

TUFTS MEDICARE PREFERRED HMO 2013 FORMULARY



Please Read

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

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.

What is the Tufts Medicare Preferred HMO Formulary?

A formulary is a list of covered drugs selected by Tufts Medicare Preferred HMO 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. Tufts Medicare Preferred HMO will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Tufts Medicare Preferred HMO 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 change?

Generally, if you are taking a drug on our 2013 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2013 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. 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. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or 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 60 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 60-day supply of the drug. 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. The enclosed formulary is current as of January 1, 2013. To get updated information about the drugs covered by Tufts Medicare Preferred HMO, please visit our website at tuftsmedicarepreferred.org or call Customer Relations at 1-800-701-9000, Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 –Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message, and a representative will return your call on the next business day. TTY users should call 1-800-208-9562.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list that begins on 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 66. 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?

Tufts Medicare Preferred HMO 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:** Tufts Medicare Preferred HMO requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from Tufts Medicare Preferred HMO before you fill your prescriptions. If you don't get approval, Tufts Medicare Preferred HMO may not cover the drug.
- **Quantity Limits:** For certain drugs, Tufts Medicare Preferred HMO limits the amount of the drug that Tufts Medicare Preferred HMO will cover. For example, Tufts Medicare Preferred HMO provides 30 tablets per prescription for zolpidem. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, Tufts Medicare Preferred HMO 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, Tufts Medicare Preferred HMO may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Tufts Medicare Preferred HMO will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at tuftsmedicarepreferred.org.

You can ask Tufts Medicare Preferred HMO to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Tufts Medicare Preferred HMO formulary?" on the next page 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, you should first contact Customer Relations and confirm that your drug is not covered. If you learn that Tufts Medicare Preferred HMO does not cover your drug, you have two options:

- You can ask Customer Relations for a list of similar drugs that are covered by Tufts Medicare Preferred HMO. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Tufts Medicare Preferred HMO.
- You can ask Tufts Medicare Preferred HMO 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 Tufts Medicare Preferred HMO Formulary?

You can ask Tufts Medicare Preferred HMO 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 your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Tufts Medicare Preferred HMO 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 more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our highest tier subject to the tiering exceptions process tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the lowest tier subject to the tiering exceptions process tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the tier designated as the Specialty drug tier.

Generally, Tufts Medicare Preferred HMO will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered 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, tiering or utilization restriction exception. When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescriber's or prescribing physician'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 your prescriber's or prescribing physician's supporting statement.

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 (unless you have a prescription written for fewer days) when you go to a network pharmacy. 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, we will allow you to refill your prescription until we have provided you with a 93-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If 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 (unless you have a prescription for fewer days) while you pursue a formulary exception.

For more information

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

If you have questions about Tufts Medicare Preferred HMO, please call Customer Relations at 1-800-701-9000, Monday – Friday, 8:00 a.m. – 8:00 p.m. (From Oct. 1 –Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message, and a representative will return your call on the next business day. TTY users should call 1-800-208-9562. Or visit tuftsmedicarepreferred.org.

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/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

Tufts Medicare Preferred’s HMO Formulary

The formulary that begins on page 2 provides coverage information about some of the drugs covered by Tufts Medicare Preferred HMO. If you have trouble finding your drug in the list, turn to the Index that begins on page 66.

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

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

B/D: Medicare Part B or D

These drugs require prior authorization to determine appropriate coverage under Medicare Part B or Part D.

QL: Quantity Limit Applies.

Because of potential safety and utilization concerns, Tufts Medicare Preferred HMO has placed dispensing limitations on a small number of prescription drugs. This means that the pharmacy will only dispense a certain quantity of a drug within a given time period. These quantities are based on recognized standards of care, such as U.S. Food and Drug Administration recommendations for use. If your doctor believes you need a quantity greater than the program limitation, your doctor can submit a request for coverage under the Medical Review Process.

HI: Home Infusion Drug.

This prescription drug may be covered under our medical benefit. For more information, call Customer Relations at 1-800-701-9000, Monday-Friday 8:00 a.m. – 8:00 p.m. (From Oct. 1 –Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day. TTY users should call 1-800-208-9562.

LA: Limited Access Drug.

This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Relations at 1-800-701-9000, Monday-Friday 8:00 a.m. – 8:00 p.m. (From Oct. 1 –Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call the on next business day. TTY users should call 1-800-208-9562.

PA: Prior Authorization Required.

The Prior Authorization process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member's medical need for a particular drug. If approved, the member pays the designated tier co-payment. An appeal process exists for denied requests.

STPA: Step Therapy Prior Authorization Applies.

Step Therapy is an automated form of Prior Authorization, which uses claims history for approval of a drug at the point of sale. Step Therapy Programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered.

Members who are currently on drugs that meet the initial Step Therapy criteria will automatically be able to fill their prescriptions for a stepped medication. If the member does not meet the initial Step Therapy criteria, the prescription will deny at the point of sale with a message indicating that Prior Authorization (PA) is required. Physicians may submit Prior Authorization requests to Tufts Medicare Preferred HMO for members who do not meet the Step Therapy criteria at the point of sale under the Medical Review process.

Coverage Gap:

For Tufts Medicare Preferred HMO Prime Rx Plus members, we provide coverage for Tier 1 and Tier 2 drugs in the Coverage Gap. Please refer to our Evidence of Coverage for more information about this coverage.

*** Part B Drug:**

No co-payment is required and the cost of the medication does not apply to your Part D benefit.

**2013 Tufts Medicare Preferred Formulary
HMO Individual Members**

Table of Contents

ANTI-INFECTIVES AND INFECTIOUS DISEASE.....	2
BLOOD THINNERS AND BLOOD MODIFYING AGENTS.....	10
CANCER DRUGS.....	11
CARDIOVASCULAR AGENTS.....	17
DIABETES MELLITUS.....	24
EAR, NOSE AND THROAT.....	27
EYE.....	29
GASTROINTESTINAL DRUGS.....	32
HOME INFUSION THERAPY.....	36
HORMONES.....	44
IMMUNOLOGIC AGENTS.....	46
MISCELLANEOUS DRUGS.....	49
NEUROLOGICAL DRUGS.....	56
PAIN AND INFLAMMATORY DISEASES.....	60
PSYCHIATRIC.....	64
RESPIRATORY DRUGS.....	70
SKIN.....	72
WOMENS HEALTH.....	78

**2013 Tufts Medicare Preferred Formulary
HMO Individual Members**

Drug Name	Drug Tier	Coverage Notes
ANTI-INFECTIVES AND INFECTIOUS DISEASE		
ANTIFUNGALS, SYSTEMIC AND ORAL TOPICAL		
ANCOBON	Tier-4	
<i>clotrimazole</i>	Tier-2	
<i>fluconazole oral suspension</i>	Tier-2	
<i>fluconazole tablet</i>	Tier-1	
<i>flucytosine</i>	Tier-2	
GRIS-PEG (ULTRAMICROSIZED)	Tier-3	
<i>griseofulvin microsize</i>	Tier-2	
<i>griseofulvin ultramicrosize</i>	Tier-2	
<i>itraconazole</i>	Tier-2	PA
<i>ketoconazole</i>	Tier-2	
LAMISIL ORAL GRANULES IN PACKET 125 MG	Tier-4	QL (56 EA per 30 day(s))
LAMISIL ORAL GRANULES IN PACKET 187.5 MG	Tier-4	QL (28 EA per 30 day(s))
NAFTIN TOPICAL CREAM	Tier-3	
NAFTIN TOPICAL GEL 1 %	Tier-3	
<i>nystatin</i>	Tier-2	
<i>terbinafine</i>	Tier-1	QL (42 EA per 42 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Vfend oral suspension	Tier-5	QL (150 ML per 14 day(s))
<i>voriconazole tablet 200 mg</i>	Tier-2	QL (28 EA per 14 day(s))
<i>voriconazole tablet 50 mg</i>	Tier-2	QL (56 EA per 14 day(s))
ANTI-INFECTIVES, MISCELLANEOUS		
ALBENZA	Tier-3	
ALINIA	Tier-4	
BILTRICIDE	Tier-3	
<i>methenamine hippurate</i>	Tier-2	
<i>metronidazole</i>	Tier-2	
MONUROL	Tier-4	
<i>neomycin</i>	Tier-2	
PRIMSOL	Tier-3	
STROMECTOL	Tier-3	
<i>trimethoprim</i>	Tier-2	
Vancocin	Tier-5	
<i>vancomycin</i>	Tier-2	
XIFAXAN TABLET 200 MG	Tier-4	QL (9 EA per 30 day(s))
XIFAXAN TABLET 550 MG	Tier-4	PA; QL (60 EA per 30 day(s))
Zyvox	Tier-5	
ANTIMALARIALS AND ANTIPROTOZOALS		
<i>atovaquone-proguanil</i>	Tier-2	
<i>chloroquine phosphate</i>	Tier-2	
COARTEM	Tier-3	QL (24 EA per 30 day(s))
<i>dapsone</i>	Tier-2	
DARAPRIM	Tier-3	
<i>hydroxychloroquine</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>mefloquine</i>	Tier-2	
MEPRON	Tier-3	
NEBUPENT	Tier-4	B/D
<i>paromomycin</i>	Tier-2	
PENTAM	Tier-3	B/D
<i>primaquine</i>	Tier-2	
QUALAQUIN	Tier-4	
<i>quinine sulfate</i>	Tier-2	
<i>tinidazole</i>	Tier-2	
ANTIVIRALS		
<i>abacavir</i>	Tier-2	
<i>acyclovir capsule</i>	Tier-1	
<i>acyclovir oral suspension</i>	Tier-2	
<i>acyclovir tablet</i>	Tier-2	
<i>acyclovir top</i>	Tier-2	
<i>amantadine hcl</i>	Tier-2	
APTIVUS	Tier-3	
ATRIPLA	Tier-5	
BARACLUDE	Tier-3	
Complera	Tier-5	
Copegus	Tier-5	
CRIXIVAN	Tier-3	
<i>didanosine</i>	Tier-2	
EDURANT	Tier-3	
EMTRIVA	Tier-3	
EPIVIR ORAL SOLUTION	Tier-3	
EPIVIR HBV	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
EPZICOM	Tier-3	
<i>famciclovir</i>	Tier-3	
Fuzeon	Tier-5	
Hepsera	Tier-5	
Incivek	Tier-5	PA
Infergen	Tier-5	PA
INTELENCE	Tier-3	
INTRON A INJECTION SOLUTION	Tier-3	
Intron A solution for injection	Tier-5	
INTRON A SUBCUTANEOUS PEN KIT 10 MILLION UNIT/0.2 ML, 3 MILLION UNIT /0.2 ML-6 DOSES	Tier-3	
Intron A subcutaneous pen kit 5 million unit/0.2 mL	Tier-5	
INVIRASE	Tier-3	
Isentress chewable tablet 100 mg	Tier-5	QL (180 EA per 30 day(s))
Isentress chewable tablet 25 mg	Tier-5	QL (720 EA per 30 day(s))
Isentress tablet	Tier-5	QL (360 EA per 90 day(s))
KALETRA	Tier-3	
<i>lamivudine</i>	Tier-2	
<i>lamivudine-zidovudine</i>	Tier-2	
LEXIVA	Tier-3	
<i>megestrol oral suspension</i>	Tier-2	
<i>megestrol tablet</i>	Tier-1	
<i>nevirapine</i>	Tier-2	
NORVIR	Tier-3	
Pegasys	Tier-5	PA; QL (4 ML per 30 day(s))
Pegasys Convenience Pack	Tier-5	PA; QL (4 EA per 30 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Pegasys ProClick	Tier-5	PA; QL (4 ML per 30 day(s))
PegIntron	Tier-5	PA; QL (8 EA per 30 day(s))
PegIntron Redipen	Tier-5	PA; QL (4 EA per 30 day(s))
PREZISTA	Tier-3	
REBETOL ORAL SOLUTION	Tier-3	
RELENZA DISKHALER	Tier-3	QL (60 EA per 180 day(s))
RESCRIPTOR	Tier-3	
REYATAZ	Tier-3	
RibaPak Dose Pack	Tier-5	
<i>ribasphere capsule</i>	Tier-2	
<i>ribasphere tablet 200 mg, 400 mg</i>	Tier-2	
Ribasphere tablet 600 mg	Tier-5	
<i>ribavirin</i>	Tier-2	
<i>rimantadine</i>	Tier-2	
Selzentry tablet 150 mg	Tier-5	QL (60 EA per 30 day(s))
Selzentry tablet 300 mg	Tier-5	QL (120 EA per 30 day(s))
<i>stavudine</i>	Tier-2	
STRIBILD	Tier-3	
SUSTIVA	Tier-3	
TAMIFLU CAPSULE 30 MG	Tier-3	QL (56 EA per 180 day(s))
TAMIFLU CAPSULE 45 MG, 75 MG	Tier-3	QL (28 EA per 180 day(s))
TAMIFLU ORAL SUSPENSION	Tier-3	QL (360 ML per 180 day(s))
Tivicay	Tier-5	
TRIZIVIR	Tier-3	
TRUVADA	Tier-3	
TYZEKA	Tier-3	QL (30 EA per 30 day(s))
<i>valacyclovir</i>	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Valcyte	Tier-5	
Victralis	Tier-5	PA
VIDEX 2 GRAM PEDIATRIC	Tier-3	
VIRACEPT	Tier-3	
VIRAMUNE ORAL SUSPENSION	Tier-3	
VIRAMUNE XR	Tier-3	
VIREAD	Tier-3	
Zelboraf	Tier-5	PA
ZERIT ORAL SOLUTION	Tier-4	
ZIAGEN	Tier-3	
<i>zidovudine</i>	Tier-2	
BETA-LACTAM ANTIBIOTICS		
<i>amoxicillin</i>	Tier-1	
<i>amoxicillin-pot clavulanate</i>	Tier-2	
<i>ampicillin capsule</i>	Tier-1	
<i>ampicillin oral suspension</i>	Tier-2	
BICILLIN C-R	Tier-3	* Part B
BICILLIN L-A	Tier-3	* Part B
CEDAX	Tier-4	
<i>cefaclor</i>	Tier-2	
<i>cefadroxil</i>	Tier-2	
<i>cefdinir</i>	Tier-2	
<i>cefepodoxime</i>	Tier-2	
<i>cefprozil</i>	Tier-2	
<i>cefuroxime axetil</i>	Tier-2	
<i>cephalexin</i>	Tier-2	
<i>dicloxacillin</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>penicillin v potassium</i>	Tier-1	
SPECTRACEF	Tier-4	
SUPRAX CHEWABLE TABLET	Tier-4	
SUPRAX ORAL SUSPENSION	Tier-4	
SUPRAX TABLET	Tier-4	
KETOLIDES		
KETEK	Tier-3	
MACROLIDES AND CLINDAMYCIN		
<i>azithromycin</i>	Tier-2	
<i>clarithromycin</i>	Tier-2	
<i>clindamycin hcl</i>	Tier-2	
<i>clindamycin pediatric</i>	Tier-2	
Dificid	Tier-5	PA
<i>e.e.s. 400</i>	Tier-2	
E.E.S. GRANULES	Tier-4	
ERY-TAB	Tier-4	
<i>eryped 200</i>	Tier-2	
<i>eryped 400</i>	Tier-2	
<i>erythrocin stearate</i>	Tier-2	
<i>erythromycin</i>	Tier-2	
<i>erythromycin ethylsuccinate</i>	Tier-2	
PCE	Tier-4	
ZMAX	Tier-4	
MYCOBACTERIAL INFECTIONS- TUBERCULOSIS AND MYCOBACTERIUM AVIUM COMPLEX		
<i>ethambutol</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>isoniazid oral solution</i>	Tier-2	
<i>isoniazid tablet</i>	Tier-1	
MYCOBUTIN	Tier-3	
PASER	Tier-4	
PRIFTIN	Tier-3	
<i>pyrazinamide</i>	Tier-2	
RIFAMATE	Tier-4	
<i>rifampin</i>	Tier-2	
RIFATER	Tier-4	
SEROMYCIN	Tier-3	
SIRTURO	Tier-3	PA
TRECTOR	Tier-4	
QUINOLONES		
<i>ciprofloxacin</i>	Tier-1	
<i>ciprofloxacin (mixture)</i>	Tier-2	
LEVAQUIN ORAL SOLUTION	Tier-4	
<i>levofloxacin oral</i>	Tier-3	
NOROXIN	Tier-4	
<i>ofloxacin</i>	Tier-2	
SULFONAMIDES		
<i>sulfadiazine</i>	Tier-2	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	Tier-2	
<i>sulfamethoxazole-trimethoprim tablet</i>	Tier-1	
TETRACYCLINES		
<i>demeclocycline</i>	Tier-2	
<i>doxycycline hyclate</i>	Tier-1	
<i>doxycycline monohydrate capsule</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>doxycycline monohydrate oral suspension</i>	Tier-2	
<i>doxycycline monohydrate tablet</i>	Tier-1	
<i>minocycline</i>	Tier-2	
<i>tetracycline</i>	Tier-1	
VIBRAMYCIN SYRUP	Tier-4	
BLOOD THINNERS AND BLOOD MODIFYING AGENTS		
ANTIPLATELET THERAPY		
AGGRENOX	Tier-4	
<i>clopidogrel</i>	Tier-2	
<i>dipyridamole</i>	Tier-2	
EFFIENT	Tier-4	
BLOOD MODIFYING AGENTS		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	Tier-3	QL (4 ML per 30 day(s))
Aranesp (in polysorbate) injection solution 200 mcg/mL, 300 mcg/mL	Tier-5	QL (4 ML per 30 day(s))
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML	Tier-3	QL (4 ML per 30 day(s))
Aranesp (in polysorbate) injection syringe 150 mcg/0.3 mL, 200 mcg/0.4 mL, 300 mcg/0.6 mL, 500 mcg/mL	Tier-5	QL (4 ML per 30 day(s))
EPOGEN	Tier-3	QL (10 ML per 14 day(s))
Leukine	Tier-5	
Mozobil	Tier-5	PA; * Part B
Neulasta	Tier-5	QL (1 ML per 14 day(s))
Neumega	Tier-5	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Neupogen	Tier-5	QL (10 ML per 14 day(s))
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	Tier-3	QL (10 ML per 14 day(s))
Procrit injection solution 20,000 unit/mL, 40,000 unit/mL	Tier-5	QL (10 ML per 14 day(s))
Promacta	Tier-5	PA; QL (30 EA per 30 day(s))
BLOOD THINNERS		
BRILINTA	Tier-4	
COUMADIN	Tier-4	
<i>enoxaparin</i>	Tier-2	
<i>fondaparinux</i>	Tier-2	
FRAGMIN	Tier-3	
<i>jantoven</i>	Tier-1	
PRADAXA	Tier-4	PA
<i>warfarin</i>	Tier-1	
XARELTO TABLET 10 MG	Tier-4	QL (35 EA per 30 day(s))
XARELTO TABLET 15 MG, 20 MG	Tier-4	
BLOOD, MISCELLANEOUS		
<i>anagrelide</i>	Tier-2	
<i>cilostazol</i>	Tier-2	
CYKLOKAPRON	Tier-3	
<i>pentoxifylline</i>	Tier-2	
STIMATE	Tier-4	
<i>ticlopidine</i>	Tier-2	
<i>tranexamic acid</i>	Tier-2	
CANCER DRUGS		
INJECTABLE AGENTS		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
ABRAXANE	Tier-3	* Part B
ADRIAMYCIN PFS	Tier-3	* Part B
Alimta	Tier-5	* Part B
ALKERAN	Tier-3	* Part B
<i>amifostine crystalline</i>	Tier-2	* Part B
ARRANON	Tier-3	* Part B
Arzerra	Tier-5	* Part B
AVASTIN	Tier-5	* Part B
BICNU	Tier-3	* Part B
<i>bleomycin</i>	Tier-2	* Part B
BUSULFEX	Tier-3	* Part B
CAMPATH	Tier-3	* Part B
<i>carboplatin</i>	Tier-2	* Part B
CERUBIDINE	Tier-3	* Part B
<i>cisplatin</i>	Tier-2	* Part B
<i>cladribine</i>	Tier-2	* Part B
CLOLAR	Tier-3	* Part B
COSMEGEN	Tier-3	* Part B
<i>cytarabine</i>	Tier-2	* Part B
<i>cytarabine (pf)</i>	Tier-2	* Part B
CYTOVENE	Tier-3	* Part B
<i>dacarbazine</i>	Tier-2	* Part B
DACOGEN	Tier-3	* Part B
<i>daunorubicin</i>	Tier-2	* Part B
<i>decitabine</i>	Tier-2	* Part B
<i>dexrazoxane</i>	Tier-2	* Part B
DOCEFREZ	Tier-3	* Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>docetaxel</i>	Tier-2	* Part B
<i>doxorubicin</i>	Tier-2	* Part B
Elitek	Tier-5	* Part B
Ellence	Tier-5	* Part B
ELSPAR	Tier-3	* Part B
<i>epirubicin</i>	Tier-2	* Part B
ERBITUX	Tier-3	* Part B
ETOPOPHOS	Tier-3	* Part B
<i>etoposide</i>	Tier-2	* Part B
Faslodex	Tier-5	* Part B
<i>fludarabine</i>	Tier-2	* Part B
<i>gemcitabine</i>	Tier-2	* Part B
Halaven	Tier-5	* Part B
Herceptin	Tier-5	* Part B
<i>idarubicin</i>	Tier-2	* Part B
IFEX	Tier-3	* Part B
<i>ifosfamide</i>	Tier-2	* Part B
irinotecan	Tier-5	* Part B
Istodax	Tier-5	* Part B
IXEMPRA	Tier-3	* Part B
Jevtana	Tier-5	* Part B
Kadcyla	Tier-5	PA; * Part B
<i>leuprolide</i>	Tier-2	
<i>melphalan</i>	Tier-2	* Part B
<i>mitomycin</i>	Tier-2	* Part B
<i>mitoxantrone</i>	Tier-2	* Part B
MUSTARGEN	Tier-3	* Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
ONTAK	Tier-3	* Part B
<i>oxaliplatin</i>	Tier-2	* Part B
<i>paclitaxel</i>	Tier-2	* Part B
<i>pentostatin</i>	Tier-2	* Part B
PERJETA	Tier-3	PA; * Part B
Proleukin	Tier-5	* Part B
Rituxan	Tier-5	PA; * Part B
Sylatron	Tier-5	PA; QL (4 EA per 28 day(s))
Synribo	Tier-5	
Taxotere	Tier-5	* Part B
<i>thiotepa</i>	Tier-2	* Part B
<i>toposar</i>	Tier-2	* Part B
<i>topotecan</i>	Tier-3	* Part B
Torisel	Tier-5	* Part B
Treanda	Tier-5	* Part B
UVADEX	Tier-3	* Part B
VECTIBIX	Tier-3	* Part B
Velcade	Tier-5	* Part B
Vidaza	Tier-5	* Part B
<i>vinblastine</i>	Tier-2	* Part B
<i>vincristine</i>	Tier-2	* Part B
<i>vinorelbine</i>	Tier-2	* Part B
YERVOY	Tier-3	* Part B
ZALTRAP	Tier-3	* Part B
ZANOSAR	Tier-3	* Part B
ORAL AGENTS		
Afinitor	Tier-5	PA; QL (30 EA per 30 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Afinitor Disperz	Tier-5	QL (30 EA per 30 Day(s))
<i>anastrozole</i>	Tier-2	
<i>bicalutamide</i>	Tier-2	
Bosulif tablet 100 mg	Tier-5	PA; QL (120 EA per 30 day(s))
Bosulif tablet 500 mg	Tier-5	PA; QL (30 EA per 30 day(s))
Caprelsa tablet 100 mg	Tier-5	PA; QL (60 EA per 30 day(s))
Caprelsa tablet 300 mg	Tier-5	PA; QL (30 EA per 30 day(s))
CEENU	Tier-3	
Cometriq	Tier-5	PA
<i>cyclophosphamide</i>	Tier-2	B/D
DROXIA	Tier-4	
EMCYT	Tier-3	
Erivedge	Tier-5	PA
<i>exemestane</i>	Tier-2	
FARESTON	Tier-3	
<i>flutamide</i>	Tier-2	
Gilotrif	Tier-5	PA; QL (30 EA per 30 Day(s))
Gleevec	Tier-5	
Hexalen	Tier-5	
<i>hydroxyurea</i>	Tier-2	
Iclusig tablet 15 mg	Tier-5	PA; QL (60 EA per 30 day(s))
Iclusig tablet 45 mg	Tier-5	PA; QL (30 EA per 30 day(s))
Inlyta	Tier-5	PA
Jakafi	Tier-5	PA
<i>letrozole</i>	Tier-2	
LEUKERAN	Tier-3	
Matulane	Tier-5	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Mekinist	Tier-5	PA
<i>mercaptopurine</i>	Tier-2	
Nexavar	Tier-5	PA; QL (220 EA per 30 day(s))
NILANDRON	Tier-3	
Pomalyst	Tier-5	PA; QL (21 EA per 21 Day(s))
REVLIMID capsule 10 mg, 15 mg, 25 mg, 5 mg	Tier-5	PA; LA
REVLIMID capsule 2.5 mg	Tier-5	PA
SOLTAMOX	Tier-3	
Sprycel tablet 100 mg, 140 mg	Tier-5	PA; QL (30 EA per 30 day(s))
Sprycel tablet 20 mg, 50 mg, 70 mg, 80 mg	Tier-5	PA; QL (60 EA per 30 day(s))
Stivarga	Tier-5	PA; QL (84 EA per 28 day(s))
Sutent	Tier-5	PA
TABLOID	Tier-3	
Tafinlar	Tier-5	PA
<i>tamoxifen</i>	Tier-2	
Tarceva tablet 100 mg	Tier-5	QL (90 EA per 30 day(s))
Tarceva tablet 150 mg, 25 mg	Tier-5	QL (30 EA per 30 day(s))
Targretin	Tier-5	
Tasigna	Tier-5	PA
TEMODAR ORAL	Tier-3	* Part B
Thalomid	Tier-5	
tretinoin (chemotherapy)	Tier-5	
TRISENOX	Tier-3	
Tykerb	Tier-5	PA; QL (180 EA per 30 day(s))
Votrient	Tier-5	PA; QL (120 EA per 30 day(s))
Xalkori	Tier-5	PA
Xeloda	Tier-5	* Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Xtandi	Tier-5	PA; QL (120 EA per 30 day(s))
Zolinza	Tier-5	PA
Zytiga	Tier-5	PA; QL (120 EA per 30 day(s))
PROTECTIVE AGENTS		
FUSILEV	Tier-3	* Part B
<i>leucovorin calcium inj</i>	Tier-2	* Part B
<i>leucovorin calcium oral</i>	Tier-2	
<i>mesna</i>	Tier-2	* Part B
MESNEX ORAL	Tier-4	
VORAXAZE	Tier-3	* Part B
ZINECARD	Tier-4	* Part B
TOPICAL		
Targretin	Tier-5	
CARDIOVASCULAR AGENTS		
ACE INHIBITORS		
<i>benazepril</i>	Tier-1	
<i>captopril</i>	Tier-1	
<i>enalapril maleate</i>	Tier-1	
<i>fosinopril</i>	Tier-1	
<i>lisinopril</i>	Tier-1	
<i>moexipril</i>	Tier-2	
<i>perindopril erbumine</i>	Tier-2	
<i>quinapril</i>	Tier-2	
<i>ramipril</i>	Tier-2	
<i>trandolapril</i>	Tier-2	
ALPHA1 BLOCKERS		
CARDURA XL	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>doxazosin</i>	Tier-1	
<i>prazosin</i>	Tier-1	
<i>terazosin</i>	Tier-1	
ANGINA		
<i>isosorbide dinitrate</i>	Tier-1	
<i>isosorbide mononitrate</i>	Tier-2	
NITRO-BID	Tier-4	
<i>nitroglycerin</i>	Tier-2	
NITROLINGUAL	Tier-4	
NITROMIST	Tier-4	
NITROSTAT	Tier-3	
RANEXA	Tier-3	
ANGIOTENSIN II RECEPTOR BLOCKERS		
BENICAR	Tier-3	
<i>candesartan</i>	Tier-3	
<i>candesartan-hydrochlorothiazid</i>	Tier-3	
DIOVAN	Tier-3	
<i>eprosartan</i>	Tier-2	
<i>irbesartan</i>	Tier-3	
<i>losartan</i>	Tier-2	
ANTI-ARRHYTHMICS AND CARDIAC GLYCOSIDES		
<i>amiodarone oral</i>	Tier-2	
<i>digoxin oral</i>	Tier-1	
<i>disopyramide</i>	Tier-2	
<i>flecainide</i>	Tier-3	
LANOXIN	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
LANOXIN PEDIATRIC	Tier-4	
<i>mexiletine</i>	Tier-2	
MULTAQ	Tier-4	
NEXTERONE	Tier-3	* Part B
NORPACE CR	Tier-4	
PACERONE	Tier-4	
<i>propafenone</i>	Tier-2	
<i>quinidine gluconate oral</i>	Tier-2	
<i>quinidine sulfate</i>	Tier-2	
<i>sorine</i>	Tier-2	
<i>sotalol oral</i>	Tier-1	
<i>sotalol af</i>	Tier-1	
TIKOSYN	Tier-3	
ANTIHYPERTENSIVE FIXED-DOSE COMBINATION PRODUCTS		
<i>amlodipine-atorvastatin</i>	Tier-3	
<i>amlodipine-benazepril</i>	Tier-3	
<i>atenolol-chlorthalidone</i>	Tier-1	
AZOR	Tier-3	
<i>benazepril-hydrochlorothiazide</i>	Tier-1	
BENICAR HCT	Tier-3	
<i>bisoprolol-hydrochlorothiazide</i>	Tier-1	
<i>captopril-hydrochlorothiazide</i>	Tier-2	
<i>clorpres</i>	Tier-2	
DUTOPROL	Tier-4	
<i>enalapril-hydrochlorothiazide</i>	Tier-1	
EXFORGE	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
EXFORGE HCT	Tier-4	
<i>fosinopril-hydrochlorothiazide</i>	Tier-1	
<i>irbesartan-hydrochlorothiazide</i>	Tier-3	
<i>lisinopril-hydrochlorothiazide</i>	Tier-1	
<i>losartan-hydrochlorothiazide</i>	Tier-2	
<i>methyldopa-hydrochlorothiazide</i>	Tier-2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier-2	
<i>moexipril-hydrochlorothiazide</i>	Tier-2	
<i>nadolol-bendroflumethiazide</i>	Tier-2	
<i>propranolol-hydrochlorothiazid</i>	Tier-2	
<i>quinapril-hydrochlorothiazide</i>	Tier-2	
TARKA	Tier-4	
<i>triamterene-hydrochlorothiazid</i>	Tier-1	
<i>valsartan-hydrochlorothiazide</i>	Tier-3	
BETA AND ALPHA BLOCKERS		
<i>carvedilol</i>	Tier-1	
COREG CR	Tier-4	
<i>labetalol</i>	Tier-2	
BETA BLOCKERS		
<i>acebutolol</i>	Tier-2	
<i>atenolol</i>	Tier-1	
<i>betaxolol</i>	Tier-2	
<i>bisoprolol fumarate</i>	Tier-2	
LEVATOL	Tier-4	
<i>metoprolol succinate</i>	Tier-2	
<i>metoprolol tartrate</i>	Tier-1	
<i>nadolol</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>pindolol</i>	Tier-2	
<i>propranolol er capsule,24 hr,extended release</i>	Tier-2	
<i>propranolol oral solution</i>	Tier-2	
<i>propranolol tablet</i>	Tier-1	
<i>timolol maleate</i>	Tier-2	
CALCIUM CHANNEL BLOCKERS		
<i>afeditab cr</i>	Tier-2	
<i>amlodipine</i>	Tier-2	
<i>cartia xt</i>	Tier-2	
COVERA-HS	Tier-4	
<i>dilt-cd</i>	Tier-2	
<i>dilt-xr</i>	Tier-2	
<i>diltiazem cd capsule,extended release 24 hr</i>	Tier-2	
<i>diltiazem er capsule,extended release</i>	Tier-2	
<i>diltiazem er capsule,extended release 12 hr</i>	Tier-2	
<i>diltiazem tablet</i>	Tier-1	
<i>felodipine</i>	Tier-2	
<i>isradipine</i>	Tier-2	
<i>matzim la</i>	Tier-2	
<i>nicardipine oral</i>	Tier-2	
<i>nifediac cc</i>	Tier-2	
<i>nifedical xl</i>	Tier-2	
<i>nifedipine</i>	Tier-2	
<i>nimodipine</i>	Tier-2	
<i>nisoldipine</i>	Tier-2	
<i>taztia xt</i>	Tier-2	
<i>verapamil oral</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
CENTRALLY ACTING AGENTS		
<i>clonidine oral</i>	Tier-1	
<i>clonidine transdermal</i>	Tier-2	
<i>guanfacine</i>	Tier-1	
<i>methyldopa</i>	Tier-2	
<i>reserpine</i>	Tier-2	
DIURETICS		
<i>amiloride</i>	Tier-2	
<i>amiloride-hydrochlorothiazide</i>	Tier-1	
<i>bumetanide</i>	Tier-1	
<i>chlorothiazide</i>	Tier-2	
<i>chlorthalidone</i>	Tier-1	
<i>furosemide oral solution</i>	Tier-2	
<i>furosemide tablet</i>	Tier-1	
<i>hydrochlorothiazide</i>	Tier-1	
<i>indapamide</i>	Tier-1	
<i>methyclothiazide</i>	Tier-2	
<i>metolazone</i>	Tier-2	
<i>spironolacton-hydrochlorothiaz</i>	Tier-2	
<i>spironolactone</i>	Tier-1	
THALITONE	Tier-4	
<i>torseamide</i>	Tier-2	
<i>triamterene-hydrochlorothiazid</i>	Tier-1	
LIPID LOWERING AGENTS		
ADVICOR	Tier-4	
<i>atorvastatin</i>	Tier-2	
<i>cholestyramine light</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>colestipol</i>	Tier-2	
<i>fenofibrate</i>	Tier-2	
<i>fenofibrate micronized</i>	Tier-2	
<i>fenofibrate nanocrystallized</i>	Tier-2	
<i>fenofibric acid (choline)</i>	Tier-2	
<i>fluvastatin</i>	Tier-1	
<i>gemfibrozil</i>	Tier-2	
Juxtapid capsule 10 mg, 5 mg	Tier-5	PA; QL (30 EA per 30 Day(s))
Juxtapid capsule 20 mg	Tier-5	PA; QL (90 EA per 30 Day(s))
Kynamro	Tier-5	PA; QL (4 ML per 30 Day(s))
<i>lovastatin</i>	Tier-1	
LOVAZA	Tier-3	
<i>niacor</i>	Tier-2	
NIASPAN EXTENDED-RELEASE	Tier-3	
<i>pravastatin</i>	Tier-1	
PREVALITE	Tier-4	
SIMCOR	Tier-3	
<i>simvastatin</i>	Tier-1	
VYTORIN 10-10	Tier-4	
VYTORIN 10-20	Tier-4	
VYTORIN 10-40	Tier-4	
VYTORIN 10-80	Tier-4	
WELCHOL	Tier-4	
ZETIA	Tier-3	
POTASSIUM REPLACEMENT		
K-TAB	Tier-4	
<i>klor-con</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>klor-con 10</i>	Tier-2	
KLOR-CON M15	Tier-4	
<i>klor-con m20</i>	Tier-2	
<i>potassium chloride er capsule,extended release 10 meq</i>	Tier-1	
<i>potassium chloride er capsule,extended release 8 meq</i>	Tier-2	
<i>potassium chloride er tablet,extended release(part/cryst)</i>	Tier-2	
SELECTIVE ALDOSTERONE BLOCKER		
<i>eplerenone</i>	Tier-2	STPA
<i>spironolactone</i>	Tier-1	
VASODILATORS		
BIDIL	Tier-3	
<i>hydralazine inj</i>	Tier-2	
<i>hydralazine oral</i>	Tier-1	
<i>isosorbide dinitrate</i>	Tier-1	
DIABETES MELLITUS		
DIABETIC SUPPLIES		
ACCU-CHEK ACTIVE TEST	Tier-3	* Part B
ACCU-CHEK AVIVA	Tier-3	* Part B
ACCU-CHEK AVIVA PLUS	Tier-3	* Part B
ACCU-CHEK COMFORT CURVE TEST	Tier-3	* Part B
ACCU-CHEK COMPACT TEST	Tier-3	* Part B
ACCU-CHEK SMARTVIEW STRIPS	Tier-3	* Part B
<i>alcohol swabs</i>	Tier-2	
<i>curity gauze</i>	Tier-2	
<i>huber safety needles (disp.)</i>	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>insulin syringe-needle u-100</i>	Tier-3	
ONE TOUCH TEST	Tier-3	* Part B
ONE TOUCH ULTRA TEST	Tier-3	* Part B
ONE TOUCH VERIO	Tier-3	* Part B
GLUCOSE ELEVATING		
GLUCAGEN HYPOKIT	Tier-3	
GLUCAGON EMERGENCY	Tier-3	
PROGLYCEM	Tier-4	
INSULINS		
HUMALOG	Tier-3	
HUMALOG KWIKPEN	Tier-4	
HUMALOG MIX 50-50	Tier-3	
HUMALOG MIX 50-50 KWIKPEN	Tier-4	
HUMALOG MIX 75-25	Tier-3	
HUMALOG MIX 75-25 KWIKPEN	Tier-4	
HUMULIN 70/30	Tier-3	
HUMULIN 70/30 PEN	Tier-4	
HUMULIN N	Tier-3	
HUMULIN N PEN	Tier-4	
HUMULIN R	Tier-3	
HUMULIN R U-500 "CONCENTRATED"	Tier-3	
LANTUS	Tier-3	
LANTUS SOLOSTAR	Tier-4	
LEVEMIR	Tier-3	
LEVEMIR FLEXPEN	Tier-4	
NOVOLIN 70/30	Tier-3	
NOVOLIN N	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
NOVOLIN R	Tier-3	
NOVOLOG	Tier-3	
NOVOLOG FLEXPEN	Tier-4	
NOVOLOG MIX 70-30	Tier-3	
NOVOLOG MIX 70-30 FLEXPEN	Tier-4	
NON-INSULIN INJECTABLES		
BYDUREON	Tier-3	
BYETTA	Tier-3	
SYMLINPEN 120	Tier-4	
SYMLINPEN 60	Tier-4	
VICTOZA 3-PAK	Tier-4	
ORAL AGENTS		
<i>acarbose</i>	Tier-2	
ACTOPLUS MET	Tier-4	
ACTOPLUS MET XR	Tier-4	
ACTOS	Tier-4	
<i>chlorpropamide</i>	Tier-2	
DUETACT	Tier-4	
<i>glimepiride</i>	Tier-1	
<i>glipizide er tablet, extended release 24 hr</i>	Tier-2	
<i>glipizide tablet</i>	Tier-1	
<i>glipizide-metformin</i>	Tier-1	
<i>glyburide</i>	Tier-1	
<i>glyburide micronized</i>	Tier-1	
<i>glyburide-metformin</i>	Tier-2	
JANUMET	Tier-3	
JANUMET XR	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
JANUVIA	Tier-3	
JENTADUETO	Tier-4	
JUVISYNC	Tier-3	
KOMBIGLYZE XR	Tier-3	
Korlym	Tier-5	PA; QL (120 EA per 30 Day(s))
<i>metformin er tablet,extended release 24 hr</i>	Tier-2	
<i>metformin er tablet,extended release 24hr</i>	Tier-2	
<i>metformin tablet</i>	Tier-1	
<i>nateglinide</i>	Tier-2	
ONGLYZA	Tier-3	
<i>pioglitazone</i>	Tier-3	
<i>pioglitazone-glimepiride</i>	Tier-3	
<i>pioglitazone-metformin</i>	Tier-3	
PRANDIMET	Tier-4	
PRANDIN	Tier-3	
<i>repaglinide</i>	Tier-2	
RIOMET	Tier-4	
<i>tolazamide</i>	Tier-2	
<i>tolbutamide</i>	Tier-2	
TRADJENTA	Tier-4	
EAR, NOSE AND THROAT		
EAR		
<i>acetazol hc</i>	Tier-2	
<i>acetic acid</i>	Tier-2	
CIPRODEX	Tier-3	
COLY-MYCIN S	Tier-4	
CORTISPORIN-TC	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
DERMOTIC OIL	Tier-3	
<i>fluocinolone acetonide oil</i>	Tier-2	
<i>hydrocortisone-acetic acid</i>	Tier-2	
<i>ofloxacin</i>	Tier-2	
MOUTH AND THROAT		
<i>cevimeline</i>	Tier-2	
<i>chlorhexidine gluconate</i>	Tier-1	
<i>doxycycline hyclate</i>	Tier-1	
EVOXAC	Tier-3	
<i>periogard</i>	Tier-1	
<i>pilocarpine hcl</i>	Tier-2	
<i>sodium fluoride</i>	Tier-2	
<i>triamcinolone acetonide</i>	Tier-2	
NOSE		
ASTEPRO	Tier-3	QL (120 ML per 90 day(s))
<i>azelastine</i>	Tier-2	QL (120 ML per 90 day(s))
BACTROBAN NASAL	Tier-4	
<i>desloratadine</i>	Tier-3	
<i>flunisolide</i>	Tier-2	QL (150 ML per 90 day(s))
<i>fluticasone</i>	Tier-2	QL (48 GM per 90 day(s))
<i>hydroxyzine hcl</i>	Tier-2	
<i>hydroxyzine pamoate</i>	Tier-2	
<i>ipratropium bromide nasal spray 0.03 %</i>	Tier-2	QL (180 ML per 90 day(s))
<i>ipratropium bromide nasal spray 0.06 %</i>	Tier-2	QL (90 ML per 90 day(s))
<i>levocetirizine</i>	Tier-2	
NASONEX	Tier-3	QL (102 GM per 90 day(s))
<i>triamcinolone acetonide</i>	Tier-3	QL (49.5 GM per 90 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
TYZINE	Tier-4	
EYE		
ALLERGY		
ALOCRIIL	Tier-4	
ALOMIDE	Tier-4	
<i>azelastine</i>	Tier-2	
<i>cromolyn</i>	Tier-2	
EMADINE	Tier-4	
<i>epinastine</i>	Tier-2	
LASTACAFT	Tier-4	
<i>naphazoline</i>	Tier-2	
ANTI-INFECTIVES		
AZASITE	Tier-4	QL (2.5 ML per 7 day(s))
<i>bacitracin oph</i>	Tier-2	
<i>bacitracin-polymyxin b</i>	Tier-2	
BESIVANCE	Tier-4	
BLEPHAMIDE	Tier-4	
BLEPHAMIDE S.O.P.	Tier-4	
<i>ciprofloxacin</i>	Tier-2	
<i>erythromycin</i>	Tier-2	
<i>gentak</i>	Tier-1	
<i>gentamicin</i>	Tier-1	
<i>levofloxacin oph</i>	Tier-2	
MOXEZA	Tier-4	
<i>neomycin-bacitracin-poly-hc</i>	Tier-2	
<i>neomycin-bacitracin-polymyxin</i>	Tier-2	
<i>neomycin-polymyxin-hc</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>ofloxacin</i>	Tier-2	
<i>sulfacetamide sodium</i>	Tier-2	
<i>sulfacetamide-prednisolone</i>	Tier-2	
TOBRADEX	Tier-4	
TOBRADEX ST	Tier-4	
<i>tobramycin</i>	Tier-2	
<i>tobramycin-dexamethasone</i>	Tier-2	
<i>trimethoprim-polymyxin b</i>	Tier-1	
VIGAMOX	Tier-4	
ANTI-INFLAMMATORIES		
ALREX	Tier-4	
<i>bromfenac</i>	Tier-2	
<i>dexamethasone sodium phosphate</i>	Tier-2	
<i>diclofenac sodium</i>	Tier-2	
FLAREX	Tier-4	
<i>fluor-op</i>	Tier-2	
<i>fluorometholone</i>	Tier-2	
<i>flurbiprofen sodium</i>	Tier-2	
FML FORTE	Tier-4	
FML S.O.P.	Tier-3	
<i>ketorolac ophth</i>	Tier-2	
LOTEMAX EYE DROPS,SUSPENSION	Tier-4	
MAXIDEX	Tier-4	
<i>neomycin-polymyxin-dexameth</i>	Tier-2	
<i>neomycin-polymyxin-gramicidin</i>	Tier-2	
<i>neomycin-polymyxin-hc</i>	Tier-2	
NEVANAC	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
PRED MILD	Tier-3	
PRED-G	Tier-3	
PRED-G S.O.P.	Tier-3	
<i>prednisolone acetate</i>	Tier-2	
PROLENSA	Tier-4	
VEXOL	Tier-3	
ZYLET	Tier-4	
ANTIVIRALS		
<i>trifluridine</i>	Tier-2	
ZIRGAN	Tier-4	
GLAUCOMA		
<i>acetazolamide</i>	Tier-2	
ALPHAGAN P EYE DROPS 0.1 %	Tier-4	
<i>apraclonidine</i>	Tier-2	
AZOPT	Tier-3	
<i>betaxolol</i>	Tier-2	
BETIMOL	Tier-3	
BETOPTIC S	Tier-4	
<i>brimonidine</i>	Tier-2	
<i>carteolol</i>	Tier-2	
COMBIGAN	Tier-4	QL (10 ML per 30 day(s))
<i>dorzolamide</i>	Tier-2	
<i>dorzolamide-timolol</i>	Tier-2	
IOPIDINE	Tier-4	
<i>latanoprost</i>	Tier-2	
<i>levobunolol</i>	Tier-1	
LUMIGAN	Tier-4	STPA

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>methazolamide</i>	Tier-2	
<i>metipranolol</i>	Tier-2	
PILOPINE HS	Tier-3	
SIMBRINZA	Tier-4	
<i>timolol eye gel forming solution</i>	Tier-2	
<i>timolol maleate eye drops</i>	Tier-1	
TRAVATAN Z	Tier-4	STPA
<i>travoprost (benzalkonium)</i>	Tier-3	
ZIOPTAN (PF)	Tier-4	STPA; QL (90 EA per 90 day(s))
OPHTHALMIC DRUGS, MISCELLANEOUS		
ALCAINE	Tier-4	
NATACYN	Tier-4	
RESTASIS	Tier-3	PA
GASTROINTESTINAL DRUGS		
EMESIS		
ALOXI	Tier-3	B/D; QL (5 ML per 7 day(s))
ANZEMET TABLET 100 MG	Tier-3	B/D; QL (5 EA per 7 day(s))
ANZEMET TABLET 50 MG	Tier-3	B/D; QL (3 EA per 7 day(s))
CESAMET	Tier-3	B/D; QL (30 EA per 7 day(s))
<i>compro</i>	Tier-2	
dronabinol capsule 10 mg	Tier-5	B/D
<i>dronabinol capsule 2.5 mg, 5 mg</i>	Tier-2	B/D
EMEND CAPSULE 125 MG	Tier-3	B/D; QL (1 EA per 7 day(s))
EMEND CAPSULE 40 MG, 80 MG	Tier-3	B/D; QL (2 EA per 7 day(s))
EMEND CAPSULES IN A DOSE PACK	Tier-3	B/D; QL (3 EA per 7 day(s))
<i>granisetron</i>	Tier-2	B/D; QL (10 EA per 7 day(s))
GRANISOL	Tier-3	B/D; QL (45 ML per 7 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>meclizine</i>	Tier-2	
<i>metoclopramide hcl</i>	Tier-2	
<i>ondansetron</i>	Tier-2	B/D; QL (12 EA per 7 day(s))
<i>ondansetron hcl oral solution</i>	Tier-2	B/D; QL (150 ML per 7 day(s))
<i>ondansetron hcl tablet 24 mg</i>	Tier-2	B/D; QL (4 EA per 7 day(s))
<i>ondansetron hcl tablet 4 mg, 8 mg</i>	Tier-2	B/D; QL (12 EA per 7 day(s))
<i>prochlorperazine</i>	Tier-2	
<i>prochlorperazine edisylate</i>	Tier-2	
<i>prochlorperazine maleate</i>	Tier-2	
SANCUSO	Tier-4	B/D; QL (1 EA per 7 day(s))
TRANSDERM-SCOP	Tier-4	
ENZYMES		
Buphenyl	Tier-5	
CARBAGLU	Tier-3	PA
CREON	Tier-3	
CYSTAGON	Tier-4	
PANCREAZE	Tier-4	
PERTZYE	Tier-4	
<i>sodium phenylbutyrate</i>	Tier-2	
ULTRESA	Tier-4	
VIOKACE	Tier-4	
ZENPEP	Tier-4	
GASTROINTESTINAL DRUGS, MISCELLANEOUS		
CANTIL	Tier-4	
Cimzia	Tier-5	PA; QL (2 EA per 30 day(s))
Cimzia Powder for Reconst	Tier-5	PA; * Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
COLYTE WITH FLAVOR PACKS	Tier-4	
<i>constulose</i>	Tier-2	
<i>cromolyn</i>	Tier-2	
<i>dicyclomine</i>	Tier-1	
<i>enulose</i>	Tier-2	
Fulyzaq	Tier-5	PA
Gattex One-Vial	Tier-5	PA; QL (30 EA per 30 Day(s))
<i>generlac</i>	Tier-2	
<i>glycopyrrolate oral</i>	Tier-2	
GOLYTELY	Tier-3	
HALFLYTELY-BISACODYL W-FLAV PK	Tier-3	
KRISTALOSE	Tier-3	
<i>lactulose</i>	Tier-2	
<i>levocarnitine</i>	Tier-2	B/D
<i>levocarnitine (with sugar)</i>	Tier-2	B/D
LINZESS	Tier-4	QL (30 EA per 30 Day(s))
<i>loperamide</i>	Tier-2	
LOTRONEX	Tier-3	
MOVIPREP	Tier-4	
OSMOPREP	Tier-4	
<i>polyethylene glycol 3350</i>	Tier-2	
<i>propantheline</i>	Tier-2	
SUPREP	Tier-4	
<i>trilyte with flavor packets</i>	Tier-2	
<i>ursodiol</i>	Tier-2	

GASTROINTESTINAL DRUGS, PEPTIC ULCER TREATMENT, REFLUX (GERD)

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
CARAFATE	Tier-4	
<i>cimetidine oral solution</i>	Tier-2	
<i>cimetidine tablet</i>	Tier-1	
<i>famotidine oral suspension</i>	Tier-2	
<i>famotidine tablet</i>	Tier-1	
HELIDAC	Tier-4	
<i>lansoprazole</i>	Tier-3	
<i>methscopolamine</i>	Tier-2	
<i>misoprostol</i>	Tier-2	
<i>nizatidine</i>	Tier-2	
<i>omeprazole</i>	Tier-2	
<i>omeprazole-sodium bicarbonate</i>	Tier-3	
<i>pantoprazole</i>	Tier-2	
PREVPAC	Tier-4	
PYLERA	Tier-3	
<i>ranitidine capsule</i>	Tier-1	
<i>ranitidine syrup</i>	Tier-2	
<i>ranitidine tablet</i>	Tier-1	
RELISTOR	Tier-3	
<i>sucralfate</i>	Tier-2	
INFLAMMATORY BOWEL DISEASE		
AMITIZA	Tier-3	
APRISO	Tier-3	
ASACOL	Tier-3	
ASACOL HD	Tier-3	
<i>balsalazide</i>	Tier-2	
<i>budesonide</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
CANASA	Tier-3	
<i>colocort</i>	Tier-2	
DELZICOL	Tier-3	
DIPENTUM	Tier-3	
ENTOCORT EC	Tier-4	
<i>hydrocortisone</i>	Tier-2	
<i>mesalamine-cleansing wipes</i>	Tier-2	
PENTASA	Tier-3	
SFROWASA	Tier-4	
<i>sulfasalazine</i>	Tier-2	
<i>sulfazine ec</i>	Tier-2	
UCERIS	Tier-4	

HOME INFUSION THERAPY

ACUTE CARE DRUGS

ABELCET	Tier-3	HI; * Part B
<i>acetazolamide sodium</i>	Tier-2	HI
<i>acyclovir sodium</i>	Tier-2	HI
<i>allopurinol sodium</i>	Tier-2	HI
AMBISOME	Tier-3	HI; * Part B
<i>amikacin</i>	Tier-2	HI; * Part B
AMPHOTEC	Tier-3	HI; * Part B
<i>amphotericin b</i>	Tier-2	HI; * Part B
<i>ampicillin sodium</i>	Tier-2	HI; * Part B
<i>ampicillin-sulbactam</i>	Tier-2	HI; * Part B
ANZEMET	Tier-3	QL (10 ML per 7 day(s))
ARGATROBAN	Tier-4	HI
ARGATROBAN IN 0.9 % SOD CHLOR	Tier-4	HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
ATGAM	Tier-3	HI; * Part B
<i>atropine injection syringe 0.05 mg/ml</i>	Tier-2	HI
AVELOX IN NAACL (ISO-OSMOTIC)	Tier-3	HI; * Part B
AZACTAM	Tier-3	HI; * Part B
AZACTAM IN DEXTROSE (ISO-OSM)	Tier-3	HI; * Part B
<i>azathioprine sodium</i>	Tier-2	B/D
<i>azithromycin</i>	Tier-2	HI; * Part B
<i>aztreonam</i>	Tier-2	HI; * Part B
<i>benztropine</i>	Tier-2	HI
BONIVA IV	Tier-3	PA
<i>bumetanide</i>	Tier-2	HI
<i>buprenorphine inj</i>	Tier-2	HI
<i>butorphanol tartrate</i>	Tier-2	HI
<i>calcitriol</i>	Tier-2	
CANCIDAS	Tier-3	HI; * Part B
CAPASTAT	Tier-3	HI
<i>cefazolin</i>	Tier-2	HI; * Part B
<i>cefazolin in dextrose (iso-os)</i>	Tier-2	HI; * Part B
<i>cefepime</i>	Tier-2	HI; * Part B
<i>cefotaxime</i>	Tier-2	HI; * Part B
<i>cefotetan</i>	Tier-2	HI; * Part B
<i>cefoxitin</i>	Tier-2	HI; * Part B
<i>cefoxitin in dextrose, iso-osm</i>	Tier-2	HI; * Part B
<i>ceftazidime</i>	Tier-2	HI; * Part B
<i>ceftazidime in d5w</i>	Tier-2	HI; * Part B
<i>ceftriaxone</i>	Tier-2	HI; * Part B
<i>cefuroxime sodium</i>	Tier-2	HI; * Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>chloramphenicol sod succinate</i>	Tier-2	HI; * Part B
<i>cidofovir</i>	Tier-2	
<i>cimetidine hcl</i>	Tier-2	HI
<i>ciprofloxacin</i>	Tier-2	HI; * Part B
CLEOCIN INJ	Tier-3	HI; * Part B
CLEOCIN IN 5 % DEXTROSE	Tier-3	HI; * Part B
<i>clindamycin phosphate</i>	Tier-2	HI; * Part B
<i>colistin (colistimethate na)</i>	Tier-2	HI; * Part B
CUBICIN	Tier-5	B/D; HI
<i>cyclosporine</i>	Tier-2	B/D
<i>dexamethasone sodium phosphate</i>	Tier-2	HI
<i>diltiazem hcl</i>	Tier-2	HI
DORIBAX	Tier-3	HI; * Part B
<i>doxycycline hyclate</i>	Tier-2	HI; * Part B
<i>duramorph (pf)</i>	Tier-2	HI
ERAXIS(WATER DILUENT)	Tier-3	HI; * Part B
ERYTHROCIN	Tier-3	HI; * Part B
<i>fluconazole in dextrose(iso-o)</i>	Tier-2	HI; * Part B
FORTAZ	Tier-3	HI; * Part B
FORTAZ IN DEXTROSE 5 %	Tier-3	HI; * Part B
<i>foscarnet</i>	Tier-2	HI
<i>gentamicin</i>	Tier-2	HI; * Part B
<i>gentamicin in nacl (iso-osm)</i>	Tier-2	HI; * Part B
<i>gentamicin sulfate (pf)</i>	Tier-2	HI; * Part B
<i>granisetron</i>	Tier-2	B/D; HI; QL (40 ML per 7 day(s))
<i>granisetron (pf)</i>	Tier-2	B/D; HI; QL (40 ML per 7 day(s))
HECTOROL	Tier-3	B/D

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>heparin (porcine)</i>	Tier-2	B/D; HI
<i>heparin (porcine) in d5w</i>	Tier-2	B/D; HI
<i>heparin (porcine) in nacl (pf)</i>	Tier-2	B/D; HI
<i>heparin(porcine) in 0.45% nacl</i>	Tier-2	B/D; HI
<i>hydromorphone (pf)</i>	Tier-2	HI
<i>imipenem-cilastatin</i>	Tier-2	HI; * Part B
INVANZ	Tier-3	HI; * Part B
<i>isoniazid</i>	Tier-2	HI
<i>kanamycin</i>	Tier-2	HI; * Part B
<i>lactated ringers iv</i>	Tier-2	HI
LEVAQUIN IN D5W	Tier-3	HI; * Part B
<i>levocarnitine</i>	Tier-2	B/D; HI
<i>levofloxacin in d5w</i>	Tier-2	HI; * Part B
<i>lidocaine (pf)</i>	Tier-2	HI
LINCOCIN	Tier-3	HI; * Part B
<i>meropenem</i>	Tier-2	HI; * Part B
MERREM	Tier-3	HI; * Part B
<i>methadone</i>	Tier-2	HI
<i>methotrexate sodium (pf)</i>	Tier-2	HI
<i>metoprolol tartrate</i>	Tier-2	HI
<i>metronidazole in nacl (iso-os)</i>	Tier-2	HI; * Part B
MYCAMINE	Tier-3	HI; * Part B
<i>nafcillin</i>	Tier-2	HI; * Part B
<i>nafcillin in dextrose iso-osm</i>	Tier-2	HI; * Part B
<i>ondansetron hcl (pf)</i>	Tier-2	B/D; HI
<i>oxacillin</i>	Tier-2	HI; * Part B
<i>oxacillin in dextrose(iso-osm)</i>	Tier-2	HI; * Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>pamidronate</i>	Tier-2	HI
<i>pantoprazole</i>	Tier-2	
<i>penicillin g pot in dextrose</i>	Tier-2	HI; * Part B
<i>penicillin g potassium</i>	Tier-2	HI; * Part B
<i>penicillin g sodium</i>	Tier-2	HI; * Part B
PFIZERPEN-G	Tier-3	HI; * Part B
<i>piperacillin-tazobactam</i>	Tier-2	HI; * Part B
<i>polymyxin b sulfate</i>	Tier-2	HI; * Part B
<i>potassium chloride</i>	Tier-2	HI
PRIMAXIN IV	Tier-3	HI; * Part B
PROGRAF IV	Tier-3	B/D; HI
PROTONIX IV	Tier-3	
Remodulin	Tier-5	PA
RETROVIR IV	Tier-3	HI
<i>sulfamethoxazole-trimethoprim</i>	Tier-2	HI
SYNERCID	Tier-3	HI; * Part B
TEFLARO	Tier-3	HI; * Part B
TIMENTIN	Tier-3	HI; * Part B
<i>tobramycin in 0.9 % nacl</i>	Tier-2	HI; * Part B
<i>tobramycin sulfate</i>	Tier-2	HI; * Part B
TYGACIL	Tier-3	HI; * Part B
<i>valproate sodium</i>	Tier-2	HI
<i>vancomycin</i>	Tier-2	B/D; HI
VFEND IV	Tier-3	HI; * Part B
VIBATIV	Tier-3	HI; * Part B
VISTIDE	Tier-3	HI; * Part B
<i>voriconazole</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
ZEMPLAR	Tier-3	HI
ZINACEF	Tier-3	HI; * Part B
ZINACEF IN DEXTROSE (ISO-OSM)	Tier-3	HI; * Part B
ZINACEF IN STERILE WATER	Tier-3	HI; * Part B
ZOSYN	Tier-3	HI; * Part B
ZOSYN IN DEXTROSE (ISO-OSM)	Tier-3	HI; * Part B
Zyvox	Tier-5	HI; * Part B
ELECTROLYTES		
<i>ammonium chloride</i>	Tier-2	HI
<i>d10 % & 0.45 % sodium chloride</i>	Tier-2	HI
<i>d2.5 %-0.45 % sodium chloride</i>	Tier-2	HI
<i>d5 % and 0.9 % sodium chloride</i>	Tier-2	HI
<i>d5 %-0.45 % sodium chloride</i>	Tier-2	HI
<i>dextrose 10 % & 0.2 % nacl</i>	Tier-2	HI
<i>dextrose 10 % in water (d10w)</i>	Tier-2	HI
<i>dextrose 5 % in water (d5w)</i>	Tier-2	HI
<i>dextrose 5%-0.2 % sod chloride</i>	Tier-2	HI
<i>dextrose 5%-0.3 % sod.chloride</i>	Tier-2	HI
<i>dextrose 5%-lactated ringers</i>	Tier-2	HI
IONOSOL-B IN D5W	Tier-3	HI
IONOSOL-MB IN D5W	Tier-3	HI
ISOLYTE-H IN D5W	Tier-3	HI
ISOLYTE-M IN D5W	Tier-3	HI
ISOLYTE-P IN D5W	Tier-3	HI
ISOLYTE-S	Tier-3	HI
ISOLYTE-S IN D5W	Tier-3	HI
NORMOSOL-M IN D5W	Tier-3	HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
NORMOSOL-R IN D5W	Tier-3	HI
NORMOSOL-R PH 7.4	Tier-3	HI
PLASMA-LYTE 148	Tier-3	HI
PLASMA-LYTE A	Tier-3	HI
PLASMA-LYTE-56 IN D5W	Tier-3	HI
<i>potassium chlorid-d5-0.45%nacl</i>	Tier-2	HI
<i>potassium chloride</i>	Tier-2	HI
<i>potassium chloride in 0.9%nacl</i>	Tier-2	HI
<i>potassium chloride in d5w</i>	Tier-2	HI
<i>potassium chloride in lr-d5</i>	Tier-2	HI
<i>potassium chloride-0.45 % nacl</i>	Tier-2	HI
<i>potassium chloride-d5-0.2%nacl</i>	Tier-2	HI
<i>potassium chloride-d5-0.3%nacl</i>	Tier-2	HI
<i>potassium chloride-d5-0.9%nacl</i>	Tier-2	HI
<i>ringers iv</i>	Tier-2	HI
<i>sodium chloride</i>	Tier-2	HI
<i>sodium chloride 0.45 %</i>	Tier-2	HI
<i>sodium chloride 0.9 %</i>	Tier-2	HI
<i>sodium chloride 3 %</i>	Tier-2	HI
<i>sodium chloride 5 %</i>	Tier-2	HI
<i>sodium lactate</i>	Tier-2	HI
IV NUTRITION		
AMINOSYN 8.5 %-ELECTROLYTES	Tier-3	B/D; HI
AMINOSYN II 10 %	Tier-3	B/D; HI
AMINOSYN II 15%	Tier-3	B/D; HI
AMINOSYN II 7 %	Tier-3	B/D; HI
AMINOSYN II 8.5 %	Tier-3	B/D; HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
AMINOSYN II 8.5 %-ELECTROLYTES	Tier-3	B/D; HI
AMINOSYN M 3.5 %	Tier-3	B/D; HI
AMINOSYN-HBC 7%	Tier-3	B/D; HI
AMINOSYN-PF 10 %	Tier-3	B/D; HI
AMINOSYN-PF 7 % (SULFITE-FREE)	Tier-3	B/D; HI
CLINIMIX 5%/D15W SULFITE FREE	Tier-3	B/D; HI
CLINIMIX 5%/D25W SULFITE FREE	Tier-3	B/D; HI
CLINIMIX 2.75%/D5W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX 4.25%/D10W SULF FREE	Tier-3	B/D; HI
CLINIMIX 4.25%/D20W SULF FREE	Tier-3	B/D; HI
CLINIMIX 4.25%/D25W SULF FREE	Tier-3	B/D; HI
CLINIMIX 4.25%/D5W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX 5%/D20W SULFITE FREE	Tier-3	B/D; HI
CLINIMIX E 2.75%/D10W SUL FREE	Tier-3	B/D; HI
CLINIMIX E 2.75%/D5W SULF FREE	Tier-3	B/D; HI
CLINIMIX E 4.25%/D25W SUL FREE	Tier-3	B/D; HI
CLINIMIX E 4.25%/D5W SULF FREE	Tier-3	B/D; HI
CLINIMIX E 5%/D15W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX E 5%/D20W SULFIT FREE	Tier-3	B/D; HI
CLINIMIX E 5%/D25W SULFIT FREE	Tier-3	B/D; HI
CLINISOL SF 15 %	Tier-3	B/D; HI
FREAMINE III 3 %-ELECTROLYTES	Tier-3	B/D; HI
FREAMINE III 8.5 %	Tier-3	B/D; HI
HEPATAMINE 8%	Tier-3	B/D; HI
HEPATASOL 8 %	Tier-3	B/D; HI
INTRALIPID	Tier-3	B/D; HI
NEPHRAMINE 5.4 %	Tier-3	B/D; HI

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
PREMASOL 10 %	Tier-3	B/D; HI
PREMASOL 6 %	Tier-3	B/D; HI
PROCALAMINE 3%	Tier-3	B/D; HI
PROSOL 20%	Tier-3	B/D; HI
<i>tpn electrolytes</i>	Tier-2	B/D; HI
TRAVASOL 10 %	Tier-3	B/D; HI
TROPHAMINE 10 %	Tier-3	B/D; HI
TROPHAMINE 6%	Tier-3	B/D; HI
HORMONES		
ADRENAL CORTICOSTEROIDS		
<i>a-hydrocort</i>	Tier-2	
<i>cortisone</i>	Tier-2	
DEPO-MEDROL	Tier-3	
<i>dexamethasone oral elixir</i>	Tier-2	
<i>dexamethasone tablet</i>	Tier-1	
<i>dexamethasone intensol</i>	Tier-2	
<i>dexpak 13 day</i>	Tier-2	
<i>fludrocortisone</i>	Tier-2	
<i>hydrocortisone</i>	Tier-2	
LYSODREN	Tier-3	
<i>methylprednisolone</i>	Tier-2	Transplant
<i>methylprednisolone acetate</i>	Tier-2	
<i>methylprednisolone sodium succ</i>	Tier-2	Transplant
MILLIPRED	Tier-4	Transplant
ORAPRED	Tier-4	Transplant
ORAPRED ODT	Tier-4	Transplant
<i>prednisolone sodium phosphate</i>	Tier-2	Transplant

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>prednisone oral solution</i>	Tier-2	Transplant
<i>prednisone tablet</i>	Tier-1	Transplant
PREDNISONE INTENSOL	Tier-4	Transplant
SOLU-CORTEF (PF)	Tier-4	
SOLU-MEDROL (PF)	Tier-4	Transplant
VERIPRED 20	Tier-4	Transplant
ANDROGENS		
ANDROGEL	Tier-3	
ANDROXY	Tier-4	
<i>danazol</i>	Tier-2	
DELATESTRYL	Tier-4	
DEPO-TESTOSTERONE	Tier-4	
METHITEST	Tier-4	
oxandrolone tablet 10 mg	Tier-5	
<i>oxandrolone tablet 2.5 mg</i>	Tier-2	
STRIANT	Tier-4	
TESTIM	Tier-3	
<i>testosterone cypionate</i>	Tier-2	
<i>testosterone enanthate</i>	Tier-2	
TESTRED	Tier-4	
GONADOTROPIN RELEASING AGONISTS		
ELIGARD	Tier-3	* Part B
FIRMAGON	Tier-3	* Part B
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	Tier-3	* Part B
Lupron Depot intramuscular syringe kit 7.5 mg	Tier-5	* Part B
Lupron Depot (3 Month)	Tier-5	* Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Lupron Depot (4 Month)	Tier-5	* Part B
Lupron Depot (6 Month)	Tier-5	* Part B
Lupron Depot-Ped	Tier-5	* Part B
Lupron Depot-Ped (3 Month)	Tier-5	* Part B
SYNAREL	Tier-3	
TRELSTAR	Tier-3	* Part B
THYROID REPLACEMENT AND ANTITHYROID AGENTS		
<i>levothroid</i>	Tier-1	
<i>levothyroxine</i>	Tier-1	
<i>levoxyl</i>	Tier-1	
<i>liothyronine oral</i>	Tier-2	
<i>methimazole</i>	Tier-2	
<i>propylthiouracil</i>	Tier-2	
SYNTHROID	Tier-4	
THYROLAR-1	Tier-4	
THYROLAR-1/2	Tier-4	
THYROLAR-1/4	Tier-4	
THYROLAR-2	Tier-4	
THYROLAR-3	Tier-4	
TIROSINT	Tier-4	
<i>unithroid</i>	Tier-1	
IMMUNOLOGIC AGENTS		
IMMUNE STIMULANTS		
ACTHIB (PF)	Tier-3	* Part B
Actimmune	Tier-5	
ADACEL (ADOLESCENT &ADULT)(PF)	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Adagen	Tier-5	
AFLURIA 2011-2012	Tier-3	* Part B
AFLURIA 2011-2012 (PF)	Tier-3	* Part B
BOOSTRIX	Tier-3	
Carimune NF Nanofiltered	Tier-5	PA; HI; * Part B
CERVARIX VACCINE (PF)	Tier-3	
COMVAX (PF)	Tier-3	
DAPTACEL (PEDIATRIC) (PF)	Tier-3	
DECAVAC (PF)	Tier-3	
ENGERIX-B (PF)	Tier-3	B/D
ENGERIX-B PEDIATRIC (PF)	Tier-3	B/D
FLUARIX 2011-2012 (PF)	Tier-3	* Part B
FLULAVAL 2011-2012	Tier-3	* Part B
FLUVIRIN 2011-2012	Tier-3	* Part B
FLUVIRIN 2011-2012 (PF)	Tier-3	* Part B
FLUZONE 2011-2012	Tier-3	* Part B
FLUZONE 2011-2012 (PF)	Tier-3	* Part B
FLUZONE HIGH-DOSE 2011-12 (PF)	Tier-3	* Part B
FLUZONE INTRADERM 2011-12 (PF)	Tier-3	* Part B
Gammagard Liquid	Tier-5	PA; HI; * Part B
Gammaplex	Tier-5	PA; HI; * Part B
Gamunex-C	Tier-5	PA; HI; * Part B
GARDASIL (PF)	Tier-3	
HAVRIX (PF)	Tier-3	
HIBERIX (PF)	Tier-3	* Part B
IMOVAX RABIES VACCINE (PF)	Tier-3	
INFANRIX (PF)	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
IPOL	Tier-3	
IXIARO (PF)	Tier-3	
M-M-R II (PF)	Tier-3	
MENACTRA (PF)	Tier-3	
MENOMUNE - A/C/Y/W-135 (PF)	Tier-3	
MENVEO A-C-Y-W-135-DIP (PF)	Tier-3	
PEDVAX HIB (PF)	Tier-3	
PNEUMOVAX 23	Tier-3	* Part B
PREVNAR 13 (PF)	Tier-3	* Part B
Privigen	Tier-5	PA; HI; * Part B
PROQUAD (PF)	Tier-3	
RABAVERT (PF)	Tier-3	
RECOMBIVAX HB (PF)	Tier-3	B/D
ROTATEQ VACCINE	Tier-3	
<i>tetanus toxoid,adsorbed (pf)</i>	Tier-3	
<i>tetanus-diphtheria toxoids-td</i>	Tier-3	
TWINRIX (PF)	Tier-3	
TYPHIM VI	Tier-3	
VAQTA (PF)	Tier-3	
VARIVAX (PF)	Tier-3	
YF-VAX (PF)	Tier-3	
ZOSTAVAX (PF)	Tier-3	
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	Tier-4	B/D
BENLYSTA	Tier-3	PA; * Part B
CELLCEPT ORAL SUSPENSION	Tier-4	B/D
<i>cyclosporine</i>	Tier-2	B/D

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>cyclosporine modified</i>	Tier-2	B/D
<i>gengraf</i>	Tier-2	B/D
<i>mycophenolate mofetil</i>	Tier-2	B/D
MYFORTIC	Tier-4	B/D
NULOJIX	Tier-3	B/D
RAPAMUNE	Tier-3	B/D
Simulect	Tier-5	B/D
<i>tacrolimus capsule 0.5 mg, 1 mg</i>	Tier-2	B/D
tacrolimus capsule 5 mg	Tier-5	B/D
ZORTRESS	Tier-3	B/D; QL (180 EA per 90 day(s))
MISCELLANEOUS DRUGS		
ACROMEGALY		
octreotide acetate injection solution 1,000 mcg/mL, 500 mcg/mL	Tier-5	
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	Tier-2	
Sandostatin injection solution 1,000 mcg/mL, 100 mcg/mL, 200 mcg/mL, 500 mcg/mL	Tier-5	
SANDOSTATIN INJECTION SOLUTION 50 MCG/ML	Tier-3	
Sandostatin LAR Depot	Tier-5	
Somatuline Depot	Tier-5	* Part B
Somavert	Tier-5	PA
AMYOTROPHIC LATERAL SCLEROSIS		
Rilutek	Tier-5	
<i>riluzole</i>	Tier-3	
ANAPHYLAXIS EMERGENCY		
AUVI-Q	Tier-4	QL (2 EA per 7 Day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>epinephrine</i>	Tier-2	QL (2 ML per 7 Day(s))
EPIPEN 2-PAK	Tier-3	QL (2 EA per 7 day(s))
EPIPEN JR 2-PAK	Tier-3	QL (2 EA per 7 day(s))
<i>midodrine</i>	Tier-2	
TWINJECT AUTOINJECTOR	Tier-3	QL (2 EA per 7 day(s))
CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES		
ARCALYST	Tier-3	PA
ILARIS (PF)	Tier-3	PA; * Part B
CUSHING DISEASE		
Signifor	Tier-5	PA
CYSTIC FIBROSIS		
Cayston	Tier-5	
Kalydeco	Tier-5	PA; QL (60 EA per 30 day(s))
Pulmozyme	Tier-5	B/D
Tobi	Tier-5	B/D
Tobi Podhaler	Tier-5	
CYSTINURIA		
CYSTADANE	Tier-3	
DETOXIFICATION AGENTS		
CHEMET	Tier-4	
EXJADE DISPERSIBLE TABLET 125 MG	Tier-3	
Exjade dispersible tablet 250 mg, 500 mg	Tier-5	
FABRY DISEASE		
Fabrazyme	Tier-5	PA; * Part B
GAUCHER DISEASE		
Cerezyme	Tier-5	PA; * Part B

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Elelyso	Tier-5	PA; * Part B
VPRIV	Tier-5	PA; * Part B
Zavesca	Tier-5	PA
GROWTH HORMONE DEFICIENCY		
Egrifta	Tier-5	PA
Genotropin	Tier-5	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	Tier-3	PA
Genotropin Miniquick subcutaneous syringe 0.4 mg/0.25 mL, 0.6 mg/0.25 mL, 0.8 mg/0.25 mL, 1 mg/0.25 mL, 1.2 mg/0.25 mL, 1.4 mg/0.25 mL, 1.6 mg/0.25 mL, 1.8 mg/0.25 mL, 2 mg/0.25 mL	Tier-5	PA
Humatrope injection cartridge 12 (36 unit) mg, 24 (72 unit) mg	Tier-5	PA
HUMATROPE INJECTION CARTRIDGE 6 (18 UNIT) MG	Tier-3	PA
Humatrope solution for injection	Tier-5	PA
Increlex	Tier-5	PA
Norditropin FlexPro	Tier-5	PA
Norditropin Nordiflex	Tier-5	PA
Nutropin	Tier-5	PA
Nutropin AQ	Tier-5	PA
Nutropin AQ Nuspin	Tier-5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE	Tier-3	PA
Omnitrope subcutaneous solution	Tier-5	PA
Saizen	Tier-5	PA
Saizen click.easy	Tier-5	PA
Serostim	Tier-5	PA
TEV-TROPIN	Tier-3	PA

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Zorbtive	Tier-5	PA
HEREDITARY ANGIOEDEMA		
Cinryze	Tier-5	PA; * Part B
Firazyr	Tier-5	PA; QL (3 ML per 7 day(s))
HEREDITARY TYROSINEMIA TYPE 2		
Orfadin	Tier-5	PA
HUNTINGTON DISEASE		
Xenazine tablet 12.5 mg	Tier-5	PA; QL (90 EA per 30 day(s))
Xenazine tablet 25 mg	Tier-5	PA; QL (120 EA per 30 day(s))
HYPERCALCEMIA		
HECTOROL	Tier-3	B/D
SENSIPAR TABLET 30 MG	Tier-3	
Sensipar tablet 60 mg, 90 mg	Tier-5	
HYPERPARATHYROIDISM		
<i>calcitriol</i>	Tier-2	
ZEMPLAR	Tier-3	
MUCOPOLYSACCHARIDOSIS		
Aldurazyme	Tier-5	* Part B
ELAPRASE	Tier-5	* Part B
Naglazyme	Tier-5	* Part B
MULTIPLE SCLEROSIS		
AMPYRA	Tier-3	PA; QL (60 EA per 30 day(s))
Aubagio	Tier-5	PA; QL (28 EA per 28 day(s))
Avonex	Tier-5	QL (4 EA per 30 day(s))
Avonex Administration Pack	Tier-5	QL (4 EA per 30 day(s))
Betaseron	Tier-5	QL (15 EA per 30 day(s))
Copaxone	Tier-5	QL (30 EA per 30 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Extavia	Tier-5	QL (15 EA per 30 day(s))
Gilenya	Tier-5	PA; QL (28 EA per 28 day(s))
Rebif	Tier-5	QL (11 ML per 30 day(s))
Rebif Titration Pack	Tier-5	QL (12 ML per 30 day(s))
Tecfidera capsule,delayed release 120 mg, 240 mg	Tier-5	PA; QL (60 EA per 30 Day(s))
Tecfidera capsule,delayed release 120 mg (14)-240 mg (46)	Tier-5	PA; QL (1 EA per 30 Day(s))
TYSABRI	Tier-5	PA; LA; * Part B
MYASTHENIA GRAVIS		
<i>guanidine</i>	Tier-2	
MESTINON SYRUP	Tier-4	
MESTINON TIMESPAN	Tier-3	
MYTELASE	Tier-4	
<i>pyridostigmine bromide</i>	Tier-2	
PAGET'S DISEASE		
<i>etidronate disodium</i>	Tier-2	
SKELID	Tier-3	
PHENYLKETONURIA		
Kuvan	Tier-5	PA
PHOSPHATE BINDERS		
<i>calcium acetate</i>	Tier-2	
FOSRENOL	Tier-3	
PHOSLYRA	Tier-3	
RENAGEL	Tier-3	
RENVELA	Tier-3	
POMPE DISEASE		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
LUMIZYME	Tier-3	* Part B
Myozyme	Tier-5	* Part B
POTASSIUM BINDER		
KAYEXALATE	Tier-4	
<i>kionex</i>	Tier-2	
<i>sodium polystyrene (sorb free)</i>	Tier-2	
PULMONARY HYPERTENSION		
Adcirca	Tier-5	PA; QL (60 EA per 30 day(s))
Letairis	Tier-5	PA
REVATIO IV	Tier-3	* Part B
Revatio oral	Tier-5	PA; QL (90 EA per 30 day(s))
sildenafil	Tier-5	PA; QL (90 EA per 30 day(s))
Tracleer	Tier-5	PA; LA
Ventavis	Tier-5	PA; LA; * Part B
RESPIRATORY SYNCYTIAL VIRUS		
Synagis	Tier-5	* Part B
SMOKING CESSATION		
<i>buproban</i>	Tier-2	
CHANTIX	Tier-4	QL (60 EA per 30 day(s))
CHANTIX STARTING MONTH BOX	Tier-4	QL (53 EA per 30 day(s))
NICOTROL	Tier-3	
NICOTROL NS	Tier-4	
SYMPTOMATIC BENIGN PROSTATIC HYPERPLASIA		
<i>alfuzosin</i>	Tier-2	
AVODART	Tier-3	
CIALIS	Tier-4	PA; QL (30 EA per 30 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>finasteride</i>	Tier-2	
JALYN	Tier-3	
<i>tamsulosin</i>	Tier-2	
UROLOGIC DISORDERS		
<i>bethanechol chloride</i>	Tier-2	
<i>desmopressin</i>	Tier-2	
DETROL LA	Tier-4	STPA
ELMIRON	Tier-4	
ENABLEX	Tier-4	STPA
<i>flavoxate</i>	Tier-2	
GELNIQUE	Tier-3	
MYRBETRIQ	Tier-4	STPA
<i>oxybutynin chloride er tablet, extended release 24 hr</i>	Tier-2	
<i>oxybutynin chloride syrup</i>	Tier-2	
<i>oxybutynin chloride tablet</i>	Tier-1	
OXYTROL	Tier-3	
<i>potassium citrate</i>	Tier-2	
SAMSCA	Tier-4	QL (14 EA per 7 day(s))
SANCTURA XR	Tier-4	
<i>trospium er capsule, extended release 24 hr</i>	Tier-3	
<i>trospium tablet</i>	Tier-2	
UROCIT-K 10	Tier-4	
UROCIT-K 15	Tier-4	
UROCIT-K 5	Tier-4	
VESICARE	Tier-3	
WILSON'S DISEASE		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
DEPEN TITRATABS	Tier-3	
SYPRINE	Tier-3	
NEUROLOGICAL DRUGS		
ALZHEIMERS DISEASE		
<i>donepezil</i>	Tier-2	
<i>ergoloid</i>	Tier-2	
EXELON ORAL SOLUTION	Tier-4	
EXELON TRANSDERMAL	Tier-4	
<i>galantamine</i>	Tier-2	
NAMENDA	Tier-3	
NAMENDA TITRATION PAK	Tier-3	
NAMENDA XR	Tier-3	
<i>rivastigmine</i>	Tier-2	
MIGRAINE THERAPY		
<i>butalbital-acetaminop-caf-cod</i>	Tier-2	QL (360 EA per 30 day(s))
<i>dihydroergotamine</i>	Tier-2	
MIGERGOT	Tier-3	
MIGRANAL	Tier-4	QL (8 ML per 30 day(s))
<i>naratriptan</i>	Tier-2	QL (9 EA per 30 day(s))
<i>rizatriptan</i>	Tier-2	QL (9 EA per 30 day(s))
<i>sumatriptan subcutaneous</i>	Tier-2	QL (4 ML per 30 day(s))
<i>sumatriptan succinate oral</i>	Tier-2	QL (9 EA per 30 day(s))
PARKINSONS DISEASE		
APOKYN	Tier-5	
AZILECT	Tier-3	
<i>benztropine</i>	Tier-1	
<i>bromocriptine</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>cabergoline</i>	Tier-2	
<i>carbidopa-levodopa</i>	Tier-2	
COMTAN	Tier-3	
CYCLOSET	Tier-3	
<i>entacapone</i>	Tier-2	
LODOSYN	Tier-3	
MIRAPEX ER	Tier-4	
NEUPRO	Tier-4	QL (30 EA per 30 day(s))
<i>pramipexole</i>	Tier-2	
<i>ropinirole</i>	Tier-2	
<i>selegiline hcl</i>	Tier-2	
STALEVO 100	Tier-3	
STALEVO 125	Tier-3	
STALEVO 150	Tier-3	
STALEVO 200	Tier-3	
STALEVO 50	Tier-3	
STALEVO 75	Tier-3	
TASMAR	Tier-3	
<i>trihexyphenidyl</i>	Tier-1	
PSEUDOBULBAR AFFECT		
NUEDEXTA	Tier-3	PA
SEIZURES		
BANZEL ORAL SUSPENSION	Tier-3	PA; QL (2400 ML per 30 day(s))
BANZEL TABLET 200 MG	Tier-3	PA; QL (1440 EA per 90 day(s))
BANZEL TABLET 400 MG	Tier-3	PA; QL (720 EA per 90 day(s))
<i>carbamazepine chewable tablet</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>carbamazepine er capsule,extended release mphase12hr</i>	Tier-2	
<i>carbamazepine er tablet,extended release,12 hr</i>	Tier-2	
<i>carbamazepine oral suspension</i>	Tier-2	
<i>carbamazepine tablet</i>	Tier-1	
CELONTIN	Tier-4	
<i>clonazepam</i>	Tier-2	
<i>diazepam oral</i>	Tier-2	
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 5-7.5-10 mg</i>	Tier-2	
<i>diazepam intensol</i>	Tier-2	
DILANTIN	Tier-3	
DILANTIN INFATABS	Tier-3	
<i>divalproex</i>	Tier-2	
<i>epitol</i>	Tier-1	
<i>ethosuximide</i>	Tier-2	
<i>felbamate</i>	Tier-2	
<i>gabapentin</i>	Tier-2	
GABITRIL	Tier-3	
LAMICTAL ODT	Tier-4	
LAMICTAL XR	Tier-4	
<i>lamotrigine chewable dispersible tablet</i>	Tier-2	
<i>lamotrigine er tablet,extended release 24 hr</i>	Tier-3	
<i>lamotrigine tablet</i>	Tier-2	
<i>levetiracetam</i>	Tier-2	
LYRICA CAPSULE	Tier-4	STPA
LYRICA ORAL SOLUTION	Tier-3	STPA

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
ONFI ORAL SUSPENSION	Tier-4	QL (480 ML per 30 Day(s))
ONFI TABLET	Tier-4	QL (60 EA per 30 day(s))
<i>oxcarbazepine</i>	Tier-2	
PEGANONE	Tier-4	
<i>phenobarbital</i>	Tier-2	
<i>phenytoin</i>	Tier-2	
<i>phenytoin sodium</i>	Tier-2	
<i>phenytoin sodium extended</i>	Tier-2	
POTIGA	Tier-4	PA
<i>primidone</i>	Tier-2	
Sabril	Tier-5	
SAVELLA TABLET	Tier-3	STPA; QL (180 EA per 90 day(s))
STAVZOR	Tier-4	
TEGRETOL XR TABLET,EXTENDED RELEASE 100 MG	Tier-3	
<i>tiagabine</i>	Tier-2	
<i>topiramate</i>	Tier-2	
TRILEPTAL ORAL SUSPENSION	Tier-4	
<i>valproic acid</i>	Tier-2	
<i>valproic acid (as sodium salt)</i>	Tier-2	
VIMPAT IV	Tier-4	* Part B
VIMPAT ORAL SOLUTION	Tier-4	PA; QL (1200 ML per 30 day(s))
VIMPAT TABLET	Tier-4	PA; QL (180 EA per 90 day(s))
<i>zonisamide</i>	Tier-2	
SPASTICITY		
<i>baclofen</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>cyclobenzaprine er capsule,extended release 24 hr</i>	Tier-2	
<i>cyclobenzaprine tablet</i>	Tier-1	
<i>dantrolene</i>	Tier-2	
<i>tizanidine</i>	Tier-2	
PAIN AND INFLAMMATORY DISEASES		
ARTHRITIS		
Actemra	Tier-5	PA; * Part B
ARTHROTEC 50	Tier-4	
ARTHROTEC 75	Tier-4	
AZASAN	Tier-4	B/D
<i>azathioprine</i>	Tier-2	B/D
CELEBREX	Tier-4	PA
<i>diclofenac potassium</i>	Tier-1	
<i>diclofenac sodium</i>	Tier-1	
<i>diclofenac-misoprostol</i>	Tier-2	
Enbrel subcutaneous kit	Tier-5	PA; QL (8 EA per 30 day(s))
Enbrel subcutaneous syringe 25 mg/0.5mL (0.51)	Tier-5	PA; QL (8.16 ML per 30 day(s))
Enbrel subcutaneous syringe 50 mg/mL (0.98 mL)	Tier-5	PA; QL (7.84 ML per 30 day(s))
<i>fenoprofen</i>	Tier-2	
<i>flurbiprofen</i>	Tier-2	
Humira	Tier-5	PA; QL (6 EA per 30 day(s))
Humira Crohn's Dis Start Pck	Tier-5	PA; QL (1 EA per 365 day(s))
INDOCIN	Tier-4	
<i>indomethacin</i>	Tier-1	
Kineret	Tier-5	PA; QL (20.1 ML per 30 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>leflunomide</i>	Tier-2	
<i>meclofenamate</i>	Tier-2	
<i>meloxicam</i>	Tier-1	
<i>methotrexate sodium</i>	Tier-2	B/D
<i>nabumetone</i>	Tier-2	
NALFON	Tier-4	
Orencia IV	Tier-5	PA; * Part B
Orencia subcutaneous	Tier-5	PA; QL (4 ML per 30 day(s))
PENNSAID	Tier-4	QL (450 ML per 30 day(s))
<i>piroxicam</i>	Tier-2	
Remicade	Tier-5	PA; * Part B
RIDAURA	Tier-3	
Simponi	Tier-5	PA; QL (0.5 ML per 30 day(s))
<i>sulindac</i>	Tier-2	
<i>tolmetin</i>	Tier-2	
TREXALL	Tier-4	B/D
VOLTAREN TOP	Tier-4	QL (200 GM per 1 day(s))
Xeljanz	Tier-5	PA; QL (60 EA per 30 day(s))
GOUT		
<i>allopurinol</i>	Tier-1	
<i>colchicine-probenecid</i>	Tier-2	
COLCRYS	Tier-3	QL (60 EA per 30 day(s))
<i>probenecid</i>	Tier-2	
ULORIC	Tier-4	STPA
PAIN, NSAID ANALGESICS		
<i>diflunisal</i>	Tier-2	
<i>etodolac</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>ibuprofen oral suspension</i>	Tier-2	
<i>ibuprofen tablet</i>	Tier-1	
<i>ketoprofen</i>	Tier-2	
<i>mefenamic acid</i>	Tier-2	
<i>naproxen oral suspension</i>	Tier-2	
<i>naproxen tablet</i>	Tier-1	
<i>naproxen tablet, delayed release</i>	Tier-1	
<i>naproxen sodium</i>	Tier-1	
PAIN, OPIOID AND OTHER ANALGESICS		
ABSTRAL	Tier-4	QL (32 EA per 30 day(s))
<i>acetaminophen-codeine oral solution</i>	Tier-2	QL (5000 ML per 30 day(s))
<i>acetaminophen-codeine tablet 300-15 mg</i>	Tier-2	QL (300 EA per 30 day(s))
<i>acetaminophen-codeine tablet 300-30 mg, 300-60 mg</i>	Tier-2	QL (400 EA per 30 day(s))
<i>butorphanol tartrate</i>	Tier-2	QL (7.5 ML per 30 day(s))
BUTRANS	Tier-4	QL (4 EA per 30 day(s))
<i>co-gesic</i>	Tier-2	QL (240 EA per 30 day(s))
<i>codeine sulfate</i>	Tier-2	QL (180 EA per 30 day(s))
<i>dihydrocode-acetaminophen-caff</i>	Tier-2	QL (168 EA per 30 day(s))
DILAUDID ORAL LIQUID	Tier-4	QL (1440 ML per 30 day(s))
<i>endocet tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier-2	QL (360 EA per 30 day(s))
<i>endocet tablet 10-650 mg</i>	Tier-2	QL (180 EA per 30 day(s))
<i>endocet tablet 7.5-500 mg</i>	Tier-2	QL (240 EA per 30 day(s))
<i>endodan</i>	Tier-2	QL (360 EA per 30 day(s))
<i>fentanyl</i>	Tier-2	QL (10 EA per 30 day(s))
<i>fentanyl citrate</i>	Tier-2	QL (120 EA per 30 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5 ml</i>	Tier-2	QL (5540 ML per 30 day(s))
<i>hydrocodone-acetaminophen oral solution 7.5-500 mg/15 ml</i>	Tier-2	QL (3600 ML per 30 day(s))
<i>hydrocodone-acetaminophen tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	Tier-2	QL (400 EA per 30 day(s))
<i>hydrocodone-acetaminophen tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier-2	QL (360 EA per 30 day(s))
<i>hydrocodone-acetaminophen tablet 10-500 mg, 2.5-500 mg, 5-500 mg, 7.5-500 mg</i>	Tier-2	QL (240 EA per 30 day(s))
<i>hydrocodone-acetaminophen tablet 10-650 mg, 7.5-650 mg</i>	Tier-2	QL (185 EA per 30 day(s))
<i>hydrocodone-acetaminophen tablet 10-660 mg</i>	Tier-2	QL (181 EA per 30 day(s))
<i>hydrocodone-acetaminophen tablet 10-750 mg, 7.5-750 mg</i>	Tier-2	QL (160 EA per 30 day(s))
<i>hydrocodone-ibuprofen</i>	Tier-2	QL (480 EA per 30 day(s))
<i>hydromorphone</i>	Tier-2	QL (360 EA per 30 day(s))
<i>ibuprofen-oxycodone</i>	Tier-2	QL (240 EA per 30 day(s))
<i>levorphanol tartrate</i>	Tier-2	QL (240 EA per 30 day(s))
<i>methadone oral concentrate</i>	Tier-2	QL (360 ML per 30 day(s))
<i>methadone oral solution 10 mg/5 ml</i>	Tier-2	QL (1800 ML per 30 day(s))
<i>methadone oral solution 5 mg/5 ml</i>	Tier-2	QL (3600 ML per 30 day(s))
<i>methadone tablet</i>	Tier-2	QL (120 EA per 30 day(s))
<i>methadose</i>	Tier-2	QL (120 EA per 30 day(s))
<i>morphine er capsule,extended release pellets</i>	Tier-2	QL (90 EA per 30 day(s))
<i>morphine er tablet,extended release</i>	Tier-2	QL (90 EA per 30 day(s))
<i>morphine oral solution</i>	Tier-2	QL (360 ML per 30 day(s))
<i>morphine tablet</i>	Tier-2	QL (180 EA per 30 day(s))
<i>morphine concentrate</i>	Tier-2	QL (360 ML per 30 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>oxycodone capsule</i>	Tier-2	QL (360 EA per 30 day(s))
<i>oxycodone oral concentrate</i>	Tier-2	QL (120 ML per 30 day(s))
<i>oxycodone oral solution</i>	Tier-2	QL (240 ML per 30 day(s))
<i>oxycodone tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	Tier-2	QL (180 EA per 30 day(s))
<i>oxycodone tablet 5 mg</i>	Tier-2	QL (360 EA per 30 day(s))
<i>oxycodone-acetaminophen capsule</i>	Tier-2	QL (240 EA per 30 day(s))
<i>oxycodone-acetaminophen tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier-2	QL (360 EA per 30 day(s))
<i>oxycodone-acetaminophen tablet 10-650 mg</i>	Tier-2	QL (180 EA per 30 day(s))
<i>oxycodone-acetaminophen tablet 7.5-500 mg</i>	Tier-2	QL (240 EA per 30 day(s))
<i>oxycodone-aspirin</i>	Tier-2	QL (360 EA per 30 day(s))
OXYCONTIN	Tier-3	QL (120 EA per 30 day(s))
<i>oxymorphone er tablet, extended release, 12 hr</i>	Tier-3	QL (60 EA per 30 Day(s))
<i>oxymorphone tablet</i>	Tier-2	QL (180 EA per 30 day(s))
<i>pentazocine-acetaminophen</i>	Tier-2	QL (185 EA per 30 day(s))
ROXICET ORAL SOLUTION	Tier-4	QL (1850 ML per 30 day(s))
ROXICET TABLET	Tier-4	QL (240 EA per 30 day(s))
SUBSYS	Tier-4	QL (120 EA per 30 day(s))
<i>tramadol</i>	Tier-2	
<i>tramadol-acetaminophen</i>	Tier-2	QL (360 EA per 30 day(s))
ZYDONE	Tier-4	QL (300 EA per 30 day(s))
PSYCHIATRIC		
ALCOHOL DETERRENTS		
<i>acamprosate</i>	Tier-2	
CAMPRAL	Tier-3	
<i>disulfiram</i>	Tier-2	
<i>naltrexone</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
ANXIETY		
<i>alprazolam</i>	Tier-2	
<i>alprazolam intensol</i>	Tier-2	
<i>amitriptyline-chlordiazepoxide</i>	Tier-2	
<i>buspirone</i>	Tier-1	
<i>clorazepate dipotassium</i>	Tier-2	
<i>lorazepam</i>	Tier-2	
<i>lorazepam intensol</i>	Tier-2	
<i>meprobamate</i>	Tier-2	
<i>oxazepam</i>	Tier-2	
ATTENTION DEFICIT DISORDER		
ADDERALL XR	Tier-4	STPA
<i>amphetamine salt combo</i>	Tier-2	
CONCERTA	Tier-4	STPA
DAYTRANA	Tier-3	STPA
DESOXYN	Tier-4	
DEXEDRINE SPANSULE	Tier-4	
<i>dexmethylphenidate</i>	Tier-2	
<i>dextroamphetamine</i>	Tier-2	
<i>dextroamphetamine-amphetamine</i>	Tier-2	
FOCALIN XR	Tier-3	STPA
INTUNIV ER	Tier-4	QL (90 EA per 90 day(s))
METADATE CD	Tier-4	
METADATE ER	Tier-4	
<i>methamphetamine</i>	Tier-2	
METHYLIN CHEWABLE TABLET	Tier-3	
<i>methylphenidate</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
QUILLIVANT XR	Tier-4	STPA
STRATTERA CAPSULE 10 MG, 18 MG, 25 MG, 40 MG, 60 MG	Tier-3	QL (60 EA per 30 day(s))
STRATTERA CAPSULE 100 MG, 80 MG	Tier-3	QL (30 EA per 30 day(s))
VYVANSE	Tier-4	STPA
BIPOLAR DISORDER		
EQUETRO	Tier-4	
<i>lithium carbonate</i>	Tier-1	
<i>lithium citrate</i>	Tier-2	
<i>olanzapine-fluoxetine</i>	Tier-2	STPA
RISPERDAL CONSTA	Tier-3	* Part B
<i>risperidone</i>	Tier-2	
SYMBYAX	Tier-3	STPA
DEPRESSION		
<i>amitriptyline</i>	Tier-1	
<i>amoxapine</i>	Tier-2	
APLENZIN	Tier-4	STPA
<i>budeprion sr</i>	Tier-2	
<i>bupropion hcl</i>	Tier-2	
<i>citalopram</i>	Tier-1	
<i>clomipramine</i>	Tier-2	
CYMBALTA CAPSULE,DELAYED RELEASE 20 MG, 30 MG	Tier-4	STPA; QL (60 EA per 30 day(s))
CYMBALTA CAPSULE,DELAYED RELEASE 60 MG	Tier-4	STPA; QL (120 EA per 30 Day(s))
<i>desipramine</i>	Tier-2	
<i>desvenlafaxine</i>	Tier-3	
<i>doxepin capsule</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>doxepin oral concentrate</i>	Tier-2	
EMSAM	Tier-4	STPA
<i>escitalopram</i>	Tier-3	
<i>fluoxetine capsule</i>	Tier-1	
<i>fluoxetine capsule, delayed release</i>	Tier-1	
<i>fluoxetine oral solution</i>	Tier-2	
<i>fluoxetine tablet 10 mg, 20 mg</i>	Tier-1	
<i>fluoxetine tablet 60 mg</i>	Tier-2	
<i>fluvoxamine</i>	Tier-2	
<i>imipramine hcl</i>	Tier-2	
<i>imipramine pamoate</i>	Tier-2	
LEXAPRO	Tier-4	STPA
LUVOX CR	Tier-4	STPA
<i>maprotiline</i>	Tier-2	
MARPLAN	Tier-4	
<i>mirtazapine</i>	Tier-2	
<i>nefazodone</i>	Tier-2	
<i>nortriptyline</i>	Tier-1	
OLEPTRO ER	Tier-4	STPA
<i>paroxetine hcl</i>	Tier-1	
PAXIL ORAL SUSPENSION	Tier-4	
PEXEVA	Tier-4	STPA
<i>phenelzine</i>	Tier-2	
PRISTIQ	Tier-3	STPA
<i>protriptyline</i>	Tier-2	
<i>sertraline</i>	Tier-2	
<i>tranylcypromine</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>trazodone</i>	Tier-1	
<i>trimipramine</i>	Tier-2	
<i>venlafaxine er capsule,extended release 24 hr</i>	Tier-2	
VENLAFAXINE ER TABLET,EXTENDED RELEASE 24 HR	Tier-4	STPA
<i>venlafaxine tablet</i>	Tier-2	
VIIBRYD	Tier-4	STPA
VIVACTIL	Tier-4	
INSOMNIA		
<i>estazolam</i>	Tier-2	
<i>flurazepam</i>	Tier-2	
LUNESTA	Tier-4	STPA; QL (30 EA per 30 day(s))
ROZEREM	Tier-4	STPA; QL (30 EA per 30 day(s))
<i>temazepam</i>	Tier-2	
<i>triazolam</i>	Tier-2	
<i>zaleplon</i>	Tier-2	QL (30 EA per 30 day(s))
<i>zolpidem er tablet,extended release,multiphase</i>	Tier-2	STPA; QL (30 EA per 30 day(s))
<i>zolpidem tablet</i>	Tier-2	QL (30 EA per 30 day(s))
NARCOLEPSY		
<i>modafinil</i>	Tier-2	STPA
PROVIGIL	Tier-4	STPA
Xyrem	Tier-5	LA
OPIOID ANTAGONISTS		
BUPRENORPHINE-NALOXONE	Tier-4	PA; QL (90 EA per 30 Day(s))
<i>naloxone</i>	Tier-2	
SUBOXONE	Tier-4	PA
ZUBSOLV	Tier-4	PA; QL (90 EA per 30 Day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
PSYCHOSES		
ABILIFY IM	Tier-3	* Part B
ABILIFY ORAL	Tier-4	STPA
ABILIFY DISCMELT	Tier-4	STPA
ABILIFY MAINTENA	Tier-3	* Part B
<i>chlorpromazine</i>	Tier-2	
<i>clozapine</i>	Tier-2	
FANAPT	Tier-4	
FAZACLO	Tier-3	
<i>fluphenazine decanoate</i>	Tier-2	
<i>fluphenazine hcl</i>	Tier-2	
GEODON IM	Tier-4	* Part B
GEODON ORAL	Tier-4	STPA
<i>haloperidol</i>	Tier-1	
<i>haloperidol decanoate</i>	Tier-2	
<i>haloperidol lactate</i>	Tier-2	
INVEGA	Tier-4	STPA
INVEGA SUSTENNA	Tier-3	* Part B
LATUDA TABLET 120 MG	Tier-4	
LATUDA TABLET 20 MG, 40 MG, 80 MG	Tier-4	QL (30 EA per 30 day(s))
<i>loxapine succinate</i>	Tier-2	
<i>olanzapine im</i>	Tier-2	* Part B
<i>olanzapine oral</i>	Tier-2	STPA
ORAP	Tier-3	
<i>perphenazine</i>	Tier-2	
<i>perphenazine-amitriptyline</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>quetiapine tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	Tier-3	STPA
<i>quetiapine tablet 25 mg, 50 mg</i>	Tier-3	STPA; QL (60 EA per 30 day(s))
<i>risperidone</i>	Tier-2	
SAPHRIS	Tier-4	
SEROQUEL TABLET 100 MG, 200 MG, 300 MG, 400 MG	Tier-4	STPA
SEROQUEL TABLET 25 MG, 50 MG	Tier-4	STPA; QL (60 EA per 30 day(s))
SEROQUEL XR	Tier-3	STPA
<i>thioridazine</i>	Tier-1	
<i>thiothixene</i>	Tier-1	
<i>trifluoperazine</i>	Tier-2	
<i>ziprasidone hcl</i>	Tier-2	STPA
ZYPREXA IM	Tier-4	* Part B
RESPIRATORY DRUGS		
ASTHMA		
ADVAIR DISKUS	Tier-3	QL (180 EA per 90 day(s))
ADVAIR HFA	Tier-3	QL (72 GM per 90 day(s))
<i>albuterol sulfate oral</i>	Tier-1	
<i>albuterol sulfate solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %)</i>	Tier-2	B/D; QL (1080 ML per 90 day(s))
<i>albuterol sulfate solution for nebulization 5 mg/ml</i>	Tier-2	B/D; QL (180 ML per 90 day(s))
ALVESCO AEROSOL INHALER 160 MCG/ACTUATION	Tier-4	QL (36.6 GM per 90 day(s))
ALVESCO AEROSOL INHALER 80 MCG/ACTUATION	Tier-4	QL (18.3 GM per 90 day(s))
<i>aminophylline</i>	Tier-2	
ASMANEX TWISTHALER	Tier-3	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
ATROVENT HFA	Tier-3	QL (77.4 GM per 90 day(s))
BROVANA	Tier-4	B/D; QL (360 ML per 90 day(s))
<i>budesonide</i>	Tier-2	B/D; QL (720 ML per 90 day(s))
COMBIVENT	Tier-3	QL (88.2 GM per 90 day(s))
COMBIVENT RESPIMAT	Tier-3	QL (24 GM per 90 day(s))
<i>cromolyn</i>	Tier-2	B/D; QL (720 ML per 90 day(s))
<i>elixophyllin</i>	Tier-2	
FLOVENT DISKUS	Tier-3	QL (360 EA per 90 day(s))
FLOVENT HFA AEROSOL INHALER 110 MCG/ACTUATION, 220 MCG/ACTUATION	Tier-3	QL (72 GM per 90 day(s))
FLOVENT HFA AEROSOL INHALER 44 MCG/ACTUATION	Tier-3	QL (63.6 GM per 90 day(s))
FORADIL AEROLIZER	Tier-4	QL (180 EA per 90 day(s))
<i>ipratropium bromide</i>	Tier-2	B/D; QL (900 ML per 90 day(s))
<i>ipratropium-albuterol</i>	Tier-2	B/D; QL (1620 ML per 90 day(s))
<i>levalbuterol hcl</i>	Tier-2	B/D; QL (270 EA per 90 day(s))
LUFYLLIN	Tier-4	
MAXAIR AUTOHALER	Tier-4	QL (42 GM per 90 day(s))
<i>metaproterenol</i>	Tier-2	
<i>montelukast</i>	Tier-2	
PERFOROMIST	Tier-3	B/D; QL (360 ML per 90 day(s))
PROAIR HFA	Tier-3	QL (51 GM per 90 day(s))
PROVENTIL HFA	Tier-4	QL (40.2 GM per 90 day(s))
PULMICORT SUSPENSION FOR NEBULIZATION 1 MG/2 ML	Tier-4	B/D; QL (720 ML per 90 day(s))
PULMICORT FLEXHALER	Tier-4	QL (6 EA per 90 day(s))
QVAR	Tier-4	QL (52.2 GM per 90 day(s))
SEREVENT DISKUS	Tier-4	QL (180 EA per 90 day(s))

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
SPIRIVA WITH HANDIHALER	Tier-3	QL (90 EA per 90 day(s))
SYMBICORT	Tier-3	QL (61.2 GM per 90 day(s))
<i>terbutaline oral</i>	Tier-2	
<i>theophylline</i>	Tier-2	
TUDORZA PRESSAIR	Tier-4	QL (3 EA per 90 day(s))
VENTOLIN HFA	Tier-4	QL (108 GM per 90 day(s))
XOPENEX	Tier-4	B/D; QL (810 ML per 90 day(s))
XOPENEX HFA	Tier-4	QL (90 GM per 90 day(s))
<i>zafirlukast</i>	Tier-2	
PULMONARY HYPERTENSION		
TYVASO	Tier-3	PA; * Part B
VENTAVIS	Tier-3	PA; * Part B
RESPIRATORY DRUGS, MISCELLANEOUS		
<i>acetylcysteine</i>	Tier-2	B/D
Aralast NP	Tier-5	* Part B
DALIRESP	Tier-4	
Glassia	Tier-5	* Part B
Prolastin C	Tier-5	* Part B
Xolair	Tier-5	PA; * Part B
Zemaira	Tier-5	* Part B
SKIN		
ACNE ROSACEA		
FINACEA	Tier-3	
METROGEL	Tier-4	
<i>metronidazole</i>	Tier-2	
ACNE VULGARIS		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>adapalene</i>	Tier-2	PA
<i>amnestem</i>	Tier-2	
ATRALIN	Tier-4	PA
<i>avita</i>	Tier-2	PA
AZELEX	Tier-4	
<i>claravis</i>	Tier-2	
<i>clindamycin phosphate</i>	Tier-2	
<i>clindamycin-benzoyl peroxide</i>	Tier-2	
DIFFERIN	Tier-4	PA
<i>ery pads</i>	Tier-2	
<i>erythromycin with ethanol</i>	Tier-2	
<i>erythromycin-benzoyl peroxide</i>	Tier-2	
<i>myorisan</i>	Tier-2	
RETIN-A	Tier-4	PA
RETIN-A MICRO	Tier-4	PA
TRETIN-X	Tier-4	PA
TRETIN-X (GEL)	Tier-4	PA
<i>tretinoin</i>	Tier-2	PA
BACTERIAL INFECTIONS, TOPICAL		
ALTABAX	Tier-4	QL (5 GM per 7 day(s))
BACTROBAN TOPICAL CREAM	Tier-3	
CORTISPORIN TOP	Tier-4	
<i>gentamicin</i>	Tier-1	
<i>mupirocin</i>	Tier-2	
<i>mupirocin calcium</i>	Tier-2	
<i>silver sulfadiazine</i>	Tier-2	
<i>ssd</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
CORTICOSTEROIDS, TOPICAL		
<i>ala-cort</i>	Tier-1	
ALA-SCALP	Tier-4	
<i>alclometasone</i>	Tier-2	
<i>amcinonide</i>	Tier-2	
<i>betamethasone dipropionate</i>	Tier-2	
<i>betamethasone valerate</i>	Tier-2	
<i>betamethasone, augmented</i>	Tier-2	
CAPEX	Tier-4	
<i>clobetasol</i>	Tier-2	
<i>clobetasol-emollient</i>	Tier-2	
CLOBEX LOTION	Tier-4	
CLOBEX TOPICAL SPRAY	Tier-4	
CLODERM	Tier-4	
CORDRAN	Tier-4	
DERMA-SMOOTHIE/FS BODY OIL	Tier-4	
<i>desonide</i>	Tier-2	
<i>desoximetasone</i>	Tier-3	
<i>diflorasone</i>	Tier-2	
<i>fluocinolone</i>	Tier-1	
<i>fluocinonide</i>	Tier-1	
<i>fluocinonide-e</i>	Tier-1	
<i>fluticasone</i>	Tier-2	
<i>halobetasol propionate</i>	Tier-2	
HALOG	Tier-4	
<i>hydrocortisone</i>	Tier-1	
<i>hydrocortisone butyrate</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>hydrocortisone valerate</i>	Tier-1	
KENALOG	Tier-4	
LOCOID LIPOCREAM	Tier-4	
<i>lokara</i>	Tier-2	
LUXIQ	Tier-4	
<i>mometasone lotion 0.1 %</i>	Tier-2	
<i>mometasone topical cream</i>	Tier-2	
<i>mometasone topical ointment</i>	Tier-2	
PANDEL	Tier-4	
<i>prednicarbate</i>	Tier-2	
<i>triamcinolone acetonide</i>	Tier-2	
<i>triderm</i>	Tier-2	
<i>u-cort</i>	Tier-1	
VANOS	Tier-4	
WESTCORT	Tier-4	
FUNGAL INFECTIONS, TOPICAL		
<i>ciclopirox</i>	Tier-2	
<i>clotrimazole</i>	Tier-2	
<i>clotrimazole-betamethasone</i>	Tier-2	
<i>econazole</i>	Tier-2	
ERTACZO	Tier-4	
EXELDERM	Tier-4	
<i>ketconazole</i>	Tier-2	
MENTAX	Tier-4	
<i>nyamyc</i>	Tier-2	
<i>nystatin oral</i>	Tier-2	
<i>nystatin topical cream</i>	Tier-1	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>nystatin topical ointment</i>	Tier-2	
<i>nystatin topical powder</i>	Tier-2	
<i>nystatin-triamcinolone</i>	Tier-1	
<i>nystop</i>	Tier-2	
OXISTAT	Tier-3	
<i>pedi-dri</i>	Tier-2	
PSORIASIS AND SEBORRHEA		
8-MOP	Tier-3	
<i>acitretin</i>	Tier-2	
<i>calcipotriene</i>	Tier-2	
DOVONEX	Tier-3	
SORIATANE	Tier-3	
Stelara	Tier-5	PA; * Part B
TAZORAC	Tier-3	PA
SCABIES AND PEDICULOSIS		
EURAX	Tier-3	
<i>lindane</i>	Tier-2	
<i>malathion</i>	Tier-2	
<i>permethrin</i>	Tier-2	
SKLICE	Tier-4	QL (117 GM per 1 day(s))
ULESFIA	Tier-4	
TOPICAL, MISCELLANEOUS		
<i>ammonium lactate</i>	Tier-2	
ANUSOL-HC	Tier-4	
CARAC	Tier-3	
CORTIFOAM	Tier-4	
ELIDEL	Tier-4	STPA

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
FLUOROPLEX	Tier-3	
<i>fluorouracil</i>	Tier-2	
<i>laclotion</i>	Tier-2	
<i>lidocaine</i>	Tier-2	
<i>lidocaine hcl</i>	Tier-2	
<i>lidocaine-prilocaine</i>	Tier-2	
LIDODERM	Tier-3	PA; QL (90 EA per 30 day(s))
<i>mafenide acetate</i>	Tier-2	
OXSORALEN	Tier-3	
OXSORALEN ULTRA	Tier-3	
Panretin	Tier-5	
PICATO TOPICAL GEL 0.015 %	Tier-4	QL (3 EA per 3 day(s))
PICATO TOPICAL GEL 0.05 %	Tier-4	QL (2 EA per 2 day(s))
<i>proctocream-hc</i>	Tier-2	
PROTOPIC	Tier-4	STPA
<i>pradoxin</i>	Tier-2	
Regranex	Tier-5	
SANTYL	Tier-3	
<i>selenium sulfide</i>	Tier-2	
<i>sodium chloride</i>	Tier-2	
SOLARAZE	Tier-3	
<i>sulfacetamide sodium (acne)</i>	Tier-2	
SULFAMYLON	Tier-4	
SYNERA	Tier-4	
<i>water for irrigation, sterile</i>	Tier-2	
ZONALON	Tier-4	

VIRAL INFECTIONS, TOPICAL

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
CONDYLOX	Tier-4	
DENAVIR	Tier-4	
<i>imiquimod</i>	Tier-2	
<i>podofilox</i>	Tier-2	
ZOVIRAX TOP	Tier-3	
WOMENS HEALTH		
CONTRACEPTIVES		
<i>amethia</i>	Tier-2	
<i>amethyst</i>	Tier-2	
<i>apri</i>	Tier-2	
<i>aranelle (28)</i>	Tier-2	
<i>aviane</i>	Tier-2	
<i>balziva (28)</i>	Tier-2	
BEYAZ	Tier-4	
<i>briellyn</i>	Tier-2	
<i>camila</i>	Tier-2	
<i>drospirenone-ethinyl estradiol</i>	Tier-2	
ELLA	Tier-4	QL (1 EA per 1 day(s))
<i>emoquette</i>	Tier-2	
<i>errin</i>	Tier-2	
<i>estradiol-norethindrone acet</i>	Tier-2	
GENERESS FE	Tier-4	
<i>gianvi</i>	Tier-2	
<i>gildagia</i>	Tier-2	
<i>introvale</i>	Tier-2	
<i>jinteli</i>	Tier-2	
<i>junel 1.5/30 (21)</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>junel 1/20 (21)</i>	Tier-2	
<i>junel fe 1.5/30 (28)</i>	Tier-2	
<i>junel fe 1/20 (28)</i>	Tier-2	
<i>kariva (28)</i>	Tier-2	
<i>kelnor 1/35 (28)</i>	Tier-2	
<i>leena 28</i>	Tier-2	
<i>lessina</i>	Tier-2	
<i>levonest (28)</i>	Tier-2	
<i>levonorgestrel-ethinyl estrad</i>	Tier-2	
<i>levora-28</i>	Tier-2	
LO LOESTRIN FE	Tier-4	
LO MINASTRIN FE	Tier-4	
LORYNA	Tier-3	
<i>low-ogestrel (28)</i>	Tier-2	
<i>lyza</i>	Tier-2	
<i>marlissa</i>	Tier-2	
<i>microgestin 1.5/30 (21)</i>	Tier-2	
<i>microgestin 1/20 (21)</i>	Tier-2	
<i>microgestin fe 1.5/30 (28)</i>	Tier-2	
<i>microgestin fe 1/20 (28)</i>	Tier-2	
MINASTRIN 24 FE	Tier-3	
<i>necon 0.5/35 (28)</i>	Tier-2	
<i>necon 1/35 (28)</i>	Tier-2	
NECON 10/11 (28)	Tier-3	
<i>necon 7/7/7 (28)</i>	Tier-2	
<i>nora-be</i>	Tier-2	
<i>norethindrone (contraceptive)</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>nortrel 0.5/35 (28)</i>	Tier-2	
<i>nortrel 1/35 (21)</i>	Tier-2	
<i>nortrel 1/35 (28)</i>	Tier-2	
<i>nortrel 7/7/7 (28)</i>	Tier-2	
NUVARING	Tier-3	
<i>orsythia</i>	Tier-2	
ORTHO EVRA	Tier-4	
ORTHO TRI-CYCLEN (28)	Tier-4	
OVCON-50 (28)	Tier-4	
<i>pirmella</i>	Tier-2	
<i>portia</i>	Tier-2	
QUARTETTE	Tier-4	
<i>quasense</i>	Tier-2	
SAFYRAL	Tier-4	
<i>tri-previfem (28)</i>	Tier-2	
<i>tri-sprintec (28)</i>	Tier-2	
<i>trinessa (28)</i>	Tier-2	
<i>trivora (28)</i>	Tier-2	
<i>velivet triphasic regimen (28)</i>	Tier-2	
<i>vestura</i>	Tier-2	
ZENCHENT FE	Tier-4	
<i>zeosa</i>	Tier-2	
<i>zovia 1/35e (28)</i>	Tier-2	
<i>zovia 1/50e (28)</i>	Tier-2	
MENOPAUSAL SYMPTOMS/OSTEOPOROSIS		
ACTONEL	Tier-4	STPA

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>alendronate</i>	Tier-2	
ALORA	Tier-4	
ANGELIQ	Tier-4	
<i>calcitonin (salmon)</i>	Tier-2	B/D
CENESTIN	Tier-4	
CLIMARA PRO	Tier-4	
COMBIPATCH	Tier-4	
CRINONE VAGINAL GEL 8 %	Tier-3	
DELESTROGEN	Tier-4	
DEPO-ESTRADIOL	Tier-3	
DEPO-PROVERA	Tier-3	
DEPO-SUBQ PROVERA 104	Tier-3	
DIVIGEL	Tier-4	
ELESTRIN	Tier-4	
ENJUVIA	Tier-4	
ESTRACE VAGL	Tier-3	
<i>estradiol oral</i>	Tier-1	
<i>estradiol transdermal</i>	Tier-2	
<i>estradiol valerate</i>	Tier-2	
ESTRING	Tier-3	
<i>estropipate</i>	Tier-2	
EVAMIST	Tier-4	QL (8.1 ML per 1 day(s))
EVISTA	Tier-3	
FEMHRT 1/5	Tier-4	
FEMHRT LOW DOSE	Tier-4	
FEMRING	Tier-3	
FEMTRACE	Tier-4	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
Forteo	Tier-5	PA
FOSAMAX ORAL SOLUTION	Tier-3	
<i>ibandronate</i>	Tier-3	STPA
<i>medroxyprogesterone oral</i>	Tier-1	
MENEST	Tier-4	
MENOSTAR	Tier-4	
<i>methylergonovine</i>	Tier-2	
MIACALCIN INJ	Tier-3	
MINIVELLE	Tier-4	
<i>norethindrone acetate</i>	Tier-2	
PREMARIN	Tier-4	
PREMPHASE	Tier-4	
PREMPRO	Tier-4	
<i>progesterone micronized</i>	Tier-2	
PROLIA	Tier-3	PA; * Part B
RECLAST	Tier-3	PA; * Part B
VAGIFEM	Tier-3	
VIVELLE-DOT	Tier-3	
Xgeva	Tier-5	PA; * Part B
<i>zoledronic acid</i>	Tier-2	PA; * Part B
<i>zoledronic acid-mannitol-water</i>	Tier-2	PA; * Part B
ZOMETA	Tier-3	PA; * Part B
PRENATAL VITAMINS		
<i>prenatal plus with iron (ca)</i>	Tier-2	
VAGINAL INFECTIONS		
CLEOCIN VAGINAL SUPPOSITORY	Tier-4	
<i>clindamycin phosphate</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Drug Name	Drug Tier	Coverage Notes
<i>fluconazole</i>	Tier-1	
<i>metronidazole</i>	Tier-2	
<i>miconazole-3</i>	Tier-2	
<i>terconazole</i>	Tier-2	
<i>vandazole</i>	Tier-2	
<i>zazole</i>	Tier-2	

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Index

8-MOP	76	<i>acyclovir sodium</i>	36	ALPHAGAN P 0.1 %	31
<i>abacavir</i>	4	ADACEL (ADOLESCENT		<i>alprazolam</i>	65
ABELCET	36	&ADULT)(PF)	46	<i>alprazolam intensol</i>	65
ABILIFY	69	Adagen	47	ALREX	30
ABILIFY DISCMELT	69	<i>adapalene</i>	72	ALTABAX	73
ABILIFY MAINTENA	69	Adcirca	54	ALVESCO 160	
ABRAXANE	11	ADDERALL XR	65	MCG/ACTUATION	70
ABSTRAL	62	ADRIAMYCIN PFS	12	ALVESCO 80	
<i>acamprosate</i>	64	ADVAIR DISKUS	70	MCG/ACTUATION	70
<i>acarbose</i>	26	ADVAIR HFA	70	<i>amantadine hcl</i>	4
ACCU-CHEK ACTIVE TEST		ADVICOR	22	AMBISOME	36
.....	24	<i>afeditab cr</i>	21	<i>amcinonide</i>	74
ACCU-CHEK AVIVA	24	Afinitor	14	<i>amethia</i>	78
ACCU-CHEK AVIVA PLUS		Afinitor Disperz	15	<i>amethyst</i>	78
.....	24	AFLURIA 2011-2012	47	<i>amifostine crystalline</i>	12
ACCU-CHEK COMFORT		AFLURIA 2011-2012 (PF)	47	<i>amikacin</i>	36
CURVE TEST	24	AGGRENEX	10	<i>amiloride</i>	22
ACCU-CHEK COMPACT		<i>a-hydrocort</i>	44	<i>amiloride-hydrochlorothiazide</i>	
TEST	24	<i>ala-cort</i>	74	.....	22
ACCU-CHEK SMARTVIEW		ALA-SCALP	74	<i>aminophylline</i>	70
.....	24	ALBENZA	3	AMINOSYN 8.5	
<i>acebutolol</i>	20	<i>albuterol sulfate</i>	70	%-ELECTROLYTES	42
<i>acetaminophen-codeine</i>	62	<i>albuterol sulfate 0.63 mg/3 ml,</i>		AMINOSYN II 10 %	42
<i>acetaminophen-codeine 300-15</i>		<i>1.25 mg/3 ml, 2.5 mg /3 ml</i>		AMINOSYN II 15%	42
<i>mg</i>	62	(0.083 %).....	70	AMINOSYN II 7 %	42
<i>acetaminophen-codeine 300-30</i>		<i>albuterol sulfate 5 mg/ml</i>	70	AMINOSYN II 8.5 %	42
<i>mg, 300-60 mg</i>	62	ALCAINE	32	AMINOSYN II 8.5	
<i>acetazol hc</i>	27	<i>alclometasone</i>	74	%-ELECTROLYTES	43
<i>acetazolamide</i>	31	<i>alcohol swabs</i>	24	AMINOSYN M 3.5 %	43
<i>acetazolamide sodium</i>	36	Aldurazyme	52	AMINOSYN-HBC 7%	43
<i>acetic acid</i>	27	<i>alendronate</i>	81	AMINOSYN-PF 10 %	43
<i>acetylcysteine</i>	72	<i>alfuzosin</i>	54	AMINOSYN-PF 7 %	
<i>acitretin</i>	76	Alimta	12	(SULFITE-FREE)	43
Actemra	60	ALINIA	3	<i>amiodarone</i>	18
ACTHIB (PF)	46	ALKERAN	12	AMITIZA	35
Actimmune	46	<i>allopurinol</i>	61	<i>amitriptyline</i>	66
ACTONEL	80	<i>allopurinol sodium</i>	36	<i>amitriptyline-chlordiazepoxide</i>	
ACTOPLUS MET	26	ALOCRIAL	29	.....	65
ACTOPLUS MET XR	26	ALOMIDE	29	<i>amlodipine</i>	21
ACTOS	26	ALORA	81	<i>amlodipine-atorvastatin</i>	19
<i>acyclovir</i>	4	ALOXI	32	<i>amlodipine-benazepril</i>	19

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>ammonium chloride</i>	41	Aranesp (in polysorbate) 150	60	AZASAN	60
<i>ammonium lactate</i>	76	mcg/0.3 mL, 200 mcg/0.4 mL,	29	AZASITE	29
<i>amnestem</i>	73	300 mcg/0.6 mL, 500	60	<i>azathioprine</i>	60
<i>amoxapine</i>	66	mcg/mL	10	<i>azathioprine sodium</i>	37
<i>amoxicillin</i>	7	Aranesp (in polysorbate) 200	10	<i>azelastine</i>	28
<i>amoxicillin-pot clavulanate</i>	7	mcg/mL, 300 mcg/mL	10	<i>azelastine</i>	29
<i>amphetamine salt combo</i>	65	ARCALYST	50	AZELEX	73
AMPHOTEC	36	ARGATROBAN	36	AZILECT	56
<i>amphotericin b</i>	36	ARGATROBAN IN 0.9 % SOD	36	<i>azithromycin</i>	8
<i>ampicillin</i>	7	CHLOR	36	<i>azithromycin</i>	37
<i>ampicillin sodium</i>	36	ARRANON	12	AZOPT	31
<i>ampicillin-sulbactam</i>	36	ARTHROTEC 50	60	AZOR	19
AMPYRA	52	ARTHROTEC 75	60	<i>aztreonam</i>	37
<i>anagrelide</i>	11	Arzerra	12	<i>bacitracin</i>	29
<i>anastrozole</i>	15	ASACOL	35	<i>bacitracin-polymyxin b</i>	29
ANCOBON	2	ASACOL HD	35	<i>baclofen</i>	59
ANDROGEL	45	ASMANEX TWISTHALER	70	BACTROBAN	73
ANDROXY	45	.....	70	BACTROBAN NASAL	28
ANGELIQ	81	ASTAGRAF XL	48	<i>balsalazide</i>	35
ANUSOL-HC	76	ASTEPRO	28	<i>balziva (28)</i>	78
ANZEMET	36	<i>atenolol</i>	20	BANZEL	57
ANZEMET 100 MG	32	<i>atenolol-chlorthalidone</i>	19	BANZEL 200 MG	57
ANZEMET 50 MG	32	ATGAM	37	BANZEL 400 MG	57
APLENZIN	66	<i>atorvastatin</i>	22	BARACLUDE	4
APOKYN	56	<i>atovaquone-proguanil</i>	3	<i>benazepril</i>	17
<i>apraclonidine</i>	31	ATRALIN	73	<i>benazepril-hydrochlorothiazide</i>	19
<i>apri</i>	78	ATRIPLA	4	.....	19
APRISO	35	<i>atropine 0.05 mg/ml</i>	37	BENICAR	18
APTIVUS	4	ATROVENT HFA	71	BENICAR HCT	19
Aralast NP	72	Aubagio	52	BENLYSTA	48
<i>aranelle (28)</i>	78	AUVI-Q	49	<i>benztropine</i>	37
ARANESP (IN		AVASTIN	12	<i>benztropine</i>	56
POLYSORBATE) 100 MCG/0.5		AVELOX IN NAACL		BESIVANCE	29
ML, 25 MCG/0.42 ML, 40		(ISO-OSMOTIC)	37	<i>betamethasone dipropionate</i>	74
MCG/0.4 ML, 60 MCG/0.3		<i>aviane</i>	78	<i>betamethasone valerate</i>	74
ML	10	<i>avita</i>	73	<i>betamethasone, augmented</i>	74
ARANESP (IN		AVODART	54	Betaseron	52
POLYSORBATE) 100		Avonex	52	<i>betaxolol</i>	20
MCG/ML, 25 MCG/ML, 40		Avonex Administration Pack		<i>betaxolol</i>	31
MCG/ML, 60 MCG/ML	10	.....	52	<i>bethanechol chloride</i>	55
		AZACTAM	37	BETIMOL	31
		AZACTAM IN DEXTROSE		BETOPTIC S	31
		(ISO-OSM)	37	BEYAZ	78
				<i>bicalutamide</i>	15

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

BICILLIN C-R	7	<i>calcitonin (salmon)</i>	81	<i>cefotetan</i>	37
BICILLIN L-A	7	<i>calcitriol</i>	37	<i>cefoxitin</i>	37
BICNU	12	<i>calcitriol</i>	52	<i>cefoxitin in dextrose, iso-osm</i>	37
BIDIL	24	<i>calcium acetate</i>	53		37
BILTRICIDE	3	<i>camila</i>	78	<i>cefpodoxime</i>	7
<i>bisoprolol fumarate</i>	20	CAMPATH	12	<i>cefprozil</i>	7
<i>bisoprolol-hydrochlorothiazide</i>	19	CAMPRAL	64	<i>ceftazidime</i>	37
<i>bleomycin</i>	12	CANASA	36	<i>ceftazidime in d5w</i>	37
BLEPHAMIDE	29	CANCIDAS	37	<i>ceftriaxone</i>	37
BLEPHAMIDE S.O.P.	29	<i>candesartan</i>	18	<i>cefuroxime axetil</i>	7
BONIVA	37	<i>candesartan-hydrochlorothiazid</i>	18	<i>cefuroxime sodium</i>	37
BOOSTRIX	47		18	CELEBREX	60
Bosulif 100 mg	15	CANTIL	33	CELLCEPT	48
Bosulif 500 mg	15	CAPASTAT	37	CELONTIN	58
<i>briellyn</i>	78	CAPEX	74	CENESTIN	81
BRILINTA	11	Caprelsa 100 mg	15	<i>cephalexin</i>	7
<i>brimonidine</i>	31	Caprelsa 300 mg	15	Cerezyme	50
<i>bromfenac</i>	30	<i>captopril</i>	17	CERUBIDINE	12
<i>bromocriptine</i>	56	<i>captopril-hydrochlorothiazide</i>	19	CERVARIX VACCINE (PF)	47
BROVANA	71		19		47
<i>budeprion sr</i>	66	CARAC	76	CESAMET	32
<i>budesonide</i>	35	CARAFATE	34	<i>cevimeline</i>	28
<i>budesonide</i>	71	CARBAGLU	33	CHANTIX	54
<i>bumetanide</i>	22	<i>carbamazepine</i>	57	CHANTIX STARTING	
<i>bumetanide</i>	37	<i>carbamazepine</i>	58	MONTH BOX	54
Buphenyl	33	<i>carbidopa-levodopa</i>	57	CHEMET	50
<i>buprenorphine</i>	37	<i>carboplatin</i>	12	<i>chloramphenicol sod succinate</i>	38
BUPRENORPHINE-NALOXO		CARDURA XL	17		38
NE	68	Carimune NF Nanofiltered	47	<i>chlorhexidine gluconate</i>	28
<i>buproban</i>	54	<i>carteolol</i>	31	<i>chloroquine phosphate</i>	3
<i>bupropion hcl</i>	66	<i>cartia xt</i>	21	<i>chlorothiazide</i>	22
<i>bupirone</i>	65	<i>carvedilol</i>	20	<i>chlorpromazine</i>	69
BUSULFEX	12	Cayston	50	<i>chlorpropamide</i>	26
<i>butalbital-acetaminop-caf-cod</i>	56	CEDAX	7	<i>chlorthalidone</i>	22
	56	CEENU	15	<i>cholestyramine light</i>	22
<i>butorphanol tartrate</i>	37	<i>cefaclor</i>	7	CIALIS	54
<i>butorphanol tartrate</i>	62	<i>cefadroxil</i>	7	<i>ciclopirox</i>	75
BUTRANS	62	<i>cefazolin</i>	37	<i>cidofovir</i>	38
BYDUREON	26	<i>cefazolin in dextrose (iso-os)</i>	37	<i>cilostazol</i>	11
BYETTA	26		37	<i>cimetidine</i>	35
<i>cabergoline</i>	57	<i>cefdinir</i>	7	<i>cimetidine hcl</i>	38
<i>calcipotriene</i>	76	<i>cefepime</i>	37	Cimzia	33
		<i>cefotaxime</i>	37	Cimzia Powder for Reconst	33

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

Cinryze	52	CLINIMIX E 4.25%/D25W		<i>compro</i>	32
CIPRODEX	27	SUL FREE	43	COMTAN	57
<i>ciprofloxacin</i>	9	CLINIMIX E 4.25%/D5W		COMVAX (PF)	47
<i>ciprofloxacin</i>	29	SULF FREE	43	CONCERTA	65
<i>ciprofloxacin</i>	38	CLINIMIX E 5%/D15W		CONDYLOX	77
<i>ciprofloxacin (mixture)</i>	9	SULFIT FREE	43	<i>constulose</i>	34
<i>cisplatin</i>	12	CLINIMIX E 5%/D20W		Copaxone	52
<i>citalopram</i>	66	SULFIT FREE	43	Copegus	4
<i>cladribine</i>	12	CLINIMIX E 5%/D25W		CORDRAN	74
<i>claravis</i>	73	SULFIT FREE	43	COREG CR	20
<i>clarithromycin</i>	8	CLINISOL SF 15 %	43	CORTIFOAM	76
CLEOCIN	38	<i>clobetasol</i>	74	<i>cortisone</i>	44
CLEOCIN	82	<i>clobetasol-emollient</i>	74	CORTISPORIN	73
CLEOCIN IN 5 % DEXTROSE		CLOBEX	74	CORTISPORIN-TC	27
.....	38	CLODERM	74	COSMEGEN	12
CLIMARA PRO	81	CLOLAR	12	COUMADIN	11
<i>clindamycin hcl</i>	8	<i>clomipramine</i>	66	COVERA-HS	21
<i>clindamycin pediatric</i>	8	<i>clonazepam</i>	58	CREON	33
<i>clindamycin phosphate</i>	38	<i>clonidine</i>	22	CRINONE 8 %	81
<i>clindamycin phosphate</i>	73	<i>clopidogrel</i>	10	CRIXIVAN	4
<i>clindamycin phosphate</i>	82	<i>clorazepate dipotassium</i>	65	<i>cromolyn</i>	29
<i>clindamycin-benzoyl peroxide</i>		<i>clorpres</i>	19	<i>cromolyn</i>	34
.....	73	<i>clotrimazole</i>	2	<i>cromolyn</i>	71
CLINIMIX 5%/D15W		<i>clotrimazole</i>	75	CUBICIN	38
SULFITE FREE	43	<i>clotrimazole-betamethasone</i>	75	<i>curity gauze</i>	24
CLINIMIX 5%/D25W		<i>clozapine</i>	69	<i>cyclobenzaprine</i>	60
SULFITE FREE	43	COARTEM	3	<i>cyclophosphamide</i>	15
CLINIMIX 2.75%/D5W		<i>codeine sulfate</i>	62	CYCLOSET	57
SULFIT FREE	43	<i>co-gesic</i>	62	<i>cyclosporine</i>	38
CLINIMIX 4.25%/D10W SULF		<i>colchicine-probenecid</i>	61	<i>cyclosporine</i>	48
FREE	43	COLCRYS	61	<i>cyclosporine modified</i>	49
CLINIMIX 4.25%/D20W SULF		<i>colestipol</i>	23	CYKLOKAPRON	11
FREE	43	<i>colistin (colistimethate na)</i>	38	CYMBALTA 20 MG, 30	
CLINIMIX 4.25%/D25W SULF		<i>colocort</i>	36	MG	66
FREE	43	COLY-MYCIN S	27	CYMBALTA 60 MG	66
CLINIMIX 4.25%/D5W		COLYTE WITH FLAVOR		CYSTADANE	50
SULFIT FREE	43	PACKS	34	CYSTAGON	33
CLINIMIX 5%/D20W		COMBIGAN	31	<i>cytarabine</i>	12
SULFITE FREE	43	COMBIPATCH	81	<i>cytarabine (pf)</i>	12
CLINIMIX E 2.75%/D10W		COMBIVENT	71	CYTOVENE	12
SUL FREE	43	COMBIVENT RESPIMAT	71	<i>d10 % & 0.45 % sodium</i>	
CLINIMIX E 2.75%/D5W		Cometriq	15	<i>chloride</i>	41
SULF FREE	43	Complera	4		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>d2.5 %-0.45 % sodium chloride</i>	<i>dexamethasone intensol</i>	DILAUDID
41	44	62
<i>d5 % and 0.9 % sodium chloride</i>	<i>dexamethasone sodium phosphate</i>	<i>dilt-cd</i>
41	30	21
<i>d5 %-0.45 % sodium chloride</i>	<i>dexamethasone sodium phosphate</i>	<i>diltiazem hcl</i>
41	38	21
<i>dacarbazine</i>	DEXEDRINE SPANSULE	<i>diltiazem hcl</i>
12	65	38
DACOGEN	<i>dexmethylphenidate</i>	<i>dilt-xr</i>
12	65	21
DALIRESP	<i>dexpak 13 day</i>	DIOVAN
72	44	18
<i>danazol</i>	<i>dextrazoxane</i>	DIPENTUM
45	12	36
<i>dantrolene</i>	<i>dextroamphetamine</i>	<i>dipyridamole</i>
60	65	10
<i>dapsone</i>	<i>dextroamphetamine-amphetamin e</i>	<i>disopyramide</i>
3	65	18
DAPTACEL (PEDIATRIC) (PF)	<i>dextrose 10 % & 0.2 % nacl</i>	<i>disulfiram</i>
47	41	64
DARAPRIM	<i>dextrose 10 % in water (d10w)</i>	<i>divalproex</i>
3	41	58
<i>daunorubicin</i>	<i>dextrose 5 % in water (d5w)</i>	DIVIGEL
12	41	81
DAYTRANA	<i>dextrose 5%-0.2 % sod chloride</i>	DOCEFREZ
65	41	12
DECAVAC (PF)	<i>dextrose 5%-0.3 % sod.chloride</i>	<i>docetaxel</i>
47	41	13
<i>decitabine</i>	<i>dextrose 5%-lactated ringers</i>	<i>donepezil</i>
12	41	56
DELATESTRYL	<i>diazepam</i>	DORIBAX
45	58	38
DELESTROGEN	<i>diazepam 12.5-15-17.5-20 mg, 5-7.5-10 mg</i>	<i>dorzolamide</i>
81	58	31
DELZICOL	<i>diazepam intensol</i>	<i>dorzolamide-timolol</i>
36	58	31
<i>demeclocycline</i>	<i>diclofenac potassium</i>	DOVONEX
9	60	76
DENAVIR	<i>diclofenac sodium</i>	<i>doxazosin</i>
78	30	18
DEPEN TITRATABS	<i>diclofenac sodium</i>	<i>doxepin</i>
55	60	66
DEPO-ESTRADIOL	<i>diclofenac-misoprostol</i>	<i>doxepin</i>
81	60	67
DEPO-MEDROL	<i>dicloxacillin</i>	<i>doxorubicin</i>
44	7	13
DEPO-PROVERA	<i>dicyclomine</i>	<i>doxycycline hyclate</i>
81	34	9
DEPO-SUBQ PROVERA 104	<i>didanosine</i>	<i>doxycycline hyclate</i>
81	4	28
DEPO-TESTOSTERONE	DIFFERIN	<i>doxycycline hyclate</i>
45	73	38
DERMA-SMOOTHIE/FS BODY OIL	Dificid	<i>doxycycline monohydrate</i>
74	8	9
DERMOTIC OIL	<i>diflorasone</i>	<i>doxycycline monohydrate</i>
28	74	10
<i>desipramine</i>	<i>diflunisal</i>	dronabinol 10 mg
66	61	32
<i>desloratadine</i>	<i>digoxin</i>	dronabinol 2.5 mg, 5 mg
28	18	32
<i>desmopressin</i>	<i>dihydrocode-acetaminophen-cafff</i>	<i>drospirenone-ethinyl estradiol</i>
55	62	78
<i>desonide</i>	<i>dihydroergotamine</i>	DROXIA
74	56	15
<i>desoximetasone</i>	DILANTIN	DUETACT
74	58	26
DESXYN	DILANTIN INFATABS	<i>duramorph (pf)</i>
65	58	38
<i>desvenlafaxine</i>		DUTOPROL
66		19
DETROL LA		<i>e.e.s. 400</i>
55		8
<i>dexamethasone</i>		E.E.S. GRANULES
44		8
		<i>econazole</i>
		75
		EDURANT
		4
		EFFIENT
		10
		Egrifta
		51
		ELAPRASE
		52
		Elelyso
		51

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

ELESTRIN	81	EPIVIR	4	EVISTA	81
ELIDEL	76	EPIVIR HBV	4	EVOXAC	28
ELIGARD	45	<i>eplerenone</i>	24	EXELDERM	75
Elitek	13	EPOGEN	10	EXELON	56
<i>elixophyllin</i>	71	<i>eprosartan</i>	18	<i>exemestane</i>	15
ELLA	78	EPZICOM	5	EXFORGE	19
Ellence	13	EQUETRO	66	EXFORGE HCT	20
ELMIRON	55	ERAXIS(WATER DILUENT)	38	EXJADE 125 MG	50
ELSPAR	13	.....	38	Exjade 250 mg, 500 mg	50
EMADINE	29	ERBITUX	13	Extavia	53
EMCYT	15	<i>ergoloid</i>	56	Fabrazyme	50
EMEND	32	Erivedge	15	<i>famciclovir</i>	5
EMEND 125 MG	32	<i>errin</i>	78	<i>famotidine</i>	35
EMEND 40 MG, 80 MG	32	ERTACZO	75	FANAPT	69
<i>emoquette</i>	78	<i>ery pads</i>	73	FARESTON	15
EMSAM	67	<i>eryped 200</i>	8	Faslodex	13
EMTRIVA	4	<i>eryped 400</i>	8	FAZACLO	69
ENABLEX	55	ERY-TAB	8	<i>felbamate</i>	58
<i>enalapril maleate</i>	17	ERYTHROCIN	38	<i>felodipine</i>	21
<i>enalapril-hydrochlorothiazide</i>	19	<i>erythrocin stearate</i>	8	FEMHRT 1/5	81
.....	19	<i>erythromycin</i>	8	FEMHRT LOW DOSE	81
Enbrel	60	<i>erythromycin</i>	29	FEMRING	81
Enbrel 25 mg/0.5mL (0.51)	60	<i>erythromycin ethylsuccinate</i>	8	FEMTRACE	81
Enbrel 50 mg/mL (0.98 mL)	60	<i>erythromycin with ethanol</i>	73	<i>fenofibrate</i>	23
<i>endocet 10-325 mg, 5-325 mg,</i>	62	<i>erythromycin-benzoyl peroxide</i>	73	<i>fenofibrate micronized</i>	23
<i>7.5-325 mg</i>	62	.....	73	<i>fenofibrate nanocrystallized</i>	23
<i>endocet 10-650 mg</i>	62	<i>escitalopram</i>	67	<i>fenofibric acid (choline)</i>	23
<i>endocet 7.5-500 mg</i>	62	<i>estazolam</i>	68	<i>fenopropfen</i>	60
<i>endodan</i>	62	ESTRACE	81	<i>fentanyl</i>	62
ENGERIX-B (PF)	47	<i>estradiol</i>	81	<i>fentanyl citrate</i>	62
ENGERIX-B PEDIATRIC (PF)	47	<i>estradiol valerate</i>	81	FINACEA	72
.....	47	<i>estradiol-norethindrone acet</i>	78	<i>finasteride</i>	55
ENJUVIA	81	.....	78	Firazyr	52
<i>enoxaparin</i>	11	ESTRING	81	FIRMAGON	45
<i>entacapone</i>	57	<i>estropipate</i>	81	FLAREX	30
ENTOCORT EC	36	<i>ethambutol</i>	8	<i>flavoxate</i>	55
<i>enulose</i>	34	<i>ethosuximide</i>	58	<i>flecainide</i>	18
<i>epinastine</i>	29	<i>etidronate disodium</i>	53	FLOVENT DISKUS	71
<i>epinephrine</i>	50	<i>etodolac</i>	61	FLOVENT HFA 110	
EPIPEN 2-PAK	50	ETOPOPHOS	13	MCG/ACTUATION, 220	
EPIPEN JR 2-PAK	50	<i>etoposide</i>	13	MCG/ACTUATION	71
<i>epirubicin</i>	13	EURAX	76	FLOVENT HFA 44	
<i>epitol</i>	58	EVAMIST	81	MCG/ACTUATION	71

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

FLUARIX 2011-2012 (PF)	47	FORADIL AEROLIZER	71	<i>gentamicin</i>	29
<i>fluconazole</i>	2	FORTAZ	38	<i>gentamicin</i>	38
<i>fluconazole</i>	83	FORTAZ IN DEXTROSE 5 %		<i>gentamicin</i>	73
<i>fluconazole in dextrose(iso-o)</i>		.....	38	<i>gentamicin in nacl (iso-osm)</i>	
.....	38	Forteo	82	.....	38
<i>flucytosine</i>	2	FOSAMAX	82	<i>gentamicin sulfate (pf)</i>	38
<i>fludarabine</i>	13	<i>foscarnet</i>	38	GEODON	69
<i>fludrocortisone</i>	44	<i>fosinopril</i>	17	<i>gianvi</i>	78
FLULAVAL 2011-2012	47	<i>fosinopril-hydrochlorothiazide</i>		<i>gildagia</i>	78
<i>flunisolide</i>	28	.....	20	Gilenya	53
<i>fluocinolone</i>	74	FOSRENOL	53	Gilotrif	15
<i>fluocinolone acetonide oil</i>	28	FRAGMIN	11	Glassia	72
<i>fluocinonide</i>	74	FREAMINE III 3		Gleevec	15
<i>fluocinonide-e</i>	74	%-ELECTROLYTES	43	<i>glimepiride</i>	26
<i>fluorometholone</i>	30	FREAMINE III 8.5 %	43	<i>glipizide</i>	26
<i>fluor-op</i>	30	Fulyzaq	34	<i>glipizide-metformin</i>	26
FLUOROPLEX	77	<i>furosemide</i>	22	GLUCAGEN HYPOKIT	25
<i>fluorouracil</i>	77	FUSILEV	17	GLUCAGON EMERGENCY	
<i>fluoxetine</i>	67	Fuzeon	5	.....	25
<i>fluoxetine 10 mg, 20 mg</i>	67	<i>gabapentin</i>	58	<i>glyburide</i>	26
<i>fluoxetine 60 mg</i>	67	GABITRIL	58	<i>glyburide micronized</i>	26
<i>fluphenazine decanoate</i>	69	<i>galantamine</i>	56	<i>glyburide-metformin</i>	26
<i>fluphenazine hcl</i>	69	Gammagard Liquid	47	<i>glycopyrrolate</i>	34
<i>flurazepam</i>	68	Gammaplex	47	GOLYTELY	34
<i>flurbiprofen</i>	60	Gamunex-C	47	<i>granisetron</i>	32
<i>flurbiprofen sodium</i>	30	GARDASIL (PF)	47	<i>granisetron</i>	38
<i>flutamide</i>	15	Gattex One-Vial	34	<i>granisetron (pf)</i>	38
<i>fluticasone</i>	28	GELNIQUE	55	GRANISOL	32
<i>fluticasone</i>	74	<i>gemcitabine</i>	13	<i>griseofulvin microsize</i>	2
<i>fluvastatin</i>	23	<i>gemfibrozil</i>	23	<i>griseofulvin ultramicrosize</i>	2
FLUVIRIN 2011-2012	47	GENERESS FE	78	GRIS-PEG	
FLUVIRIN 2011-2012 (PF)	47	<i>generlac</i>	34	(ULTRAMICROSIZED)	2
<i>fluvoxamine</i>	67	<i>engraf</i>	49	<i>guanfacine</i>	22
FLUZONE 2011-2012	47	Genotropin	51	<i>guanidine</i>	53
FLUZONE 2011-2012 (PF)	47	GENOTROPIN MINIQUICK		Halaven	13
FLUZONE HIGH-DOSE		0.2 MG/0.25 ML	51	HALFLYTELY-BISACODYL	
2011-12 (PF)	47	Genotropin Miniquick 0.4		W-FLAV PK	34
FLUZONE INTRADERM		mg/0.25 mL, 0.6 mg/0.25 mL,		<i>halobetasol propionate</i>	74
2011-12 (PF)	47	0.8 mg/0.25 mL, 1 mg/0.25 mL,		HALOG	74
FML FORTE	30	1.2 mg/0.25 mL, 1.4 mg/0.25		<i>haloperidol</i>	69
FML S.O.P.	30	mL, 1.6 mg/0.25 mL, 1.8		<i>haloperidol decanoate</i>	69
FOCALIN XR	65	mg/0.25 mL, 2 mg/0.25 mL	51	<i>haloperidol lactate</i>	69
<i>fondaparinux</i>	11	<i>gentak</i>	29	HAVRIX (PF)	47

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

HECTOROL	38	<i>hydrocodone-acetaminophen</i>		<i>imipramine pamoate</i>	67
HECTOROL	52	10-300 mg, 5-300 mg, 7.5-300		<i>imiquimod</i>	78
HELIDAC	35	mg	63	IMOVAX RABIES VACCINE	
<i>heparin (porcine)</i>	39	<i>hydrocodone-acetaminophen</i>		(PF)	47
<i>heparin (porcine) in d5w</i>	39	10-325 mg, 5-325 mg, 7.5-325		Incivek	5
<i>heparin (porcine) in nacl (pf)</i>		mg	63	Increlex	51
.....	39	<i>hydrocodone-acetaminophen</i>		<i>indapamide</i>	22
<i>heparin(porcine) in 0.45% nacl</i>		10-500 mg, 2.5-500 mg, 5-500		INDOCIN	60
.....	39	mg, 7.5-500 mg	63	<i>indomethacin</i>	60
HEPATAMINE 8%	43	<i>hydrocodone-acetaminophen</i>		INFANRIX (PF)	47
HEPATASOL 8 %	43	10-650 mg, 7.5-650 mg	63	Infergen	5
Hepsera	5	<i>hydrocodone-acetaminophen</i>		Inlyta	15
Herceptin	13	10-660 mg	63	<i>insulin syringe-needle u-100</i>	25
Hexalen	15	<i>hydrocodone-acetaminophen</i>		INTELENCE	5
HIBERIX (PF)	47	10-750 mg, 7.5-750 mg	63	INTRALIPID	43
<i>huber safety needles (disp.)</i>	24	<i>hydrocodone-acetaminophen</i>		INTRON A	5
HUMALOG	25	2.5-108 mg/5 ml	63	INTRON A 10 MILLION	
HUMALOG KWIKPEN	25	<i>hydrocodone-acetaminophen</i>		UNIT/0.2 ML, 3 MILLION	
HUMALOG MIX 50-50	25	7.5-500 mg/15 ml	63	UNIT /0.2 ML-6 DOSES	5
HUMALOG MIX 50-50		<i>hydrocodone-ibuprofen</i>	63	Intron A 5 million unit/0.2	
KWIKPEN	25	<i>hydrocortisone</i>	36	mL	5
HUMALOG MIX 75-25	25	<i>hydrocortisone</i>	44	<i>introvale</i>	78
HUMALOG MIX 75-25		<i>hydrocortisone</i>	74	INTUNIV ER	65
KWIKPEN	25	<i>hydrocortisone</i>	74	INVANZ	39
Humatrope	51	<i>hydrocortisone butyrate</i>	74	INVEGA	69
Humatrope 12 (36 unit) mg, 24		<i>hydrocortisone valerate</i>	75	INVEGA SUSTENNA	69
(72 unit) mg	51	<i>hydrocortisone-acetic acid</i>	28	INVIRASE	5
HUMATROPE 6 (18 UNIT)		<i>hydromorphone</i>	63	IONOSOL-B IN D5W	41
MG	51	<i>hydromorphone (pf)</i>	39	IONOSOL-MB IN D5W	41
Humira	60	<i>hydroxychloroquine</i>	3	IOPIDINE	31
Humira Crohn's Dis Start Pck		<i>hydroxyurea</i>	15	IPOL	48
.....	60	<i>hydroxyzine hcl</i>	28	<i>ipratropium bromide</i>	71
HUMULIN 70/30	25	<i>hydroxyzine pamoate</i>	28	<i>ipratropium bromide 0.03 %</i>	28
HUMULIN 70/30 PEN	25	<i>ibandronate</i>	82	<i>ipratropium bromide 0.06 %</i>	28
HUMULIN N	25	<i>ibuprofen</i>	62	<i>ipratropium-albuterol</i>	71
HUMULIN N PEN	25	<i>ibuprofen-oxycodone</i>	63	<i>irbesartan</i>	18
HUMULIN R	25	Iclusig 15 mg	15	<i>irbesartan-hydrochlorothiazide</i>	
HUMULIN R U-500		Iclusig 45 mg	15	.....	20
"CONCENTRATED"	25	<i>idarubicin</i>	13	irinotecan	13
<i>hydralazine</i>	24	IFEX	13	Isentress	5
<i>hydrochlorothiazide</i>	22	<i>ifosfamide</i>	13	Isentress 100 mg	5
		ILARIS (PF)	50	Isentress 25 mg	5
		<i>imipenem-cilastatin</i>	39	ISOLYTE-H IN D5W	41
		<i>imipramine hcl</i>	67		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

ISOLYTE-M IN D5W	41	<i>kionex</i>	54	LEVATOL	20
ISOLYTE-P IN D5W	41	<i>klor-con</i>	23	LEVEMIR	25
ISOLYTE-S	41	<i>klor-con 10</i>	24	LEVEMIR FLEXPEN	25
ISOLYTE-S IN D5W	41	KLOR-CON M15	24	<i>levetiracetam</i>	58
<i>isoniazid</i>	9	<i>klor-con m20</i>	24	<i>levobunolol</i>	31
<i>isoniazid</i>	39	KOMBIGLYZE XR	27	<i>levocarnitine</i>	34
<i>isosorbide dinitrate</i>	18	Korlym	27	<i>levocarnitine</i>	39
<i>isosorbide dinitrate</i>	24	KRISTALOSE	34	<i>levocarnitine (with sugar)</i>	34
<i>isosorbide mononitrate</i>	18	K-TAB	23	<i>levocetirizine</i>	28
<i>isradipine</i>	21	Kuvan	53	<i>levofloxacin</i>	9
Istodax	13	Kynamro	23	<i>levofloxacin</i>	29
<i>itraconazole</i>	2	<i>labetalol</i>	20	<i>levofloxacin in d5w</i>	39
IXEMPRA	13	<i>laclotion</i>	77	<i>levonest (28)</i>	79
IXIARO (PF)	48	<i>lactated ringers</i>	39	<i>levonorgestrel-ethinyl estrad</i>	
Jakafi	15	<i>lactulose</i>	34		79
JALYN	55	LAMICTAL ODT	58	<i>levora-28</i>	79
<i>jantoven</i>	11	LAMICTAL XR	58	<i>levorphanol tartrate</i>	63
JANUMET	26	LAMISIL 125 MG	2	<i>levothroid</i>	46
JANUMET XR	26	LAMISIL 187.5 MG	2	<i>levothyroxine</i>	46
JANUVIA	27	<i>lamivudine</i>	5	<i>levoxyl</i>	46
JENTADUETO	27	<i>lamivudine-zidovudine</i>	5	LEXAPRO	67
Jevtana	13	<i>lamotrigine</i>	58	LEXIVA	5
<i>jinteli</i>	78	LANOXIN	18	<i>lidocaine</i>	77
<i>junel 1.5/30 (21)</i>	78	LANOXIN PEDIATRIC	19	<i>lidocaine (pf)</i>	39
<i>junel 1/20 (21)</i>	79	<i>lansoprazole</i>	35	<i>lidocaine hcl</i>	77
<i>junel fe 1.5/30 (28)</i>	79	LANTUS	25	<i>lidocaine-prilocaine</i>	77
<i>junel fe 1/20 (28)</i>	79	LANTUS SOLOSTAR	25	LIDODERM	77
JUVISYNC	27	LASTACFT	29	LINCOCIN	39
Juxtapid 10 mg, 5 mg	23	<i>latanoprost</i>	31	<i>lindane</i>	76
Juxtapid 20 mg	23	LATUDA 120 MG	69	LINZESS	34
Kadcyla	13	LATUDA 20 MG, 40 MG, 80		<i>liothyronine</i>	46
KALETRA	5	MG	69	<i>lisinopril</i>	17
Kalydeco	50	<i>leena 28</i>	79	<i>lisinopril-hydrochlorothiazide</i>	
<i>kanamycin</i>	39	<i>leflunomide</i>	61		20
<i>kariva (28)</i>	79	<i>lessina</i>	79	<i>lithium carbonate</i>	66
KAYEXALATE	54	Letairis	54	<i>lithium citrate</i>	66
<i>kelnor 1/35 (28)</i>	79	<i>letrozole</i>	15	LO LOESTRIN FE	79
KENALOG	75	<i>leucovorin calcium</i>	17	LO MINASTRIN FE	79
KETEK	8	LEUKERAN	15	LOCOID LIPOCREAM	75
<i>ketoconazole</i>	2	Leukine	10	LODOSYN	57
<i>ketoconazole</i>	75	<i>leuprolide</i>	13	<i>lokara</i>	75
<i>ketoprofen</i>	62	<i>levabuterol hcl</i>	71	<i>loperamide</i>	34
<i>ketorolac</i>	30	LEVAQUIN	9	<i>lorazepam</i>	65
Kineret	60	LEVAQUIN IN D5W	39		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>lorazepam intensol</i>	65	Mekinst	16	<i>methylergonovine</i>	82
LORYNA	79	<i>meloxicam</i>	61	METHYLIN	65
<i>losartan</i>	18	<i>melphalan</i>	13	<i>methylphenidate</i>	65
<i>losartan-hydrochlorothiazide</i>	20	MENACTRA (PF)	48	<i>methylprednisolone</i>	44
LOTEMAX	30	MENEST	82	<i>methylprednisolone acetate</i>	44
LOTRONEX	34	MENOMUNE - A/C/Y/W-135 (PF)	48	<i>methylprednisolone sodium succ</i>	44
<i>lovastatin</i>	23	MENOSTAR	82	<i>metipranolol</i>	32
LOVAZA	23	MENTAX	75	<i>metoclopramide hcl</i>	33
<i>low-ogestrel (28)</i>	79	MENVEO A-C-Y-W-135-DIP (PF)	48	<i>metolazone</i>	22
<i>loxapine succinate</i>	69	<i>meprobamate</i>	65	<i>metoprolol succinate</i>	20
LUFYLLIN	71	MEPRON	4	<i>metoprolol ta-hydrochlorothiaz</i>	20
LUMIGAN	31	<i>mercaptapurine</i>	16	<i>metoprolol tartrate</i>	20
LUMIZYME	53	<i>meropenem</i>	39	<i>metoprolol tartrate</i>	39
LUNESTA	68	MERREM	39	METROGEL	72
Lupron Depot (3 Month)	45	<i>mesalamine-cleansing wipes</i>	36	<i>metronidazole</i>	3
Lupron Depot (4 Month)	46	<i>mesna</i>	17	<i>metronidazole</i>	72
Lupron Depot (6 Month)	46	MESNEX	17	<i>metronidazole</i>	83
LUPRON DEPOT 3.75 MG	45	MESTINON	53	<i>metronidazole in nacl (iso-os)</i>	39
Lupron Depot 7.5 mg	45	MESTINON TIMESPAN	53	<i>mexiletine</i>	19
Lupron Depot-Ped	46	METADATE CD	65	MIACALCIN	82
Lupron Depot-Ped (3 Month)	46	METADATE ER	65	<i>miconazole-3</i>	83
LUVOX CR	67	<i>metaproterenol</i>	71	<i>microgestin 1.5/30 (21)</i>	79
LUXIQ	75	<i>metformin</i>	27	<i>microgestin 1/20 (21)</i>	79
LYRICA	58	<i>methadone</i>	39	<i>microgestin fe 1.5/30 (28)</i>	79
LYSODREN	44	<i>methadone</i>	63	<i>microgestin fe 1/20 (28)</i>	79
<i>lyza</i>	79	<i>methadone 10 mg/5 ml</i>	63	<i>midodrine</i>	50
<i>mafenide acetate</i>	77	<i>methadone 5 mg/5 ml</i>	63	MIGERGOT	56
<i>malathion</i>	76	<i>methadose</i>	63	MIGRANAL	56
<i>maprotiline</i>	67	<i>methamphetamine</i>	65	MILLIPRED	44
<i>marlissa</i>	79	<i>methazolamide</i>	32	MINASTRIN 24 FE	79
MARPLAN	67	<i>methenamine hippurate</i>	3	MINIVELLE	82
Matulane	15	<i>methimazole</i>	46	<i>minocycline</i>	10
<i>matzim la</i>	21	METHITEST	45	MIRAPEX ER	57
MAXAIR AUTOHALER	71	<i>methotrexate sodium</i>	61	<i>mirtazapine</i>	67
MAXIDEX	30	<i>methotrexate sodium (pf)</i>	39	<i>misoprostol</i>	35
<i>meclizine</i>	33	<i>methscopolamine</i>	35	<i>mitomycin</i>	13
<i>meclofenamate</i>	61	<i>methyclothiazide</i>	22	<i>mitoxantrone</i>	13
<i>medroxyprogesterone</i>	82	<i>methyldopa</i>	22	M-M-R II (PF)	48
<i>mefenamic acid</i>	62	<i>methyldopa-hydrochlorothiazide</i>	20	<i>modafinil</i>	68
<i>mefloquine</i>	4			<i>moexipril</i>	17
<i>megestrol</i>	5				

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>moexipril-hydrochlorothiazide</i>	NASONEX	28	NITROLINGUAL	18
.....	NATACYN	32	NITROMIST	18
<i>mometasone</i>	<i>nateglinide</i>	27	NITROSTAT	18
<i>mometasone 0.1 %</i>	NEBUPENT	4	<i>nizatidine</i>	35
<i>montelukast</i>	<i>necon 0.5/35 (28)</i>	79	<i>nora-be</i>	79
MONUROL	<i>necon 1/35 (28)</i>	79	Norditropin FlexPro	51
<i>morphine</i>	NECON 10/11 (28)	79	Norditropin Nordiflex	51
<i>morphine concentrate</i>	<i>necon 7/7/7 (28)</i>	79	<i>norethindrone (contraceptive)</i>	79
MOVIPREP	<i>nefazodone</i>	67	.....	79
MOXEZA	<i>neomycin</i>	3	<i>norethindrone acetate</i>	82
Mozobil	<i>neomycin-bacitracin-poly-hc</i>	29	NORMOSOL-M IN D5W	41
MULTAQ	.....	29	NORMOSOL-R IN D5W	42
<i>mupirocin</i>	<i>neomycin-bacitracin-polymyxin</i>	29	NORMOSOL-R PH 7.4	42
<i>mupirocin calcium</i>	.....	29	NOROXIN	9
MUSTARGEN	<i>neomycin-polymyxin-dexameth</i>	30	NORPACE CR	19
MYCAMINE	.....	30	<i>nortrel 0.5/35 (28)</i>	80
MYCOBUTIN	<i>neomycin-polymyxin-gramicidin</i>	30	<i>nortrel 1/35 (21)</i>	80
<i>mycophenolate mofetil</i>	.....	30	<i>nortrel 1/35 (28)</i>	80
MYFORTIC	<i>neomycin-polymyxin-hc</i>	29	<i>nortrel 7/7/7 (28)</i>	80
<i>myorisan</i>	<i>neomycin-polymyxin-hc</i>	30	<i>nortriptyline</i>	67
Myozyme	NEPHRAMINE 5.4 %	43	NORVIR	5
MYRBETRIQ	Neulasta	10	NOVOLIN 70/30	25
MYTELASE	Neumega	10	NOVOLIN N	25
<i>nabumetone</i>	Neupogen	11	NOVOLIN R	26
<i>nadolol</i>	NEUPRO	57	NOVOLOG	26
<i>nadolol-bendroflumethiazide</i>	NEVANAC	30	NOVOLOG FLEXPEN	26
.....	<i>nevirapine</i>	5	NOVOLOG MIX 70-30	26
<i>nafcillin</i>	Nexavar	16	NOVOLOG MIX 70-30	26
<i>nafcillin in dextrose iso-osm</i>	NEXTERONE	19	FLEXPEN	26
NAFTIN	<i>niacor</i>	23	NUEDEXTA	57
NAFTIN 1 %	NIASPAN	23	NULOJIX	49
Naglazyme	EXTENDED-RELEASE	23	Nutropin	51
NALFON	<i>nicardipine</i>	21	Nutropin AQ	51
<i>naloxone</i>	NICOTROL	54	Nutropin AQ Nuspin	51
<i>naltrexone</i>	NICOTROL NS	54	NUVARING	80
NAMENDA	<i>nifediac cc</i>	21	<i>nyamyc</i>	75
NAMENDA TITRATION PAK	<i>nifedical xl</i>	21	<i>nystatin</i>	2
.....	<i>nifedipine</i>	21	<i>nystatin</i>	75
NAMENDA XR	NILANDRON	16	<i>nystatin</i>	76
<i>naphazoline</i>	<i>nimodipine</i>	21	<i>nystatin-triamcinolone</i>	76
<i>naproxen</i>	<i>nisoldipine</i>	21	<i>nystop</i>	76
<i>naproxen sodium</i>	NITRO-BID	18	octreotide acetate 1,000	
<i>naratriptan</i>	<i>nitroglycerin</i>	18	mcg/mL, 500 mcg/mL	49

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>octreotide acetate 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	OXISTAT	76	<i>penicillin g sodium</i>	40
<i>ofloxacin</i>	OXSORALEN	77	<i>penicillin v potassium</i>	8
<i>ofloxacin</i>	OXSORALEN ULTRA	77	PENNSAID	61
<i>ofloxacin</i>	<i>oxybutynin chloride</i>	55	PENTAM	4
<i>olanzapine</i>	<i>oxycodone</i>	64	PENTASA	36
<i>olanzapine-fluoxetine</i>	<i>oxycodone 10 mg, 15 mg, 20 mg, 30 mg</i>	64	<i>pentazocine-acetaminophen</i>	64
OLEPTRO ER	<i>oxycodone 5 mg</i>	64	<i>pentostatin</i>	14
<i>omeprazole</i>	<i>oxycodone-acetaminophen</i>	64	<i>pentoxifylline</i>	11
<i>omeprazole-sodium bicarbonate</i>	<i>oxycodone-acetaminophen 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	64	PERFOROMIST	71
OMNITROPE	<i>oxycodone-acetaminophen 10-650 mg</i>	64	<i>perindopril erbumine</i>	17
<i>ondansetron</i>	<i>oxycodone-acetaminophen 7.5-500 mg</i>	64	<i>periogard</i>	28
<i>ondansetron hcl</i>	<i>oxycodone-acetaminophen 10-650 mg</i>	64	PERJETA	14
<i>ondansetron hcl (pf)</i>	<i>oxycodone-acetaminophen 7.5-500 mg</i>	64	<i>permethrin</i>	76
<i>ondansetron hcl 24 mg</i>	<i>oxycodone-aspirin</i>	64	<i>perphenazine</i>	69
<i>ondansetron hcl 4 mg, 8 mg</i>	OXYCONTIN	64	<i>perphenazine-amitriptyline</i>	69
ONE TOUCH TEST	<i>oxymorphone</i>	64	PERTZYE	33
ONE TOUCH ULTRA TEST	OXYTROL	55	PEXEVA	67
.....	PACERONE	19	PFIZERPEN-G	40
ONE TOUCH VERIO	<i>paclitaxel</i>	14	<i>phenelzine</i>	67
ONFI	<i>pamidronate</i>	40	<i>phenobarbital</i>	59
ONGLYZA	PANCREAZE	33	<i>phenytoin</i>	59
ONTAK	PANDEL	75	<i>phenytoin sodium</i>	59
ORAP	Panretin	77	<i>phenytoin sodium extended</i>	59
ORAPRED	<i>pantoprazole</i>	35	PHOSLYRA	53
ORAPRED ODT	<i>pantoprazole</i>	40	PICATO 0.015 %.....	77
Orencia	<i>paromomycin</i>	4	PICATO 0.05 %.....	77
Orfadin	<i>paroxetine hcl</i>	67	<i>pilocarpine hcl</i>	28
<i>orsythia</i>	PASER	9	PILOPINE HS	32
ORTHO EVRA	PAXIL	67	<i>pindolol</i>	21
ORTHO TRI-CYCLEN (28)	PCE	8	<i>pioglitazone</i>	27
.....	<i>pedi-dri</i>	76	<i>pioglitazone-glimepiride</i>	27
OSMOPREP	PEDVAX HIB (PF)	48	<i>pioglitazone-metformin</i>	27
OVCON-50 (28)	PEGANONE	59	<i>piperacillin-tazobactam</i>	40
<i>oxacillin</i>	Pegasys	5	<i>pirmella</i>	80
<i>oxacillin in dextrose(iso-osm)</i>	Pegasys Convenience Pack	5	<i>piroxicam</i>	61
.....	Pegasys ProClick	6	PLASMA-LYTE 148	42
<i>oxaliplatin</i>	PegIntron	6	PLASMA-LYTE A	42
<i>oxandrolone 10 mg</i>	PegIntron Redipen	6	PLASMA-LYTE-56 IN D5W	42
<i>oxandrolone 2.5 mg</i>	<i>penicillin g pot in dextrose</i>	40	.....	42
<i>oxazepam</i>	<i>penicillin g potassium</i>	40	PNEUMOVAX 23	48
<i>oxcarbazepine</i> .....	.....	.....	<i>podofilox</i>	78
.....	.....	.....	<i>polyethylene glycol 3350</i>	34
.....	.....	.....	<i>polymyxin b sulfate</i>	40
.....	.....	.....	Pomalyst	16

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>portia</i>	80	PREVALITE	23	PROVIGIL	68
<i>potassium chlorid-d5-0.45%nacl</i>	42	PREVNAR 13 (PF)	48	<i>prudoxin</i>	77
<i>potassium chloride</i>	24	PREVPAC	35	PULMICORT 1 MG/2 ML	71
<i>potassium chloride</i>	40	PREZISTA	6	PULMICORT FLEXHALER	71
<i>potassium chloride</i>	42	PRIFTIN	9	Pulmozyme	50
<i>potassium chloride 10 meq</i>	24	<i>primaquine</i>	4	PYLERA	35
<i>potassium chloride 8 meq</i>	24	PRIMAXIN IV	40	<i>pyrazinamide</i>	9
<i>potassium chloride in 0.9%nacl</i>	42	<i>primidone</i>	59	<i>pyridostigmine bromide</i>	53
<i>potassium chloride in d5w</i>	42	PRIMSOL	3	QUALAQUIN	4
<i>potassium chloride in lr-d5</i>	42	PRISTIQ	67	QUARTETTE	80
<i>potassium chloride-0.45 % nacl</i>	42	Privigen	48	<i>quasense</i>	80
<i>potassium chloride-d5-0.2%nacl</i>	42	PROAIR HFA	71	<i>quetiapine 100 mg, 200 mg, 300 mg, 400 mg</i>	70
<i>potassium chloride-d5-0.3%nacl</i>	42	<i>probenecid</i>	61	<i>quetiapine 25 mg, 50 mg</i>	70
<i>potassium chloride-d5-0.9%nacl</i>	42	PROCALAMINE 3%	44	QUILLIVANT XR	66
<i>potassium citrate</i>	55	<i>prochlorperazine</i>	33	<i>quinapril</i>	17
POTIGA	59	<i>prochlorperazine edisylate</i>	33	<i>quinapril-hydrochlorothiazide</i>	20
PRADAXA	11	<i>prochlorperazine maleate</i>	33	<i>quinidine gluconate</i>	19
<i>pramipexole</i>	57	PROCRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	11	<i>quinidine sulfate</i>	19
PRANDIMET	27	Procrit 20,000 unit/mL, 40,000 unit/mL	11	<i>quinine sulfate</i>	4
PRANDIN	27	<i>proctocream-hc</i>	77	QVAR	71
<i>pravastatin</i>	23	<i>progesterone micronized</i>	82	RABAVERT (PF)	48
<i>prazosin</i>	18	PROGLYCEM	25	<i>ramipril</i>	17
PRED MILD	31	PROGRAF	40	RANEXA	18
PRED-G	31	Prolastin C	72	<i>ranitidine hcl</i>	35
PRED-G S.O.P.	31	PROLENSA	31	RAPAMUNE	49
<i>prednicarbate</i>	75	Proleukin	14	REBETOL	6
<i>prednisolone acetate</i>	31	PROLIA	82	Rebif	53
<i>prednisolone sodium phosphate</i>	44	Promacta	11	Rebif Titration Pack	53
<i>prednisone</i>	45	<i>propafenone</i>	19	RECLAST	82
PREDNISONONE INTENSOL	45	<i>propantheline</i>	34	RECOMBIVAX HB (PF)	48
PREMARIN	82	<i>propranolol</i>	21	Regranex	77
PREMASOL 10 %	44	<i>propranolol-hydrochlorothiazid</i>	20	RELENZA DISKHALER	6
PREMASOL 6 %	44	<i>propylthiouracil</i>	46	RELISTOR	35
PREMPHASE	82	PROQUAD (PF)	48	Remicade	61
PREMPRO	82	PROSOL 20%	44	Remodulin	40
<i>prenatal plus with iron (ca)</i>	82	PROTONIX	40	RENAGEL	53
		PROTOPIC	77	REVELA	53
		<i>protriptyline</i>	67	<i>repaglinide</i>	27
		PROVENTIL HFA	71	RESCRIPTOR	6
				<i>reserpine</i>	22

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

RESTASIS	32	SANDOSTATIN 50		SOLARAZE	77
RETIN-A	73	MCG/ML	49	SOLTAMOX	16
RETIN-A MICRO	73	Sandostatin LAR Depot	49	SOLU-CORTEF (PF)	45
RETROVIR	40	SANTYL	77	SOLU-MEDROL (PF)	45
REVATIO	54	SAPHRIS	70	Somatuline Depot	49
REVLIMID 10 mg, 15 mg, 25		SAVELLA	59	Somavert	49
mg, 5 mg	16	<i>selegiline hcl</i>	57	SORIATANE	76
REVLIMID 2.5 mg	16	<i>selenium sulfide</i>	77	<i>sorine</i>	19
REYATAZ	6	Selzentry 150 mg	6	<i>sotalol</i>	19
RibaPak Dose Pack	6	Selzentry 300 mg	6	<i>sotalol af</i>	19
<i>ribasphere</i>	6	SENSIPAR 30 MG	52	SPECTRACEF	8
<i>ribasphere 200 mg, 400 mg</i>	6	Sensipar 60 mg, 90 mg	52	SPIRIVA WITH	
Ribasphere 600 mg	6	SEREVENT DISKUS	71	HANDIHALER	72
<i>ribavirin</i>	6	SEROMYCIN	9	<i>spironolactone</i>	22
RIDAURA	61	SEROQUEL 100 MG, 200 MG,		<i>spironolactone</i>	24
RIFAMATE	9	300 MG, 400 MG	70	<i>spironolacton-hydrochlorothiaz</i>	
<i>rifampin</i>	9	SEROQUEL 25 MG, 50 MG	70	.....	22
RIFATER	9	SEROQUEL XR	70	Sprycel 100 mg, 140 mg	16
Rilutek	49	Serostim	51	Sprycel 20 mg, 50 mg, 70 mg,	
<i>riluzole</i>	49	<i>sertraline</i>	67	80 mg	16
<i>rimantadine</i>	6	SFROWASA	36	<i>ssd</i>	73
<i>ringers</i>	42	Signifor	50	STALEVO 100	57
RIOMET	27	sildenafil	54	STALEVO 125	57
RISPERDAL CONSTA	66	<i>silver sulfadiazine</i>	73	STALEVO 150	57
<i>risperidone</i>	66	SIMBRINZA	32	STALEVO 200	57
<i>risperidone</i>	70	SIMCOR	23	STALEVO 50	57
Rituxan	14	Simponi	61	STALEVO 75	57
<i>rivastigmine</i>	56	Simulect	49	<i>stavudine</i>	6
<i>rizatriptan</i>	56	<i>simvastatin</i>	23	STAVZOR	59
<i>ropinirole</i>	57	SIRTURO	9	Stelara	76
ROTATEQ VACCINE	48	SKELID	53	STIMATE	11
ROXICET	64	SKLICE	76	Stivarga	16
ROZEREM	68	<i>sodium chloride</i>	42	STRATTERA 10 MG, 18 MG,	
Sabril	59	<i>sodium chloride</i>	77	25 MG, 40 MG, 60 MG	66
SAFYRAL	80	<i>sodium chloride 0.45 %</i>	42	STRATTERA 100 MG, 80	
Saizen	51	<i>sodium chloride 0.9 %</i>	42	MG	66
Saizen click.easy	51	<i>sodium chloride 3 %</i>	42	STRIANT	45
SAMSCA	55	<i>sodium chloride 5 %</i>	42	STRIBILD	6
SANCTURA XR	55	<i>sodium fluoride</i>	28	STROMEKTOL	3
SANCUSO	33	<i>sodium lactate</i>	42	SUBOXONE	68
Sandostatin 1,000 mcg/mL, 100		<i>sodium phenylbutyrate</i>	33	SUBSYS	64
mcg/mL, 200 mcg/mL, 500		<i>sodium polystyrene (sorb free)</i>		<i>sucralfate</i>	35
mcg/mL	49	.....	54	<i>sulfacetamide sodium</i>	30

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>sulfacetamide sodium (acne)</i>	Tasigna	TIROSINT
.....77	TASMAR	Tivicay
<i>sulfacetamide-prednisolone</i> .....30	Taxotere	<i>tizanidine</i> .....60
<i>sulfadiazine</i> .....9	TAZORAC	Tobi
<i>sulfamethoxazole-trimethoprim</i>	<i>taztia xt</i> .....21	Tobi Podhaler
.....9	Tecfidera 120 mg (14)- 240 mg	TOBRADEX
<i>sulfamethoxazole-trimethoprim</i>	(46).....53	TOBRADEX ST
.....40	Tecfidera 120 mg, 240 mg	<i>tobramycin</i> .....30
SULFAMYLON	TEFLARO	<i>tobramycin in 0.9 % nacl</i> .....40
.....77	TEGRETOL XR 100 MG	<i>tobramycin sulfate</i> .....40
<i>sulfasalazine</i> .....36	<i>temazepam</i> .....68	<i>tobramycin-dexamethasone</i> .....30
<i>sulfazine ec</i> .....36	TEMODAR	<i>tolazamide</i> .....27
<i>sulindac</i> .....61	<i>terazosin</i> .....18	<i>tolbutamide</i> .....27
<i>sumatriptan succinate</i> .....56	<i>terbinafine</i> .....2	<i>tolmetin</i> .....61
SUPRAX	<i>terbutaline</i> .....72	<i>topiramate</i> .....59
.....8	<i>terconazole</i> .....83	<i>toposar</i> .....14
SUPREP	TESTIM	<i>topotecan</i> .....14
.....34	.....45	Torisel
SUSTIVA	<i>testosterone cypionate</i> .....45	.....14
.....6	<i>testosterone enanthate</i> .....45	<i>torseamide</i> .....22
Sutent	TESTRED	<i>tpn electrolytes</i> .....44
.....16	.....45	Tracleer
Sylatron	<i>tetanus toxoid,adsorbed (pf)</i> .....48	.....54
.....14	<i>tetanus-diphtheria toxoids-td</i>	TRADJENTA
SYMBICORT	.....48	.....27
.....72	<i>tetracycline</i> .....10	<i>tramadol</i> .....64
SYMBYAX	TEV-TROPIN	<i>tramadol-acetaminophen</i> .....64
.....66	.....51	<i>trandolapril</i> .....17
SYMLINPEN 120	THALITONE	<i>tranexamic acid</i> .....11
.....26	.....22	TRANSDERM-SCOP
SYMLINPEN 60	Thalomid	.....33
.....26	.....16	<i>tranylcypromine</i> .....67
Synagis	<i>theophylline</i> .....72	TRAVASOL 10 %
.....54	<i>thioridazine</i> .....70	.....44
SYNAREL	<i>thiotepa</i> .....14	TRAVATAN Z
.....46	<i>thiothixene</i> .....70	.....32
SYNERA	THYROLAR-1	<i>travoprost (benzalkonium)</i> .....32
.....77	.....46	<i>trazodone</i> .....68
SYNERCID	THYROLAR-1/2	Treanda
.....40	.....46	.....14
Synribo	THYROLAR-1/4	TRECATOR
.....14	.....46	.....9
SYNTHROID	THYROLAR-2	TRELSTAR
.....46	.....46	.....46
SYPRINE	THYROLAR-3	<i>tretinoin</i> .....73
.....56	<i>tiagabine</i> .....59	<i>tretinoin (chemotherapy)</i> .....16
TABLOID	<i>ticlopidine</i> .....11	TRETIN-X
.....16	TIKOSYN	.....73
<i>tacrolimus 0.5 mg, 1 mg</i>.....49	TIMENTIN	TRETIN-X (GEL)
<i>tacrolimus 5 mg</i>.....49	.....40	.....73
Tafinlar	<i>timolol maleate</i> .....21	TREXALL
.....16	<i>timolol maleate</i> .....32	.....61
TAMIFLU	<i>tinidazole</i> .....4	<i>triamcinolone acetonide</i> .....28
.....6		<i>triamcinolone acetonide</i> .....75
TAMIFLU 30 MG		<i>triamterene-hydrochlorothiazid</i>
.....6		.....20
TAMIFLU 45 MG, 75 MG		
.....6		
<i>tamoxifen</i> .....16		
<i>tamsulosin</i> .....55		
Tarceva 100 mg		
.....16		
Tarceva 150 mg, 25 mg		
.....16		
Targretin		
.....16		
Targretin		
.....17		
TARKA		
.....20		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>triamterene-hydrochlorothiazid</i>	UVADEx	14	<i>vincristine</i>	14
.....	VAGIFEM	82	<i>vinorelbine</i>	14
<i>triazolam</i>	<i>valacyclovir</i>	6	VIOKACE	33
<i>triderm</i>	Valcyte	7	VIRACEPT	7
<i>trifluoperazine</i>	<i>valproate sodium</i>	40	VIRAMUNE	7
<i>trifluridine</i>	<i>valproic acid</i>	59	VIRAMUNE XR	7
<i>trihexyphenidyl</i>	<i>valproic acid (as sodium salt)</i>	59	VIREAD	7
TRILEPTAL	.....	59	VISTIDE	40
<i>trilyte with flavor packets</i>	<i>valsartan-hydrochlorothiazide</i>	20	VIVACTIL	68
<i>trimethoprim</i>	.....	20	VIVELLE-DOT	82
<i>trimethoprim-polymyxin b</i>	Vancocin	3	VOLTAREN	61
<i>trimipramine</i>	<i>vancomycin</i>	3	VORAXAZE	17
<i>trinessa (28)</i>	<i>vancomycin</i>	40	<i>voriconazole</i>	40
<i>tri-previfem (28)</i>	<i>vandazole</i>	83	<i>voriconazole 200 mg</i>	3
TRISENOX	VANOS	75	<i>voriconazole 50 mg</i>	3
<i>tri-sprintec (28)</i>	VAQTA (PF)	48	Votrient	16
<i>trivora (28)</i>	VARIVAX (PF)	48	VPRIV	51
TRIZIVIR	VECTIBIX	14	VYTORIN 10-10	23
TROPHAMINE 10 %	Velcade	14	VYTORIN 10-20	23
TROPHAMINE 6%	<i>velivet triphasic regimen (28)</i>	80	VYTORIN 10-40	23
<i>tropium</i>	.....	80	VYTORIN 10-80	23
TRUVADA	<i>venlafaxine</i>	68	VYVANSE	66
TUDORZA PRESSAIR	Ventavis	54	<i>warfarin</i>	11
TWINJECT AUTOINJECTOR	VENTAVIS	72	<i>water for irrigation, sterile</i>	77
.....	VENTOLIN HFA	72	WELCHOL	23
TWINRIX (PF)	<i>verapamil</i>	21	WESTCORT	75
TYGACIL	VERIPRED 20	45	Xalkori	16
Tykerb	VESICARE	55	XARELTO 10 MG	11
TYPHIM VI	<i>vestura</i>	80	XARELTO 15 MG, 20 MG	11
TYSABRI	VEXOL	31	Xeljanz	61
TYVASO	Vfend	3	Xeloda	16
TYZEKA	VFEND IV	40	Xenazine 12.5 mg	52
TYZINE	VIBATIV	40	Xenazine 25 mg	52
UCERIS	VIBRAMYCIN	10	Xgeva	82
<i>u-cort</i>	VICTOZA 3-PAK	26	XIFAXAN 200 MG	3
ULESFIA	Victrelis	7	XIFAXAN 550 MG	3
ULORIC	Vidaza	14	Xolair	72
ULTRESA	VIDEX 2 GRAM PEDIATRIC	7	XOPENEX	72
<i>unithroid</i>	.....	7	XOPENEX HFA	72
UROCIT-K 10	VIGAMOX	30	Xtandi	17
UROCIT-K 15	VIIBRYD	68	Xyrem	68
UROCIT-K 5	VIMPAT	59	YERVOY	14
<i>ursodiol</i>	<i>vinblastine</i>	14	YF-VAX (PF)	48
			<i>zafirlukast</i>	72

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.

<i>zaleplon</i>	68	ZUBSOLV	68
ZALTRAP	14	ZYDONE	64
ZANOSAR	14	ZYLET	31
Zavesca	51	ZYPREXA	70
<i>zazole</i>	83	Zytiga	17
Zelboraf	7	Zyvox	3
Zemaira	72	Zyvox	41
ZEMPLAR	41		
ZEMPLAR	52		
ZENCHENT FE	80		
ZENPEP	33		
<i>zeosa</i>	80		
ZERIT	7		
ZETIA	23		
ZIAGEN	7		
<i>zidovudine</i>	7		
ZINACEF	41		
ZINACEF IN DEXTROSE (ISO-OSM)	41		
ZINACEF IN STERILE WATER	41		
ZINECARD	17		
ZIOPTAN (PF)	32		
<i>ziprasidone hcl</i>	70		
ZIRGAN	31		
ZMAX	8		
<i>zoledronic acid</i>	82		
<i>zoledronic acid-mannitol-water</i>	82		
Zolinza	17		
<i>zolpidem</i>	68		
ZOMETA	82		
ZONALON	77		
<i>zonisamide</i>	59		
Zorbtive	52		
ZORTRESS	49		
ZOSTAVAX (PF)	48		
ZOSYN	41		
ZOSYN IN DEXTROSE (ISO-OSM)	41		
<i>zovia 1/35e (28)</i>	80		
<i>zovia 1/50e (28)</i>	80		
ZOVIRAX	78		

For Tufts Medicare Preferred HMO Prime Rx Plus members we provide coverage for Tier-1 and Tier-2 drugs through the Coverage Gap.

B/D: Medicare Part B or D \ HI: Home Infusion Drug \ LA: Limited Access Drug \ PA: Prior Authorization Required \ QL: Quantity Limit Applies \ STPA: Step Therapy Prior Authorization Applies \ Transplant: This drug is covered under Part B for members who have received a Medicare-covered organ transplant

* Part B Drug - No co-payment is required and the cost of the medication does not apply to your Part D benefit.