ER (Antihyperlipidemic)</i>	2	
NIACOR	2	
<i>Omega-3-acid Ethyl Esters</i>	2	QL (120 EA per 30 days)
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR	3	PA; *; 30DS; *Not available at mail-order; QL (2 ML per 28 days)
PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR	3	PA; *; 30DS; *Not available at mail-order; QL (2 ML per 28 days)
<i>Pravastatin Sodium</i>	1	
PREVALITE	2	
REPATHA	3	PA; 30DS; QL (2 ML per 28 days)
REPATHA PUSHTRONEX SYSTEM	3	PA; 30DS; QL (3.5 ML per 28 days)
REPATHA SURECLICK	3	PA; 30DS; QL (2 ML per 28 days)
<i>Rosuvastatin Calcium</i>	1	QL (30 EA per 30 days)
<i>Simvastatin Oral Tablet 10 MG, 20 MG, 40 MG, 5 MG</i>	1	
<i>Simvastatin Oral Tablet 80 MG</i>	1	QL (30 EA per 30 days)
Beta-Adrenergic Blocking Agents		
<i>Acebutolol HCl Oral</i>	2	
<i>Atenolol Oral</i>	1	
<i>Atenolol-Chlorthalidone</i>	1	
<i>Betaxolol HCl Oral</i>	3	
<i>Bisoprolol Fumarate</i>	2	
<i>Bisoprolol-Hydrochlorothiazide</i>	1	
<i>Carvedilol</i>	1	
<i>Labetalol HCl Oral</i>	2	
<i>Metoprolol Succinate ER</i>	2	
<i>Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Metoprolol-Hydrochlorothiazide</i>	2	
<i>Nadolol Oral Tablet 20 MG, 40 MG, 80 MG</i>	1	
<i>Pindolol</i>	2	
<i>Propranolol HCl ER</i>	1	
<i>Propranolol HCl Oral</i>	1	
<i>Propranolol-HCTZ</i>	2	
<i>SORINE</i>	2	
<i>Sotalol HCl (AF)</i>	2	
<i>Sotalol HCl Oral</i>	2	
<i>Timolol Maleate Oral</i>	2	
Calcium-Channel Blocking Agents		
<i>AFEDITAB CR</i>	1	
<i>Amlodipine Besy-Benazepril HCl</i>	1	
<i>AmLODIPine Besylate Oral</i>	1	
<i>Amlodipine-Olmesartan</i>	1	
<i>CARTIA XT</i>	1	
<i>DilTIAZem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 300 MG, 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>	2	
<i>Diltiazem HCl Oral</i>	1	
<i>Dilt-XR</i>	1	
<i>Felodipine ER</i>	1	
<i>NIFEdipine ER</i>	1	
<i>NIFEdipine ER Osmotic Release</i>	1	
<i>NiMODipine Oral</i>	5	30DS
<i>TAZTIA XT</i>	1	
<i>TIADYLT ER</i>	1	
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 120 MG, 180 MG, 200 MG, 240 MG, 300 MG</i>	3	
<i>Verapamil HCl ER Oral Capsule Extended Release 24 Hour 360 MG</i>	4	
<i>Verapamil HCl ER Oral Tablet Extended Release</i>	2	
<i>Verapamil HCl Oral</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
Cardiac Drugs, Miscellaneous		
CORLANOR ORAL SOLUTION	4	PA; QL (300 ML per 30 days)
CORLANOR ORAL TABLET	4	PA; QL (60 EA per 30 days)
DIGITEK ORAL TABLET 125 MCG	1	
DIGITEK ORAL TABLET 250 MCG	1	ST
DIGOX ORAL TABLET 125 MCG	1	
DIGOX ORAL TABLET 250 MCG	1	ST
<i>Digoxin Oral Solution</i>	2	
<i>Digoxin Oral Tablet 125 MCG</i>	1	
<i>Digoxin Oral Tablet 250 MCG</i>	1	ST
ENTRESTO	3	QL (60 EA per 30 days)
<i>Midodrine HCl</i>	3	
NORTHERA	5	PA; *, 30DS; *Not available at mail-order; QL (180 EA per 30 days)
<i>Pentoxifylline ER</i>	2	
<i>Ranolazine ER</i>	4	PA; QL (60 EA per 30 days)
Hypotensive Agents		
<i>CloNIDine</i>	2	
<i>CloNIDine HCl Oral</i>	1	
<i>Diazoxide Oral</i>	2	
<i>guanFACINE HCl Oral</i>	2	PA
<i>HydrALAZINE HCl Oral</i>	2	
<i>Minoxidil Oral</i>	2	
PROGLYCEM	3	
Renin-Angiotensin-Aldosterone System Inhibitors		
<i>Benazepril HCl Oral</i>	1	
<i>Benazepril-Hydrochlorothiazide</i>	1	
<i>Candesartan Cilexetil</i>	1	
<i>Candesartan Cilexetil-HCTZ</i>	1	
<i>Captopril Oral</i>	1	
<i>Captopril-Hydrochlorothiazide</i>	1	
<i>Enalapril Maleate Oral</i>	1	
<i>Enalapril-Hydrochlorothiazide</i>	1	
<i>Eplerenone</i>	2	
<i>Fosinopril Sodium</i>	1	
<i>Fosinopril Sodium-HCTZ</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Irbesartan</i>	1	
<i>Irbesartan-Hydrochlorothiazide</i>	1	
<i>Lisinopril Oral</i>	1	
<i>Lisinopril-hydroCHLOROthiazide</i>	1	
<i>Losartan Potassium Oral</i>	1	
<i>Losartan Potassium-HCTZ</i>	1	
<i>Quinapril HCl</i>	1	
<i>Quinapril-Hydrochlorothiazide</i>	1	
<i>Ramipril</i>	1	
<i>Spironolactone Oral</i>	1	
<i>Spironolactone-HCTZ</i>	1	
<i>Trandolapril</i>	1	
<i>Valsartan</i>	1	
<i>Valsartan-Hydrochlorothiazide</i>	1	
Vasodilating Agents		
ALYQ	5	PA; *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
<i>Ambrisentan</i>	5	PA; *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
<i>Aspirin-Dipyridamole ER</i>	1	QL (60 EA per 30 days)
<i>Isosorbide Dinitrate Oral</i>	2	
<i>Isosorbide Mononitrate</i>	2	
<i>Isosorbide Mononitrate ER</i>	2	
NITRO-BID	4	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	4	
<i>Nitroglycerin Sublingual</i>	2	
<i>Nitroglycerin Transdermal Patch 24 Hour</i>	2	
<i>Nitroglycerin Translingual</i>	2	
NITROMIST	3	
<i>Sildenafil Citrate Oral Tablet 20 MG</i>	3	PA; *; *Not available at mail-order; QL (90 EA per 30 days)
<i>Tadalafil (PAH)</i>	5	PA; *; 30DS; Not available at mail-order; QL (60 EA per 30 days)
VENTAVIS	5	PA; *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
Central Nervous System Agents		
Anorexigenic Agents And Respiratory And Cns Stimulants		
<i>Amphetamine-Dextroamphet ER Oral Capsule Extended Release 24 Hour 10 MG, 15 MG, 20 MG, 25 MG, 5 MG</i>	4	QL (30 EA per 30 days)
<i>Amphetamine-Dextroamphet ER Oral Capsule Extended Release 24 Hour 30 MG</i>	4	QL (60 EA per 30 days)
<i>Amphetamine-Dextroamphetamine Oral Tablet 10 MG, 12.5 MG, 15 MG, 20 MG, 30 MG, 5 MG</i>	2	QL (60 EA per 30 days)
<i>Amphetamine-Dextroamphetamine Oral Tablet 7.5 MG</i>	3	QL (60 EA per 30 days)
<i>Dextroamphetamine Sulfate ER Oral Capsule Extended Release 24 Hour 10 MG</i>	2	QL (60 EA per 30 days)
<i>Dextroamphetamine Sulfate ER Oral Capsule Extended Release 24 Hour 15 MG</i>	2	QL (120 EA per 30 days)
<i>Dextroamphetamine Sulfate ER Oral Capsule Extended Release 24 Hour 5 MG</i>	2	QL (30 EA per 30 days)
<i>Dextroamphetamine Sulfate Oral Tablet 10 MG</i>	2	QL (180 EA per 30 days)
<i>Dextroamphetamine Sulfate Oral Tablet 5 MG</i>	2	QL (120 EA per 30 days)
<i>Modafinil</i>	2	PA
Anticonvulsants		
BANZEL ORAL SUSPENSION	5	30DS
BANZEL ORAL TABLET	5	PA (NS); 30DS
BRIVIACT	5	PA (NS); 30DS
<i>CarBAMazepine ER</i>	2	
<i>carBAMazepine Oral</i>	2	
CELONTIN	3	
<i>CloBAZam</i>	3	
<i>clonazepam Oral Tablet 0.5 MG, 1 MG</i>	2	QL (90 EA per 30 days)
<i>clonazepam Oral Tablet 2 MG</i>	2	QL (300 EA per 30 days)
<i>Clonazepam Oral Tablet Dispersible 0.125 MG, 0.25 MG, 0.5 MG, 1 MG</i>	2	QL (90 EA per 30 days)
<i>Clonazepam Oral Tablet Dispersible 2 MG</i>	2	QL (300 EA per 30 days)
<i>Clorazepate Dipotassium Oral Tablet 15 MG</i>	2	QL (180 EA per 30 days)
<i>Clorazepate Dipotassium Oral Tablet 3.75 MG</i>	2	QL (720 EA per 30 days)
<i>Clorazepate Dipotassium Oral Tablet 7.5 MG</i>	2	QL (360 EA per 30 days)
DIAZEPAM INTENSOL	2	QL (240 ML per 30 days)
<i>Diazepam Oral Concentrate</i>	2	QL (240 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>DiazePAM Oral Solution 5 MG/5ML</i>	2	QL (1200 ML per 30 days)
<i>diazePAM Oral Tablet</i>	2	QL (120 EA per 30 days)
<i>DiazePAM Rectal</i>	4	
DILANTIN ORAL CAPSULE 30 MG	4	
<i>Divalproex Sodium ER Oral Tablet Extended Release 24 Hour</i>	2	
<i>Divalproex Sodium Oral Capsule Delayed Release Sprinkle</i>	2	
<i>Divalproex Sodium Oral Tablet Delayed Release</i>	2	
EPIDIOLEX	5	PA (NS); LA; 30DS; *Not available at mail-order
EPITOL	2	
<i>Ethosuximide Oral</i>	2	
<i>Felbamate Oral Suspension</i>	5	30DS
<i>Felbamate Oral Tablet</i>	2	
FINTEPLA	5	PA (NS); 30DS; QL (360 ML per 30 days)
FYCOMPA ORAL SUSPENSION	5	PA (NS); 30DS; QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 8 MG	5	PA (NS); 30DS; QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG	4	PA (NS); QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 6 MG	5	PA (NS); 30DS; QL (60 EA per 30 days)
<i>Gabapentin Oral Capsule 100 MG</i>	2	QL (1080 EA per 30 days)
<i>Gabapentin Oral Capsule 300 MG</i>	2	QL (360 EA per 30 days)
<i>Gabapentin Oral Capsule 400 MG</i>	2	QL (270 EA per 30 days)
<i>Gabapentin Oral Solution 250 MG/5ML</i>	4	QL (2160 ML per 30 days)
<i>Gabapentin Oral Tablet 600 MG</i>	4	QL (180 EA per 30 days)
<i>Gabapentin Oral Tablet 800 MG</i>	4	QL (120 EA per 30 days)
GRALISE ORAL TABLET 300 MG	3	QL (180 EA per 30 days)
GRALISE ORAL TABLET 600 MG	3	QL (90 EA per 30 days)
<i>LamoTRiGINE ER</i>	4	
<i>lamoTRiGINE Oral Tablet</i>	2	
<i>LamoTRiGINE Oral Tablet Chewable</i>	2	
<i>LevETIRAcetam ER</i>	2	
<i>LevETIRAcetam Oral</i>	2	
NAYZILAM	4	
<i>OXcarbazepine</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
PEGANONE	3	
<i>PHENobarbital Oral Elixir</i>	2	PA (NS)
<i>PHENobarbital Oral Tablet 100 MG, 16.2 MG, 32.4 MG, 64.8 MG</i>	2	PA (NS); QL (90 EA per 30 days)
<i>PHENobarbital Oral Tablet 15 MG, 30 MG</i>	2	PA (NS); QL (180 EA per 30 days)
<i>PHENobarbital Oral Tablet 60 MG</i>	2	PA (NS); QL (120 EA per 30 days)
<i>PHENobarbital Oral Tablet 97.2 MG</i>	2	PA (NS); QL (60 EA per 30 days)
<i>Phenytoin Oral Suspension 125 MG/5ML</i>	2	
<i>Phenytoin Oral Tablet Chewable</i>	2	
<i>Phenytoin Sodium Extended</i>	2	
<i>Pregabalin Oral Capsule 100 MG, 200 MG, 25 MG, 50 MG</i>	3	PA (NS); QL (90 EA per 30 days)
<i>Pregabalin Oral Capsule 150 MG, 225 MG, 300 MG, 75 MG</i>	3	PA (NS); QL (60 EA per 30 days)
<i>Pregabalin Oral Solution</i>	3	PA (NS); QL (946 ML per 30 days)
<i>Primidone Oral</i>	2	
ROWEEPRA	2	
ROWEEPRA XR	2	
<i>Rufinamide</i>	5	30DS
SPRITAM	4	PA (NS)
SUBVENITE	2	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	30DS
SYMPAZAN ORAL FILM 5 MG	4	
<i>TiaGABine HCl</i>	2	
<i>Topiramate Oral</i>	2	
<i>Valproate Sodium Oral Solution</i>	2	
<i>Valproic Acid Oral Capsule</i>	2	
<i>Valproic Acid Oral Solution</i>	2	
VALTOCO 10 MG DOSE	4	
VALTOCO 15 MG DOSE	4	
VALTOCO 20 MG DOSE	4	
VALTOCO 5 MG DOSE	4	
<i>Vigabatrin</i>	5	PA (NS); *, LA; 30DS; *Not available at mail-order; QL (180 EA per 30 days)
VIGADRONE	5	PA (NS); 30DS; QL (180 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
VIMPAT INTRAVENOUS	5	30DS; ; QL (1200 ML per 30 days)
VIMPAT ORAL SOLUTION	5	30DS; QL (1200 ML per 30 days)
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	5	30DS; QL (60 EA per 30 days)
VIMPAT ORAL TABLET 50 MG	4	QL (120 EA per 30 days)
XCOPRI (250 MG DAILY DOSE)	5	PA (NS); 30DS; QL (56 EA per 28 days)
XCOPRI (350 MG DAILY DOSE)	5	PA (NS); 30DS; QL (56 EA per 28 days)
XCOPRI ORAL TABLET 100 MG, 150 MG, 50 MG	5	PA (NS); 30DS; QL (30 EA per 30 days)
XCOPRI ORAL TABLET 200 MG	5	PA (NS); 30DS; QL (60 EA per 30 days)
XCOPRI ORAL TABLET THERAPY PACK	5	PA (NS); 30DS; QL (28 EA per 28 days)
<i>Zonisamide Oral</i>	2	
Anticonvulsants, Miscellaneous		
APTiom ORAL TABLET 200 MG, 400 MG	5	30DS; QL (30 EA per 30 days)
APTiom ORAL TABLET 600 MG, 800 MG	5	30DS; QL (60 EA per 30 days)
<i>Magnesium Sulfate Injection Solution 50 %</i>	2	B/D
Antidepressants		
<i>Amitriptyline HCl Oral</i>	1	PA (NS)
<i>Amoxapine</i>	2	PA (NS)
<i>BuPROPion HCl ER (Smoking Det)</i>	2	
<i>buPROPion HCl ER (SR)</i>	2	
<i>BuPROPion HCl ER (XL) Oral Tablet Extended Release 24 Hour 150 MG, 300 MG</i>	2	
<i>buPROPion HCl Oral</i>	2	
<i>Citalopram Hydrobromide Oral Solution</i>	2	
<i>Citalopram Hydrobromide Oral Tablet</i>	1	QL (30 EA per 30 days)
<i>ClomiPRAMINE HCl Oral</i>	4	PA (NS)
<i>Desipramine HCl Oral</i>	2	PA (NS)
<i>Desvenlafaxine Succinate ER</i>	2	QL (30 EA per 30 days)
<i>Doxepin HCl Oral Capsule</i>	4	PA (NS)
<i>Doxepin HCl Oral Concentrate</i>	4	PA (NS)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG	4	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG	4	QL (30 EA per 30 days)
<i>DULoxetine HCl Oral Capsule Delayed Release Particles 20 MG, 30 MG, 60 MG</i>	2	QL (60 EA per 30 days)
<i>DULoxetine HCl Oral Capsule Delayed Release Particles 40 MG</i>	2	QL (30 EA per 30 days)
<i>Escitalopram Oxalate Oral Solution</i>	2	
<i>Escitalopram Oxalate Oral Tablet</i>	1	QL (30 EA per 30 days)
FETZIMA	4	QL (30 EA per 30 days)
FETZIMA TITRATION	4	QL (28 EA per 28 days)
<i>FLUoxetine HCl Oral Capsule 10 MG</i>	1	QL (30 EA per 30 days)
<i>FLUoxetine HCl Oral Capsule 20 MG, 40 MG</i>	1	
<i>FLUoxetine HCl Oral Solution</i>	1	
<i>Fluvoxamine Maleate Oral Tablet 100 MG</i>	1	
<i>Fluvoxamine Maleate Oral Tablet 25 MG, 50 MG</i>	1	QL (30 EA per 30 days)
<i>Imipramine HCl Oral</i>	2	PA (NS)
<i>Maprotiline HCl</i>	2	
MARPLAN	3	QL (180 EA per 30 days)
<i>Mirtazapine Oral Tablet 15 MG, 30 MG, 45 MG</i>	2	QL (30 EA per 30 days)
<i>Mirtazapine Oral Tablet 7.5 MG</i>	2	
<i>Mirtazapine Oral Tablet Dispersible</i>	2	QL (30 EA per 30 days)
<i>Nefazodone HCl</i>	2	
<i>Nortriptyline HCl Oral</i>	1	PA (NS)
<i>OLANzapine-FLUoxetine HCl</i>	2	QL (30 EA per 30 days)
<i>PARoxetine HCl ER Oral Tablet Extended Release 24 Hour 12.5 MG, 25 MG</i>	2	ST (NS); QL (30 EA per 30 days)
<i>PARoxetine HCl ER Oral Tablet Extended Release 24 Hour 37.5 MG</i>	2	ST (NS); QL (60 EA per 30 days)
<i>PARoxetine HCl Oral Tablet 10 MG, 20 MG, 40 MG</i>	1	ST (NS); QL (30 EA per 30 days)
<i>PARoxetine HCl Oral Tablet 30 MG</i>	1	ST (NS); QL (60 EA per 30 days)
PAXIL ORAL SUSPENSION 10 MG/5ML	3	ST; QL (900 ML per 30 days)
PAXIL ORAL SUSPENSION 10 MG/5ML	3	ST (NS); QL (900 ML per 30 days)
<i>Phenelzine Sulfate Oral</i>	2	
<i>Protriptyline HCl</i>	2	PA (NS)
<i>Sertraline HCl Oral Concentrate</i>	2	
<i>Sertraline HCl Oral Tablet 100 MG</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Sertraline HCl Oral Tablet 25 MG, 50 MG</i>	1	QL (30 EA per 30 days)
<i>Tranylcypromine Sulfate</i>	2	
<i>traZODone HCl Oral Tablet 100 MG, 150 MG, 50 MG</i>	1	
<i>TraZODone HCl Oral Tablet 300 MG</i>	2	
<i>Trimipramine Maleate Oral Capsule 100 MG</i>	4	PA (NS); QL (60 EA per 30 days)
<i>Trimipramine Maleate Oral Capsule 25 MG, 50 MG</i>	4	PA (NS); QL (120 EA per 30 days)
TRINTELLIX	4	PA (NS); QL (30 EA per 30 days)
<i>Venlafaxine HCl</i>	1	
<i>Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour</i>	1	
<i>Venlafaxine HCl ER Oral Tablet Extended Release 24 Hour</i>	4	
VIIBRYD ORAL TABLET	4	PA (NS); QL (30 EA per 30 days)
VIIBRYD STARTER PACK	4	PA (NS); QL (30 EA per 30 days)
Antimigraine Agents		
AIMOVIG (140 MG DOSE)	3	PA; QL (1 ML per 30 days)
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	3	PA; QL (1 ML per 30 days)
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML	3	PA; QL (2 ML per 30 days)
AJOVY	3	PA; QL (1.5 ML per 30 days)
<i>Rizatriptan Benzoate</i>	2	QL (18 EA per 30 days)
<i>SUMatriptan Nasal</i>	2	QL (12 EA per 30 days)
<i>SUMatriptan Succinate Oral Tablet 100 MG</i>	2	QL (9 EA per 30 days)
<i>SUMatriptan Succinate Oral Tablet 25 MG, 50 MG</i>	2	QL (18 EA per 30 days)
<i>SUMatriptan Succinate Refill Subcutaneous Solution Cartridge 4 MG/0.5ML</i>	4	QL (9 ML per 30 days)
<i>SUMatriptan Succinate Refill Subcutaneous Solution Cartridge 6 MG/0.5ML</i>	2	QL (4 ML per 30 days)
<i>SUMatriptan Succinate Subcutaneous Solution 6 MG/0.5ML</i>	2	QL (4 ML per 30 days)
<i>SUMatriptan Succinate Subcutaneous Solution Auto-Injector 4 MG/0.5ML</i>	4	QL (9 ML per 30 days)
<i>SUMatriptan Succinate Subcutaneous Solution Auto-Injector 6 MG/0.5ML</i>	2	QL (4 ML per 30 days)
<i>SUMatriptan Succinate Subcutaneous Solution Prefilled Syringe 6 MG/0.5ML</i>	2	QL (4 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
Antiparkinsonian Agents		
<i>Amantadine HCl Oral Capsule</i>	2	QL (120 EA per 30 days)
<i>Amantadine HCl Oral Syrup</i>	2	
<i>Amantadine HCl Oral Tablet</i>	2	
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE	5	*; LA; 30DS; *Not available at mail-order; QL (60 ML per 30 days)
<i>Benztropine Mesylate Oral</i>	1	PA
<i>Bromocriptine Mesylate Oral</i>	2	
<i>Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG, 50-200 MG</i>	2	
<i>Carbidopa-Levodopa Oral Tablet</i>	1	
<i>Carbidopa-Levodopa Oral Tablet Dispersible</i>	2	
<i>Carbidopa-Levodopa-Entacapone</i>	2	
EMSAM	5	30DS; QL (30 EA per 30 days)
<i>Entacapone</i>	2	
NEUPRO	4	PA; QL (30 EA per 30 days)
<i>Pramipexole Dihydrochloride</i>	1	
<i>Rasagiline Mesylate Oral</i>	2	QL (30 EA per 30 days)
<i>rOPINIRole HCl</i>	2	
<i>ROPINIRole HCl ER</i>	2	
<i>Selegiline HCl Oral</i>	2	
<i>Tolcapone</i>	2	
<i>Trihexyphenidyl HCl</i>	1	PA
Antipsychotic Agents		
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 300 MG	4	PA (NS); QL (2 EA per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG	4	PA (NS); QL (1 EA per 28 days)
Antipsychotics		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE	5	PA (NS); 30DS; QL (1 EA per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	5	PA (NS); 30DS; QL (1 EA per 28 days)
ABILIFY MYCITE	5	PA (NS); 30DS; QL (30 EA per 30 days)
<i>ARIPiprazole Oral Solution</i>	5	30DS; QL (900 ML per 30 days)
<i>ARIPiprazole Oral Tablet 10 MG</i>	4	QL (90 EA per 30 days)
<i>ARIPiprazole Oral Tablet 15 MG, 2 MG, 5 MG</i>	4	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>ARIPiprazole Oral Tablet 20 MG, 30 MG</i>	4	QL (30 EA per 30 days)
<i>ARIPiprazole Oral Tablet Dispersible 10 MG</i>	5	30DS; QL (90 EA per 30 days)
<i>ARIPiprazole Oral Tablet Dispersible 15 MG</i>	5	30DS; QL (60 EA per 30 days)
ARISTADA INITIO	5	*; 30DS; Not available at mail-order; QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	5	30DS; QL (3.9 ML per 56 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	5	30DS; QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	5	30DS; QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	5	30DS; QL (3.2 ML per 28 days)
CAPLYTA	5	PA (NS); 30DS; QL (30 EA per 30 days)
<i>chlorproMAZINE HCl Oral</i>	4	
<i>CloZAPine Oral Tablet</i>	2	
<i>CloZAPine Oral Tablet Dispersible 100 MG, 12.5 MG, 200 MG</i>	2	
<i>CloZAPine Oral Tablet Dispersible 150 MG, 25 MG</i>	4	
FANAPT	4	PA (NS); QL (60 EA per 30 days)
FANAPT TITRATION PACK	4	PA (NS); QL (8 EA per 30 days)
<i>FluPHENAZine Decanoate Injection</i>	2	
<i>FluPHENAZine HCl Injection</i>	2	
<i>FluPHENAZine HCl Oral</i>	2	
<i>Haloperidol Decanoate Intramuscular Solution 100 MG/ML, 50 MG/ML, 50 MG/ML(1ML)</i>	2	
<i>Haloperidol Lactate</i>	2	
<i>Haloperidol Oral</i>	2	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	5	PA (NS); 30DS; QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	5	PA (NS); 30DS; QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	5	PA (NS); 30DS; QL (1.5 ML per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	PA (NS); QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	5	PA (NS); 30DS; QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML	5	PA (NS); 30DS; QL (0.875 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.315ML	5	PA (NS); 30DS; QL (1.315 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML	5	PA (NS); 30DS; QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.625ML	5	PA (NS); 30DS; QL (2.625 ML per 84 days)
LATUDA ORAL TABLET 120 MG	4	QL (30 EA per 30 days)
LATUDA ORAL TABLET 20 MG, 60 MG, 80 MG	4	QL (60 EA per 30 days)
LATUDA ORAL TABLET 40 MG	4	QL (120 EA per 30 days)
<i>Loxapine Succinate Oral</i>	2	
<i>Molindone HCl</i>	2	
NUPLAZID ORAL CAPSULE	5	PA (NS); *; 30DS; Not available at mail-order; QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 10 MG	5	PA (NS); *; 30DS; Not available at mail-order; QL (30 EA per 30 days)
<i>OLANZapine Intramuscular</i>	4	QL (3 EA per 1 day)
<i>OLANZapine Oral Tablet 10 MG, 2.5 MG</i>	3	QL (60 EA per 30 days)
<i>OLANZapine Oral Tablet 15 MG, 20 MG, 7.5 MG</i>	3	QL (30 EA per 30 days)
<i>OLANZapine Oral Tablet 5 MG</i>	3	QL (120 EA per 30 days)
<i>OLANZapine Oral Tablet Dispersible 10 MG, 15 MG, 20 MG</i>	4	QL (30 EA per 30 days)
<i>OLANZapine Oral Tablet Dispersible 5 MG</i>	4	QL (120 EA per 30 days)
<i>Paliperidone ER Oral Tablet Extended Release 24 Hour 1.5 MG, 3 MG</i>	4	30DS; QL (30 EA per 30 days)
<i>Paliperidone ER Oral Tablet Extended Release 24 Hour 6 MG</i>	4	30DS; QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Paliperidone ER Oral Tablet Extended Release 24 Hour 9 MG</i>	5	30DS; QL (30 EA per 30 days)
<i>Perphenazine Oral</i>	2	
PERSERIS	5	PA (NS); *; 30DS; Not available at mail-order; QL (1 EA per 28 days)
<i>Pimozide</i>	2	
<i>QUetiapine Fumarate ER</i>	4	ST (NS); QL (60 EA per 30 days)
<i>QUetiapine Fumarate Oral Tablet 100 MG, 200 MG, 50 MG</i>	1	QL (120 EA per 30 days)
<i>QUetiapine Fumarate Oral Tablet 25 MG</i>	1	QL (360 EA per 30 days)
<i>QUetiapine Fumarate Oral Tablet 300 MG, 400 MG</i>	1	QL (60 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG	5	30DS; QL (90 EA per 30 days)
REXULTI ORAL TABLET 2 MG	5	30DS; QL (60 EA per 30 days)
REXULTI ORAL TABLET 3 MG, 4 MG	5	30DS; QL (30 EA per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED 12.5 MG, 25 MG	4	PA (NS); QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED 37.5 MG, 50 MG	5	PA (NS); 30DS; QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG	4	PA (NS); QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 37.5 MG, 50 MG	5	PA (NS); 30DS; QL (2 EA per 28 days)
<i>RisperiDONE Oral Solution</i>	2	QL (480 ML per 30 days)
<i>RisperiDONE Oral Tablet 0.25 MG, 0.5 MG, 2 MG</i>	1	QL (60 EA per 30 days)
<i>RisperiDONE Oral Tablet 1 MG, 4 MG</i>	1	QL (120 EA per 30 days)
<i>RisperiDONE Oral Tablet 3 MG</i>	1	QL (150 EA per 30 days)
<i>RisperiDONE Oral Tablet Dispersible 0.25 MG</i>	2	QL (30 EA per 30 days)
<i>RisperiDONE Oral Tablet Dispersible 0.5 MG, 2 MG</i>	2	QL (60 EA per 30 days)
<i>RisperiDONE Oral Tablet Dispersible 1 MG, 4 MG</i>	2	QL (120 EA per 30 days)
<i>RisperiDONE Oral Tablet Dispersible 3 MG</i>	2	QL (150 EA per 30 days)
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG	4	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 2.5 MG	4	QL (240 EA per 30 days)
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 5 MG	4	QL (120 EA per 30 days)
SECUADO	5	PA (NS); 30DS; QL (30 EA per 30 days)
<i>Thioridazine HCl Oral</i>	2	
<i>Thiothixene Oral</i>	2	
<i>Trifluoperazine HCl Oral</i>	2	
VERSACLOZ	5	30DS; QL (540 ML per 30 days)
VRAYLAR ORAL CAPSULE	5	PA (NS); 30DS; QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE THERAPY PACK	4	PA (NS)
<i>Ziprasidone HCl Oral Capsule 20 MG, 40 MG</i>	2	QL (120 EA per 30 days)
<i>Ziprasidone HCl Oral Capsule 60 MG, 80 MG</i>	2	QL (60 EA per 30 days)
<i>Ziprasidone Mesylate</i>	4	QL (6 EA per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG	4	PA (NS); QL (2 EA per 28 days)
Anxiolytics, Sedatives And Hypnotics,Misc.		
BELSOMRA	3	QL (30 EA per 30 days)
<i>busPIRone HCl Oral</i>	1	
<i>Butalbital-Acetaminophen Oral Tablet 50-325 MG</i>	2	PA; QL (180 EA per 30 days)
<i>Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG</i>	2	PA; QL (180 EA per 30 days)
<i>Doxepin HCl Oral Tablet</i>	2	QL (30 EA per 30 days)
HETLIOZ	5	PA; 30DS
<i>HydrOXYzine HCl Oral Syrup</i>	2	PA (NS)
<i>hydrOXYzine HCl Oral Tablet</i>	2	PA (NS)
<i>HydrOXYzine Pamoate Oral</i>	2	PA (NS)
<i>Temazepam Oral Capsule 15 MG, 30 MG</i>	1	QL (30 EA per 30 days)
<i>Zaleplon</i>	1	ST; QL (30 EA per 30 days)
<i>Zolpidem Tartrate Oral</i>	1	ST; QL (30 EA per 30 days)
Benzodiazepines (Anxiolytic,Sedativ/Hyp)		
ALPRAZolam ER	2	QL (90 EA per 30 days)
ALPRAZOLAM INTENSOL	2	QL (300 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>ALPRAZolam Oral Tablet 0.25 MG, 0.5 MG, 1 MG</i>	2	QL (120 EA per 30 days)
<i>ALPRAZolam Oral Tablet 2 MG</i>	2	QL (150 EA per 30 days)
<i>ALPRAZolam Oral Tablet Dispersible 0.25 MG, 0.5 MG, 1 MG</i>	2	QL (120 EA per 30 days)
<i>ALPRAZolam Oral Tablet Dispersible 2 MG</i>	2	QL (150 EA per 30 days)
<i>LORazepam Oral Concentrate 2 MG/ML</i>	2	QL (150 ML per 30 days)
<i>LORazepam Oral Tablet</i>	2	QL (120 EA per 30 days)
Central Nervous System Agents, Misc.		
<i>Acamprosate Calcium</i>	1	
<i>Atomoxetine HCl Oral Capsule 10 MG, 18 MG, 25 MG</i>	2	QL (120 EA per 30 days)
<i>Atomoxetine HCl Oral Capsule 100 MG, 60 MG, 80 MG</i>	2	QL (30 EA per 30 days)
<i>Atomoxetine HCl Oral Capsule 40 MG</i>	2	QL (60 EA per 30 days)
<i>GuanFACINE HCl ER</i>	2	PA; QL (30 EA per 30 days)
INGREZZA ORAL CAPSULE	5	PA; 30DS; QL (30 EA per 30 days)
<i>Lithium</i>	2	
<i>Lithium Carbonate ER</i>	2	
<i>Lithium Carbonate Oral</i>	1	
<i>Memantine HCl Oral Solution 2 MG/ML</i>	2	QL (300 ML per 30 days)
<i>Memantine HCl Oral Tablet 10 MG, 5 MG</i>	2	QL (60 EA per 30 days)
<i>Memantine HCl Oral Tablet 28 x 5 MG & 21 x 10 MG</i>	2	
NUEDEXTA	4	PA; QL (60 EA per 30 days)
<i>Riluzole</i>	3	
<i>Tetrabenazine Oral Tablet 12.5 MG</i>	5	PA; *; LA; 30DS; *Not available at mail-order; QL (240 EA per 30 days)
<i>Tetrabenazine Oral Tablet 25 MG</i>	5	PA; *; LA; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
XYREM	5	LA; 30DS; QL (540 ML per 30 days)
Nonsteroidal Anti-Inflammatory Agents		
<i>Celecoxib Oral Capsule 100 MG, 200 MG, 50 MG</i>	2	QL (60 EA per 30 days)
<i>Celecoxib Oral Capsule 400 MG</i>	2	QL (30 EA per 30 days)
<i>Diclofenac Potassium</i>	3	QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Diclofenac Sodium ER</i>	2	
<i>Diclofenac Sodium Oral Tablet Delayed Release 25 MG</i>	4	
<i>Diclofenac Sodium Oral Tablet Delayed Release 50 MG, 75 MG</i>	2	
<i>Diclofenac Sodium Transdermal Gel 1 %</i>	2	
<i>Diflunisal Oral</i>	4	
<i>Etodolac ER</i>	2	
<i>Etodolac Oral</i>	2	
<i>Flurbiprofen Oral Tablet 100 MG</i>	2	
<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 ER</i>	2	
<i>Ketoprofen Oral</i>	2	
<i>Meloxicam Oral Tablet</i>	1	
<i>Nabumetone Oral</i>	2	
<i>Naproxen DR</i>	1	
<i>Naproxen Oral Suspension</i>	4	
<i>Naproxen Oral Tablet</i>	1	
<i>Naproxen Sodium Oral Tablet 275 MG</i>	1	
<i>Naproxen Sodium Oral Tablet 550 MG</i>	4	
<i>Piroxicam Oral</i>	2	
<i>Sulindac Oral</i>	1	
Opiate Agonists		
<i>Acetaminophen-Codeine #3</i>	2	QL (180 EA per 30 days)
<i>Acetaminophen-Codeine Oral Solution</i>	2	QL (2700 ML per 30 days)
<i>Acetaminophen-Codeine Oral Tablet 300-15 MG, 300-60 MG</i>	2	QL (180 EA per 30 days)
<i>Butorphanol Tartrate Nasal</i>	4	
<i>Codeine Sulfate Oral Tablet</i>	4	QL (180 EA per 30 days)
<i>Duramorph</i>	4	B/D
<i>ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG</i>	4	QL (180 EA per 30 days)
<i>FentaNYL</i>	4	QL (10 EA per 30 days)
<i>FentaNYL Citrate Buccal Lozenge On A Handle</i>	5	PA; 30DS; QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>HYDROcodone-Acetaminophen Oral Tablet 10-300 MG, 10-325 MG, 5-300 MG, 5-325 MG, 7.5-300 MG, 7.5-325 MG</i>	2	QL (180 EA per 30 days)
<i>Hydrocodone-Ibuprofen Oral Tablet 7.5-200 MG</i>	3	QL (150 EA per 30 days)
<i>HYDROmorphine HCl Injection Solution 1 MG/ML, 4 MG/ML</i>	2	
<i>HYDROmorphine HCl Oral Liquid</i>	4	QL (1500 ML per 30 days)
<i>HYDROmorphine HCl Oral Tablet</i>	3	QL (180 EA per 30 days)
<i>HYDROmorphine HCl PF Injection Solution 10 MG/ML</i>	4	
<i>HYDROmorphine HCl PF Injection Solution 50 MG/5ML, 500 MG/50ML</i>	4	B/D
LORCET	2	QL (180 EA per 30 days)
LORCET HD	2	QL (180 EA per 30 days)
LORCET PLUS ORAL TABLET 7.5-325 MG	2	QL (180 EA per 30 days)
<i>Meperidine HCl Injection Solution 100 MG/ML, 25 MG/ML, 50 MG/ML</i>	2	PA; QL (180 ML per 30 days)
<i>Meperidine HCl Oral Solution</i>	2	ST; QL (1000 ML per 30 days)
<i>Meperidine HCl Oral Tablet</i>	2	ST; QL (180 EA per 30 days)
<i>Methadone HCl Oral Solution</i>	3	QL (450 ML per 30 days)
<i>Methadone HCl Oral Tablet</i>	3	QL (300 EA per 30 days)
<i>Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML</i>	3	QL (180 ML per 30 days)
<i>Morphine Sulfate (PF) Injection Solution 0.5 MG/ML, 1 MG/ML</i>	4	B/D
<i>Morphine Sulfate (PF) Intravenous Solution 10 MG/ML</i>	4	B/D
<i>Morphine Sulfate ER Oral Tablet Extended Release</i>	3	QL (90 EA per 30 days)
<i>Morphine Sulfate Intravenous Solution 1 MG/ML, 150 MG/30ML, 25 MG/ML, 50 MG/ML</i>	4	B/D
<i>Morphine Sulfate Oral Solution</i>	3	QL (1000 ML per 30 days)
<i>Morphine Sulfate Oral Tablet</i>	3	QL (180 EA per 30 days)
<i>OxyCODONE HCl Oral Capsule</i>	4	QL (180 EA per 30 days)
<i>OxyCODONE HCl Oral Concentrate 100 MG/5ML</i>	4	QL (180 ML per 30 days)
<i>OxyCODONE HCl Oral Solution</i>	4	QL (3600 ML per 30 days)
<i>oxyCODONE HCl Oral Tablet</i>	3	QL (180 EA per 30 days)
<i>Oxycodone-Acetaminophen Oral Tablet 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG</i>	3	QL (180 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>oxyCODONE-Aspirin Oral Tablet 4.8355-325 MG</i>	3	QL (180 EA per 30 days)
<i>Oxymorphone HCl</i>	2	QL (120 EA per 30 days)
<i>oxyMORphone HCl ER</i>	2	QL (60 EA per 30 days)
<i>TraMADol HCl ER (Biphasic) Oral Tablet Extended Release 24 Hour 100 MG</i>	2	QL (90 EA per 30 days)
<i>TraMADol HCl ER (Biphasic) Oral Tablet Extended Release 24 Hour 200 MG, 300 MG</i>	2	QL (30 EA per 30 days)
<i>TraMADol HCl ER Oral Tablet Extended Release 24 Hour 100 MG</i>	2	QL (90 EA per 30 days)
<i>TraMADol HCl ER Oral Tablet Extended Release 24 Hour 200 MG, 300 MG</i>	2	QL (30 EA per 30 days)
<i>traMADol HCl Oral Tablet 50 MG</i>	2	QL (240 EA per 30 days)
<i>Tramadol-Acetaminophen</i>	3	QL (240 EA per 30 days)
Opiate Antagonists		
<i>Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML</i>	2	
<i>Naloxone HCl Injection Solution Cartridge</i>	2	
<i>Naloxone HCl Injection Solution Prefilled Syringe</i>	2	
<i>Naltrexone HCl Oral</i>	2	
NARCAN	3	
Opiate Partial Agonists		
<i>Buprenorphine HCl Sublingual Tablet Sublingual 2 MG</i>	2	QL (90 EA per 30 days)
<i>Buprenorphine HCl Sublingual Tablet Sublingual 8 MG</i>	2	QL (60 EA per 30 days)
<i>Buprenorphine HCl-Naloxone HCl Sublingual Film</i>	2	QL (60 EA per 30 days)
<i>Pentazocine-Naloxone HCl</i>	2	ST; QL (360 EA per 30 days)
Respiratory And Cns Stimulants		
<i>Dexmethylphenidate HCl</i>	2	QL (60 EA per 30 days)
<i>Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 10 MG, 15 MG, 20 MG</i>	2	QL (60 EA per 30 days)
<i>Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 25 MG, 30 MG, 35 MG, 40 MG, 5 MG</i>	2	QL (30 EA per 30 days)
<i>Metadate ER Oral Tablet Extended Release 20 MG</i>	2	QL (90 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Methylphenidate HCl ER Oral Tablet Extended Release 18 MG, 27 MG, 36 MG, 54 MG, 72 MG</i>	2	QL (30 EA per 30 days)
<i>Methylphenidate HCl ER Oral Tablet Extended Release 20 MG</i>	2	QL (90 EA per 30 days)
<i>Methylphenidate HCl ER Oral Tablet Extended Release 24 Hour</i>	2	QL (30 EA per 30 days)
<i>Methylphenidate HCl Oral Tablet</i>	2	QL (90 EA per 30 days)
Devices		
Devices		
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML	1	
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML	1	
<i>CVS Gauze Sterile Pad 2"X2"</i>	1	
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM	1	
<i>Preferred Plus Insulin Syringe 28G X 1/2" 0.5 ML</i>	1	
RELI-ON INSULIN SYRINGE 29G 0.3 ML	1	
Electrolytic, Caloric, And Water Balance		
Alkalinizing Agents		
<i>Potassium Citrate ER</i>	2	
Ammonia Detoxicants		
CARBAGLU	5	PA; 30DS
<i>Constulose</i>	2	
<i>Enulose</i>	2	
<i>Generlac</i>	2	
<i>Lactulose Encephalopathy</i>	2	
<i>Lactulose Oral Solution 10 GM/15ML</i>	2	
RAVICTI	5	PA; *; 30DS; *Not available at mail-order
<i>Sodium Phenylbutyrate Oral Powder 3 GM/TSP</i>	5	PA; *; 30DS; *Not available at mail-order
Caloric Agents		
AMINOSYN II INTRAVENOUS SOLUTION 10 %, 15 %	4	B/D
AMINOSYN-PF INTRAVENOUS SOLUTION 7 %	4	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
CLINOLIPID	3	B/D
<i>Dextrose Intravenous Solution 10 %, 250 MG/ML, 30 %, 5 %, 50 %, 70 %</i>	2	
<i>Dextrose-NaCl Intravenous Solution 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.45 %, 5-0.9 %</i>	2	
INTRALIPID	3	B/D
NUTRILIPID	3	B/D
PREMASOL INTRAVENOUS SOLUTION 10 %	3	B/D
TRAVASOL	3	B/D
TROPHAMINE INTRAVENOUS SOLUTION 10 %	3	B/D
Diuretics		
<i>AMILoride HCl Oral</i>	2	
<i>Amiloride-Hydrochlorothiazide</i>	2	
<i>Bumetanide Injection</i>	2	
<i>Bumetanide Oral</i>	1	
<i>Chlorothiazide Oral</i>	1	
<i>Chlorthalidone Oral Tablet 25 MG, 50 MG</i>	1	
DIURIL	4	
<i>Furosemide Injection Solution 10 MG/ML</i>	2	
<i>Furosemide Oral Solution 10 MG/ML, 8 MG/ML</i>	1	
<i>Furosemide Oral Tablet</i>	1	
<i>HydroCHLOROthiazide Oral</i>	1	
<i>Indapamide Oral</i>	1	
<i>metOLazone</i>	2	
<i>Torsemide Oral</i>	1	
<i>Triamterene-HCTZ Oral Capsule 37.5-25 MG</i>	1	
<i>Triamterene-HCTZ Oral Tablet</i>	1	
Ion-Removing Agents		
AURYXIA	5	PA; 30DS; QL (360 EA per 30 days)
<i>Calcium Acetate (Phos Binder)</i>	2	QL (360 EA per 30 days)
KIONEX ORAL SUSPENSION	2	
<i>Sevelamer Carbonate Oral Tablet</i>	4	QL (540 EA per 30 days)
<i>Sodium Polystyrene Sulfonate Oral Powder</i>	2	
SPS	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
Replacement Preparations		
<i>KCl in Dextrose-NaCl Intravenous Solution 10-5-0.45 MEQ/L-%-%, 20-5-0.2 MEQ/L-%-%, 20-5-0.225 MEQ/L-%-%, 20-5-0.9 MEQ/L-%-%</i>	2	
<i>KCl in Dextrose-NaCl Intravenous Solution 20-5-0.45 MEQ/L-%-%, 30-5-0.45 MEQ/L-%-%, 40-5-0.45 MEQ/L-%-%</i>	2	B/D
KLOR-CON 10	2	
KLOR-CON M10	2	
KLOR-CON M15	2	
KLOR-CON M20	2	
KLOR-CON ORAL TABLET EXTENDED RELEASE	1	
KLOR-CON SPRINKLE	2	
<i>Potassium Chloride Crys ER</i>	2	
<i>Potassium Chloride ER Oral Capsule Extended Release</i>	2	
<i>Potassium Chloride ER Oral Tablet Extended Release 10 MEQ, 20 MEQ</i>	2	
<i>Potassium Chloride ER Oral Tablet Extended Release 8 MEQ</i>	1	
<i>Potassium Chloride Intravenous Solution 10 MEQ/100ML, 40 MEQ/100ML</i>	1	
<i>Potassium Chloride Intravenous Solution 10 MEQ/50ML, 2 MEQ/ML, 20 MEQ/100ML, 20 MEQ/50ML</i>	2	
<i>Potassium Chloride Oral Solution 20 MEQ/15ML (10%), 40 MEQ/15ML (20%)</i>	4	
<i>Sodium Chloride Injection Solution 2.5 MEQ/ML</i>	2	
<i>Sodium Chloride Intravenous Solution 0.45 %, 0.9 %, 3 %, 4 MEQ/ML, 5 %</i>	2	
<i>Sodium Chloride Irrigation Solution 0.9 %</i>	2	
TPN ELECTROLYTES	3	B/D
Enzymes		
Enzymes		
ALDURAZYME	5	PA; *; LA; 30DS; *Not available at mail-order
ELAPRASE	5	PA; *; 30DS; *Not available at mail-order
ELELYSO	5	PA; *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 35 MG	5	PA; *; 30DS; *Not available at mail-order
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 5 MG	5	PA; *; 30DS; Not available at mail-order
NAGLAZYME	5	PA; *; 30DS; *Not available at mail-order
VPRIV	5	PA; *; 30DS; *Not available at mail-order

Eye, Ear, Nose, And Throat (Eent) Preparations

Antiallergic Agents

<i>Azelastine HCl Nasal Solution 0.1 %, 0.15 %</i>	2	
<i>Azelastine HCl Ophthalmic</i>	3	
<i>Cromolyn Sodium Ophthalmic</i>	2	
<i>Epinastine HCl</i>	4	
<i>Olopatadine HCl Ophthalmic</i>	2	

Antiglaucoma Agents

<i>acetaZOLAMIDE ER</i>	2	
<i>acetaZOLAMIDE Oral</i>	2	
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %	3	
AZOPT	3	
<i>Betaxolol HCl Ophthalmic</i>	3	
BETOPTIC-S	3	
<i>Brimonidine Tartrate Ophthalmic</i>	2	
COMBIGAN	3	
<i>Dorzolamide HCl Ophthalmic</i>	2	
<i>Dorzolamide HCl-Timolol Mal</i>	2	
<i>Latanoprost Ophthalmic</i>	2	
<i>Levobunolol HCl Ophthalmic Solution 0.5 %</i>	2	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	
<i>methazolAMIDE Oral</i>	2	
PHOSPHOLINE IODIDE	3	
<i>Pilocarpine HCl Ophthalmic Solution 1 %, 2 %, 4 %</i>	3	
RHOPRESSA	3	
SIMBRINZA	3	
<i>Timolol Maleate Ophthalmic Gel Forming Solution</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Timolol Maleate Ophthalmic Solution 0.25 %, 0.5 %</i>	1	
TRAVATAN Z	3	
Anti-Infectives (Eent)		
ACETASOL HC	2	
<i>Acetic Acid Otic</i>	2	
<i>Bacitracin Ophthalmic</i>	2	
<i>Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM</i>	2	
<i>Bacitra-Neomycin-Polymyxin-HC</i>	2	
BLEPHAMIDE	3	
BLEPHAMIDE S.O.P.	4	
<i>Chlorhexidine Gluconate Mouth/Throat</i>	1	
CILOXAN OPHTHALMIC OINTMENT	3	
CIPRODEX	3	
<i>Ciprofloxacin HCl Ophthalmic</i>	1	
<i>Erythromycin Ophthalmic</i>	1	
GENTAK OPHTHALMIC OINTMENT	1	
<i>Gentamicin Sulfate Ophthalmic Solution</i>	1	QL (10 ML per 30 days)
<i>Hydrocortisone-Acetic Acid</i>	2	
<i>Levofloxacin Ophthalmic</i>	2	
MOXEZA	3	
<i>Moxifloxacin HCl Ophthalmic</i>	2	
NATACYN	3	
<i>Neomycin-Bacitracin Zn-Polymyx Ophthalmic Ointment 5-400-10000</i>	2	
<i>Neomycin-Polymyxin-Dexameth Ophthalmic Ointment</i>	2	
<i>Neomycin-Polymyxin-Dexameth Ophthalmic Suspension 3.5-10000-0.1</i>	2	
<i>Neomycin-Polymyxin-Gramicidin Ophthalmic Solution 1.75-10000-.025</i>	2	
<i>Neomycin-Polymyxin-HC Ophthalmic Suspension 3.5-10000-1</i>	2	
<i>Neomycin-Polymyxin-HC Otic Solution 1 %</i>	2	
<i>Neomycin-Polymyxin-HC Otic Suspension</i>	2	
<i>Ofloxacin Ophthalmic</i>	1	
<i>Ofloxacin Otic</i>	2	
PERIOGARD	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Polymyxin B-Trimethoprim</i>	1	
<i>Sulfacetamide Sodium Ophthalmic Ointment</i>	3	
<i>Sulfacetamide Sodium Ophthalmic Solution</i>	4	
<i>Sulfacetamide-Prednisolone Ophthalmic Solution</i>	2	
TOBRADEX OPHTHALMIC OINTMENT	3	
<i>Tobramycin Ophthalmic</i>	1	
<i>Tobramycin-Dexamethasone</i>	2	
TOBREX OPHTHALMIC OINTMENT	3	
<i>Trifluridine Ophthalmic</i>	2	
ZIRGAN	3	
Anti-Inflammatory Agents (Eent)		
<i>Dexamethasone Sodium Phosphate Ophthalmic</i>	2	
<i>Diclofenac Sodium Ophthalmic</i>	1	
DUREZOL	3	
<i>Flunisolide Nasal Solution 25 MCG/ACT (0.025%)</i>	2	QL (75 ML per 30 days)
<i>Fluorometholone Ophthalmic</i>	3	
<i>Flurbiprofen Sodium</i>	1	
<i>Fluticasone Propionate Nasal</i>	2	QL (16 GM per 30 days)
FML FORTE	3	
<i>Ketorolac Tromethamine Ophthalmic</i>	2	
MAXIDEX	3	
PRED MILD	3	
<i>prednisoLONE Acetate Ophthalmic</i>	2	
<i>PrednisoLONE Sodium Phosphate Ophthalmic</i>	2	
RESTASIS	3	QL (120 EA per 30 days)
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 %	3	QL (5.5 ML per 30 days)
Eent Drugs, Miscellaneous		
<i>Apraclonidine HCl</i>	2	
<i>Carteolol HCl</i>	2	
CYSTARAN	5	LA; 30DS
IOPIDINE OPHTHALMIC SOLUTION 1 %	3	
<i>Ipratropium Bromide Nasal</i>	1	QL (30 ML per 30 days)
Local Anesthetics (Eent)		
<i>Lidocaine HCl External Solution</i>	2	
<i>Lidocaine HCl Mouth/Throat</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Lidocaine Viscous HCl</i>	2	
<i>Proparacaine HCl Ophthalmic</i>	2	
Gastrointestinal Drugs		
Antidiarrhea Agents		
<i>Diphenoxylate-Atropine Oral Tablet</i>	2	PA
<i>Loperamide HCl Oral Capsule</i>	2	
Antiemetics		
<i>Aprepitant Oral Capsule 125 MG</i>	2	PA; QL (2 EA per 30 days)
<i>Aprepitant Oral Capsule 40 MG, 80 MG</i>	2	PA; QL (4 EA per 30 days)
<i>Aprepitant Oral Capsule 80 & 125 MG</i>	2	PA; QL (6 EA per 30 days)
COMPRO	2	
<i>Dronabinol</i>	2	PA; QL (60 EA per 30 days)
EMEND ORAL SUSPENSION RECONSTITUTED	3	B/D
<i>Granisetron HCl Oral</i>	2	B/D
<i>Meclozine HCl Oral Tablet 12.5 MG, 25 MG</i>	2	PA
<i>Ondansetron</i>	2	B/D
<i>Ondansetron HCl Oral</i>	2	B/D
<i>Prochlorperazine</i>	2	
<i>Prochlorperazine Maleate Oral</i>	2	
<i>Promethazine HCl Rectal Suppository 12.5 MG, 25 MG</i>	2	
<i>Scopolamine</i>	4	QL (10 EA per 30 days)
Anti-Inflammatory Agents (Gi Drugs)		
APRISO	3	QL (120 EA per 30 days)
<i>Balsalazide Disodium</i>	2	
DELZICOL	4	
<i>Mesalamine Oral Tablet Delayed Release</i>	4	
<i>Mesalamine Rectal Enema</i>	4	
<i>Mesalamine-Cleanser</i>	4	
Antiulcer Agents And Acid Suppressants		
<i>Amoxicill-Clarithro-Lansopraz</i>	2	
CARAFATE ORAL SUSPENSION	4	
<i>Cimetidine HCl Oral</i>	1	
<i>Cimetidine Oral</i>	1	
DEXILANT	4	ST; QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Famotidine Oral Tablet 20 MG, 40 MG</i>	1	
<i>Lansoprazole Oral Capsule Delayed Release</i>	2	QL (60 EA per 30 days)
<i>Misoprostol Oral</i>	2	
<i>Omeprazole Oral Capsule Delayed Release</i>	1	QL (60 EA per 30 days)
<i>Pantoprazole Sodium Oral Tablet Delayed Release</i>	1	QL (60 EA per 30 days)
<i>RABEprazole Sodium Oral Tablet Delayed Release</i>	2	QL (60 EA per 30 days)
<i>Sucralfate Oral Suspension</i>	4	
<i>Sucralfate Oral Tablet</i>	2	
Cathartics And Laxatives		
AMITIZA	3	QL (60 EA per 30 days)
GAVILYTE-C	2	
GAVILYTE-G	2	
GAVILYTE-H	2	
GAVILYTE-N WITH FLAVOR PACK	2	
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM	3	
<i>PEG 3350/Electrolytes</i>	2	
<i>PEG 3350-KCl-Na Bicarb-NaCl</i>	2	
<i>PEG-3350/Electrolytes</i>	2	
TRILYTE	2	
Gi Drugs, Miscellaneous		
<i>Alosetron HCl</i>	5	PA; 30DS
CHENODAL	5	ST; LA; 30DS
CREON	3	
GATTEX	5	PA; *; 30DS; *Not available at mail-order
LINZESS	3	QL (30 EA per 30 days)
<i>Metoclopramide HCl Oral Solution 10 MG/10ML, 5 MG/5ML</i>	2	
<i>Metoclopramide HCl Oral Tablet</i>	1	
MOVANTIK	3	QL (30 EA per 30 days)
RELISTOR ORAL	4	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML	5	PA; 30DS; QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML	5	PA; 30DS; QL (12 ML per 30 days)
<i>Ursodiol Oral</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
XIFAXAN ORAL TABLET 200 MG	5	PA; 30DS; QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; 30DS; QL (84 EA per 28 days)
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT	4	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-14000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT	3	
Heavy Metal Antagonists		
Heavy Metal Antagonists		
CHEMET	3	
CLOVIQUE	5	PA; 30DS
<i>Deferasirox Oral Tablet Soluble</i>	5	PA; 30DS
<i>Deferiprone</i>	5	PA; 30DS
<i>penicillAMINE Oral Tablet</i>	5	30DS
<i>Trientine HCl</i>	5	PA; 30DS
Metallic Poison,Agents To Treat		
FERRIPROX ORAL TABLET 1000 MG	5	PA; 30DS
Hormones And Synthetic Substitutes		
Adrenals		
<i>Budesonide Oral</i>	4	30DS
<i>Cortisone Acetate Oral</i>	2	
<i>Dexamethasone Oral Elixir</i>	2	
<i>Dexamethasone Oral Solution</i>	2	
<i>Dexamethasone Oral Tablet</i>	1	
<i>Fludrocortisone Acetate Oral</i>	2	
<i>Hydrocortisone Oral</i>	1	
<i>MethylPREDNISolone Oral</i>	2	
MILLIPRED ORAL TABLET 5 MG	3	
MILLIPRED ORAL TABLET 5 MG	4	
<i>PrednisoLONE Oral Solution</i>	1	
<i>PrednisoLONE Sodium Phosphate Oral Solution 10 MG/5ML, 15 MG/5ML, 20 MG/5ML, 25 MG/5ML, 6.7 (5 Base) MG/5ML</i>	1	
PREDNISONE INTENSOL	1	
<i>PredniSONE Oral Solution</i>	1	
<i>PredniSONE Oral Tablet</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>predniSONE Oral Tablet Therapy Pack 10 MG (48), 5 MG (48)</i>	1	
Androgens		
ANDRODERM TRANSDERMAL PATCH 24 HOUR	4	QL (30 EA per 30 days)
<i>Danazol Oral</i>	2	
<i>Oxandrolone Oral Tablet 10 MG</i>	2	PA; QL (60 EA per 30 days)
<i>Oxandrolone Oral Tablet 2.5 MG</i>	2	PA; QL (90 EA per 30 days)
<i>Testosterone Cypionate Intramuscular Solution 100 MG/ML, 200 MG/ML</i>	2	
<i>Testosterone Enanthate Intramuscular Solution</i>	2	
<i>Testosterone Transdermal Gel 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>	2	
<i>Testosterone Transdermal Solution</i>	2	QL (180 ML per 30 days)
Antidiabetic Agents		
<i>Acarbose Oral Tablet 100 MG, 50 MG</i>	1	QL (90 EA per 30 days)
<i>Acarbose Oral Tablet 25 MG</i>	1	
AVANDIA ORAL TABLET 2 MG	3	QL (30 EA per 30 days)
AVANDIA ORAL TABLET 4 MG	3	QL (60 EA per 30 days)
BYDUREON BCISE	3	QL (3.4 ML per 28 days)
BYDUREON SUBCUTANEOUS PEN-INJECTOR	3	QL (4 EA per 28 days)
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	4	QL (2.4 ML per 30 days)
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	4	QL (1.2 ML per 30 days)
FIASP	3	QL (30 ML per 30 days)
FIASP FLEXTOUCH	3	QL (30 ML per 30 days)
FIASP PENFILL	3	QL (30 ML per 30 days)
<i>Glimepiride Oral Tablet 1 MG, 4 MG</i>	1	QL (60 EA per 30 days)
<i>Glimepiride Oral Tablet 2 MG</i>	1	QL (30 EA per 30 days)
<i>glipiZIDE ER Oral Tablet Extended Release 24 Hour 10 MG</i>	1	QL (60 EA per 30 days)
<i>glipiZIDE ER Oral Tablet Extended Release 24 Hour 2.5 MG, 5 MG</i>	1	QL (90 EA per 30 days)
<i>glipiZIDE Oral Tablet 10 MG</i>	1	QL (120 EA per 30 days)
<i>glipiZIDE Oral Tablet 5 MG</i>	1	QL (90 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>GlipiZIDE-MetFORMIN HCl Oral Tablet 2.5-250 MG</i>	1	QL (60 EA per 30 days)
<i>GlipiZIDE-MetFORMIN HCl Oral Tablet 2.5-500 MG</i>	1	QL (90 EA per 30 days)
<i>glipiZIDE-metFORMIN HCl Oral Tablet 5-500 MG</i>	1	QL (120 EA per 30 days)
GLYXAMBI	3	QL (30 EA per 30 days)
HUMULIN R U-500 (CONCENTRATED)	5	30DS; QL (30 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN- INJECTOR	3	QL (30 ML per 30 days)
INVOKAMET	3	QL (60 EA per 30 days)
INVOKAMET XR	3	QL (60 EA per 30 days)
INVOKANA	3	QL (30 EA per 30 days)
JANUMET	3	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUVIA	3	QL (30 EA per 30 days)
JARDIANCE	3	QL (30 EA per 30 days)
JENTADUETO	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG	3	QL (30 EA per 30 days)
LANTUS	3	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR	3	QL (30 ML per 30 days)
LEVEMIR	3	QL (30 ML per 30 days)
LEVEMIR FLEXTOUCH	3	QL (30 ML per 30 days)
<i>metFORMIN HCl ER Oral Tablet Extended Release 24 Hour 500 MG</i>	1	QL (120 EA per 30 days)
<i>metFORMIN HCl ER Oral Tablet Extended Release 24 Hour 750 MG</i>	1	QL (90 EA per 30 days)
<i>MetFORMIN HCl Oral Tablet 1000 MG</i>	1	QL (60 EA per 30 days)
<i>MetFORMIN HCl Oral Tablet 500 MG</i>	1	QL (120 EA per 30 days)
<i>MetFORMIN HCl Oral Tablet 850 MG</i>	1	QL (90 EA per 30 days)
<i>Miglitol Oral Tablet 100 MG, 50 MG</i>	2	QL (90 EA per 30 days)
<i>Miglitol Oral Tablet 25 MG</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
NOVOLIN 70/30	3	QL (30 ML per 30 days)
NOVOLIN 70/30 FLEXPEN	3	QL (30 ML per 30 days)
NOVOLIN N	3	QL (30 ML per 30 days)
NOVOLIN N FLEXPEN	3	QL (30 ML per 30 days)
NOVOLIN R	3	QL (30 ML per 30 days)
NOVOLIN R FLEXPEN	3	QL (30 ML per 30 days)
NOVOLOG	3	QL (30 ML per 30 days)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	3	QL (30 ML per 30 days)
NOVOLOG MIX 70/30	3	QL (30 ML per 30 days)
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR	3	QL (30 ML per 30 days)
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE	3	QL (30 ML per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE)	3	QL (1.5 ML per 28 days)
OZEMPIC (1 MG/DOSE)	3	QL (3 ML per 28 days)
<i>Pioglitazone HCl</i>	1	QL (30 EA per 30 days)
<i>Pioglitazone HCl-Glimepiride</i>	2	QL (30 EA per 30 days)
<i>Pioglitazone HCl-Metformin HCl</i>	2	QL (90 EA per 30 days)
SOLIQUA	3	QL (18 ML per 30 days)
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR	3	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR	3	PA
SYNJARDY	3	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG	3	QL (30 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG	3	QL (60 EA per 30 days)
TOUJEO MAX SOLOSTAR	3	QL (30 ML per 30 days)
TOUJEO SOLOSTAR	3	QL (30 ML per 30 days)
TRADJENTA	3	QL (30 EA per 30 days)
<i>Tresiba</i>	3	QL (30 ML per 30 days)
TRESIBA FLEXTOUCH	3	QL (30 ML per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML	3	QL (2 ML per 28 days)
<i>Trulicity Subcutaneous Solution Pen-Injector 3 MG/0.5ML, 4.5 MG/0.5ML</i>	3	QL (2 ML per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR	3	QL (9 ML per 30 days)
XULTOPHY	3	QL (15 ML per 30 days)
Antihypoglycemic Agents		
GLUCAGEN HYPOKIT	3	
<i>Glucagon Emergency Injection Kit</i>	4	
KORLYM	5	PA; 30DS
Contraceptives		
ALTAVERA	2	
<i>Alyacen 1/35</i>	2	
APRI	2	
AUBRA	2	
AVIANE	2	
BALZIVA	2	
BLISOVI 24 FE	2	
BLISOVI FE 1.5/30	2	
<i>Briellyn</i>	2	
CAMILA	2	
CAZIAN	2	
CRYSSELLE-28	2	
CYCLAFEM 1/35	2	
CYCLAFEM 7/7/7	2	
CYRED EQ	2	
DEBLITANE	2	
DELYLA	2	
<i>Desogestrel-Ethinyl Estradiol</i>	2	
ELURYNG	2	QL (1 EA per 28 days)
EMOQUETTE	2	
ENPRESSE-28	2	
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	2	
ERRIN	2	
ESTARYLLA	2	
<i>Ethinodiol Diac-Eth Estradiol</i>	2	
<i>Etonogestrel-Ethinyl Estradiol</i>	2	QL (1 EA per 28 days)
FALMINA	2	
FEMYNOR	2	
HAILEY 24 FE	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
INCASSIA	2	
INTROVALE	2	
ISIBLOOM	2	
JULEBER	2	
JUNEL FE 1.5/30	2	
JUNEL FE 1/20	2	
JUNEL FE 24	2	
KAITLIB FE	2	
KARIVA	2	
KELNOR 1/35	2	
KELNOR 1/50	2	
KURVELO	2	
LARIN FE 1.5/30	2	
LARIN FE 1/20	2	
LARISSIA	2	
LAYOLIS FE	2	
LESSINA	2	
LEVONEST	2	
<i>Levonorgest-Eth Estrad 91-Day Oral Tablet 0.15-0.03 MG</i>	2	
<i>Levonorgestrel-Ethinyl Estrad Oral Tablet 0.1-20 MG-MCG, 0.15-30 MG-MCG</i>	2	
<i>Levonorg-Eth Estrad Triphasic</i>	2	
LEVORA 0.15/30 (28)	2	
LOESTRIN 1.5/30 (21)	2	
LOESTRIN 1/20 (21)	2	
LOESTRIN FE 1.5/30	2	
LOESTRIN FE 1/20	2	
LOW-OGESTREL	2	
LUTERA	2	
LYZA	2	
<i>Marlissa</i>	2	
MICROGESTIN 1.5/30	2	
MICROGESTIN 1/20	2	
MICROGESTIN FE 1.5/30	2	
MICROGESTIN FE 1/20	2	
MILI	2	
NECON 0.5/35 (28)	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
NORA-BE	2	
<i>Norethin Ace-Eth Estrad-FE Oral Tablet 1-20 MG-MCG(24)</i>	2	
<i>Norethindrone Oral</i>	2	
<i>Norethin-Eth Estradiol-Fe Oral Tablet Chewable 0.8-25 MG-MCG</i>	2	
<i>Norgestimate-Eth Estradiol Oral Tablet 0.25-35 MG-MCG</i>	2	
<i>Norgestim-Eth Estrad Triphasic</i>	2	
NORLYROC	2	
NORTREL 0.5/35 (28)	2	
NORTREL 1/35 (21)	2	
NORTREL 1/35 (28)	2	
NORTREL 7/7/7	2	
ORSYTHIA	2	
PIMTREA	2	
PIRMELLA 1/35	2	
PORTIA-28	2	
PREVIFEM	2	
RECLIPSEN	2	
SETLAKIN	2	
SHAROBEL	2	
SPRINTEC 28	2	
SRONYX	2	
TARINA FE 1/20	2	
TRI-ESTARYLLA	2	
TRI-LEGEST FE	2	
TRI-LO-ESTARYLLA	2	
TRI-LO-SPRINTEC	2	
TRI-MILI	2	
TRINESSA (28)	2	
TRI-PREVIFEM	2	
TRI-SPRINTEC	2	
TRIVORA (28)	2	
TRI-VYLIBRA	2	
TRI-VYLIBRA LO	2	
VELIVET	2	
VIENVA	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
VYFEMLA	2	
VYLIBRA	2	
ZOVIA 1/35E (28)	2	
Estrogens And Antiestrogens		
DUAVEE	3	PA (NS)
<i>Estradiol Oral</i>	2	PA (NS)
<i>Estradiol Transdermal Patch Weekly</i>	3	
ESTRING	3	
PREMARIN ORAL	4	PA (NS)
PREMARIN VAGINAL	3	
PREMPHASE	3	PA (NS)
PREMPRO	3	PA (NS)
<i>Raloxifene HCl</i>	1	
Gonadotropins		
<i>Chorionic Gonadotropin Intramuscular</i>	2	PA; *; *Not available at mail-order
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT	2	PA; *; *Not available at mail-order
PREGNYL	2	PA; *; *Not available at mail-order
Meglitinides		
<i>Nateglinide</i>	1	QL (90 EA per 30 days)
<i>Repaglinide Oral Tablet 0.5 MG, 1 MG</i>	1	QL (120 EA per 30 days)
<i>Repaglinide Oral Tablet 2 MG</i>	1	QL (240 EA per 30 days)
Parathyroid		
<i>Calcitonin (Salmon)</i>	2	B/D
FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML	5	*; 30DS; *Not available at mail-order; QL (2.4 ML per 28 days)
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR	5	*; 30DS; *Not available at mail-order; QL (2.4 ML per 28 days)
NATPARA	5	*; 30DS; *Not available at mail-order
Pituitary		
<i>Desmopressin Ace Spray Refrig</i>	2	
<i>Desmopressin Acetate Oral</i>	2	
<i>Desmopressin Acetate Spray</i>	2	
GENOTROPIN	5	PA; *; 30DS; *Not available at mail-order
GENOTROPIN MINIQUICK	5	PA; *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG	5	PA; *; 30DS; *Not available at mail-order
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG, 30 MG	5	*; LA; 30DS; *Not available at mail-order
SYNAREL	5	30DS
Progestins		
<i>MedroxyPROGESTERone Acetate Intramuscular</i>	2	
<i>MedroxyPROGESTERone Acetate Oral</i>	1	
<i>Norethindrone Acetate Oral</i>	3	
<i>Progesterone Micronized Oral</i>	3	
Somatostatin Agonists		
<i>Octreotide Acetate Injection Solution 100 MCG/ML, 50 MCG/ML</i>	2	*; *Not available at mail-order
<i>Octreotide Acetate Injection Solution 1000 MCG/ML, 500 MCG/ML</i>	5	*; 30DS; *Not available at mail-order
<i>Octreotide Acetate Injection Solution 200 MCG/ML</i>	4	*; *Not available at mail-order
SIGNIFOR	5	PA; 30DS
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 20 MG, 40 MG, 60 MG	5	PA; 30DS
Somatotropin Agonists		
EGRIFTA SUBCUTANEOUS SOLUTION RECONSTITUTED 1 MG	5	PA; LA; 30DS; *Not available at mail-order
EGRIFTA SV	5	PA; LA; 30DS; *Not available at mail-order
INCRELEX	5	PA; *; 30DS; *Not available at mail-order
SOMATULINE DEPOT	5	PA (NS); *; 30DS; *Not available at mail-order
Thyroid And Antithyroid Agents		
EUTHYROX	2	
LEVO-T	2	
<i>Levothyroxine Sodium Oral Tablet</i>	1	
LEVOXYL	2	
<i>Liothyronine Sodium Oral</i>	2	
<i>Methimazole Oral</i>	1	
<i>Propylthiouracil Oral</i>	1	
SYNTHROID	3	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
UNITHROID	1	
Miscellaneous Therapeutic Agents		
5-Alpha-Reductase Inhibitors		
<i>Dutasteride Oral</i>	2	QL (30 EA per 30 days)
<i>Finasteride Oral Tablet 5 MG</i>	1	
Complement Inhibitors		
CINRYZE	5	PA; *; 30DS; *Not available at mail-order
<i>Icatibant Acetate</i>	5	PA; *; 30DS; *Not available at mail-order; QL (18 ML per 30 days)
Miscellaneous Therapeutic Agents		
ACTIMMUNE	5	PA (NS); *; 30DS; *Not available at mail-order
<i>Alendronate Sodium Oral Solution</i>	2	
<i>Alendronate Sodium Oral Tablet 10 MG, 40 MG, 5 MG</i>	1	QL (30 EA per 30 days)
<i>Alendronate Sodium Oral Tablet 35 MG</i>	1	QL (8 EA per 28 days)
<i>Alendronate Sodium Oral Tablet 70 MG</i>	1	
<i>Allopurinol Oral</i>	1	
<i>Anagrelide HCl</i>	2	
ARCALYST	5	PA; *; 30DS; *Not available at mail-order
AUBAGIO	5	PA; *; 30DS; *Not available at mail-order
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT	5	PA; *; 30DS; *Not available at mail-order; QL (4 EA per 28 days)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT	5	PA; *; 30DS; *Not available at mail-order; QL (4 EA per 28 days)
<i>azaTHIOprine Oral</i>	2	B/D
<i>Baclofen Oral</i>	1	
BENLYSTA	5	PA; *; 30DS; *Not available at mail-order
BETASERON SUBCUTANEOUS KIT	5	PA; *; 30DS; *Not available at mail-order; QL (14 EA per 28 days)
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT	4	PA
<i>Cabergoline</i>	4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Cinacalcet HCl Oral Tablet 30 MG, 60 MG</i>	5	B/D; 30DS; QL (60 EA per 30 days)
<i>Cinacalcet HCl Oral Tablet 90 MG</i>	5	B/D; 30DS; QL (120 EA per 30 days)
<i>Colchicine Oral</i>	2	
<i>Colchicine-Probenecid</i>	2	
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	5	PA; *; 30DS; *Not available at mail-order; QL (12 ML per 28 days)
<i>CycloSPORINE Modified</i>	2	B/D
<i>CycloSPORINE Oral Capsule</i>	2	B/D
CYSTADANE	5	LA; 30DS
CYSTAGON	4	PA; *; LA; *Not available at mail-order
<i>Dalfampridine ER</i>	5	PA; *; 30DS; Not available at mail-order; QL (60 EA per 30 days)
DEMSER	5	30DS
<i>Disulfiram Oral</i>	2	
ELMIRON	4	
<i>Etidronate Disodium</i>	2	
<i>Everolimus Oral Tablet 0.25 MG, 0.5 MG, 0.75 MG</i>	5	B/D; 30DS
<i>Febuxostat</i>	4	ST; QL (30 EA per 30 days)
GAMMAGARD INJECTION SOLUTION 1 GM/10ML	5	B/D; *; 30DS; Not available at mail-order
GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML	5	B/D; *; 30DS; *Not available at mail-order
GAMMAGARD S/D LESS IGA	5	B/D; *; 30DS; *Not available at mail-order
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML	5	B/D; *; 30DS; *Not available at mail-order
GAMUNEX-C INJECTION SOLUTION 2.5 GM/25ML	5	B/D; *; 30DS; Not available at mail-order
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	B/D
GENGRAF ORAL SOLUTION	2	B/D
GILENYA ORAL CAPSULE 0.5 MG	5	PA; *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Glatisamer Acetate Subcutaneous Solution Prefilled Syringe 20 MG/ML</i>	5	PA; *; 30DS; *Not available at mail-order; QL (30 ML per 30 days)
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	5	PA; *; 30DS; *Not available at mail-order; QL (30 ML per 30 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML	5	PA; *; 30DS; *Not available at mail-order; QL (6 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML	5	PA; *; 30DS; *Not available at mail-order; QL (3 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; *; 30DS; *Not available at mail-order; QL (2 EA per 28 days)
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT	5	PA; *; 30DS; *Not available at mail-order; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; *; 30DS; *Not available at mail-order; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	5	PA; *; 30DS; Not available at mail-order; QL (3 EA per 28 days)
HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; *; 30DS; *Not available at mail-order; QL (6 EA per 28 days)
HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; *; 30DS; Not available at mail-order; QL (3 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML, 20 MG/0.2ML	5	PA; *; 30DS; *Not available at mail-order; QL (2 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML	5	PA; *; 30DS; *Not available at mail-order; QL (12 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML, 40 MG/0.8ML	5	PA; *; 30DS; *Not available at mail-order; QL (6 EA per 28 days)
<i>Ibandronate Sodium Oral</i>	2	
INFLECTRA	5	PA; *; 30DS; *Not available at mail-order
<i>Leflunomide Oral Tablet 10 MG</i>	2	QL (60 EA per 30 days)
<i>Leflunomide Oral Tablet 20 MG</i>	2	
<i>Leucovorin Calcium Injection Solution 500 MG/50ML</i>	2	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Leucovorin Calcium Injection Solution Reconstituted 100 MG, 350 MG</i>	2	
<i>Leucovorin Calcium Injection Solution Reconstituted 200 MG, 50 MG</i>	2	B/D; *; Not available at mail-order
<i>Leucovorin Calcium Injection Solution Reconstituted 500 MG</i>	2	B/D
<i>Leucovorin Calcium Oral</i>	2	
<i>levOCARNitine Oral Solution</i>	2	B/D
<i>levOCARNitine Oral Tablet</i>	2	B/D
MESNEX ORAL	5	30DS
<i>metyroSINE</i>	5	30DS
<i>Miglustat</i>	5	PA; *; 30DS; *Not available at mail-order
<i>Mycophenolate Mofetil Oral Capsule</i>	2	B/D
<i>Mycophenolate Mofetil Oral Suspension Reconstituted</i>	5	B/D; 30DS
<i>Mycophenolate Mofetil Oral Tablet</i>	2	B/D
<i>Mycophenolate Sodium</i>	4	B/D
<i>Nitisinone</i>	5	PA; 30DS
ORFADIN	5	PA; 30DS
<i>Pamidronate Disodium Intravenous Solution</i>	2	PA
PLEGRIDY	5	PA; *; 30DS; *Not available at mail-order
PLEGRIDY STARTER PACK	5	PA; *; 30DS; *Not available at mail-order
<i>Probenecid Oral</i>	2	
PROGRAF ORAL PACKET	4	B/D
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	4	PA; *; *Not available at mail-order; QL (1 ML per 180 days)
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR	5	PA; *; 30DS; *Not available at mail-order; QL (6 ML per 28 days)
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR	5	PA; *; 30DS; *Not available at mail-order; QL (6 ML per 28 days)
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA; *; 30DS; *Not available at mail-order; QL (6 ML per 28 days)
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA; *; 30DS; *Not available at mail-order; QL (6 ML per 28 days)
REMICADE	5	PA; *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
RENFLEXIS	5	PA; *; 30DS; *Not available at mail-order
RIDAURA	4	
<i>Risedronate Sodium Oral Tablet 150 MG</i>	2	QL (1 EA per 28 days)
<i>Risedronate Sodium Oral Tablet 30 MG, 5 MG</i>	2	QL (30 EA per 30 days)
<i>Risedronate Sodium Oral Tablet 35 MG</i>	2	QL (4 EA per 28 days)
<i>Risedronate Sodium Oral Tablet Delayed Release</i>	4	QL (4 EA per 28 days)
SANDIMMUNE ORAL SOLUTION	4	B/D
SANDOSTATIN LAR DEPOT	5	*; 30DS; *Not available at mail-order
<i>Sapropterin Dihydrochloride</i>	5	PA; *; LA; 30DS; *Not available at mail-order
<i>Sirolimus Oral Solution</i>	5	B/D; 30DS
<i>Sirolimus Oral Tablet 0.5 MG</i>	1	B/D
<i>Sirolimus Oral Tablet 1 MG</i>	2	B/D
<i>Sirolimus Oral Tablet 2 MG</i>	5	B/D; 30DS
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; *; 30DS; *Not available at mail-order; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	5	PA; *; 30DS; *Not available at mail-order; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	5	PA; *; 30DS; *Not available at mail-order; QL (1 ML per 28 days)
<i>Tacrolimus Oral</i>	2	B/D
TECFIDERA	5	PA; *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	*; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	5	*; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
<i>Tranexamic Acid Oral</i>	3	
TYBOST	4	
XELJANZ ORAL TABLET 10 MG	5	PA; *; 30DS; Not available at mail-order; QL (60 EA per 30 days)
XELJANZ ORAL TABLET 5 MG	5	PA; *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG	5	PA; *; 30DS; *Not available at mail-order; QL (30 EA per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG	5	PA; 30DS; QL (30 EA per 30 days)
XGEVA	5	PA (NS); *; 30DS; *Not available at mail-order
ZORTRESS ORAL TABLET 1 MG	5	B/D; *; 30DS; Not available at mail-order
Other Miscellaneous Therapeutic Agents		
BOTOX INJECTION SOLUTION RECONSTITUTED 200 UNIT	4	PA
Nutritional/Supplements		
Vitamins		
<i>Prenatal Oral Tablet 27-1 MG</i>	1	
Pharmaceutical Aids		
Pharmaceutical Aids		
<i>Global Alcohol Prep Ease</i>	1	
Respiratory Tract Agents		
Corticosteroids (Respiratory Tract)		
ADVAIR DISKUS	3	QL (60 EA per 30 days)
ADVAIR HFA	3	QL (12 GM per 30 days)
AIRDUO RESPICLICK 113/14	3	QL (1 EA per 30 days)
AIRDUO RESPICLICK 232/14	3	QL (1 EA per 30 days)
AIRDUO RESPICLICK 55/14	3	QL (1 EA per 30 days)
ARNUITY ELLIPTA	3	QL (30 EA per 30 days)
BREO ELLIPTA	3	QL (60 EA per 30 days)
<i>Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML</i>	2	B/D
<i>Budesonide Inhalation Suspension 1 MG/2ML</i>	2	B/D; QL (60 ML per 30 days)
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/BLIST, 50 MCG/BLIST	3	QL (60 EA per 30 days)
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 250 MCG/BLIST	3	QL (240 EA per 30 days)
FLOVENT HFA	3	QL (24 GM per 30 days)
PULMICORT FLEXHALER	4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
SPIRIVA HANDIHALER	3	QL (30 EA per 30 days)
SPIRIVA RESPIMAT	3	QL (4 GM per 30 days)
SYMBICORT	3	QL (10.2 GM per 30 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACT	3	QL (1 EA per 30 days)
Leukotriene Modifiers		
<i>Montelukast Sodium Oral</i>	2	QL (30 EA per 30 days)
<i>Zafirlukast</i>	2	QL (60 EA per 30 days)
Respiratory Tract Agents, Miscellaneous		
<i>Acetylcysteine Inhalation</i>	2	B/D
BEVESPI AEROSPHERE	3	
<i>Bosentan Oral Tablet 125 MG</i>	5	PA; *; 30DS; *Not available at mail-order; QL (60 EA per 30 days)
<i>Bosentan Oral Tablet 62.5 MG</i>	5	PA; *; 30DS; *Not available at mail-order; QL (120 EA per 30 days)
<i>Cromolyn Sodium Inhalation</i>	2	B/D; QL (240 ML per 30 days)
<i>Cromolyn Sodium Oral</i>	5	30DS
DALIRESP ORAL TABLET 250 MCG	4	PA
DALIRESP ORAL TABLET 500 MCG	4	PA; QL (30 EA per 30 days)
<i>EPINEPHrine Injection Solution Auto-Injector</i>	2	
ESBRIET ORAL CAPSULE	5	PA; *; 30DS; *Not available at mail-order
<i>Esbriet Oral Tablet 267 MG</i>	5	PA; *; 30DS; *Not available at mail-order
ESBRIET ORAL TABLET 267 MG, 801 MG	5	PA; *; 30DS; *Not available at mail-order
KALYDECO ORAL PACKET 25 MG	5	PA; 30DS; QL (56 EA per 28 days)
KALYDECO ORAL PACKET 50 MG, 75 MG	5	PA; 30DS; QL (60 EA per 30 days)
KALYDECO ORAL TABLET	5	PA; 30DS; QL (60 EA per 30 days)
NUCALA	5	PA; *; 30DS; *Not available at mail-order
OFEV	5	PA; *; 30DS; *Not available at mail-order

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
ORKAMBI ORAL PACKET 100-125 MG	5	PA; *; 30DS; *Not available at mail-order; QL (112 EA per 28 days)
ORKAMBI ORAL PACKET 150-188 MG	5	PA; *; 30DS; *Not available at mail-order; QL (56 EA per 28 days)
ORKAMBI ORAL TABLET	5	PA; *; 30DS; *Not available at mail-order; QL (112 EA per 28 days)
PROLASTIN-C INTRAVENOUS SOLUTION	5	PA; 30DS
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED	5	PA; *; 30DS; *Not available at mail-order
PULMOZYME	5	PA; *; 30DS; *Not available at mail-order; QL (150 ML per 30 days)
STIOLTO RESPIMAT	3	QL (4 GM per 28 days)
<i>Theophylline</i>	2	
<i>Theophylline ER Oral Tablet Extended Release 12 Hour 300 MG</i>	2	
<i>Theophylline ER Oral Tablet Extended Release 24 Hour</i>	2	
TRELEGY ELLIPTA	3	QL (60 EA per 30 days)
TRIKAFTA	5	PA; 30DS; QL (90 EA per 30 days)
XOLAIR	5	PA; *; 30DS; *Not available at mail-order
ZEMAIRA	3	PA; *; LA; *Not available at mail-order
Serums, Toxoids, And Vaccines		
Serums		
GAMMAGARD INJECTION SOLUTION 10 GM/100ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	5	B/D; *; 30DS; Not available at mail-order
GAMUNEX-C INJECTION SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	5	B/D; *; 30DS; Not available at mail-order
Toxoids		
ADACEL	4	
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 , 5-2.5-18.5 (0.5ML SYRINGE)	4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	4	
<i>Diphtheria-Tetanus Toxoids DT</i>	4	
INFANRIX	4	
TDVAX	4	
TENIVAC	4	
<i>Tetanus-Diphtheria Toxoids Td</i>	4	
Vaccines		
ACTHIB	4	
<i>BCG Vaccine</i>	4	
BEXSERO	4	
ENGRIX-B	4	B/D
GARDASIL 9	4	
HAVRIX	3	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE	3	B/D
HIBERIX INJECTION	4	
IMOVAX RABIES	4	
IPOL	4	
IXIARO	4	
KINRIX INTRAMUSCULAR SUSPENSION	4	
MENACTRA	4	
MENQUADFI	4	
MENVEO	4	
M-M-R II INJECTION	3	
PEDIARIX	4	
PEDVAX HIB INTRAMUSCULAR SUSPENSION	4	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	4	
QUADRACEL	4	
RABAVERT	4	
RECOMBIVAX HB	3	B/D
ROTARIX	4	
ROTATEQ ORAL SOLUTION	4	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	4	
<i>Stamaril</i>	4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
TRUMENBA	4	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	4	
TYPHIM VI	4	
VAQTA	3	
VARIVAX	4	
VARIZIG INTRAMUSCULAR SOLUTION	4	*; *Not available at mail-order
YF-VAX	4	
ZOSTAVAX SUBCUTANEOUS SUSPENSION RECONSTITUTED	4	

Skin And Mucous Membrane Agents

Antibacterials (Skin And Mucous Membrane)

<i>Benzoyl Peroxide-Erythromycin</i>	2	
CLINDACIN-P	2	
<i>Clindamycin Phosphate External Foam</i>	2	
<i>Clindamycin Phosphate External Gel</i>	2	
<i>Clindamycin Phosphate External Lotion</i>	2	
<i>Clindamycin Phosphate External Solution</i>	2	QL (60 ML per 28 days)
<i>Clindamycin Phosphate External Swab</i>	2	
<i>Clindamycin Phosphate Vaginal</i>	2	
Ery	2	
<i>Erythromycin External Gel</i>	2	
<i>Erythromycin External Solution</i>	2	
<i>Gentamicin Sulfate External Cream</i>	1	QL (90 GM per 30 days)
<i>Gentamicin Sulfate External Ointment</i>	1	
<i>MetroNIDAZOLE Vaginal</i>	2	
<i>Mupirocin Calcium</i>	2	QL (44 GM per 28 days)
<i>Mupirocin External</i>	2	
VANDAZOLE	2	

Antifungals (Skin And Mucous Membrane)

<i>Ciclopirox External Solution</i>	2	
<i>Ciclopirox Olamine External</i>	3	
<i>Clotrimazole External Cream</i>	2	
<i>Clotrimazole External Solution</i>	2	
<i>Clotrimazole Mouth/Throat</i>	2	QL (70 EA per 14 days)
<i>Clotrimazole-Betamethasone</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Econazole Nitrate External</i>	4	QL (85 GM per 30 days)
<i>Ketoconazole External Cream</i>	2	QL (60 GM per 28 days)
<i>Ketoconazole External Foam</i>	2	
<i>Ketoconazole External Shampoo 2 %</i>	2	
KETODAN EXTERNAL FOAM	3	
<i>Miconazole 3 Vaginal Suppository</i>	2	
NYAMYC	2	
<i>Nystatin External</i>	2	
<i>Nystatin-Triamcinolone</i>	2	
NYSTOP	2	
<i>Terconazole</i>	2	
Anti-Inflammatory Agents (Skin And Mucous)		
<i>Ala-Cort External Cream</i>	1	
<i>Alclometasone Dipropionate</i>	3	
<i>Betamethasone Dipropionate Aug External Cream</i>	2	
<i>Betamethasone Dipropionate Aug External Gel</i>	4	
<i>Betamethasone Dipropionate Aug External Lotion</i>	4	
<i>Betamethasone Dipropionate Aug External Ointment</i>	4	
<i>Betamethasone Dipropionate External Cream</i>	2	
<i>Betamethasone Dipropionate External Lotion</i>	2	
<i>Betamethasone Dipropionate External Ointment</i>	4	
<i>Betamethasone Valerate External Cream</i>	2	
<i>Betamethasone Valerate External Foam 0.12 %</i>	2	
<i>Betamethasone Valerate External Foam 0.12 %</i>	4	
<i>Betamethasone Valerate External Lotion</i>	2	
<i>Betamethasone Valerate External Ointment</i>	2	
<i>Clobetasol Prop Emollient Base</i>	2	
<i>Clobetasol Propionate E</i>	2	
<i>Clobetasol Propionate External Cream</i>	2	
<i>Clobetasol Propionate External Foam</i>	2	
<i>Clobetasol Propionate External Gel</i>	2	
<i>Clobetasol Propionate External Liquid</i>	2	
<i>Clobetasol Propionate External Lotion</i>	2	
<i>Clobetasol Propionate External Ointment</i>	2	
<i>Clobetasol Propionate External Shampoo</i>	4	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
<i>Clobetasol Propionate External Solution</i>	2	QL (50 ML per 30 days)
CLODAN EXTERNAL SHAMPOO	4	
COLOCORT	1	
<i>Desonide External Cream</i>	2	
<i>Desonide External Lotion</i>	2	
<i>Desonide External Ointment</i>	2	
<i>Desoximetasone External Cream</i>	2	
<i>Desoximetasone External Gel</i>	2	
<i>Desoximetasone External Ointment</i>	2	
<i>Fluocinolone Acetonide Body</i>	2	
<i>Fluocinolone Acetonide External</i>	2	
<i>Fluocinolone Acetonide Scalp</i>	2	
<i>Fluocinonide External Gel</i>	2	
<i>Fluocinonide External Ointment</i>	2	
<i>Fluocinonide External Solution</i>	2	
<i>Fluticasone Propionate External Cream</i>	3	
<i>Fluticasone Propionate External Ointment</i>	3	
<i>Halobetasol Propionate External Cream</i>	4	
<i>Halobetasol Propionate External Ointment</i>	4	
<i>Hydrocortisone Butyrate External Ointment</i>	4	
<i>Hydrocortisone External Cream 1 %, 2.5 %</i>	1	
<i>Hydrocortisone External Lotion 2.5 %</i>	1	
<i>Hydrocortisone External Ointment 1 %</i>	1	
<i>Hydrocortisone External Ointment 2.5 %</i>	2	
<i>Hydrocortisone Rectal Enema</i>	1	
<i>Hydrocortisone Valerate</i>	2	
<i>Mometasone Furoate External</i>	1	
PROCTO-MED HC	1	
PROCTO-PAK	1	
PROCTOSOL HC	1	
PROCTOZONE-HC	1	
<i>Triamcinolone Acetonide External Cream 0.025 %, 0.5 %</i>	2	
<i>Triamcinolone Acetonide External Cream 0.1 %</i>	1	
<i>Triamcinolone Acetonide External Lotion</i>	3	
<i>Triamcinolone Acetonide External Ointment 0.025 %, 0.1 %, 0.5 %</i>	2	
<i>Triamcinolone Acetonide Mouth/Throat</i>	3	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
TRIDERM EXTERNAL CREAM 0.1 %	1	
<i>Triderm External Cream 0.5 %</i>	2	
Antivirals (Skin & Mucous Membrane)		
<i>Acyclovir External Cream</i>	2	
Antivirals (Skin And Mucous Membrane)		
<i>Acyclovir External Ointment</i>	4	
DENAVIR	3	
Cell Stimulants And Proliferants		
KEPIVANCE	4	PA
Local Anti-Infectives, Miscellaneous		
<i>MetroNIDAZOLE External Cream</i>	2	
<i>MetroNIDAZOLE External Gel 0.75 %</i>	2	
<i>MetroNIDAZOLE External Gel 1 %</i>	4	
<i>MetroNIDAZOLE External Lotion</i>	2	
<i>Selenium Sulfide External Lotion</i>	1	
<i>Silver Sulfadiazine External</i>	1	
SSD	1	
<i>Sulfacetamide Sodium (Acne)</i>	4	
Scabicides And Pediculicides		
CROTAN	2	
<i>Lindane External Shampoo</i>	2	
<i>Malathion External</i>	2	
<i>Permethrin External Cream</i>	3	
Skin And Mucous Membrane Agents, Misc.		
<i>Acitretin</i>	5	PA; 30DS
<i>Adapalene External Cream</i>	4	
<i>Adapalene External Gel</i>	4	
<i>Ammonium Lactate External</i>	2	
AMNESTEEM	2	
AVITA	2	
<i>Calcipotriene External Cream</i>	4	QL (120 GM per 30 days)
<i>Calcipotriene External Ointment</i>	4	QL (120 GM per 30 days)
<i>Calcipotriene External Solution</i>	3	QL (120 ML per 30 days)
CALCITRENE	4	QL (120 GM per 30 days)
CLARAVIS	2	

You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
CONDYLOX EXTERNAL GEL	4	
<i>Diclofenac Sodium Transdermal Gel 3 %</i>	4	PA
ELIDEL	3	ST
<i>Fluorouracil External Cream 0.5 %</i>	2	
<i>Fluorouracil External Cream 5 %</i>	4	
<i>Fluorouracil External Solution</i>	2	
<i>Imiquimod External</i>	2	
<i>ISOTretinoin Oral</i>	2	
<i>Lidocaine External Ointment</i>	2	QL (180 GM per 30 days)
<i>Lidocaine External Patch 5 %</i>	2	PA; QL (90 EA per 30 days)
<i>Lidocaine-Prilocaine External Cream</i>	2	B/D; QL (30 GM per 30 days)
<i>Methoxsalen Rapid</i>	2	
MYORISAN	2	
PANRETIN	3	
<i>Pimecrolimus</i>	2	ST
<i>Podofilox External</i>	2	
RECTIV	4	PA
SANTYL	4	QL (90 GM per 30 days)
<i>Tacrolimus External Ointment</i>	4	ST
TARGRETIN EXTERNAL	5	PA (NS); *; 30DS; *Not available at mail-order
<i>Tazarotene External</i>	4	
<i>Tretinoin External Cream 0.025 %, 0.1 %</i>	2	
<i>Tretinoin External Cream 0.05 %</i>	4	
<i>Tretinoin External Gel</i>	2	
ZENATANE	2	

Smooth Muscle Relaxants

Genitourinary Smooth Muscle Relaxants

<i>FlavoxATE HCl</i>	2	
MYRBETRIQ	4	QL (30 EA per 30 days)
<i>Oxybutynin Chloride ER</i>	1	QL (60 EA per 30 days)
<i>Oxybutynin Chloride Oral</i>	1	
<i>Solifenacin Succinate</i>	4	QL (30 EA per 30 days)
TOVIAZ	3	ST; QL (30 EA per 30 days)

Respiratory Smooth Muscle Relaxants

<i>Theophylline ER Oral Tablet Extended Release 12 Hour 450 MG</i>	2	
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You can find information on what the symbols and abbreviations on this table mean by going to page 3

Drug Name	Drug Tier	Requirements/Limits
Vitamins		
Vitamin D		
<i>Calcitriol Oral</i>	2	B/D
<i>Paricalcitol Oral</i>	2	B/D

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<i>Abacavir Sulfate</i>	5	<i>ALPRAZolam</i>	42	<i>ASSURE ID INSULIN</i>	
<i>Abacavir Sulfate-lamiVUDine</i>	5	<i>ALPRAZolam ER</i>	41	<i>SAFETY SYR</i>	46
<i>Abacavir-Lamivudine-Zidovudine</i>	6	<i>ALPRAZOLAM INTENSOL</i>	41	<i>Atazanavir Sulfate</i>	6
<i>ABELCET</i>	4	<i>ALTAVERA</i>	58	<i>Atenolol</i>	27
<i>ABILIFY MAINTENA</i>	37	<i>ALUNBRIG</i>	14	<i>Atenolol-Chlorthalidone</i>	27
<i>ABILIFY MYCITE</i>	37	<i>Alyacen 1/35</i>	58	<i>Atomoxetine HCl</i>	42
<i>Abiraterone Acetate</i>	14	<i>ALYQ</i>	30	<i>Atorvastatin Calcium</i>	26
<i>Acamprosate Calcium</i>	42	<i>Amantadine HCl</i>	37	<i>Atovaquone</i>	5
<i>Acarbose</i>	55	<i>AMBISOME</i>	4	<i>Atovaquone-Proguanil HCl</i>	5
<i>Acebutolol HCl</i>	27	<i>Ambrisentan</i>	30	<i>ATROVENT HFA</i>	23
<i>Acetaminophen-Codeine</i>	43	<i>Amikacin Sulfate</i>	3	<i>AUBAGIO</i>	63
<i>Acetaminophen-Codeine #3</i>	43	<i>AMILoride HCl</i>	47	<i>AUBRA</i>	58
<i>ACETASOL HC</i>	50	<i>Amiloride-Hydrochlorothiazide</i> ..	47	<i>AURYXIA</i>	47
<i>acetaZOLAMIDE</i>	49	<i>AMINOSYN II</i>	46	<i>AVANDIA</i>	55
<i>acetaZOLAMIDE ER</i>	49	<i>AMINOSYN-PF</i>	46	<i>AVIANE</i>	58
<i>Acetic Acid</i>	50	<i>Amiodarone HCl</i>	26	<i>AVITA</i>	75
<i>Acetylcysteine</i>	69	<i>AMITIZA</i>	53	<i>AVONEX PEN</i>	63
<i>Acitretin</i>	75	<i>Amitriptyline HCl</i>	34	<i>AVONEX PREFILLED</i>	63
<i>ACTHIB</i>	71	<i>Amlodipine Besy-Benzepiril HCl</i>	28	<i>AYVAKIT</i>	14
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<i>Hydroxyurea</i>	16	<i>Ivermectin</i>	4	<i>lamiVUDine-Zidovudine</i>	7
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Gateway HealthSM complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Gateway HealthSM does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Gateway HealthSM:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- o Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- o Qualified interpreters
- o Information written in other languages

If you need these services, contact Member Services at 1-800-685-5209, 8 a.m. – 8 p.m., 7 days a week from October 1 through March 31. From April 1 through September 30 our business hours are 8 a.m.- 8 p.m., Monday through Friday. TTY users should call 711.

If you believe that Gateway HealthSM 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:

Gateway HealthSM Appeals and Grievances

PO Box 22278

Pittsburgh, PA 15222

Phone: 1-844-207-0336

Fax: 1-412-255-4503

You can file a grievance by mail, or by fax. If you need help filing a grievance, Gateway HealthSM Appeals and Grievances 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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

ENGLISH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-685-5209, (TTY: 711).

SPANISH

ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-800-685-5209, (TTY: 711).

CHINESE

小贴士：如果您说普通话，欢迎使用免费语言协助服务。请拨1-800-685-5209, (TTY: 711)。

VIETNAMESE

CHÚ Ý: Nếu quý vị nói tiếng Việt, thì có sẵn các dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số 1-800-685-5209, (TTY: 711).

KOREAN

알림: 한국어를 하시는 경우 무료 통역 서비스가 준비되어 있습니다. 1-800-685-5209, (TTY: 711)로 연락주시기 바랍니다.

TAGALOG

Pansinin: Kung nagsasalita ka ng Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tawagan ang 1-800-685-5209, (TTY: 711).

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, вам будут бесплатно предоставлены услуги переводчика. Звоните по телефону: 1-800-685-5209, (телетайп: 711).

ARABIC

1-800-685-5209, PA: لاحظ: إذا كنت تتحدث البرعية، تتوفر مدخات السماعة اللغوية مجاناً من أجلك. اصتبل بلاقرم (أهلاتف النصي: 711).

FRENCH CREOLE

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-685-5209, (TTY: 711).

FRENCH

ATTENTION: Si vous parlez français, des services gratuits d'interprétation sont à votre disposition. Veuillez appeler le 1-800-685-5209, (TTY: 711).

POLISH

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer 1-800-685-5209, (TTY: 711).

PORTUGUESE

ATENÇÃO: Se fala português, estão disponíveis serviços gratuitos de assistência linguística na sua língua. Telefone para 1-800-685-5209, (TTY: 711).

ITALIAN

ATTENZIONE: Se lei parla italiano, sono disponibili servizi gratuiti di assistenza linguistica nella sua lingua. Chiami 1-800-685-5209, (TTY: 711).

JAPANESE

お知らせ: 日本語での対応を望まれる方には、無料で通訳サービスをご利用になれます。電話番号 1-800-685-5209, (TTY: 711) までお問い合わせ下さい。

GERMAN

BITTE BEACHTEN: Wenn Sie Deutsch sprechen, stehen Ihnen unsere Dolmetscher unter der Nummer 1-800-685-5209, (TTY: 711) kostenlos zur Verfügung.

FARSI

توجه: چانه‌چز به زبان فارسی صحبت می‌کنید، مدخات کمک زبانی، به صوت رایگان، رد اخلیتر مشا قرار خواهد گرفت.
متسا گیبیرد. اب شماره 1-800-685-5209, (TTY: 711)

SERBO-CROATIAN

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-685-5209, (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

PENNSYLVANIA DUTCH

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-685-5209, (TTY: 711).

NEPALI

यान ददनुहोस्: यदद तपाईं अंग्रेजी बोल्नुहुन्छ भने, भाषा सहायता सेवाहरू, नन: शुल्क, तपाईंलाई उपलब्ध छ। तपाईंको आईडी कार्डको ब्याकमा नम्बर कल गर्नुहोस् 1-800-685-5209 (TTY: 711)।

OROMO

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-685-5209, (TTY: 711).

BANTU

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-685-5209, (TTY: 711).

CAMBODIAN

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ ។
ការហៅ 800-685-5209, (TTY: 711)។

HMONG

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-685-5209, (TTY: 711).

HINDI

ध्यान दें: यदद आप अंग्रेजी बोलते हैं, तो मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अपने आईडी कार्ड 1-800-685-5209 (TTY: 711) के पीछे नंबर पर कॉल करें

LAO

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ ຄ່າ, ແມ່ນມີຂຶ້ນໃຫ້ທ່ານ. ໂທ 1-800-685-5209, (TTY: 711).

GUJARATI

સુચના: જો તમ ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-685-5209, (TTY: 711).

DUTCH

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-685-5209, (TTY: 711).

UKRAINIAN

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-685-5209, (телетайп: 711).

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-685-5209, (TTY: 711).

2020 Comprehensive Formulary (List of Covered Drugs)

This formulary is current as of December 11, 2020.

For more recent information or other questions, please contact Gateway HealthSM Member Services toll-free at: **1-800-685-5209 (TTY 711)**.

Our business hours are 8 a.m. - 8 p.m., 7 days a week from October 1 through March 31. From April 1 through September 30 our business hours are 8 a.m. - 8 p.m., Monday through Friday. Or visit us at **GatewayHealthPlan.com**

Member Services also has free language interpreter services available for non-English speakers.



Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

Gateway HealthSM offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.