



Essential Drug List

Drug list — Five Tier Drug Plan

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

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

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

Here are a few things to remember:

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 Please note: The formulary is subject to change and all previous versions of the formulary are no longer in effect.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

Essential Drug List

Five-Tier

Table of Contents

INFORMATIONAL SECTION	4
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS FOR THE NERVOUS SYSTEM	11
AMINOGLYCOSIDES - DRUGS FOR INFECTIONS	14
ANALGESICS - ANTI-INFLAMMATORY - DRUGS FOR PAIN AND FEVER	14
ANALGESICS - NONNARCOTIC - DRUGS FOR PAIN AND FEVER	17
ANALGESICS - OPIOID - DRUGS FOR PAIN AND FEVER	19
ANDROGENS-ANABOLIC - HORMONES	21
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS	22
ANTHELMINTICS - DRUGS FOR INFECTIONS	22
ANTIANGINAL AGENTS - DRUGS FOR THE HEART	22
ANTIANKXIETY AGENTS - DRUGS FOR THE NERVOUS SYSTEM	23
ANTIARRHYTHMICS - DRUGS FOR THE HEART	23
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS FOR THE LUNGS	24
ANTICOAGULANTS - DRUGS FOR THE BLOOD	27
ANTICONVULSANTS - DRUGS FOR THE NERVOUS SYSTEM	28
ANTIDEPRESSANTS - DRUGS FOR THE NERVOUS SYSTEM	31
ANTIDIABETICS - HORMONES	33
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS FOR THE STOMACH	38
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING	38
ANTIEMETICS - DRUGS FOR THE STOMACH	39
ANTIFUNGALS - DRUGS FOR INFECTIONS	40
ANTIHIISTAMINES - DRUGS FOR THE LUNGS	41
ANTIHYPERLIPIDEMICS - DRUGS FOR THE HEART	41
ANTIHYPERTENSIVES - DRUGS FOR THE HEART	43
ANTI-INFECTIVE AGENTS - MISC. - DRUGS FOR INFECTIONS	46
ANTIMALARIALS - DRUGS FOR INFECTIONS	48
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS FOR NERVES AND MUSCLES	48
ANTIMYCOBACTERIAL AGENTS - DRUGS FOR INFECTIONS	48
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS FOR CANCER	49
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS FOR THE NERVOUS SYSTEM	55
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS FOR THE NERVOUS SYSTEM	56
ANTIVIRALS - DRUGS FOR INFECTIONS	59
BETA BLOCKERS - DRUGS FOR THE HEART	62
CALCIUM CHANNEL BLOCKERS - DRUGS FOR THE HEART	63
CARDIOTONICS - DRUGS FOR THE HEART	65
CARDIOVASCULAR AGENTS - MISC. - DRUGS FOR THE HEART	66
CEPHALOSPORINS - DRUGS FOR INFECTIONS	67
CONTRACEPTIVES - DRUGS FOR WOMEN	68
CORTICOSTEROIDS - HORMONES	73
COUGH/COLD/ALLERGY - DRUGS FOR THE LUNGS	74
DERMATOLOGICALS - DRUGS FOR THE SKIN	75
DIAGNOSTIC PRODUCTS	82
DIGESTIVE AIDS - DRUGS FOR THE STOMACH	83
DIURETICS - DRUGS FOR THE HEART	83
ENDOCRINE AND METABOLIC AGENTS - MISC. - HORMONES	84
ESTROGENS - HORMONES	87
FLUOROQUINOLONES - DRUGS FOR INFECTIONS	88
GASTROINTESTINAL AGENTS - MISC. - DRUGS FOR THE STOMACH	88
GENERAL ANESTHETICS - DRUGS FOR PAIN AND FEVER	90
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS FOR THE URINARY SYSTEM	90
GOUT AGENTS - DRUGS FOR PAIN AND FEVER	91
HEMATOLOGICAL AGENTS - MISC. - DRUGS FOR THE BLOOD	91
HEMATOPOIETIC AGENTS - DRUGS FOR NUTRITION	93
HEMOSTATICS - DRUGS FOR THE BLOOD	95
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS FOR THE NERVOUS SYSTEM	95
LAXATIVES - DRUGS FOR THE STOMACH	96
LOCAL ANESTHETICS-PARENTERAL - DRUGS FOR PAIN AND FEVER	99
MACROLIDES - DRUGS FOR INFECTIONS	99

MEDICAL DEVICES AND SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT	100
MIGRAINE PRODUCTS - DRUGS FOR THE NERVOUS SYSTEM.....	108
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION	109
MISCELLANEOUS THERAPEUTIC CLASSES - VITAMINS AND MINERALS.....	111
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT	113
MULTIVITAMINS - DRUGS FOR NUTRITION.....	114
MUSCULOSKELETAL THERAPY AGENTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES.....	118
*NASAL AGENTS - SYSTEMIC AND TOPICAL * - DRUGS FOR THE NOSE	119
NEUROMUSCULAR AGENTS - DRUGS FOR NERVES AND MUSCLES	119
NUTRIENTS - DRUGS FOR NUTRITION	120
OPHTHALMIC AGENTS - DRUGS FOR THE EYE	120
OTIC AGENTS - DRUGS FOR THE EAR.....	123
OXYTOCICS - HORMONES.....	124
PASSIVE IMMUNIZING AND TREATMENT AGENTS - BIOLOGICAL AGENTS.....	124
PENICILLINS - DRUGS FOR INFECTIONS	124
PROGESTINS - HORMONES	125
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS FOR THE NERVOUS SYSTEM.....	126
RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS	131
SULFONAMIDES - DRUGS FOR INFECTIONS.....	132
TETRACYCLINES - DRUGS FOR INFECTIONS	132
THYROID AGENTS - HORMONES.....	132
TOXOIDS - BIOLOGICAL AGENTS	133
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR THE STOMACH.....	134
URINARY ANTISPASMODICS - DRUGS FOR THE URINARY SYSTEM.....	135
VACCINES - BIOLOGICAL AGENTS.....	136
VAGINAL AND RELATED PRODUCTS - DRUGS FOR WOMEN.....	139
VASOPRESSORS - DRUGS FOR THE HEART	139
VITAMINS - DRUGS FOR NUTRITION	140



Essential Drug List – Informational Section

Definitions

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

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

“Coinsurance” means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

“Copayment” means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

“Deductible” means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

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

“Drug Tier” means a group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.

“Exception request” means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

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

“Formulary” or “prescription drug list” means the list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.

“Generic drug” means a drug that is the same as its BRAND name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.

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

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

“Non-formulary drug” means a prescription drug that is not listed on this formulary.

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



“Out-of-pocket costs” means your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

“Prescribing provider” means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

“Prescription” means an oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.

“Prescription drug” means a drug that by law requires a prescription.

“Prior Authorization (PA)” means a decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

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

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

“Step therapy (ST)” means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.



Frequently Asked Questions

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

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

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

How can I find a drug on the list?

(A) A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the BRAND name or **generic** name of the drug in the alphabetical index; and

(B) If a **generic** equivalent for a BRAND name drug is not available on the market or is not covered, the drug will not be separately listed by its **generic** name.

You can search the PDF drug list by:

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

How are drugs shown on the list?

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

PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS TYPE - DRUGS FOR SEVERE MENTAL DISORDERS
NUEDEXTA ORAL CAPSULE (<i>dextromethorphan</i>)

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

AMINOPENICILLIN ANTIBIOTIC - ANTIBIOTICS
<i>amoxicillin oral capsule</i>

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

<i>levonorgestrel-ethinyl estrad</i> (Portia 28 Oral Tablet)

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

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



What are my options for getting my prescriptions?

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

Current Anthem members can find out more by logging in at [anthem.com/ca](https://www.anthem.com/ca) and choose Prescription Benefits or call 833-236-6196. For more details about your coverage, you can call the phone number on your member ID card.

What if my drug isn't on the list?

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

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

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

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

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

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

Who decides what drugs are on the list?

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

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

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

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

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

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



What kind of drugs can I find on the formulary?

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

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

What drugs can I find in each tier?

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

- Tier 1 drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions. Some plans split Tier 1 into Tier 1a and Tier 1b:
 - Tier 1a drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.
 - Tier 1b drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.
- Tier 2 drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.
- Tier 3 drugs have the highest cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition. Tier 3 may also include drugs that were recently approved by the FDA or specialty drugs that are used to treat serious, long-term health conditions and that may need special handling.
- Tier 4 drugs have the highest cost share and usually include specialty BRAND and generic drugs. They may cost more than drugs on lower tiers that are used to treat the same condition. Tier 4 may also include drugs recently approved by the FDA or specialty drugs used to treat serious, long-term health conditions and that may need special handling.
- Tier 5 drugs have the highest cost share. Drugs in this tier are non-preferred specialty brand and generic drugs. Tier 5 may also include drugs recently approved by the FDA or specialty drugs used to treat serious, long-term health conditions and that may need special handling.

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

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

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

How does Anthem promote safety?

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



Our clinical edit programs are:

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

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

How does my doctor start the Prior Authorization process?

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

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

What is Step Therapy? How does it work?

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

A few more notes about the exception process:

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

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

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

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

KEY

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

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

generic drugs are in lower case, italic bold type.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Tier 4 = Tier 4 drugs have a higher cost share and usually include preferred specialty brand and generic drugs.

Tier 5 = Tier 5 drugs have the highest cost share. Drugs in this tier are non-preferred specialty brand and generic drugs.

Five-Tier

CURRENT AS OF 1/1/2025

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

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; DO
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; QL (1 capsule per 1 day)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; DO
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG (<i>lisdexamfetamine dimesylate</i>)	2	PA; QL (1 tablet per 1 day)
<i>zenzedi oral tablet 10 mg, 7.5 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>zenzedi oral tablet 15 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>zenzedi oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>zenzedi oral tablet 20 mg, 30 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
*ANALEPTICS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>caffeine citrate oral solution</i>	2	
*ANOREXIANTS NON-AMPHETAMINE*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>benzphetamine hcl oral tablet</i>	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
<i>diethylpropion hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
<i>diethylpropion hcl oral tablet</i>	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
<i>phendimetrazine tartrate oral tablet</i>	1 or 1b*	PA; BE; QL (6 tablets per 1 day)
<i>phentermine hcl oral capsule</i>	1 or 1b*	PA; BE; QL (1 capsule per 1 day)
<i>phentermine hcl oral tablet</i>	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
*ANTI-OBESITY - GIP & GLP-1 RECEPTOR AGONISTS*** - DRUGS FOR THE NERVOUS SYSTEM		
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tirzepatide-weight management</i>)	2	PA; BE; QL (1 pen per 1 week)
*ANTI-OBESITY - GLP-1 RECEPTOR AGONISTS*** - DRUGS FOR THE NERVOUS SYSTEM		
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>liraglutide - weight management</i>)	3	PA; BE; QL (3 mg per 1 day)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>semaglutide-weight management</i>)	2	PA; BE; QL (1 pen per 1 week)
*HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS*** - DRUGS FOR SLEEP DISORDER		
WAKIX ORAL TABLET 17.8 MG (<i>pitolisant hcl</i>)	5	PA; LD; QL (2 tablets per 1 day); SP
WAKIX ORAL TABLET 4.45 MG (<i>pitolisant hcl</i>)	5	PA; LD; DO; SP
*LIPASE INHIBITORS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>orlistat oral capsule</i>	2	PA; BE; QL (3 capsules per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*STIMULANTS - MISC.*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	2	PA; QL (1 tablet per 1 day)
<i>armodafinil oral tablet 50 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg</i>	1 or 1b*	ST; DO
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg</i>	1 or 1b*	ST; QL (1 capsule per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 5 mg</i>	1 or 1b*	PA; DO
<i>dexmethylphenidate hcl oral tablet 10 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg</i>	1 or 1b*	PA; QL (2 capsules per 1 day)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 45 mg, 63 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 54 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
METHYLPHENIDATE HCL ER (OSM) ORAL TABLET EXTENDED RELEASE 72 MG	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 40 mg, 50 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	1 or 1b*	PA; QL (30 mL per 1 day)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	1 or 1b*	PA; QL (60 mL per 1 day)
<i>methylphenidate hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl oral tablet 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl oral tablet chewable 10 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl oral tablet chewable 2.5 mg</i>	1 or 1b*	ST; DO
<i>methylphenidate hcl oral tablet chewable 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr</i>	2	ST; DO

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate transdermal patch 20 mg/9hr, 30 mg/9hr</i>	2	ST; QL (1 patch per 1 day)
<i>modafinil oral tablet 100 mg</i>	2	PA; DO
<i>modafinil oral tablet 200 mg</i>	2	PA; QL (1 tablet per 1 day)
AMINOGLYCOSIDES - DRUGS FOR INFECTIONS		
*AMINOGLYCOSIDES*** - ANTIBIOTICS		
<i>amikacin sulfate injection solution</i>	2	
<i>gentamicin in saline intravenous solution</i>	2	
<i>gentamicin sulfate injection solution</i>	2	
<i>neomycin sulfate oral tablet</i>	1 or 1a*	
<i>streptomycin sulfate intramuscular solution reconstituted</i>	1 or 1b*	
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	4	LD; QL (224 mL per 28 days); SP
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	4	LD; QL (10 mL per 1 day); SP
<i>tobramycin sulfate injection solution 1.2 gm/30ml</i>	2	QL (900 mL per 30 days)
<i>tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml</i>	2	QL (180 mL per 30 days)
<i>tobramycin sulfate injection solution 2 gm/50ml</i>	2	QL (1500 mL per 30 days)
<i>tobramycin sulfate injection solution reconstituted</i>	2	QL (30 vials per 30 days)
ANALGESICS - ANTI-INFLAMMATORY - DRUGS FOR PAIN AND FEVER		
*ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
RINVOQ LQ ORAL SOLUTION (<i>upadacitinib</i>)	4	PA; LD; QL (12 mL per 1 day); SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (<i>upadacitinib</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (<i>upadacitinib</i>)	4	PA; LD; QL (84 tablets per 12 weeks); SP
XELJANZ ORAL SOLUTION (<i>tofacitinib citrate</i>)	5	PA; LD; QL (10 mL per 1 day); SP
XELJANZ ORAL TABLET (<i>tofacitinib citrate</i>)	5	PA; LD; QL (2 tablets per 1 day); SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>tofacitinib citrate</i>)	5	PA; LD; QL (1 tablet per 1 day); SP
*ANTIRHEUMATIC ANTIMETABOLITES*** - ARTHRITIS AND PAIN DRUGS		
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>methotrexate (anti-rheumatic)</i>)	4	PA; LD; QL (4 auto-injector per 28 days); SP
*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES*** - ARTHRITIS AND PAIN DRUGS		
<i>adalimumab-adbm (2 pen) subcutaneous auto-injector kit</i>	4	PA; LD; QL (2 auto-injectors per 28 days)
<i>adalimumab-adbm (2 syringe) subcutaneous prefilled syringe kit</i>	4	PA; LD; QL (2 syringes per 28 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.4ml</i>	4	PA; LD; QL (1 month per 6 one-time fills)
<i>adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.8ml</i>	4	PA; LD; QL (1 kit per 1 one-time fill)
<i>adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.4ml</i>	4	PA; LD; QL (1 month per 6 one-time fills)
<i>adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.8ml</i>	4	PA; LD; QL (1 kit per 1 one-time fill)
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab</i>)	4	PA; LD; QL (2 pens per 28 days); SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	4	PA; LD; QL (2 pens per 28 days (QL exception needed for maintenance therapies); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT (<i>adalimumab</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (<i>adalimumab</i>)	4	PA; LD; QL (1 kit per 1 one-time fill); SP
HUMIRA-PSORIASIS/UEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (<i>adalimumab</i>)	4	PA; LD; QL (1 kit per 1 one-time fill); SP
SIMPONI ARIA INTRAVENOUS SOLUTION (<i>golimumab</i>)	4	PA; LD; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>golimumab</i>)	4	PA; LD; QL (1 pen per 28 days); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>golimumab</i>)	4	PA; LD; QL (1 syringe per 28 days); SP
*CYCLOOXYGENASE 2 (COX-2) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	2	QL (2 capsules per 1 day)
<i>celecoxib oral capsule 400 mg</i>	2	QL (1 capsule per 1 day)
*GOLD COMPOUNDS*** - ARTHRITIS AND PAIN DRUGS		
RIDAURA ORAL CAPSULE (<i>auranofin</i>)	2	QL (3 capsules per 1 day)
*NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg</i>	2	QL (4 tablets per 1 day)
<i>diclofenac-misoprostol oral tablet delayed release 75-0.2 mg</i>	2	QL (2 tablets per 1 day)
*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*** - ARTHRITIS AND PAIN DRUGS		
<i>diclofenac potassium oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diclofenac sodium er oral tablet extended release 24 hour</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 25 mg</i>	1 or 1b*	QL (5 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>ec-naproxen oral tablet delayed release</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>etodolac er oral tablet extended release 24 hour 600 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>etodolac oral capsule 200 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>etodolac oral capsule 300 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>etodolac oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>flurbiprofen oral tablet 100 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>flurbiprofen oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>ibu oral tablet</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>indomethacin er oral capsule extended release</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>indomethacin oral capsule 25 mg</i>	1 or 1b*	QL (3 capsule per 1 day)
<i>indomethacin oral capsule 50 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>ketoprofen er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>ketorolac tromethamine injection solution 15 mg/ml</i>	2	QL (4 ML per 30 days)
KETOROLAC TROMETHAMINE INJECTION SOLUTION 30 MG/ML	2	QL (2 mL per 30 days)
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	2	QL (2 mL per 30 days)
<i>ketorolac tromethamine oral tablet</i>	1 or 1a*	QL (20 tablets per 30 days)
<i>meclofenamate sodium oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>mefenamic acid oral capsule</i>	1 or 1b*	QL (29 capsule per 1 fill)
<i>meloxicam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>nabumetone oral tablet 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>nabumetone oral tablet 750 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>naproxen dr oral tablet delayed release</i>	1 or 1b*	
<i>naproxen oral tablet 250 mg, 375 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>naproxen oral tablet 500 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>naproxen oral tablet delayed release</i>	1 or 1b*	
<i>naproxen sodium oral tablet 275 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>naproxen sodium oral tablet 550 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>oxaprozin oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>piroxicam oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>sulindac oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>tolmetin sodium oral capsule</i>	2	QL (3 capsules per 1 day)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
OTEZLA ORAL TABLET (<i>apremilast</i>)	4	PA; LD; QL (2 tablets per 1 day); SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	4	PA; LD; QL (1 pack per 365 days); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (apremilast)	4	PA; LD; QL (1 pack per 1 one-time fill); SP
*PYRIMIDINE SYNTHESIS INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
<i>leflunomide oral tablet</i>	2	QL (1 tablet per 1 day)
*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS*** - ARTHRITIS AND PAIN DRUGS		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE (etanercept)	4	PA; LD; QL (4 cartridge per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION (etanercept)	4	PA; LD; QL (8 injections per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (etanercept)	4	PA; LD; QL (8 syringes per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (etanercept)	4	PA; LD; QL (4 syringes per 28 days); SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (etanercept)	4	PA; LD; QL (4 pens per 28 days); SP
ANALGESICS - NONNARCOTIC - DRUGS FOR PAIN AND FEVER		
*ANALGESICS OTHER*** - ARTHRITIS AND PAIN DRUGS		
<i>acetaminophen intravenous solution</i>	1 or 1b*	
*ANALGESICS-SEDATIVES*** - ARTHRITIS AND PAIN DRUGS		
<i>bac oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-acetaminophen oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-apap-cafeine oral capsule 50-300-40 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>butalbital-apap-cafeine oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-aspirin-cafeine oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>tencon oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*SALICYLATES*** - ARTHRITIS AND PAIN DRUGS		
<i>aspirin 81 oral tablet chewable</i>	1 or 1a*; \$0	
<i>aspirin 81 oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin adult low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin adult low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin childrens oral tablet chewable</i>	1 or 1a*; \$0	
<i>aspirin ec adult low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin ec low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin ec low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>aspirin oral tablet chewable</i>	1 or 1a*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aspirin oral tablet delayed release 81 mg</i>	1 or 1a*; \$0	
<i>aspirin regimen oral tablet delayed release</i>	1 or 1a*; \$0	
<i>bayer aspirin ec low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>bayer low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>bayer low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>childrens aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>cvs aspirin adult low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>cvs aspirin adult low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs aspirin ec oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>cvs aspirin low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>diflunisal oral tablet</i>	1 or 1b*	
<i>ecotrin low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>eq aspirin adult low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>eq aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>eql aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>eql aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ft aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ft aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>gnp adult aspirin low strength oral tablet chewable</i>	1 or 1a*; \$0	
<i>gnp aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	1 or 1a*; \$0	
<i>goodsense aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>goodsense aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>h-e-b aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>kls aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>kp aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>mm aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>qc aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>qc aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>qc childrens aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin adult low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin adult low strength oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin childrens oral tablet chewable</i>	1 or 1a*; \$0	
<i>ra aspirin ec adult low st oral tablet delayed release</i>	1 or 1a*; \$0	
<i>ra aspirin ec oral tablet delayed release 81 mg</i>	1 or 1a*; \$0	
<i>sb childrens aspirin oral tablet chewable</i>	1 or 1a*; \$0	
<i>sb low dose asa ec oral tablet delayed release</i>	1 or 1a*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm aspirin adult low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sm aspirin ec low strength oral tablet delayed release</i>	1 or 1a*; \$0	
<i>sm aspirin low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>sm aspirin low dose oral tablet delayed release</i>	1 or 1a*; \$0	
<i>st joseph aspirin oral tablet delayed release</i>	1 or 1a*; \$0	
<i>st joseph low dose oral tablet chewable</i>	1 or 1a*; \$0	
<i>st joseph low dose oral tablet delayed release</i>	1 or 1a*; \$0	
ANALGESICS - OPIOID - DRUGS FOR PAIN AND FEVER		
*CODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>acetaminophen-codeine oral solution</i>	1 or 1a*	AL; QL (30 mL per 1 day)
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	1 or 1a*	AL; QL (6 tablets per 1 day)
<i>acetaminophen-codeine oral tablet 300-30 mg, 300-60 mg</i>	1 or 1a*	AL; QL (6 tablet per 1 day)
<i>ascomp-codeine oral capsule</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg</i>	1 or 1b*	AL; QL (6 capsules per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
<i>butalbital-asa-caff-codeine oral capsule</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
*DIHYDROCODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>apap-caff-dihydrocodeine oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>trezix oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
*HYDROCODONE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>hydrocodone-acetaminophen oral solution</i>	1 or 1b*	QL (90 mL per 1 day)
<i>hydrocodone-acetaminophen oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>hydrocodone-ibuprofen oral tablet</i>	1 or 1b*	QL (5 tablets per 1 day)
*OPIOID AGONISTS*** - ARTHRITIS AND PAIN DRUGS		
<i>codeine sulfate oral tablet 30 mg</i>	2	AL; QL (6 tablets per 1 day)
<i>duramorph injection solution</i>	1 or 1b*	
FENTANYL CITRATE (PF) INJECTION SOLUTION 100 MCG/2ML, 250 MCG/5ML	1 or 1b*	
<i>fentanyl citrate (pf) injection solution 1000 mcg/20ml, 2500 mcg/50ml, 500 mcg/10ml</i>	1 or 1b*	
<i>fentanyl citrate buccal lozenge on a handle</i>	2	PA; QL (4 lozenge per 1 day)
<i>fentanyl citrate buccal tablet</i>	2	PA; QL (4 tablet per 1 day)
<i>fentanyl transdermal patch 72 hour</i>	2	PA; QL (15 patches per 30 days)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>hydromorphone hcl er oral tablet extended release 24 hour</i>	2	PA; QL (1 tablet per 1 day)
<i>hydromorphone hcl injection solution 4 mg/ml</i>	1 or 1b*	
<i>hydromorphone hcl oral liquid</i>	1 or 1b*	QL (24 mL per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydromorphone hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
hydromorphone hcl pf injection solution 50 mg/5ml, 500 mg/50ml	1 or 1b*	
levorphanol tartrate oral tablet 3 mg	2	PA; QL (6 tablets per 1 day)
meperidine hcl injection solution	1 or 1b*	
meperidine hcl oral solution	1 or 1b*	QL (7 days per 1 fill)
meperidine hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
methadone hcl intensol oral concentrate	1 or 1b*	PA; QL (6 mL per 1 day)
methadone hcl oral concentrate	1 or 1b*	PA; QL (6 mL per 1 day)
methadone hcl oral solution	1 or 1b*	PA; QL (30 mL per 1 day)
methadone hcl oral tablet 10 mg	1 or 1b*	PA; QL (6 tablet per 1 day)
methadone hcl oral tablet 5 mg	1 or 1b*	PA; QL (6 tablets per 1 day)
methadone hcl oral tablet soluble	1 or 1b*	PA; QL (1 tablet per 1 day)
methadose oral tablet soluble	1 or 1b*	PA; QL (1 tablet per 1 day)
mitigo injection solution	2	
morphine sulfate (concentrate) oral solution 100 mg/5ml	1 or 1b*	QL (6 mL per 1 day)
morphine sulfate (pf) injection solution 0.5 mg/ml, 1 mg/ml	1 or 1b*	
morphine sulfate er beads oral capsule extended release 24 hour	2	PA; QL (1 capsule per 1 day)
morphine sulfate er oral capsule extended release 24 hour	2	PA; QL (2 capsules per 1 day)
morphine sulfate er oral tablet extended release 100 mg, 200 mg	2	PA; QL (2 tablets per 1 day)
morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg	2	PA; QL (3 tablet per 1 day)
morphine sulfate intravenous solution 10 mg/ml, 4 mg/ml, 8 mg/ml	1 or 1b*	
morphine sulfate oral solution	1 or 1b*	QL (30 mL per 1 day)
morphine sulfate oral tablet	1 or 1b*	QL (6 tablets per 1 day)
oxycodone hcl oral capsule	2	QL (7 days per 1 fill)
oxycodone hcl oral concentrate	2	QL (6 mL per 1 day)
oxycodone hcl oral solution	2	QL (30 mL per 1 day)
oxycodone hcl oral tablet	2	QL (6 tablets per 1 day)
oxycodone hcl oral tablet abuse-deterrent	2	PA; QL (6 tablets per 1 day)
oxymorphone hcl er oral tablet extended release 12 hour	2	PA; QL (2 tablets per 1 day)
oxymorphone hcl oral tablet 10 mg	2	QL (6 tablet per 1 day)
oxymorphone hcl oral tablet 5 mg	2	QL (6 tablets per 1 day)
remifentanyl hcl intravenous solution reconstituted	1 or 1b*	
SUFENTANIL CITRATE INTRAVENOUS SOLUTION	1 or 1b*	
tramadol hcl (er biphasic) oral capsule extended release 24 hour	2	PA; QL (1 capsule per 1 day)
tramadol hcl (er biphasic) oral tablet extended release 24 hour	2	PA; QL (1 tablet per 1 day)
tramadol hcl er oral tablet extended release 24 hour	2	PA; QL (1 tablet per 1 day)
tramadol hcl oral tablet 100 mg	1 or 1b*	AL; QL (4 tablets per 1 day)
tramadol hcl oral tablet 25 mg	2	PA; QL (16 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tramadol hcl oral tablet 50 mg	1 or 1b*	AL; QL (8 tablets per 1 day)
*OPIOID COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
endocet oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	1 or 1b*	QL (6 tablets per 1 day)
endocet oral tablet 5-325 mg	1 or 1b*	QL (6 tablet per 1 day)
OXYCODONE-ACETAMINOPHEN ORAL SOLUTION 5-325 MG/5ML	1 or 1b*	QL (30 ML per 1 day)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	1 or 1b*	QL (6 tablets per 1 day)
oxycodone-acetaminophen oral tablet 5-325 mg	1 or 1b*	QL (6 tablet per 1 day)
*OPIOID PARTIAL AGONISTS*** - ARTHRITIS AND PAIN DRUGS		
buprenorphine hcl injection solution	2	
buprenorphine hcl sublingual tablet sublingual 2 mg	1 or 1b*	QL (12 tablets per 90 days)
buprenorphine hcl sublingual tablet sublingual 8 mg	1 or 1b*	QL (3 tablets per 90 days)
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	1 or 1b*	QL (2 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg	1 or 1b*	QL (16 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual film 4-1 mg	1 or 1b*	QL (8 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual film 8-2 mg	1 or 1b*	QL (4 films per 1 day)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg	1 or 1b*	QL (16 tablets per 1 day)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg	1 or 1b*	QL (4 tablets per 1 day)
buprenorphine transdermal patch weekly	2	PA; QL (1 package per 28 days)
butorphanol tartrate injection solution	2	
butorphanol tartrate nasal solution	1 or 1b*	QL (2 bottles per 30 days)
nalbuphine hcl injection solution	2	QL (2 mL per 1 day)
pentazocine-naloxone hcl oral tablet	1 or 1b*	QL (6 tablets per 1 day)
*TRAMADOL COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
tramadol-acetaminophen oral tablet	1 or 1b*	AL; QL (8 tablet per 1 day)
ANDROGENS-ANABOLIC - HORMONES		
*ANDROGENS*** - DRUGS FOR MEN		
danazol oral capsule 100 mg, 50 mg	2	QL (2 capsules per 1 day)
danazol oral capsule 200 mg	2	QL (4 capsules per 1 day)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION (testosterone cypionate)	1 or 1b*	PA
testosterone cypionate intramuscular solution	1 or 1b*	PA
testosterone enanthate intramuscular solution	1 or 1b*	PA
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	2	PA; QL (1 bottle per 30 days)
testosterone transdermal gel 10 mg/act (2%)	2	PA; QL (1 pump per 30 days)
testosterone transdermal gel 12.5 mg/act (1%)	2	PA; QL (2 bottles per 30 days)
testosterone transdermal gel 20.25 mg/1.25gm (1.62%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	2	PA; QL (1 packet per 1 day)
testosterone transdermal gel 25 mg/2.5gm (1%)	2	PA; QL (2 packet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>testosterone transdermal solution</i>	2	PA; QL (1 pump bottle per 30 days)
XYOSTED SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>testosterone enanthate</i>)	3	PA
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS		
*INTRARECTAL STEROIDS*** - RECTAL PREPARATIONS		
<i>budesonide rectal foam 2 mg</i>	2	QL (4.78 gm per 1 day)
<i>budesonide rectal foam 2 mg/act</i>	2	QL (4.78 grams per 1 day)
<i>hydrocortisone rectal enema</i>	1 or 1b*	
*NITRATE VASODILATING AGENTS*** - RECTAL PREPARATIONS		
<i>nitroglycerin rectal ointment</i>	2	QL (1 unit per 1 day)
*RECTAL ANESTHETIC/STEROIDS*** - RECTAL PREPARATIONS		
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	1 or 1b*	
*RECTAL STEROIDS*** - RECTAL PREPARATIONS		
<i>hydrocortisone (perianal) external cream</i>	1 or 1b*	
PROCTOCORT EXTERNAL CREAM (<i>hydrocortisone</i>)	1 or 1b*	
<i>procto-med hc external cream</i>	1 or 1b*	
<i>proctosol hc external cream</i>	1 or 1b*	
<i>proctozone-hc external cream</i>	1 or 1b*	
ANTHELMINTICS - DRUGS FOR INFECTIONS		
*ANTHELMINTICS*** - DRUGS FOR PARASITES		
<i>albendazole oral tablet</i>	1 or 1b*	PA; QL (4 tablets per 1 day)
<i>ivermectin oral tablet</i>	1 or 1b*	QL (9 tablets per 1 fill)
<i>praziquantel oral tablet</i>	2	
ANTIANGINAL AGENTS - DRUGS FOR THE HEART		
*ANTIANGINALS-OTHER*** - DRUGS FOR ANGINA		
<i>ranolazine er oral tablet extended release 12 hour</i>	2	QL (2 tablets per 1 day)
*NITRATES*** - DRUGS FOR ANGINA		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1 or 1b*	
<i>isosorbide dinitrate oral tablet 40 mg</i>	2	
<i>isosorbide mononitrate er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>isosorbide mononitrate oral tablet</i>	1 or 1b*	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR (<i>nitroglycerin</i>)	2	
<i>nitroglycerin in d5w intravenous solution</i>	1 or 1b*	
<i>nitroglycerin sublingual tablet sublingual</i>	1 or 1b*	
<i>nitroglycerin transdermal patch 24 hour</i>	1 or 1b*	
<i>nitroglycerin translingual solution</i>	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIANXIETY AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTIANXIETY AGENTS - MISC.*** - DRUGS FOR ANXIETY		
<i>buspirone hcl oral tablet</i>	1 or 1b*	
<i>droperidol injection solution</i>	1 or 1b*	
<i>hydroxyzine hcl intramuscular solution</i>	1 or 1b*	
<i>hydroxyzine hcl oral syrup</i>	1 or 1b*	
<i>hydroxyzine hcl oral tablet</i>	1 or 1b*	
<i>hydroxyzine pamoate oral capsule</i>	1 or 1a*	
<i>meprobamate oral tablet</i>	3	
*BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg</i>	1 or 1b*	DO
<i>alprazolam er oral tablet extended release 24 hour 2 mg, 3 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>alprazolam oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>alprazolam oral tablet dispersible</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg</i>	1 or 1b*	DO
<i>alprazolam xr oral tablet extended release 24 hour 2 mg, 3 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>chlordiazepoxide hcl oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>clorazepate dipotassium oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diazepam injection solution 10 mg/2ml</i>	1 or 1a*	
<i>diazepam intensol oral concentrate</i>	1 or 1a*	QL (8 mL per 1 day)
<i>diazepam oral concentrate</i>	1 or 1a*	QL (8 mL per 1 day)
<i>diazepam oral solution</i>	1 or 1a*	
<i>diazepam oral tablet</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lorazepam injection solution</i>	1 or 1b*	
<i>lorazepam intensol oral concentrate</i>	1 or 1b*	QL (3 mL per 1 day)
<i>lorazepam oral concentrate 2 mg/ml</i>	1 or 1b*	QL (3 mL per 1 day)
<i>lorazepam oral tablet 0.5 mg</i>	1 or 1b*	DO
<i>lorazepam oral tablet 1 mg, 2 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>oxazepam oral capsule</i>	2	QL (4 capsules per 1 day)
ANTIARRHYTHMICS - DRUGS FOR THE HEART		
*ANTIARRHYTHMICS - MISC.*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>adenosine intravenous solution 12 mg/4ml, 6 mg/2ml</i>	1 or 1b*	
*ANTIARRHYTHMICS TYPE I-A*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>disopyramide phosphate oral capsule</i>	2	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR (disopyramide phosphate)	2	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>procainamide hcl injection solution</i>	2	
<i>quinidine gluconate er oral tablet extended release</i>	2	
<i>quinidine sulfate oral tablet</i>	1 or 1a*	
*ANTIARRHYTHMICS TYPE I-B*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>lidocaine hcl (cardiac) intravenous solution prefilled syringe 50 mg/5ml</i>	1 or 1b*	
<i>lidocaine hcl (cardiac) pf intravenous solution prefilled syringe</i>	1 or 1b*	
<i>lidocaine in d5w intravenous solution 4-5 mg/ml-%, 8-5 mg/ml-%</i>	1 or 1b*	
<i>mexiletine hcl oral capsule</i>	2	
*ANTIARRHYTHMICS TYPE I-C*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>flecainide acetate oral tablet 100 mg</i>	2	QL (4 tablets per 1 day)
<i>flecainide acetate oral tablet 150 mg</i>	2	QL (2 tablets per 1 day)
<i>flecainide acetate oral tablet 50 mg</i>	2	QL (3 tablets per 1 day)
<i>propafenone hcl er oral capsule extended release 12 hour</i>	2	
<i>propafenone hcl oral tablet</i>	2	
*ANTIARRHYTHMICS TYPE III*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>amiodarone hcl intravenous solution</i>	1 or 1b*	
<i>amiodarone hcl oral tablet 100 mg, 400 mg</i>	1 or 1b*	
<i>amiodarone hcl oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>dofetilide oral capsule</i>	4	LD
<i>ibutilide fumarate intravenous solution</i>	1 or 1b*	
<i>pacerone oral tablet 100 mg, 400 mg</i>	1 or 1b*	
<i>pacerone oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS FOR THE LUNGS		
*ADRENERGIC COMBINATIONS*** - DRUGS FOR ASTHMA/COPD		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>umeclidinium-vilanterol</i>)	2	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>fluticasone furoate-vilanterol</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide-formoterol fumarate</i> (Breyna Inhalation Aerosol)	1 or 1b*	QL (1.03 grams per 1 day)
BREZTRI AEROSPHERE INHALATION AEROSOL (<i>budeson-glycopyrrol-formoterol</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol</i>	1 or 1b*	QL (1.03 grams per 1 day)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION (<i>ipratropium-albuterol</i>)	2	QL (2 inhalers per 30 days)
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated</i>	2	QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol inhalation aerosol</i>	1 or 1b*	QL (1 inhaler per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1 or 1b*	QL (1 package per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>ipratropium-albuterol inhalation solution</i>	1 or 1b*	QL (540 mL per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION (tiotropium bromide-olodaterol)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)	2	QL (2 EA per 1 day)
<i>wixela inhub inhalation aerosol powder breath activated</i>	1 or 1b*	QL (1 package per 30 days)
*ANTI-IGE MONOCLONAL ANTIBODIES*** - DRUGS FOR ASTHMA/COPD		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (omalizumab)	4	PA; LD; QL (4 auto-injectors per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML, 75 MG/0.5ML (omalizumab)	4	PA; LD; QL (2 auto-injectors per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (omalizumab)	4	PA; LD; QL (4 prefilled syringes per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML, 75 MG/0.5ML (omalizumab)	4	PA; LD; QL (2 prefilled syringes per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED (omalizumab)	4	PA; LD; QL (4 vials/syringes/autoinjectors per 28 days); SP
*ANTI-INFLAMMATORY AGENTS*** - DRUGS FOR ASTHMA/COPD		
<i>cromolyn sodium inhalation nebulization solution</i>	1 or 1b*	
*BETA ADRENERGICS*** - DRUGS FOR ASTHMA/COPD		
<i>albuterol sulfate hfa inhalation aerosol solution</i>	1 or 1b*	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml</i>	1 or 1b*	QL (360 mL per 30 days)
ALBUTEROL SULFATE INHALATION NEBULIZATION SOLUTION (5 MG/ML) 0.5%	1 or 1b*	QL (4 boxes per 30 days)
<i>albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml</i>	1 or 1b*	QL (4 boxes per 30 days)
<i>albuterol sulfate oral syrup</i>	1 or 1b*	
<i>albuterol sulfate oral tablet</i>	1 or 1b*	
<i>arformoterol tartrate inhalation nebulization solution</i>	2	QL (60 vial per 30 days)
<i>formoterol fumarate inhalation nebulization solution</i>	2	QL (120 ML per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml</i>	2	QL (90 vials per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml</i>	2	QL (90 mL per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levalbuterol tartrate inhalation aerosol</i>	1 or 1b*	ST; QL (2 inhalers per 30 days)
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>albuterol sulfate</i>)	2	QL (2 inhalers per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>salmeterol xinafoate</i>)	2	QL (1 inhaler per 30 days)
<i>terbutaline sulfate injection solution</i>	1 or 1b*	
<i>terbutaline sulfate oral tablet</i>	1 or 1b*	
*BRONCHODILATORS - ANTICHOLINERGICS*** - DRUGS FOR ASTHMA/COPD		
ATROVENT HFA INHALATION AEROSOL SOLUTION (<i>ipratropium bromide hfa</i>)	2	QL (2 inhalers per 30 days)
<i>ipratropium bromide inhalation solution</i>	1 or 1b*	QL (300 ML per 30 days)
SPIRIVA HANDIHALER INHALATION CAPSULE (<i>tiotropium bromide monohydrate</i>)	2	QL (1 capsule per 1 day)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION (<i>tiotropium bromide monohydrate</i>)	2	QL (1 inhaler per 30 days)
<i>tiotropium bromide monohydrate inhalation capsule</i>	2	QL (1 capsule per 1 day)
*INTERLEUKIN-5 ANTAGONISTS (IGG1 KAPPA)*** - DRUGS FOR ASTHMA/COPD		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>mepolizumab</i>)	4	PA; LD; QL (1 autoinjector per 4 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	4	PA; LD; QL (1 syringe per 4 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	4	PA; LD; QL (1 injection per 28 days); SP
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>mepolizumab</i>)	4	PA; LD; QL (1 injections per 28 days); SP
*LEUKOTRIENE RECEPTOR ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD		
<i>montelukast sodium oral packet</i>	1 or 1b*	QL (1 packet per 1 day)
<i>montelukast sodium oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>montelukast sodium oral tablet chewable</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zafirlukast oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - DRUGS FOR ASTHMA/COPD		
<i>roflumilast oral tablet</i>	2	PA; QL (1 tablet per 1 day)
*STEROID INHALANTS*** - DRUGS FOR ASTHMA/COPD		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>fluticasone furoate</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1 or 1b*	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	1 or 1b*	QL (60 ML per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 50 mcg/act</i>	2	QL (1 inhaler per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 250 mcg/act</i>	2	QL (4 inhalers per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 44 mcg/act</i>	2	QL (1 inhaler per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 220 mcg/act</i>	2	QL (2 inhalers per 30 days)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (beclomethasone diprop hfa)	2	QL (1 inhaler per 30 days)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (beclomethasone diprop hfa)	2	QL (2 inhalers per 30 days)
*XANTHINES*** - DRUGS FOR ASTHMA/COPD		
<i>aminophylline intravenous solution</i>	1 or 1b*	
ELIXOPHYLLIN ORAL ELIXIR (theophylline)	1 or 1b*	QL (112.5 mL per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (theophylline)	2	QL (4 tablets per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG (theophylline)	2	QL (3 capsules per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 400 MG (theophylline)	2	QL (2 capsules per 1 day)
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	
<i>theophylline er oral tablet extended release 12 hour 300 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>theophylline er oral tablet extended release 12 hour 450 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>theophylline er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>theophylline oral elixir</i>	1 or 1b*	QL (112.5 mL per 1 day)
<i>theophylline oral solution</i>	1 or 1b*	QL (112.5 mL per 1 day)
ANTICOAGULANTS - DRUGS FOR THE BLOOD		
*COUMARIN ANTICOAGULANTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>jantoven oral tablet</i>	1 or 1a*	
<i>warfarin sodium oral tablet</i>	1 or 1a*	
*DIRECT FACTOR XA INHIBITORS*** - DRUGS TO PREVENT BLOOD CLOTS		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK (apixaban)	2	QL (74 tablets per 365 days)
ELIQUIS ORAL TABLET 2.5 MG (apixaban)	2	QL (2 tablets per 1 day)
ELIQUIS ORAL TABLET 5 MG (apixaban)	2	QL (74 tablets per 30 days)
XARELTO ORAL SUSPENSION RECONSTITUTED (rivaroxaban)	2	QL (20 mL per 1 day)
XARELTO ORAL TABLET 10 MG, 20 MG (rivaroxaban)	2	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG, 2.5 MG (rivaroxaban)	2	QL (2 tablets per 1 day)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK (rivaroxaban)	2	QL (1 pack per 365 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*HEPARINS AND HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>bd heparin posiflush intravenous solution</i>	2	
<i>heparin (porcine) in nacl intravenous solution 1000-0.9 ut/500ml-%, 2000-0.9 unit/l-%</i>	2	
<i>heparin na (pork) lock flsh pf intravenous solution</i>	2	
<i>heparin sod (porcine) in d5w intravenous solution 40-5 unit/ml-%</i>	2	
<i>heparin sod (pork) lock flush intravenous solution</i>	2	
<i>heparin sodium (porcine) injection solution</i>	2	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml</i>	2	
*LOW MOLECULAR WEIGHT HEPARINS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>enoxaparin sodium injection solution</i>	1 or 1b*	QL (30 syringes per 30 days)
<i>enoxaparin sodium injection solution prefilled syringe</i>	1 or 1b*	QL (2 syringes per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML (dalteparin sodium)	3	QL (8 mL per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (dalteparin sodium)	3	QL (6 vials per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (dalteparin sodium)	3	QL (30 syringes per 30 days)
*SYNTHETIC HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>fondaparinux sodium subcutaneous solution</i>	1 or 1b*	QL (30 syringes per 30 days)
ANTICONVULSANTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTICONVULSANTS - BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>clobazam oral suspension</i>	2	QL (16 mL per 1 day)
<i>clobazam oral tablet</i>	2	QL (2 tablets per 1 day)
<i>clonazepam oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>clonazepam oral tablet dispersible</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>diazepam rectal gel</i>	1 or 1b*	QL (2 syringes per 1 fill)
*ANTICONVULSANTS - MISC.*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>carbamazepine er oral capsule extended release 12 hour 300 mg</i>	1 or 1b*	QL (5 capsules per 1 day)
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>carbamazepine er oral tablet extended release 12 hour 400 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carbamazepine oral suspension</i>	1 or 1b*	QL (50 mL per 1 day)
<i>carbamazepine oral tablet</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>carbamazepine oral tablet chewable 100 mg</i>	1 or 1b*	QL (10 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
carbamazepine oral tablet chewable 200 mg	1 or 1b*	QL (8 tablets per 1 day)
epitol oral tablet	1 or 1b*	QL (8 tablets per 1 day)
gabapentin oral capsule	1 or 1b*	DO
gabapentin oral solution	2	QL (72 mL per 1 day)
gabapentin oral tablet 600 mg	1 or 1b*	QL (6 tablets per 1 day)
gabapentin oral tablet 800 mg	1 or 1b*	QL (4 tablets per 1 day)
lacosamide intravenous solution	2	
lacosamide oral solution	2	QL (40 mL per 1 day)
lacosamide oral tablet	2	QL (2 tablets per 1 day)
lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1 or 1b*	DO
lamotrigine er oral tablet extended release 24 hour 200 mg	1 or 1b*	QL (3 tablets per 1 day)
lamotrigine er oral tablet extended release 24 hour 250 mg, 300 mg	1 or 1b*	QL (2 tablets per 1 day)
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg	1 or 1b*	QL (1 kit per 28 days)
lamotrigine oral kit 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	1 or 1b*	QL (1 kit per 35 days)
lamotrigine oral tablet	1 or 1b*	DO
lamotrigine oral tablet chewable 25 mg	1 or 1b*	QL (2 tablets per 1 day)
lamotrigine oral tablet chewable 5 mg	1 or 1b*	QL (4 tablets per 1 day)
lamotrigine oral tablet dispersible 100 mg, 200 mg	1 or 1b*	QL (2 tablets per 1 day)
lamotrigine oral tablet dispersible 25 mg	1 or 1b*	QL (3 tablets per 1 day)
lamotrigine oral tablet dispersible 50 mg	1 or 1b*	DO
lamotrigine starter kit-blue oral kit	1 or 1b*	QL (1 kit per 28 days)
lamotrigine starter kit-green oral kit	1 or 1b*	QL (1 kit per 35 days)
lamotrigine starter kit-orange oral kit	1 or 1b*	QL (1 kit per 35 days)
levetiracetam er oral tablet extended release 24 hour 500 mg	2	QL (6 tablets per 1 day)
levetiracetam er oral tablet extended release 24 hour 750 mg	2	QL (4 tablets per 1 day)
levetiracetam intravenous solution	2	
levetiracetam oral solution	2	QL (30 mL per 1 day)
levetiracetam oral tablet 1000 mg	2	QL (3 tablets per 1 day)
levetiracetam oral tablet 250 mg, 500 mg, 750 mg	2	DO
oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg	2	DO
oxcarbazepine er oral tablet extended release 24 hour 600 mg	2	QL (4 tablets per 1 day)
oxcarbazepine oral suspension	1 or 1b*	QL (40 mL per 1 day)
oxcarbazepine oral tablet 150 mg, 300 mg	1 or 1b*	QL (2 tablets per 1 day)
oxcarbazepine oral tablet 600 mg	1 or 1b*	QL (4 tablets per 1 day)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	2	QL (3 capsule per 1 day)
pregabalin oral capsule 225 mg, 300 mg	2	QL (2 capsules per 1 day)
pregabalin oral capsule 75 mg	2	QL (3 capsules per 1 day)
pregabalin oral solution	2	QL (30 mL per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
primidone oral tablet 125 mg	1 or 1b*	QL (3 tablets per 1 day)
primidone oral tablet 250 mg	1 or 1b*	QL (8 tablets per 1 day)
primidone oral tablet 50 mg	1 or 1b*	QL (4 tablets per 1 day)
roweepra oral tablet	2	DO
rufinamide oral suspension	2	QL (80 mL per 1 day)
rufinamide oral tablet 200 mg	2	DO
rufinamide oral tablet 400 mg	2	QL (8 tablets per 1 day)
subvenite oral tablet	1 or 1b*	DO
subvenite starter kit-blue oral kit	1 or 1b*	QL (1 kit per 28 days)
subvenite starter kit-green oral kit	1 or 1b*	QL (1 kit per 35 days)
subvenite starter kit-orange oral kit	1 or 1b*	QL (1 kit per 35 days)
topiramate er oral capsule er 24 hour sprinkle 100 mg, 50 mg	1 or 1b*	QL (1 capsule per 1 day)
topiramate er oral capsule er 24 hour sprinkle 150 mg, 200 mg	1 or 1b*	QL (2 capsules per 1 day)
topiramate er oral capsule er 24 hour sprinkle 25 mg	1 or 1b*	DO
topiramate er oral capsule extended release 24 hour 100 mg, 50 mg	2	QL (1 capsule per 1 day)
topiramate er oral capsule extended release 24 hour 200 mg	2	QL (2 capsules per 1 day)
topiramate er oral capsule extended release 24 hour 25 mg	2	DO
topiramate oral capsule sprinkle	1 or 1b*	QL (2 capsules per 1 day)
topiramate oral tablet 100 mg, 25 mg, 50 mg	1 or 1b*	DO
topiramate oral tablet 200 mg	1 or 1b*	QL (2 tablets per 1 day)
zonisamide oral capsule	2	QL (6 capsule per 1 day)
*CARBAMATES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
felbamate oral suspension	2	QL (30 mL per 1 day)
felbamate oral tablet	2	QL (6 tablets per 1 day)
*GABA MODULATORS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
tiagabine hcl oral tablet	2	QL (2 tablets per 1 day)
vigabatrin oral packet	4	LD; QL (6 packets per 1 day); SP
vigabatrin oral tablet	4	LD; QL (6 tablets per 1 day); SP
vigadrone oral packet	4	LD; QL (6 packets per 1 day)
vigabatrin (Vigadrone Oral Tablet)	4	LD; QL (6 tablets per 1 day); SP
vigabatrin (Vigpoder Oral Packet)	4	LD; QL (6 packets per 1 day)
*HYDANTOINS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
DILANTIN ORAL CAPSULE 30 MG (phenytoin sodium extended)	2	
fosphenytoin sodium injection solution	2	
PHENYTEK ORAL CAPSULE (phenytoin sodium extended)	1 or 1b*	
phenytoin infatabs oral tablet chewable	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phenytoin oral suspension</i>	1 or 1b*	
<i>phenytoin oral tablet chewable</i>	1 or 1b*	
<i>phenytoin sodium extended oral capsule</i>	1 or 1b*	
<i>phenytoin sodium injection solution</i>	1 or 1b*	
*SUCCINIMIDES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>ethosuximide oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>ethosuximide oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>methsuximide oral capsule</i>	2	QL (4 capsules per 1 day)
*VALPROIC ACID*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>divalproex sodium er oral tablet extended release 24 hour 500 mg</i>	1 or 1b*	QL (7 tablets per 1 day)
<i>divalproex sodium oral capsule delayed release sprinkle</i>	1 or 1b*	QL (8 capsules per 1 day)
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>divalproex sodium oral tablet delayed release 500 mg</i>	1 or 1b*	QL (7 tablets per 1 day)
<i>valproate sodium intravenous solution 100 mg/ml</i>	1 or 1b*	
<i>valproic acid oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>valproic acid oral solution</i>	1 or 1b*	
ANTIDEPRESSANTS - DRUGS FOR THE NERVOUS SYSTEM		
*ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)*** - DRUGS FOR DEPRESSION		
<i>mirtazapine oral tablet</i>	1 or 1b*	
<i>mirtazapine oral tablet dispersible</i>	1 or 1b*	
*ANTIDEPRESSANTS - MISC.*** - DRUGS FOR DEPRESSION		
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg</i>	1 or 1b*	DO
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg</i>	1 or 1b*	DO
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg, 450 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>bupropion hcl oral tablet 100 mg</i>	1 or 1b*	QL (4.5 tablet per 1 day)
<i>bupropion hcl oral tablet 75 mg</i>	1 or 1b*	DO
*MONOAMINE OXIDASE INHIBITORS (MAOIS)*** - DRUGS FOR DEPRESSION		
<i>phenelzine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>tranylcypromine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)*** - DRUGS FOR DEPRESSION		
<i>citalopram hydrobromide oral solution</i>	1 or 1b*	
<i>citalopram hydrobromide oral tablet</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>escitalopram oxalate oral solution</i>	1 or 1b*	
<i>escitalopram oxalate oral tablet</i>	1 or 1b*	
<i>fluoxetine hcl oral capsule</i>	1 or 1b*	
<i>fluoxetine hcl oral capsule delayed release</i>	1 or 1b*	
<i>fluoxetine hcl oral solution</i>	1 or 1b*	
<i>fluoxetine hcl oral tablet 10 mg, 20 mg</i>	1 or 1b*	
<i>fluvoxamine maleate er oral capsule extended release 24 hour</i>	1 or 1b*	
<i>fluvoxamine maleate oral tablet</i>	1 or 1b*	
<i>paroxetine hcl er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>paroxetine hcl oral suspension</i>	2	
<i>paroxetine hcl oral tablet</i>	1 or 1b*	
<i>sertraline hcl oral concentrate</i>	1 or 1b*	
<i>sertraline hcl oral tablet</i>	1 or 1b*	
*SEROTONIN MODULATORS*** - DRUGS FOR DEPRESSION		
<i>nefazodone hcl oral tablet 100 mg, 50 mg</i>	1 or 1b*	DO
<i>nefazodone hcl oral tablet 150 mg, 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>nefazodone hcl oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg</i>	1 or 1a*	DO
<i>trazodone hcl oral tablet 300 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
TRINTELLIX ORAL TABLET 10 MG, 5 MG (<i>vortioxetine hbr</i>)	3	DO
TRINTELLIX ORAL TABLET 20 MG (<i>vortioxetine hbr</i>)	3	QL (1 tablet per 1 day)
<i>vilazodone hcl oral tablet 10 mg, 20 mg</i>	1 or 1b*	DO
<i>vilazodone hcl oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)*** - DRUGS FOR DEPRESSION		
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg</i>	1 or 1b*	DO
<i>duloxetine hcl oral capsule delayed release particles 20 mg</i>	2	QL (6 capsules per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 30 mg</i>	2	QL (4 capsules per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	2	QL (3 capsule per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 60 mg</i>	2	QL (2 capsules per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour 225 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>venlafaxine hcl oral tablet</i>	1 or 1b*	QL (3 tablet per 1 day)
*TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION		
<i>amitriptyline hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg</i>	1 or 1a*	DO

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
amitriptyline hcl oral tablet 100 mg	1 or 1a*	QL (3 tablets per 1 day)
amitriptyline hcl oral tablet 150 mg	1 or 1a*	QL (2 tablets per 1 day)
amoxapine oral tablet 100 mg	1 or 1b*	QL (4 tablets per 1 day)
amoxapine oral tablet 150 mg	1 or 1b*	QL (2 tablets per 1 day)
amoxapine oral tablet 25 mg, 50 mg	1 or 1b*	DO
clomipramine hcl oral capsule 25 mg	1 or 1b*	DO
clomipramine hcl oral capsule 50 mg	1 or 1b*	QL (5 capsules per 1 day)
clomipramine hcl oral capsule 75 mg	1 or 1b*	QL (3 capsules per 1 day)
desipramine hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg	2	DO
desipramine hcl oral tablet 100 mg	2	QL (3 tablets per 1 day)
desipramine hcl oral tablet 150 mg	2	QL (2 tablets per 1 day)
doxepin hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1 or 1b*	DO
doxepin hcl oral capsule 100 mg	1 or 1b*	QL (3 capsules per 1 day)
doxepin hcl oral capsule 150 mg	1 or 1b*	QL (2 capsules per 1 day)
doxepin hcl oral concentrate	1 or 1b*	QL (30 mL per 1 day)
imipramine hcl oral tablet 10 mg, 25 mg	1 or 1b*	DO
imipramine hcl oral tablet 50 mg	1 or 1b*	QL (6 tablets per 1 day)
imipramine pamoate oral capsule 100 mg, 75 mg	1 or 1b*	DO
imipramine pamoate oral capsule 125 mg, 150 mg	1 or 1b*	QL (2 capsules per 1 day)
nortriptyline hcl oral capsule 10 mg, 25 mg	1 or 1b*	DO
nortriptyline hcl oral capsule 50 mg	1 or 1b*	QL (3 capsules per 1 day)
nortriptyline hcl oral capsule 75 mg	1 or 1b*	QL (2 capsules per 1 day)
nortriptyline hcl oral solution	1 or 1b*	QL (75 mL per 1 day)
protriptyline hcl oral tablet 10 mg	2	QL (6 tablets per 1 day)
protriptyline hcl oral tablet 5 mg	2	DO
trimipramine maleate oral capsule 100 mg	1 or 1b*	QL (2 capsules per 1 day)
trimipramine maleate oral capsule 25 mg, 50 mg	1 or 1b*	QL (3 capsules per 1 day)
ANTIDIABETICS - HORMONES		
*ALPHA-GLUCOSIDASE INHIBITORS*** - DRUGS FOR DIABETES		
acarbose oral tablet	1 or 1b*	QL (3 tablets per 1 day)
miglitol oral tablet	1 or 1b*	QL (3 tablets per 1 day)
*ANTIDIABETIC - AMYLIN ANALOGS*** - DRUGS FOR DIABETES		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR (pramlintide acetate)	2	QL (4 pens per 30 days)
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR (pramlintide acetate)	2	QL (2 boxes per 30 days)
*BIGUANIDES*** - DRUGS FOR DIABETES		
metformin hcl er oral tablet extended release 24 hour 500 mg	1 or 1b*	QL (4 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
metformin hcl er oral tablet extended release 24 hour 750 mg	1 or 1b*	QL (2 tablets per 1 day)
metformin hcl oral solution	3	PA; QL (2 bottles per 30 days)
metformin hcl oral tablet 1000 mg	1 or 1b*	QL (2 tablets per 1 day)
metformin hcl oral tablet 500 mg	1 or 1b*	QL (5 tablets per 1 day)
metformin hcl oral tablet 850 mg	1 or 1b*; \$0	QL (3 tablets per 1 day)
*DIABETIC OTHER*** - DRUGS FOR DIABETES		
BAQSIMI ONE PACK NASAL POWDER (glucagon)	3	QL (2 packs per 30 days)
BAQSIMI TWO PACK NASAL POWDER (glucagon)	3	QL (1 pack per 30 days)
diazoxide oral suspension	2	
GLUCAGON EMERGENCY INJECTION KIT	1 or 1b*	QL (2 kits per 30 days)
GLUCAGON EMERGENCY INJECTION SOLUTION RECONSTITUTED	3	QL (2 kits per 30 days)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (glucagon)	3	QL (2 packs per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (glucagon)	3	QL (1 pack per 30 days)
GVOKE KIT SUBCUTANEOUS SOLUTION (glucagon)	3	QL (2 kits per 30 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (glucagon)	3	QL (2 packs per 30 days)
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (dasiglucagon hcl)	3	QL (1.2 mL per 30 days)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (dasiglucagon hcl)	3	QL (1.2 mL per 30 days)
*DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS*** - DRUGS FOR DIABETES		
alogliptin benzoate oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
JANUVIA ORAL TABLET (sitagliptin phosphate)	2	ST; QL (1 tablet per 1 day)
*DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
alogliptin-metformin hcl oral tablet	1 or 1b*	ST; QL (2 tablets per 1 day)
JANUMET ORAL TABLET (sitagliptin-metformin hcl)	2	ST; QL (2 tablets per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (sitagliptin-metformin hcl)	2	ST; QL (1 tablet per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (sitagliptin-metformin hcl)	2	ST; QL (2 tablets per 1 day)
*DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES		
alogliptin-pioglitazone oral tablet	1 or 1b*	ST; QL (1 tablet per 1 day)
*HUMAN INSULIN*** - DRUGS FOR DIABETES		
HUMALOG INJECTION SOLUTION (insulin lispro)	2	QL (30 mL per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin nph isophane & regular</i>)	2	QL (30 mL per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (<i>insulin nph isophane & regular</i>)	2	QL (30 mL per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin nph human (isophane)</i>)	2	QL (30 mL per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION (<i>insulin nph human (isophane)</i>)	2	QL (30 mL per 30 days)
HUMULIN R INJECTION SOLUTION (<i>insulin regular human</i>)	2	QL (30 mL per 30 days)
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION (<i>insulin regular human</i>)	2	PA; QL (20 mL per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin regular human</i>)	2	PA; QL (18 mL per 30 days)
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR	2	ST; QL (30 mL per 30 days)
INSULIN LISPRO INJECTION SOLUTION	2	QL (30 mL per 30 days)
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	2	QL (30 mL per 30 days)
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR	2	QL (30 mL per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (30 mL per 30 days)
LANTUS SUBCUTANEOUS SOLUTION (<i>insulin glargine</i>)	2	QL (30 mL per 30 days)
LYUMJEV INJECTION SOLUTION (<i>insulin lispro-aabc</i>)	2	QL (30 mL per 30 days)
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro-aabc</i>)	2	QL (30 mL per 30 days)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (12 mL per 30 days)
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (13.5 mL per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin degludec</i>)	2	QL (30 mL per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (<i>insulin degludec</i>)	2	QL (18 mL per 30 days)
TRESIBA SUBCUTANEOUS SOLUTION (<i>insulin degludec</i>)	2	QL (30 mL per 30 days)
*INCRETIN MIMETIC AGENTS (GIP & GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES		
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tirzepatide</i>)	2	PA; QL (4 pens per 28 days)
*INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES		
<i>liraglutide subcutaneous solution pen-injector</i>	2	PA; QL (1 box per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (1 pen per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (1 unit per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (0.11 mL per 1 day)
RYBELSUS ORAL TABLET 14 MG, 7 MG (<i>semaglutide</i>)	2	PA; QL (1 carton per 30 days)
RYBELSUS ORAL TABLET 3 MG (<i>semaglutide</i>)	2	PA; QL (1 carton per 1 lifetime)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (<i>dulaglutide</i>)	2	PA; QL (4 pens per 28 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	2	PA; QL (4 syringes per 28 days)
*INSULIN-INCRETIN MIMETIC COMBINATIONS*** - DRUGS FOR DIABETES		
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine-lixisenatide</i>)	2	ST; QL (5 pen per 25 days)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin degludec-liraglutide</i>)	2	ST; QL (5 pen per 30 days)
*MEGLITINIDE ANALOGUES*** - DRUGS FOR DIABETES		
<i>nateglinide oral tablet</i>	2	QL (3 tablets per 1 day)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	2	QL (4 tablets per 1 day)
<i>repaglinide oral tablet 2 mg</i>	2	QL (8 tablets per 1 day)
*PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR DIABETES		
<i>mifepristone oral tablet 300 mg</i>	4	PA; LD; QL (4 tablets per 1 day)
*SGLT2 INHIBITOR - DPP-4 INHIBITOR - BIGUANIDE COMB*** - DRUGS FOR DIABETES		
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	ST; QL (1 tablet per 1 day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	ST; QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS*** - DRUGS FOR DIABETES		
GLYXAMBI ORAL TABLET (<i>empagliflozin-linagliptin</i>)	2	ST; QL (1 tablet per 1 day)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS*** - DRUGS FOR DIABETES		
<i>dapagliflozin propanediol oral tablet</i>	2	ST; QL (1 tablet per 1 day)
FARXIGA ORAL TABLET (<i>dapagliflozin propanediol</i>)	2	ST; QL (1 tablet per 1 day)
JARDIANCE ORAL TABLET (<i>empagliflozin</i>)	2	ST; QL (1 tablet per 1 day)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB*** - DRUGS FOR DIABETES		
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg</i>	2	ST; QL (1 tablet per 1 day)
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 5-1000 mg</i>	2	ST; QL (2 tablets per 1 day)
SYNJARDY ORAL TABLET (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (2 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (2 tablets per 1 day)
*SULFONYLUREA-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
*SULFONYLUREAS*** - DRUGS FOR DIABETES		
<i>glimepiride oral tablet 1 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glimepiride oral tablet 2 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>glimepiride oral tablet 4 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 10 mg</i>	1 or 1a*	ST; QL (2 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 2.5 mg</i>	1 or 1a*	ST; QL (8 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 5 mg</i>	1 or 1a*	ST; QL (4 tablets per 1 day)
<i>glipizide oral tablet 10 mg</i>	1 or 1a*	ST; QL (4 tablets per 1 day)
<i>glipizide oral tablet 2.5 mg</i>	1 or 1a*	ST; QL (16 tablets per 1 day)
<i>glipizide oral tablet 5 mg</i>	1 or 1a*	ST; QL (8 tablets per 1 day)
<i>glipizide xl oral tablet extended release 24 hour 10 mg</i>	1 or 1a*	ST; QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glipizide xl oral tablet extended release 24 hour 2.5 mg</i>	1 or 1a*	ST; QL (8 tablets per 1 day)
<i>glipizide xl oral tablet extended release 24 hour 5 mg</i>	1 or 1a*	ST; QL (4 tablets per 1 day)
<i>glyburide micronized oral tablet 1.5 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glyburide micronized oral tablet 3 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>glyburide micronized oral tablet 6 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>glyburide oral tablet 1.25 mg</i>	1 or 1b*	ST; QL (16 tablets per 1 day)
<i>glyburide oral tablet 2.5 mg</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>glyburide oral tablet 5 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
*SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl-glimepiride oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
*THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl-metformin hcl oral tablet</i>	1 or 1b*	ST; QL (3 tablets per 1 day)
*THIAZOLIDINEDIONES*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS FOR THE STOMACH		
*ANTIPERISTALTIC AGENTS*** - DRUGS FOR DIARRHEA		
<i>diphenoxylate-atropine oral liquid</i>	1 or 1b*	
<i>diphenoxylate-atropine oral tablet</i>	1 or 1b*	
<i>loperamide hcl oral capsule</i>	1 or 1b*	QL (8 capsules per 1 day)
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
*ANTIDOTES - CHELATING AGENTS*** - DRUGS FOR OVERDOSE OR POISONING		
<i>deferasirox granules oral packet</i>	4	PA; LD; SP
<i>deferasirox oral packet</i>	4	PA; LD; SP
<i>deferasirox oral tablet</i>	4	PA; LD; SP
<i>deferasirox oral tablet soluble</i>	4	PA; LD; SP
<i>deferiprone oral tablet</i>	4	PA; LD
*ANTIDOTES AND SPECIFIC ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
<i>acetylcysteine intravenous solution</i>	2	
<i>fomepizole intravenous solution</i>	1 or 1b*	
<i>methylene blue (antidote) intravenous solution</i>	1 or 1b*	
<i>methylene blue intravenous solution</i>	1 or 1b*	
SODIUM THIOSULFATE INTRAVENOUS SOLUTION	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*BENZODIAZEPINE ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
<i>flumazenil intravenous solution</i>	1 or 1b*	
*OPIOID ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
KLOXXADO NASAL LIQUID (<i>naloxone hcl</i>)	2	QL (6 nasal sprays per 3 monthss)
<i>naloxone hcl injection solution</i>	1 or 1b*	QL (6 vial per 90 days)
<i>naloxone hcl injection solution cartridge</i>	1 or 1b*	QL (6 syringe per 90 days)
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml</i>	1 or 1b*	ST; QL (6 syringes per 3 months)
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	1 or 1b*	QL (6 syringe per 90 days)
<i>naloxone hcl nasal liquid</i>	1 or 1b*	QL (6 nasal sprays per 3 monthss)
<i>naltrexone hcl oral tablet</i>	1 or 1b*	
OPVEE NASAL SOLUTION (<i>nalmeffene hcl</i>)	2	QL (3 cartons per 90 days)
REXTOVY NASAL LIQUID (<i>naloxone hcl</i>)	2	QL (6 nasal sprays per 3 monthss)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE (<i>naloxone hcl</i>)	2	QL (6 syringes per 3 monthss)
ANTIEMETICS - DRUGS FOR THE STOMACH		
*5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA		
<i>granisetron hcl intravenous solution</i>	2	LD
<i>granisetron hcl oral tablet</i>	2	LD; QL (10 tablets per 30 days)
<i>ondansetron hcl injection solution</i>	2	
<i>ondansetron hcl injection solution prefilled syringe</i>	2	LD
<i>ondansetron hcl oral solution</i>	2	LD; QL (8 mL per 1 day)
<i>ondansetron hcl oral tablet 24 mg</i>	2	LD; QL (8 tablet per 30 days)
<i>ondansetron hcl oral tablet 4 mg</i>	2	LD; QL (48 tablets per 30 days)
<i>ondansetron hcl oral tablet 8 mg</i>	2	LD; QL (24 tablets per 30 days)
<i>ondansetron oral tablet dispersible 16 mg</i>	2	QL (4 tablets per 30 days)
<i>ondansetron oral tablet dispersible 4 mg</i>	2	LD; QL (48 tablets per 30 days)
<i>ondansetron oral tablet dispersible 8 mg</i>	2	LD; QL (24 tablets per 30 days)
<i>palonosetron hcl intravenous solution 0.25 mg/5ml</i>	2	PA; LD
<i>palonosetron hcl intravenous solution prefilled syringe</i>	2	PA; LD
*ANTIEMETIC COMBINATIONS*** - DRUGS FOR VOMITING AND NAUSEA		
<i>doxylamine-pyridoxine oral tablet delayed release</i>	1 or 1b*	PA; QL (4 tablet per 1 day)
*ANTIEMETICS - ANTICHOLINERGIC*** - DRUGS FOR VOMITING AND NAUSEA		
<i>meclizine hcl oral tablet 25 mg</i>	1 or 1a*	
<i>meclizine hcl oral tablet 50 mg</i>	1 or 1b*	
<i>scopolamine transdermal patch 72 hour</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
trimethobenzamide hcl oral capsule	1 or 1b*	
*ANTIEMETICS - MISCELLANEOUS*** - DRUGS FOR VOMITING AND NAUSEA		
dronabinol oral capsule	2	QL (4 capsules per 1 day)
*SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA		
aprepitant oral	2	LD; QL (15 capsules per 25 days)
aprepitant oral capsule 125 mg	2	LD; QL (5 capsules per 25 days)
aprepitant oral capsule 40 mg	2	LD; QL (1 capsule per 1 fill)
aprepitant oral capsule 80 & 125 mg	2	LD; QL (15 capsules per 25 days)
aprepitant oral capsule 80 mg	2	LD; QL (10 capsules per 25 days)
fosaprepitant dimeglumine intravenous solution reconstituted	2	PA; LD; QL (5 vial per 30 days)
ANTIFUNGALS - DRUGS FOR INFECTIONS		
*ANTIFUNGALS*** - DRUGS FOR FUNGUS		
amphotericin b intravenous solution reconstituted	2	
amphotericin b liposome intravenous suspension reconstituted	2	
flucytosine oral capsule	2	PA
griseofulvin microsize oral suspension	1 or 1b*	
griseofulvin microsize oral tablet	1 or 1b*	
griseofulvin ultramicrosize oral tablet	1 or 1b*	
nystatin oral tablet	1 or 1b*	
terbinafine hcl oral tablet	1 or 1b*	QL (1 tablet per 1 day)
*IMIDAZOLES*** - DRUGS FOR FUNGUS		
ketoconazole oral tablet	1 or 1b*	QL (2 tablets per 1 day)
*TRIAZOLES*** - DRUGS FOR FUNGUS		
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%	1 or 1b*	
fluconazole oral suspension reconstituted 10 mg/ml	1 or 1b*	QL (40 mL per 1 day)
fluconazole oral suspension reconstituted 40 mg/ml	1 or 1b*	QL (10 mL per 1 day)
fluconazole oral tablet 100 mg	1 or 1b*	QL (4 tablet per 1 day)
fluconazole oral tablet 150 mg, 200 mg	1 or 1b*	QL (2 tablets per 1 day)
fluconazole oral tablet 50 mg	1 or 1b*	QL (8 tablet per 1 day)
itraconazole oral capsule	2	PA; QL (4.2 capsules per 1 day)
itraconazole oral solution	2	PA; QL (20 mL per 1 day)
posaconazole intravenous solution	2	
posaconazole oral suspension	2	PA; QL (20 mL per 1 day)
posaconazole oral tablet delayed release	2	PA; QL (93 tablets per 30 days)
voriconazole oral suspension reconstituted	2	PA; QL (17.5 mL per 1 day)
voriconazole oral tablet 200 mg	2	PA; QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
voriconazole oral tablet 50 mg	2	PA; QL (6 tablets per 1 day)
ANTIHISTAMINES - DRUGS FOR THE LUNGS		
*ANTIHISTAMINES - ETHANOLAMINES*** - DRUGS FOR ALLERGIES		
carbinoxamine maleate er oral suspension extended release	1 or 1b*	ST; QL (40 mL per 1 day)
carbinoxamine maleate oral solution	1 or 1b*	ST
carbinoxamine maleate oral tablet 4 mg	1 or 1b*	ST
clemastine fumarate oral tablet	1 or 1b*	ST; QL (3 tablets per 1 day)
diphenhydramine hcl injection solution	2	
*ANTIHISTAMINES - NON-SEDATING*** - DRUGS FOR ALLERGIES		
cetirizine hcl oral solution	1 or 1b*	BE; QL (10 mL per 1 day)
desloratadine oral tablet	3	QL (1 tablet per 1 day)
desloratadine oral tablet dispersible	3	QL (1 tablet per 1 day)
levocetirizine dihydrochloride oral tablet	1 or 1b*	BE; QL (1 tablet per 1 day)
*ANTIHISTAMINES - PHENOTHIAZINES*** - DRUGS FOR ALLERGIES		
promethazine hcl injection solution	1 or 1a*	
promethazine hcl oral solution	1 or 1a*	QL (40 mL per 1 day)
promethazine hcl oral tablet 12.5 mg, 25 mg	1 or 1a*	QL (4 tablets per 1 day)
promethazine hcl oral tablet 50 mg	1 or 1a*	QL (1 tablet per 1 day)
promethazine hcl rectal suppository	2	QL (6 suppositories per 1 day)
promethegan rectal suppository 12.5 mg, 25 mg	2	QL (6 suppositories per 1 day)
promethegan rectal suppository 50 mg	2	QL (1 suppository per 1 day)
*ANTIHISTAMINES - PIPERIDINES*** - DRUGS FOR ALLERGIES		
cyproheptadine hcl oral syrup	1 or 1b*	
cyproheptadine hcl oral tablet	1 or 1b*	
ANTHYPERLIPIDEMICS - DRUGS FOR THE HEART		
*ANTHYPERLIPIDEMICS - MISC.*** - DRUGS FOR CHOLESTEROL		
icosapent ethyl oral capsule 0.5 gm	2	PA; QL (8 capsules per 1 day)
icosapent ethyl oral capsule 1 gm	2	PA; QL (4 capsule per 1 day)
omega-3-acid ethyl esters oral capsule	1 or 1b*	PA; QL (4 capsule per 1 day)
VASCEPA ORAL CAPSULE 0.5 GM (icosapent ethyl)	2	PA; QL (8 capsules per 1 day)
VASCEPA ORAL CAPSULE 1 GM (icosapent ethyl)	2	PA; QL (4 capsule per 1 day)
*BILE ACID SEQUESTRANTS*** - DRUGS FOR CHOLESTEROL		
cholestyramine light oral packet	2	QL (24 grams per 1 day)
cholestyramine light oral powder	2	QL (30 grams per 1 day)
cholestyramine oral packet	2	QL (6 packets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cholestyramine oral powder	2	QL (54 gm per 1 day)
colesevelam hcl oral packet	3	QL (1 packet per 1 day)
colesevelam hcl oral tablet	2	QL (6 tablets per 1 day)
colestipol hcl oral granules	1 or 1b*	QL (45 grams per 1 day)
colestipol hcl oral packet	1 or 1b*	QL (30 grams per 1 day)
colestipol hcl oral tablet	1 or 1b*	QL (16 tablets per 1 day)
prevalite oral packet	2	QL (24 grams per 1 day)
prevalite oral powder	2	QL (30 grams per 1 day)
*FIBRIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL		
fenofibrate micronized oral capsule	1 or 1b*	QL (1 capsule per 1 day)
fenofibrate oral capsule	1 or 1b*	QL (1 capsule per 1 day)
fenofibrate oral tablet 120 mg, 40 mg	3	ST; QL (1 tablet per 1 day)
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	1 or 1b*	QL (1 tablet per 1 day)
fenofibric acid oral capsule delayed release	1 or 1b*	QL (1 capsule per 1 day)
fenofibric acid oral tablet	1 or 1b*	QL (1 tablet per 1 day)
gemfibrozil oral tablet	1 or 1b*	QL (2 tablets per 1 day)
*HMG COA REDUCTASE INHIBITORS*** - DRUGS FOR CHOLESTEROL		
atorvastatin calcium oral tablet 10 mg, 20 mg	1 or 1b*; \$0	DO
atorvastatin calcium oral tablet 40 mg	1 or 1b*	DO
atorvastatin calcium oral tablet 80 mg	1 or 1b*	QL (1 tablet per 1 day)
fluvastatin sodium oral capsule	1 or 1b*; \$0	DO
lovastatin oral tablet 10 mg, 20 mg	1 or 1b*; \$0	DO
lovastatin oral tablet 40 mg	1 or 1b*; \$0	QL (2 tablets per 1 day)
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg	1 or 1b*; \$0	DO
pravastatin sodium oral tablet 80 mg	1 or 1b*; \$0	QL (1 tablet per 1 day)
rosuvastatin calcium oral tablet 10 mg, 5 mg	2; \$0	DO
rosuvastatin calcium oral tablet 20 mg	2	DO
rosuvastatin calcium oral tablet 40 mg	2	QL (1 tablet per 1 day)
simvastatin oral tablet 10 mg, 20 mg, 5 mg	1 or 1b*; \$0	DO
simvastatin oral tablet 40 mg	1 or 1b*; \$0	QL (1 tablet per 1 day)
simvastatin oral tablet 80 mg	1 or 1b*	PA; QL (1 tablet per 1 day)
*INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB*** - DRUGS FOR CHOLESTEROL		
ezetimibe-simvastatin oral tablet	2	ST; QL (1 tablet per 1 day)
*INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS*** - DRUGS FOR CHOLESTEROL		
ezetimibe oral tablet	2	QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*NICOTINIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL		
<i>niacin (antihyperlipidemic) oral tablet</i>	1 or 1b*	ST; QL (12 tablets per 1 day)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 750 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>niacin er (antihyperlipidemic) oral tablet extended release 500 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>niacor oral tablet</i>	1 or 1b*	ST; QL (12 tablets per 1 day)
*PCSK9 INHIBITORS*** - DRUGS FOR CHOLESTEROL		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE (evolocumab)	3	PA; QL (1 cartridge per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (evolocumab)	3	PA; QL (2 syringe per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (evolocumab)	3	PA; QL (2 syringe per 28 days)
ANTIHYPERTENSIVES - DRUGS FOR THE HEART		
*ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-40 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>amlodipine besy-benazepril hcl oral capsule 2.5-10 mg</i>	1 or 1b*	DO
<i>amlodipine besy-benazepril hcl oral capsule 5-10 mg, 5-20 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>trandolapril-verapamil hcl er oral tablet extended release</i>	1 or 1b*	QL (1 tablet per 1 day)
*ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 5-6.25 mg</i>	1 or 1b*	DO
<i>captopril-hydrochlorothiazide oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg</i>	1 or 1b*	DO
<i>fosinopril sodium-hctz oral tablet 20-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	DO
<i>lisinopril-hydrochlorothiazide oral tablet 20-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 20-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	DO
<i>quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*ACE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>benazepril hcl oral tablet 10 mg, 5 mg</i>	1 or 1a*	DO
<i>benazepril hcl oral tablet 20 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>benazepril hcl oral tablet 40 mg</i>	1 or 1a*	QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>captopril oral tablet 100 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>captopril oral tablet 12.5 mg, 25 mg</i>	1 or 1b*	DO
<i>captopril oral tablet 50 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>enalapril maleate oral solution</i>	2	QL (40 mg per 1 day)
<i>enalapril maleate oral tablet 10 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>enalapril maleate oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	DO
<i>enalapril maleate oral tablet 20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalaprilat intravenous solution</i>	1 or 1b*	
<i>fosinopril sodium oral tablet 10 mg</i>	1 or 1b*	DO
<i>fosinopril sodium oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>fosinopril sodium oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lisinopril oral tablet 10 mg, 20 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lisinopril oral tablet 2.5 mg, 5 mg</i>	1 or 1a*	DO
<i>lisinopril oral tablet 30 mg, 40 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>moexipril hcl oral tablet 15 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>moexipril hcl oral tablet 7.5 mg</i>	1 or 1b*	DO
<i>perindopril erbumine oral tablet 2 mg, 4 mg</i>	1 or 1b*	DO
<i>perindopril erbumine oral tablet 8 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>quinapril hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	DO
<i>quinapril hcl oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>quinapril hcl oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>ramipril oral capsule 1.25 mg, 2.5 mg</i>	1 or 1b*	DO
<i>ramipril oral capsule 10 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>ramipril oral capsule 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>trandolapril oral tablet 1 mg, 2 mg</i>	1 or 1b*	DO
<i>trandolapril oral tablet 4 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*AGENTS FOR PHEOCHROMOCYTOMA*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>metirosine oral capsule</i>	1 or 1b*	PA; LD; QL (16 capsules per 1 day); SP
<i>phenoxybenzamine hcl oral capsule</i>	2	PA; QL (12 capsules per 1 day)
<i>phentolamine mesylate injection solution reconstituted</i>	1 or 1b*	
*ANGIOTENSIN II RECEPTOR ANTAG & CA CHANNEL BLOCKER COMB*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-320 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate-valsartan oral tablet 5-160 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-olmesartan oral tablet 5-20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>telmisartan-amlodipine oral tablet 40-10 mg, 80-10 mg, 80-5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
telmisartan-amlodipine oral tablet 40-5 mg	1 or 1b*	QL (2 tablets per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE		
candesartan cilexetil-hctz oral tablet 16-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg	1 or 1b*	QL (1 tablet per 1 day)
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium-hctz oral tablet 50-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
olmesartan medoxomil-hctz oral tablet 20-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
olmesartan medoxomil-hctz oral tablet 40-12.5 mg, 40-25 mg	1 or 1b*	QL (1 tablet per 1 day)
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
telmisartan-hctz oral tablet 80-25 mg	1 or 1b*	QL (1 tablet per 1 day)
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 80-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
valsartan-hydrochlorothiazide oral tablet 160-25 mg, 320-12.5 mg, 320-25 mg	1 or 1b*	QL (1 tablet per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE		
candesartan cilexetil oral tablet 16 mg	1 or 1b*	QL (2 tablets per 1 day)
candesartan cilexetil oral tablet 32 mg	1 or 1b*	QL (1 tablet per 1 day)
candesartan cilexetil oral tablet 4 mg, 8 mg	1 or 1b*	DO
irbesartan oral tablet 150 mg, 75 mg	1 or 1b*	DO
irbesartan oral tablet 300 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium oral tablet 100 mg	1 or 1b*	QL (1 tablet per 1 day)
losartan potassium oral tablet 25 mg	1 or 1b*	DO
losartan potassium oral tablet 50 mg	1 or 1b*	QL (2 tablets per 1 day)
olmesartan medoxomil oral tablet 20 mg, 5 mg	1 or 1b*	DO
olmesartan medoxomil oral tablet 40 mg	1 or 1b*	QL (1 tablet per 1 day)
telmisartan oral tablet 20 mg, 40 mg	1 or 1b*	DO
telmisartan oral tablet 80 mg	1 or 1b*	QL (2 tablets per 1 day)
VALSARTAN ORAL SOLUTION	2	PA; QL (80 mL per 1 day)
valsartan oral tablet 160 mg	1 or 1b*	QL (2 tablets per 1 day)
valsartan oral tablet 320 mg	1 or 1b*	QL (1 tablet per 1 day)
valsartan oral tablet 40 mg, 80 mg	1 or 1b*	DO
*ANGIOTENSIN II RECEPTOR ANT-CA CHANNEL BLOCKER-THIAZIDES*** - DRUGS FOR HIGH BLOOD PRESSURE		
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-25 mg	1 or 1b*	QL (1 tablet per 1 day)
amlodipine-valsartan-hctz oral tablet 5-160-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg	1 or 1b*	QL (2 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
olmesartan-amlodipine-hctz oral tablet 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	1 or 1b*	QL (1 tablet per 1 day)
*ANTIADRENERGICS - CENTRALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE		
clonidine hcl oral tablet 0.1 mg	1 or 1a*	DO
clonidine hcl oral tablet 0.2 mg	1 or 1a*	QL (6 tablets per 1 day)
clonidine hcl oral tablet 0.3 mg	1 or 1a*	QL (4 tablets per 1 day)
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr	2	QL (12 patches per 28 days)
clonidine transdermal patch weekly 0.3 mg/24hr	2	QL (0.29 patches per 1 day)
guanfacine hcl oral tablet	1 or 1b*	
methyldopa oral tablet 250 mg	1 or 1b*	DO
methyldopa oral tablet 500 mg	1 or 1b*	QL (6 tablets per 1 day)
*ANTIADRENERGICS - PERIPHERALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE		
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg	1 or 1b*	QL (1 tablet per 1 day)
doxazosin mesylate oral tablet 8 mg	1 or 1b*	QL (2 tablets per 1 day)
prazosin hcl oral capsule	1 or 1b*	
terazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1 or 1b*	QL (1 capsule per 1 day)
terazosin hcl oral capsule 10 mg	1 or 1b*	QL (2 capsules per 1 day)
*BETA BLOCKER & DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
atenolol-chlorthalidone oral tablet	1 or 1b*	QL (1 tablet per 1 day)
bisoprolol-hydrochlorothiazide oral tablet	1 or 1b*	QL (2 tablets per 1 day)
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 50-25 mg	1 or 1b*	QL (2 tablets per 1 day)
metoprolol-hydrochlorothiazide oral tablet 100-50 mg	1 or 1b*	QL (1 tablet per 1 day)
*DIRECT RENIN INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
aliskiren fumarate oral tablet 150 mg	2	DO
aliskiren fumarate oral tablet 300 mg	2	QL (1 tablet per 1 day)
*SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)*** - DRUGS FOR HIGH BLOOD PRESSURE		
eplerenone oral tablet	2	
*VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
hydralazine hcl injection solution	2	
hydralazine hcl oral tablet	1 or 1b*	
minoxidil oral tablet	1 or 1b*	
ANTI-INFECTIVE AGENTS - MISC. - DRUGS FOR INFECTIONS		
*ANTI-INFECTIVE AGENTS - MISC.*** - DRUGS FOR INFECTIONS		
metronidazole oral capsule	1 or 1a*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metronidazole oral tablet</i>	1 or 1a*	
<i>pentamidine isethionate inhalation solution reconstituted</i>	2	LD
<i>pentamidine isethionate injection solution reconstituted</i>	4	LD
<i>tinidazole oral tablet 250 mg</i>	1 or 1b*	QL (5 tablets per 28 days)
<i>tinidazole oral tablet 500 mg</i>	1 or 1b*	QL (20 tablets per 1 fill)
TRIMETHOPRIM ORAL TABLET	1 or 1a*	
XIFAXAN ORAL TABLET 200 MG (rifaximin)	3	PA; QL (9 tablets per 1 fill)
XIFAXAN ORAL TABLET 550 MG (rifaximin)	3	PA; QL (126 tablet per 252 days)
*ANTI-INFECTIVE MISC. - COMBINATIONS*** - ANTIBIOTICS		
<i>sulfamethoxazole-trimethoprim intravenous solution</i>	2	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1 or 1a*	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1 or 1a*	
<i>sulfatrim pediatric oral suspension</i>	1 or 1a*	
*ANTIPROTOZOAL AGENTS*** - DRUGS FOR PARASITES		
<i>atovaquone oral suspension</i>	2	
<i>nitazoxanide oral tablet</i>	2	QL (6 tablets per 1 fill)
*CARBAPENEM COMBINATIONS*** - ANTIBIOTICS		
<i>imipenem-cilastatin intravenous solution reconstituted</i>	2	
*CARBAPENEMS*** - ANTIBIOTICS		
<i>meropenem intravenous solution reconstituted 1 gm, 500 mg</i>	2	
*CHLORAMPHENICALS*** - ANTIBIOTICS		
<i>chloramphenicol sod succinate intravenous solution reconstituted</i>	2	
*GLYCOPEPTIDES*** - ANTIBIOTICS		
<i>vancomycin hcl intravenous solution reconstituted 100 gm</i>	2	QL (1 vial per 30 days)
<i>vancomycin hcl oral capsule</i>	2	PA; QL (240 capsules per 30 days)
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml</i>	2	PA; QL (1200 mL per 30 days)
VANCOMYCIN HCL ORAL SOLUTION RECONSTITUTED 250 MG/5ML	2	PA; QL (1200 mL per 30 days)
*LEPROSTATICS*** - ANTIBIOTICS		
<i>dapsone oral tablet</i>	2	
*LINCOSAMIDES*** - ANTIBIOTICS		
<i>clindamycin hcl oral capsule</i>	1 or 1b*	
<i>clindamycin palmitate hcl oral solution reconstituted</i>	1 or 1b*	
<i>clindamycin phosphate in d5w intravenous solution</i>	1 or 1b*	
<i>clindamycin phosphate injection solution</i>	1 or 1b*	
*MONOBACTAMS*** - ANTIBIOTICS		
<i>aztreonam injection solution reconstituted</i>	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*OXAZOLIDINONES*** - ANTIBIOTICS		
<i>linezolid intravenous solution</i>	1 or 1b*	
<i>linezolid oral suspension reconstituted</i>	1 or 1b*	PA; QL (900 mL per 30 days)
<i>linezolid oral tablet</i>	1 or 1b*	PA; QL (28 tablet per 30 days)
*POLYMYXINS*** - ANTIBIOTICS		
<i>colistimethate sodium (cba) injection solution reconstituted</i>	2	
<i>polymyxin b sulfate injection solution reconstituted</i>	2	
*URINARY ANTI-INFECTIVES*** - ANTIBIOTICS		
<i>fosfomycin tromethamine oral packet</i>	1 or 1b*	
<i>methenamine hippurate oral tablet</i>	2	
<i>nitrofurantoin macrocrystal oral capsule</i>	1 or 1b*	
<i>nitrofurantoin monohyd macro oral capsule</i>	1 or 1b*	
<i>nitrofurantoin oral suspension 25 mg/5ml, 50 mg/10ml</i>	1 or 1b*	
ANTIMALARIALS - DRUGS FOR INFECTIONS		
*ANTIMALARIAL COMBINATIONS*** - DRUGS FOR PARASITES		
<i>atovaquone-proguanil hcl oral tablet</i>	1 or 1b*	
*ANTIMALARIALS*** - DRUGS FOR PARASITES		
<i>chloroquine phosphate oral tablet</i>	1 or 1a*	
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 100 MG, 300 MG	1 or 1b*	QL (2 tablets per 1 day)
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 400 MG	1 or 1b*	QL (1 tablet per 1 day)
<i>mefloquine hcl oral tablet</i>	1 or 1b*	QL (5 tablets per 28 days)
<i>pyrimethamine oral tablet</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>quinine sulfate oral capsule</i>	1 or 1b*	PA; QL (60 capsule per 30 days)
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS FOR NERVES AND MUSCLES		
*ANTIMYASTHENIC/CHOLINERGIC AGENTS*** - DRUGS FOR NERVES AND MUSCLES		
<i>pyridostigmine bromide er oral tablet extended release</i>	2	
<i>pyridostigmine bromide oral solution</i>	2	
<i>pyridostigmine bromide oral tablet</i>	2	
ANTIMYCOBACTERIAL AGENTS - DRUGS FOR INFECTIONS		
*ANTIMYCOBACTERIAL AGENTS*** - ANTIBIOTICS		
<i>cycloserine oral capsule</i>	1 or 1b*	
<i>ethambutol hcl oral tablet</i>	2	
<i>isoniazid injection solution</i>	1 or 1a*	
<i>isoniazid oral syrup</i>	1 or 1a*	
<i>isoniazid oral tablet</i>	1 or 1a*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRIFTIN ORAL TABLET (<i>rifapentine</i>)	2	
<i>pyrazinamide oral tablet</i>	2	
<i>rifabutin oral capsule</i>	2	
<i>rifampin intravenous solution reconstituted</i>	2	
<i>rifampin oral capsule</i>	2	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS FOR CANCER		
*ALKYLATING AGENTS*** - DRUGS FOR CANCER		
MYLERAN ORAL TABLET (<i>busulfan</i>)	4; OC	LD; OC
*ANDROGEN BIOSYNTHESIS INHIBITORS*** - DRUGS FOR CANCER		
<i>abiraterone acetate oral tablet 250 mg</i>	4; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
<i>abiraterone acetate oral tablet 500 mg</i>	4; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
*ANTIADRENALS*** - DRUGS FOR CANCER		
LYSODREN ORAL TABLET (<i>mitotane</i>)	4; OC	LD; QL (38 tablet per 1 day); OC
*ANTIANDROGENS*** - DRUGS FOR CANCER		
<i>bicalutamide oral tablet</i>	2; OC	LD; QL (1 tablet per 1 day); OC
ERLEADA ORAL TABLET 240 MG (<i>apalutamide</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
ERLEADA ORAL TABLET 60 MG (<i>apalutamide</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
<i>nilutamide oral tablet</i>	4; OC	LD; QL (1 tablet per 1 day); OC
NUBEQA ORAL TABLET (<i>darolutamide</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
XTANDI ORAL CAPSULE (<i>enzalutamide</i>)	4; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
XTANDI ORAL TABLET 40 MG (<i>enzalutamide</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
XTANDI ORAL TABLET 80 MG (<i>enzalutamide</i>)	4; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
*ANTIESTROGENS*** - DRUGS FOR CANCER		
SOLTAMOX ORAL SOLUTION (<i>tamoxifen citrate</i>)	2; OC; \$0	LD; OC
<i>tamoxifen citrate oral tablet</i>	2; OC; \$0	LD; OC
<i>toremifene citrate oral tablet</i>	4; OC	LD; QL (1 tablet per 1 day); OC
*ANTIMETABOLITES*** - DRUGS FOR CANCER		
<i>capecitabine oral tablet</i>	4; OC	PA; LD; SP; OC
<i>mercaptopurine oral tablet</i>	2; OC	LD; OC
<i>methotrexate sodium (pf) injection solution</i>	1 or 1b*	LD
<i>methotrexate sodium injection solution</i>	1 or 1b*	LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methotrexate sodium injection solution reconstituted</i>	1 or 1b*	LD
<i>methotrexate sodium oral tablet</i>	2; OC	LD; OC
TABLOID ORAL TABLET (<i>thioguanine</i>)	2; OC	LD; OC
TREXALL ORAL TABLET (<i>methotrexate sodium</i>)	2; OC	ST; LD; OC
*ANTINEOPLASTIC - ALK INHIBITORS*** - DRUGS FOR CANCER		
ALECENSA ORAL CAPSULE (<i>alectinib hcl</i>)	2; OC	PA; LD; QL (8 capsule per 1 day); SP; OC
ALUNBRIG ORAL TABLET 180 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
ALUNBRIG ORAL TABLET 30 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (6 tablets per 1 day); OC
ALUNBRIG ORAL TABLET 90 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (2 tablets per 1 day); OC
ALUNBRIG ORAL TABLET THERAPY PACK (<i>brigatinib</i>)	2; OC	PA; LD; QL (1 pack per 30 days); OC
XALKORI ORAL CAPSULE (<i>crizotinib</i>)	4; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
*ANTINEOPLASTIC - ANTI-HER2 AGENTS*** - DRUGS FOR CANCER		
HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab</i>)	4	LD; SP
KANJINTI INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab-anns</i>)	4	LD; SP
*ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS*** - DRUGS FOR CANCER		
BOSULIF ORAL CAPSULE 100 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
BOSULIF ORAL CAPSULE 50 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
BOSULIF ORAL TABLET 100 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
BOSULIF ORAL TABLET 400 MG, 500 MG (<i>bosutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
<i>dasatinib oral tablet</i>	1 or 1b*; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
<i>imatinib mesylate oral tablet</i>	1 or 1b*; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
TASIGNA ORAL CAPSULE (<i>nilotinib hcl</i>)	4; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
*ANTINEOPLASTIC - BRAF KINASE INHIBITORS*** - DRUGS FOR CANCER		
TAFINLAR ORAL CAPSULE (<i>dabrafenib mesylate</i>)	4; OC	PA; LD; QL (4 capsule per 1 day); SP; OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZELBORAF ORAL TABLET (<i>vemurafenib</i>)	4; OC	PA; LD; QL (8 tablet per 1 day); SP; OC
*ANTINEOPLASTIC - BTK INHIBITORS*** - DRUGS FOR CANCER		
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	2; OC	PA; LD; QL (3 capsule per 1 day); OC
IMBRUVICA ORAL CAPSULE 70 MG (<i>ibrutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
IMBRUVICA ORAL SUSPENSION (<i>ibrutinib</i>)	2; OC	PA; LD; QL (8 mL per 1 day); OC
IMBRUVICA ORAL TABLET (<i>ibrutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
*ANTINEOPLASTIC - EGFR INHIBITORS*** - DRUGS FOR CANCER		
erlotinib hcl oral tablet 100 mg, 150 mg	1 or 1b*; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
erlotinib hcl oral tablet 25 mg	1 or 1b*; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
gefitinib oral tablet	4; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
GILOTRIF ORAL TABLET (<i>afatinib dimaleate</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); OC
*ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS*** - DRUGS FOR CANCER		
ERIVEDGE ORAL CAPSULE (<i>vismodegib</i>)	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
*ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS*** - DRUGS FOR CANCER		
ZOLINZA ORAL CAPSULE (<i>vorinostat</i>)	4; OC	PA; LD; QL (4 capsule per 1 day); SP; OC
*ANTINEOPLASTIC - IMMUNOMODULATORS*** - DRUGS FOR CANCER		
POMALYST ORAL CAPSULE (<i>pomalidomide</i>)	4; OC	PA; LD; QL (21 capsules per 28 days); SP; OC
*ANTINEOPLASTIC - MEK INHIBITORS*** - DRUGS FOR CANCER		
MEKINIST ORAL TABLET 0.5 MG (<i>trametinib dimethyl sulfoxide</i>)	4; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
MEKINIST ORAL TABLET 2 MG (<i>trametinib dimethyl sulfoxide</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
*ANTINEOPLASTIC - MTOR KINASE INHIBITORS*** - DRUGS FOR CANCER		
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	4; OC	PA; LD; SP; OC
everolimus oral tablet soluble	4; OC	PA; LD; SP; OC
everolimus (Torpenz Oral Tablet)	4; OC	PA; LD; SP; OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTINEOPLASTIC - MULTIKINASE INHIBITORS*** - DRUGS FOR CANCER		
CABOMETYX ORAL TABLET (<i>cabozantinib s-malate</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
CAPRELSA ORAL TABLET 100 MG (<i>vandetanib</i>)	4; OC	PA; LD; QL (3 tablet per 1 day); OC
CAPRELSA ORAL TABLET 300 MG (<i>vandetanib</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); OC
COMETRIQ (100 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	4; OC	PA; LD; QL (1 dose-pack per 56 days); SP; OC
COMETRIQ (140 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	4; OC	PA; LD; QL (1 dose pack per 28 days); SP; OC
COMETRIQ (60 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	4; OC	PA; LD; QL (1 dose pack per 28 days); SP; OC
<i>lapatinib ditosylate oral tablet</i>	4; OC	PA; LD; QL (6 tablet per 1 day); SP; OC
<i>pazopanib hcl oral tablet</i>	4; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
<i>sorafenib tosylate oral tablet</i>	4; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
STIVARGA ORAL TABLET (<i>regorafenib</i>)	4; OC	PA; LD; QL (84 tablets per 28 days); SP; OC
<i>sunitinib malate oral capsule</i>	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
*ANTINEOPLASTIC COMBINATIONS*** - DRUGS FOR CANCER		
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION (<i>trastuzumab-hyaluronidase-oysk</i>)	4	LD; SP
*ANTINEOPLASTICS MISC.*** - DRUGS FOR CANCER		
ACTIMMUNE SUBCUTANEOUS SOLUTION (<i>interferon gamma-1b</i>)	5	PA; LD; SP
<i>hydroxyurea oral capsule</i>	2; OC	LD; OC
MATULANE ORAL CAPSULE (<i>procarbazine hcl</i>)	4; OC	LD; OC
*AROMATASE INHIBITORS*** - DRUGS FOR CANCER		
<i>anastrozole oral tablet</i>	2; OC; \$0	LD; QL (1 tablet per 1 day); OC
<i>exemestane oral tablet</i>	2; OC; \$0	LD; QL (2 tablets per 1 day); OC
<i>letrozole oral tablet</i>	2; OC; \$0	LD; QL (1 tablet per 1 day); OC
*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS*** - DRUGS FOR CANCER		
IBRANCE ORAL CAPSULE (<i>palbociclib</i>)	4; OC	PA; LD; QL (21 capsules per 28 days); SP; OC
IBRANCE ORAL TABLET 100 MG, 75 MG (<i>palbociclib</i>)	4; OC	PA; LD; QL (21 tablets per 28 days); SP; OC
IBRANCE ORAL TABLET 125 MG (<i>palbociclib</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); SP; OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	4; OC	PA; LD; QL (0.75 tablet per 1 day); SP; OC
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	4; OC	PA; LD; QL (1.5 tablets per 1 day); SP; OC
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	4; OC	PA; LD; QL (2.25 tablets per 1 day); SP; OC
VERZENIO ORAL TABLET (<i>abemaciclib</i>)	5; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
*FOLIC ACID ANTAGONISTS RESCUE AGENTS*** - DRUGS FOR CANCER		
<i>leucovorin calcium injection solution</i>	1 or 1b*	LD
<i>leucovorin calcium injection solution reconstituted</i>	1 or 1b*	LD
<i>leucovorin calcium oral tablet</i>	2	
*GONADOTROPIN RELEASING HORMONE (GNRH) ANTAGONISTS*** - DRUGS FOR CANCER		
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>degarelix acetate</i>)	4	PA; LD; QL (2 units per 310 days); SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>degarelix acetate</i>)	4	PA; LD; QL (1 kit per 28 days); SP
*IMIDAZOTETRAZINES*** - DRUGS FOR CANCER		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 250 mg</i>	4; OC	PA; LD; QL (2 capsules per 1 day); SP; OC
<i>temozolomide oral capsule 20 mg</i>	4; OC	PA; LD; QL (4 capsule per 1 day); SP; OC
<i>temozolomide oral capsule 5 mg</i>	4; OC	PA; LD; QL (3 capsule per 1 day); SP; OC
*JANUS ASSOCIATED KINASE (JAK) INHIBITORS*** - DRUGS FOR CANCER		
JAKAFI ORAL TABLET (<i>ruxolitinib phosphate</i>)	4; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
*LHRH ANALOGS*** - DRUGS FOR CANCER		
<i>leuprolide acetate injection kit</i>	4	PA; LD; SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (<i>triptorelin pamoate</i>)	4	PA; LD; QL (1 vial per 84 days); SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 22.5 MG (<i>triptorelin pamoate</i>)	4	PA; LD; QL (1 syringe per 168 days); SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (<i>triptorelin pamoate</i>)	4	PA; LD; QL (1 kit per 28 days); SP
*MITOTIC INHIBITORS*** - DRUGS FOR CANCER		
<i>etoposide oral capsule</i>	4; OC	LD; SP; OC
*NITROGEN MUSTARDS AND RELATED ANALOGUES*** - DRUGS FOR CANCER		
<i>cyclophosphamide oral capsule</i>	4; OC	LD; SP; OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKERAN ORAL TABLET (<i>chlorambucil</i>)	2; OC	LD; OC
*POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS*** - DRUGS FOR CANCER		
LYNPARZA ORAL TABLET (<i>olaparib</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
*PROGESTINS-ANTINEOPLASTIC*** - DRUGS FOR CANCER		
<i>megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 800 mg/20ml</i>	1 or 1b*; OC	LD; OC
<i>megestrol acetate oral tablet</i>	1 or 1b*; OC	LD; OC
*RETINOIDS*** - DRUGS FOR CANCER		
<i>tretinoin oral capsule</i>	2; OC	LD; OC
*SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR CANCER		
<i>bexarotene oral capsule</i>	4; OC	PA; LD; QL (10 capsules per 1 day); SP; OC
*TOPOISOMERASE I INHIBITORS*** - DRUGS FOR CANCER		
HYCAMTIN ORAL CAPSULE (<i>topotecan hcl</i>)	4; OC	PA; LD; SP; OC
*URINARY TRACT PROTECTIVE AGENTS*** - DRUGS FOR CANCER		
<i>mesna intravenous solution</i>	1 or 1b*	PA; LD
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS*** - DRUGS FOR CANCER		
AVASTIN INTRAVENOUS SOLUTION (<i>bevacizumab</i>)	4	PA; LD; SP
INLYTA ORAL TABLET 1 MG (<i>axitinib</i>)	2; OC	PA; LD; QL (6 tablets per 1 day); SP; OC
INLYTA ORAL TABLET 5 MG (<i>axitinib</i>)	2; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (30 capsules per 30 days); SP; OC
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (60 capsules per 30 days); SP; OC
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (60 capsules per 30 days); SP; OC
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (90 capsules per 30 days); SP; OC
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (30 capsules per 30 days); SP; OC
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MVASI INTRAVENOUS SOLUTION (bevacizumab-awwb)	4	PA; LD; SP
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTIPARKINSON ANTICHOLINERGICS*** - DRUGS FOR PARKINSON		
benztropine mesylate injection solution	1 or 1a*	
benztropine mesylate oral tablet	1 or 1a*	
trihexyphenidyl hcl oral solution	1 or 1a*	
trihexyphenidyl hcl oral tablet	1 or 1a*	
*ANTIPARKINSON DOPAMINERGICS*** - DRUGS FOR PARKINSON		
amantadine hcl oral capsule	1 or 1b*	QL (4 capsule per 1 day)
amantadine hcl oral solution	1 or 1b*	QL (40 mL per 1 day)
amantadine hcl oral tablet	1 or 1b*	QL (4 tablet per 1 day)
bromocriptine mesylate oral capsule	1 or 1b*	
bromocriptine mesylate oral tablet	1 or 1b*	
*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS*** - DRUGS FOR PARKINSON		
rasagiline mesylate oral tablet 0.5 mg	2	QL (2 tablets per 1 day)
rasagiline mesylate oral tablet 1 mg	2	QL (1 tablet per 1 day)
selegiline hcl oral capsule	2	
selegiline hcl oral tablet	2	
*CENTRAL/PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON		
tolcapone oral tablet	2	PA; QL (6 tablet per 1 day)
*DECARBOXYLASE INHIBITORS*** - DRUGS FOR PARKINSON		
carbidopa oral tablet	2	
*LEVODOPA COMBINATIONS*** - DRUGS FOR PARKINSON		
carbidopa-levodopa er oral tablet extended release	2	
carbidopa-levodopa oral tablet	1 or 1b*	
carbidopa-levodopa oral tablet dispersible	2	
carbidopa-levodopa-entacapone oral tablet	2	
*NONERGOLINE DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR PARKINSON		
apomorphine hcl subcutaneous solution cartridge	4	PA; LD; QL (2 mL per 1 day); SP
pramipexole dihydrochloride er oral tablet extended release 24 hour	1 or 1b*	QL (1 tablet per 1 day)
pramipexole dihydrochloride oral tablet	1 or 1b*	QL (3 tablet per 1 day)
ropinirole hcl er oral tablet extended release 24 hour	1 or 1b*	
ropinirole hcl oral tablet	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON		
<i>entacapone oral tablet</i>	2	QL (8 tablet per 1 day)
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTIMANIC AGENTS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>lithium carbonate er oral tablet extended release 300 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>lithium carbonate er oral tablet extended release 450 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lithium carbonate oral capsule 150 mg, 300 mg</i>	1 or 1a*	DO
<i>lithium carbonate oral capsule 600 mg</i>	1 or 1a*	QL (3 capsules per 1 day)
<i>lithium carbonate oral tablet</i>	1 or 1a*	DO
<i>lithium oral solution</i>	1 or 1b*	
*ANTIPSYCHOTICS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>lurasidone hcl oral tablet 120 mg</i>	2	AL
<i>lurasidone hcl oral tablet 20 mg, 40 mg</i>	2	DO; AL
<i>lurasidone hcl oral tablet 60 mg</i>	2	AL; QL (1 tablet per 1 day)
<i>lurasidone hcl oral tablet 80 mg</i>	2	AL; QL (2 tablets per 1 day)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG (cariprazine hcl)	3	ST; DO
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG (cariprazine hcl)	3	ST; QL (1 capsule per 1 day)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg</i>	2	DO; AL
<i>ziprasidone hcl oral capsule 60 mg, 80 mg</i>	2	AL; QL (2 capsules per 1 day)
<i>ziprasidone mesylate intramuscular solution reconstituted</i>	2	AL; QL (6 vials per 28 days)
*BENZISOXAZOLES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg</i>	2	DO; AL
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	2	AL; QL (2 tablets per 1 day)
<i>paliperidone er oral tablet extended release 24 hour 9 mg</i>	2	AL; QL (1 tablet per 1 day)
<i>risperidone microspheres er intramuscular suspension reconstituted er</i>	2	AL; QL (2 injections per 28 days)
<i>risperidone oral solution</i>	1 or 1b*	AL; QL (8 mL per 1 day)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>risperidone oral tablet 3 mg, 4 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	DO; AL
<i>risperidone oral tablet dispersible 3 mg, 4 mg</i>	2	AL; QL (4 tablets per 1 day)
*BUTYROPHENONES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>haloperidol decanoate intramuscular solution 100 mg/ml</i>	1 or 1b*	AL; QL (5 injections per 30 days)
<i>haloperidol decanoate intramuscular solution 50 mg/ml</i>	1 or 1b*	AL; QL (5 ampules per 30 days)
<i>haloperidol lactate injection solution</i>	1 or 1b*	AL

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
haloperidol lactate oral concentrate 2 mg/ml	1 or 1b*	AL; QL (30 mL per 1 day)
haloperidol oral tablet 0.5 mg, 1 mg, 2 mg	1 or 1b*	DO; AL
haloperidol oral tablet 10 mg, 20 mg, 5 mg	1 or 1b*	AL; QL (3 tablets per 1 day)
*DIBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
clozapine oral tablet 100 mg	2	AL; QL (9 tablets per 1 day)
clozapine oral tablet 200 mg	2	AL; QL (4 tablets per 1 day)
clozapine oral tablet 25 mg, 50 mg	2	DO; AL
clozapine oral tablet dispersible 100 mg	2	AL; QL (9 tablets per 1 day)
clozapine oral tablet dispersible 12.5 mg, 25 mg	2	DO; AL
clozapine oral tablet dispersible 150 mg	2	AL; QL (6 tablets per 1 day)
clozapine oral tablet dispersible 200 mg	2	AL; QL (4 tablets per 1 day)
*DIBENZO-OXEPINO PYRROLES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
asenapine maleate sublingual tablet sublingual 10 mg	2	AL; QL (2 tablets per 1 day)
asenapine maleate sublingual tablet sublingual 2.5 mg, 5 mg	2	DO; AL
*DIBENZOTHIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg	2	DO; AL
quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg	2	AL; QL (2 tablets per 1 day)
quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	2	DO; AL
quetiapine fumarate oral tablet 150 mg	2	AL; QL (5 tablets per 1 day)
quetiapine fumarate oral tablet 300 mg, 400 mg	2	AL; QL (2 tablets per 1 day)
*DIBENZOXAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg	1 or 1b*	DO; AL
loxapine succinate oral capsule 50 mg	1 or 1b*	AL; QL (4 capsules per 1 day)
*DIHYDROINDOLONES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
molindone hcl oral tablet 10 mg, 5 mg	2	DO; AL
molindone hcl oral tablet 25 mg	2	AL; QL (4 tablets per 1 day)
*PHENOTHIAZINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
chlorpromazine hcl injection solution	1 or 1b*	AL
CHLORPROMAZINE HCL ORAL CONCENTRATE 100 MG/ML	1 or 1b*	AL; QL (8 mL per 1 day)
CHLORPROMAZINE HCL ORAL CONCENTRATE 30 MG/ML	1 or 1b*	AL; QL (26 mL per 1 day)
chlorpromazine hcl oral tablet 10 mg, 25 mg, 50 mg	1 or 1b*	DO; AL
chlorpromazine hcl oral tablet 100 mg, 200 mg	1 or 1b*	AL; QL (4 tablets per 1 day)
compro rectal suppository	1 or 1b*	AL

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluphenazine decanoate injection solution	1 or 1b*	AL
fluphenazine hcl injection solution	1 or 1b*	AL
fluphenazine hcl oral concentrate	1 or 1b*	AL; QL (8 mL per 1 day)
fluphenazine hcl oral elixir	1 or 1b*	AL; QL (80 mL per 1 day)
fluphenazine hcl oral tablet 1 mg, 2.5 mg, 5 mg	1 or 1b*	DO; AL
fluphenazine hcl oral tablet 10 mg	1 or 1b*	AL; QL (4 tablets per 1 day)
perphenazine oral tablet 16 mg	1 or 1b*	AL; QL (1 tablet per 1 day)
perphenazine oral tablet 2 mg	1 or 1b*	DO; AL
perphenazine oral tablet 4 mg	1 or 1b*	AL; QL (4 tablets per 1 day)
perphenazine oral tablet 8 mg	1 or 1b*	AL; QL (3 tablets per 1 day)
prochlorperazine edisylate injection solution	1 or 1b*	AL
prochlorperazine maleate oral tablet	1 or 1a*	AL
prochlorperazine rectal suppository	1 or 1b*	AL
thioridazine hcl oral tablet 10 mg, 25 mg, 50 mg	1 or 1b*	DO; AL
thioridazine hcl oral tablet 100 mg	1 or 1b*	AL; QL (8 tablets per 1 day)
trifluoperazine hcl oral tablet 1 mg, 2 mg	1 or 1b*	DO; AL
trifluoperazine hcl oral tablet 10 mg, 5 mg	1 or 1b*	AL; QL (4 tablets per 1 day)
*QUINOLINONE DERIVATIVES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
aripiprazole oral solution	2	AL; QL (30 mL per 1 day)
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg	2	DO; AL
aripiprazole oral tablet 20 mg, 30 mg	2	AL; QL (1 tablet per 1 day)
aripiprazole oral tablet dispersible 10 mg	2	AL; QL (3 tablets per 1 day)
aripiprazole oral tablet dispersible 15 mg	2	AL; QL (2 tablets per 1 day)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG (brexpiprazole)	3	ST; DO
REXULTI ORAL TABLET 3 MG, 4 MG (brexpiprazole)	3	ST; QL (1 tablet per 1 day)
*THIENBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
olanzapine intramuscular solution reconstituted	2	AL; QL (3 injections per 1 fill)
olanzapine oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	2	DO; AL
olanzapine oral tablet 15 mg, 20 mg	2	AL; QL (1 tablets per 1 day)
olanzapine oral tablet dispersible 10 mg, 5 mg	2	DO; AL
olanzapine oral tablet dispersible 15 mg	2	AL; QL (1 tablets per 1 day)
olanzapine oral tablet dispersible 20 mg	2	AL; QL (1 tablet per 1 day)
*THIOXANTHENES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
thiothixene oral capsule 1 mg, 2 mg, 5 mg	1 or 1b*	PA; DO
thiothixene oral capsule 10 mg	1 or 1b*	PA; QL (6 capsules per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - DRUGS FOR INFECTIONS		
*ANTIRETROVIRAL COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS		
<i>abacavir sulfate-lamivudine oral tablet</i>	2	LD; QL (1 tablet per 1 day)
BIKTARVY ORAL TABLET (<i>bictegravir-emtricitab-tenofovir</i>)	4	LD; QL (1 tablet per 1 day)
CIMDUO ORAL TABLET (<i>lamivudine-tenofovir</i>)	4	LD; QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	2	LD; QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	2; \$0	LD; QL (1 tablet per 1 day)
DOVATO ORAL TABLET (<i>dolutegravir-lamivudine</i>)	4	LD; QL (1 tablet per 1 day)
<i>efavirenz-emtricitab-tenofo df oral tablet</i>	4	LD; QL (1 tablet per 1 day)
<i>efavirenz-lamivudine-tenofovir oral tablet</i>	4	LD; QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1 or 1b*	LD; QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1 or 1b*; \$0	LD; QL (1 tablet per 1 day)
GENVOYA ORAL TABLET (<i>elviteg-cobic-emtricit-tenofaf</i>)	4	LD; QL (1 tablet per 1 day)
<i>lamivudine-zidovudine oral tablet</i>	2	LD; QL (2 tablets per 1 day)
<i>lopinavir-ritonavir oral solution</i>	4	LD; QL (16 mL per 1 day)
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	4	LD; QL (10 tablets per 1 day)
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	4	LD; QL (4 tablets per 1 day)
STRIBILD ORAL TABLET (<i>elviteg-cobic-emtricit-tenofdf</i>)	4	LD; QL (1 tablet per 1 day)
TRIUMEQ ORAL TABLET (<i>abacavir-dolutegravir-lamivud</i>)	4	LD; QL (1 tablet per 1 day)
TRIUMEQ PD ORAL TABLET SOLUBLE	4	LD; QL (6 tablets per 1 day)
*ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)*** - DRUGS FOR VIRAL INFECTIONS		
<i>maraviroc oral tablet</i>	4	LD; QL (4 tablets per 1 day)
*ANTIRETROVIRALS - FUSION INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>enfuvirtide</i>)	4	PA; LD; QL (2 vials per 1 day)
*ANTIRETROVIRALS - INTEGRASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
ISENTRESS ORAL TABLET (<i>raltegravir potassium</i>)	4	LD; QL (4 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 100 MG (<i>raltegravir potassium</i>)	4	LD; QL (6 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 25 MG (<i>raltegravir potassium</i>)	4	LD; QL (24 tablets per 1 day)
TIVICAY ORAL TABLET (<i>dolutegravir sodium</i>)	4	LD; QL (2 tablets per 1 day)
TIVICAY PD ORAL TABLET SOLUBLE (<i>dolutegravir sodium</i>)	4	LD; QL (12 tablets per 1 day)
*ANTIRETROVIRALS - PROTEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
APTIVUS ORAL CAPSULE (<i>tipranavir</i>)	4	PA; LD; QL (4 capsules per 1 day)
<i>atazanavir sulfate oral capsule 150 mg, 200 mg</i>	4	LD; QL (2 capsules per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
atazanavir sulfate oral capsule 300 mg	4	LD; QL (1 capsule per 1 day)
darunavir oral tablet 600 mg	4	LD; QL (2 tablets per 1 day)
darunavir oral tablet 800 mg	4	LD; QL (1 tablet per 1 day)
fosamprenavir calcium oral tablet	4	LD; QL (4 tablets per 1 day)
PREZISTA ORAL SUSPENSION (darunavir)	4	LD; QL (14 mL per 1 day)
PREZISTA ORAL TABLET 150 MG (darunavir)	4	LD; QL (6 tablets per 1 day)
PREZISTA ORAL TABLET 75 MG (darunavir)	4	LD; QL (10 tablets per 1 day)
REYATAZ ORAL PACKET (atazanavir sulfate)	4	LD; QL (5 packets per 1 day)
ritonavir oral tablet	4	LD; QL (12 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
EDURANT ORAL TABLET (rilpivirine hcl)	4	PA; LD; QL (1 tablet per 1 day)
efavirenz oral tablet	4	LD; QL (1 tablet per 1 day)
etravirine oral tablet 100 mg	4	PA; LD; QL (4 tablets per 1 day)
etravirine oral tablet 200 mg	4	PA; LD; QL (2 tablets per 1 day)
INTELENCE ORAL TABLET 25 MG (etravirine)	4	PA; LD; QL (16 tablets per 1 day)
nevirapine er oral tablet extended release 24 hour	4	LD; QL (1 tablet per 1 day)
nevirapine oral suspension	4	LD; QL (40 mL per 1 day)
nevirapine oral tablet	4	LD; QL (2 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES*** - DRUGS FOR VIRAL INFECTIONS		
abacavir sulfate oral solution	4	LD; QL (32 mL per 1 day)
abacavir sulfate oral tablet	4	LD; QL (2 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES*** - DRUGS FOR VIRAL INFECTIONS		
emtricitabine oral capsule	4; \$0	LD; QL (1 capsule per 1 day)
EMTRIVA ORAL SOLUTION (emtricitabine)	4	LD; QL (29 mL per 1 day)
lamivudine oral solution	4	LD; QL (32 mL per 1 day)
lamivudine oral tablet 150 mg	4	PA; LD; QL (2 tablets per 1 day)
lamivudine oral tablet 300 mg	4	PA; LD; QL (1 tablet per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES*** - DRUGS FOR VIRAL INFECTIONS		
zidovudine oral capsule	4	LD; QL (6 capsules per 1 day)
zidovudine oral syrup	4	LD; QL (64 mL per 1 day)
zidovudine oral tablet	4	LD; QL (2 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
tenofovir disoproxil fumarate oral tablet	4; \$0	LD; QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>tenofovir disoproxil fumarate</i>)	4	LD; QL (1 tablet per 1 day)
*ANTIVIRAL COMBINATIONS*** - DRUGS FOR INFECTIONS		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK (<i>nirmatrelvir-ritonavir</i>)	3	QL (1 pack per 90 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK (<i>nirmatrelvir-ritonavir</i>)	3	QL (1 pack per 90 days)
*CMV AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>valganciclovir hcl oral solution reconstituted</i>	4	LD
<i>valganciclovir hcl oral tablet</i>	4	LD
*HEPATITIS B AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>adefovir dipivoxil oral tablet</i>	4	PA; LD; QL (1 tablet per 1 day); SP
BARACLUDE ORAL SOLUTION (<i>entecavir</i>)	5	PA; LD; QL (20 mL per 1 day)
<i>entecavir oral tablet</i>	4	PA; LD; QL (1 tablet per 1 day)
<i>lamivudine oral tablet 100 mg</i>	4	PA; LD; QL (1 tablet per 1 day)
VEMLIDY ORAL TABLET (<i>tenofovir alafenamide fumarate</i>)	5	PA; LD; QL (1 tablet per 1 day); SP
*HEPATITIS C AGENT - COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS		
EPCLUSA ORAL PACKET 150-37.5 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; LD; QL (1 packet per 1 day); SP
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; LD; QL (2 packets per 1 day); SP
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; LD; QL (2 tablets per 1 day); SP
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
HARVONI ORAL PACKET 33.75-150 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; LD; QL (1 packet per 1 day); SP
HARVONI ORAL PACKET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; LD; QL (2 packets per 1 day); SP
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; LD; QL (2 tablets per 1 day); SP
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
VOSEVI ORAL TABLET (<i>sofosbuv-velpatasv-voxilaprev</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
*HEPATITIS C AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>ribavirin oral capsule</i>	4	LD; QL (6 capsules per 1 day); SP
<i>ribavirin oral tablet</i>	4	LD; QL (6 tablets per 1 day); SP
*HERPES AGENTS - PURINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>acyclovir oral capsule</i>	1 or 1b*	
<i>acyclovir oral suspension</i>	1 or 1b*	
<i>acyclovir oral tablet</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
acyclovir sodium intravenous solution	1 or 1b*	
valacyclovir hcl oral tablet 1 gm	1 or 1b*	QL (30 tablets per 1 fill)
valacyclovir hcl oral tablet 500 mg	1 or 1b*	QL (60 tablets per 30 days)
*HERPES AGENTS - THYMIDINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
famciclovir oral tablet 125 mg, 250 mg	1 or 1b*	QL (60 tablets per 1 fill)
famciclovir oral tablet 500 mg	1 or 1b*	QL (21 tablets per 1 fill)
*INFLUENZA AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
rimantadine hcl oral tablet	1 or 1b*	
*MISC. ANTIVIRALS*** - DRUGS FOR VIRAL INFECTIONS		
LAGEVRIO ORAL CAPSULE (molnupiravir)	3	QL (40 capsules per 90 days)
*NEURAMINIDASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
oseltamivir phosphate oral capsule 30 mg	1 or 1b*	QL (20 capsule per 90 days)
oseltamivir phosphate oral capsule 45 mg, 75 mg	1 or 1b*	QL (10 capsule per 90 days)
oseltamivir phosphate oral suspension reconstituted	1 or 1b*	QL (20 Ml per 90 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED (zanamivir)	2	QL (1 unit per 90 days)
*PA ENDONUCLEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK (baloxavir marboxil)	3	QL (1 dose pack per 90 days)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK (baloxavir marboxil)	3	QL (1 dose pack per 90 days)
*RSV AGENTS - NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
ribavirin inhalation solution reconstituted	2	
BETA BLOCKERS - DRUGS FOR THE HEART		
*ALPHA-BETA BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE		
carvedilol oral tablet 12.5 mg, 3.125 mg, 6.25 mg	1 or 1b*	DO
carvedilol oral tablet 25 mg	1 or 1b*	QL (4 tablets per 1 day)
carvedilol phosphate er oral capsule extended release 24 hour 10 mg	2	DO
carvedilol phosphate er oral capsule extended release 24 hour 20 mg	2	QL (4 capsules per 1 day)
carvedilol phosphate er oral capsule extended release 24 hour 40 mg	2	QL (2 capsules per 1 day)
carvedilol phosphate er oral capsule extended release 24 hour 80 mg	2	QL (1 capsule per 1 day)
labetalol hcl oral tablet 100 mg	1 or 1b*	DO
labetalol hcl oral tablet 200 mg	1 or 1b*	QL (12 tablets per 1 day)
labetalol hcl oral tablet 300 mg	1 or 1b*	QL (8 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*BETA BLOCKERS CARDIO-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>acebutolol hcl oral capsule</i>	1 or 1b*	
<i>atenolol oral tablet</i>	1 or 1a*	
<i>betaxolol hcl oral tablet</i>	1 or 1b*	
<i>bisoprolol fumarate oral tablet</i>	1 or 1b*	
<i>esmolol hcl intravenous solution 100 mg/10ml</i>	1 or 1b*	
<i>metoprolol succinate er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>metoprolol tartrate intravenous solution</i>	1 or 1a*	
<i>metoprolol tartrate oral tablet</i>	1 or 1a*	
<i>nebivolol hcl oral tablet</i>	2	
*BETA BLOCKERS NON-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>nadolol oral tablet 20 mg, 40 mg</i>	1 or 1b*	DO
<i>nadolol oral tablet 80 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>pindolol oral tablet 10 mg</i>	2	QL (6 tablets per 1 day)
<i>pindolol oral tablet 5 mg</i>	2	DO
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 60 mg, 80 mg</i>	1 or 1b*	DO
<i>propranolol hcl er oral capsule extended release 24 hour 160 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>propranolol hcl intravenous solution</i>	1 or 1b*	
<i>propranolol hcl oral solution</i>	1 or 1b*	QL (80 mL per 1 day)
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg</i>	1 or 1b*	DO
<i>propranolol hcl oral tablet 80 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>sotalol hcl (af) oral tablet</i>	2	
<i>sotalol hcl oral tablet 120 mg, 80 mg</i>	2	QL (3 tablets per 1 day)
<i>sotalol hcl oral tablet 160 mg</i>	2	QL (4 tablets per 1 day)
<i>sotalol hcl oral tablet 240 mg</i>	2	QL (2 tablets per 1 day)
<i>timolol maleate oral tablet 10 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>timolol maleate oral tablet 20 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>timolol maleate oral tablet 5 mg</i>	1 or 1b*	DO
CALCIUM CHANNEL BLOCKERS - DRUGS FOR THE HEART		
*CALCIUM CHANNEL BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besylate oral tablet 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	DO
<i>cartia xt oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>cartia xt oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>cartia xt oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cartia xt oral capsule extended release 24 hour 300 mg	1 or 1b*	QL (1 capsule per 1 day)
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er beads oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
diltiazem hcl er beads oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
diltiazem hcl er beads oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg	1 or 1b*	QL (1 capsule per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg, 360 mg	1 or 1b*	QL (1 capsule per 1 day)
diltiazem hcl er oral capsule extended release 12 hour 120 mg	1 or 1b*	QL (2 capsules per 1 day)
diltiazem hcl er oral capsule extended release 12 hour 60 mg	1 or 1b*	DO
diltiazem hcl er oral capsule extended release 12 hour 90 mg	1 or 1b*	QL (4 capsules per 1 day)
diltiazem hcl er oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
diltiazem hcl er oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
diltiazem hcl er oral tablet extended release 24 hour 120 mg	1 or 1b*	DO
diltiazem hcl er oral tablet extended release 24 hour 180 mg	1 or 1b*	QL (3 tablets per 1 day)
diltiazem hcl er oral tablet extended release 24 hour 240 mg	1 or 1b*	QL (2 tablets per 1 day)
diltiazem hcl er oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg	1 or 1b*	QL (1 tablet per 1 day)
diltiazem hcl intravenous solution	1 or 1b*	
diltiazem hcl oral tablet 120 mg	1 or 1b*	QL (3 tablet per 1 day)
diltiazem hcl oral tablet 30 mg, 60 mg	1 or 1b*	DO
diltiazem hcl oral tablet 90 mg	1 or 1b*	QL (4 tablet per 1 day)
dilt-xr oral capsule extended release 24 hour 120 mg	1 or 1b*	DO
dilt-xr oral capsule extended release 24 hour 180 mg	1 or 1b*	QL (3 capsules per 1 day)
dilt-xr oral capsule extended release 24 hour 240 mg	1 or 1b*	QL (2 capsules per 1 day)
felodipine er oral tablet extended release 24 hour 10 mg	1 or 1b*	QL (1 tablet per 1 day)
felodipine er oral tablet extended release 24 hour 2.5 mg, 5 mg	1 or 1b*	DO
isradipine oral capsule 2.5 mg	1 or 1b*	DO
isradipine oral capsule 5 mg	1 or 1b*	QL (4 capsule per 1 day)
levamlodipine maleate oral tablet 2.5 mg	1 or 1b*	ST; DO
levamlodipine maleate oral tablet 5 mg	1 or 1b*	ST; QL (1 tablet per 1 day)
matzim la oral tablet extended release 24 hour 180 mg	1 or 1b*	QL (3 tablets per 1 day)
matzim la oral tablet extended release 24 hour 240 mg	1 or 1b*	QL (2 tablets per 1 day)
matzim la oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg	1 or 1b*	QL (1 tablet per 1 day)
nicardipine hcl oral capsule 20 mg	1 or 1b*	QL (6 capsule per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicardipine hcl oral capsule 30 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg</i>	2	QL (1 tablet per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 60 mg</i>	2	QL (2 tablets per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg</i>	2	DO
<i>nifedipine er osmotic release oral tablet extended release 24 hour 60 mg</i>	2	QL (2 tablets per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 90 mg</i>	2	QL (1 tablet per 1 day)
<i>nifedipine oral capsule 10 mg</i>	2	DO
<i>nifedipine oral capsule 20 mg</i>	2	QL (4 capsule per 1 day)
<i>nimodipine oral capsule</i>	2	QL (12 capsule per 1 day)
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 8.5 mg</i>	1 or 1b*	DO
<i>nisoldipine er oral tablet extended release 24 hour 25.5 mg, 30 mg, 34 mg, 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>tiadylt er oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg</i>	1 or 1b*	DO
<i>verapamil hcl er oral capsule extended release 24 hour 200 mg, 300 mg, 360 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>verapamil hcl er oral tablet extended release 120 mg</i>	1 or 1b*	DO
<i>verapamil hcl er oral tablet extended release 180 mg, 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>verapamil hcl intravenous solution</i>	1 or 1b*	
<i>verapamil hcl oral tablet 120 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>verapamil hcl oral tablet 40 mg, 80 mg</i>	1 or 1b*	DO
CARDIOTONICS - DRUGS FOR THE HEART		
*CARDIAC GLYCOSIDES*** - DRUGS FOR THE HEART		
<i>digoxin injection solution</i>	1 or 1b*	
<i>digoxin oral solution</i>	1 or 1b*	QL (10 mL per 1 day)
<i>digoxin oral tablet 125 mcg, 62.5 mcg</i>	1 or 1b*	DO
<i>digoxin oral tablet 250 mcg</i>	1 or 1b*	QL (2 tablets per 1 day)
LANOXIN PEDIATRIC INJECTION SOLUTION (<i>digoxin</i>)	2	
*INOTROPES*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>dobutamine hcl intravenous solution</i>	1 or 1b*	
<i>milrinone lactate in dextrose intravenous solution</i>	1 or 1b*	
<i>milrinone lactate intravenous solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARDIOVASCULAR AGENTS - MISC. - DRUGS FOR THE HEART		
*CALCIUM CHANNEL BLOCKER & HMG COA REDUCTASE INHIBIT COMB*** - DRUGS FOR CHOLESTEROL		
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-80 mg	1 or 1b*	QL (1 tablet per 1 day)
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg	1 or 1b*	DO
*NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB*** - DRUGS FOR HIGH BLOOD PRESSURE		
ENTRESTO ORAL CAPSULE SPRINKLE (sacubitril-valsartan)	3	QL (8 capsules per 1 day)
ENTRESTO ORAL TABLET (sacubitril-valsartan)	3	QL (6 tablets per 1 day)
*NITRATE & VASODILATOR COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
isosorb dinitrate-hydralazine oral tablet	2	QL (6 tablets per 1 day)
*PROSTAGLANDIN VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
treprostinil injection solution	4	PA; LD; SP
VENTAVIS INHALATION SOLUTION (iloprost)	5	PA; LD; QL (9 mL per 1 day); SP
*PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE		
ambrisentan oral tablet	4	PA; LD; QL (1 tablet per 1 day); SP
bosentan oral tablet	4	PA; LD; QL (2 tablets per 1 day); SP
OPSUMIT ORAL TABLET (macitentan)	4	PA; LD; QL (1 tablet per 1 day); SP
TRACLEER ORAL TABLET SOLUBLE (bosentan)	4	PA; LD; QL (2 tablets per 1 day); SP
*PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
alyq oral tablet	4	PA; LD; QL (2 tablets per 1 day); SP
sildenafil citrate oral suspension reconstituted	4	PA; LD; QL (24 mL per 1 day); SP
sildenafil citrate oral tablet 20 mg	4	PA; LD; QL (12 tablets per 1 day); SP
tadalafil (pah) oral tablet	4	PA; LD; QL (2 tablets per 1 day); SP
*SELECTIVE CGMP PHOSPHODIESTERASE TYPE 5 INHIBITORS*** - DRUGS FOR THE HEART		
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	1 or 1b*	PA
tadalafil oral tablet 10 mg, 20 mg	1 or 1b*	PA
tadalafil oral tablet 2.5 mg, 5 mg	1 or 1b*	PA; QL (30 tablets per 30 days)
vardenafil hcl oral tablet dispersible	1 or 1b*	PA

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SINUS NODE INHIBITORS** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>ivabradine hcl oral tablet</i>	2	PA; QL (2 tablets per 1 day)
CEPHALOSPORINS - DRUGS FOR INFECTIONS		
*CEPHALOSPORINS - 1ST GENERATION*** - ANTIBIOTICS		
<i>cefadroxil oral capsule</i>	1 or 1b*	
<i>cefadroxil oral suspension reconstituted</i>	1 or 1b*	
<i>cefadroxil oral tablet</i>	1 or 1b*	
<i>cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm, 3 gm, 500 mg</i>	2	
<i>cefazolin sodium intravenous solution reconstituted 1 gm</i>	2	
<i>cephalexin oral capsule</i>	1 or 1a*	
<i>cephalexin oral suspension reconstituted</i>	1 or 1a*	
<i>cephalexin oral tablet</i>	1 or 1a*	
*CEPHALOSPORINS - 2ND GENERATION*** - ANTIBIOTICS		
CEFACLO ER ORAL TABLET EXTENDED RELEASE 12 HOUR	2	
<i>cefactor oral capsule</i>	1 or 1b*	
<i>cefactor oral suspension reconstituted</i>	1 or 1b*	
<i>cefotetan disodium injection solution reconstituted</i>	2	
<i>cefoxitin sodium intravenous solution reconstituted</i>	2	
<i>cefprozil oral suspension reconstituted</i>	1 or 1b*	
<i>cefprozil oral tablet</i>	1 or 1b*	
<i>cefuroxime axetil oral tablet</i>	1 or 1b*	
<i>cefuroxime sodium injection solution reconstituted</i>	2	
<i>cefuroxime sodium intravenous solution reconstituted</i>	2	
*CEPHALOSPORINS - 3RD GENERATION*** - ANTIBIOTICS		
<i>cefdinir oral capsule</i>	1 or 1b*	
<i>cefdinir oral suspension reconstituted</i>	1 or 1b*	
<i>cefixime oral capsule</i>	2	
<i>cefixime oral suspension reconstituted</i>	2	
<i>cefpodoxime proxetil oral suspension reconstituted</i>	2	
<i>cefpodoxime proxetil oral tablet</i>	2	
<i>ceftazidime injection solution reconstituted</i>	2	
<i>ceftazidime intravenous solution reconstituted</i>	2	
<i>ceftriaxone sodium in dextrose intravenous solution</i>	2	QL (3000 mL per 30 days)
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 500 mg</i>	2	QL (60 vials per 30 fills)
<i>ceftriaxone sodium injection solution reconstituted 250 mg</i>	2	QL (1 vial per 30 fills)
<i>ceftriaxone sodium intravenous solution reconstituted 1 gm, 2 gm</i>	2	QL (60 vials per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ceftriaxone sodium intravenous solution reconstituted 10 gm</i>	2	QL (1 vial per 30 days)
<i>tazicef injection solution reconstituted</i>	2	
<i>tazicef intravenous solution reconstituted</i>	2	
*CEPHALOSPORINS - 4TH GENERATION*** - ANTIBIOTICS		
<i>cefepime hcl injection solution reconstituted</i>	2	
<i>cefepime hcl intravenous solution reconstituted 2 gm</i>	2	
CONTRACEPTIVES - DRUGS FOR WOMEN		
*BIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>azurette oral tablet</i>	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>kariva oral tablet</i>	1 or 1b*; \$0	
LO LOESTRIN FE ORAL TABLET (<i>norethin-eth estrad-fe biphas</i>)	2	\$0
<i>pimtree oral tablet</i>	1 or 1b*; \$0	
<i>simliya oral tablet</i>	1 or 1b*; \$0	
<i>viorele oral tablet</i>	1 or 1b*; \$0	
<i>volnea oral tablet</i>	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>afirmelle oral tablet</i>	1 or 1a*; \$0	
<i>altavera oral tablet</i>	1 or 1a*; \$0	
<i>alyacen 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>apri oral tablet</i>	1 or 1a*; \$0	
<i>aubra eq oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>aurovela fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>aviane oral tablet</i>	1 or 1a*; \$0	
<i>ayuna oral tablet</i>	1 or 1a*; \$0	
<i>balziva oral tablet</i>	1 or 1a*; \$0	
<i>blisovi 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>blisovi fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>blisovi fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>briellyn oral tablet</i>	1 or 1a*; \$0	
<i>charlotte 24 fe oral tablet chewable</i>	1 or 1a*; \$0	
<i>chateal eq oral tablet</i>	1 or 1a*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cryselle-28 oral tablet</i>	1 or 1a*; \$0	
<i>cyred eq oral tablet</i>	1 or 1a*; \$0	
<i>dasetta 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>delyla oral tablet</i>	1 or 1a*; \$0	
<i>drospiren-eth estrad-levomefol oral tablet</i>	1 or 1b*; \$0	
<i>drospirenone-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>elinest oral tablet</i>	1 or 1a*; \$0	
<i>enskyce oral tablet</i>	1 or 1a*; \$0	
<i>estarylla oral tablet</i>	1 or 1a*; \$0	
<i>ethynodiol diac-eth estradiol oral tablet</i>	1 or 1a*; \$0	
<i>falmina oral tablet</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe (Finzala Oral Tablet Chewable)</i>	1 or 1a*; \$0	
<i>gemmily oral capsule</i>	1 or 1b*; \$0	
<i>hailey 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>hailey 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>hailey fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>hailey fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>isibloom oral tablet</i>	1 or 1a*; \$0	
<i>jasmiel oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad-fe bisg (Joyeaux Oral Tablet)</i>	1 or 1b*; \$0	
<i>juleber oral tablet</i>	1 or 1a*; \$0	
<i>junel 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>junel 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 24 oral tablet</i>	1 or 1a*; \$0	
<i>kaitlib fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>kalliga oral tablet</i>	1 or 1a*; \$0	
<i>kelnor 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>kelnor 1/50 oral tablet</i>	1 or 1a*; \$0	
<i>kurvelo oral tablet</i>	1 or 1a*; \$0	
<i>larin 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>larin 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>larin 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>larin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>larin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>layolis fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>lessina oral tablet</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estradiol-iron oral tablet</i>	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	1 or 1a*; \$0	
<i>levora 0.15/30 (28) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin 1.5/30 (21) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin 1/20 (21) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>loestrin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>loryna oral tablet</i>	1 or 1b*; \$0	
<i>low-ogestrel oral tablet</i>	1 or 1a*; \$0	
<i>lo-zumandimine oral tablet</i>	1 or 1b*; \$0	
<i>luteru oral tablet</i>	1 or 1a*; \$0	
<i>marlissa oral tablet</i>	1 or 1a*; \$0	
<i>merzee oral capsule</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe (Mibelas 24 Fe Oral Tablet Chewable)</i>	1 or 1a*; \$0	
<i>microgestin 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>mili oral tablet</i>	1 or 1a*; \$0	
<i>mono-lynyah oral tablet</i>	1 or 1a*; \$0	
<i>necon 0.5/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>nikki oral tablet</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe oral capsule</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe oral tablet</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe oral tablet chewable</i>	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est oral tablet</i>	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1 or 1a*; \$0	
<i>nortrel 0.5/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>nortrel 1/35 (21) oral tablet</i>	1 or 1a*; \$0	
<i>nortrel 1/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>nylia 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>ocella oral tablet</i>	1 or 1b*; \$0	
<i>philith oral tablet</i>	1 or 1a*; \$0	
<i>portia-28 oral tablet</i>	1 or 1a*; \$0	
<i>reclipsen oral tablet</i>	1 or 1a*; \$0	
<i>sprintec 28 oral tablet</i>	1 or 1a*; \$0	
<i>sronyx oral tablet</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
syeda oral tablet	1 or 1b*; \$0	
tarina 24 fe oral tablet	1 or 1a*; \$0	
tarina fe 1/20 eq oral tablet	1 or 1a*; \$0	
taysofy oral capsule	1 or 1b*; \$0	
norgestrel-ethinyl estradiol (Turqoz Oral Tablet)	1 or 1a*; \$0	
tydemy oral tablet	1 or 1b*; \$0	
vestura oral tablet	1 or 1b*; \$0	
vienva oral tablet	1 or 1a*; \$0	
vyfemla oral tablet	1 or 1a*; \$0	
vylibra oral tablet	1 or 1a*; \$0	
wera oral tablet	1 or 1a*; \$0	
wymzya fe oral tablet chewable	1 or 1b*; \$0	
zovia 1/35 (28) oral tablet	1 or 1a*; \$0	
zumandimine oral tablet	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - TRANSDERMAL*** - BIRTH CONTROL PILLS		
norelgestromin-eth estradiol transdermal patch weekly	1 or 1b*; \$0	
xulane transdermal patch weekly	1 or 1b*; \$0	
zafemy transdermal patch weekly	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - VAGINAL*** - BIRTH CONTROL PILLS		
eluryng vaginal ring	1 or 1b*; \$0	
etonogestrel-ethinyl estradiol (Enilloring Vaginal Ring)	1 or 1b*; \$0	
etonogestrel-ethinyl estradiol vaginal ring	1 or 1b*; \$0	
etonogestrel-ethinyl estradiol (Haloette Vaginal Ring)	1 or 1b*; \$0	
*CONTINUOUS CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
amethyst oral tablet	1 or 1b*; \$0	
dolishale oral tablet	1 or 1b*; \$0	
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg	1 or 1b*; \$0	
*EMERGENCY CONTRACEPTIVES*** - BIRTH CONTROL PILLS		
aftera oral tablet	1 or 1b*; \$0	
afterpill oral tablet	1 or 1b*; \$0	
CURAE ORAL TABLET (levonorgestrel)	1 or 1b*; \$0	
econtra one-step oral tablet	1 or 1b*; \$0	
ELLA ORAL TABLET (ulipristal acetate)	2; \$0	
HER STYLE ORAL TABLET (levonorgestrel)	1 or 1b*; \$0	
levonorgestrel oral tablet	1 or 1b*; \$0	
my choice oral tablet	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>my way oral tablet</i>	1 or 1b*; \$0	
<i>new day oral tablet</i>	1 or 1b*; \$0	
<i>opcicon one-step oral tablet</i>	1 or 1b*; \$0	
<i>option 2 oral tablet</i>	1 or 1b*; \$0	
<i>react oral tablet</i>	1 or 1b*; \$0	
<i>take action oral tablet</i>	1 or 1b*; \$0	
*EXTENDED-CYCLE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>ashlyna oral tablet</i>	1 or 1b*; \$0	
<i>camrese lo oral tablet</i>	1 or 1b*; \$0	
<i>camrese oral tablet</i>	1 or 1b*; \$0	
<i>daysee oral tablet</i>	1 or 1b*; \$0	
<i>iclevia oral tablet</i>	1 or 1b*; \$0	
<i>introvale oral tablet</i>	1 or 1b*; \$0	
<i>jaimiess oral tablet</i>	1 or 1b*; \$0	
<i>jolessa oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth est & eth est oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day oral tablet</i>	1 or 1b*; \$0	
<i>lojaimiess oral tablet</i>	1 or 1b*; \$0	
<i>rivelsa oral tablet</i>	1 or 1b*; \$0	
<i>setlakin oral tablet</i>	1 or 1b*; \$0	
<i>simpesse oral tablet</i>	1 or 1b*; \$0	
*PROGESTIN CONTRACEPTIVES - INJECTABLE*** - BIRTH CONTROL PILLS		
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (<i>medroxyprogesterone acetate</i>)	2; \$0	
<i>medroxyprogesterone acetate intramuscular suspension</i>	1 or 1b*; \$0	
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe</i>	1 or 1b*; \$0	
*PROGESTIN CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>camila oral tablet</i>	1 or 1b*; \$0	
<i>deblitane oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone</i> (Emzahh Oral Tablet)	1 or 1b*; \$0	
<i>errin oral tablet</i>	1 or 1b*; \$0	
<i>heather oral tablet</i>	1 or 1b*; \$0	
<i>incassia oral tablet</i>	1 or 1b*; \$0	
<i>jencycla oral tablet</i>	1 or 1b*; \$0	
<i>lyleq oral tablet</i>	1 or 1b*; \$0	
<i>lyza oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

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

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dexamethasone oral elixir</i>	1 or 1a*	
<i>dexamethasone oral solution</i>	1 or 1a*	
<i>dexamethasone oral tablet</i>	1 or 1a*	
<i>dexamethasone oral tablet therapy pack</i>	1 or 1b*	
<i>dexamethasone sod phos + rfid injection solution prefilled syringe</i>	1 or 1b*	
<i>dexamethasone sod phosphate pf injection solution</i>	1 or 1b*	
DEXAMETHASONE SOD PHOSPHATE PF INJECTION SOLUTION PREFILLED SYRINGE	1 or 1b*	
<i>dexamethasone sodium phosphate injection solution 100 mg/10ml, 120 mg/30ml, 20 mg/5ml</i>	1 or 1b*	
DEXAMETHASONE SODIUM PHOSPHATE INJECTION SOLUTION PREFILLED SYRINGE	1 or 1b*	
<i>hidex 6-day oral tablet therapy pack</i>	1 or 1b*	
<i>hydrocortisone oral tablet</i>	1 or 1b*	
<i>hydrocortisone sod suc (pf) injection solution reconstituted</i>	1 or 1b*	
<i>methylprednisolone oral tablet</i>	1 or 1a*	
<i>methylprednisolone oral tablet therapy pack</i>	1 or 1a*	
<i>methylprednisolone sodium succ injection solution reconstituted</i>	1 or 1b*	
<i>prednisolone oral solution</i>	1 or 1a*	
<i>prednisolone oral tablet</i>	2	
<i>prednisolone sodium phosphate oral solution</i>	1 or 1a*	
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg, 30 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>prednisolone sodium phosphate oral tablet dispersible 15 mg</i>	1 or 1a*	DO
<i>prednisone oral solution</i>	1 or 1a*	
<i>prednisone oral tablet</i>	1 or 1a*	
<i>prednisone oral tablet therapy pack</i>	1 or 1a*	
SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED (hydrocortisone sod succinate)	3	
<i>taperdex 12-day oral tablet therapy pack</i>	1 or 1b*	
<i>taperdex 6-day oral tablet therapy pack</i>	1 or 1b*	
<i>taperdex 7-day oral tablet therapy pack</i>	1 or 1b*	
*MINERALOCORTICOIDS*** - DRUGS FOR INFLAMMATION		
<i>fludrocortisone acetate oral tablet</i>	1 or 1b*	
COUGH/COLD/ALLERGY - DRUGS FOR THE LUNGS		
*ANTITUSSIVE - NONNARCOTIC*** - DRUGS FOR ALLERGIES		
<i>benzonatate oral capsule</i>	1 or 1b*	
*ANTITUSSIVE - OPIOID*** - DRUGS FOR COUGH AND COLD		
<i>hydrocodone bit-homatrop mbr oral solution</i>	1 or 1a*	AL; QL (150 mL per 5 days)
<i>hydrocodone bit-homatrop mbr oral tablet</i>	1 or 1a*	PA; QL (30 tablets per 5 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydromet oral solution</i>	1 or 1a*	AL; QL (150 mL per 5 days)
*ANTITUSSIVE-EXPECTORANT*** - DRUGS FOR COUGH AND COLD		
<i>g tussin ac oral solution</i>	1 or 1a*	AL; QL (120 mL per 1 fill)
<i>guaifenesin-codeine oral solution</i>	1 or 1a*	AL; QL (120 mL per 1 fill)
<i>maxi-tuss ac oral solution</i>	1 or 1a*	AL; QL (120 mL per 1 fill)
*DECONGESTANT & ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>promethazine vc oral syrup</i>	1 or 1b*	QL (2 fills per 30 days)
<i>promethazine-phenylephrine oral syrup</i>	1 or 1b*	QL (2 fills per 30 days)
*MISC. RESPIRATORY INHALANTS*** - DRUGS FOR ALLERGIES		
<i>sodium chloride</i> (Nebusal Inhalation Nebulization Solution 3 %)	2	
<i>sodium chloride</i> (Pulmosal Inhalation Nebulization Solution)	1 or 1b*	
<i>sodium chloride inhalation nebulization solution</i>	2	
*MUCOLYTICS*** - DRUGS FOR THE LUNGS		
<i>acetylcysteine inhalation solution</i>	2	
*NON-NARC ANTITUSSIVE-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>promethazine-dm oral syrup</i>	1 or 1a*	QL (2 fills per 30 days)
*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>pseudoeph-bromphen-dm oral syrup</i>	1 or 1b*	
*OPIOID ANTITUSSIVE-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>hydrocod poli-chlorphe poli er oral suspension extended release</i>	1 or 1b*	AL; QL (120 mL per 1 fill)
<i>promethazine-codeine oral solution</i>	1 or 1a*	AL; QL (100 mL per 5 days)
*OPIOID ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
POLY-TUSSIN AC ORAL LIQUID	2	AL; QL (300 mL per 5 days)
DERMATOLOGICALS - DRUGS FOR THE SKIN		
*ACNE ANTIBIOTICS*** - DRUGS FOR THE SKIN		
<i>clindacin etz external swab</i>	1 or 1b*	QL (2 pads per 1 day)
<i>clindamycin phosphate</i> (Clindacin External Foam)	1 or 1b*	QL (100 grams per 30 days)
<i>clindacin-p external swab</i>	1 or 1b*	QL (2 pads per 1 day)
<i>clindamycin phosphate external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>clindamycin phosphate external gel</i>	1 or 1b*	QL (75 ml/gm per 30 days)
<i>clindamycin phosphate external lotion</i>	1 or 1b*	QL (4 mL per 1 day)
<i>clindamycin phosphate external solution</i>	1 or 1b*	QL (4 mL per 1 day)
<i>clindamycin phosphate external swab</i>	1 or 1b*	QL (2 pads per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dapsone external gel</i>	3	ST; QL (90 grams per 30 days)
<i>ery external pad</i>	1 or 1b*	QL (2 pads per 1 day)
<i>erythromycin external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>erythromycin external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>sulfacetamide sodium (acne) external lotion</i>	1 or 1b*	
*ACNE COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>adapalene-benzoyl peroxide external gel 0.3-2.5 %</i>	1 or 1b*	PA; QL (60 grams per 30 days)
<i>benzoyl peroxide-erythromycin external gel</i>	1 or 1b*	QL (46.6 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1.2-3.75 %</i>	2	QL (50 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1 or 1b*	QL (45 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %</i>	1 or 1b*	QL (50 grams per 30 days)
<i>clindamycin-tretinoin external gel</i>	3	PA; QL (60 grams per 30 days)
<i>neuac external gel</i>	1 or 1b*	QL (45 grams per 30 days)
*ACNE PRODUCTS*** - DRUGS FOR THE SKIN		
<i>accutane oral capsule</i>	2	PA
<i>adapalene external cream</i>	1 or 1b*	PA; QL (1.5 grams per 1 day)
<i>adapalene external gel</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>adapalene external pad</i>	1 or 1b*	PA; QL (1 swab per 1 day)
<i>amnestem oral capsule</i>	2	PA
<i>claravis oral capsule</i>	2	PA
<i>isotretinoin oral capsule</i>	2	PA
<i>tretinoin external cream</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>tretinoin external gel</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>tretinoin microsphere external gel 0.04 %, 0.1 %</i>	1 or 1b*	PA; QL (50 grams per 30 days)
<i>tretinoin microsphere pump external gel 0.04 %, 0.1 %</i>	1 or 1b*	PA; QL (50 grams per 30 days)
<i>zenatane oral capsule</i>	2	PA
*ANTIBIOTICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>gentamicin sulfate external cream</i>	1 or 1b*	QL (30 grams per 1 fill)
<i>gentamicin sulfate external ointment</i>	1 or 1b*	QL (30 grams per 1 fill)
<i>mupirocin external ointment</i>	1 or 1b*	QL (30 grams per 1 fill)
*ANTIFUNGALS - TOPICAL COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>clotrimazole-betamethasone external cream</i>	1 or 1b*	QL (180 grams per 30 days)
<i>clotrimazole-betamethasone external lotion</i>	1 or 1b*	QL (120 mL per 30 days)
<i>nystatin-triamcinolone external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin-triamcinolone external ointment</i>	1 or 1b*	QL (120 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>ciclodan external solution</i>	1 or 1b*	QL (7 mL per 30 days)
<i>ciclopirox external gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>ciclopirox external shampoo</i>	1 or 1b*	QL (120 mL per 30 days)
<i>ciclopirox external solution</i>	1 or 1b*	QL (7 mL per 30 days)
<i>ciclopirox olamine external cream</i>	1 or 1b*	QL (90 grams per 30 days)
<i>ciclopirox olamine external suspension</i>	1 or 1b*	QL (60 mL per 30 days)
<i>nystatin (Klayesta External Powder)</i>	1 or 1b*	QL (60 grams per 30 days)
<i>naftifine hcl external cream 1 %</i>	2	ST; QL (90 grams per 30 days)
<i>naftifine hcl external cream 2 %</i>	2	ST; QL (60 grams per 30 days)
<i>naftifine hcl external gel</i>	2	ST; QL (60 grams per 30 days)
<i>nyamyc external powder</i>	1 or 1b*	QL (60 grams per 30 days)
<i>nystatin external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin external powder</i>	1 or 1b*	QL (60 grams per 30 days)
<i>nystop external powder</i>	1 or 1b*	QL (60 grams per 30 days)
*ANTI-INFLAMMATORY AGENTS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>diclofenac sodium external gel 1 %</i>	2	BE; QL (1000 gm per 30 days)
*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL*** - DRUGS FOR THE SKIN		
<i>fluorouracil external cream</i>	1 or 1b*	AL; QL (40 gm per 365 days)
<i>fluorouracil external solution</i>	1 or 1b*	AL; QL (10 mL per 365 days)
*ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S*** - DRUGS FOR THE SKIN		
<i>diclofenac sodium external gel 3 %</i>	2	PA; QL (300 grams per 1 year)
*ANTIPRURITICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>doxepin hcl external cream</i>	2	PA; QL (1 tube per 1 fill)
*ANTIPSORIATICS - SYSTEMIC*** - DRUGS FOR THE SKIN		
<i>acitretin oral capsule 10 mg, 17.5 mg</i>	2	QL (1 capsule per 1 day)
<i>acitretin oral capsule 25 mg</i>	2	QL (2 capsules per 1 day)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>secukinumab</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	4	PA; LD; QL (2 pens per 28 days); SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	4	PA; LD; QL (1 pen per 28 days); SP
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>secukinumab</i>)	4	PA; LD; QL (1 syringe per 28 days); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	4	PA; LD; QL (1 pen per 28 days); SP
<i>methoxsalen rapid oral capsule</i>	4	LD; SP
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>risankizumab-rzaa</i>)	4	PA; LD; QL (1 unit per 12 weeks); SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>risankizumab-rzaa</i>)	4	PA; LD; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION (<i>ustekinumab</i>)	4	PA; LD; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (<i>ustekinumab</i>)	4	PA; LD; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (<i>ustekinumab</i>)	4	PA; LD; QL (1 syringe per 12 weeks); SP
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>ixekizumab</i>)	5	PA; LD; QL (1 auto-injector per 28 days); SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>ixekizumab</i>)	5	PA; LD; QL (1 syringe per 28 days); SP
TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	4	PA; LD; QL (1 mL per 56 days); SP
TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	4	PA; LD; QL (1 pen/syringe per 28 Straight PA no ST embedded); SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	4	PA; LD; QL (1 mL per 56 days); SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (<i>guselkumab</i>)	4	PA; LD; QL (1 pen/syringe per 28 Straight PA no ST embedded); SP
*ANTIPSORIATICS*** - DRUGS FOR THE SKIN		
<i>calcipotriene external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external foam</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>calcitrene external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcitriol external ointment</i>	1 or 1b*	QL (800 grams per 28 days)
<i>tazarotene external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>tazarotene external gel</i>	2	QL (100 grams per 30 days)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	3	PA; QL (60 grams per 30 days)
*ANTISEBORRHEIC PRODUCTS*** - DRUGS FOR THE SKIN		
<i>selenium sulfide external lotion</i>	1 or 1a*	QL (120 mL per 30 days)
*ANTIVIRALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>acyclovir external cream</i>	1 or 1b*	PA; QL (5 gm per 30 days)
<i>acyclovir external ointment</i>	1 or 1b*	QL (30 gm per 30 days)
<i>penciclovir external cream</i>	2	PA; QL (5 gm per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ATOPIC DERMATITIS - JANUS KINASE (JAK) INHIBITORS*** - DRUGS FOR THE SKIN		
OPZELURA EXTERNAL CREAM (<i>ruxolitinib phosphate</i>)	3	PA; QL (1 tube per 30 days)
*ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE SKIN		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>dupilumab</i>)	4	PA; LD; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>dupilumab</i>)	4	PA; LD; SP
*BURN PRODUCTS*** - DRUGS FOR THE SKIN		
<i>mafenide acetate external packet</i>	2	
<i>silver sulfadiazine external cream</i>	1 or 1a*	
<i>ssd external cream</i>	1 or 1a*	
*CORTICOSTEROIDS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>ala-cort external cream</i>	1 or 1a*	QL (454 grams per 30 days)
<i>alclometasone dipropionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>alclometasone dipropionate external ointment</i>	1 or 1b*	QL (2 grams per 1 day)
<i>betamethasone dipropionate aug external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate aug external gel</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate aug external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone dipropionate aug external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone dipropionate external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone dipropionate external ointment</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone valerate external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone valerate external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone valerate external ointment</i>	1 or 1b*	QL (45 grams per 30 days)
<i>clobetasol propionate e external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate emulsion external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>clobetasol propionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external foam</i>	1 or 1b*	QL (100 mL per 30 days)
<i>clobetasol propionate external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external liquid</i>	1 or 1b*	QL (125 mL per 30 days)
<i>clobetasol propionate external lotion</i>	1 or 1b*	QL (118 mL per 30 days)
<i>clobetasol propionate external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external shampoo</i>	1 or 1b*	QL (3.94 mL per 1 day)
<i>clobetasol propionate external solution</i>	1 or 1b*	QL (50 mL per 30 days)
<i>clodan external shampoo</i>	1 or 1b*	QL (3.94 mL per 1 day)
<i>desonide external cream</i>	1 or 1b*	QL (60 grams per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desonide external gel</i>	1 or 1b*	QL (2 grams per 1 day)
<i>desonide external lotion</i>	1 or 1b*	QL (118 mL per 30 days)
<i>desonide external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinolone acetonide body external oil</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluocinolone acetonide external cream 0.01 %</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinolone acetonide external cream 0.025 %</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinolone acetonide external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinolone acetonide external solution</i>	1 or 1b*	QL (90 mL per 30 days)
<i>fluocinolone acetonide scalp external oil</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluocinonide emulsified base external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinonide external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>fluticasone propionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluticasone propionate external lotion</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluticasone propionate external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>halobetasol propionate external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>halobetasol propionate external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>hydrocortisone external cream 2.5 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>hydrocortisone external lotion 2.5 %</i>	1 or 1a*	QL (118 mL per 30 days)
<i>hydrocortisone external ointment 2.5 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>mometasone furoate external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>mometasone furoate external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>mometasone furoate external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>tovet external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>triamcinolone acetonide external cream</i>	1 or 1a*	QL (454 grams per 30 days)
<i>triamcinolone acetonide external lotion</i>	1 or 1a*	QL (60 mL per 30 days)
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>triamcinolone acetonide external ointment 0.5 %</i>	1 or 1a*	QL (30 grams per 30 days)
<i>triderm external cream</i>	1 or 1a*	QL (454 grams per 30 days)
*IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>econazole nitrate external cream</i>	1 or 1b*	QL (85 grams per 30 days)
<i>ketoconazole external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>ketoconazole external foam</i>	3	QL (100 grams per 30 days)
<i>ketoconazole external shampoo</i>	1 or 1b*	QL (120 mL per 30 days)
<i>ketodan external foam</i>	3	QL (100 grams per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>luliconazole external cream</i>	1 or 1b*	ST; QL (60 grams per 30 days)
<i>oxiconazole nitrate external cream</i>	3	ST; QL (90 grams per 30 days)
<i>sulconazole nitrate external cream</i>	1 or 1b*	ST; QL (60 grams per 30 days)
<i>sulconazole nitrate external solution</i>	1 or 1b*	ST; QL (60 mL per 30 days)
*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL*** - DRUGS FOR THE SKIN		
<i>imiquimod external cream 3.75 %</i>	1 or 1b*	QL (28 units per 28 days)
<i>imiquimod external cream 5 %</i>	1 or 1b*	QL (48 packet per 365 days)
<i>imiquimod pump external cream</i>	1 or 1b*	ST; QL (1 pump bottle per 28 days)
*KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS*** - DRUGS FOR THE SKIN		
<i>podofilox external gel</i>	2	QL (7 grams per 28 days)
<i>podofilox external solution</i>	1 or 1b*	QL (7 mL per 28 days)
*LOCAL ANESTHETICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>glydo external prefilled syringe</i>	2	
<i>lidocaine external ointment 5 %</i>	2	QL (5 grams per 1 day)
<i>lidocaine external patch 5 %</i>	2	PA; QL (3 patches per 1 day)
<i>lidocaine hcl external solution</i>	2	QL (10 mL per 1 day)
<i>lidocaine hcl urethral/mucosal external prefilled syringe</i>	2	
<i>lidocaine (Tridacaine Ii External Patch)</i>	2	PA; QL (3 patches per 1 day)
<i>lidocaine (Tridacaine Iii External Patch)</i>	2	PA; QL (3 patches per 1 day)
*MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>pimecrolimus external cream</i>	1 or 1b*	ST; QL (100 grams per 30 days)
<i>tacrolimus external ointment</i>	1 or 1b*	ST; QL (100 grams per 30 days)
*OXABOROLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>tavaborole external solution</i>	2	ST; QL (1 bottle per 30 days)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL*** - DRUGS FOR THE SKIN		
EUCRISA EXTERNAL OINTMENT (<i>crisaborole</i>)	3	ST; QL (100 grams per 30 days)
*ROSACEA AGENTS*** - DRUGS FOR THE SKIN		
<i>azelaic acid external gel</i>	1 or 1b*	QL (50 grams per 30 days)
<i>brimonidine tartrate external gel</i>	2	QL (30 grams per 30 days)
<i>ivermectin external cream</i>	2	QL (45 grams per 30 days)
<i>metronidazole external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>metronidazole external gel 0.75 %</i>	1 or 1b*	QL (45 grams per 30 days)
<i>metronidazole external gel 1 %</i>	1 or 1b*	QL (60 grams per 30 days)
<i>metronidazole external lotion</i>	1 or 1b*	QL (59 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZILXI EXTERNAL FOAM (<i>minocycline hcl micronized</i>)	2	QL (1 gram per 1 day)
*SCABICIDES & PEDICULICIDES*** - DRUGS FOR THE SKIN		
<i>crotan external lotion</i>	2	QL (60 grams per 30 days)
<i>malathion external lotion</i>	1 or 1b*	QL (4 mL per 1 day)
<i>permethrin external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>spinosad external suspension</i>	1 or 1b*	QL (120 mL per 7 days)
*STEROID-LOCAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN		
PRAMOSONE EXTERNAL CREAM (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL LOTION (<i>pramoxine-hc</i>)	2	
*TAR PRODUCTS*** - DRUGS FOR THE SKIN		
<i>coal tar external solution</i>	1 or 1b*	
*TOPICAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>lidocaine-prilocaine external cream</i>	2	QL (30 grams per 30 days)
<i>lidocaine-prilocaine external kit</i>	2	QL (1 kit per 30 days)
*TOPICAL SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR THE SKIN		
<i>bexarotene external gel</i>	4	PA; LD; QL (60 grams per 30 days); SP
*TOPICAL STEROID COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>calcipotriene-betameth diprop external ointment</i>	3	ST; QL (400 grams per 28 days)
<i>calcipotriene-betameth diprop external suspension</i>	3	ST; QL (420 grams per 28 days)
*TYPE II 5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE SKIN		
<i>finasteride oral tablet 1 mg</i>	1 or 1b*	
DIAGNOSTIC PRODUCTS		
*DIAGNOSTIC TESTS***		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ACCU-CHEK GUIDE TEST IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ACCU-CHEK SMARTVIEW IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ACCUTREND GLUCOSE IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA BLUE TEST IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA TEST IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)
ONETOUCH VERIO IN VITRO STRIP (<i>glucose blood</i>)	2	QL (204 strips per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIGESTIVE AIDS - DRUGS FOR THE STOMACH		
*DIGESTIVE ENZYMES*** - DRUGS FOR THE STOMACH		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES (pancrelipase (lip-prot-amyl))	2	QL (25 capsules per 1 day)
VIOKACE ORAL TABLET (pancrelipase (lip-prot-amyl))	3	QL (25 tablets per 1 day)
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES (pancrelipase (lip-prot-amyl))	2	QL (25 capsules per 1 day)
DIURETICS - DRUGS FOR THE HEART		
*CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
acetazolamide er oral capsule extended release 12 hour	1 or 1b*	
acetazolamide oral tablet	1 or 1b*	
acetazolamide sodium injection solution reconstituted	1 or 1b*	
dichlorphenamide oral tablet	4	PA; LD; QL (4 tablet per 1 day)
methazolamide oral tablet	2	
dichlorphenamide (Ormalvi Oral Tablet)	4	PA; LD; QL (4 tablet per 1 day)
*DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
amiloride-hydrochlorothiazide oral tablet	1 or 1b*	
spironolactone-hctz oral tablet	1 or 1b*	
triamterene-hctz oral capsule	1 or 1a*	
triamterene-hctz oral tablet	1 or 1a*	
*LOOP DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
bumetanide injection solution	1 or 1b*	
bumetanide oral tablet	1 or 1b*	
ethacrynic acid oral tablet	2	
furosemide injection solution	1 or 1a*	
furosemide oral solution	1 or 1a*	
furosemide oral tablet	1 or 1a*	
toremide oral tablet	1 or 1b*	
*OSMOTIC DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
mannitol intravenous solution	1 or 1b*	
osmitrol intravenous solution	1 or 1b*	
*POTASSIUM SPARING DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
amiloride hcl oral tablet	2	
spironolactone oral suspension	1 or 1b*	
spironolactone oral tablet	1 or 1a*	
triamterene oral capsule	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*THIAZIDES AND THIAZIDE-LIKE DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>chlorothiazide sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>chlorthalidone oral tablet</i>	1 or 1a*	
<i>hydrochlorothiazide oral capsule</i>	1 or 1a*	
<i>hydrochlorothiazide oral tablet</i>	1 or 1a*	
<i>indapamide oral tablet</i>	1 or 1b*	
<i>metolazone oral tablet</i>	1 or 1b*	
ENDOCRINE AND METABOLIC AGENTS - MISC. - HORMONES		
*ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR WOMEN		
<i>mifepristone oral tablet 200 mg</i>	1 or 1b*	\$0 for Fully insured members in California
*BISPHOSPHONATES*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>alendronate sodium oral solution</i>	1 or 1b*	QL (10.72 mg per 1 day)
<i>alendronate sodium oral tablet 10 mg, 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>alendronate sodium oral tablet 35 mg, 70 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
FOSAMAX PLUS D ORAL TABLET (<i>alendronate-cholecalciferol</i>)	2	QL (0.15 tablets per 1 day)
<i>ibandronate sodium oral tablet</i>	1 or 1b*	QL (1 tablet per 28 days)
<i>risedronate sodium oral tablet 150 mg</i>	1 or 1b*	QL (0.04 tablets per 1 day)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>risedronate sodium oral tablet 35 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
<i>risedronate sodium oral tablet delayed release</i>	1 or 1b*	QL (4 tablets per 28 days)
*CALCIMIMETIC AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	4	PA; LD; QL (2 tablets per 1 day)
<i>cinacalcet hcl oral tablet 90 mg</i>	4	PA; LD; QL (4 tablets per 1 day)
*CALCITONINS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>calcitonin (salmon) injection solution</i>	4	LD
<i>calcitonin (salmon) nasal solution</i>	2	QL (0.13 mL per 1 day)
*CARNITINE REPLENISHER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>levocarnitine intravenous solution</i>	2	
<i>levocarnitine oral solution</i>	2	
<i>levocarnitine oral tablet</i>	2	
<i>levocarnitine sf oral solution</i>	2	
*DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR WOMEN		
<i>cabergoline oral tablet</i>	1 or 1b*	QL (0.58 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*GNRH/LHRH ANTAGONISTS*** - DRUGS FOR WOMEN		
ORLISSA ORAL TABLET 150 MG (<i>elagolix sodium</i>)	2	PA; QL (1 tablet per 1 day)
ORLISSA ORAL TABLET 200 MG (<i>elagolix sodium</i>)	2	PA; QL (2 tablets per 1 day)
*GROWTH HORMONE RECEPTOR ANTAGONISTS*** - DRUGS FOR GROWTH		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>pegvisomant</i>)	5	PA; LD; QL (1 vial per 1 day); SP
*GROWTH HORMONES*** - DRUGS FOR GROWTH		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (<i>somatropin</i>)	4	PA; LD; QL (1 syringe per 1 day); SP
GENOTROPIN SUBCUTANEOUS CARTRIDGE (<i>somatropin</i>)	4	PA; LD; QL (1 vial per 1 day); SP
HUMATROPE INJECTION CARTRIDGE 12 MG, 6 MG (<i>somatropin</i>)	4	PA; LD; QL (1 vial per 1 day); SP
HUMATROPE INJECTION CARTRIDGE 24 MG (<i>somatropin</i>)	4	PA; LD; QL (1 injection per 1 day); SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 7.6 MG, 9.1 MG (<i>lonapegsomatropin-tcgd</i>)	4	PA; LD; QL (8 cartridges per 28 days); SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG (<i>lonapegsomatropin-tcgd</i>)	4	PA; LD; QL (4 cartridges per 28 days); SP
*HEREDITARY TYROSINEMIA TYPE 1 (HT-1) TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>nitisinone oral capsule 10 mg, 2 mg, 5 mg</i>	4	PA; LD; SP
<i>nitisinone oral capsule 20 mg</i>	4	PA; LD
*HOMOCYSTINURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>betaine oral powder</i>	4	LD
*HYPERAMMONEMIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>carglumic acid oral tablet soluble</i>	4	PA; LD
*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>calcitriol intravenous solution</i>	1 or 1b*	PA
<i>calcitriol oral capsule</i>	1 or 1b*	PA
<i>calcitriol oral solution</i>	2	PA
<i>doxercalciferol intravenous solution</i>	2	PA
<i>doxercalciferol oral capsule</i>	2	PA
<i>paricalcitol oral capsule</i>	2	PA
*HYPOPHOSPHATASIA (HPP) AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
STRENSIQ SUBCUTANEOUS SOLUTION (<i>asfotase alfa</i>)	5	PA; LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS*** - DRUGS FOR WOMEN		
SYNAREL NASAL SOLUTION (<i>nafarelin acetate</i>)	5	PA; LD; QL (5 bottle per 30 days); SP
*OVULATION STIMULANTS-GONADOTROPINS*** - DRUGS FOR WOMEN		
GONAL-F INJECTION SOLUTION RECONSTITUTED (<i>follitropin alfa</i>)	4	PA; LD; SP
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>follitropin alfa</i>)	4	PA; LD; SP
GONAL-F RFF SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>follitropin alfa</i>)	4	PA; LD; SP
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chorionic gonadotropin</i>)	5	PA; LD; SP
*OVULATION STIMULANTS-SYNTHETIC*** - DRUGS FOR WOMEN		
clomiphene citrate (Clomid Oral Tablet)	1 or 1b*	PA
clomiphene citrate oral tablet	1 or 1b*	PA
*PARATHYROID HORMONE AND DERIVATIVES*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml	4	LD; QL (1 pen per 28 days); SP
TERIPARATIDE SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML	4	LD; QL (1 pen per 28 days); SP
*PHENYLKETONURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
sapropterin dihydrochloride (Javygtor Oral Packet)	4	PA; LD
sapropterin dihydrochloride (Javygtor Oral Tablet)	4	PA; LD
sapropterin dihydrochloride oral packet	4	PA; LD; SP
sapropterin dihydrochloride oral tablet	4	PA; LD; SP
*RANK LIGAND (RANKL) INHIBITORS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>denosumab</i>)	4	PA; LD; QL (1 syringe per 180 days); SP
*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
raloxifene hcl oral tablet	1 or 1b*; \$0	QL (1 tablet per 1 day)
*SELECTIVE VASOPRESSIN V2-RECEPTOR ANTAGONISTS*** - HORMONES		
tolvaptan oral tablet 15 mg	4	PA; LD; QL (1 tablet per 1 day); SP
tolvaptan oral tablet 30 mg	4	PA; LD; QL (2 tablets per 1 day); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SOMATOSTATIC AGENTS*** - DRUGS FOR GROWTH		
LANREOTIDE ACETATE SUBCUTANEOUS SOLUTION	5	PA; LD; QL (1 syringe/vial per 28 days); SP
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION (<i>lanreotide acetate</i>)	5	PA; LD; QL (1 syringe/vial per 28 days); SP
*UREA CYCLE DISORDER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
PHEBURANE ORAL PELLETT (<i>sodium phenylbutyrate</i>)	5	PA; LD; QL (8 bottles per 30 days); SP
<i>sodium phenylbutyrate oral powder</i>	4	PA; LD; QL (25 GM per 1 day); SP
<i>sodium phenylbutyrate oral tablet</i>	4	PA; LD; QL (40 tablets per 1 day); SP
*VASOPRESSIN*** - HORMONES		
<i>desmopressin ace spray refrig nasal solution</i>	1 or 1b*	
<i>desmopressin acetate injection solution</i>	1 or 1b*	LD
<i>desmopressin acetate oral tablet 0.1 mg</i>	1 or 1b*	LD; DO
<i>desmopressin acetate oral tablet 0.2 mg</i>	1 or 1b*	LD; QL (6 tablets per 1 day)
<i>desmopressin acetate pf injection solution</i>	1 or 1b*	LD
<i>desmopressin acetate spray nasal solution</i>	1 or 1b*	
<i>vasopressin + rfid intravenous solution</i>	2	
<i>vasopressin intravenous solution</i>	2	
ESTROGENS - HORMONES		
*ESTROGEN & PROGESTIN*** - DRUGS FOR WOMEN		
BIJUVA ORAL CAPSULE (<i>estradiol-progesterone</i>)	2	QL (1 capsule per 1 day)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY (<i>estradiol-levonorgestrel</i>)	2	QL (4 patch per 28 days)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY (<i>estradiol-norethindrone acet</i>)	2	QL (8 patch per 28 days)
<i>estradiol-norethindrone acet oral tablet</i>	1 or 1b*	
<i>fyavolv oral tablet</i>	1 or 1b*	
<i>jinteli oral tablet</i>	1 or 1b*	
<i>mimvey oral tablet</i>	1 or 1b*	
<i>norethindrone-eth estradiol oral tablet</i>	1 or 1b*	
PREMPHASE ORAL TABLET (<i>conj estrog-medroxyprogest ace</i>)	2	
PREMPRO ORAL TABLET (<i>conj estrog-medroxyprogest ace</i>)	2	
*ESTROGENS*** - DRUGS FOR WOMEN		
<i>dotti transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
<i>estradiol oral tablet</i>	1 or 1b*	
<i>estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm</i>	2	QL (1 packet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)	2	QL (50 grams per 30 days)
estradiol transdermal gel 1.25 mg/1.25gm	2	QL (30 packets per 30 days)
estradiol transdermal patch twice weekly	1 or 1b*	QL (8 patch per 28 days)
estradiol transdermal patch weekly	1 or 1b*	QL (4 patches per 28 days)
estradiol valerate intramuscular oil	1 or 1b*	
EVAMIST TRANSDERMAL SOLUTION (estradiol)	2	QL (16.2 mL per 30 days)
lyllana transdermal patch twice weekly	1 or 1b*	QL (8 patch per 28 days)
MENEST ORAL TABLET (esterified estrogens)	2	
PREMARIN INJECTION SOLUTION RECONSTITUTED (estrogens conjugated)	2	
PREMARIN ORAL TABLET (estrogens conjugated)	2	QL (1 tablet per 1 day)
FLUOROQUINOLONES - DRUGS FOR INFECTIONS		
*FLUOROQUINOLONES*** - ANTIBIOTICS		
ciprofloxacin hcl oral tablet	1 or 1b*	
ciprofloxacin in d5w intravenous solution	2	
levofloxacin in d5w intravenous solution	2	
levofloxacin intravenous solution	2	QL (1 fill per 30 days)
levofloxacin oral solution	2	
levofloxacin oral tablet	1 or 1b*	
moxifloxacin hcl oral tablet	2	
ofloxacin oral tablet	1 or 1b*	
GASTROINTESTINAL AGENTS - MISC. - DRUGS FOR THE STOMACH		
*GALLSTONE SOLUBILIZING AGENTS*** - DRUGS FOR THE STOMACH		
ursodiol oral capsule 300 mg	2	
ursodiol oral tablet	2	
*GASTROINTESTINAL ANTIALLERGY AGENTS*** - DRUGS FOR THE STOMACH		
cromolyn sodium oral concentrate	1 or 1b*	
*GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME		
lubiprostone oral capsule	2	QL (2 capsules per 1 day)
*GASTROINTESTINAL STIMULANTS*** - DRUGS FOR THE STOMACH		
metoclopramide hcl injection solution	1 or 1a*	
metoclopramide hcl oral solution	1 or 1a*	QL (60 mL per 1 day)
metoclopramide hcl oral tablet 10 mg	1 or 1a*	QL (6 tablets per 1 day)
metoclopramide hcl oral tablet 5 mg	1 or 1a*	QL (12 tablets per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metoclopramide hcl oral tablet dispersible</i>	1 or 1a*	ST; QL (12 tablets per 1 day)
*IBS AGENT - GUANYLATE CYCLASE-C (GC-C) AGONISTS*** - DRUGS FOR CONSTIPATION		
LINZESS ORAL CAPSULE (<i>linaclotide</i>)	2	QL (1 capsule per 1 day)
*IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME		
<i>alosetron hcl oral tablet</i>	2	PA; QL (2 tablets per 1 day)
*INFLAMMATORY BOWEL AGENTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
<i>balsalazide disodium oral capsule</i>	1 or 1b*	QL (9 capsule per 1 day)
<i>mesalamine er oral capsule extended release</i>	2	QL (8 capsule per 1 day)
<i>mesalamine er oral capsule extended release 24 hour</i>	2	QL (4 capsules per 1 day)
<i>mesalamine oral capsule delayed release</i>	2	QL (6 tablets per 1 day)
<i>mesalamine oral tablet delayed release 1.2 gm</i>	2	QL (4 tablets per 1 day)
<i>mesalamine oral tablet delayed release 800 mg</i>	2	QL (6 tablet per 1 day)
<i>mesalamine rectal enema</i>	2	QL (60 mL per 1 day)
<i>mesalamine rectal suppository</i>	2	QL (1 suppository per 1 day)
<i>mesalamine-cleanser rectal kit</i>	2	QL (1 kit per 30 days)
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG (<i>mesalamine</i>)	2	QL (16 capsule per 1 day)
<i>sulfasalazine oral tablet</i>	1 or 1b*	QL (8 tablet per 1 day)
<i>sulfasalazine oral tablet delayed release</i>	1 or 1b*	QL (8 tablet per 1 day)
*INTEGRIN RECEPTOR ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED (<i>vedolizumab</i>)	4	PA; LD; QL (1 vial per 56 days); SP
*INTERLEUKIN ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
SKYRIZI INTRAVENOUS SOLUTION (<i>risankizumab-rzaa</i>)	4	PA; LD; QL (30 mL per 365 days); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE (<i>risankizumab-rzaa</i>)	4	PA; LD; QL (1 kit per 56 days); SP
STELARA INTRAVENOUS SOLUTION (<i>ustekinumab</i>)	4	PA; LD; QL (4 vial per 365 days); SP
*INTESTINAL ACIDIFIERS*** - DRUGS FOR THE STOMACH		
<i>enulose oral solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>generlac oral solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>lactulose encephalopathy oral solution</i>	1 or 1b*	QL (60 mL per 30 days)
*PERIPHERAL OPIOID RECEPTOR ANTAGONISTS*** - DRUGS FOR THE STOMACH		
<i>alvimopan oral capsule</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PHOSPHATE BINDER AGENTS*** - DRUGS FOR THE STOMACH		
<i>calcium acetate (phos binder) oral capsule</i>	2	QL (12 capsules per 1 day)
<i>calcium acetate oral tablet 667 mg</i>	2	QL (12 tablets per 1 day)
<i>lanthanum carbonate oral tablet chewable</i>	2	QL (3 tablets per 1 day)
<i>sevelamer carbonate oral packet 0.8 gm</i>	2	QL (6 packets per 1 day)
<i>sevelamer carbonate oral packet 2.4 gm</i>	2	QL (3 packets per 1 day)
<i>sevelamer carbonate oral tablet</i>	2	QL (9 tablets per 1 day)
<i>sevelamer hcl oral tablet 400 mg</i>	2	QL (15 tablets per 1 day)
<i>sevelamer hcl oral tablet 800 mg</i>	2	QL (9 tablets per 1 day)
*TUMOR NECROSIS FACTOR ALPHA BLOCKERS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED (<i>infliximab-axxq</i>)	4	PA; LD; SP
INFLIXIMAB INTRAVENOUS SOLUTION RECONSTITUTED	4	PA; LD; SP
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED (<i>infliximab</i>)	4	PA; LD; SP
GENERAL ANESTHETICS - DRUGS FOR PAIN AND FEVER		
*ANESTHETICS - MISC.*** - DRUGS FOR SEDATION		
<i>etomidate intravenous solution</i>	1 or 1b*	
<i>fresenius propoven intravenous emulsion</i>	1 or 1b*	
<i>ketamine hcl injection solution 100 mg/ml, 50 mg/ml</i>	1 or 1b*	
<i>propofol intravenous emulsion</i>	1 or 1b*	
*VOLATILE ANESTHETICS*** - DRUGS FOR SEDATION		
<i>desflurane inhalation solution</i>	1 or 1b*	
<i>isoflurane inhalation solution</i>	1 or 1b*	
<i>sevoflurane inhalation solution</i>	1 or 1b*	
<i>terrell inhalation solution</i>	1 or 1b*	
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS FOR THE URINARY SYSTEM		
*5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE PROSTATE		
<i>dutasteride oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>finasteride oral tablet 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*ALPHA 1-ADRENOCEPTOR ANTAGONISTS*** - DRUGS FOR THE PROSTATE		
<i>alfuzosin hcl er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>silodosin oral capsule</i>	2	QL (1 capsule per 1 day)
<i>tamsulosin hcl oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTI-INFECTIVE GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>neomycin-polymyxin b gu irrigation solution</i>	2	
*CITRATES*** - DRUGS FOR INFECTIONS		
<i>potassium citrate er oral tablet extended release</i>	1 or 1b*	
*GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>acetic acid irrigation solution</i>	1 or 1b*	
<i>curity sterile saline irrigation solution</i>	2	
<i>glycine irrigation solution</i>	1 or 1b*	
<i>glycine urologic irrigation solution</i>	1 or 1b*	
<i>sodium chloride irrigation solution</i>	2	
*PROSTATIC HYPERTROPHY AGENT COMBINATIONS*** - DRUGS FOR THE PROSTATE		
<i>dutasteride-tamsulosin hcl oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
*URINARY STONE AGENTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>tiopronin oral tablet</i>	2	PA; LD; QL (10 tablet per 1 day)
<i>tiopronin oral tablet delayed release</i>	2	PA; LD; QL (10 tablet per 1 day)
GOUT AGENTS - DRUGS FOR PAIN AND FEVER		
*GOUT AGENT COMBINATIONS*** - GOUT DRUGS		
<i>colchicine-probenecid oral tablet</i>	1 or 1b*	
*GOUT AGENTS*** - GOUT DRUGS		
<i>allopurinol oral tablet 100 mg</i>	1 or 1a*	QL (8 tablets per 1 day)
<i>allopurinol oral tablet 300 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>allopurinol sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>colchicine oral tablet</i>	2	QL (2.3 tablet per 1 day)
<i>febuxostat oral tablet</i>	2	ST; QL (1 tablet per 1 day)
*URICOSURICS*** - GOUT DRUGS		
<i>probenecid oral tablet</i>	1 or 1b*	
HEMATOLOGICAL AGENTS - MISC. - DRUGS FOR THE BLOOD		
*BRADYKININ B2 RECEPTOR ANTAGONISTS*** - DRUGS FOR THE BLOOD		
<i>icatibant acetate subcutaneous solution prefilled syringe</i>	4	PA; LD; QL (18 syringes per 30 days); SP
<i>sajazir subcutaneous solution prefilled syringe</i>	4	PA; LD; QL (18 syringes per 30 days)
*C1 ESTERASE INHIBITORS*** - DRUGS FOR THE BLOOD		
BERINERT INTRAVENOUS KIT (<i>c1 esterase inhibitor (human)</i>)	5	PA; LD; QL (24 kits per 30 days); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (<i>c1 esterase inhibitor (human)</i>)	5	PA; LD; QL (24 vials per 28 days); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (<i>c1 esterase inhibitor (human)</i>)	5	PA; LD; QL (16 vials per 28 days); SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED (<i>c1 esterase inhibitor (recomb)</i>)	5	PA; LD; QL (16 vials per 30 days); SP
*DIRECT-ACTING P2Y12 INHIBITORS*** - DRUGS FOR THE BLOOD		
BRILINTA ORAL TABLET (<i>ticagrelor</i>)	2	QL (2 tablets per 1 day)
*GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>eptifibatide intravenous solution</i>	2	
<i>tirofiban hcl in nacl intravenous solution</i>	2	
*HEMATORHEOLOGIC AGENTS*** - DRUGS FOR THE BLOOD		
<i>pentoxifylline er oral tablet extended release</i>	1 or 1b*	
*PHOSPHODIESTERASE III INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>cilostazol oral tablet</i>	2	
*PLASMA EXPANDERS*** - DRUGS FOR THE BLOOD		
<i>hetastarch-nacl intravenous solution</i>	1 or 1b*	
<i>lmd in d5w intravenous solution</i>	1 or 1b*	
<i>lmd in nacl intravenous solution</i>	1 or 1b*	
*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE BLOOD		
TAKHZYRO SUBCUTANEOUS SOLUTION (<i>lanadelumab-flyo</i>)	5	PA; LD; QL (1 vial per 28 days); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>lanadelumab-flyo</i>)	5	PA; LD; QL (1 syringe per 28 days); SP
*PLASMA KALLIKREIN INHIBITORS*** - DRUGS FOR THE BLOOD		
KALBITOR SUBCUTANEOUS SOLUTION (<i>ecallantide</i>)	5	PA; LD; QL (36 vials per 30 days); SP
*PLATELET AGGREGATION INHIBITOR COMBINATIONS*** - DRUGS FOR THE BLOOD		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour</i>	1 or 1b*	QL (2 capsules per 1 day)
*PLATELET AGGREGATION INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>dipyridamole oral tablet</i>	2	
*PROTAMINE*** - DRUGS FOR THE BLOOD		
<i>protamine sulfate intravenous solution</i>	1 or 1b*	
*QUINAZOLINE AGENTS*** - DRUGS FOR THE BLOOD		
<i>anagrelide hcl oral capsule 0.5 mg</i>	1 or 1b*	QL (20 capsules per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>anagrelide hcl oral capsule 1 mg</i>	1 or 1b*	QL (10 capsules per 1 day)
*THIENOPYRIDINE DERIVATIVES*** - DRUGS FOR THE BLOOD		
<i>clopidogrel bisulfate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>prasugrel hcl oral tablet</i>	2	QL (1 tablet per 1 day)
HEMATOPOIETIC AGENTS - DRUGS FOR NUTRITION		
*AGENTS FOR GAUCHER DISEASE*** - DRUGS FOR NUTRITION		
CERDELGA ORAL CAPSULE (<i>eliglustat tartrate</i>)	2	PA; LD; QL (2 capsules per 1 day); SP
<i>miglustat oral capsule</i>	2	PA; LD; QL (3 capsules per 1 day); SP
<i>miglustat</i> (Yargesa Oral Capsule)	2	PA; LD; QL (3 capsules per 1 day); SP
*AMINO ACIDS*** - DRUGS FOR NUTRITION		
<i>l-glutamine oral packet</i>	4	PA; LD; SP
*COBALAMINS*** - DRUGS FOR NUTRITION		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1 or 1a*	
<i>dodex injection solution</i>	1 or 1a*	
<i>hydroxocobalamin acetate intramuscular solution</i>	1 or 1b*	
*CYTOTOXIC AGENTS*** - DRUGS FOR NUTRITION		
DROXIA ORAL CAPSULE (<i>hydroxyurea</i>)	2	
*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)*** - DRUGS FOR NUTRITION		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION (<i>darbepoetin alfa</i>)	4	PA; LD; QL (4 vials per 28 days); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	4	PA; LD; QL (4 syringes per 28 days); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	4	PA; LD; QL (4 syringes per 30 days); SP
PROCRIT INJECTION SOLUTION (<i>epoetin alfa</i>)	4	PA; LD; QL (12 mL per 28 days); SP
RETACRIT INJECTION SOLUTION (<i>epoetin alfa-epbx</i>)	4	PA; LD; QL (12 mL per 28 days); SP
*FOLIC ACID/FOLATE COMBINATIONS*** - DRUGS FOR NUTRITION		
<i>foltabs 800 oral tablet</i>	1 or 1b*; \$0	
*FOLIC ACID/FOLATES*** - DRUGS FOR NUTRITION		
<i>cvs folic acid oral tablet</i>	1 or 1a*; \$0	
<i>fa-8 oral capsule</i>	1 or 1b*; \$0	
<i>folate oral tablet</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>folic acid injection solution</i>	1 or 1a*	
<i>folic acid oral capsule 0.8 mg</i>	1 or 1b*; \$0	
<i>folic acid oral tablet 1 mg</i>	1 or 1a*	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	1 or 1a*; \$0	
<i>ft folic acid oral tablet</i>	1 or 1a*; \$0	
<i>gnp folic acid oral tablet</i>	1 or 1a*; \$0	
<i>kp folic acid oral tablet 800 mcg</i>	1 or 1a*; \$0	
<i>qc folic acid oral tablet</i>	1 or 1a*; \$0	
<i>ra folic acid oral tablet</i>	1 or 1a*; \$0	
<i>sm folic acid oral tablet</i>	1 or 1a*; \$0	
<i>true folic acid oral tablet 400 mcg</i>	1 or 1a*; \$0	
<i>yl folic acid oral tablet</i>	1 or 1a*; \$0	
*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)*** - DRUGS FOR NUTRITION		
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT (<i>pegfilgrastim</i>)	4	PA; LD; QL (2 injectors/kits per 28 days); SP
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim-cbqv</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>pegfilgrastim-cbqv</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim-cbqv</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE (<i>filgrastim-sndz</i>)	4	PA; LD; SP
*IRON*** - DRUGS FOR NUTRITION		
FERAHEME INTRAVENOUS SOLUTION (<i>ferumoxytol</i>)	5	PA; LD; QL (2 vials per 6 days); SP
FERRLECIT INTRAVENOUS SOLUTION (<i>na ferric gluc cplx in sucrose</i>)	5	PA; LD; QL (16 vials per 8 weekss); SP
<i>ferumoxytol intravenous solution</i>	4	PA; LD; QL (2 vials per 6 days); SP
INFED INJECTION SOLUTION (<i>iron dextran</i>)	5	PA; LD; SP
<i>na ferric gluc cplx in sucrose intravenous solution</i>	4	PA; LD; QL (16 vials per 8 weekss); SP
VENOFER INTRAVENOUS SOLUTION (<i>iron sucrose</i>)	5	PA; LD; QL (15 mL per 84 days); SP
*THROMBOPOIETIN (TPO) RECEPTOR AGONISTS*** - DRUGS FOR NUTRITION		
PROMACTA ORAL TABLET 12.5 MG, 25 MG (<i>eltrombopag olamine</i>)	5	PA; LD; DO; SP
PROMACTA ORAL TABLET 50 MG (<i>eltrombopag olamine</i>)	5	PA; LD; QL (3 tablets per 1 day); SP

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROMACTA ORAL TABLET 75 MG (<i>eltrombopag olamine</i>)	5	PA; LD; QL (1 tablet per 1 day); SP
HEMOSTATICS - DRUGS FOR THE BLOOD		
*HEMOSTATICS - SYSTEMIC*** - DRUGS TO PREVENT BLEEDING		
<i>aminocaproic acid intravenous solution</i>	1 or 1b*	
<i>aminocaproic acid oral solution</i>	2	QL (120 mL per 1 day)
<i>aminocaproic acid oral tablet 1000 mg</i>	2	
<i>aminocaproic acid oral tablet 500 mg</i>	2	QL (60 tablets per 1 day)
<i>tranexamic acid intravenous solution</i>	2	
<i>tranexamic acid oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*BARBITURATE HYPNOTICS*** - DRUGS FOR INSOMNIA		
<i>pentobarbital sodium injection solution</i>	1 or 1b*	
<i>phenobarbital oral elixir</i>	1 or 1b*	QL (100 mL per 1 day)
<i>phenobarbital oral tablet 100 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>phenobarbital oral tablet 15 mg, 16.2 mg, 30 mg, 32.4 mg</i>	1 or 1b*	DO
<i>phenobarbital sodium injection solution</i>	1 or 1b*	
*BENZODIAZEPINE HYPNOTICS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>estazolam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>flurazepam hcl oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>midazolam hcl (pf) injection solution</i>	1 or 1b*	
<i>midazolam hcl injection solution</i>	1 or 1b*	
<i>midazolam hcl oral syrup</i>	1 or 1b*	QL (10 mL per 1 fill)
<i>quazepam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>temazepam oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>triazolam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
*HYPNOTICS - TRICYCLIC AGENTS*** - DRUGS FOR INSOMNIA		
<i>doxepin hcl oral tablet</i>	2	ST; QL (1 tablet per 1 day)
*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS*** - DRUGS FOR INSOMNIA		
<i>eszopiclone oral tablet 1 mg, 2 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>eszopiclone oral tablet 3 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
<i>zaleplon oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>zolpidem tartrate er oral tablet extended release</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zolpidem tartrate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zolpidem tartrate sublingual tablet sublingual</i>	2	ST; QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES*** - DRUGS FOR INSOMNIA		
<i>dexmedetomidine hcl in nacl intravenous solution</i>	1 or 1b*	
<i>dexmedetomidine hcl intravenous solution 200 mcg/2ml</i>	1 or 1b*	
*SELECTIVE MELATONIN RECEPTOR AGONISTS*** - DRUGS FOR INSOMNIA		
<i>ramelteon oral tablet</i>	2	QL (1 tablet per 1 day)
<i>tasimelteon oral capsule</i>	4	PA; LD; QL (1 capsule per 1 day)
LAXATIVES - DRUGS FOR THE STOMACH		
*BOWEL EVACUANT COMBINATIONS*** - DRUGS TO PREVENT CONSTIPATION		
GAVILYTE-C ORAL SOLUTION RECONSTITUTED (<i>peg 3350-kcl-nabcb-nacl-nasulf</i>)	1 or 1a*; \$0	QL (1 bottle per 30 days)
<i>gavilyte-g oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg 3350-kcl-na bicarb-nacl</i> (Gavilyte-N With Flavor Pack Oral Solution Reconstituted)	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>na sulfate-k sulfate-mg sulf oral solution</i>	1 or 1b*; \$0	QL (1 kit per 30 days)
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg-3350/electrolytes oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted</i>	1 or 1b*; \$0	QL (1 gram per 30 days)
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted</i>	1 or 1b*; \$0	QL (1 gram per 30 days)
SUTAB ORAL TABLET (<i>sodium sulfate-mag sulfate-kcl</i>)	2	QL (24 tablets per 30 days)
*LAXATIVES - MISCELLANEOUS*** - DRUGS TO PREVENT CONSTIPATION		
<i>clearlax oral powder</i>	1 or 1b*; \$0	
<i>constulose oral solution</i>	1 or 1b*	QL (120 mL per 1 day)
<i>cvs purelax oral packet</i>	1 or 1b*; \$0	
<i>cvs purelax oral powder</i>	1 or 1b*; \$0	
<i>eq clearlax oral powder</i>	1 or 1b*; \$0	
<i>eq laxative oral packet</i>	1 or 1b*; \$0	
<i>eql clearlax oral powder</i>	1 or 1b*; \$0	
<i>ft clearlax oral powder</i>	1 or 1b*; \$0	
<i>gavilax oral powder</i>	1 or 1b*; \$0	
<i>gentlelax oral powder</i>	1 or 1b*; \$0	
<i>glycolax oral powder</i>	1 or 1b*; \$0	
<i>gnp clearlax oral packet</i>	1 or 1b*; \$0	
<i>gnp clearlax oral powder</i>	1 or 1b*; \$0	
<i>goodsense clearlax oral powder</i>	1 or 1b*; \$0	
<i>healthylax oral packet</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hm clearlax oral powder</i>	1 or 1b*; \$0	
<i>kls laxaclear oral powder</i>	1 or 1b*; \$0	
<i>lactulose oral solution</i>	1 or 1b*	QL (120 mL per 1 day)
<i>mm clearlax oral powder</i>	1 or 1b*; \$0	
<i>peg 3350 oral packet</i>	1 or 1b*; \$0	
<i>peg 3350 oral powder</i>	1 or 1b*; \$0	
<i>polyethylene glycol 3350 oral packet</i>	1 or 1b*; \$0	
<i>polyethylene glycol 3350 oral powder</i>	1 or 1b*; \$0	
<i>qc natura-lax oral powder</i>	1 or 1b*; \$0	
<i>ra laxative oral powder</i>	1 or 1b*; \$0	
<i>sb polyethylene glycol 3350 oral powder</i>	1 or 1b*; \$0	
<i>sm clearlax oral powder</i>	1 or 1b*; \$0	
<i>smooth lax oral packet</i>	1 or 1b*; \$0	
<i>smooth lax oral powder</i>	1 or 1b*; \$0	
<i>true laxative oral powder</i>	1 or 1b*; \$0	
*SALINE LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION		
<i>citrate of magnesia oral solution</i>	1 or 1a*; \$0	
<i>citroma oral solution</i>	1 or 1a*; \$0	
<i>cvs magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>cvs milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>dulcolax milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>dulcolax oral suspension</i>	1 or 1b*; \$0	
<i>eq magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>eql magnesium citrate oral solution</i>	1 or 1a*; \$0	
FRESKARO MAGNESIUM CITRATE ORAL SOLUTION (<i>magnesium citrate</i>)	1 or 1a*; \$0	
<i>ft magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>ft milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>gentle laxative oral suspension</i>	1 or 1b*; \$0	
<i>gnp magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>gnp milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>goodsense magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>goodsense milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>hm milk of magnesia oral suspension</i>	1 or 1b*; \$0	
<i>magnesium citrate oral solution</i>	1 or 1a*; \$0	
<i>milk of magnesia oral suspension</i>	1 or 1b*; \$0	
ONELAX MAGNESIUM CITRATE ORAL SOLUTION (<i>magnesium citrate</i>)	1 or 1a*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

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

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
womens laxative oral tablet delayed release	1 or 1a*; \$0	
LOCAL ANESTHETICS-PARENTERAL - DRUGS FOR PAIN AND FEVER		
*LOCAL ANESTHETIC & SYMPATHOMIMETIC*** - DRUGS FOR SEDATION		
bupivacaine-epinephrine (pf) injection solution	1 or 1b*	
bupivacaine-epinephrine injection solution	1 or 1b*	
lidocaine-epinephrine (pf) injection solution 1.5 %-1:200000	1 or 1b*	
lidocaine-epinephrine injection solution	1 or 1b*	
sensorcaine/epinephrine injection solution	1 or 1b*	
sensorcaine-mpf/epinephrine injection solution 0.25% -1:200000	1 or 1b*	
*LOCAL ANESTHETICS - AMIDES*** - DRUGS FOR SEDATION		
bupivacaine hcl (pf) injection solution	1 or 1b*	
lidocaine hcl (pf) injection solution	1 or 1b*	
lidocaine hcl injection solution 0.5 %	1 or 1b*	
polocaine injection solution	1 or 1b*	
polocaine-mpf injection solution	1 or 1b*	
ropivacaine hcl injection solution 10 mg/ml, 5 mg/ml, 7.5 mg/ml	1 or 1b*	
sensorcaine injection solution	1 or 1b*	
sensorcaine-mpf injection solution	1 or 1b*	
*LOCAL ANESTHETICS - ESTERS*** - DRUGS FOR SEDATION		
chloroprocaine hcl (pf) injection solution	1 or 1b*	
MACROLIDES - DRUGS FOR INFECTIONS		
*AZITHROMYCIN*** - ANTIBIOTICS		
azithromycin intravenous solution reconstituted	2	
azithromycin oral suspension reconstituted	1 or 1b*	
azithromycin oral tablet	1 or 1b*	
*CLARITHROMYCIN*** - ANTIBIOTICS		
clarithromycin er oral tablet extended release 24 hour	1 or 1b*	
clarithromycin oral suspension reconstituted	1 or 1b*	
clarithromycin oral tablet	1 or 1b*	
*ERYTHROMYCINS*** - ANTIBIOTICS		
e.e.s. 400 oral tablet	1 or 1b*	
ery-tab oral tablet delayed release	1 or 1b*	
erythromycin base oral capsule delayed release particles	1 or 1b*	
erythromycin base oral tablet	1 or 1b*	
erythromycin base oral tablet delayed release	1 or 1b*	
erythromycin ethylsuccinate oral suspension reconstituted	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>erythromycin ethylsuccinate oral tablet</i>	1 or 1b*	
<i>erythromycin lactobionate intravenous solution reconstituted</i>	2	
<i>erythromycin oral tablet delayed release</i>	1 or 1b*	
MEDICAL DEVICES AND SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
*CERVICAL CAPS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
FEMCAP VAGINAL DEVICE (<i>cervical caps</i>)	2; \$0	
*CONDOMS - FEMALE*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
FC2 FEMALE CONDOM (<i>condoms - female</i>)	2; \$0	QL (12 units per 1 fill)
*DIAPHRAGMS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
CAYA VAGINAL DIAPHRAGM (<i>diaphragm arc-spring</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
*GLUCOSE MONITORING TEST SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
ACCU-CHEK FASTCLIX LANCET KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
ACCU-CHEK FASTCLIX LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ACCU-CHEK SAFE-T PRO LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ACCU-CHEK SOFTCLIX LANCET DEV KIT (<i>lancets misc.</i>)	2	QL (200 units per 30 days)
ACCU-CHEK SOFTCLIX LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
COAGUCHEK LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (3 units per 30 days)
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	2	PA; QL (1 unit per 90 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 receiver per 1 year)
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (3 sensors per 30 days)
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 units per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 kits per 30 days)
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 reader per 1 year)
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 units per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 sensors per 30 days)
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 1 year)
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 sensors per 28 days)
FREESTYLE LIBRE READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
ONETOUCH DELICA PLUS LANCET30G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ONETOUCH DELICA PLUS LANCET33G (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ONETOUCH DELICA PLUS LANCING (<i>lancet devices</i>)	2	
ONETOUCH DELICA SAFETY LANCING (<i>lancets</i>)	2	QL (204 lancets per 30 days)
ONETOUCH ULTRASOFT 2 LANCETS (<i>lancets</i>)	2	QL (204 lancets per 30 days)
*INSULIN ADMINISTRATION SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD 5 LIBRE2 PLUS G6 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 years)
OMNIPOD 5 LIBRE2 PLUS G6 PODS (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD CLASSIC PODS (GEN 3) (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PDM (GEN 4) KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PODS (GEN 4) (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
*NEEDLES & SYRINGES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
1ST TIER UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
1ST TIER UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ADVOCATE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
<i>aq insulin syringe</i>	3	ST; QL (200 syringes per 30 days)
<i>aqinject pen needle</i>	3	ST; QL (200 needles per 30 days)
ASSURE ID DUO PRO PEN NEEDLES (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
ASSURE ID PRO PEN NEEDLES (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
ASSURE ID SAFETY PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aum insulin safety pen needle</i>	3	ST; QL (200 needles per 30 days)
AUM MINI INSULIN PEN NEEDLE	3	ST; QL (200 needles per 30 days)
<i>aum pen needle</i>	3	ST; QL (200 needles per 30 days)
AUM READYGARD DUO PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
AUM SAFETY PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
AURORA PEN NEEDLES	3	ST; QL (200 needles per 30 days)
BD AUTOSHIELD DUO (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD INSULIN SYR ULTRAFINE II (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE HALF-UNIT (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE MICROFINE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U/F (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U/F 1/2UNIT (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U-500 (<i>insulin syringe/needle u-500</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE ULTRAFINE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD PEN NEEDLE MICRO U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE MINI U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE NANO 2ND GEN (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE NANO U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE ORIGINAL U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD PEN NEEDLE SHORT U/F (<i>insulin pen needle</i>)	2	QL (200 needles per 30 days)
BD SAFETYGLIDE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD VEO INSULIN SYR U/F 1/2UNIT (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD VEO INSULIN SYRINGE U/F (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
CAREFINE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
CAREONE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
CAREONE UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
CARETOUCH INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
CARETOUCH PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
CLEVER CHOICE COMFORT EZ 29G X 12MM , 33G X 4 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
CLICKFINE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
COMFORT ASSIST INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML (insulin syringe-needle u-100)	3	QL (200 syringes per 30 days)
COMFORT EZ MICRO PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM , 31G X 4 MM (insulin pen needle)	3	ST; QL (200 needles per 30 days)
COMFORT EZ PRO PEN NEEDLES 31G X 5 MM (insulin pen needle)	3	QL (200 needles per 30 days)
COMFORT EZ SHORT PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
COMFORT TOUCH INSULIN PEN NEED (insulin pen needle)	3	ST; QL (200 needles per 30 days)
DIATHRIVE PEN NEEDLE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 15/64" 0.3 ML, 30G X 15/64" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML (insulin syringe-needle u-100)	3	QL (200 syringes per 30 days)
DROPLET MICRON (insulin pen needle)	3	QL (200 needles per 30 days)
DROPLET PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
DROPSAFE SAFETY PEN NEEDLES	3	ST; QL (200 needles per 30 days)
DROPSAFE SAFETY SYRINGE/NEEDLE (insulin syringe-needle u-100)	3	ST; QL (200 needles per 30 days)
DRUG MART UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
DRUG MART UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
EASY COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML, 32G X 5/16" 0.5 ML, 32G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
easy comfort insulin syringe 31g x 1/2" 0.3 ml, 31g x 5/16" 0.3 ml	3	ST; QL (200 syringes per 30 days)
EASY COMFORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
EASY GLIDE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
EASY TOUCH FLIPLOCK INSULIN SY (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SAFETY SYR (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML, 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML (insulin syringe-needle u-100)	3	QL (200 syringes per 30 days)
EASY TOUCH PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
EASY TOUCH SAFETY PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML, 30G X 1/2" 1 ML, 30G X 5/16" 1 ML, 31G X 5/16" 1 ML (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
EMBRACE PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
EQL INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
FIFTY50 PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
FIFTY50 SUPERIOR COMFORT SYR (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
GLOBAL EASE INJECT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GLOBAL EASY GLIDE INSULIN SYR	3	ST; QL (200 syringes per 30 days)
GLOBAL EASY GLIDE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GLOBAL INJECT EASE INSULIN SYR	3	ST; QL (200 syringes per 30 days)
GLOBAL INSULIN SYRINGES	3	ST; QL (200 syringes per 30 days)
GLUCOPRO INSULIN SYRINGE (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
GNP CLICKFINE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GNP INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 28GX1/2"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 29GX1/2"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 30GX5/16"	3	ST; QL (200 syringes per 30 days)
GNP INSULIN SYRINGES 31GX5/16"	3	ST; QL (200 syringes per 30 days)
GNP ULTICARE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
GNP ULTIGUARD SAFEPAK NEEDLE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
GNP ULTRA COM INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
GOODSENSE CLICKFINE PEN NEEDLE	3	ST; QL (200 needles per 30 days)
GOODSENSE PEN NEEDLE PENFINE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
HEALTHWISE INSULIN SYR/NEEDLE	3	ST; QL (200 syringes per 30 days)
HEALTHWISE MICRON PEN NEEDLES	3	ST; QL (200 needles per 30 days)
HEALTHWISE SHORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
H-E-B INCONTROL PEN NEEDLES	3	ST; QL (200 needles per 30 days)
H-E-B INCONTROL UNIFINE PENTIP (insulin pen needle)	3	ST; QL (200 needles per 30 days)
HM ULTICARE INSULIN SYRINGE (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
HM ULTICARE MINI PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
HM ULTICARE SHORT PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
INCONTROL ULTICARE PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
insulin syringe-needle u-100 27g x 1/2" 0.5 ml, 27g x 1/2" 1 ml, 28g x 1/2" 0.5 ml, 28g x 1/2" 1 ml, 30g x 1/2" 1 ml	3	ST; QL (200 syringes per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 1/4" 0.3 ML, 31G X 1/4" 0.5 ML, 31G X 1/4" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
INSUPEN PEN NEEDLES	3	ST; QL (200 needles per 30 days)
KINRAY INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
KMART VALU INSULIN SYRINGE 29G	3	ST; QL (200 syringes per 30 days)
KMART VALU INSULIN SYRINGE 30G	3	ST; QL (200 syringes per 30 days)
KROGER INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
KROGER PEN NEEDLES	3	ST; QL (200 needles per 30 days)
LEADER INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
LEADER UNIFINE PENTIPS (insulin pen needle)	3	ST; QL (200 needles per 30 days)
LEADER UNIFINE PENTIPS PLUS (insulin pen needle)	3	ST; QL (200 needles per 30 days)
LITETOUCH INSULIN SYRINGE (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
LITETOUCH PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
LONGS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
MAGELLAN INSULIN SAFETY SYR (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
MARATHON MEDICAL PENTIPS (insulin pen needle)	3	ST; QL (200 needles per 30 days)
MAXICOMFORT II PEN NEEDLE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
MAXI-COMFORT INSULIN SYRINGE (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
MAXI-COMFORT SAFETY PEN NEEDLE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
MAXICOMFORT SYR 27G X 1/2" (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
MEDIC INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
MEDICINE SHOPPE PEN NEEDLES	3	ST; QL (200 needles per 30 days)
MEIJER PEN NEEDLES	3	ST; QL (200 needles per 30 days)
MICRODOT PEN NEEDLE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
MM INSULIN SYRINGE/NEEDLE	3	ST; QL (200 syringes per 30 days)
MM PEN NEEDLES (insulin pen needle)	3	ST; QL (200 needles per 30 days)
MONOJECT INSULIN SYRINGE (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
MONOJECT ULTRA COMFORT SYRINGE (insulin syringe-needle u-100)	3	ST; QL (200 syringes per 30 days)
MS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
NOVOFINE PEN NEEDLE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
NOVOFINE PLUS PEN NEEDLE (insulin pen needle)	3	ST; QL (200 needles per 30 days)
PC UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
pen needle/5-bevel tip	3	ST; QL (200 needles per 30 days)
PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PEN NEEDLES 5/16"	3	ST; QL (200 needles per 30 days)
PENTIPS (insulin pen needle)	3	ST; QL (200 needles per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENTIPS GENERIC PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
<i>pip pen needles 31g x 5mm</i>	3	ST; QL (200 needles per 30 days)
<i>pip pen needles 32g x 4mm</i>	3	ST; QL (200 needles per 30 days)
PRECISION SURE-DOSE SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
PREFERRED PLUS INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
PREFERRED PLUS UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
PREVENT DROPSAFE PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
PREVENT SAFETY PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
PRO COMFORT INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
PRO COMFORT PEN NEEDLES 32G X 4 MM , 32G X 5 MM , 32G X 6 MM	3	ST; QL (200 needles per 30 days)
PRODIGY INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
PURE COMFORT PEN NEEDLE	3	ST; QL (200 needles per 30 days)
<i>pure comfort safety pen needle</i>	3	QL (200 needles per 30 days)
PX EXTRA SHORT PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PX INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
PX MINI PEN NEEDLES	3	ST; QL (200 needles per 30 days)
PX PEN NEEDLE	3	ST; QL (200 needles per 30 days)
QC PEN NEEDLES	3	ST; QL (200 needles per 30 days)
QC UNIFINE PENTIPS	3	ST; QL (200 needles per 30 days)
RA INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
RA PEN NEEDLES	3	ST; QL (200 needles per 30 days)
<i>raya sure pen needle</i>	3	ST; QL (200 needles per 30 days)
REALITY INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
RELION INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
RELION MINI PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
RELION PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
RELION SHORT PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
<i>safety pen needles</i>	3	ST; QL (200 needles per 30 days)
SB INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
SECURESAFE INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
SECURESAFE SAFETY PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
SURE COMFORT INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
SURE COMFORT PEN NEEDLES 29G X 12.7MM , 30G X 8 MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM	3	ST; QL (200 needles per 30 days)
<i>sure comfort pen needles 31g x 6 mm</i>	3	ST; QL (200 needles per 30 days)
TECHLITE INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
TECHLITE PEN NEEDLES 29G X 12MM , 31G X 5 MM (<i>insulin pen needle</i>)	3	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

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

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA-THIN II MINI PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II PEN NEEDLE SHORT (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTRA-THIN II PEN NEEDLES (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE PENTIPS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE PENTIPS PLUS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
UNIFINE PROTECT PEN NEEDLE 30G X 8 MM , 32G X 4 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE SAFECONTROL PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
UNIFINE ULTRA PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
VALUE HEALTH INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
VANISHPOINT INSULIN SYRINGE 29G X 1/2" 1 ML, 29G X 5/16" 1 ML, 30G X 1/2" 0.5 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML, 30G X 3/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	QL (200 syringes per 30 days)
VERIFINE INSULIN PEN NEEDLE 29G X 12MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
VERIFINE INSULIN PEN NEEDLE 31G X 5 MM (<i>insulin pen needle</i>)	3	QL (200 needles per 30 days)
VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
VERIFINE INSULIN SYRINGE 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	QL (200 syringes per 30 days)
VERIFINE PLUS PEN NEEDLE (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
VP INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
WEGMANS UNIFINE PENTIPS PLUS	3	ST; QL (200 needles per 30 days)
ZEVRX INSULIN SYRINGE	3	ST; QL (200 syringes per 30 days)
ZEVRX PEN NEEDLES	3	ST; QL (200 needles per 30 days)
MIGRAINE PRODUCTS - DRUGS FOR THE NERVOUS SYSTEM		
*CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAG (CGRP)*** - DRUGS FOR MIGRAINE HEADACHES		
NURTEC ORAL TABLET DISPERSIBLE (<i>rimegepant sulfate</i>)	2	PA; QL (8 tablets per 30 days)
QULIPTA ORAL TABLET (<i>atogepant</i>)	2	PA; QL (1 tablet per 1 day)
UBRELVIY ORAL TABLET (<i>ubrogepant</i>)	2	ST; QL (16 tablets per 30 days)
*CGRP RECEPTOR ANTAGONISTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR MIGRAINE HEADACHES		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>erenumab-aooe</i>)	3	PA; QL (1 autoinjector per 28 days)
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>fremanezumab-vfrm</i>)	3	PA; QL (3 syringes per 90 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (fremanezumab-vfrm)	3	PA; QL (3 syringes per 90 days)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (galcanezumab-gnlm)	3	PA; QL (3 syringes per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (galcanezumab-gnlm)	3	PA; QL (1 pen per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (galcanezumab-gnlm)	3	PA; QL (1 syringe per 28 days)
*ERGOT COMBINATIONS*** - DRUGS FOR MIGRAINE HEADACHES		
ergotamine-caffeine oral tablet	1 or 1b*	
migergot rectal suppository	1 or 1b*	
*MIGRAINE PRODUCTS*** - DRUGS FOR MIGRAINE HEADACHES		
dihydroergotamine mesylate injection solution	1 or 1b*	PA; QL (24 mL per 28 days)
*SELECTIVE SEROTONIN AGONISTS 5-HT(1)*** - DRUGS FOR MIGRAINE HEADACHES		
almotriptan malate oral tablet	1 or 1b*	QL (9 tablets per 30 days)
eletriptan hydrobromide oral tablet	1 or 1b*	QL (9 tablets per 30 days)
frovatriptan succinate oral tablet	1 or 1b*	ST; QL (9 tablets per 30 days)
naratriptan hcl oral tablet	1 or 1b*	QL (9 tablets per 30 days)
rizatriptan benzoate oral tablet	1 or 1b*	QL (9 tablets per 30 days)
rizatriptan benzoate oral tablet dispersible	1 or 1b*	QL (9 tablets per 30 days)
sumatriptan nasal solution	1 or 1b*	QL (6 nasal inhalers per 30 days)
sumatriptan succinate oral tablet	1 or 1b*	QL (9 tablets per 30 days)
sumatriptan succinate refill subcutaneous solution cartridge	2	QL (6 cartridges per 30 days)
sumatriptan succinate subcutaneous solution	2	QL (5 vials per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml	2	QL (6 syringes (2 ML) per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	2	QL (6 cartridges per 30 days)
zolmitriptan nasal solution	1 or 1b*	ST; QL (6 nasal inhalers per 30 days)
zolmitriptan oral tablet	1 or 1b*	QL (9 tablets per 30 days)
zolmitriptan oral tablet dispersible	1 or 1b*	QL (9 tablets per 30 days)
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION		
*BICARBONATES*** - DRUGS FOR NUTRITION		
sodium acetate intravenous solution 4 meq/ml	1 or 1b*	
sodium bicarbonate intravenous solution 4.2 %, 7.5 %	2	
*ELECTROLYTES & DEXTROSE*** - DRUGS FOR NUTRITION		
dextrose in lactated ringers intravenous solution	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dextrose-sodium chloride intravenous solution 10-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.45 %, 5-0.9 %	1 or 1b*	
kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%	1 or 1b*	
potassium cl in dextrose 5% intravenous solution	1 or 1b*	
*ELECTROLYTES PARENTERAL*** - DRUGS FOR NUTRITION		
KCL (0.149%) IN NACL INTRAVENOUS SOLUTION 20-0.45 MEQ/L-%	1 or 1b*	
kcl (0.149%) in nacl intravenous solution 20-0.9 meq/l-%	1 or 1b*	
KCL (0.298%) IN NACL INTRAVENOUS SOLUTION	1 or 1b*	
lactated ringers intravenous solution	1 or 1b*	
multiple electro type 1 ph 5.5 intravenous solution	1 or 1b*	
multiple electro type 1 ph 7.4 intravenous solution	1 or 1b*	
ringers intravenous solution	1 or 1b*	
*FLUORIDE*** - DRUGS FOR NUTRITION		
sodium fluoride oral solution	1 or 1a*; \$0	
sodium fluoride oral tablet	1 or 1a*; \$0	
sodium fluoride oral tablet chewable	1 or 1a*; \$0	
*MAGNESIUM*** - DRUGS FOR NUTRITION		
MAGNESIUM SULFATE INJECTION SOLUTION	2	
*MANGANESE*** - DRUGS FOR NUTRITION		
manganese chloride intravenous solution	1 or 1b*	
*PHOSPHATE*** - DRUGS FOR NUTRITION		
K-PHOS ORAL TABLET (potassium phosphate monobasic)	2	
phospha 250 neutral oral tablet	1 or 1b*	
phosphorous oral tablet	1 or 1b*	
phospho-trin k500 oral tablet	1 or 1b*	
potassium phosphates intravenous solution 45 mmole/15ml	1 or 1b*	
sodium phosphates intravenous solution	1 or 1b*	
*POTASSIUM*** - DRUGS FOR NUTRITION		
klor-con 10 oral tablet extended release	1 or 1b*	
klor-con m10 oral tablet extended release	1 or 1a*	
klor-con m15 oral tablet extended release	1 or 1a*	
klor-con m20 oral tablet extended release	1 or 1a*	
klor-con oral packet	1 or 1b*	
klor-con oral tablet extended release	1 or 1b*	
potassium chloride crys er oral tablet extended release	1 or 1a*	
potassium chloride er oral capsule extended release	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>potassium chloride er oral tablet extended release</i>	1 or 1b*	
<i>potassium chloride intravenous solution 2 meq/ml</i>	1 or 1b*	
<i>potassium chloride oral packet</i>	1 or 1b*	
<i>potassium chloride oral solution</i>	1 or 1b*	
*SODIUM*** - DRUGS FOR NUTRITION		
<i>aquastat intravenous solution</i>	2	
<i>sodium chloride flush (Aquastat Sfr Intravenous Solution)</i>	2	
<i>bd posiflush intravenous solution</i>	2	
<i>sodium chloride flush (Bd Posiflush Safescrib Intravenous Solution)</i>	2	
<i>monoject flush syringe intravenous solution</i>	2	
<i>monoject sodium chloride flush intravenous solution</i>	2	
<i>normal saline flush intravenous solution</i>	2	
<i>saline flush intravenous solution</i>	2	
<i>sodium chloride (pf) injection solution</i>	2	
<i>sodium chloride injection solution</i>	2	
<i>sodium chloride intravenous solution 0.45 %, 3 %, 5 %</i>	2	
*TRACE MINERALS*** - DRUGS FOR NUTRITION		
<i>chromic chloride intravenous solution</i>	1 or 1b*	
SELENIOUS ACID INTRAVENOUS SOLUTION 40 MCG/ML	1 or 1b*	
*ZINC*** - DRUGS FOR NUTRITION		
<i>zinc sulfate intravenous solution</i>	1 or 1b*	
MISCELLANEOUS THERAPEUTIC CLASSES - VITAMINS AND MINERALS		
*ANTILEPROTICS*** - VITAMINS AND MINERALS		
THALOMID ORAL CAPSULE (thalidomide)	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
*CHELATING AGENTS*** - VITAMINS AND MINERALS		
<i>penicillamine oral tablet</i>	2	PA; LD; QL (8 tablets per 1 day); SP
<i>trientine hcl oral capsule 250 mg</i>	4	PA; LD; QL (8 capsules per 1 day); SP
*CYCLOSPORINE ANALOGS*** - VITAMINS AND MINERALS		
<i>cyclosporine modified oral capsule</i>	4	LD
<i>cyclosporine modified oral solution</i>	4	LD
<i>cyclosporine oral capsule</i>	4	LD
<i>engraf oral capsule</i>	4	LD
<i>engraf oral solution</i>	4	LD

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES*** - VITAMINS AND MINERALS		
<i>lenalidomide oral capsule</i>	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
REVLIMID ORAL CAPSULE (<i>lenalidomide</i>)	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS*** - VITAMINS AND MINERALS		
<i>mycophenolate mofetil oral capsule</i>	4	LD
<i>mycophenolate mofetil oral suspension reconstituted</i>	4	LD
<i>mycophenolate mofetil oral tablet</i>	4	LD
<i>mycophenolate sodium oral tablet delayed release</i>	4	LD
<i>mycophenolic acid oral tablet delayed release</i>	4	LD
*IRRIGATION SOLUTIONS*** - VITAMINS AND MINERALS		
<i>argyle sterile water irrigation solution</i>	1 or 1b*	
<i>lactated ringers irrigation solution</i>	1 or 1b*	
<i>physiolyte irrigation solution</i>	1 or 1b*	
<i>physiosol irrigation irrigation solution</i>	1 or 1b*	
<i>ringers irrigation irrigation solution</i>	1 or 1b*	
<i>sterile water for irrigation irrigation solution</i>	1 or 1b*	
<i>tis-u-sol irrigation solution</i>	1 or 1b*	
<i>water for irrigation, sterile irrigation solution</i>	1 or 1b*	
*MACROLIDE IMMUNOSUPPRESSANTS*** - VITAMINS AND MINERALS		
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	4	LD
<i>sirolimus oral solution</i>	4	LD
<i>sirolimus oral tablet</i>	4	LD
<i>tacrolimus oral capsule</i>	4	LD
*POTASSIUM REMOVING AGENTS*** - VITAMINS AND MINERALS		
LOKELMA ORAL PACKET 10 GM (<i>sodium zirconium cyclosilicate</i>)	3	QL (34 packets per 30 days)
LOKELMA ORAL PACKET 5 GM (<i>sodium zirconium cyclosilicate</i>)	3	QL (3 packets per 1 day)
<i>sodium polystyrene sulfonate oral powder</i>	2	
<i>sps (sodium polystyrene sulf) rectal suspension</i>	2	
*PURINE ANALOGS*** - VITAMINS AND MINERALS		
<i>azasan oral tablet</i>	1 or 1b*	LD
<i>azathioprine oral tablet</i>	1 or 1b*	LD
*SCLEROSING AGENTS*** - VITAMINS AND MINERALS		
<i>sodium tetradecyl sulfate intravenous solution</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOTRADECOL INTRAVENOUS SOLUTION 1 % (<i>sodium tetradecyl sulfate</i>)	1 or 1b*	
<i>sotradecol intravenous solution 3 %</i>	1 or 1b*	
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT		
*ANESTHETICS TOPICAL ORAL*** - DRUGS FOR THE MOUTH AND THROAT		
<i>lidocaine hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
<i>lidocaine viscous hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
*ANTI-INFECTIVES - THROAT*** - DRUGS FOR THE MOUTH AND THROAT		
<i>clotrimazole mouth/throat troche</i>	1 or 1b*	QL (5 tablet per 1 day)
*ANTISEPTICS - MOUTH/THROAT*** - DRUGS FOR THE MOUTH AND THROAT		
<i>chlorhexidine gluconate mouth/throat solution</i>	1 or 1a*	QL (480 mL per 30 days)
<i>periogard mouth/throat solution</i>	1 or 1a*	QL (480 mL per 30 days)
*DENTAL PRODUCTS - COMBINATIONS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>sodium fluoride 5000 enamel dental gel</i>	1 or 1b*	
<i>sodium fluoride 5000 sensitive dental gel</i>	1 or 1b*	
*FLUORIDE DENTAL PRODUCTS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>clinpro 5000 dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>denta 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>dentagel dental gel</i>	1 or 1a*	QL (100 grams per 30 days)
<i>easygel dental gel</i>	1 or 1b*	
<i>fluoridex daily renewal mouth/throat concentrate</i>	1 or 1b*	
<i>fluoridex dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>fluoridex enhanced whitening dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>fraiche 5000 dental dental gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>sf 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sf dental gel</i>	1 or 1a*	QL (100 grams per 30 days)
<i>sodium fluoride 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride 5000 ppm dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride 5000 ppm dental gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>sodium fluoride 5000 ppm dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>sodium fluoride dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride mouth/throat solution</i>	1 or 1a*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SALIVA STIMULANTS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>cevimeline hcl oral capsule</i>	2	
<i>pilocarpine hcl oral tablet</i>	2	QL (4 tablets per 1 day)
*STEROIDS - MOUTH/THROAT/DENTAL*** - DRUGS FOR THE MOUTH AND THROAT		
<i>triamcinolone acetonide (Kourzeq Mouth/Throat Paste)</i>	1 or 1b*	
<i>oralone mouth/throat paste</i>	1 or 1b*	
<i>triamcinolone acetonide mouth/throat paste</i>	1 or 1b*	
MULTIVITAMINS - DRUGS FOR NUTRITION		
*B-COMPLEX VITAMINS*** - DRUGS FOR NUTRITION		
<i>b complex-b12 oral tablet</i>	1 or 1b*; \$0	
<i>b-complex plus b-12 oral tablet</i>	1 or 1b*; \$0	
<i>b-complex/b-12 oral tablet</i>	1 or 1b*; \$0	
<i>ra b-complex oral tablet</i>	1 or 1b*; \$0	
<i>ra b-complex with b-12 oral tablet</i>	1 or 1b*; \$0	
<i>vitamin b complex oral tablet</i>	1 or 1b*; \$0	
<i>vitamin b complex w/b-12 oral tablet</i>	1 or 1b*; \$0	
<i>vitamin-b complex oral tablet</i>	1 or 1b*; \$0	
*B-COMPLEX W/ C & CALCIUM*** - DRUGS FOR NUTRITION		
<i>gnp b-complex plus vitamin c oral tablet</i>	1 or 1b*; \$0	
<i>qc b-complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
*B-COMPLEX W/ C & FOLIC ACID*** - DRUGS FOR NUTRITION		
<i>b complex-c-folic acid oral tablet</i>	1 or 1b*; \$0	
<i>b-complex balanced oral tablet</i>	1 or 1b*; \$0	
<i>b-complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
<i>b-complex-c (w/folic acid) oral tablet</i>	1 or 1b*; \$0	
<i>dialyvite 800 oral tablet</i>	1 or 1b*; \$0	
<i>eql super b complex/vitamin c oral tablet</i>	1 or 1b*; \$0	
FULL SPECTRUM B/VITAMIN C ORAL TABLET	1 or 1b*; \$0	
<i>kp b complex-c oral tablet</i>	1 or 1b*; \$0	
<i>nephro vitamins oral tablet</i>	1 or 1b*; \$0	
NEPHRO-VITE ORAL TABLET (b complex-c-folic acid)	1 or 1b*; \$0	
<i>renal vitamin oral tablet</i>	1 or 1b*; \$0	
<i>rena-vite oral tablet</i>	1 or 1b*; \$0	
<i>sm b super vitamin complex oral tablet</i>	1 or 1b*; \$0	
SM B-COMPLEX/VITAMIN C ORAL TABLET	2; \$0	
<i>stress formula (folic acid) oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

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

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>b-complex oral tablet</i>	1 or 1b*; \$0	
<i>big 100 (biotin) oral tablet</i>	1 or 1b*; \$0	
<i>complex b-100 oral tablet extended release</i>	1 or 1b*; \$0	
<i>complex b-50 prolonged release oral tablet extended release</i>	1 or 1b*; \$0	
<i>endur-b oral tablet extended release</i>	1 or 1b*; \$0	
<i>eql b complex 50 oral tablet</i>	1 or 1b*; \$0	
<i>eql b-100 complex oral tablet extended release</i>	1 or 1b*; \$0	
<i>ft b-100 complex pr oral tablet extended release</i>	1 or 1b*; \$0	
<i>gnp b-100 complex oral tablet extended release</i>	1 or 1b*; \$0	
<i>gnp b-50 complex oral tablet extended release</i>	1 or 1b*; \$0	
<i>qc b50 prolonged release oral tablet extended release</i>	1 or 1b*; \$0	
<i>quin b strong b-25 oral tablet</i>	1 or 1b*; \$0	
<i>ra balanced b-100 cr oral tablet extended release</i>	1 or 1b*; \$0	
<i>ra balanced b-100 oral tablet</i>	1 or 1b*; \$0	
<i>ra balanced b-50 oral tablet</i>	1 or 1b*; \$0	
<i>ra balanced b-50 tr oral tablet extended release</i>	1 or 1b*; \$0	
<i>sm b100 complex oral tablet</i>	1 or 1b*; \$0	
<i>sm b-complex oral tablet</i>	1 or 1b*; \$0	
<i>super b-complex oral tablet</i>	1 or 1b*; \$0	
<i>super dec b-100 oral tablet</i>	1 or 1b*; \$0	
<i>super quints b-50 oral tablet</i>	1 or 1b*; \$0	
<i>yl balanced b-100 oral tablet</i>	1 or 1b*; \$0	
*PED MULTI VITAMINS W/FL & FE*** - DRUGS FOR NUTRITION		
<i>multi-vitamin/fluoride/iron oral solution</i>	1 or 1b*	
*PED MV W/ FLUORIDE*** - DRUGS FOR NUTRITION		
<i>multivitamin w/fluoride oral tablet chewable</i>	1 or 1b*; \$0	
<i>multi-vitamin/fluoride oral solution</i>	1 or 1b*; \$0	
*PED VITAMINS ACD W/ FLUORIDE*** - DRUGS FOR NUTRITION		
<i>tri-vite/fluoride oral solution</i>	1 or 1b*; \$0	
*PRENATAL MV & MIN W/FE-FA*** - DRUGS FOR NUTRITION		
ATABEX EC ORAL TABLET DELAYED RELEASE (<i>prenatal vit-dss-fe cbn-fa</i>)	2	QL (1 tablet per 1 day)
ATABEX OB ORAL TABLET (<i>prenatal vit w/ fe bisg-fa</i>)	2	QL (1 tablet per 1 day)
CITRANATAL B-CALM ORAL (<i>prenat w/o a fecbnfeglu-fa &b6</i>)	2	QL (3 tablets per 1 day)
CLASSIC PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
C-NATE DHA ORAL CAPSULE	2	QL (1 capsule per 1 day)
COMPLETENATE ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)
CO-NATAL FA ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONCEPT DHA ORAL CAPSULE (<i>prenat-fefum-fepo-fa-omega 3</i>)	2	QL (1 capsule per 1 day)
CONCEPT OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
<i>elite-ob oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
EQL PRENATAL FORMULA ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
FOLIVANE-OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
GNP PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
<i>inatal gt oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
M-NATAL PLUS ORAL TABLET	1 or 1b*	QL (1 tablet per 1 day)
NATALVIT ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
NIVA-PLUS ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
ONE VITE WOMENS PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
<i>pnv prenatal plus multivit+dha oral</i>	2	QL (2 units per 1 day)
<i>pnv-select oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
PRENATAL (W/IRON & FA) ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET 29-1 MG	2	QL (1 tablet per 1 day)
<i>prenatal 19 oral tablet chewable</i>	1 or 1a*	QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET CHEWABLE 29-1 MG	2	QL (1 tablet per 1 day)
PRENATAL COMPLETE ORAL TABLET	2; \$0	ST; QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 27-1 MG	2	QL (1 tablet per 1 day)
PRENATAL PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL PLUS VITAMIN/MINERAL ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL VITAMIN AND MINERAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
PRENATAL VITAMINS ORAL TABLET 28-0.8 MG	2; \$0	QL (1 tablet per 1 day)
PRENATAL-U ORAL CAPSULE (<i>prenatal w/o a vit-fe fum-fa</i>)	2	QL (1 capsule per 1 day)
PROVIDA OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
QC PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
RA PRENATAL ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (<i>prenatal vit-fe psac cmplx-fa</i>)	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)
SM PRENATAL VITAMINS ORAL TABLET	2; \$0	QL (1 tablet per 1 day)
TARON-C DHA ORAL CAPSULE (<i>prenat-fefum-fepo-fa-omega 3</i>)	2	QL (1 capsule per 1 day)
THRIVITE RX ORAL TABLET	2	ST; QL (1 tablet per 1 day)
TRICARE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
TRINATAL RX 1 ORAL TABLET	2	QL (1 tablet per 1 day)
<i>trinate oral tablet</i>	1 or 1a*	QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAFOL GUMMIES ORAL TABLET CHEWABLE (<i>prenatal vit-fe phos-fa-omega</i>)	2	QL (3 gummies per 1 day)
WESTAB PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
*PRENATAL MV & MIN W/FE-FA-CA-OMEGA 3 FISH OIL*** - DRUGS FOR NUTRITION		
COMPLETE NATAL DHA ORAL	2	QL (2 units per 1 day)
<i>wesnatal dha complete oral</i>	2	QL (2 units per 1 day)
*PRENATAL MV & MIN W/FE-FA-DHA*** - DRUGS FOR NUTRITION		
ENFAMIL EXPECTA ORAL (<i>prenatal mv-min-fe fum-fa-dha</i>)	2; \$0	QL (2 tablets per 1 day)
<i>pnv-dha oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>prena 1 true oral</i>	2	
PRENATAL MULTIVITAMIN + DHA ORAL (<i>prenatal mv-min-fe fum-fa-dha</i>)	2; \$0	QL (2 tablets per 1 day)
*VITAMINS W/ LIPOTROPICS*** - DRUGS FOR NUTRITION		
<i>b complex formula 1 (lipotrop) oral tablet</i>	1 or 1b*; \$0	
<i>balance b-100 oral tablet</i>	1 or 1b*; \$0	
<i>balanced b-50 complex oral tablet</i>	1 or 1b*; \$0	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
*CENTRAL MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
<i>baclofen oral tablet 10 mg, 5 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>baclofen oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carisoprodol oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 375 mg, 750 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>cyclobenzaprine hcl oral tablet 10 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>cyclobenzaprine hcl oral tablet 5 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>methocarbamol injection solution</i>	1 or 1b*	
<i>methocarbamol oral tablet 500 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>methocarbamol oral tablet 750 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>orphenadrine citrate er oral tablet extended release 12 hour</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>orphenadrine citrate injection solution</i>	1 or 1b*	
<i>tizanidine hcl oral capsule 6 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>tizanidine hcl oral tablet 2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>tizanidine hcl oral tablet 4 mg</i>	1 or 1b*	QL (9 tablets per 1 day)
*DIRECT MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
<i>dantrolene sodium intravenous solution reconstituted</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dantrolene sodium oral capsule</i>	2	
<i>revonto intravenous solution reconstituted</i>	1 or 1b*	
*MUSCLE RELAXANT COMBINATIONS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
<i>norgesic oral tablet</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
ORPHENADRINE-ASPIRIN-CAFFEINE ORAL TABLET	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>orphengesic forte oral tablet</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
*VISCOSUPPLEMENTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
MONOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hyaluronan</i>)	4	PA; LD
ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hyaluronan</i>)	4	PA; LD
SYNISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hylan g-f 20</i>)	4	PA; LD
SYNISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE (<i>hylan g-f 20</i>)	4	PA; LD
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE		
*ANTIHISTAMINE-STEROID*** - ALLERGY		
<i>azelastine-fluticasone nasal suspension</i>	3	QL (1 bottle per 30 days)
*NASAL ANTICHOLINERGICS*** - ALLERGY		
<i>ipratropium bromide nasal solution 0.03 %</i>	1 or 1b*	QL (2 bottles per 30 days)
<i>ipratropium bromide nasal solution 0.06 %</i>	1 or 1b*	QL (1 mL per 1 day)
*NASAL ANTIHISTAMINES*** - ALLERGY		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	1 or 1b*	QL (1 package per 25 days)
<i>azelastine hcl nasal solution 0.15 %</i>	1 or 1b*	QL (1 bottle per 25 days)
<i>olopatadine hcl nasal solution</i>	1 or 1b*	QL (1 bottle per 30 days)
*NASAL STEROIDS*** - ALLERGY		
<i>fluticasone propionate nasal suspension</i>	1 or 1a*	BE; QL (1 bottle per 30 days)
<i>mometasone furoate nasal suspension</i>	3	ST; BE; QL (1 bottle per 30 days)
NEUROMUSCULAR AGENTS - DRUGS FOR NERVES AND MUSCLES		
*BENZATHIAZOLES*** - DRUGS FOR NERVES AND MUSCLES		
<i>riluzole oral tablet</i>	4	PA; LD; QL (4 tablets per 1 day); SP
*NONDEPOLARIZING MUSCLE RELAXANTS*** - DRUGS FOR NERVES AND MUSCLES		
<i>atracurium besylate intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate (pf) intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate intravenous solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
rocuronium bromide intravenous solution	1 or 1b*	
vecuronium bromide intravenous solution reconstituted	1 or 1b*	
NUTRIENTS - DRUGS FOR NUTRITION		
*AMINO ACID MIXTURES*** - DRUGS FOR NUTRITION		
aminosyn ii intravenous solution 15 %	1 or 1b*	
clinisol sf intravenous solution	1 or 1b*	
plenamine intravenous solution	1 or 1b*	
*CARBOHYDRATES*** - DRUGS FOR NUTRITION		
dextrose intravenous solution 10 %, 5 %, 70 %	1 or 1b*	
OPHTHALMIC AGENTS - DRUGS FOR THE EYE		
*ALPHA ADRENERGIC AGONIST & CARBONIC ANHYDRASE INHIB COMB*** - DRUGS FOR GLAUCOMA		
SIMBRINZA OPHTHALMIC SUSPENSION (brinzolamide-brimonidine)	2	QL (8 mL per 30 days)
*BETA-BLOCKERS - OPHTHALMIC COMBINATIONS*** - DRUGS FOR GLAUCOMA		
brimonidine tartrate-timolol ophthalmic solution	1 or 1b*	QL (15 mL per 30 days)
dorzolamide hcl-timolol mal ophthalmic solution	1 or 1b*	QL (10 mL per 30 days)
dorzolamide hcl-timolol mal pf ophthalmic solution	1 or 1b*	QL (60 units per 30 days)
*BETA-BLOCKERS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA		
betaxolol hcl ophthalmic solution	1 or 1b*	QL (0.5 mL per 1 day)
BETOPTIC-S OPHTHALMIC SUSPENSION (betaxolol hcl)	2	QL (15 mL per 30 days)
carteolol hcl ophthalmic solution	1 or 1a*	
levobunolol hcl ophthalmic solution	1 or 1b*	
timolol hemihydrate ophthalmic solution	2	QL (15 mL per 30 days)
timolol maleate (once-daily) ophthalmic solution	1 or 1b*	QL (5 mL per 30 days)
timolol maleate ocudose ophthalmic solution	1 or 1b*	QL (20 mL per 30 days)
timolol maleate ophthalmic gel forming solution	1 or 1b*	QL (5 mL per 30 days)
timolol maleate ophthalmic solution	1 or 1b*	QL (20 mL per 30 days)
timolol maleate pf ophthalmic solution 0.25 %	1 or 1b*	QL (18 mL per 30 days)
timolol maleate pf ophthalmic solution 0.5 %	1 or 1b*	QL (20 mL per 30 days)
*CYCLOPLEGIC MYDRIATICS*** - DRUGS FOR THE EYE		
cyclopentolate hcl ophthalmic solution	1 or 1b*	QL (15 mL per 30 days)
phenylephrine hcl ophthalmic solution	1 or 1b*	
tropicamide ophthalmic solution	1 or 1b*	
*LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
XIIDRA OPHTHALMIC SOLUTION (lifitegrast)	2	PA; QL (2 vial per 1 day)
*MIOTICS - DIRECT ACTING*** - DRUGS FOR GLAUCOMA		
pilocarpine hcl ophthalmic solution	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*OPHTHALMIC - MULTIPLE RECEPTOR ANGIOGENESIS INHIBITORS*** - DRUGS FOR THE EYE		
VABYSMO INTRAVITREAL SOLUTION (<i>faricimab-svoa</i>)	4	PA; LD; SP
VABYSMO INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>faricimab-svoa</i>)	4	PA; LD; SP
*OPHTHALMIC ANTIALLERGIC*** - DRUGS FOR ITCHY EYE		
<i>azelastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 24 days)
<i>cromolyn sodium ophthalmic solution</i>	1 or 1a*	QL (2 bottles per 30 days)
<i>epinastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 30 days)
*OPHTHALMIC ANTIBIOTICS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitracin ophthalmic ointment</i>	1 or 1b*	QL (7 grams per 30 days)
<i>ciprofloxacin hcl ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>gatifloxacin ophthalmic solution</i>	1 or 1b*	QL (2.5 mL per 30 days)
<i>gentamicin sulfate ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>levofloxacin ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>moxifloxacin hcl (2x day) ophthalmic solution</i>	1 or 1b*	QL (3 mL per 30 days)
<i>moxifloxacin hcl ophthalmic solution</i>	2	QL (3 mL per 30 days)
<i>ofloxacin ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>tobramycin ophthalmic solution</i>	1 or 1a*	QL (20 mL per 30 days)
*OPHTHALMIC ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitracin-polymyxin b ophthalmic ointment</i>	1 or 1a*	QL (3.5 grams per 30 days)
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>neomycin-polymyxin-gramicidin ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
<i>neo-polycin ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>polycin ophthalmic ointment</i>	1 or 1a*	QL (3.5 grams per 30 days)
<i>polymyxin b-trimethoprim ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
*OPHTHALMIC ANTIVIRALS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>trifluridine ophthalmic solution</i>	1 or 1b*	QL (7.5 mL per 30 days)
*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR GLAUCOMA		
<i>brinzolamide ophthalmic suspension</i>	1 or 1b*	QL (15 mL per 30 days)
<i>dorzolamide hcl ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
*OPHTHALMIC DIAGNOSTIC PRODUCTS*** - DRUGS FOR THE EYE		
<i>ak-fluor intravenous solution 10 %</i>	1 or 1b*	
<i>altafluor benox ophthalmic solution</i>	1 or 1b*	
<i>fluorescein intravenous solution</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluorescein-benoxinate ophthalmic solution</i>	1 or 1b*	
*OPHTHALMIC IMMUNOMODULATORS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>cyclosporine ophthalmic emulsion</i>	1 or 1b*	PA; QL (2 vials per 1 day)
RESTASIS MULTIDOSE OPHTHALMIC EMULSION (<i>cyclosporine</i>)	2	PA; QL (1 bottle per 28 days)
RESTASIS OPHTHALMIC EMULSION (<i>cyclosporine</i>)	2	PA; QL (2 vials per 1 day)
*OPHTHALMIC LOCAL ANESTHETICS*** - DRUGS FOR THE EYE		
<i>proparacaine hcl ophthalmic solution</i>	1 or 1b*	
<i>tetracaine hcl ophthalmic solution</i>	1 or 1b*	
*OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bromfenac sodium (once-daily) ophthalmic solution</i>	2	QL (1.7 mL per 30 days)
<i>bromfenac sodium ophthalmic solution 0.07 %</i>	2	QL (3 mL per 30 days)
<i>bromfenac sodium ophthalmic solution 0.075 %</i>	2	QL (5 mL per 30 days)
<i>diclofenac sodium ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>flurbiprofen sodium ophthalmic solution</i>	1 or 1b*	QL (2.5 mL per 30 days)
ILEVRO OPHTHALMIC SUSPENSION (<i>nepafenac</i>)	2	QL (3 mL per 30 days)
<i>ketorolac tromethamine ophthalmic solution 0.4 %</i>	1 or 1b*	QL (5 mL per 30 days)
<i>ketorolac tromethamine ophthalmic solution 0.5 %</i>	1 or 1b*	QL (10 mL per 30 days)
*OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR GLAUCOMA		
<i>apraclonidine hcl ophthalmic solution</i>	1 or 1b*	
<i>brimonidine tartrate ophthalmic solution 0.1 %</i>	2	QL (30 mL per 30 days)
<i>brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %</i>	1 or 1b*	QL (30 mL per 30 days)
*OPHTHALMIC STEROID COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment</i>	1 or 1b*	QL (7 mL per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic ointment</i>	1 or 1a*	QL (7 mL per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	1 or 1a*	QL (20 mL per 30 days)
<i>neomycin-polymyxin-hc ophthalmic suspension</i>	1 or 1b*	
<i>neo-polycin hc ophthalmic ointment</i>	1 or 1b*	QL (7 mL per 30 days)
<i>sulfacetamide-prednisolone ophthalmic solution</i>	1 or 1a*	QL (15 mL per 30 days)
TOBRADEX OPHTHALMIC OINTMENT (<i>tobramycin-dexamethasone</i>)	2	
<i>tobramycin-dexamethasone ophthalmic suspension</i>	1 or 1b*	QL (10 mL per 30 days)
ZYLET OPHTHALMIC SUSPENSION (<i>loteprednol-tobramycin</i>)	2	QL (20 mL per 30 days)
*OPHTHALMIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>dexamethasone sodium phosphate ophthalmic solution</i>	1 or 1b*	
<i>difluprednate ophthalmic emulsion</i>	1 or 1b*	QL (10 mL per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluorometholone ophthalmic suspension	1 or 1b*	
LOTEMAX OPHTHALMIC OINTMENT (loteprednol etabonate)	3	QL (7 grams per 30 days)
loteprednol etabonate ophthalmic gel	1 or 1b*	QL (10 grams per 30 days)
loteprednol etabonate ophthalmic suspension 0.5 %	1 or 1b*	QL (30 mL per 30 days)
prednisolone acetate ophthalmic suspension	1 or 1b*	QL (20 mL per 30 days)
*OPHTHALMIC SULFONAMIDES*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
sulfacetamide sodium ophthalmic ointment	1 or 1b*	QL (3.5 grams per 30 days)
sulfacetamide sodium ophthalmic solution	1 or 1b*	QL (15 mL per 30 days)
*OPHTHALMICS - CYSTINOSIS AGENTS** - DRUGS FOR THE EYE		
CYSTARAN OPHTHALMIC SOLUTION (cysteamine hcl)	4	PA; LD; QL (60 mL per 28 days)
*PROSTAGLANDINS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA		
bimatoprost ophthalmic solution	2	
latanoprost ophthalmic solution	1 or 1b*	QL (5 mL per 30 days)
LUMIGAN OPHTHALMIC SOLUTION (bimatoprost)	2	QL (7.5 mL per 30 days)
tafluprost (pf) ophthalmic solution	2	QL (9 mL per 30 days)
travoprost (bak free) ophthalmic solution	1 or 1b*	QL (10 mL per 30 days)
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS*** - DRUGS FOR THE EYE		
BYOOVIZ INTRAVITREAL SOLUTION (ranibizumab-nuna)	4	PA; LD; SP
CIMERLI INTRAVITREAL SOLUTION (ranibizumab-eqrn)	4	PA; LD; SP
EYLEA HD INTRAVITREAL SOLUTION (aflibercept)	4	PA; LD; SP
EYLEA INTRAVITREAL SOLUTION (aflibercept)	4	PA; LD; SP
EYLEA INTRAVITREAL SOLUTION PREFILLED SYRINGE (aflibercept)	4	PA; LD; SP
LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE (ranibizumab)	4	PA; LD; SP
OTIC AGENTS - DRUGS FOR THE EAR		
*OTIC AGENTS - MISCELLANEOUS*** - WAX REMOVAL		
acetic acid otic solution	1 or 1b*	
*OTIC ANTI-INFECTIVES*** - ANTIBIOTICS		
ciprofloxacin hcl otic solution	1 or 1b*	QL (28 containers per 1 fill)
ofloxacin otic solution	1 or 1b*	QL (10 mL per 1 fill)
*OTIC STEROID-ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
ciprofloxacin-dexamethasone otic suspension	1 or 1b*	QL (7.5 mL per 1 fill)
ciprofloxacin-fluocinolone pf otic solution	1 or 1b*	QL (28 vials per 1 fill)
neomycin-polymyxin-hc otic solution	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
neomycin-polymyxin-hc otic suspension	1 or 1b*	QL (15 mL per 30 days)
*OTIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
flac otic oil	1 or 1b*	
fluocinolone acetonide otic oil	1 or 1b*	
hydrocortisone-acetic acid otic solution	1 or 1b*	QL (10 mL per 1 fill)
OXYTOCICS - HORMONES		
*ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS*** - DRUGS FOR WOMEN		
carboprost tromethamine intramuscular solution	1 or 1b*	
*OXYTOCICS*** - DRUGS FOR WOMEN		
methergine oral tablet	1 or 1b*	
methylergonovine maleate injection solution	1 or 1b*	
methylergonovine maleate oral tablet	1 or 1b*	
oxytocin injection solution	1 or 1b*	
PASSIVE IMMUNIZING AND TREATMENT AGENTS - BIOLOGICAL AGENTS		
*ANTITOXINS-ANTIVENINS*** - BIOLOGICAL AGENTS		
ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED (centruroides (scorpion) im fab)	2	
ANTIVENIN LATRODECTUS MACTANS INJECTION KIT	2	
ANTIVENIN MICRURUS FULVIUS INTRAVENOUS SOLUTION RECONSTITUTED	2	
CROFAB INTRAVENOUS SOLUTION RECONSTITUTED (crotalidae polyval immune fab)	2	
*IMMUNE SERUMS*** - BIOLOGICAL AGENTS		
CUTAQUIG SUBCUTANEOUS SOLUTION (immune globulin (human)-hipp)	4	PA; LD; SP
GAMUNEX-C INJECTION SOLUTION (immune globulin (human))	4	PA; LD; SP
HIZENTRA SUBCUTANEOUS SOLUTION (immune globulin (human))	4	PA; LD; SP
HIZENTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (immune globulin (human))	4	PA; LD; SP
OCTAGAM INTRAVENOUS SOLUTION (immune globulin (human))	4	PA; LD; SP
XEMBIFY SUBCUTANEOUS SOLUTION (immune globulin (human)-klhw)	4	PA; LD; SP
PENICILLINS - DRUGS FOR INFECTIONS		
*AMINOPENICILLINS*** - ANTIBIOTICS		
amoxicillin oral capsule	1 or 1a*	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml	1 or 1a*	
amoxicillin oral tablet	1 or 1a*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amoxicillin oral tablet chewable</i>	1 or 1a*	
<i>ampicillin oral capsule</i>	1 or 1a*	
<i>ampicillin sodium injection solution reconstituted</i>	2	
<i>ampicillin sodium intravenous solution reconstituted</i>	2	
*NATURAL PENICILLINS*** - ANTIBIOTICS		
<i>penicillin g potassium injection solution reconstituted</i>	2	
<i>penicillin g sodium injection solution reconstituted</i>	2	
<i>penicillin v potassium oral solution reconstituted</i>	1 or 1b*	
<i>penicillin v potassium oral tablet</i>	1 or 1b*	
<i>pfizerpen injection solution reconstituted</i>	2	
*PENICILLIN COMBINATIONS*** - ANTIBIOTICS		
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral suspension reconstituted</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral tablet</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral tablet chewable</i>	1 or 1b*	
<i>ampicillin-sulbactam sodium injection solution reconstituted</i>	2	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted</i>	2	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED (<i>amoxicillin-pot clavulanate</i>)	2	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted</i>	2	
*PENICILLINASE-RESISTANT PENICILLINS*** - ANTIBIOTICS		
<i>dicloxacillin sodium oral capsule</i>	1 or 1b*	
<i>nafcillin sodium injection solution reconstituted</i>	2	
<i>nafcillin sodium intravenous solution reconstituted</i>	2	
<i>oxacillin sodium injection solution reconstituted</i>	2	
<i>oxacillin sodium intravenous solution reconstituted</i>	2	
PROGESTINS - HORMONES		
*PROGESTINS*** - DRUGS FOR WOMEN		
<i>norethindrone acetate</i> (Gallifrey Oral Tablet)	1 or 1b*	
<i>medroxyprogesterone acetate oral tablet</i>	1 or 1a*	QL (1 tablet per 1 day)
<i>megestrol acetate oral suspension 625 mg/5ml</i>	1 or 1b*	
<i>norethindrone acetate oral tablet</i>	1 or 1b*	
<i>progesterone intramuscular oil</i>	1 or 1b*	
<i>progesterone oral capsule 100 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>progesterone oral capsule 200 mg</i>	1 or 1b*	QL (2 capsule per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS FOR THE NERVOUS SYSTEM		
*AGENTS FOR OPIOID WITHDRAWAL*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>lofexidine hcl oral tablet</i>	2	QL (16 tablets per 1 day)
*ALCOHOL DETERRENTS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>acamprosate calcium oral tablet delayed release</i>	2	QL (6 tablet per 1 day)
<i>disulfiram oral tablet</i>	1 or 1b*	
*BENZODIAZEPINES & TRICYCLIC AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>chlordiazepoxide-amitriptyline oral tablet</i>	1 or 1b*	
*CHOLINOMIMETICS - ACHE INHIBITORS*** - DRUGS FOR ALZHEIMER'S DISEASE		
<i>donepezil hcl oral tablet 10 mg, 23 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>donepezil hcl oral tablet 5 mg</i>	1 or 1b*	DO
<i>donepezil hcl oral tablet dispersible</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg</i>	2	QL (1 capsule per 1 day)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 8 mg</i>	2	DO
<i>galantamine hydrobromide oral solution</i>	2	QL (6 mL per 1 day)
<i>galantamine hydrobromide oral tablet 12 mg, 8 mg</i>	2	QL (2 tablets per 1 day)
<i>galantamine hydrobromide oral tablet 4 mg</i>	2	DO
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg</i>	2	DO
<i>rivastigmine tartrate oral capsule 4.5 mg, 6 mg</i>	2	QL (2 capsules per 1 day)
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 9.5 mg/24hr</i>	2	QL (1 patch per 1 day)
<i>rivastigmine transdermal patch 24 hour 4.6 mg/24hr</i>	2	QL (1 gram per 1 day)
*MOVEMENT DISORDER DRUG THERAPY*** - DRUGS FOR THE NERVOUS SYSTEM		
AUSTEDO ORAL TABLET (<i>deutetrabenazine</i>)	4	PA; LD; QL (4 tablets per 1 day); SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 24 MG, 6 MG (<i>deutetrabenazine</i>)	4	PA; LD; QL (2 tablets per 1 day); SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG (<i>deutetrabenazine</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>deutetrabenazine</i>)	4	PA; LD; QL (2 kits per 1 year); SP
INGREZZA ORAL CAPSULE 40 MG (<i>valbenazine tosylate</i>)	4	PA; LD; DO; SP
INGREZZA ORAL CAPSULE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	4	PA; LD; QL (1 capsule per 1 day); SP
INGREZZA ORAL CAPSULE SPRINKLE 40 MG (<i>valbenazine tosylate</i>)	4	PA; LD; DO; SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	4	PA; LD; QL (1 capsule per 1 day); SP
INGREZZA ORAL CAPSULE THERAPY PACK (<i>valbenazine tosylate</i>)	4	PA; LD; QL (1 pack per 1 one-time fill); SP
tetrabenazine oral tablet 12.5 mg	4	PA; LD; QL (8 tablets per 1 day); SP
tetrabenazine oral tablet 25 mg	4	PA; LD; QL (4 tablets per 1 day); SP
*MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
teriflunomide oral tablet	4	PA; LD; QL (1 tablet per 1 day); SP
*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES*** - DRUGS FOR MULTIPLE SCLEROSIS		
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
*MULTIPLE SCLEROSIS AGENTS - INTERFERONS*** - DRUGS FOR MULTIPLE SCLEROSIS		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (<i>interferon beta-1a</i>)	4	PA; LD; QL (4 kits per 28 days); SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (<i>interferon beta-1a</i>)	4	PA; LD; QL (4 kits per 28 days); SP
BETASERON SUBCUTANEOUS KIT (<i>interferon beta-1b</i>)	4	PA; LD; QL (15 kits per 30 days); SP
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (1 ML per 28 days); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (peginterferon beta-1a)	4	PA; LD; QL (1 ML per 28 days); SP
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (interferon beta-1a)	4	PA; LD; QL (12 ML per 28 days); SP
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (interferon beta-1a)	4	PA; LD; QL (4.2 ML per 28 days); SP
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (interferon beta-1a)	4	PA; LD; QL (12 syringes per 28 days); SP
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (interferon beta-1a)	4	PA; LD; QL (1 pack per 1 fill); SP
*MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
dimethyl fumarate oral capsule delayed release 120 mg	1 or 1b*	PA; LD; QL (14 capsules per 365 days); SP
dimethyl fumarate oral capsule delayed release 240 mg	1 or 1b*	PA; LD; QL (2 capsules per 1 day); SP
dimethyl fumarate starter pack oral capsule delayed release therapy pack	1 or 1b*	PA; LD; QL (1 kit per 365 days); SP
VUMERITY ORAL CAPSULE DELAYED RELEASE (diroximel fumarate)	4	PA; LD; QL (4 capsules per 1 day); SP
*MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS*** - DRUGS FOR MULTIPLE SCLEROSIS		
dalfampridine er oral tablet extended release 12 hour	1 or 1b*	PA; LD; QL (2 tablets per 1 day); SP
*MULTIPLE SCLEROSIS AGENTS*** - DRUGS FOR MULTIPLE SCLEROSIS		
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (glatiramer acetate)	4	PA; LD; QL (12 syringe per 28 days); SP
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	4	PA; LD; QL (1 syringe per 1 day); SP
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	4	PA; LD; QL (12 syringe per 28 days); SP
glatopa subcutaneous solution prefilled syringe 20 mg/ml	4	PA; LD; QL (1 syringe per 1 day); SP
glatopa subcutaneous solution prefilled syringe 40 mg/ml	4	PA; LD; QL (12 syringe per 28 days); SP
*N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS*** - DRUGS FOR ALZHEIMER'S DISEASE		
memantine hcl er oral capsule extended release 24 hour 14 mg, 7 mg	2	DO
memantine hcl er oral capsule extended release 24 hour 21 mg, 28 mg	2	QL (1 capsule per 1 day)
memantine hcl oral solution	2	QL (10 mL per 1 day)
memantine hcl oral tablet 10 mg	2	QL (2 tablets per 1 day)
memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg	2	QL (1 tablet per 6 months)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>memantine hcl oral tablet 5 mg</i>	2	DO
*PHENOTHIAZINES & TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION		
<i>perphenazine-amitriptyline oral tablet</i>	1 or 1b*	AL
*POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>gabapentin (once-daily) oral tablet</i>	2	PA; DO
<i>pregabalin er oral tablet extended release 24 hour 165 mg, 82.5 mg</i>	2	PA; DO
<i>pregabalin er oral tablet extended release 24 hour 330 mg</i>	2	PA; QL (2 tablets per 1 day)
*PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS - SSRIS*** - DRUGS FOR DEPRESSION		
<i>fluoxetine hcl (pmdd) oral tablet 10 mg</i>	1 or 1b*	DO
<i>fluoxetine hcl (pmdd) oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>ergoloid mesylates oral tablet</i>	2	QL (3 tablets per 1 day)
<i>pimozide oral tablet 1 mg</i>	1 or 1b*	AL; QL (10 tablets per 1 day)
<i>pimozide oral tablet 2 mg</i>	1 or 1b*	AL; QL (5 tablets per 1 day)
*SMOKING DETERRENTS*** - DRUGS FOR DEPRESSION		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour</i>	1 or 1b*; \$0	QL (2 tablets per 1 day)
<i>cvs nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>cvs nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>cvs nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>cvs nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>cvs nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>eq nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>eq nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>eq nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>eq nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>eq nicotine step 3 transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>eq nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>ft nicotine mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ft nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>ft nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ft nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>gnp nicotine mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>gnp nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>gnp nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>gnp nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>goodsense nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>goodsense nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>habitrol transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>hm nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>hm nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>kls quit2 mouth/throat gum</i>	1 or 1b*; \$0	
<i>kls quit2 mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>kls quit4 mouth/throat gum</i>	1 or 1b*; \$0	
<i>kls quit4 mouth/throat lozenge</i>	1 or 1b*; \$0	
NICODERM CQ TRANSDERMAL PATCH 24 HOUR (nicotine)	2; \$0	
NICORETTE MINI MOUTH/THROAT LOZENGE (nicotine polacrilex)	2; \$0	
NICORETTE MOUTH/THROAT GUM (nicotine polacrilex)	2; \$0	
NICORETTE MOUTH/THROAT LOZENGE (nicotine polacrilex)	2; \$0	
NICORETTE STARTER KIT MOUTH/THROAT GUM (nicotine polacrilex)	2; \$0	
<i>nicotine mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>nicotine polacrilex mini mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>nicotine step 1 transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>nicotine step 2 transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>nicotine step 3 transdermal patch 24 hour</i>	1 or 1b*; \$0	
NICOTINE TRANSDERMAL KIT	2; \$0	
<i>nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
NICOTROL INHALATION INHALER (nicotine)	2; \$0	QL (16 cartridges per 1 day)
NICOTROL NS NASAL SOLUTION (nicotine)	2; \$0	QL (4 mL per 1 day)
<i>qc nicotine transdermal system transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>ra mini nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ra nicotine gum mouth/throat gum</i>	1 or 1b*; \$0	
<i>ra nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>ra nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>ra nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>sm nicotine mouth/throat gum</i>	1 or 1b*; \$0	
<i>sm nicotine mouth/throat lozenge</i>	1 or 1b*; \$0	
<i>sm nicotine polacrilex mouth/throat gum</i>	1 or 1b*; \$0	
<i>sm nicotine polacrilex mouth/throat lozenge</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm nicotine transdermal patch 24 hour</i>	1 or 1b*; \$0	
<i>thrive mouth/throat gum</i>	1 or 1b*; \$0	
<i>varenicline tartrate (starter) oral tablet therapy pack</i>	2; \$0	QL (53 dose pack per 365 days)
<i>varenicline tartrate oral tablet 0.5 mg</i>	2; \$0	QL (2 tablets per 1 day)
<i>varenicline tartrate oral tablet 1 mg</i>	2; \$0	QL (2 tablet per 1 day)
<i>varenicline tartrate(continue) oral tablet</i>	2; \$0	QL (2 tablet per 1 day)
*SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>fingolimod hcl oral capsule</i>	4	PA; LD; QL (1 capsule per 1 day); SP
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (4 tablets per 1 day); SP
MAYZENT ORAL TABLET 1 MG, 2 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (1 pack per 1 one time fill); SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (1 pack per 1 fill); SP
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK (<i>ozanimod hcl</i>)	4	PA; LD; QL (1 pack per 1 fill); SP
ZEPOSIA ORAL CAPSULE (<i>ozanimod hcl</i>)	4	PA; LD; QL (1 capsule per 1 day); SP
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK (<i>ozanimod hcl</i>)	4	PA; LD; QL (1 pack per 1 fill); SP
*THIENBENZODIAZEPINES & SSRIS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg</i>	1 or 1b*	AL; QL (1 capsule per 1 day)
<i>olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg</i>	1 or 1b*	DO; AL
*VASOMOTOR SYMPTOM AGENTS - SSRIS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>paroxetine mesylate oral capsule</i>	1 or 1b*	
RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS		
*CYSTIC FIBROSIS AGENT - COMBINATIONS*** - DRUGS FOR CYSTIC FIBROSIS		
TRIKAFTA ORAL TABLET THERAPY PACK (<i>elexacaftor-tezacaftor-ivacaft</i>)	5	PA; LD; QL (1 carton per 28 days)
TRIKAFTA ORAL THERAPY PACK (<i>elexacaftor-tezacaftor-ivacaft</i>)	5	PA; LD; QL (1 carton per 28 days)
*HYDROLYTIC ENZYMES*** - DRUGS FOR THE LUNGS		
PULMOZYME INHALATION SOLUTION (<i>dornase alfa</i>)	5	PA; LD; QL (150 mL per 30 days); SP

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS*** - DRUGS FOR THE LUNGS		
OFEV ORAL CAPSULE (<i>nintedanib esylate</i>)	5	PA; LD; QL (2 capsules per 1 day); SP
*PULMONARY FIBROSIS AGENTS*** - DRUGS FOR THE LUNGS		
<i>pirfenidone oral capsule</i>	4	PA; LD; QL (9 capsule per 1 day); SP
<i>pirfenidone oral tablet 267 mg</i>	4	PA; LD; QL (9 tablets per 1 day); SP
<i>pirfenidone oral tablet 534 mg</i>	4	PA; LD; QL (3 tablets per 1 day)
<i>pirfenidone oral tablet 801 mg</i>	4	PA; LD; QL (3 tablets per 1 day); SP
SULFONAMIDES - DRUGS FOR INFECTIONS		
*SULFONAMIDES*** - ANTIBIOTICS		
<i>sulfadiazine oral tablet</i>	2	
TETRACYCLINES - DRUGS FOR INFECTIONS		
*TETRACYCLINES*** - ANTIBIOTICS		
<i>demeclocycline hcl oral tablet</i>	2	
<i>doxy 100 intravenous solution reconstituted</i>	2	QL (2 vials per 1 day)
<i>doxycycline hyclate intravenous solution reconstituted</i>	2	QL (2 vials per 1 day)
<i>doxycycline hyclate oral capsule 100 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxycycline hyclate oral capsule 50 mg</i>	1 or 1b*	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg, 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxycycline monohydrate oral capsule 150 mg</i>	3	ST; QL (1 capsule per 1 day)
<i>doxycycline monohydrate oral suspension reconstituted</i>	1 or 1b*	QL (600 mL per 30 days)
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral tablet 150 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>minocycline hcl oral capsule 100 mg, 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>minocycline hcl oral capsule 50 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>minocycline hcl oral tablet 100 mg, 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>minocycline hcl oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>mondoxylene nl oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>tetracycline hcl oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
THYROID AGENTS - HORMONES		
*ANTITHYROID AGENTS*** - DRUGS FOR THYROID		
<i>methimazole oral tablet</i>	1 or 1a*	
<i>propylthiouracil oral tablet</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*THYROID HORMONES*** - DRUGS FOR THYROID		
<i>euthyrox oral tablet</i>	1 or 1b*	
<i>levo-t oral tablet</i>	1 or 1b*	
<i>levothyroxine sodium oral capsule</i>	2	
<i>levothyroxine sodium oral tablet</i>	1 or 1a*	
<i>levoxyl oral tablet</i>	1 or 1a*	
<i>liothyronine sodium intravenous solution</i>	1 or 1b*	
<i>liothyronine sodium oral tablet</i>	1 or 1b*	
<i>np thyroid oral tablet</i>	1 or 1a*	
<i>unithroid oral tablet</i>	1 or 1a*	
TOXOIDS - BIOLOGICAL AGENTS		
*TOXOID COMBINATIONS*** - VACCINES		
ADACEL INTRAMUSCULAR SUSPENSION (<i>tetanus-diphth-acell pertussis</i>)	2; \$0	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>tetanus-diphth-acell pertussis</i>)	2; \$0	
DAPTACEL INTRAMUSCULAR SUSPENSION (<i>diphth-acell pertussis-tetanus</i>)	2; \$0	
INFANRIX INTRAMUSCULAR SUSPENSION (<i>diphth-acell pertussis-tetanus</i>)	2; \$0	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv vaccine</i>)	2; \$0	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	2; \$0	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	2; \$0	
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	2; \$0	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv vaccine</i>)	2; \$0	
TDVAX INTRAMUSCULAR SUSPENSION (<i>tetanus-diphtheria toxoids td</i>)	2; \$0	
TENIVAC INTRAMUSCULAR INJECTABLE (<i>tetanus-diphtheria toxoids td</i>)	2; \$0	
TETANUS-DIPHThERIA TOXOIDS TD INTRAMUSCULAR SUSPENSION	2; \$0	
VAXELIS INTRAMUSCULAR SUSPENSION (<i>dtap-ipv-hib-hepatitis b recomb</i>)	2	
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recomb</i>)	2	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR THE STOMACH		
*ANTICHOLINERGIC COMBINATIONS*** - DRUGS FOR STOMACH CRAMPS		
<i>chlordiazepoxide-clidinium oral capsule</i>	1 or 1b*	
*ANTISPASMODICS*** - DRUGS FOR STOMACH CRAMPS		
<i>dicyclomine hcl intramuscular solution</i>	2	
<i>dicyclomine hcl oral capsule</i>	1 or 1a*	
<i>dicyclomine hcl oral solution</i>	1 or 1a*	
<i>dicyclomine hcl oral tablet</i>	1 or 1a*	
*H-2 ANTAGONISTS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>cimetidine hcl oral solution</i>	1 or 1b*	QL (90 mL per 1 day)
<i>cimetidine oral tablet 300 mg, 400 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>cimetidine oral tablet 800 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>famotidine (pf) intravenous solution</i>	1 or 1b*	
<i>famotidine intravenous solution</i>	1 or 1b*	
<i>famotidine oral suspension reconstituted</i>	1 or 1b*	QL (5 mL per 1 day)
<i>famotidine oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>famotidine premixed intravenous solution</i>	1 or 1b*	
<i>nizatidine oral capsule 150 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>nizatidine oral capsule 300 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
*MISC. ANTI-ULCER*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>sucralfate oral suspension</i>	2	
<i>sucralfate oral tablet</i>	1 or 1b*	
*PROTON PUMP INHIBITORS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>esomeprazole magnesium oral capsule delayed release</i>	1 or 1b*	
<i>esomeprazole magnesium oral packet</i>	1 or 1b*	
<i>lansoprazole oral capsule delayed release 15 mg</i>	1 or 1b*	ST; BE; QL (1 capsule per 1 day)
<i>lansoprazole oral capsule delayed release 30 mg</i>	1 or 1b*	
<i>omeprazole oral capsule delayed release</i>	1 or 1b*	
<i>pantoprazole sodium oral tablet delayed release</i>	1 or 1b*	
*QUATERNARY ANTICHOLINERGICS*** - DRUGS FOR STOMACH CRAMPS		
<i>glycopyrrolate injection solution</i>	1 or 1b*	
<i>glycopyrrolate oral solution</i>	2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLYCOPYRROLATE PF INJECTION SOLUTION PREFILLED SYRINGE 0.2 MG/ML, 0.4 MG/2ML	1 or 1b*	
<i>methscopolamine bromide oral tablet</i>	1 or 1b*	
*ULCER ANTI-INFECTIVE W/ BISMUTH COMBINATIONS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>bis subcit-metronid-tetracyc oral capsule</i>	2	ST; QL (1 pack per 1 fill)
<i>bismuth/metronidaz/tetracyclin oral capsule</i>	2	ST; QL (1 pack per 1 fill)
*ULCER DRUGS - PROSTAGLANDINS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>misoprostol oral tablet</i>	1 or 1a*	\$0 for Fully insured members in California
URINARY ANTISPASMODICS - DRUGS FOR THE URINARY SYSTEM		
*URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)*** - DRUGS FOR THE BLADDER		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
<i>fesoterodine fumarate er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>oxybutynin chloride er oral tablet extended release 24 hour 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>oxybutynin chloride oral solution</i>	1 or 1b*	QL (20 mL per 1 day)
<i>oxybutynin chloride oral tablet 2.5 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>oxybutynin chloride oral tablet 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>solifenacin succinate oral tablet</i>	2	QL (1 tablet per 1 day)
<i>tolterodine tartrate er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>tolterodine tartrate oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>tropium chloride er oral capsule extended release 24 hour</i>	2	QL (1 capsule per 1 day)
<i>tropium chloride oral tablet</i>	2	QL (2 tablets per 1 day)
*URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS*** - DRUGS FOR THE BLADDER		
<i>mirabegron er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER (mirabegron)	3	ST; QL (3 bottles per 30 days)
*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS*** - DRUGS FOR THE BLADDER		
<i>bethanechol chloride oral tablet</i>	2	
*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS*** - DRUGS FOR THE BLADDER		
<i>flavoxate hcl oral tablet</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINES - BIOLOGICAL AGENTS		
*BACTERIAL VACCINES*** - VACCINES		
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	2; \$0	
BCG VACCINE INJECTION SOLUTION RECONSTITUTED	2; \$0	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>meningococcal b recomb omv adj</i>)	2; \$0	
BIOTHRAX INTRAMUSCULAR SUSPENSION (<i>anthrax vaccine adsorbed</i>)	2	
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>pneumococcal 21-valent conjuga</i>)	2; \$0	
HIBERIX INJECTION SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	2; \$0	
MENQUADFI INTRAMUSCULAR SOLUTION (<i>mening acy&w-135 tetanus conj</i>)	2; \$0	
MENVEO INTRAMUSCULAR SOLUTION (<i>meningococcal a c y&w-135 olig</i>)	2; \$0	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>meningococcal a c y&w-135 olig</i>)	2; \$0	
PEDVAX HIB INTRAMUSCULAR SUSPENSION (<i>haemophilus b polysac conj vac</i>)	2; \$0	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>mening acyw(tet conj)-b(rcmb)</i>)	2; \$0	
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE (<i>pneumococcal vac polyvalent</i>)	2; \$0	
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>pneumococcal 20-val conj vacc</i>)	2; \$0	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>meningococcal b vac (recomb)</i>)	2; \$0	
TYPHIM VI INTRAMUSCULAR SOLUTION (<i>typhoid vi polysaccharide vacc</i>)	2	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>typhoid vi polysaccharide vacc</i>)	2	
VAXCHORA ORAL SUSPENSION RECONSTITUTED (<i>cholera vac live attenuated</i>)	2	
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>pneumococcal 15-val conj vacc</i>)	2; \$0	
VIVOTIF ORAL CAPSULE DELAYED RELEASE (<i>typhoid vaccine</i>)	2	
*VIRAL VACCINE COMBINATIONS*** - VACCINES		
M-M-R II INJECTION SOLUTION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	2; \$0	
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	2; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (measles-mumps-rubella-varicell)	2; \$0	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (hepatitis a-hep b recomb vac)	2; \$0	
*VIRAL VACCINES*** - VACCINES		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED (rsv pre-fusion f a&b vac rcmb)	2; \$0	QL (1 injection per 1 lifetime)
ACAM2000 INJECTION SOLUTION RECONSTITUTED (smallpox vaccine)	2; \$0	
AFLURIA INTRAMUSCULAR SUSPENSION (influenza virus vaccine split)	2; \$0	QL (1 mL per 1 one-time fill)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (influenza virus vacc split pf)	2; \$0	QL (1 mL per 1 one-time fill)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED (rsvpref3 vac recomb adjuvanted)	2; \$0	PA; AL; QL (1 injection per 1 lifetime)
AUDENZ INTRAMUSCULAR EMULSION (influenza a (h5n1) subunit adj)	2; \$0	
AUDENZ INTRAMUSCULAR PREFILLED SYRINGE (influenza a (h5n1) subunit adj)	2; \$0	
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (covid-19 mrna virus vaccine)	2; \$0	
DENG VAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (dengue virus vaccine live tetr)	2	
ENGRIX-B INJECTION SUSPENSION (hepatitis b vac recombinant)	2; \$0	
ENGRIX-B INJECTION SUSPENSION PREFILLED SYRINGE (hepatitis b vac recombinant)	2; \$0	
ERVEBO INTRAMUSCULAR SUSPENSION (ebola zaire virus vaccine live)	2	
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (influenza vac a&b surf ant adj)	2; \$0	QL (1 mL per 1 one-time fill)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (influenza virus vacc split pf)	2; \$0	QL (1 mL per 1 one-time fill)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (influenza vac recombinant ha)	2; \$0	QL (1 fill per 180 days)
FLUCELVAX INTRAMUSCULAR SUSPENSION (influenza vac tiss-cult subunt)	2; \$0	QL (1 fill per 180 days)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (influenza vac tiss-cult subunt)	2; \$0	QL (1 fill per 180 days)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (influenza virus vacc split pf)	2; \$0	QL (1 mL per 1 one-time fill)
FLUMIST NASAL LIQUID (influenza virus vaccine live)	2; \$0	QL (1 fill per 180 days)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (influenza vac split high-dose)	2; \$0	QL (1 mL per 1 one-time fill)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUZONE INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
GARDASIL 9 INTRAMUSCULAR SUSPENSION (<i>hpv 9-valent recomb vaccine</i>)	2; \$0	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>hpv 9-valent recomb vaccine</i>)	2; \$0	
HAVRIX INTRAMUSCULAR SUSPENSION (<i>hepatitis a vaccine</i>)	2; \$0	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>hepatitis b vac recomb adj</i>)	2; \$0	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rabies virus vaccine, hdc</i>)	2	
IPOLE INJECTION INJECTABLE (<i>poliovirus vaccine inactivated</i>)	2; \$0	
IXCHIQ INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chikungunya virus vaccine live</i>)	2	
IXIARO INTRAMUSCULAR SUSPENSION (<i>japanese encephalitis vac inac</i>)	2	
JYNNEOS SUBCUTANEOUS SUSPENSION (<i>smallpox & monkeypox vac, live</i>)	2; \$0	
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>rsv mrna pre-f virus vaccine</i>)	2; \$0	AL; QL (1 syringe per 1 lifetime)
<i>novavax covid-19 vaccine intramuscular suspension prefilled syringe</i>	2; \$0	
PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
<i>pfizer covid-19 vac-tris 6m-4y intramuscular suspension</i>	2; \$0	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rabies vaccine, pcec</i>)	2	
RECOMBIVAX HB INJECTION SUSPENSION (<i>hepatitis b vac recombinant</i>)	2; \$0	
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE (<i>hepatitis b vac recombinant</i>)	2; \$0	
ROTARIX ORAL SUSPENSION (<i>rotavirus vaccine live oral</i>)	2; \$0	
ROTATEQ ORAL SOLUTION (<i>rotavirus vac live pentavalent</i>)	2; \$0	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>zoster vac recomb adjuvanted</i>)	2; \$0	
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
STAMARIL INJECTION SUSPENSION RECONSTITUTED	2	
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>tick-borne encephalitis vacc</i>)	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAQTA INTRAMUSCULAR SUSPENSION (<i>hepatitis a vaccine</i>)	2; \$0	
VARIVAX INJECTION SUSPENSION RECONSTITUTED (<i>varicella virus vaccine live</i>)	2; \$0	
YF-VAX SUBCUTANEOUS INJECTABLE (<i>yellow fever vaccine</i>)	2	
VAGINAL AND RELATED PRODUCTS - DRUGS FOR WOMEN		
*IMIDAZOLE-RELATED ANTIFUNGALS*** - DRUGS FOR INFECTIONS		
<i>miconazole 3 vaginal suppository</i>	1 or 1b*	
<i>terconazole vaginal cream 0.4 %</i>	1 or 1b*	QL (90 grams per 30 days)
<i>terconazole vaginal cream 0.8 %</i>	1 or 1b*	QL (40 grams per 30 days)
<i>terconazole vaginal suppository</i>	1 or 1b*	QL (6 suppositories per 30 days)
*SPERMICIDES*** - BIRTH CONTROL PILLS		
ENCARE VAGINAL SUPPOSITORY (<i>nonoxynol-9</i>)	2; \$0	
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL (<i>nonoxynol-9</i>)	2; \$0	
TODAY SPONGE VAGINAL (<i>nonoxynol-9</i>)	2; \$0	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM (<i>nonoxynol-9</i>)	2; \$0	
*VAGINAL ANTI-INFECTIVES*** - DRUGS FOR INFECTIONS		
CLEOCIN VAGINAL SUPPOSITORY (<i>clindamycin phosphate</i>)	2	
<i>clindamycin phosphate vaginal cream</i>	1 or 1b*	
<i>metronidazole vaginal gel</i>	1 or 1b*	
VANDAZOLE VAGINAL GEL (<i>metronidazole</i>)	1 or 1b*	
*VAGINAL ESTROGENS*** - DRUGS FOR WOMEN		
<i>estradiol vaginal cream</i>	1 or 1b*	QL (42.5 grams per 30 days)
<i>estradiol vaginal tablet</i>	1 or 1b*	QL (18 tablet per 28 days)
PREMARIN VAGINAL CREAM (<i>estrogens, conjugated</i>)	2	QL (1 gm per 1 day)
<i>yuvafem vaginal tablet</i>	1 or 1b*	QL (18 tablet per 28 days)
*VAGINAL PROGESTINS*** - DRUGS FOR WOMEN		
ENDOMETRIN VAGINAL INSERT (<i>progesterone</i>)	2	PA
VASOPRESSORS - DRUGS FOR THE HEART		
*ANAPHYLAXIS THERAPY AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>epinephrine (anaphylaxis) injection solution</i>	1 or 1b*	
<i>epinephrine injection solution auto-injector</i>	1 or 1b*	QL (2 pens per 1 fill)
*NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>droxidopa oral capsule 100 mg</i>	4	PA; LD; QL (3 capsules per 1 day); SP
<i>droxidopa oral capsule 200 mg, 300 mg</i>	4	PA; LD; QL (6 capsules per 1 day); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*VASOPRESSORS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>midodrine hcl oral tablet</i>	2	
VITAMINS - DRUGS FOR NUTRITION		
*VITAMIN B-1*** - DRUGS FOR NUTRITION		
<i>thiamine hcl injection solution</i>	1 or 1b*	
*VITAMIN D*** - DRUGS FOR NUTRITION		
<i>ergocalciferol oral capsule</i>	1 or 1a*	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i>	1 or 1a*	
*VITAMIN K*** - DRUGS FOR NUTRITION		
<i>phytonadione injection solution</i>	1 or 1b*	
<i>phytonadione oral tablet</i>	2	
<i>vitamin k1 injection solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with a higher cost share than Tier 3 and usually include preferred specialty brand and generic drugs **Tier 5**=Drugs with the highest cost share and are non-preferred specialty brand and generic drugs **\$0**=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 01012025

Index

1ST TIER UNIFINE PENTIPS	101	<i>albuterol sulfate</i>	25	ANTIVENIN LATRODECTUS	
1ST TIER UNIFINE PENTIPS PLUS	101	ALBUTEROL SULFATE	25	MACTANS	124
<i>abacavir sulfate</i>	60	<i>albuterol sulfate hfa</i>	25	ANTIVENIN MICRURUS	
<i>abacavir sulfate-lamivudine</i>	59	<i>alclometasone dipropionate</i>	79	FULVIUS	124
<i>abiraterone acetate</i>	49	ALECENSA	50	<i>apap-caff-dihydrocodeine</i>	19
ABRYSVO	137	<i>alendronate sodium</i>	84	<i>apomorphine hcl</i>	55
ACAM2000	137	<i>alfuzosin hcl er</i>	90	<i>apraclonidine hcl</i>	122
<i>acamprosate calcium</i>	126	<i>aliskiren fumarate</i>	46	<i>aprepitant</i>	40
<i>acarbose</i>	33	<i>allbee/c</i>	115	<i>apri</i>	68
ACCU-CHEK AVIVA PLUS	82	<i>allopurinol</i>	91	APTIVUS	59
ACCU-CHEK FASTCLIX LANCET		<i>allopurinol sodium</i>	91	<i>aq insulin syringe</i>	101
.....	100	<i>almotriptan malate</i>	109	<i>aqinject pen needle</i>	101
ACCU-CHEK FASTCLIX LANCETS	100	<i>alogliptin benzoate</i>	34	<i>aquastat</i>	111
ACCU-CHEK GUIDE TEST	82	<i>alogliptin-metformin hcl</i>	34	<i>Aquastat Sfr</i>	111
ACCU-CHEK SAFE-T PRO LANCETS	100	<i>alogliptin-pioglitazone</i>	34	<i>aranelle</i>	73
ACCU-CHEK SMARTVIEW	82	<i>alophen</i>	98	ARANESP (ALBUMIN FREE)	93
ACCU-CHEK SOFTCLIX LANCET DEV	100	<i>alosetron hcl</i>	89	AREXVY	137
ACCU-CHEK SOFTCLIX LANCETS	100	<i>alprazolam</i>	23	<i>arformoterol tartrate</i>	25
<i>accutane</i>	76	<i>alprazolam er</i>	23	<i>argyle sterile water</i>	112
ACCUTREND GLUCOSE	82	<i>alprazolam xr</i>	23	<i>aripiprazole</i>	58
<i>acebutolol hcl</i>	63	<i>altafluor benox</i>	121	<i>armodafinil</i>	13
<i>acetaminophen</i>	17	<i>altavera</i>	68	ARNUITY ELLIPTA	26
<i>acetaminophen-codeine</i>	19	ALUNBRIG	50	<i>ascomp-codeine</i>	19
<i>acetazolamide</i>	83	<i>alvimopan</i>	89	<i>asenapine maleate</i>	57
<i>acetazolamide er</i>	83	<i>alyacen 1/35</i>	68	<i>ashlyna</i>	72
<i>acetazolamide sodium</i>	83	<i>alyacen 7/7/7</i>	73	<i>aspirin</i>	17, 18
<i>acetic acid</i>	91, 123	<i>alyq</i>	66	<i>aspirin 81</i>	17
<i>acetylcysteine</i>	38, 75	<i>amantadine hcl</i>	55	<i>aspirin adult low dose</i>	17
<i>acitretin</i>	77	<i>ambrisentan</i>	66	<i>aspirin adult low strength</i>	17
ACTHIB	136	<i>amethyst</i>	71	<i>aspirin childrens</i>	17
ACTIMMUNE	52	<i>amikacin sulfate</i>	14	<i>aspirin ec adult low dose</i>	17
<i>acyclovir</i>	61, 78	<i>amiloride hcl</i>	83	<i>aspirin ec low dose</i>	17
<i>acyclovir sodium</i>	62	<i>amiloride-hydrochlorothiazide</i>	83	<i>aspirin ec low strength</i>	17
ADACEL	133	<i>aminocaproic acid</i>	95	<i>aspirin low dose</i>	17
<i>adalimumab-adbm (2 pen)</i>	14	<i>aminophylline</i>	27	<i>aspirin regimen</i>	18
<i>adalimumab-adbm (2 syringe)</i>	14	<i>aminosyn ii</i>	120	<i>aspirin-dipyridamole er</i>	92
<i>adalimumab-adbm(cd/uc/hs strt)</i>	15	<i>amiodarone hcl</i>	24	ASSURE ID DUO PRO PEN	
<i>adalimumab-adbm(ps/uv starter)</i>	15	<i>amitriptyline hcl</i>	32, 33	NEEDLES	101
<i>adapalene</i>	76	<i>amlodipine besy-benazepril hcl</i>	43	ASSURE ID PRO PEN NEEDLES ...	101
<i>adapalene-benzoyl peroxide</i>	76	<i>amlodipine besylate</i>	63	ASSURE ID SAFETY PEN	
<i>adefovir dipivoxil</i>	61	<i>amlodipine besylate-valsartan</i>	44	NEEDLES	101
<i>adenosine</i>	23	<i>amlodipine-atorvastatin</i>	66	ATABEX EC	116
ADVOCATE INSULIN PEN		<i>amlodipine-olmesartan</i>	44	ATABEX OB	116
NEEDLE	101	<i>amlodipine-valsartan-hctz</i>	45	<i>atazanavir sulfate</i>	59, 60
ADVOCATE INSULIN PEN		<i>amnestem</i>	76	<i>atenolol</i>	63
NEEDLES	101	<i>amoxapine</i>	33	<i>atenolol-chlorthalidone</i>	46
ADVOCATE INSULIN SYRINGE ..	101	<i>amoxicillin</i>	124, 125	<i>atomoxetine hcl</i>	11
<i>afirmelle</i>	68	<i>amoxicillin-pot clavulanate</i>	125	<i>atorvastatin calcium</i>	42
AFLURIA	137	<i>amoxicillin-pot clavulanate er</i>	125	<i>atovaquone</i>	47
AFLURIA PRESERVATIVE FREE	137	<i>amphetamine sulfate</i>	11	<i>atovaquone-proguanil hcl</i>	48
<i>aftera</i>	71	<i>amphetamine-dextroamphet er</i>	11	<i>atracurium besylate</i>	119
<i>afterpill</i>	71	<i>amphetamine-dextroamphetamine</i>	11	ATROVENT HFA	26
AIMOVIG	108	<i>amphet-dextroamphet 3-bead er</i>	11	<i>aubra eq</i>	68
AJOVY	108, 109	<i>amphotericin b</i>	40	AUDENZ	137
<i>ak-fluor</i>	121	<i>amphotericin b liposome</i>	40	AUGMENTIN	125
<i>ala-cort</i>	79	<i>ampicillin</i>	125	<i>aum insulin safety pen needle</i>	102
<i>albendazole</i>	22	<i>ampicillin sodium</i>	125	AUM MINI INSULIN PEN	
		<i>ampicillin-sulbactam sodium</i>	125	NEEDLE	102
		<i>anagrelide hcl</i>	92, 93	<i>aum pen needle</i>	102
		ANASCORP	124	AUM READYGARD DUO PEN	
		<i>anastrozole</i>	52	NEEDLE	102
		ANORO ELLIPTA	24	AUM SAFETY PEN NEEDLE	102

AURORA PEN NEEDLES	102	<i>b-complex-c</i>	115	<i>blisovi fe 1/20</i>	68
<i>aurovela 1.5/30</i>	68	<i>b-complex-c (w/folic acid)</i>	114	BOOSTRIX	133
<i>aurovela 1/20</i>	68	BD AUTOSHIELD DUO	102	<i>bosentan</i>	66
<i>aurovela 24 fe</i>	68	<i>bd heparin posiflush</i>	28	BOSULIF	50
<i>aurovela fe 1.5/30</i>	68	BD INSULIN SYR ULTRAFINE II	102	BREO ELLIPTA	24
<i>aurovela fe 1/20</i>	68	BD INSULIN SYRINGE	102	<i>Breyna</i>	24
AUSTEDO	126	BD INSULIN SYRINGE HALF-UNIT	102	BREZTRI AEROSPHERE	24
AUSTEDO XR	126	BD INSULIN SYRINGE MICROFINE	102	<i>briellyn</i>	68
AUSTEDO XR PATIENT TITRATION	126	BD INSULIN SYRINGE U/F	102	BRILINTA	92
AVASTIN	54	BD INSULIN SYRINGE U/F 1/2UNIT	102	<i>brimonidine tartrate</i>	81, 122
<i>aviane</i>	68	BD INSULIN SYRINGE U-500	102	<i>brimonidine tartrate-timolol</i>	120
AVONEX PEN	127	BD INSULIN SYRINGE ULTRAFINE	102	<i>brinzolamide</i>	121
AVONEX PREFILLED	127	BD PEN NEEDLE MICRO U/F	102	<i>bromfenac sodium</i>	122
AVSOLA	90	BD PEN NEEDLE MINI U/F	102	<i>bromfenac sodium (once-daily)</i>	122
<i>ayuna</i>	68	BD PEN NEEDLE NANO 2ND GEN	102	<i>bromocriptine mesylate</i>	55
<i>azasan</i>	112	BD PEN NEEDLE NANO U/F	102	<i>budesonide</i>	22, 26, 73
<i>azathioprine</i>	112	BD PEN NEEDLE ORIGINAL U/F	102	<i>budesonide er</i>	73
<i>azelaic acid</i>	81	BD PEN NEEDLE SHORT U/F	102	<i>budesonide-formoterol fumarate</i>	24
<i>azelastine hcl</i>	119, 121	<i>bd posiflush</i>	111	<i>bumetanide</i>	83
<i>azelastine-fluticasone</i>	119	<i>Bd Posiflush Safescrub</i>	111	<i>bupivacaine hcl (pf)</i>	99
<i>azithromycin</i>	99	BD SAFETYGLIDE INSULIN SYRINGE	102	<i>bupivacaine-epinephrine</i>	99
<i>aztreonam</i>	47	BD VEO INSULIN SYR U/F 1/2UNIT	102	<i>bupivacaine-epinephrine (pf)</i>	99
<i>azurette</i>	68	BD VEO INSULIN SYRINGE U/F	102	<i>buprenorphine</i>	21
<i>b complex 100 tr</i>	115	<i>benazepril hcl</i>	43	<i>buprenorphine hcl</i>	21
<i>b complex formula 1 (lipotrop)</i>	118	<i>benazepril-hydrochlorothiazide</i>	43	<i>buprenorphine hcl-naloxone hcl</i>	21
<i>b complex formula 1 (w/ fa)</i>	115	<i>benzonatate</i>	74	<i>bupropion hcl</i>	31
<i>b complex-b12</i>	114	<i>benzoyl peroxide-erythromycin</i>	76	<i>bupropion hcl er (smoking det)</i>	129
<i>b complex-c</i>	115	<i>benzphetamine hcl</i>	12	<i>bupropion hcl er (sr)</i>	31
B COMPLEX-C-BIOTIN-E-FA	115	<i>benztropine mesylate</i>	55	<i>bupropion hcl er (xl)</i>	31
<i>b complex-c-folic acid</i>	114	BERINERT	91	<i>buspirone hcl</i>	23
<i>b-100 b-complex</i>	115	<i>betaine</i>	85	<i>butalbital-acetaminophen</i>	17
<i>b-100 complex cr</i>	115	<i>betamethasone dipropionate</i>	79	<i>butalbital-apap-caff-cod</i>	19
<i>b-100 tr</i>	115	<i>betamethasone dipropionate aug</i>	79	<i>butalbital-apap-caffeine</i>	17
<i>b-50 complex</i>	115	<i>betamethasone valerate</i>	79	<i>butalbital-asa-caff-codeine</i>	19
<i>bac</i>	17	BETASERON	127	<i>butalbital-aspirin-caffeine</i>	17
<i>bacitracin</i>	121	<i>betaxolol hcl</i>	63, 120	<i>butorphanol tartrate</i>	21
<i>bacitracin-polymyxin b</i>	121	<i>bethanechol chloride</i>	135	BYOOVIZ	123
<i>bacitra-neomycin-polymyxin-hc</i>	122	BETOPTIC-S	120	<i>cabergoline</i>	84
<i>baclofen</i>	118	<i>better b complex</i>	115	CABOMETYX	52
<i>balance b-100</i>	118	<i>bexarotene</i>	54, 82	<i>caffeine citrate</i>	12
<i>balance b-50</i>	115	BEXSERO	136	<i>calcipotriene</i>	78
<i>balanced b complex</i>	115	<i>bicalutamide</i>	49	<i>calcipotriene-betameth diprop</i>	82
<i>balanced b-100</i>	115	<i>big 100</i>	115	<i>calcitonin (salmon)</i>	84
<i>balanced b-50 complex</i>	118	<i>big 100 (biotin)</i>	116	<i>calcitrene</i>	78
<i>balanced b-50/fa</i>	115	BIJUVA	87	<i>calcitriol</i>	78, 85
<i>balsalazide disodium</i>	89	BIKTARVY	59	<i>calcium acetate</i>	90
<i>balziva</i>	68	<i>bimatoprost</i>	123	<i>calcium acetate (phos binder)</i>	90
BAQSIMI ONE PACK	34	BIOTHRAX	136	<i>camila</i>	72
BAQSIMI TWO PACK	34	<i>bisacodyl</i>	98	<i>camrese</i>	72
BARACLUDE	61	<i>bisacodyl ec</i>	98	<i>camrese lo</i>	72
<i>bayer aspirin ec low dose</i>	18	<i>bismuth/metronidaz/tetracyclin</i>	135	<i>candesartan cilexetil</i>	45
<i>bayer low dose</i>	18	<i>bisoprolol fumarate</i>	63	<i>candesartan cilexetil-hctz</i>	45
BCG VACCINE	136	<i>bisoprolol-hydrochlorothiazide</i>	46	<i>capecitabine</i>	49
<i>b-compleet-100</i>	115	<i>blisovi 24 fe</i>	68	CAPRELSA	52
<i>b-compleet-50</i>	115	<i>blisovi fe 1.5/30</i>	68	<i>captropril</i>	44
<i>b-complex</i>	116			<i>captropril-hydrochlorothiazide</i>	43
<i>b-complex (folic acid)</i>	115			CAPVAXIE	136
<i>b-complex balanced</i>	114			<i>carbamazepine</i>	28, 29
<i>b-complex plus b-12</i>	114			<i>carbamazepine er</i>	28
<i>b-complex/b-12</i>	114			<i>carbidopa</i>	55
<i>b-complex/electrolytes</i>	115			<i>carbidopa-levodopa</i>	55
<i>b-complex/vitamin c</i>	114			<i>carbidopa-levodopa er</i>	55
				<i>carbidopa-levodopa-entacapone</i>	55

<i>carbinoxamine maleate</i>	41	<i>cimetidine hcl</i>	134	COMETRIQ (140 MG DAILY DOSE)	52
<i>carbinoxamine maleate er</i>	41	<i>cinacalcet hcl</i>	84	COMETRIQ (60 MG DAILY DOSE)	52
<i>carboprost tromethamine</i>	124	<i>ciprofloxacin hcl</i>	88, 121, 123	COMFORT ASSIST INSULIN SYRINGE	102
CAREFINE PEN NEEDLES	102	<i>ciprofloxacin in d5w</i>	88	COMFORT EZ INSULIN SYRINGE	102, 103
CAREONE INSULIN SYRINGE	102	<i>ciprofloxacin-dexamethasone</i>	123	COMFORT EZ MICRO PEN NEEDLES	103
CAREONE UNIFINE PENTIPS PLUS	102	<i>ciprofloxacin-fluocinolone pf</i>	123	COMFORT EZ PEN NEEDLES	103
CARETOUCH INSULIN SYRINGE	102	<i>cisatracurium besylate</i>	119	COMFORT EZ PRO PEN NEEDLES	103
CARETOUCH PEN NEEDLES	102	<i>cisatracurium besylate (pf)</i>	119	COMFORT EZ SHORT PEN NEEDLES	103
<i>carglumic acid</i>	85	<i>citalopram hydrobromide</i>	31	COMFORT TOUCH INSULIN PEN NEED	103
<i>carisoprodol</i>	118	CITRANATAL B-CALM	116	COMIRNATY	137
<i>carteolol hcl</i>	120	<i>citrate of magnesia</i>	97	COMPLETE NATAL DHA	118
<i>cartia xt</i>	63, 64	<i>citroma</i>	97	COMPLETENATE	116
<i>carvedilol</i>	62	<i>claravis</i>	76	<i>complex b-100</i>	116
<i>carvedilol phosphate er</i>	62	<i>clarithromycin</i>	99	<i>complex b-50 prolonged release</i>	116
CAYA	100	<i>clarithromycin er</i>	99	<i>compro</i>	57
<i>cefaclor</i>	67	CLASSIC PRENATAL	116	CO-NATAL FA	116
CEFACLOR ER	67	<i>clearlax</i>	96	CONCEPT DHA	117
<i>cefadroxil</i>	67	<i>clemastine fumarate</i>	41	CONCEPT OB	117
<i>cefazolin sodium</i>	67	CLEOCIN	139	<i>constulose</i>	96
<i>cefdinir</i>	67	CLEVER CHOICE COMFORT EZ	102	COPAXONE	128
<i>cefepime hcl</i>	68	CLICKFINE PEN NEEDLES	102	COSENTYX	77
<i>cefixime</i>	67	CLIMARA PRO	87	COSENTYX (300 MG DOSE)	77
<i>cefotetan disodium</i>	67	<i>Clindacin</i>	75	COSENTYX SENSOREADY (300 MG)	77
<i>cefoxitin sodium</i>	67	<i>clindacin etz</i>	75	COSENTYX SENSOREADY PEN	77
<i>cefpodoxime proxetil</i>	67	<i>clindacin-p</i>	75	COSENTYX UNOREADY	78
<i>cefprozil</i>	67	<i>clindamycin hcl</i>	47	CREON	83
<i>ceftazidime</i>	67	<i>clindamycin palmitate hcl</i>	47	CROFAB	124
<i>ceftriaxone sodium</i>	67, 68	<i>clindamycin phos-benzoyl perox</i>	76	<i>cromolyn sodium</i>	25, 88, 121
<i>ceftriaxone sodium in dextrose</i>	67	<i>clindamycin phosphate</i>	47, 75, 139	<i>crotan</i>	82
<i>cefuroxime axetil</i>	67	<i>clindamycin phosphate in d5w</i>	47	<i>cryselle-28</i>	69
<i>cefuroxime sodium</i>	67	<i>clindamycin-tretinoin</i>	76	CURAE	71
<i>celecoxib</i>	15	<i>clinisol sf</i>	120	<i>curity sterile saline</i>	91
<i>cephalexin</i>	67	<i>clinpro 5000</i>	113	CUTAQUIG	124
CERDELGA	93	<i>clobazam</i>	28	<i>cvs aspirin adult low dose</i>	18
<i>cetirizine hcl</i>	41	<i>clobetasol propionate</i>	79	<i>cvs aspirin adult low strength</i>	18
<i>cevimeline hcl</i>	114	<i>clobetasol propionate e</i>	79	<i>cvs aspirin ec</i>	18
<i>charlotte 24 fe</i>	68	<i>clobetasol propionate emulsion</i>	79	<i>cvs aspirin low dose</i>	18
<i>chateal eq</i>	68	<i>clodan</i>	79	<i>cvs aspirin low strength</i>	18
<i>childrens aspirin</i>	18	<i>Clomid</i>	86	<i>cvs b complex plus c</i>	115
<i>chloramphenicol sod succinate</i>	47	<i>clomiphene citrate</i>	86	<i>cvs c-lax laxative</i>	98
<i>chlordiazepoxide hcl</i>	23	<i>clomipramine hcl</i>	33	<i>cvs folic acid</i>	93
<i>chlordiazepoxide-amitriptyline</i>	126	<i>clonazepam</i>	28	<i>cvs gentle laxative</i>	98
<i>chlordiazepoxide-clidinium</i>	134	<i>clonidine</i>	46	<i>cvs gentle laxative womens</i>	98
<i>chlorhexidine gluconate</i>	113	<i>clonidine hcl</i>	46	<i>cvs magnesium citrate</i>	97
<i>chloroprocaine hcl (pf)</i>	99	<i>clonidine hcl er</i>	11	<i>cvs milk of magnesia</i>	97
<i>chloroquine phosphate</i>	48	<i>clopidogrel bisulfate</i>	93	<i>cvs nicotine</i>	129
<i>chlorothiazide sodium</i>	84	<i>clorazepate dipotassium</i>	23	<i>cvs nicotine polacrilex</i>	129
<i>chlorpromazine hcl</i>	57	<i>clotrimazole</i>	113	<i>cvs purelax</i>	96
CHLORPROMAZINE HCL	57	<i>clotrimazole-betamethasone</i>	76	<i>cvs super b complex/c</i>	115
<i>chlorthalidone</i>	84	<i>clozapine</i>	57	<i>cyanocobalamin</i>	93
<i>chlorzoxazone</i>	118	C-NATE DHA	116	<i>cyclobenzaprine hcl</i>	118
<i>cholestyramine</i>	41, 42	COAGUCHEK LANCETS	100	<i>cyclopentolate hcl</i>	120
<i>cholestyramine light</i>	41	<i>coal tar</i>	82	<i>cyclophosphamide</i>	53
<i>chromic chloride</i>	111	<i>codeine sulfate</i>	19	<i>cycloserine</i>	48
<i>ciclodan</i>	77	<i>colchicine</i>	91		
<i>ciclopirox</i>	77	<i>colchicine-probenecid</i>	91		
<i>ciclopirox olamine</i>	77	<i>colesevelam hcl</i>	42		
<i>cilostazol</i>	92	<i>colistipol hcl</i>	42		
CIMDUO	59	<i>colistimethate sodium (cba)</i>	48		
CIMERLI	123	COMBIPATCH	87		
<i>cimetidine</i>	134	COMBIVENT RESPIMAT	24		
		COMETRIQ (100 MG DAILY DOSE)	52		

cyclosporine.....	111, 122	dialyvit 800.....	114	DRUG MART UNIFINE PENTIPS.	103
cyclosporine modified.....	111	DIATHRIVE PEN NEEDLE	103	DRUG MART UNIFINE PENTIPS	
cyproheptadine hcl.....	41	diazepam.....	23, 28	PLUS	103
cyred eq.....	69	diazepam intensol.....	23	dulcolax.....	97
CYSTARAN	123	diazoxide.....	34	dulcolax milk of magnesia.....	97
dalfampridine er.....	128	dichlorphenamide.....	83	duloxetine hcl.....	32
danazol.....	21	diclofenac potassium.....	15	DUPIXENT	79
dantrolene sodium.....	118, 119	diclofenac sodium.....	15, 77, 122	duramorph.....	19
dapagliflozin pro-metformin er.....	37	diclofenac sodium er.....	15	dutasteride.....	90
dapagliflozin propanediol.....	37	diclofenac-misoprostol.....	15	dutasteride-tamsulosin hcl.....	91
dapsone.....	47, 76	dicloxacillin sodium.....	125	e.e.s. 400.....	99
DAPTACEL	133	dicyclomine hcl.....	134	EASY COMFORT INSULIN	
darifenacin hydrobromide er.....	135	diethylpropion hcl.....	12	SYRINGE	103
darunavir.....	60	diethylpropion hcl er.....	12	easy comfort insulin syringe.....	103
dasatinib.....	50	diflunisal.....	18	EASY COMFORT PEN NEEDLES.	103
dasetta 1/35.....	69	difluprednate.....	122	EASY GLIDE PEN NEEDLES	103
dasetta 7/7/7.....	73	digoxin.....	65	EASY TOUCH FLIPLOCK	
daysee.....	72	dihydroergotamine mesylate.....	109	INSULIN SY	103
deblitane.....	72	DILANTIN	30	EASY TOUCH INSULIN SAFETY	
deferasirox.....	38	diltiazem hcl.....	64	SYR	103
deferasirox granules.....	38	diltiazem hcl er.....	64	EASY TOUCH INSULIN SYRINGE	
deferiprone.....	38	diltiazem hcl er beads.....	64		103
delyla.....	69	diltiazem hcl er coated beads.....	64	EASY TOUCH PEN NEEDLES.....	103
demeclocycline hcl.....	132	dilt-xr.....	64	EASY TOUCH SAFETY PEN	
DENG VAXIA	137	dimethyl fumarate.....	128	NEEDLES.....	103
denta 5000 plus.....	113	dimethyl fumarate starter pack.....	128	EASY TOUCH SHEATHLOCK	
dentagel.....	113	diphenhydramine hcl.....	41	SYRINGE	104
DEPO-SUBQ PROVERA 104	72	diphenoxylate-atropine.....	38	easygel.....	113
DEPO-TESTOSTERONE	21	dipyridamole.....	92	ec-naproxen.....	15
DESCOVY	59	disopyramide phosphate.....	23	econazole nitrate.....	80
desflurane.....	90	disulfiram.....	126	econtra one-step.....	71
desipramine hcl.....	33	divalproex sodium.....	31	ecotrin low strength.....	18
desloratadine.....	41	divalproex sodium er.....	31	EDURANT	60
desmopressin ace spray refig.....	87	dobutamine hcl.....	65	efavirenz.....	60
desmopressin acetate.....	87	dodex.....	93	efavirenz-emtricitab-tenofo df.....	59
desmopressin acetate pf.....	87	dofetilide.....	24	efavirenz-lamivudine-tenofovir.....	59
desogestrel-ethinyl estradiol.....	68	dolishale.....	71	eletriptan hydrobromide.....	109
desonide.....	79, 80	donepezil hcl.....	126	elinest.....	69
desvenlafaxine succinate er.....	32	dorzolamide hcl.....	121	ELIQUIS	27
dexamethasone.....	74	dorzolamide hcl-timolol mal.....	120	ELIQUIS DVT/PE STARTER	
DEXAMETHASONE INTENSOL	73	dorzolamide hcl-timolol mal pf.....	120	PACK	27
dexamethasone sod phos +rfid.....	74	dotti.....	87	elite-ob.....	117
dexamethasone sod phosphate pf.....	74	DOVATO	59	ELIXOPHYLLIN	27
DEXAMETHASONE SOD		doxazosin mesylate.....	46	ELLA	71
PHOSPHATE PF	74	doxepin hcl.....	33, 77, 95	eluryng.....	71
dexamethasone sodium phosphate . 74, 122		doxercalciferol.....	85	EMBRACE PEN NEEDLES	104
DEXAMETHASONE SODIUM		doxy 100.....	132	EMGALITY	109
PHOSPHATE	74	doxycycline hyclate.....	132	EMGALITY (300 MG DOSE)	109
DEXCOM G6 RECEIVER	100	doxycycline monohydrate.....	132	emtricitabine.....	60
DEXCOM G6 SENSOR	100	doxylamine-pyridoxine.....	39	emtricitabine-tenofovir df.....	59
DEXCOM G6 TRANSMITTER	100	dronabinol.....	40	EMTRIVA	60
DEXCOM G7 RECEIVER	101	droperidol.....	23	Emzahh.....	72
DEXCOM G7 SENSOR	101	DROPLET INSULIN SYRINGE	103	enalapril maleate.....	44
dexmedetomidine hcl.....	96	DROPLET MICRON	103	enalaprilat.....	44
dexmedetomidine hcl in nacl.....	96	DROPLET PEN NEEDLES	103	enalapril-hydrochlorothiazide.....	43
dexmethylphenidate hcl.....	13	DROPSAFE SAFETY PEN		ENBREL	17
dexmethylphenidate hcl er.....	13	NEEDLES	103	ENBREL MINI	17
dextroamphetamine sulfate.....	11	DROPSAFE SAFETY		ENBREL SURECLICK	17
dextroamphetamine sulfate er.....	11	SYRINGE/NEEDLE	103	ENCARE	139
dextrose.....	120	drospiren-eth estrad-levomefol.....	69	endocet.....	21
dextrose in lactated ringers.....	109	drospirenone-ethinyl estradiol.....	69	ENDOMETRIN	139
dextrose-sodium chloride.....	110	DROXIA	93	endur-b.....	116
		droxidopa.....	139	ENFAMIL EXPECTA	118

ENERGIX-B	137	<i>etodolac</i>	16	<i>fluocinolone acetonide body</i>	80
<i>Enilloring</i>	71	<i>etodolac er</i>	16	<i>fluocinolone acetonide scalp</i>	80
<i>enoxaparin sodium</i>	28	<i>etomidate</i>	90	<i>fluocinonide</i>	80
<i>enpresse-28</i>	73	<i>etonogestrel-ethinyl estradiol</i>	71	<i>fluocinonide emulsified base</i>	80
<i>enskyce</i>	69	<i>etoposide</i>	53	<i>fluorescein</i>	121
<i>entacapone</i>	56	<i>etravirine</i>	60	<i>fluorescein-benoxinate</i>	122
<i>entecavir</i>	61	EUCRISA	81	<i>fluoridex</i>	113
ENTRESTO	66	<i>euthyrox</i>	133	<i>fluoridex daily renewal</i>	113
ENTYVIO	89	EVAMIST	88	<i>fluoridex enhanced whitening</i>	113
<i>enulose</i>	89	<i>everolimus</i>	51, 112	<i>fluorometholone</i>	123
EPCLUSA	61	<i>exemestane</i>	52	<i>fluorouracil</i>	77
<i>epinastine hcl</i>	121	<i>ex-lax ultra</i>	98	<i>fluoxetine hcl</i>	32
<i>epinephrine</i>	139	EYLEA	123	<i>fluoxetine hcl (pmdd)</i>	129
<i>epinephrine (anaphylaxis)</i>	139	EYLEA HD	123	<i>fluphenazine decanoate</i>	58
<i>epitol</i>	29	<i>ezetimibe</i>	42	<i>fluphenazine hcl</i>	58
<i>eplerenone</i>	46	<i>ezetimibe-simvastatin</i>	42	<i>flurazepam hcl</i>	95
<i>eptifibatide</i>	92	<i>fa-8</i>	93	<i>flurbiprofen</i>	16
<i>eq aspirin adult low dose</i>	18	<i>falmina</i>	69	<i>flurbiprofen sodium</i>	122
<i>eq aspirin low dose</i>	18	<i>famciclovir</i>	62	<i>fluticasone furoate-vilanterol</i>	24
<i>eq clearlax</i>	96	<i>famotidine</i>	134	<i>fluticasone propionate</i>	80, 119
<i>eq gentle laxative</i>	98	<i>famotidine (pf)</i>	134	<i>fluticasone propionate diskus</i>	27
<i>eq laxative</i>	96	<i>famotidine premixed</i>	134	<i>fluticasone propionate hfa</i>	27
<i>eq magnesium citrate</i>	97	FARXIGA	37	<i>fluticasone-salmeterol</i>	24, 25
<i>eq nicotine</i>	129	FC2 FEMALE CONDOM	100	<i>fluvastatin sodium</i>	42
<i>eq nicotine polacrilex</i>	129	<i>febuxostat</i>	91	<i>fluvoxamine maleate</i>	32
<i>eq nicotine step 3</i>	129	<i>felbamate</i>	30	<i>fluvoxamine maleate er</i>	32
<i>eq aspirin low dose</i>	18	<i>felodipine er</i>	64	FLUZONE	138
<i>eq b complex 50</i>	116	FEMCAP	100	FLUZONE HIGH-DOSE	137
<i>eq b-100 complex</i>	116	<i>fenofibrate</i>	42	<i>folate</i>	93
<i>eq clearlax</i>	96	<i>fenofibrate micronized</i>	42	<i>folic acid</i>	94
<i>eq gentle laxative</i>	98	<i>fenofibric acid</i>	42	FOLIVANE-OB	117
EQL INSULIN SYRINGE	104	<i>fentanyl</i>	19	<i>foltabs 800</i>	93
<i>eq laxative</i>	98	<i>fentanyl citrate</i>	19	<i>fomepizole</i>	38
<i>eq magnesium citrate</i>	97	FENTANYL CITRATE (PF)	19	<i>fondaparinux sodium</i>	28
EQL PRENATAL FORMULA	117	<i>fentanyl citrate (pf)</i>	19	<i>formoterol fumarate</i>	25
<i>eq super b complex/vitamin c</i>	114	FERAHEME	94	FOSAMAX PLUS D	84
<i>ergocalciferol</i>	140	FERRLECIT	94	<i>fosamprenavir calcium</i>	60
<i>ergoloid mesylates</i>	129	<i>ferumoxylol</i>	94	<i>fosaprepitant dimeglumine</i>	40
<i>ergotamine-caffeine</i>	109	<i>fesoterodine fumarate er</i>	135	<i>fosfomycin tromethamine</i>	48
ERIVEDGE	51	FIFTY50 PEN NEEDLES	104	<i>fosinopril sodium</i>	44
ERLEADA	49	FIFTY50 SUPERIOR COMFORT	104	<i>fosinopril sodium-hctz</i>	43
<i>erlotinib hcl</i>	51	SYR	104	<i>fosphenytoin sodium</i>	30
<i>errin</i>	72	<i>finasteride</i>	82, 90	FRAGMIN	28
ERVEBO	137	<i>finolimid hcl</i>	131	<i>fraiche 5000 dental</i>	113
<i>ery</i>	76	<i>Finzala</i>	69	FREESTYLE LIBRE 14 DAY	101
<i>ery-tab</i>	99	FIRMAGON	53	READER	101
<i>erythromycin</i>	76, 100	FIRMAGON (240 MG DOSE)	53	FREESTYLE LIBRE 14 DAY	101
<i>erythromycin base</i>	99	<i>flac</i>	124	SENSOR	101
<i>erythromycin ethylsuccinate</i>	99, 100	<i>flavoxate hcl</i>	135	FREESTYLE LIBRE 2 PLUS	101
<i>erythromycin lactobionate</i>	100	<i>flecainide acetate</i>	24	SENSOR	101
<i>escitalopram oxalate</i>	32	FLEET STIMULANT	98	FREESTYLE LIBRE 2 READER	101
<i>esmolol hcl</i>	63	FLUAD	137	FREESTYLE LIBRE 2 SENSOR	101
<i>esomeprazole magnesium</i>	134	FLUARIX	137	FREESTYLE LIBRE 3 PLUS	101
<i>estarylla</i>	69	FLUBLOK	137	SENSOR	101
<i>estazolam</i>	95	FLUCELVAX	137	FREESTYLE LIBRE 3 READER	101
<i>estradiol</i>	87, 88, 139	<i>fluconazole</i>	40	FREESTYLE LIBRE 3 SENSOR	101
<i>estradiol valerate</i>	88	<i>fluconazole in sodium chloride</i>	40	FREESTYLE LIBRE READER	101
<i>estradiol-norethindrone acet</i>	87	<i>flucytosine</i>	40	<i>fresenius propoven</i>	90
<i>eszopiclone</i>	95	<i>fludrocortisone acetate</i>	74	FRESKARO MAGNESIUM	97
<i>ethacrynic acid</i>	83	FLULAVAL	137	CITRATE	97
<i>ethambutol hcl</i>	48	<i>flumazenil</i>	39	<i>frovatriptan succinate</i>	109
<i>ethosuximide</i>	31	FLUMIST	137	<i>ft aspirin</i>	18
<i>ethynodiol diac-eth estradiol</i>	69	<i>fluocinolone acetonide</i>	80, 124	<i>ft aspirin low dose</i>	18

<i>ft b-100 complex pr</i>	116	GLYCOPYRROLATE PF	135	<i>hailey 24 fe</i>	69
<i>ft clearlax</i>	96	<i>glydo</i>	81	<i>hailey fe 1.5/30</i>	69
<i>ft folic acid</i>	94	GLYXAMBI	37	<i>hailey fe 1/20</i>	69
<i>ft laxative</i>	98	<i>gnp adult aspirin low strength</i>	18	<i>halobetasol propionate</i>	80
<i>ft magnesium citrate</i>	97	<i>gnp aspirin</i>	18	<i>Haloette</i>	71
<i>ft milk of magnesia</i>	97	<i>gnp aspirin low dose</i>	18	<i>haloperidol</i>	57
<i>ft nicotine</i>	129	<i>gnp b-100 complex</i>	116	<i>haloperidol decanoate</i>	56
<i>ft nicotine mini</i>	129	<i>gnp b-50 complex</i>	116	<i>haloperidol lactate</i>	56, 57
FULL SPECTRUM B/VITAMIN C	114	<i>gnp b-complex plus vitamin c</i>	114	HARVONI	61
<i>furosemide</i>	83	<i>gnp clearlax</i>	96	HAVRIX	138
FUZEON	59	GNP CLICKFINE PEN NEEDLES	104	HEALTHWISE INSULIN	
<i>fyavolv</i>	87	<i>gnp folic acid</i>	94	SYR/NEEDLE	104
<i>g tussin ac</i>	75	<i>gnp gentle laxative</i>	98	HEALTHWISE MICRON PEN	
<i>gabapentin</i>	29	GNP INSULIN SYRINGE	104	NEEDLES	104
<i>gabapentin (once-daily)</i>	129	GNP INSULIN SYRINGES	104	HEALTHWISE SHORT PEN	
<i>galantamine hydrobromide</i>	126	GNP INSULIN SYRINGES		NEEDLES	104
<i>galantamine hydrobromide er</i>	126	28GX1/2"	104	<i>healthylax</i>	96
<i>Gallifrey</i>	125	GNP INSULIN SYRINGES		<i>heather</i>	72
GAMUNEX-C	124	29GX1/2"	104	<i>h-e-b aspirin</i>	18
GARDASIL 9	138	GNP INSULIN SYRINGES		H-E-B INCONTROL PEN	
<i>gatifloxacin</i>	121	30GX5/16"	104	NEEDLES	104
<i>gavilax</i>	96	GNP INSULIN SYRINGES		H-E-B INCONTROL UNIFINE	
GAVILYTE-C	96	31GX5/16"	104	PENTIP	104
<i>gavilyte-g</i>	96	<i>gnp magnesium citrate</i>	97	<i>heparin (porcine) in nacl</i>	28
<i>Gavilyte-N With Flavor Pack</i>	96	<i>gnp milk of magnesia</i>	97	<i>heparin na (pork) lock flsh pf</i>	28
<i>gefitinib</i>	51	<i>gnp nicotine</i>	129, 130	<i>heparin sod (porcine) in d5w</i>	28
<i>gemfibrozil</i>	42	<i>gnp nicotine mini</i>	129	<i>heparin sod (pork) lock flush</i>	28
<i>gemmily</i>	69	<i>gnp nicotine polacrilex</i>	129, 130	<i>heparin sodium (porcine)</i>	28
<i>generlac</i>	89	GNP PRENATAL	117	<i>heparin sodium (porcine) pf</i>	28
<i>gengraf</i>	111	GNP ULTICARE PEN NEEDLES	104	HEPLISAV-B	138
GENOTROPIN	85	GNP ULTIGUARD SAFEPAK		HER STYLE	71
GENOTROPIN MINIQUICK	85	NEEDLE	104	HERCEPTIN	50
<i>gentamicin in saline</i>	14	GNP ULTRA COM INSULIN		HERCEPTIN HYLECTA	52
<i>gentamicin sulfate</i>	14, 76, 121	SYRINGE	104	<i>hetastarch-nacl</i>	92
<i>gentle laxative</i>	97, 98	<i>gnp womens gentle laxative</i>	98	HIBERIX	136
<i>gentlelax</i>	96	GONAL-F	86	<i>hidex 6-day</i>	74
GENVOYA	59	GONAL-F RFF	86	HIZENTRA	124
GILOTRIF	51	GONAL-F RFF REDIRECT	86	<i>hm clearlax</i>	97
<i>glatiramer acetate</i>	128	<i>goodsense aspirin</i>	18	<i>hm milk of magnesia</i>	97
<i>glatopa</i>	128	<i>goodsense aspirin low dose</i>	18	<i>hm nicotine polacrilex</i>	130
<i>glimepiride</i>	37	<i>goodsense bisacodyl ec</i>	98	HM ULTICARE INSULIN	
<i>glipizide</i>	37	<i>goodsense bisacodyl laxative</i>	98	SYRINGE	104
<i>glipizide er</i>	37	<i>goodsense clearlax</i>	96	HM ULTICARE MINI PEN	
<i>glipizide xl</i>	37, 38	GOODSENSE CLICKFINE PEN		NEEDLES	104
<i>glipizide-metformin hcl</i>	37	NEEDLE	104	HM ULTICARE SHORT PEN	
GLOBAL EASE INJECT PEN		<i>goodsense magnesium citrate</i>	97	NEEDLES	104
NEEDLES	104	<i>goodsense milk of magnesia</i>	97	HUMALOG	34, 35
GLOBAL EASY GLIDE INSULIN		<i>goodsense nicotine</i>	130	HUMALOG JUNIOR KWIKPEN	35
SYR	104	GOODSENSE PEN NEEDLE		HUMALOG KWIKPEN	35
GLOBAL EASY GLIDE PEN		PENFINE	104	HUMALOG MIX 50/50 KWIKPEN ..	35
NEEDLES	104	<i>granisetron hcl</i>	39	HUMALOG MIX 75/25	35
GLOBAL INJECT EASE INSULIN		<i>griseofulvin microsize</i>	40	HUMALOG MIX 75/25 KWIKPEN ..	35
SYR	104	<i>griseofulvin ultramicrosize</i>	40	HUMATROPE	85
GLOBAL INSULIN SYRINGES	104	<i>guaifenesin-codeine</i>	75	HUMIRA (2 PEN)	15
GLUCAGON EMERGENCY	34	<i>guanfacine hcl</i>	46	HUMIRA (2 SYRINGE)	15
GLUCOPRO INSULIN SYRINGE ..	104	<i>guanfacine hcl er</i>	11	HUMIRA-CD/UC/HS STARTER	15
<i>glyburide</i>	38	GVOKE HYOPEN 1-PACK	34	HUMIRA-PSORIASIS/UEVIT	
<i>glyburide micronized</i>	38	GVOKE HYOPEN 2-PACK	34	STARTER	15
<i>glyburide-metformin</i>	37	GVOKE KIT	34	HUMULIN 70/30	35
<i>glycine</i>	91	GVOKE PFS	34	HUMULIN 70/30 KWIKPEN	35
<i>glycine urologic</i>	91	<i>habitrol</i>	130	HUMULIN N	35
<i>glycolax</i>	96	HAEGARDA	92	HUMULIN N KWIKPEN	35
<i>glycopyrrolate</i>	134	<i>hailey 1.5/30</i>	69	HUMULIN R	35

HUMULIN R U-500 (CONCENTRATED)	35	<i>insulin syringe-needle u-100</i>	104	KINRAY INSULIN SYRINGE	105
HUMULIN R U-500 KWIKPEN	35	INSULIN SYRINGE-NEEDLE U-100	105	KINRIX	133
HYCAMTIN	54	INSUPEN PEN NEEDLES	105	KISQALI (200 MG DOSE)	53
<i>hydralazine hcl</i>	46	INTELENCE	60	KISQALI (400 MG DOSE)	53
<i>hydrochlorothiazide</i>	84	<i>introvale</i>	72	KISQALI (600 MG DOSE)	53
<i>hydrocod poli-chlorphe poli er</i>	75	IPOL	138	<i>Klayesta</i>	77
<i>hydrocodone bitartrate er</i>	19	<i>ipratropium bromide</i>	26, 119	<i>klor-con</i>	110
<i>hydrocodone bit-homatrop mbr</i>	74	<i>ipratropium-albuterol</i>	25	<i>klor-con 10</i>	110
<i>hydrocodone-acetaminophen</i>	19	<i>irbesartan</i>	45	<i>klor-con m10</i>	110
<i>hydrocodone-ibuprofen</i>	19	<i>irbesartan-hydrochlorothiazide</i>	45	<i>klor-con m15</i>	110
<i>hydrocortisone</i>	22, 74, 80	ISENTRESS	59	<i>klor-con m20</i>	110
<i>hydrocortisone (perianal)</i>	22	<i>isibloom</i>	69	KLOXXADO	39
<i>hydrocortisone ace-pramoxine</i>	22	<i>isoflurane</i>	90	<i>kls aspirin low dose</i>	18
<i>hydrocortisone sod suc (pf)</i>	74	<i>isoniazid</i>	48	<i>kls laxaclear</i>	97
<i>hydrocortisone-acetic acid</i>	124	<i>isosorb dinitrate-hydralazine</i>	66	<i>kls quit2</i>	130
<i>hydromet</i>	75	<i>isosorbide dinitrate</i>	22	<i>kls quit4</i>	130
<i>hydromorphone hcl</i>	19, 20	<i>isosorbide mononitrate</i>	22	KMART VALU INSULIN SYRINGE 29G	105
<i>hydromorphone hcl er</i>	19	<i>isosorbide mononitrate er</i>	22	KMART VALU INSULIN SYRINGE 30G	105
<i>hydromorphone hcl pf</i>	20	<i>isotretinoin</i>	76	<i>kobee</i>	115
<i>hydroxocobalamin acetate</i>	93	<i>isradipine</i>	64	<i>Kourzeq</i>	114
HYDROXYCHLOROQUINE SULFATE	48	<i>itraconazole</i>	40	<i>kp aspirin</i>	18
<i>hydroxychloroquine sulfate</i>	48	<i>ivabradine hcl</i>	67	<i>kp b complex-c</i>	114
<i>hydroxyurea</i>	52	<i>ivermectin</i>	22, 81	<i>kp bisacodyl</i>	98
<i>hydroxyzine hcl</i>	23	IXCHIQ	138	<i>kp folic acid</i>	94
<i>hydroxyzine pamoate</i>	23	IXIARO	138	K-PHOS	110
<i>ibandronate sodium</i>	84	<i>jaimiess</i>	72	KROGER INSULIN SYRINGE	105
IBRANCE	52	JAKAFI	53	KROGER PEN NEEDLES	105
<i>ibu</i>	16	<i>jantoven</i>	27	<i>kurvelo</i>	69
<i>ibuprofen</i>	16	JANUMET	34	<i>labetalol hcl</i>	62
<i>ibutilide fumarate</i>	24	JANUMET XR	34	<i>lacosamide</i>	29
<i>icatibant acetate</i>	91	JANUVIA	34	<i>lactated ringers</i>	110, 112
<i>iclevia</i>	72	JARDIANCE	37	<i>lactulose</i>	97
<i>icosapent ethyl</i>	41	<i>jasmiel</i>	69	<i>lactulose encephalopathy</i>	89
ILEVRO	122	<i>Javygtor</i>	86	LAGEVRIO	62
<i>imatinib mesylate</i>	50	<i>jencycla</i>	72	<i>lamivudine</i>	60, 61
IMBRUVICA	51	<i>jinteli</i>	87	<i>lamivudine-zidovudine</i>	59
<i>imipenem-cilastatin</i>	47	<i>jolessa</i>	72	<i>lamotrigine</i>	29
<i>imipramine hcl</i>	33	<i>Joyeaux</i>	69	<i>lamotrigine er</i>	29
<i>imipramine pamoate</i>	33	<i>juleber</i>	69	<i>lamotrigine starter kit-blue</i>	29
<i>imiquimod</i>	81	<i>junel 1.5/30</i>	69	<i>lamotrigine starter kit-green</i>	29
<i>imiquimod pump</i>	81	<i>junel 1/20</i>	69	<i>lamotrigine starter kit-orange</i>	29
IMOVAX RABIES	138	<i>junel fe 1.5/30</i>	69	LANOXIN PEDIATRIC	65
<i>inatal gt</i>	117	<i>junel fe 1/20</i>	69	LANREOTIDE ACETATE	87
<i>incassia</i>	72	<i>junel fe 24</i>	69	<i>lansoprazole</i>	134
INCONTROL ULTICARE PEN NEEDLES	104	JYNNEOS	138	<i>lanthanum carbonate</i>	90
<i>indapamide</i>	84	<i>kaitlib fe</i>	69	LANTUS	35
<i>indomethacin</i>	16	KALBITOR	92	LANTUS SOLOSTAR	35
<i>indomethacin er</i>	16	<i>kalliga</i>	69	<i>lapatinib ditosylate</i>	52
INFANRIX	133	KANJINTI	50	<i>larin 1.5/30</i>	69
INFED	94	<i>kariva</i>	68	<i>larin 1/20</i>	69
INFLIXIMAB	90	KCL (0.149%) IN NACL	110	<i>larin 24 fe</i>	69
INGREZZA	126, 127	<i>kcl (0.149%) in nacl</i>	110	<i>larin fe 1.5/30</i>	69
INLYTA	54	KCL (0.298%) IN NACL	110	<i>larin fe 1/20</i>	69
INSULIN LISPRO	35	<i>kcl in dextrose-nacl</i>	110	<i>latanoprost</i>	123
INSULIN LISPRO (1 UNIT DIAL)	35	<i>kelnor 1/35</i>	69	<i>laxative</i>	98
INSULIN LISPRO JUNIOR KWIKPEN	35	<i>kelnor 1/50</i>	69	<i>layolis fe</i>	69
INSULIN LISPRO PROT & LISPRO	35	<i>ketamine hcl</i>	90	LEADER INSULIN SYRINGE	105
INSULIN SYRINGE	104	<i>ketoconazole</i>	40, 80	LEADER UNIFINE PENTIPS	105
		<i>ketodan</i>	80	LEADER UNIFINE PENTIPS PLUS	105
		<i>ketoprofen er</i>	16	<i>leena</i>	73
		<i>ketorolac tromethamine</i>	16, 122		
		KETOROLAC TROMETHAMINE	16		

leflunomide	17	lmd in nacl	92	MAYZENT	131
lenalidomide	112	LO LOESTRIN FE	68	MAYZENT STARTER PACK	131
LENVIMA (10 MG DAILY DOSE) ...	54	loestrin 1.5/30 (21)	70	meclizine hcl	39
LENVIMA (12 MG DAILY DOSE) ...	54	loestrin 1/20 (21)	70	meclofenamate sodium	16
LENVIMA (14 MG DAILY DOSE) ...	54	loestrin fe 1.5/30	70	MEDIC INSULIN SYRINGE	105
LENVIMA (18 MG DAILY DOSE) ...	54	loestrin fe 1/20	70	MEDICINE SHOPPE PEN	
LENVIMA (20 MG DAILY DOSE) ...	54	lofexidine hcl	126	NEEDLES	105
LENVIMA (24 MG DAILY DOSE) ...	54	lojaimiess	72	medroxyprogesterone acetate	72, 125
LENVIMA (4 MG DAILY DOSE) ...	54	LOKELMA	112	mefenamic acid	16
LENVIMA (8 MG DAILY DOSE) ...	54	LONGS INSULIN SYRINGE	105	mefloquine hcl	48
lessina	69	loperamide hcl	38	megestrol acetate	54, 125
letrozole	52	lopinavir-ritonavir	59	MEIJER PEN NEEDLES	105
leucovorin calcium	53	lorazepam	23	MEKINIST	51
LEUKERAN	54	lorazepam intensol	23	meloxicam	16
leuprolide acetate	53	loryna	70	memantine hcl	128, 129
levabuterol hcl	25	losartan potassium	45	memantine hcl er	128
levabuterol tartrate	26	losartan potassium-hctz	45	MENEST	88
levamlodipine maleate	64	LOTEMAX	123	MENQUADFI	136
levetiracetam	29	loteprednol etabonate	123	MENVEO	136
levetiracetam er	29	lovastatin	42	meperidine hcl	20
levobunolol hcl	120	low-ogestrel	70	meprobamate	23
levocarnitine	84	loxapine succinate	57	mercaptopurine	49
levocarnitine sf	84	lo-zumandimine	70	meropenem	47
levocetirizine dihydrochloride	41	lubiprostone	88	merzee	70
levofloxacin	88, 121	LUCENTIS	123	mesalamine	89
levofloxacin in d5w	88	luliconazole	81	mesalamine er	89
levonest	73	LUMIGAN	123	mesalamine-cleanser	89
levonorgest-eth est & eth est	72	lurasidone hcl	56	mesna	54
levonorgest-eth estrad 91-day	72	lutura	70	metformin hcl	34
levonorgest-eth estradiol-iron	70	lyleq	72	metformin hcl er	33, 34
levonorgestrel	71	lyllana	88	methadone hcl	20
levonorgestrel-ethinyl estrad	70, 71	LYNPARZA	54	methadone hcl intensol	20
levonorg-eth estrad triphasic	73	LYSODREN	49	methadose	20
levora 0.15/30 (28)	70	LYUMJEV	35	methazolamide	83
levorphanol tartrate	20	LYUMJEV KWIKPEN	35	methenamine hippurate	48
levo-t	133	lyza	72	methergine	124
levothyroxine sodium	133	mafenide acetate	79	methimazole	132
levoxyl	133	MAGELLAN INSULIN SAFETY		methocarbamol	118
l-glutamine	93	SYR	105	methotrexate sodium	49, 50
lidocaine	81	magnesium citrate	97	methotrexate sodium (pf)	49
lidocaine hcl	81, 99, 113	MAGNESIUM SULFATE	110	methoxsalen rapid	78
lidocaine hcl (cardiac)	24	malathion	82	methscopolamine bromide	135
lidocaine hcl (cardiac) pf	24	manganese chloride	110	methsuximide	31
lidocaine hcl (pf)	99	mannitol	83	methyldopa	46
lidocaine hcl urethral/mucosal	81	MARATHON MEDICAL PENTIPS	105	methylene blue	38
lidocaine in d5w	24	maraviroc	59	methylene blue (antidote)	38
lidocaine viscous hcl	113	marlissa	70	methylergonovine maleate	124
lidocaine-epinephrine	99	MATULANE	52	methylphenidate	13, 14
lidocaine-epinephrine (pf)	99	matzim la	64	methylphenidate hcl	13
lidocaine-prilocaine	82	MAVENCLAD (10 TABS)	127	methylphenidate hcl er	13
linezolid	48	MAVENCLAD (4 TABS)	127	methylphenidate hcl er (cd)	13
LINZESS	89	MAVENCLAD (5 TABS)	127	methylphenidate hcl er (la)	13
liothyronine sodium	133	MAVENCLAD (6 TABS)	127	methylphenidate hcl er (osm)	13
liraglutide	36	MAVENCLAD (7 TABS)	127	METHYLPHENIDATE HCL ER	
lisdexafetamine dimesylate	11	MAVENCLAD (8 TABS)	127	(OSM)	13
lisinopril	44	MAVENCLAD (9 TABS)	127	methylphenidate hcl er (xr)	13
lisinopril-hydrochlorothiazide	43	MAXICOMFORT II PEN NEEDLE	105	methylprednisolone	74
LITETOUCH INSULIN SYRINGE	105	MAXI-COMFORT INSULIN		methylprednisolone sodium succ	74
LITETOUCH PEN NEEDLES	105	SYRINGE	105	metoclopramide hcl	88, 89
lithium	56	MAXI-COMFORT SAFETY PEN		metolazone	84
lithium carbonate	56	NEEDLE	105	metoprolol succinate er	63
lithium carbonate er	56	MAXICOMFORT SYR 27G X 1/2"	105	metoprolol tartrate	63
lmd in d5w	92	maxi-tuss ac	75	metoprolol-hydrochlorothiazide	46

metronidazole	46, 47, 81, 139	multi-vitamin/fluoride/iron	116	nifedipine	65
metyrosine	44	mupirocin	76	nifedipine er	65
mexiletine hcl	24	MVASI	55	nifedipine er osmotic release	65
Mibelas 24 Fe	70	my choice	71	nikki	70
miconazole 3	139	my way	72	nilutamide	49
MICRODOT PEN NEEDLE	105	mycophenolate mofetil	112	nimodipine	65
microgestin 1.5/30	70	mycophenolate sodium	112	nisoldipine er	65
microgestin 1/20	70	mycophenolic acid	112	nitazoxanide	47
microgestin fe 1.5/30	70	MYLERAN	49	nitisinone	85
microgestin fe 1/20	70	MYRBETRIQ	135	NITRO-DUR	22
midazolam hcl	95	na ferric gluc cplx in sucrose	94	nitrofurantoin	48
midazolam hcl (pf)	95	na sulfate-k sulfate-mg sulf	96	nitrofurantoin macrocrystal	48
midodrine hcl	140	nabumetone	16	nitrofurantoin monohyd macro	48
mifepristone	36, 84	nadolol	63	nitroglycerin	22
migergot	109	nafeillin sodium	125	nitroglycerin in d5w	22
miglitol	33	naftifine hcl	77	NIVA-PLUS	117
miglustat	93	nalbuphine hcl	21	nizatidine	134
mili	70	naloxone hcl	39	nora-be	73
milk of magnesia	97	naltrexone hcl	39	norelgestromin-eth estradiol	71
milrinone lactate	65	naproxen	16	norethin ace-eth estrad-fe	70
milrinone lactate in dextrose	65	naproxen dr	16	norethindrone	73
mimvey	87	naproxen sodium	16	norethindrone acetate	125
minocycline hcl	132	naratriptan hcl	109	norethindrone acet-ethinyl est	70
minoxidil	46	NATALVIT	117	norethindrone-eth estradiol	87
mirabegron er	135	nateglinide	36	norethindron-ethinyl estrad-fe	73
mirtazapine	31	neбиволol hcl	63	norethin-eth estradiol-fe	70
misoprostol	135	Nebusal	75	norgesic	119
mitigo	20	necon 0.5/35 (28)	70	norgestimate-eth estradiol	70
mm aspirin	18	nefazodone hcl	32	norgestim-eth estrad triphasic	73
mm clearlax	97	neomycin sulfate	14	norlyroc	73
MM INSULIN SYRINGE/NEEDLE	105	neomycin-bacitracin zn-polymyx	121	normal saline flush	111
MM PEN NEEDLES	105	neomycin-polymyxin b gu	91	NORPACE CR	23
M-M-R II	136	neomycin-polymyxin-dexameth	122	nortrel 0.5/35 (28)	70
M-NATAL PLUS	117	neomycin-polymyxin-gramicidin	121	nortrel 1/35 (21)	70
modafinil	14	neomycin-polymyxin-hc	122, 123, 124	nortrel 1/35 (28)	70
MODERNA COVID-19 VAC 6M-11Y	138	neo-polycin	121	nortrel 7/7/7	73
moexipril hcl	44	neo-polycin hc	122	nortriptyline hcl	33
molindone hcl	57	nephro vitamins	114	NOVAREL	86
mometasone furoate	80, 119	NEPHRO-VITE	114	novavax covid-19 vaccine	138
mondoxyne nl	132	neuac	76	NOVOFINE PEN NEEDLE	105
monoject flush syringe	111	NEULASTA	94	NOVOFINE PLUS PEN NEEDLE	105
MONOJECT INSULIN SYRINGE	105	NEULASTA ONPRO	94	np thyroid	133
monoject sodium chloride flush	111	nevirapine	60	NUBEQA	49
MONOJECT ULTRA COMFORT SYRINGE	105	nevirapine er	60	NUCALA	26
mono-lynyah	70	new day	72	NURTEC	108
MONOVISC	119	niacin (antihyperlipidemic)	43	nyamyc	77
montelukast sodium	26	niacin er (antihyperlipidemic)	43	nylia 1/35	70
morphine sulfate	20	niacor	43	nylia 7/7/7	73
morphine sulfate (concentrate)	20	nicardipine hcl	64, 65	nystatin	40, 77
morphine sulfate (pf)	20	NICODERM CQ	130	nystatin-triamcinolone	76
morphine sulfate er	20	NICORETTE	130	nystop	77
morphine sulfate er beads	20	NICORETTE MINI	130	ocella	70
MOUNJARO	36	NICORETTE STARTER KIT	130	OCTAGAM	124
moxifloxacin hcl	88, 121	NICOTINE	130	OFEV	132
moxifloxacin hcl (2x day)	121	nicotine	130	ofloxacin	88, 121, 123
MRESVIA	138	nicotine mini	130	olanzapine	58
MS INSULIN SYRINGE	105	nicotine polacrilex	130	olanzapine-fluoxetine hcl	131
multiple electro type 1 ph 5.5	110	nicotine polacrilex mini	130	olmesartan medoxomil	45
multiple electro type 1 ph 7.4	110	nicotine step 1	130	olmesartan medoxomil-hctz	45
multivitamin w/fluoride	116	nicotine step 2	130	olmesartan-amlodipine-hctz	45, 46
multi-vitamin/fluoride	116	nicotine step 3	130	olopatadine hcl	119
		NICOTROL	130	omega-3-acid ethyl esters	41
		NICOTROL NS	130	omeprazole	134

OMNIPOD 5 DEXG7G6 INTRO			
GEN 5	101	<i>oxymorphone hcl</i>	20
OMNIPOD 5 DEXG7G6 PODS GEN		<i>oxymorphone hcl er</i>	20
5	101	<i>oxytocin</i>	124
OMNIPOD 5 LIBRE2 PLUS G6	101	OZEMPIC (0.25 OR 0.5 MG/DOSE)	36
OMNIPOD 5 LIBRE2 PLUS G6		OZEMPIC (1 MG/DOSE)	36
PODS	101	OZEMPIC (2 MG/DOSE)	36
OMNIPOD CLASSIC PODS (GEN		<i>pacerone</i>	24
3)	101	<i>paliperidone er</i>	56
OMNIPOD DASH INTRO (GEN 4)	101	<i>palonosetron hcl</i>	39
OMNIPOD DASH PDM (GEN 4)	101	<i>pantoprazole sodium</i>	134
OMNIPOD DASH PODS (GEN 4)	101	<i>paricalcitol</i>	85
<i>ondansetron</i>	39	<i>paroxetine hcl</i>	32
<i>ondansetron hcl</i>	39	<i>paroxetine hcl er</i>	32
ONE VITE WOMENS PLUS	117	<i>paroxetine mesylate</i>	131
ONELAX MAGNESIUM CITRATE	97	PAXLOVID (150/100)	61
ONETOUCH DELICA PLUS		PAXLOVID (300/100)	61
LANCET30G	101	<i>pazopanib hcl</i>	52
ONETOUCH DELICA PLUS		PC UNIFINE PENTIPS	105
LANCET33G	101	PEDIARIX	133
ONETOUCH DELICA PLUS		PEDVAX HIB	136
LANCING	101	<i>peg 3350</i>	97
ONETOUCH DELICA SAFETY		<i>peg 3350-kcl-na bicarb-nacl</i>	96
LANCING	101	<i>peg-3350/electrolytes</i>	96
ONETOUCH ULTRA	82	<i>peg-3350/electrolytes/ascorbat</i>	96
ONETOUCH ULTRA BLUE TEST	82	<i>peg-kcl-nacl-nasulf-na asc-c</i>	96
ONETOUCH ULTRA TEST	82	<i>pen needle/5-bevel tip</i>	105
ONETOUCH ULTRASOFT 2		PEN NEEDLES	105
LANCETS	101	PEN NEEDLES 5/16"	105
ONETOUCH VERIO	82	PENBRAYA	136
<i>opcicon one-step</i>	72	<i>penciclovir</i>	78
OPILL	73	<i>penicillamine</i>	111
OPSUMIT	66	<i>penicillin g potassium</i>	125
<i>option 2</i>	72	<i>penicillin g sodium</i>	125
OPTIONS GYNOL II		<i>penicillin v potassium</i>	125
CONTRACEPTIVE	139	PENTACEL	133
OPVEE	39	<i>pentamidine isethionate</i>	47
OPZELURA	79	PENTASA	89
<i>oralone</i>	114	<i>pentazocine-naloxone hcl</i>	21
ORILISSA	85	PENTIPS	105
<i>orlistat</i>	12	PENTIPS GENERIC PEN	
<i>Ormalvi</i>	83	NEEDLES	106
<i>orphenadrine citrate</i>	118	<i>pentobarbital sodium</i>	95
<i>orphenadrine citrate er</i>	118	<i>pentoxifylline er</i>	92
ORPHENADRINE-ASPIRIN-		<i>perindopril erbumine</i>	44
CAFFEINE	119	<i>periogard</i>	113
<i>orphengesic forte</i>	119	<i>permethrin</i>	82
ORTHOVISC	119	<i>perphenazine</i>	58
<i>oseltamivir phosphate</i>	62	<i>perphenazine-amitriptyline</i>	129
<i>osmitrol</i>	83	PFIZER COVID-19 VAC-TRIS 5-	
OTEZLA	16, 17	11Y	138
<i>oxacillin sodium</i>	125	<i>pfizer covid-19 vac-tris 6m-4y</i>	138
<i>oxaprozin</i>	16	<i>pfizerpen</i>	125
<i>oxazepam</i>	23	PHEBURANE	87
<i>oxcarbazepine</i>	29	<i>phendimetrazine tartrate</i>	12
<i>oxcarbazepine er</i>	29	<i>phenelzine sulfate</i>	31
<i>oxiconazole nitrate</i>	81	<i>phenobarbital</i>	95
<i>oxybutynin chloride</i>	135	<i>phenobarbital sodium</i>	95
<i>oxybutynin chloride er</i>	135	<i>phenoxybenzamine hcl</i>	44
<i>oxycodone hcl</i>	20	<i>phentermine hcl</i>	12
OXYCODONE-		<i>phentolamine mesylate</i>	44
ACETAMINOPHEN	21	<i>phenylephrine hcl</i>	120
<i>oxycodone-acetaminophen</i>	21	PHENYTEK	30
		<i>phenytoin</i>	31
		<i>phenytoin infatabs</i>	30
		<i>phenytoin sodium</i>	31
		<i>phenytoin sodium extended</i>	31
		<i>philith</i>	70
		<i>phillips milk of magnesia</i>	98
		<i>phospha 250 neutral</i>	110
		<i>phosphorous</i>	110
		<i>phospho-trin k500</i>	110
		<i>physiolyte</i>	112
		<i>physiosol irrigation</i>	112
		<i>phytonadione</i>	140
		<i>pilocarpine hcl</i>	114, 120
		<i>pimecrolimus</i>	81
		<i>pimozide</i>	129
		<i>pimtrea</i>	68
		<i>pindolol</i>	63
		<i>pioglitazone hcl</i>	38
		<i>pioglitazone hcl-glimepiride</i>	38
		<i>pioglitazone hcl-metformin hcl</i>	38
		<i>pip pen needles 31g x 5mm</i>	106
		<i>pip pen needles 32g x 4mm</i>	106
		<i>piperacillin sod-tazobactam so</i>	125
		<i>pirfenidone</i>	132
		<i>piroxicam</i>	16
		PLEGRIDY	127, 128
		PLEGRIDY STARTER PACK	127
		<i>plenamine</i>	120
		PNEUMOVAX 23	136
		<i>pnv prenatal plus multivit+dha</i>	117
		<i>pnv-dha</i>	118
		<i>pnv-select</i>	117
		<i>podofilox</i>	81
		<i>polocaine</i>	99
		<i>polocaine-mpf</i>	99
		<i>polycin</i>	121
		<i>polyethylene glycol 3350</i>	97
		<i>polymyxin b sulfate</i>	48
		<i>polymyxin b-trimethoprim</i>	121
		POLY-TUSSIN AC	75
		POMALYST	51
		<i>portia-28</i>	70
		<i>posaconazole</i>	40
		<i>potassium chloride</i>	111
		<i>potassium chloride crys er</i>	110
		<i>potassium chloride er</i>	110, 111
		<i>potassium citrate er</i>	91
		<i>potassium cl in dextrose 5%</i>	110
		<i>potassium phosphates</i>	110
		<i>pramipexole dihydrochloride</i>	55
		<i>pramipexole dihydrochloride er</i>	55
		PRAMOSONE	82
		<i>prasugrel hcl</i>	93
		<i>pravastatin sodium</i>	42
		<i>praziquantel</i>	22
		<i>prazosin hcl</i>	46
		PRECISION SURE-DOSE	
		SYRINGE	106
		<i>prednisolone</i>	74
		<i>prednisolone acetate</i>	123
		<i>prednisolone sodium phosphate</i>	74
		<i>prednisone</i>	74
		PREFERRED PLUS INSULIN	
		SYRINGE	106

PREFERRED PLUS UNIFINE		
PENTIPS	106	
<i>pregabalin</i>	29	
<i>pregabalin er</i>	129	
PREMARIN	88, 139	
PREMPHASE	87	
PREMPRO	87	
<i>prena 1 true</i>	118	
PRENATAL	117	
PRENATAL (W/IRON & FA)	117	
PRENATAL 19	117	
<i>prenatal 19</i>	117	
PRENATAL COMPLETE	117	
PRENATAL MULTIVITAMIN +		
DHA	118	
PRENATAL PLUS	117	
PRENATAL PLUS		
VITAMIN/MINERAL	117	
PRENATAL VITAMIN AND		
MINERAL	117	
PRENATAL VITAMINS	117	
PRENATAL-U	117	
<i>prevalite</i>	42	
PREVENT DROPSAFE PEN		
NEEDLES	106	
PREVENT SAFETY PEN		
NEEDLES	106	
PREVNAR 20	136	
PREZISTA	60	
PRIFTIN	49	
<i>primidone</i>	30	
PRIORIX	136	
PRO COMFORT INSULIN		
SYRINGE	106	
PRO COMFORT PEN NEEDLES ...	106	
PROAIR RESPICLICK	26	
<i>probenecid</i>	91	
<i>procainamide hcl</i>	24	
<i>procentra</i>	11	
<i>prochlorperazine</i>	58	
<i>prochlorperazine edisylate</i>	58	
<i>prochlorperazine maleate</i>	58	
PROCRIT	93	
PROCTOCORT	22	
<i>procto-med hc</i>	22	
<i>proctosol hc</i>	22	
<i>proctozone-hc</i>	22	
PRODIGY INSULIN SYRINGE	106	
<i>progesterone</i>	125	
PROLIA	86	
PROMACTA	94, 95	
<i>promethazine hcl</i>	41	
<i>promethazine vc</i>	75	
<i>promethazine-codeine</i>	75	
<i>promethazine-dm</i>	75	
<i>promethazine-phenylephrine</i>	75	
<i>promethegan</i>	41	
<i>propafenone hcl</i>	24	
<i>propafenone hcl er</i>	24	
<i>proparacaine hcl</i>	122	
<i>propofol</i>	90	
<i>propranolol hcl</i>	63	
<i>propranolol hcl er</i>	63	
<i>propylthiouracil</i>	132	
PROQUAD	137	
<i>protamine sulfate</i>	92	
<i>protriptyline hcl</i>	33	
PROVIDA OB	117	
<i>pseudoeph-bromphen-dm</i>	75	
<i>Pulmosal</i>	75	
PULMOZYME	131	
PURE COMFORT PEN NEEDLE ...	106	
<i>pure comfort safety pen needle</i>	106	
PX EXTRA SHORT PEN		
NEEDLES	106	
PX INSULIN SYRINGE	106	
PX MINI PEN NEEDLES	106	
PX PEN NEEDLE	106	
<i>pyrazinamide</i>	49	
<i>pyridostigmine bromide</i>	48	
<i>pyridostigmine bromide er</i>	48	
<i>pyrimethamine</i>	48	
<i>qc aspirin low dose</i>	18	
<i>qc b50 prolonged release</i>	116	
<i>qc b-complex/vitamin c</i>	114	
<i>qc childrens aspirin</i>	18	
<i>qc folic acid</i>	94	
<i>qc gentle laxative</i>	98	
<i>qc gentle laxative womens</i>	98	
<i>qc laxative</i>	98	
<i>qc magnesium citrate</i>	98	
<i>qc milk of magnesia</i>	98	
<i>qc natura-lax</i>	97	
<i>qc nicotine transdermal system</i>	130	
QC PEN NEEDLES	106	
QC PRENATAL	117	
QC UNIFINE PENTIPS	106	
QUADRACEL	133	
<i>quazepam</i>	95	
<i>quetiapine fumarate</i>	57	
<i>quetiapine fumarate er</i>	57	
<i>quin b strong b-25</i>	116	
<i>quinapril hcl</i>	44	
<i>quinapril-hydrochlorothiazide</i>	43	
<i>quinidine gluconate er</i>	24	
<i>quinidine sulfate</i>	24	
<i>quinine sulfate</i>	48	
QULIPTA	108	
QVAR REDIHALER	27	
<i>ra aspirin adult low dose</i>	18	
<i>ra aspirin adult low strength</i>	18	
<i>ra aspirin childrens</i>	18	
<i>ra aspirin ec</i>	18	
<i>ra aspirin ec adult low st</i>	18	
<i>ra balanced b-100</i>	116	
<i>ra balanced b-100 cr</i>	116	
<i>ra balanced b-50</i>	116	
<i>ra balanced b-50 tr</i>	116	
<i>ra b-complex</i>	114	
<i>ra b-complex with b-12</i>	114	
<i>ra folic acid</i>	94	
RA INSULIN SYRINGE	106	
<i>ra laxative</i>	97, 98	
<i>ra magnesium citrate</i>	98	
<i>ra milk of magnesia</i>	98	
<i>ra mini nicotine</i>	130	
<i>ra nicotine</i>	130	
<i>ra nicotine gum</i>	130	
<i>ra nicotine polacrilex</i>	130	
RA PEN NEEDLES	106	
RA PRENATAL	117	
<i>ra womens laxative</i>	98	
RABAVERT	138	
<i>raloxifene hcl</i>	86	
<i>ramelteon</i>	96	
<i>ramipril</i>	44	
<i>ranolazine er</i>	22	
<i>rasagiline mesylate</i>	55	
RASUVO	14	
<i>raya sure pen needle</i>	106	
<i>react</i>	72	
REALITY INSULIN SYRINGE	106	
REBIF	128	
REBIF REBIDOSE	128	
REBIF REBIDOSE TITRATION		
PACK	128	
REBIF TITRATION PACK	128	
<i>reclipsen</i>	70	
RECOMBIVAX HB	138	
RELENZA DISKHALER	62	
RELION INSULIN SYRINGE	106	
RELION MINI PEN NEEDLES	106	
RELION PEN NEEDLES	106	
RELION SHORT PEN NEEDLES ...	106	
REMICADE	90	
<i>remifentanyl hcl</i>	20	
<i>renal vitamin</i>	114	
<i>rena-vite</i>	114	
<i>repaglinide</i>	36	
REPATHA	43	
REPATHA PUSHTRONEX		
SYSTEM	43	
REPATHA SURECLICK	43	
RESTASIS	122	
RESTASIS MULTIDOSE	122	
RETACRIT	93	
REVLIMID	112	
<i>revonto</i>	119	
REXTOVY	39	
REXULTI	58	
REYATAZ	60	
<i>ribavirin</i>	61, 62	
RIDAURA	15	
<i>rifabutin</i>	49	
<i>rifampin</i>	49	
<i>riluzole</i>	119	
<i>rimantadine hcl</i>	62	
<i>ringers</i>	110	
<i>ringers irrigation</i>	112	
RINVOQ	14	
RINVOQ LQ	14	
<i>risedronate sodium</i>	84	
<i>risperidone</i>	56	
<i>risperidone microspheres er</i>	56	
<i>ritonavir</i>	60	
<i>rivastigmine</i>	126	
<i>rivastigmine tartrate</i>	126	
<i>rivelsa</i>	72	
<i>rizatriptan benzoate</i>	109	

rocuronium bromide	120	sm aspirin ec low strength	19	STRIBILD	59
roflumilast	26	sm aspirin low dose	19	subvenite	30
ropinirole hcl	55	sm b super vitamin complex	114	subvenite starter kit-blue	30
ropinirole hcl er	55	sm b100 complex	116	subvenite starter kit-green	30
ropivacaine hcl	99	sm balanced b-100	115	subvenite starter kit-orange	30
rosuvastatin calcium	42	sm balanced b-50	115	sucralfate	134
ROTARIX	138	sm b-complex	116	SUFENTANIL CITRATE	20
ROTATEQ	138	SM B-COMPLEX/VITAMIN C	114	sulconazole nitrate	81
roweepra	30	sm clearlax	97	sulfacetamide sodium	123
RUCONEST	92	sm folic acid	94	sulfacetamide sodium (acne)	76
rufinamide	30	sm gentle laxative	98	sulfacetamide-prednisolone	122
RYBELSUS	36	sm milk of magnesia	98	sulfadiazine	132
safety pen needles	106	sm nicotine	130, 131	sulfamethoxazole-trimethoprim	47
sajazir	91	sm nicotine polacrilex	130	sulfasalazine	89
saline flush	111	SM PRENATAL VITAMINS	117	sulfatrim pediatric	47
sapropterin dihydrochloride	86	sm super b complex/c	115	sulindac	16
SAXENDA	12	sm vitamin b complex/vitamin c	115	sumatriptan	109
sb bisacodyl laxative ec	98	smooth lax	97	sumatriptan succinate	109
sb childrens aspirin	18	sodium acetate	109	sumatriptan succinate refill	109
sb gentle lax-women	98	sodium bicarbonate	109	sunitinib malate	52
SB INSULIN SYRINGE	106	sodium chloride	75, 91, 111	super b complex/fa/vit c	115
sb low dose asa ec	18	sodium chloride (pf)	111	super b complex/vitamin c	115
sb magnesium citrate	98	sodium fluoride	110, 113	super b-complex	116
sb milk of magnesia	98	sodium fluoride 5000 enamel	113	super b-complex + vitamin c	115
sb polyethylene glycol 3350	97	sodium fluoride 5000 plus	113	super b-complex/vit c/fa	115
scopolamine	39	sodium fluoride 5000 ppm	113	super dec b-100	116
SECURESAFE INSULIN SYRINGE	106	sodium fluoride 5000 sensitive	113	super quints b-50	116
SECURESAFE SAFETY PEN NEEDLES	106	sodium phenylbutyrate	87	SURE COMFORT INSULIN SYRINGE	106
SELECT-OB	117	sodium phosphates	110	SURE COMFORT PEN NEEDLES	106
selegiline hcl	55	sodium polystyrene sulfonate	112	sure comfort pen needles	106
SELENIOS ACID	111	sodium tetradecyl sulfate	112	SUTAB	96
selenium sulfide	78	SODIUM THIOSULFATE	38	syeda	71
SE-NATAL 19	117	solifenacin succinate	135	SYMLINPEN 120	33
sensorcaine	99	SOLQUA	36	SYMLINPEN 60	33
sensorcaine/epinephrine	99	SOLTAMOX	49	SYNAREL	86
sensorcaine-mpf	99	SOLU-CORTEF	74	SYNJARDY	37
sensorcaine-mpf/epinephrine	99	SOMATULINE DEPOT	87	SYNJARDY XR	37
SEREVENT DISKUS	26	SOMAVERT	85	SYNVISC	119
sertraline hcl	32	sorafenib tosylate	52	SYNVISC ONE	119
setlakin	72	sotalol hcl	63	TABLOID	50
sevelamer carbonate	90	sotalol hcl (af)	63	tacrolimus	81, 112
sevelamer hcl	90	SOTRADECOL	113	tadalafil	66
sevoflurane	90	sotradecol	113	tadalafil (pah)	66
sf	113	SPIKEVAX	138	TAFINLAR	50
sf 5000 plus	113	spinosad	82	tafluprost (pf)	123
sharobel	73	SPIRIVA HANDIHALER	26	take action	72
SHINGRIX	138	SPIRIVA RESPIMAT	26	TAKHZYRO	92
sildenafil citrate	66	spironolactone	83	TALTZ	78
silodosin	90	spironolactone-hctz	83	tamoxifen citrate	49
silver sulfadiazine	79	sprintec 28	70	tamsulosin hcl	90
SIMBRINZA	120	sps (sodium polystyrene sulf)	112	taperdex 12-day	74
simliya	68	sronyx	70	taperdex 6-day	74
simpesse	72	ssd	79	taperdex 7-day	74
SIMPONI	15	st joseph aspirin	19	tarina 24 fe	71
SIMPONI ARIA	15	st joseph low dose	19	tarina fe 1/20 eq	71
simvastatin	42	STAMARIL	138	TARON-C DHA	117
sirolimus	112	STELARA	78, 89	TASIGNA	50
SKYRIZI	78, 89	sterile water for irrigation	112	tasimelteon	96
SKYRIZI PEN	78	STIOLTO RESPIMAT	25	tavaborole	81
SKYTROFA	85	STIVARGA	52	taysofy	71
sm aspirin adult low strength	19	STRENSIQ	85	tazarotene	78
		streptomycin sulfate	14	tazicef	68
		stress formula (folic acid)	114		

TDVAX	133	<i>tolcapone</i>	55	<i>trimipramine maleate</i>	33
TECHLITE INSULIN SYRINGE	106	<i>tolmetin sodium</i>	16	TRINATAL RX 1	117
TECHLITE PEN NEEDLES	106, 107	<i>tolterodine tartrate</i>	135	<i>trinate</i>	117
TECHLITE PLUS PEN NEEDLES ..	107	<i>tolterodine tartrate er</i>	135	TRINTELLIX	32
<i>telmisartan</i>	45	<i>tolvaptan</i>	86	<i>tri-sprintec</i>	73
<i>telmisartan-amlodipine</i>	44, 45	TOPCARE CLICKFINE PEN		TRIUMEQ	59
<i>telmisartan-hctz</i>	45	NEEDLES	107	TRIUMEQ PD	59
<i>temazepam</i>	95	TOPCARE ULTRA COMFORT		<i>tri-vite/fluoride</i>	116
<i>temozolomide</i>	53	INS SYR	107	<i>trivora (28)</i>	73
<i>tencon</i>	17	<i>topiramate</i>	30	<i>tri-vylibra</i>	73
TENIVAC	133	<i>topiramate er</i>	30	<i>tri-vylibra lo</i>	73
<i>tenofovir disoproxil fumarate</i>	60	<i>toremifene citrate</i>	49	<i>tropicamide</i>	120
<i>terazosin hcl</i>	46	<i>Torpenz</i>	51	<i>tropium chloride</i>	135
<i>terbinafine hcl</i>	40	<i>torsemide</i>	83	<i>tropium chloride er</i>	135
<i>terbutaline sulfate</i>	26	TOUJEO MAX SOLOSTAR	35	<i>true comfort insulin syringe</i>	107
<i>terconazole</i>	139	TOUJEO SOLOSTAR	35	TRUE COMFORT INSULIN	
<i>teriflunomide</i>	127	<i>tovet</i>	80	SYRINGE	107
<i>teriparatide</i>	86	TRACLEER	66	TRUE COMFORT PEN NEEDLES	107
TERIPARATIDE	86	<i>tramadol hcl</i>	20, 21	TRUE COMFORT PRO INSULIN	
<i>terrell</i>	90	<i>tramadol hcl (er biphasic)</i>	20	SYR	107
<i>testosterone</i>	21, 22	<i>tramadol hcl er</i>	20	TRUE COMFORT PRO PEN	
<i>testosterone cypionate</i>	21	<i>tramadol-acetaminophen</i>	21	NEEDLES	107
<i>testosterone enanthate</i>	21	<i>trandolapril</i>	44	<i>true folic acid</i>	94
TETANUS-DIPHThERIA		<i>trandolapril-verapamil hcl er</i>	43	<i>true laxative</i>	97
TOXOIDS TD	133	<i>tranexamic acid</i>	95	TRUEPLUS 5-BEVEL PEN	
<i>tetrabenazine</i>	127	<i>tranylcypromine sulfate</i>	31	NEEDLES	107
<i>tetracaine hcl</i>	122	<i>travoprost (bak free)</i>	123	TRUEPLUS INSULIN SYRINGE	107
<i>tetracycline hcl</i>	132	<i>trazodone hcl</i>	32	TRUEPLUS PEN NEEDLES	107
THALOMID	111	TRELEGY ELLIPTA	25	TRULICITY	36
THEO-24	27	TRELSTAR MIXJECT	53	TRUMENBA	136
<i>theophylline</i>	27	TREMFYA	78	<i>Turqoz</i>	71
<i>theophylline er</i>	27	<i>treprostinil</i>	66	TWINRIX	137
<i>thiamine hcl</i>	140	TRESIBA	36	<i>tydemy</i>	71
<i>thioridazine hcl</i>	58	TRESIBA FLEXTOUCH	35, 36	TYPHIM VI	136
<i>thiothixene</i>	58	<i>tretinoin</i>	54, 76	UBRELVY	108
<i>thrive</i>	131	<i>tretinoin microsphere</i>	76	UDENYCA	94
THRIVITE RX	117	<i>tretinoin microsphere pump</i>	76	UDENYCA ONBODY	94
<i>tiadylt er</i>	65	TREXALL	50	ULTICARE INSULIN SAFETY	
<i>tiagabine hcl</i>	30	<i>trezix</i>	19	SYR	107
TICOVAC	138	<i>triamcinolone acetonide</i>	80, 114	ULTICARE INSULIN SYR 1/2	
<i>tilia fe</i>	73	<i>triamterene</i>	83	UNIT	107
<i>timolol hemihydrate</i>	120	<i>triamterene-hctz</i>	83	ULTICARE INSULIN SYRINGE	107
<i>timolol maleate</i>	63, 120	<i>triazolam</i>	95	ULTICARE MICRO PEN	
<i>timolol maleate (once-daily)</i>	120	TRICARE	117	NEEDLES	107
<i>timolol maleate ocudose</i>	120	<i>Tridacaine li</i>	81	ULTICARE MINI PEN NEEDLES ..	107
<i>timolol maleate pf</i>	120	<i>Tridacaine lii</i>	81	ULTICARE PEN NEEDLES	107
<i>tinidazole</i>	47	<i>triderm</i>	80	ULTICARE SHORT PEN	
<i>tiopronin</i>	91	<i>trientine hcl</i>	111	NEEDLES	107
<i>tiotropium bromide monohydrate</i>	26	<i>tri-estarylla</i>	73	ULTIGUARD SAFEPAK PEN	
<i>tirofiban hcl in nacl</i>	92	<i>trifluoperazine hcl</i>	58	NEEDLE	107
<i>tis-u-sol</i>	112	<i>trifluridine</i>	121	ULTIGUARD SAFEPAK	
TIVICAY	59	<i>trihexyphenidyl hcl</i>	55	SYR/NEEDLE	107
TIVICAY PD	59	TRIJDY XR	36	ULILET PEN NEEDLE	107
<i>tizanidine hcl</i>	118	TRIKAFTA	131	ULTRA COMFORT INSULIN	
TOBRADEX	122	<i>tri-legest fe</i>	73	SYRINGE	107
<i>tobramycin</i>	14, 121	<i>tri-linyah</i>	73	ULTRA FLO INSULIN PEN	
<i>tobramycin sulfate</i>	14	<i>tri-lo-estarylla</i>	73	NEEDLES	107
<i>tobramycin-dexamethasone</i>	122	<i>tri-lo-marzia</i>	73	ULTRA FLO INSULIN SYR 1/2	
TODAY SPONGE	139	<i>tri-lo-mili</i>	73	UNIT	107
TODAYS HEALTH PEN NEEDLES		<i>tri-lo-sprintec</i>	73	ULTRA FLO INSULIN SYRINGE ..	107
.....	107	<i>trimethobenzamide hcl</i>	40	ULTRA THIN PEN NEEDLES	107
TODAYS HEALTH SHORT PEN		TRIMETHOPRIM	47	ULTRACARE INSULIN SYRINGE	107
NEEDLE	107	<i>tri-mili</i>	73	ULTRACARE PEN NEEDLES	107

ULTRA-THIN II INS SYR SHORT	107	<i>vigadrone</i>	30	<i>yl folic acid</i>	94
ULTRA-THIN II INSULIN		<i>Vigadrone</i>	30	<i>yuvafem</i>	139
SYRINGE	107	<i>Vigpoder</i>	30	<i>zafemy</i>	71
ULTRA-THIN II MINI PEN		<i>vilazodone hcl</i>	32	<i>zafirlukast</i>	26
NEEDLE	108	VIOKACE	83	<i>zaleplon</i>	95
ULTRA-THIN II PEN NEEDLE		<i>viorele</i>	68	ZARXIO	94
SHORT	108	VIREAD	61	ZEGALOGUE	34
ULTRA-THIN II PEN NEEDLES	108	VITAFOL GUMMIES	118	ZELBORAF	51
UNIFINE PENTIPS	108	<i>vitamin b complex</i>	114	<i>zenatane</i>	76
UNIFINE PENTIPS PLUS	108	<i>vitamin b complex w/b-12</i>	114	ZENPEP	83
UNIFINE PROTECT PEN NEEDLE		<i>vitamin d (ergocalciferol)</i>	140	<i>zenzedi</i>	12
.....	108	<i>vitamin k1</i>	140	ZEPBOUND	12
UNIFINE SAFECONTROL PEN		<i>vitamin-b complex</i>	114	ZEPOSIA	131
NEEDLE	108	VIVOTIF	136	ZEPOSIA 7-DAY STARTER PACK	131
UNIFINE ULTRA PEN NEEDLE	108	<i>volnea</i>	68	ZEPOSIA STARTER KIT	131
<i>unithroid</i>	133	<i>voriconazole</i>	40, 41	ZEVRX INSULIN SYRINGE	108
<i>ursodiol</i>	88	VOSEVI	61	ZEVRX PEN NEEDLES	108
VABYSMO	121	VP INSULIN SYRINGE	108	<i>zidovudine</i>	60
<i>valacyclovir hcl</i>	62	VRAYLAR	56	ZILXI	82
<i>valganciclovir hcl</i>	61	VUMERITY	128	ZIMHI	39
<i>valproate sodium</i>	31	<i>vyfemla</i>	71	<i>zinc sulfate</i>	111
<i>valproic acid</i>	31	<i>vylibra</i>	71	<i>ziprasidone hcl</i>	56
VALSARTAN	45	VYVANSE	12	<i>ziprasidone mesylate</i>	56
<i>valsartan</i>	45	WAKIX	12	ZOLINZA	51
<i>valsartan-hydrochlorothiazide</i>	45	<i>warfarin sodium</i>	27	<i>zolmitriptan</i>	109
VALUE HEALTH INSULIN		<i>water for irrigation, sterile</i>	112	<i>zolpidem tartrate</i>	95
SYRINGE	108	WEGMANS UNIFINE PENTIPS		<i>zolpidem tartrate er</i>	95
<i>vancomycin hcl</i>	47	PLUS	108	<i>zonisamide</i>	30
VANCOMYCIN HCL	47	WEGOVY	12	ZORYVE	78
VANDAZOLE	139	<i>wera</i>	71	<i>zovia 1/35 (28)</i>	71
VANISHPOINT INSULIN		<i>wesnata dha complete</i>	118	<i>zumandimine</i>	71
SYRINGE	108	WESTAB PLUS	118	ZYLET	122
VAQTA	139	WIDE-SEAL DIAPHRAGM 60	100		
<i>varidenafil hcl</i>	66	WIDE-SEAL DIAPHRAGM 65	100		
<i>varenicline tartrate</i>	131	WIDE-SEAL DIAPHRAGM 70	100		
<i>varenicline tartrate (starter)</i>	131	WIDE-SEAL DIAPHRAGM 75	100		
<i>varenicline tartrate(continue)</i>	131	WIDE-SEAL DIAPHRAGM 80	100		
VARIVAX	139	WIDE-SEAL DIAPHRAGM 85	100		
VASCEPA	41	WIDE-SEAL DIAPHRAGM 90	100		
<i>vasopressin</i>	87	WIDE-SEAL DIAPHRAGM 95	100		
<i>vasopressin + rfid</i>	87	<i>wixela inhub</i>	25		
VAXCHORA	136	<i>womans laxative</i>	98		
VAXELIS	133	<i>womens laxative</i>	99		
VAXNEUVANCE	136	<i>wymzya fe</i>	71		
VCF VAGINAL		XALKORI	50		
CONTRACEPTIVE	139	XARELTO	27		
<i>vecuronium bromide</i>	120	XARELTO STARTER PACK	27		
<i>velivet</i>	73	XELJANZ	14		
VEMLIDY	61	XELJANZ XR	14		
<i>venlafaxine hcl</i>	32	XEMBIFY	124		
<i>venlafaxine hcl er</i>	32	XIFAXAN	47		
VENOFER	94	XIGDUO XR	37		
VENTAVIS	66	XIIDRA	120		
<i>verapamil hcl</i>	65	XOFLUZA (40 MG DOSE)	62		
<i>verapamil hcl er</i>	65	XOFLUZA (80 MG DOSE)	62		
VERIFINE INSULIN PEN NEEDLE		XOLAIR	25		
.....	108	XTANDI	49		
VERIFINE INSULIN SYRINGE	108	<i>xulane</i>	71		
VERIFINE PLUS PEN NEEDLE	108	XULTOPHY	36		
VERZENIO	53	XYOSTED	22		
<i>vestura</i>	71	<i>Yargesa</i>	93		
<i>vienna</i>	71	YF-VAX	139		
<i>vigabatrin</i>	30	<i>yl balanced b-100</i>	116		

For information about your pharmacy benefit, log in at anthem.com/ca.

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

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

Speech and hearing impaired (TDD/TTY) users

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



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

Rev. 3/19

Get help in your language

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

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

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

Spanish

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

Chinese

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

Vietnamese

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

Korean

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

Tagalog

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

Russian

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

Arabic

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

Armenian

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

Farsi

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

French

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

Japanese

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

Haitian

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

Italian

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

Polish

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

Punjabi

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

Navajo

Bee ná ahóót'í t'áá ni nizaad k'eh'í níká a'doowó't'áá jík'e. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí bécsh bee hane'í bikáá' áá'j' hodiilnih. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí bécsh bee hane'í bikáá' áá'j' hodiilnih. (TTY/TDD: 711)

It's important we treat you fairly

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