July 2024

Molina Healthcare of South Carolina

Medicaid

Comprehensive Drug List

Molina Healthcare of South Carolina Comprehensive Drug List

(07/01/2024)

DRUG LIST GUIDE

INTRODUCTION

We are pleased to provide the 2024 *Molina Healthcare of South Carolina Comprehensive Drug List* as a useful reference and informational tool. This document can assist medical providers in selecting clinically-appropriate and cost-effective products for their patients.

The drugs represented have been reviewed by a Pharmacy and Therapeutics (P&T) Committee and are approved for inclusion. The document is reflective of current medical practice as of the date of review.

The information contained in this document and its appendices is provided solely for the convenience of medical providers. We do not warrant or assure accuracy of such information nor is it intended to be comprehensive in nature. All the information in the document is provided as a reference for drug therapy selection.

The document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics as indicated on the state Single Preferred Drug List (SPDL).

We assume no responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.

PREFACE

The document is organized by sections. Each section is divided by therapeutic drug class primarily defined by mechanism of action.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

The services of a Pharmacy and Therapeutics Committee ("P&T Committee") are utilized to approve safe and clinically effective drug therapies. The P&T Committee is an advisory body of clinical professionals. The P&T Committee's voting members include physicians and pharmacists, all of whom have a broad background of clinical and academic expertise regarding prescription drugs. Voting members of the P&T Committee must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

DRUG LIST PRODUCT DESCRIPTIONS

To assist in understanding which specific strengths and dosage forms on the document are covered, general principles are noted below.

- The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIPITOR). Generic drugs are listed in lowercase italics (e.g.,atorvastatin).
- The second column (Requirements/Limits) contains any special requirements for coverage of your drug.

- If the OTC and Prescription versions of the product are covered, then both are listed.
- Extended-release and delayed-release products require their own entry.
- Dosage forms on the document will be consistent with the category and use where listed.

GENERIC SUBSTITUTION

Generic substitution is a pharmacy action whereby a generic version is dispensed rather than a prescribed brand-name product. In this document, lowercase italicized type indicates generic availability. In some instances, a brand-name drug for which a generic product becomes available will become non-preferred, with the generic product covered in its place, upon release of the generic product to the market. However, the document is subject to state specific regulations and rules regarding generic substitution and mandatory generic rules may apply where appropriate.

Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drug.
- Manufactured in the same strength and dosage form as the brand-name drugs.

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic equivalence).

PLAN DESIGN

The document represents a closed drug list plan design. The medications listed on the document are covered by the plan as represented. Certain medications on the list are covered if utilization management criteria are met (i.e. Step Therapy, Prior Authorization, Quantity Limits, etc.); requests for use of such medications outside of their listed criteria will be reviewed for medical necessity. If a medication is not listed on the document, a preferred drug list exception may be requested for coverage. Medical necessity or preferred drug list exception requests will be reviewed based on drug- specific prior authorization criteria or standard non-preferred prescription request criteria. Log in to www.molinahealthcare.com to check coverage.

Note: To promote safety in dosing, some medications are subject to age and dosing restrictions (i.e., edits) as per their respective FDA labeling and not denoted with AGE and/or QL indicators. Prior authorization may be required for doses or age limits outside the FDA recommendations.

PRESCRIPTION QUANTITIES

Prescriptions should be written for a therapeutic supply of medications (the amount to appropriately treat a medical condition) up to a maximum of a 31-day supply, unless otherwise specified on the Preferred Drug List. Trial quantities may be used when trying new treatments, if appropriate.

NON-COVERED MEDICATIONS

Please note that certain medications are not covered. These include, but are not limited to:

- Appetite Suppressants / Anorexiants for weight loss
- Drugs for Cosmetic Purposes, including hair growth
- Drugs used to treat infertility
- Drugs used to treat erectile dysfunction
- Pharmaceuticals determined by the Federal Drug Administration (FDA) to be less than
- effective and identical, related, or similar drugs (frequently referred to as "DESI 5 and 6" drugs)
- Experimental or Investigational Medications
- Convenience Dosage Forms not Listed in the Comprehensive Drug List
- OTC (Over-the-Counter non-prescription medications) unless specifically listed in the Comprehensive Drug Lis
- OTC Analgesics unless specifically listed in the Comprehensive Drug List
- OTC Cough and Cold products unless specifically listed in the Comprehensive Drug List
- OTC Vitamin and mineral products including calcium supplements/TUMS unless specifically listed in the Comprehensive Drug List

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Molina Comprehensive Drug List may be approved when medically necessary and when preferred drug list options have demonstrated ineffectiveness. When these exceptional situations arise, the physician may fax a completed drug prior authorization form to Molina at 1-855-571-3011. The forms may be obtained by logging into the website **www.molinahealthcare.com**. Trials of pharmaceutical samples will not be considered as rationale for approving a prior authorization request.

PRIOR AUTHORIZATION HELPFUL HINTS

To ensure the quickest response possible from Molina Healthcare of South Carolina's Pharmacy Department, please provide relevant information with the Prior Authorization request. The following are examples:

Class of Medication/Diagnosis	Requested Clinical Information

Cholesterol Lowering	Lipid Panel, Cardiovascular risk factors
Diabetes	A1c Report
Osteoporosis	T-score
Opioid dependence/addiction	Urine screen
Non-Formulary/Non-Preferred Medication	*Medication History and/or Progress Notes documenting previous use of Formulary medications

*NOTE: Samples given to members in providers' offices do not constitute evidence of existing therapy on a medication for prior authorization purposes. When choosing to provide samples, providers should choose only samples of medications on the Molina Healthcare comprehensive drug list.

CLASSES OF CONSIDERATION

OPIOID ANALGESICS

Molina Healthcare of South Carolina (MHSC) implemented a uniform and coordinated set of pharmacy benefit limits for opioids. Prior authorization (PA) is required for the following scenario(s):

- Opioid-naïve members (as defined as members with no opioid prescription for the previous 90 days) with a prescription for a short acting opioid that is either:
  - Greater than a 5 day supply, OR
  - Greater than 90 morphine milligram equivalents (MME) per day.

The following constitute exceptions from these limits:

- Members with sickle cell disease, cancer, major surgery, major trauma, neonatal abstinence syndrome, chronic pain, or those receiving palliative or end-of-life care or medication assisted therapy (MAT).

MHSC began using information systems to identify members receiving doses of opioids greater than 90 MME per day. PA is required in order to continue on chronic high dose opioids (greater than 90 MME per day). In evaluating PA requests for doses above these new limits, MHSC will be looking for supporting documentation including, but not limited to, pain consultation supporting the dose requested, signed and dated patient prescriber agreement, and medical records documenting treatment plan including rationale for the high dose and titration to current dose and plan. This edit does not apply to opioid prescriptions issued by a practitioner who orders an opioid to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility.

REQUESTING COMPREHENSIVE-DRUG LIST CHANGES

If you are a prescriber and would like to request a drug list change, please submit your request and rationale to Molina's Pharmacy Department with your contact information.

Fax: 1-855-571-3011

URGENT AND AFTER-HOURS MEDICATION POLICY

To prevent a member's condition from worsening in an urgent situation, it may be necessary to dispense a 3-day supply of a medication before prior authorization may be obtained from Molina.

(e.g., a member is discharged from a hospital after regular business hours with a special antibiotic prescription). Pharmacies are instructed to use their professional judgment and should not use this process to dispense medications that are specifically excluded from the pharmacy benefit. At the point of sale, pharmacies may enter a PAMC code of 11112222333 to allow for one-time processing of a 3-day supply of medication. This code should be submitted in the PA Auth code section on the claim. Successive 3-day supplies for a single prescription are not permitted.

In case of an emergency, a member who currently is enrolled in the South Carolina Medicaid Pharmacy Lock-In Program is allowed to obtain a 72-hour supply of a medication filled at a pharmacy that is not his/her designated lock-in pharmacy.

NOTICE

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This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers.

LEGEND

AGE	Age Limit
MED	Max 90 mg Morphine Equivalent Dose per day
OTC	Over-the-counter, covered benefit with a prescription
PA	Prior Authorization
PA, QL	Quantity Limit is applied after Prior Authorization approval
QL	Quantity Limit
SP	Specialty Drug; these drugs must be obtained through a specialty pharmacy
ST	Step Therapy
lowercase	Indicates generic availability
UPPERCASE	Indicates brand availability
90 DS	After two fills of a 30-day supply within 180 days, 90-day supply is available thereafter

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Drug Name	Drug Tier	Requirements/Limits
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
ADDERALL ORAL TABLET 10 MG, 12.5 MG, 15 MG, 20 MG, 30 MG, 5 MG, 7.5 MG (*amphetamine-dextroamphetamine*)	COVERED - sPDL	
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 5 MG (*amphetamine-dextroamphetamine*)	COVERED - sPDL	
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (*amphetamine*)	NOT COVERED PA Required	
amphetamine sulfate oral tablet 10 mg, 5 mg	NOT COVERED PA Required	
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
amphetamine-dextroamphetamine oral tablet 30 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
amphetamine-dextroamphetamine oral tablet 7.5 mg	COVERED - sPDL	QL (5 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg	NOT COVERED PA Required	
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (*methylphenidate hcl*)	NOT COVERED PA Required	
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 3 Years)
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (*serdexmethylphen-dexmethylphen*)	NOT COVERED PA Required	
caffeine citrate oral solution 60 mg/3ml	COVERED - cDL	AGE (Max 1 Years); MAX QTY 120/LIFETIME
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	COVERED - sPDL	
CONCERTA ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 36 MG, 54 MG (*methylphenidate hcl*)	COVERED - sPDL	
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG (*methylphenidate*)	NOT COVERED PA Required	
DAYTRANA TRANSDERMAL PATCH 10 MG/9HR, 15 MG/9HR, 20 MG/9HR, 30 MG/9HR (*methylphenidate*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG (*dextroamphetamine sulfate*)	NOT COVERED PA Required	
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
dextroamphetamine sulfate oral solution 5 mg/5ml	NOT COVERED PA Required	
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
dextroamphetamine sulfate oral tablet 15 mg, 2.5 mg, 20 mg, 30 mg, 7.5 mg	COVERED - sPDL	
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (*amphetamine*)	COVERED - sPDL	
DYANAVEL XR ORAL TABLET CHEWABLE EXTENDED RELEASE 10 MG, 15 MG, 20 MG, 5 MG (*amphetamine*)	NOT COVERED PA Required	
EVEKEO ORAL TABLET 10 MG, 5 MG (*amphetamine sulfate*)	NOT COVERED PA Required	
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (*dexmethylphenidate hcl*)	NOT COVERED PA Required	
FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG, 5 MG (*dexmethylphenidate hcl*)	NOT COVERED PA Required	
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	COVERED - sPDL	QL (1 EA per 1 day)
INTUNIV ORAL TABLET EXTENDED RELEASE 24 HOUR 1 MG, 2 MG, 3 MG, 4 MG (*guanfacine hcl*)	NOT COVERED PA Required	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (*methylphenidate hcl*)	NOT COVERED PA Required	
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
methamphetamine hcl oral tablet 5 mg	NOT COVERED PA Required	
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (*methylphenidate hcl*)	NOT COVERED PA Required	
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl er (la) oral capsule extended release 24 hour 60 mg	COVERED - sPDL	
methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl er (osm) oral tablet extended release 36 mg	NOT COVERED PA Required	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl er (osm) oral tablet extended release 45 mg, 63 mg, 72 mg	NOT COVERED PA Required	
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	NOT COVERED PA Required	
methylphenidate hcl er oral tablet extended release 10 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl er oral tablet extended release 20 mg	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl er oral tablet extended release 24 hour 36 mg	NOT COVERED PA Required	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl oral solution 10 mg/5ml	COVERED - sPDL	QL (30 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl oral solution 5 mg/5ml	COVERED - sPDL	QL (15 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr, 30 mg/9hr	NOT COVERED PA Required	
modafinil oral tablet 100 mg, 200 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 17 Years)
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG, 50 MG (*amphetamine-dextroamphetamine*)	NOT COVERED PA Required	
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG, 50 MG (*armodafinil*)	NOT COVERED PA Required	
dextroamphetamine sulfate (Procentra Oral Solution 5 Mg/5Ml)	NOT COVERED PA Required	
PROVIGIL ORAL TABLET 100 MG, 200 MG (*modafinil*)	NOT COVERED PA Required	
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (*viloxazine hcl*)	NOT COVERED PA Required	
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG, 40 MG (*methylphenidate hcl*)	COVERED - sPDL	
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML (*methylphenidate hcl*)	COVERED - sPDL	
RELEXXII ORAL TABLET EXTENDED RELEASE 72 MG (*methylphenidate hcl*)	NOT COVERED PA Required	
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 30 MG, 40 MG (*methylphenidate hcl*)	NOT COVERED PA Required	
RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG (*methylphenidate hcl*)	NOT COVERED PA Required	
STRATTERA ORAL CAPSULE 10 MG, 100 MG, 18 MG, 25 MG, 40 MG, 60 MG, 80 MG (*atomoxetine hcl*)	NOT COVERED PA Required	
SUNOSI ORAL TABLET 150 MG, 75 MG (*solriamfetol hcl*)	NOT COVERED PA Required	
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG (*lisdexamfetamine dimesylate*)	COVERED - sPDL	
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (*lisdexamfetamine dimesylate*)	COVERED - sPDL	
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (*pitolisant hcl*)	NOT COVERED PA Required	
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (*dextroamphetamine*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
dextroamphetamine sulfate (Zenzedi Oral Tablet 10 Mg, 15 Mg, 2.5 Mg, 20 Mg, 30 Mg, 5 Mg, 7.5 Mg)	NOT COVERED PA Required	
ALTERNATIVE MEDICINES		
melatonin er oral tablet extended release 10 mg	COVERED - cDL	QL (1 EA per 1 day)
melatonin oral capsule 3 mg	COVERED - cDL	
melatonin oral capsule 5 mg	COVERED - cDL	QL (2 EA per 1 day)
melatonin oral liquid 1 mg/4ml	COVERED - cDL	QL (20 ML per 1 day)
melatonin oral tablet 1 mg, 3 mg, 5 mg	COVERED - cDL	QL (1 EA per 1 day)
melatonin oral tablet 300 mcg	COVERED - cDL	
melatonin oral tablet dispersible 5 mg	COVERED - cDL	QL (2 EA per 1 day)
melatonin tr with vitamin b6 oral tablet extended release 3-10 mg	COVERED - cDL	QL (1 EA per 1 day)
melatonin/vitamin b-6 ex st oral tablet 3-1 mg	COVERED - cDL	QL (2 EA per 1 day)
ra melatonin oral tablet 3-2 mg	COVERED - cDL	
AMEBICIDES		
SOLOSEC ORAL PACKET 2 GM (*secnidazole*)	NOT COVERED PA Required	
AMINOGLYCOSIDES		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (*amikacin sulfate liposome*)	NOT COVERED PA Required	
BETHKIS INHALATION NEBULIZATION SOLUTION 300 MG/4ML (*tobramycin*)	NOT COVERED PA Required	
KITABIS PAK INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*)	NOT COVERED PA Required	
neomycin sulfate oral tablet 500 mg	NOT COVERED PA Required	
TOBI INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*)	NOT COVERED PA Required	
TOBI PODHALER INHALATION CAPSULE 28 MG (*tobramycin*)	COVERED with Clinical Criteria	PA
tobramycin inhalation nebulization solution 300 mg/4ml	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
tobramycin inhalation nebulization solution 300 mg/5ml	COVERED - sPDL	
ANALGESICS - ANTI-INFLAMMATORY		
ABRILADA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-afzb*)	NOT COVERED PA Required	
ABRILADA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-afzb*)	NOT COVERED PA Required	
ABRILADA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (*adalimumab-afzb*)	NOT COVERED PA Required	
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab*)	NOT COVERED PA Required	
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab*)	NOT COVERED PA Required	
adalimumab-aacf (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	NOT COVERED PA Required	
adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 80 mg/0.8ml	NOT COVERED PA Required	
adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml	NOT COVERED PA Required	
adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml	NOT COVERED PA Required	
adalimumab-adaz subcutaneous solution auto-injector 40 mg/0.4ml	NOT COVERED PA Required	
adalimumab-adaz subcutaneous solution prefilled syringe 40 mg/0.4ml	NOT COVERED PA Required	
adalimumab-adbm (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml	NOT COVERED PA Required	
adalimumab-adbm (2 syringe) subcutaneous prefilled syringe kit 10 mg/0.2ml, 20 mg/0.4ml, 40 mg/0.4ml, 40 mg/0.8ml	NOT COVERED PA Required	
adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml	NOT COVERED PA Required	
adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml	NOT COVERED PA Required	
adalimumab-fkjp subcutaneous auto-injector kit 40 mg/0.8ml	NOT COVERED PA Required	QL (2 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
adalimumab-fkjp subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml	NOT COVERED PA Required	QL (2 EA per 28 days)
adalimumab-ryvk (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml	NOT COVERED PA Required	
ADVIL JUNIOR STRENGTH ORAL TABLET 100 MG (*ibuprofen*)	COVERED - cDL	QL (4 EA per 1 day)
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (*adalimumab-atto*)	NOT COVERED PA Required	
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-atto*)	NOT COVERED PA Required	
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML (*adalimumab-atto*)	NOT COVERED PA Required	
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 20 MG/0.4ML (*adalimumab-atto*)	NOT COVERED PA Required	
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (*rilonacept*)	NOT COVERED PA Required	
ARTHROTEC ORAL TABLET DELAYED RELEASE 50-0.2 MG, 75-0.2 MG (*diclofenac-misoprostol*)	NOT COVERED PA Required	
celecoxib oral capsule 100 mg, 50 mg	COVERED - cDL	QL (4 EA per 1 day)
celecoxib oral capsule 200 mg, 400 mg	COVERED - cDL	QL (2 EA per 1 day)
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	NOT COVERED PA Required	
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	NOT COVERED PA Required	
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	NOT COVERED PA Required	
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	NOT COVERED PA Required	
DAYPRO ORAL TABLET 600 MG (*oxaprozin*)	NOT COVERED PA Required	
diclofenac potassium oral capsule 25 mg	NOT COVERED PA Required	
diclofenac potassium oral tablet 25 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
diclofenac potassium oral tablet 50 mg	NOT COVERED PA Required	QL (4 EA per 1 day)
diclofenac sodium er oral tablet extended release 24 hour 100 mg	COVERED - sPDL	QL (2 EA per 1 day)
diclofenac sodium oral tablet delayed release 25 mg, 50 mg	COVERED - sPDL	QL (3 EA per 1 day)
diclofenac sodium oral tablet delayed release 75 mg	COVERED - sPDL	QL (2 EA per 1 day)
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	NOT COVERED PA Required	
DUEXIS ORAL TABLET 800-26.6 MG (*ibuprofen-famotidine*)	NOT COVERED PA Required	
ec-naproxen oral tablet delayed release 375 mg, 500 mg	NOT COVERED PA Required	
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (*etanercept*)	COVERED - sPDL	PA; QL (4 ML per 24 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (*etanercept*)	COVERED - sPDL	PA; QL (4 ML per 24 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (*etanercept*)	COVERED - sPDL	PA; QL (4 ML per 24 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (*etanercept*)	COVERED - sPDL	PA; QL (4 ML per 24 days)
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	NOT COVERED PA Required	
etodolac oral capsule 200 mg, 300 mg	NOT COVERED PA Required	
etodolac oral tablet 400 mg	NOT COVERED PA Required	QL (3 EA per 1 day)
etodolac oral tablet 500 mg	NOT COVERED PA Required	QL (2 EA per 1 day)
fenoprofen calcium oral capsule 400 mg	NOT COVERED PA Required	
fenoprofen calcium oral tablet 600 mg	NOT COVERED PA Required	
flurbiprofen oral tablet 100 mg	NOT COVERED PA Required	QL (4 EA per 1 day)
flurbiprofen oral tablet 50 mg	COVERED - cDL	QL (4 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-bwwd*)	NOT COVERED PA Required	QL (2 EA per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-bwwd*)	NOT COVERED PA Required	QL (2 EA per 28 days)
HULIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-fkjp*)	NOT COVERED PA Required	
HULIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (*adalimumab-fkjp*)	NOT COVERED PA Required	
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (*adalimumab*)	COVERED - sPDL	
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab*)	COVERED - sPDL	
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (*adalimumab*)	COVERED - sPDL	
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (*adalimumab*)	COVERED - sPDL	
HUMIRA-PED>/=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (*adalimumab*)	COVERED - sPDL	
HUMIRA-PED>/=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (*adalimumab*)	COVERED - sPDL	
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (*adalimumab*)	COVERED - sPDL	
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML (*adalimumab-adaz*)	NOT COVERED PA Required	
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML, 20 MG/0.2ML, 40 MG/0.4ML (*adalimumab-adaz*)	NOT COVERED PA Required	
HYRIMOZ-CROHNS/UC STARTER SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*adalimumab-adaz*)	NOT COVERED PA Required	
HYRIMOZ-PED<40KG CROHN STARTER SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML (*adalimumab-adaz*)	NOT COVERED PA Required	
HYRIMOZ-PED>/=40KG CROHN START SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML (*adalimumab-adaz*)	NOT COVERED PA Required	
HYRIMOZ-PLAQUE PSORIASIS START SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML (*adalimumab-adaz*)	NOT COVERED PA Required	
ibuprofen (Ibu Oral Tablet 400 Mg, 600 Mg, 800 Mg)	COVERED - sPDL	
ibuprofen childrens oral suspension 100 mg/5ml	COVERED - sPDL	QL (160 ML per 1 day)

Drug Name	Drug Tier	Requirements/Limits
ibuprofen junior strength oral tablet chewable 100 mg	COVERED - cDL	QL (6 EA per 1 day)
ibuprofen oral capsule 200 mg	COVERED - cDL	QL (4 EA per 1 day)
ibuprofen oral suspension 100 mg/5ml	COVERED - sPDL	
ibuprofen oral tablet 200 mg	COVERED - cDL	QL (4 EA per 1 day)
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	COVERED - sPDL	QL (4 EA per 1 day)
ibuprofen-famotidine oral tablet 800-26.6 mg	NOT COVERED PA Required	
IDACIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-aacf*)	NOT COVERED PA Required	
IDACIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (*adalimumab-aacf*)	NOT COVERED PA Required	
IDACIO-CROHNS/UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-aacf*)	NOT COVERED PA Required	
IDACIO-PSORIASIS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-aacf*)	NOT COVERED PA Required	
indomethacin er oral capsule extended release 75 mg	NOT COVERED PA Required	
indomethacin oral capsule 25 mg, 50 mg	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
indomethacin oral suspension 25 mg/5ml	NOT COVERED PA Required	
indomethacin rectal suppository 50 mg	NOT COVERED PA Required	
infants ibuprofen oral suspension 50 mg/1.25ml	COVERED - cDL	QL (160 ML per 1 day)
ketoprofen er oral capsule extended release 24 hour 200 mg	NOT COVERED PA Required	
ketoprofen oral capsule 50 mg	COVERED - sPDL	QL (4 EA per 1 day)
ketorolac tromethamine oral tablet 10 mg	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years); 5
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*)	NOT COVERED PA Required	
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*anakinra*)	NOT COVERED PA Required	
KIPROFEN ORAL CAPSULE 25 MG (*ketoprofen*)	NOT COVERED PA Required	
leflunomide oral tablet 10 mg, 20 mg	COVERED - cDL	QL (1 EA per 1 day)
diclofenac potassium (Lofena Oral Tablet 25 Mg)	NOT COVERED PA Required	
meclofenamate sodium oral capsule 100 mg, 50 mg	NOT COVERED PA Required	
mefenamic acid oral capsule 250 mg	NOT COVERED PA Required	
meloxicam oral capsule 10 mg, 5 mg	NOT COVERED PA Required	
meloxicam oral tablet 15 mg, 7.5 mg	COVERED - sPDL	QL (1 EA per 1 day)
nabumetone oral tablet 500 mg, 750 mg	COVERED - sPDL	QL (4 EA per 1 day)
NALFON ORAL CAPSULE 400 MG (*fenoprofen calcium*)	NOT COVERED PA Required	
NALFON ORAL TABLET 600 MG (*fenoprofen calcium*)	NOT COVERED PA Required	
NAPRELAN ORAL TABLET EXTENDED RELEASE 24 HOUR 375 MG, 500 MG, 750 MG (*naproxen sodium*)	NOT COVERED PA Required	
NAPROSYN ORAL SUSPENSION 125 MG/5ML (*naproxen*)	NOT COVERED PA Required	
naproxen dr oral tablet delayed release 500 mg	COVERED - sPDL	
naproxen oral suspension 125 mg/5ml	COVERED - sPDL	QL (100 ML per 1 day)
naproxen oral tablet 250 mg, 375 mg, 500 mg	COVERED - sPDL	QL (3 EA per 1 day)
naproxen oral tablet delayed release 375 mg, 500 mg	COVERED - sPDL	QL (3 EA per 1 day)
naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	NOT COVERED PA Required	
naproxen sodium oral tablet 220 mg	COVERED - cDL	QL (3 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
naproxen sodium oral tablet 275 mg, 550 mg	NOT COVERED PA Required	
naproxen-esomeprazole mg oral tablet delayed release 375-20 mg, 500-20 mg	NOT COVERED PA Required	
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (*baricitinib*)	NOT COVERED PA Required	
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (*abatacept*)	NOT COVERED PA Required	
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML (*abatacept*)	NOT COVERED PA Required	
OTEZLA ORAL TABLET 30 MG (*apremilast*)	COVERED - cDL	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (*apremilast*)	COVERED - cDL	PA
OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 17.5 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML (*methotrexate (anti-rheumatic)*)	NOT COVERED PA Required	
oxaprozin oral tablet 600 mg	NOT COVERED PA Required	QL (3 EA per 1 day)
piroxicam oral capsule 10 mg	COVERED - sPDL	PA; QL (4 EA per 1 day)
piroxicam oral capsule 20 mg	COVERED - sPDL	PA; QL (2 EA per 1 day)
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML (*methotrexate (anti-rheumatic)*)	COVERED - sPDL	
RELAFEN DS ORAL TABLET 1000 MG (*nabumetone*)	NOT COVERED PA Required	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG (*upadacitinib*)	NOT COVERED PA Required	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-ryvk*)	NOT COVERED PA Required	
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-ryvk*)	NOT COVERED PA Required	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (*golimumab*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (*golimumab*)	NOT COVERED PA Required	
sm ibuprofen jr oral tablet 100 mg	COVERED - cDL	QL (4 EA per 1 day)
sulindac oral tablet 150 mg, 200 mg	COVERED - sPDL	QL (3 EA per 1 day)
TOLECTIN 600 ORAL TABLET 600 MG (*tolmetin sodium*)	NOT COVERED PA Required	
tolmetin sodium oral capsule 400 mg	NOT COVERED PA Required	
VIMOVO ORAL TABLET DELAYED RELEASE 375-20 MG, 500-20 MG (*naproxen-esomeprazole*)	NOT COVERED PA Required	
XELJANZ ORAL SOLUTION 1 MG/ML (*tofacitinib citrate*)	NOT COVERED PA Required	
XELJANZ ORAL TABLET 10 MG, 5 MG (*tofacitinib citrate*)	NOT COVERED PA Required	
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (*tofacitinib citrate*)	NOT COVERED PA Required	
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML (*adalimumab-aaty*)	NOT COVERED PA Required	
YUFLYMA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-aaty*)	NOT COVERED PA Required	
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML (*adalimumab-aaty*)	NOT COVERED PA Required	
YUFLYMA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (*adalimumab-aaty*)	NOT COVERED PA Required	
YUSIMRY SUBCUTANEOUS SOLUTION PEN-INJECTOR 40 MG/0.8ML (*adalimumab-aqvh*)	NOT COVERED PA Required	
ANALGESICS - NONNARCOTIC		
acetaminophen 8 hour oral tablet extended release 650 mg	COVERED - cDL	QL (6 EA per 1 day)
acetaminophen childrens oral tablet chewable 160 mg	COVERED - cDL	QL (6 EA per 1 day)
acetaminophen extra strength oral tablet 500 mg	COVERED - cDL	QL (8 EA per 1 day)
acetaminophen infants oral suspension 160 mg/5ml	COVERED - cDL	
acetaminophen junior strength oral tablet dispersible 160 mg	COVERED - cDL	QL (25 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
acetaminophen oral solution 160 mg/5ml	COVERED - cDL	
acetaminophen oral tablet 325 mg	COVERED - cDL	QL (12 EA per 1 day)
acetaminophen rapid tabs child oral tablet dispersible 80 mg	COVERED - cDL	QL (50 EA per 1 day)
acetaminophen rectal suppository 120 mg	COVERED - cDL	QL (34 EA per 1 day)
acetaminophen rectal suppository 650 mg	COVERED - cDL	QL (6 EA per 1 day)
apap extra strength oral liquid 500 mg/15ml	COVERED - cDL	
aspirin low dose oral tablet chewable 81 mg	COVERED - cDL	QL (1 EA per 1 day)
aspirin oral tablet 325 mg	COVERED - cDL	QL (12 EA per 1 day)
aspirin oral tablet delayed release 325 mg	COVERED - cDL	QL (12 EA per 1 day)
aspirin oral tablet delayed release 81 mg	COVERED - cDL	QL (1 EA per 1 day)
butalbital-acetaminophen oral tablet 50-325 mg	COVERED - cDL	QL (10 EA per 1 day); AGE (Max 64 Years)
butalbital-apap-caffeine oral tablet 50-325-40 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
childrens non-aspirin oral tablet chewable 80 mg	COVERED - cDL	QL (6 EA per 1 day)
cvs acetaminophen ex st oral liquid 500 mg/15ml	COVERED - cDL	
cvs fever reducing childrens rectal suppository 120 mg	COVERED - cDL	QL (34 EA per 1 day)
diflunisal oral tablet 500 mg	NOT COVERED PA Required	
ed-apap oral liquid 160 mg/5ml	COVERED - cDL	
eq pain relief/rapid burst oral liquid 500 mg/15ml	COVERED - cDL	
FEVERALL CHILDRENS RECTAL SUPPOSITORY 120 MG (*acetaminophen*)	COVERED - cDL	QL (34 EA per 1 day)
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG (*acetaminophen*)	COVERED - cDL	QL (50 EA per 1 day)
MAPAP ACETAMINOPHEN EXTRA STR ORAL LIQUID 500 MG/15ML (*acetaminophen*)	COVERED - cDL	
pain relief childrens oral elixir 325 mg/10.15ml	COVERED - cDL	
pain relief oral liquid 500 mg/15ml	COVERED - cDL	
pain reliever oral liquid 500 mg/15ml	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
pain reliever/fever reducer rectal suppository 120 mg	COVERED - cDL	QL (34 EA per 1 day)
qc pain relief extra strength oral liquid 500 mg/15ml	COVERED - cDL	
ra pain reliever ex st oral liquid 500 mg/15ml	COVERED - cDL	
salsalate oral tablet 500 mg, 750 mg	COVERED - cDL	QL (4 EA per 1 day)
sb childrens non-aspirin oral tablet dispersible 80 mg	COVERED - cDL	QL (50 EA per 1 day)
ANALGESICS - OPIOID		
acetaminophen-codeine oral solution 120-12 mg/5ml	COVERED - sPDL	
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 12 Years); MED; Max 5 day supply for initial fill or PA required
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	NOT COVERED PA Required	
butalbital-asa-caff-codeine (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	COVERED - sPDL	
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG (*buprenorphine hcl*)	NOT COVERED PA Required	
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16 MG/0.32ML, 24 MG/0.48ML, 32 MG/0.64ML, 8 MG/0.16ML (*buprenorphine*)	NOT COVERED PA Required	
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML, 64 MG/0.18ML, 96 MG/0.27ML (*buprenorphine*)	NOT COVERED PA Required	
buprenorphine hcl sublingual tablet sublingual 2 mg	COVERED - sPDL	PA; QL (12 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl sublingual tablet sublingual 8 mg	COVERED - sPDL	PA; QL (3 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	NOT COVERED PA Required	QL (2 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg	NOT COVERED PA Required	QL (12 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 4-1 mg	NOT COVERED PA Required	QL (6 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 8-2 mg	NOT COVERED PA Required	QL (3 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg	COVERED - sPDL	QL (12 EA per 1 day); AGE (Min 16 Years)

Drug Name	Drug Tier	Requirements/Limits
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 16 Years)
buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr	NOT COVERED PA Required	
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg	COVERED - sPDL	
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	COVERED - sPDL	QL (8 EA per 1 day); MED; Max 5 day supply for initial fill or PA required
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	COVERED - sPDL	
butorphanol tartrate nasal solution 10 mg/ml	NOT COVERED PA Required	
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HR, 15 MCG/HR, 20 MCG/HR, 5 MCG/HR, 7.5 MCG/HR (*buprenorphine*)	COVERED - sPDL	
codeine sulfate oral tablet 15 mg	COVERED - sPDL	
codeine sulfate oral tablet 30 mg	COVERED - sPDL	QL (12 EA per 1 day); AGE (Min 12 Years); MED; Max 5 day supply for initial fill or PA required
codeine sulfate oral tablet 60 mg	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 12 Years); MED; Max 5 day supply for initial fill or PA required
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (*tramadol hcl*)	NOT COVERED PA Required	
DILAUDID ORAL LIQUID 1 MG/ML (*hydromorphone hcl*)	NOT COVERED PA Required	
DILAUDID ORAL TABLET 2 MG, 4 MG, 8 MG (*hydromorphone hcl*)	NOT COVERED PA Required	
DSUVIA SUBLINGUAL TABLET SUBLINGUAL 30 MCG (*sufentanil citrate*)	NOT COVERED PA Required	
oxycodone-acetaminophen (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	COVERED - sPDL	
fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	NOT COVERED PA Required	
fentanyl citrate buccal tablet 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	NOT COVERED PA Required	
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	COVERED - sPDL	PA; QL (0.334 EA per 1 day); MED

Drug Name	Drug Tier	Requirements/Limits
fentanyl transdermal patch 72 hour 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr	NOT COVERED PA Required	
FENTORA BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (*fentanyl citrate*)	NOT COVERED PA Required	
FIORICET/CODEINE ORAL CAPSULE 50-300-40-30 MG (*butalbital-apap-caff-cod*)	NOT COVERED PA Required	
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg	NOT COVERED PA Required	
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	NOT COVERED PA Required	
hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml	COVERED - sPDL	
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	COVERED - sPDL	QL (3750 ML per 25 days); MED; Max 5 day supply for initial fill or PA required
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	COVERED - sPDL	
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	COVERED - sPDL	QL (6 EA per 1 day); MED; Max 5 day supply for initial fill or PA required
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	COVERED - sPDL	
hydromorphone hcl er oral tablet extended release 24 hour 12 mg, 16 mg, 32 mg, 8 mg	NOT COVERED PA Required	
hydromorphone hcl oral liquid 1 mg/ml	COVERED - sPDL	
hydromorphone hcl oral tablet 2 mg, 4 mg	COVERED - sPDL	QL (12 EA per 1 day); MED; Max 5 day supply for initial fill or PA required
hydromorphone hcl oral tablet 8 mg	COVERED - sPDL	
hydromorphone hcl rectal suppository 3 mg	COVERED - sPDL	
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG, 120 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG (*hydrocodone bitartrate*)	NOT COVERED PA Required	
levorphanol tartrate oral tablet 2 mg, 3 mg	NOT COVERED PA Required	
meperidine hcl oral solution 50 mg/5ml	COVERED - sPDL	
meperidine hcl oral tablet 50 mg	COVERED - sPDL	
methadone hcl oral tablet 10 mg, 5 mg	COVERED - cDL	MED; Max 5 day supply for initial fill or PA required

Drug Name	Drug Tier	Requirements/Limits
morphine sulfate (concentrate) oral solution 100 mg/5ml	COVERED - sPDL	MED; Max 5 day supply for initial fill or PA required
morphine sulfate (concentrate) oral solution 20 mg/ml	COVERED - sPDL	
morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	NOT COVERED PA Required	
morphine sulfate er oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg	NOT COVERED PA Required	
morphine sulfate er oral tablet extended release 100 mg, 15 mg, 30 mg, 60 mg	COVERED - sPDL	ST; QL (3 EA per 1 day); Requires prior use of IR Opioid; MED
morphine sulfate er oral tablet extended release 200 mg	COVERED - sPDL	
morphine sulfate oral solution 10 mg/5ml	COVERED - sPDL	MED; Max 5 day supply for initial fill or PA required
morphine sulfate oral solution 20 mg/5ml	COVERED - sPDL	
morphine sulfate oral tablet 15 mg, 30 mg	COVERED - sPDL	QL (3 EA per 1 day); MED; Max 5 day supply for initial fill or PA required
morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg	COVERED - sPDL	
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 15 MG, 200 MG, 30 MG, 60 MG (*morphine sulfate*)	NOT COVERED PA Required	
nalocet oral tablet 2.5-300 mg	NOT COVERED PA Required	
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG (*tapentadol hcl*)	NOT COVERED PA Required	
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (*tapentadol hcl*)	NOT COVERED PA Required	
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg	NOT COVERED PA Required	
oxycodone hcl oral capsule 5 mg	COVERED - sPDL	
oxycodone hcl oral concentrate 100 mg/5ml	COVERED - sPDL	
oxycodone hcl oral solution 5 mg/5ml	COVERED - sPDL	QL (240 ML per 1 day); MED; Max 5 day supply for initial fill or PA required
oxycodone hcl oral tablet 10 mg, 15 mg, 5 mg	COVERED - sPDL	QL (90 EA per 25 days); MED; Max 5 day supply for initial fill or PA required

Drug Name	Drug Tier	Requirements/Limits
oxycodone hcl oral tablet 20 mg, 30 mg	COVERED - sPDL	QL (120 EA per 25 days); MED; Max 5 day supply for initial fill or PA required
oxycodone-acetaminophen oral solution 5-325 mg/5ml	NOT COVERED PA Required	
oxycodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg	COVERED - sPDL	QL (6 EA per 1 day); MED; Max 5 day supply for initial fill or PA required
oxycodone-acetaminophen oral tablet 2.5-325 mg	COVERED - sPDL	
oxycodone-acetaminophen oral tablet 5-325 mg	COVERED - sPDL	QL (8 EA per 1 day); MED; Max 5 day supply for initial fill or PA required
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG (*oxycodone hcl*)	NOT COVERED PA Required	
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg	NOT COVERED PA Required	
oxymorphone hcl oral tablet 10 mg, 5 mg	NOT COVERED PA Required	
pentazocine-naloxone hcl oral tablet 50-0.5 mg	NOT COVERED PA Required	
PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG (*oxycodone-acetaminophen*)	NOT COVERED PA Required	
PROLATE ORAL SOLUTION 10-300 MG/5ML (*oxycodone-acetaminophen*)	NOT COVERED PA Required	
PROLATE ORAL TABLET 10-300 MG, 5-300 MG, 7.5-300 MG (*oxycodone-acetaminophen*)	NOT COVERED PA Required	
QDOLO ORAL SOLUTION 5 MG/ML (*tramadol hcl*)	NOT COVERED PA Required	
ROXICODONE ORAL TABLET 15 MG, 30 MG (*oxycodone hcl*)	NOT COVERED PA Required	
ROXYBOND ORAL TABLET ABUSE-DETERRENT 15 MG, 30 MG, 5 MG (*oxycodone hcl*)	NOT COVERED PA Required	
SEGLENTIS ORAL TABLET 56-44 MG (*celecoxib-tramadol hcl*)	NOT COVERED PA Required	
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML (*buprenorphine*)	COVERED - sPDL	AGE (Min 16 Years)
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (*buprenorphine hcl-naloxone hcl*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
tramadol hcl (er biphasic) oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	NOT COVERED PA Required	
tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	COVERED - sPDL	
tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	COVERED - sPDL	
tramadol hcl oral solution 5 mg/ml	NOT COVERED PA Required	
tramadol hcl oral tablet 100 mg	NOT COVERED PA Required	
tramadol hcl oral tablet 25 mg	COVERED - sPDL	
tramadol hcl oral tablet 50 mg	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 12 Years); MED; Max 5 day supply for initial fill or PA required
tramadol-acetaminophen oral tablet 37.5-325 mg	COVERED - sPDL	
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG (*oxycodone*)	COVERED - sPDL	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (*buprenorphine hcl-naloxone hcl*)	NOT COVERED PA Required	
ANDROGENS-ANABOLIC		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR (*testosterone*)	NOT COVERED PA Required	
ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%) (*testosterone*)	NOT COVERED PA Required	
testosterone cypionate (Depo-Testosterone Intramuscular Solution 100 Mg/Ml, 200 Mg/Ml)	COVERED - cDL	
NATESTO NASAL GEL 5.5 MG/ACT (*testosterone*)	NOT COVERED PA Required	
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	COVERED - sPDL	
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	COVERED - cDL	
testosterone enanthate intramuscular solution 200 mg/ml	COVERED - cDL	
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	COVERED - sPDL	
testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
testosterone transdermal solution 30 mg/act	NOT COVERED PA Required	
VOGELXO PUMP TRANSDERMAL GEL 12.5 MG/ACT (1%) (*testosterone*)	NOT COVERED PA Required	
VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	NOT COVERED PA Required	
ANORECTAL AND RELATED PRODUCTS		
budesonide rectal foam 2 mg	NOT COVERED PA Required	
CORTENEMA RECTAL ENEMA 100 MG/60ML (*hydrocortisone*)	COVERED - cDL	
dibucaine (perianal) external ointment 1 %	COVERED - cDL	
hemorrhoidal external cream 1-0.25-14.4-15 %	COVERED - cDL	
hydrocortisone acetate rectal suppository 25 mg	COVERED - cDL	QL (7 EA per 1 day)
hydrocortisone rectal enema 100 mg/60ml	COVERED - cDL	
hydrocortisone (Proctosol Hc External Cream 2.5 %)	COVERED - cDL	
UCERIS RECTAL FOAM 2 MG/ACT (*budesonide*)	NOT COVERED PA Required	
ANTACIDS		
antacid & antigas oral suspension 200-200-20 mg/5ml	COVERED - cDL	
antacid anti-gas max strength oral suspension 400-400-40 mg/5ml	COVERED - cDL	
antacid extra strength oral tablet chewable 160-105 mg, 675-135 mg	COVERED - cDL	
antacid maximum oral tablet chewable 1000 mg	COVERED - cDL	
antacid ultra strength oral tablet chewable 1000 mg	COVERED - cDL	
calcium antacid extra strength oral tablet chewable 750 mg	COVERED - cDL	
calcium antacid oral tablet chewable 500 mg	COVERED - cDL	
calcium carbonate antacid oral suspension 1250 mg/5ml	COVERED - cDL	
calcium carbonate antacid oral tablet 648 mg	COVERED - cDL	
childrens soothe oral tablet chewable 400 mg	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
cvs antacid maximum strength oral tablet chewable 1000 mg	COVERED - cDL	
cvs antacid supreme oral suspension 400-135 mg/5ml	COVERED - cDL	
cvs antacid ultra strength oral tablet chewable 1000 mg	COVERED - cDL	
eq antacid ultra strength oral tablet chewable 1000 mg	COVERED - cDL	
eql antacid ultra strength oral tablet chewable 1000 mg	COVERED - cDL	
GAVISCON ORAL SUSPENSION 95-358 MG/15ML (*alum hydroxide-mag carbonate*)	COVERED - cDL	
GELUSIL ORAL TABLET CHEWABLE 200-200-25 MG (*alum & mag hydroxide-simeth*)	COVERED - cDL	
gnp antacid ultra strength oral tablet chewable 1000 mg	COVERED - cDL	
goodsense antacid oral tablet chewable 1000 mg	COVERED - cDL	
magnesium oxide oral tablet 250 mg, 420 mg	COVERED - cDL	
MINTOX PLUS ORAL TABLET CHEWABLE 200-200-25 MG (*alum & mag hydroxide-simeth*)	COVERED - cDL	
qc antacid ultra strength oral tablet chewable 1000 mg	COVERED - cDL	
ra antacid ultra strength oral tablet chewable 1000 mg	COVERED - cDL	
sodium bicarbonate oral tablet 325 mg, 650 mg	COVERED - cDL	
TUMS ULTRA 1000 ORAL TABLET CHEWABLE 1000 MG (*calcium carbonate antacid*)	COVERED - cDL	
ANTHELMINTICS		
albendazole oral tablet 200 mg	COVERED - cDL	QL (4 EA per 1 day)
ivermectin oral tablet 3 mg	COVERED - cDL	QL (1 EA per 1 day)
pinworm medicine oral suspension 144 (50 base) mg/ml	COVERED - cDL	
ANTIANGINAL AGENTS		
ASPRUZYO SPRINKLE ORAL PACKET 1000 MG, 500 MG (*ranolazine*)	NOT COVERED PA Required	
isosorbide dinitrate oral tablet 10 mg, 30 mg, 5 mg	COVERED - cDL	QL (4 EA per 1 day)
isosorbide dinitrate oral tablet 20 mg	COVERED - cDL	QL (6 EA per 1 day)
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	COVERED - cDL	QL (2 EA per 1 day)
isosorbide mononitrate oral tablet 10 mg	COVERED - cDL	QL (3 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
isosorbide mononitrate oral tablet 20 mg	COVERED - cDL	QL (2 EA per 1 day)
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	COVERED - cDL	QL (10 EA per 1 day)
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	COVERED - cDL	QL (1 EA per 1 day)
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	COVERED - sPDL	ST; QL (2 EA per 1 day); Prior use BB/CCBs & long-acting nitrate
ANTIANXIETY AGENTS		
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Min 18 Years)
buspirone hcl oral tablet 10 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Min 6 Years)
buspirone hcl oral tablet 15 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 6 Years)
buspirone hcl oral tablet 5 mg	COVERED - cDL	QL (8 EA per 1 day); AGE (Min 6 Years)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 64 Years)
clorazepate dipotassium oral tablet 15 mg, 3.75 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 64 Years)
clorazepate dipotassium oral tablet 7.5 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 6 Years and Max 64 Years)
diazepam (Diazepam Intensol Oral Concentrate 5 Mg/Ml)	COVERED - cDL	PA; QL (3 ML per 1 day); AGE (Max 64 Years)
diazepam oral solution 5 mg/5ml	COVERED - cDL	QL (4 ML per 1 day); AGE (Max 64 Years)
diazepam oral tablet 10 mg, 2 mg, 5 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Max 64 Years)
hydroxyzine hcl oral syrup 10 mg/5ml	COVERED - cDL	QL (60 ML per 1 day); AGE (Max 64 Years)
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	COVERED - cDL	QL (8 EA per 1 day); AGE (Max 64 Years)
hydroxyzine pamoate oral capsule 100 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Max 64 Years)
hydroxyzine pamoate oral capsule 25 mg, 50 mg	COVERED - cDL	QL (8 EA per 1 day); AGE (Max 64 Years)
lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/Ml)	COVERED - cDL	QL (3 ML per 1 day); AGE (Min 12 Years)
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Min 12 Years)
oxazepam oral capsule 10 mg, 15 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Min 6 Years)
oxazepam oral capsule 30 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 6 Years)

Drug Name	Drug Tier	Requirements/Limits
ANTIARRHYTHMICS		
amiodarone hcl oral tablet 200 mg	COVERED - cDL	QL (4 EA per 1 day)
disopyramide phosphate oral capsule 100 mg	COVERED - cDL	QL (8 EA per 1 day)
disopyramide phosphate oral capsule 150 mg	COVERED - cDL	QL (5 EA per 1 day); AGE (Max 64 Years)
flecainide acetate oral tablet 100 mg	COVERED - cDL	QL (6 EA per 1 day)
flecainide acetate oral tablet 150 mg	COVERED - cDL	QL (3 EA per 1 day)
flecainide acetate oral tablet 50 mg	COVERED - cDL	QL (7 EA per 1 day)
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	COVERED - cDL	QL (6 EA per 1 day)
propafenone hcl oral tablet 150 mg	COVERED - cDL	QL (6 EA per 1 day)
propafenone hcl oral tablet 225 mg, 300 mg	COVERED - cDL	QL (3 EA per 1 day)
quinidine sulfate oral tablet 300 mg	COVERED - cDL	QL (8 EA per 1 day)
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ACCOLATE ORAL TABLET 10 MG, 20 MG (*zafirlukast*)	NOT COVERED PA Required	
ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT (*fluticasone-salmeterol*)	COVERED - sPDL	
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (*fluticasone-salmeterol*)	COVERED - sPDL	
AIRDUO RESPICLICK 113/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT (*fluticasone-salmeterol*)	NOT COVERED PA Required	
AIRDUO RESPICLICK 232/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 232-14 MCG/ACT (*fluticasone-salmeterol*)	NOT COVERED PA Required	
AIRDUO RESPICLICK 55/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 55-14 MCG/ACT (*fluticasone-salmeterol*)	NOT COVERED PA Required	
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*)	NOT COVERED PA Required	
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	NOT COVERED PA Required	QL (6.7 GM per 25 days)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%	COVERED - sPDL	
albuterol sulfate inhalation nebulization solution 0.63 mg/3ml	COVERED - sPDL	QL (200 ML per 25 days)

Drug Name	Drug Tier	Requirements/Limits
albuterol sulfate inhalation nebulization solution 1.25 mg/3ml	COVERED - sPDL	QL (150 ML per 25 days)
albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml	COVERED - sPDL	QL (150 EA per 25 days)
albuterol sulfate oral syrup 2 mg/5ml	COVERED - sPDL	QL (150 ML per 1 day)
albuterol sulfate oral tablet 2 mg	COVERED - sPDL	
albuterol sulfate oral tablet 4 mg	COVERED - sPDL	QL (8 EA per 1 day)
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT, 80 MCG/ACT (*ciclesonide*)	NOT COVERED PA Required	QL (6.1 GM per 25 days); 90DS
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (*umeclidinium-vilanterol*)	COVERED - sPDL	QL (1 EA per 1 day)
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	NOT COVERED PA Required	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT (*fluticasone furoate*)	NOT COVERED PA Required	
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (*mometasone furoate*)	COVERED - sPDL	
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (*mometasone furoate*)	COVERED - sPDL	
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT (*mometasone furoate*)	COVERED - sPDL	
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (*mometasone furoate*)	COVERED - sPDL	
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT (*mometasone furoate*)	NOT COVERED PA Required	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (*ipratropium bromide hfa*)	COVERED - sPDL	QL (12.9 GM per 25 days)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (*glycopyrrolate-formoterol*)	NOT COVERED PA Required	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (*fluticasone furoate-vilanterol*)	NOT COVERED PA Required	
budesonide-formoterol fumarate (Breyna Inhalation Aerosol 160-4.5 Mcg/Act, 80-4.5 Mcg/Act)	NOT COVERED PA Required	QL (20.6 GM per 25 days); 90DS
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML (*arformoterol tartrate*)	NOT COVERED PA Required	
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	COVERED - sPDL	QL (4 ML per 1 day); AGE (Max 9 Years)
budesonide inhalation suspension 1 mg/2ml	COVERED - sPDL	
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	NOT COVERED PA Required	QL (20.4 GM per 25 days); 90DS
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (*ipratropium-albuterol*)	COVERED - sPDL	
cromolyn sodium inhalation nebulization solution 20 mg/2ml	COVERED - cDL	QL (26 ML per 1 day)
DALIRESP ORAL TABLET 250 MCG, 500 MCG (*roflumilast*)	NOT COVERED PA Required	
DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (*aclidinium br-formoterol fum*)	NOT COVERED PA Required	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT (*mometasone furo-formoterol fum*)	COVERED - sPDL	
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (*benralizumab*)	COVERED - cDL	PA; 90DS
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML (*benralizumab*)	COVERED - cDL	PA; 90DS
fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act	NOT COVERED PA Required	
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act	NOT COVERED PA Required	
fluticasone propionate hfa inhalation aerosol 110 mcg/act	COVERED - sPDL	QL (0.4 GM per 1 day); AGE (Max 11 Years); 90DS
fluticasone propionate hfa inhalation aerosol 220 mcg/act	COVERED - sPDL	
fluticasone propionate hfa inhalation aerosol 44 mcg/act	COVERED - sPDL	QL (0.354 GM per 1 day); AGE (Max 11 Years); 90DS
fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act	NOT COVERED PA Required	
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	NOT COVERED PA Required	QL (1 EA per 1 day); 90DS
fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act	NOT COVERED PA Required	QL (0.04 EA per 1 day); 90DS
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (*umeclidinium bromide*)	COVERED - sPDL	QL (1 EA per 1 day)
ipratropium bromide inhalation solution 0.02 %	NOT COVERED PA Required	QL (10 ML per 1 day)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	NOT COVERED PA Required	QL (360 ML per 25 days)
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	NOT COVERED PA Required	
levalbuterol tartrate inhalation aerosol 45 mcg/act	NOT COVERED PA Required	
montelukast sodium oral packet 4 mg	COVERED - sPDL	
montelukast sodium oral tablet 10 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
montelukast sodium oral tablet chewable 4 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (*formoterol fumarate*)	NOT COVERED PA Required	
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (*albuterol sulfate*)	NOT COVERED PA Required	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (*budesonide*)	NOT COVERED PA Required	
PULMICORT INHALATION SUSPENSION 0.25 MG/2ML, 0.5 MG/2ML, 1 MG/2ML (*budesonide*)	NOT COVERED PA Required	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (*beclomethasone diprop hfa*)	COVERED - sPDL	QL (0.354 GM per 1 day); 90DS
roflumilast oral tablet 250 mcg, 500 mcg	NOT COVERED PA Required	
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*salmeterol xinafoate*)	COVERED - sPDL	
SINGULAIR ORAL PACKET 4 MG (*montelukast sodium*)	NOT COVERED PA Required	
SINGULAIR ORAL TABLET 10 MG (*montelukast sodium*)	NOT COVERED PA Required	
SINGULAIR ORAL TABLET CHEWABLE 4 MG, 5 MG (*montelukast sodium*)	NOT COVERED PA Required	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (*tiotropium bromide monohydrate*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (*tiotropium bromide monohydrate*)	NOT COVERED PA Required	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (*tiotropium bromide-olodaterol*)	COVERED - sPDL	
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (*olodaterol hcl*)	NOT COVERED PA Required	QL (2 GM per 1 day)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (*budesonide-formoterol fumarate*)	COVERED - sPDL	
terbutaline sulfate oral tablet 2.5 mg	NOT COVERED PA Required	QL (8 EA per 1 day)
terbutaline sulfate oral tablet 5 mg	NOT COVERED PA Required	QL (6 EA per 1 day)
theophylline er oral tablet extended release 12 hour 300 mg	COVERED - cDL	QL (4 EA per 1 day); 90DS
theophylline er oral tablet extended release 12 hour 450 mg	COVERED - cDL	QL (2 EA per 1 day); 90DS
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	COVERED - cDL	QL (3 EA per 1 day); 90DS
theophylline oral elixir 80 mg/15ml	COVERED - cDL	90DS
theophylline oral solution 80 mg/15ml	COVERED - cDL	90DS
tiotropium bromide monohydrate inhalation capsule 18 mcg	NOT COVERED PA Required	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*)	NOT COVERED PA Required	QL (1 EA per 1 day)
TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACT (*aclidinium bromide*)	NOT COVERED PA Required	
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (*albuterol sulfate*)	COVERED - sPDL	
fluticasone-salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	NOT COVERED PA Required	
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*omalizumab*)	COVERED - cDL	PA; QL (5 ML per 24 days); 90DS
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*omalizumab*)	COVERED - cDL	PA; QL (2.5 ML per 24 days); 90DS
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (*omalizumab*)	COVERED - cDL	PA; QL (5 EA per 24 days); 90DS
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (*levalbuterol tartrate*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
YUPELRI INHALATION SOLUTION 175 MCG/3ML (*revefenacin*)	NOT COVERED PA Required	
zafirlukast oral tablet 10 mg, 20 mg	COVERED - sPDL	
zileuton er oral tablet extended release 12 hour 600 mg	NOT COVERED PA Required	
ZYFLO ORAL TABLET 600 MG (*zileuton*)	NOT COVERED PA Required	
ANTICOAGULANTS		
ARIXTRA SUBCUTANEOUS SOLUTION 10 MG/0.8ML, 2.5 MG/0.5ML, 5 MG/0.4ML, 7.5 MG/0.6ML (*fondaparinux sodium*)	NOT COVERED PA Required	
dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg	NOT COVERED PA Required	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (*apixaban*)	COVERED - sPDL	QL (74 EA per 1 day)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG (*apixaban*)	COVERED - sPDL	QL (2 EA per 1 day)
enoxaparin sodium injection solution 300 mg/3ml	COVERED - sPDL	
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml	COVERED - sPDL	QL (2 ML per 1 day)
enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml	COVERED - sPDL	QL (1.6 ML per 1 day)
enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml	COVERED - sPDL	QL (0.6 ML per 1 day)
enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml	COVERED - sPDL	QL (0.8 ML per 1 day)
enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml	COVERED - sPDL	QL (1.2 ML per 1 day)
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	COVERED - sPDL	PA
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (*dalteparin sodium*)	NOT COVERED PA Required	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (*dalteparin sodium*)	NOT COVERED PA Required	
warfarin sodium (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	COVERED - sPDL	
LOVENOX INJECTION SOLUTION 300 MG/3ML (*enoxaparin sodium*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
LOVENOX INJECTION SOLUTION PREFILLED SYRINGE 100 MG/ML, 120 MG/0.8ML, 150 MG/ML, 30 MG/0.3ML, 40 MG/0.4ML, 60 MG/0.6ML, 80 MG/0.8ML (*enoxaparin sodium*)	NOT COVERED PA Required	
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG (*dabigatran etexilate mesylate*)	COVERED - sPDL	
PRADAXA ORAL PACKET 110 MG, 150 MG, 20 MG, 30 MG, 40 MG, 50 MG (*dabigatran etexilate mesylate*)	NOT COVERED PA Required	
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (*edoxaban tosylate*)	NOT COVERED PA Required	
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	COVERED - sPDL	QL (10 EA per 1 day)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (*rivaroxaban*)	COVERED - sPDL	
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG (*rivaroxaban*)	COVERED - sPDL	
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (*rivaroxaban*)	COVERED - sPDL	
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (*eslicarbazepine acetate*)	NOT COVERED PA Required	
BANZEL ORAL SUSPENSION 40 MG/ML (*rufinamide*)	COVERED with Clinical Criteria	PA
BANZEL ORAL TABLET 200 MG, 400 MG (*rufinamide*)	COVERED with Clinical Criteria	PA
BRIVIACT ORAL SOLUTION 10 MG/ML (*brivaracetam*)	NOT COVERED PA Required	
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (*brivaracetam*)	NOT COVERED PA Required	
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	NOT COVERED PA Required	QL (8 EA per 1 day)
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	NOT COVERED PA Required	QL (8 EA per 1 day)
carbamazepine oral suspension 100 mg/5ml	NOT COVERED PA Required	QL (60 ML per 1 day)
carbamazepine oral tablet 200 mg	COVERED - sPDL	QL (8 EA per 1 day)
carbamazepine oral tablet chewable 100 mg	COVERED - sPDL	QL (8 EA per 1 day)
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
CELONTIN ORAL CAPSULE 300 MG (*methsuximide*)	COVERED - sPDL	
clobazam oral suspension 2.5 mg/ml	COVERED with Clinical Criteria	PA
clobazam oral tablet 10 mg, 20 mg	COVERED - sPDL	QL (2 EA per 1 day)
clonazepam oral tablet 0.5 mg	COVERED - cDL	
clonazepam oral tablet 1 mg	COVERED - cDL	QL (10 EA per 1 day)
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (*divalproex sodium*)	NOT COVERED PA Required	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (*divalproex sodium*)	NOT COVERED PA Required	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (*divalproex sodium*)	NOT COVERED PA Required	
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (*stiripentol*)	NOT COVERED PA Required	
DIACOMIT ORAL PACKET 250 MG, 500 MG (*stiripentol*)	NOT COVERED PA Required	
diazepam rectal gel 10 mg, 20 mg	COVERED - cDL	
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (*phenytoin*)	NOT COVERED PA Required	
DILANTIN ORAL CAPSULE 100 MG (*phenytoin sodium extended*)	NOT COVERED PA Required	
DILANTIN ORAL CAPSULE 30 MG (*phenytoin sodium extended*)	NOT COVERED PA Required	QL (6 EA per 1 day)
DILANTIN ORAL SUSPENSION 125 MG/5ML (*phenytoin*)	NOT COVERED PA Required	
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (*phenytoin*)	NOT COVERED PA Required	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	COVERED - sPDL	QL (10 EA per 1 day)
divalproex sodium oral capsule delayed release sprinkle 125 mg	COVERED - sPDL	QL (10 EA per 1 day)
divalproex sodium oral tablet delayed release 125 mg	COVERED - sPDL	QL (15 EA per 1 day)
divalproex sodium oral tablet delayed release 250 mg, 500 mg	COVERED - sPDL	QL (10 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG, 1500 MG (*levetiracetam*)	NOT COVERED PA Required	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (*cannabidiol*)	NOT COVERED PA Required	
carbamazepine (Epitol Oral Tablet 200 Mg)	COVERED - sPDL	
EPRONTIA ORAL SOLUTION 25 MG/ML (*topiramate*)	NOT COVERED PA Required	
ethosuximide oral capsule 250 mg	COVERED - sPDL	QL (6 EA per 1 day)
ethosuximide oral solution 250 mg/5ml	COVERED - sPDL	QL (30 ML per 1 day)
felbamate oral suspension 600 mg/5ml	COVERED - sPDL	
felbamate oral tablet 400 mg, 600 mg	COVERED - sPDL	
FELBATOL ORAL TABLET 400 MG, 600 MG (*felbamate*)	NOT COVERED PA Required	
FINTEPLA ORAL SOLUTION 2.2 MG/ML (*fenfluramine hcl*)	NOT COVERED PA Required	
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (*perampanel*)	COVERED with Clinical Criteria	PA
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*perampanel*)	COVERED with Clinical Criteria	PA
gabapentin oral capsule 100 mg, 300 mg	COVERED - sPDL	QL (10 EA per 1 day)
gabapentin oral capsule 400 mg	COVERED - sPDL	QL (9 EA per 1 day)
gabapentin oral solution 250 mg/5ml, 300 mg/6ml	COVERED - sPDL	
gabapentin oral tablet 600 mg	COVERED - sPDL	QL (6 EA per 1 day)
gabapentin oral tablet 800 mg	COVERED - sPDL	QL (4 EA per 1 day)
KEPPRA ORAL SOLUTION 100 MG/ML (*levetiracetam*)	NOT COVERED PA Required	
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (*levetiracetam*)	NOT COVERED PA Required	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (*levetiracetam*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
KLONOPIN ORAL TABLET 2 MG (*clonazepam*)	COVERED - cDL	QL (10 EA per 1 day)
lacosamide oral solution 10 mg/ml	NOT COVERED PA Required	QL (20 ML per 1 day)
lacosamide oral solution 100 mg/10ml, 50 mg/5ml	NOT COVERED PA Required	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	NOT COVERED PA Required	QL (2 EA per 1 day)
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (*lamotrigine*)	NOT COVERED PA Required	
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (*lamotrigine*)	NOT COVERED PA Required	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (*lamotrigine*)	NOT COVERED PA Required	
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (*lamotrigine*)	NOT COVERED PA Required	
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (*lamotrigine*)	NOT COVERED PA Required	
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (*lamotrigine*)	NOT COVERED PA Required	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (*lamotrigine*)	NOT COVERED PA Required	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	COVERED - sPDL	
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	NOT COVERED PA Required	
lamotrigine oral tablet 100 mg	COVERED - sPDL	QL (8 EA per 1 day)
lamotrigine oral tablet 150 mg, 200 mg	COVERED - sPDL	QL (4 EA per 1 day)
lamotrigine oral tablet 25 mg	COVERED - sPDL	QL (10 EA per 1 day)
lamotrigine oral tablet chewable 25 mg, 5 mg	COVERED - sPDL	QL (8 EA per 1 day)
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	COVERED - sPDL	
lamotrigine starter kit-blue oral kit 35 x 25 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	NOT COVERED PA Required	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	NOT COVERED PA Required	
levetiracetam er oral tablet extended release 24 hour 500 mg	COVERED - sPDL	QL (6 EA per 1 day)
levetiracetam er oral tablet extended release 24 hour 750 mg	COVERED - sPDL	QL (4 EA per 1 day)
levetiracetam oral solution 100 mg/ml, 500 mg/5ml	COVERED - sPDL	
levetiracetam oral tablet 1000 mg	COVERED - sPDL	QL (3 EA per 1 day)
levetiracetam oral tablet 250 mg, 500 mg	COVERED - sPDL	QL (6 EA per 1 day)
levetiracetam oral tablet 750 mg	COVERED - sPDL	QL (4 EA per 1 day)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (*pregabalin*)	NOT COVERED PA Required	
LYRICA ORAL SOLUTION 20 MG/ML (*pregabalin*)	NOT COVERED PA Required	
methsuximide oral capsule 300 mg	NOT COVERED PA Required	
MOTPOLY XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (*lacosamide*)	NOT COVERED PA Required	
MYSOLINE ORAL TABLET 250 MG, 50 MG (*primidone*)	NOT COVERED PA Required	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (*midazolam (anticonvulsant)*)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 12 Years)
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (*gabapentin*)	NOT COVERED PA Required	
NEURONTIN ORAL SOLUTION 250 MG/5ML (*gabapentin*)	NOT COVERED PA Required	
NEURONTIN ORAL TABLET 600 MG, 800 MG (*gabapentin*)	NOT COVERED PA Required	
ONFI ORAL SUSPENSION 2.5 MG/ML (*clobazam*)	NOT COVERED PA Required	
ONFI ORAL TABLET 10 MG, 20 MG (*clobazam*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
oxcarbazepine oral suspension 300 mg/5ml	COVERED - sPDL	QL (16.667 ML per 1 day)
oxcarbazepine oral tablet 150 mg	COVERED - sPDL	QL (16 EA per 1 day)
oxcarbazepine oral tablet 300 mg	COVERED - sPDL	
oxcarbazepine oral tablet 600 mg	COVERED - sPDL	QL (4 EA per 1 day)
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG, 600 MG (*oxcarbazepine*)	NOT COVERED PA Required	
phenytoin sodium extended (Phenytek Oral Capsule 200 Mg, 300 Mg)	NOT COVERED PA Required	
phenytoin (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)	COVERED - sPDL	
phenytoin oral suspension 125 mg/5ml	COVERED - sPDL	QL (20 ML per 1 day)
phenytoin oral tablet chewable 50 mg	COVERED - sPDL	QL (5 EA per 1 day)
phenytoin sodium extended oral capsule 100 mg	COVERED - sPDL	
phenytoin sodium extended oral capsule 200 mg, 300 mg	COVERED - sPDL	QL (6 EA per 1 day)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg	COVERED - sPDL	PA; QL (3 EA per 1 day)
pregabalin oral capsule 225 mg, 300 mg	COVERED - sPDL	PA; QL (2 EA per 1 day)
pregabalin oral capsule 50 mg	COVERED - sPDL	PA; QL (6 EA per 1 day)
pregabalin oral capsule 75 mg	COVERED - sPDL	PA; QL (8 EA per 1 day)
pregabalin oral solution 20 mg/ml	NOT COVERED PA Required	
primidone oral tablet 125 mg	COVERED - sPDL	
primidone oral tablet 250 mg, 50 mg	COVERED - sPDL	QL (4 EA per 1 day)
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*topiramate*)	NOT COVERED PA Required	
levetiracetam (Roweepra Oral Tablet 500 Mg)	COVERED - sPDL	
rufinamide oral suspension 40 mg/ml	NOT COVERED PA Required	QL (80 ML per 1 day)
rufinamide oral tablet 200 mg	NOT COVERED PA Required	QL (16 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
rufinamide oral tablet 400 mg	NOT COVERED PA Required	QL (8 EA per 1 day)
SABRIL ORAL PACKET 500 MG (*vigabatrin*)	COVERED with Clinical Criteria	PA
SABRIL ORAL TABLET 500 MG (*vigabatrin*)	COVERED with Clinical Criteria	PA
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG (*levetiracetam*)	NOT COVERED PA Required	
lamotrigine (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	COVERED - sPDL	
lamotrigine (Subvenite Starter Kit-Blue Oral Kit 35 X 25 Mg)	NOT COVERED PA Required	
lamotrigine (Subvenite Starter Kit-Green Oral Kit 84 X 25 Mg & 14X100 Mg)	NOT COVERED PA Required	
lamotrigine (Subvenite Starter Kit-Orange Oral Kit 42 X 25 Mg & 7 X 100 Mg)	NOT COVERED PA Required	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (*clobazam*)	NOT COVERED PA Required	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (*carbamazepine*)	NOT COVERED PA Required	
TEGRETOL ORAL TABLET 200 MG (*carbamazepine*)	NOT COVERED PA Required	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (*carbamazepine*)	COVERED - sPDL	
tiagabine hcl oral tablet 12 mg	NOT COVERED PA Required	QL (4.67 EA per 1 day)
tiagabine hcl oral tablet 16 mg	NOT COVERED PA Required	QL (3.5 EA per 1 day)
tiagabine hcl oral tablet 2 mg	NOT COVERED PA Required	QL (28 EA per 1 day)
tiagabine hcl oral tablet 4 mg	NOT COVERED PA Required	QL (14 EA per 1 day)
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (*topiramate*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (*topiramate*)	NOT COVERED PA Required	
topiramate er oral capsule er 24 hour sprinkle 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	NOT COVERED PA Required	
topiramate er oral capsule extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	NOT COVERED PA Required	
topiramate oral capsule sprinkle 15 mg, 25 mg	COVERED - sPDL	QL (8 EA per 1 day)
topiramate oral tablet 100 mg, 200 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day)
topiramate oral tablet 25 mg	COVERED - sPDL	QL (4 EA per 1 day)
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (*oxcarbazepine*)	COVERED - sPDL	
TRILEPTAL ORAL TABLET 150 MG, 600 MG (*oxcarbazepine*)	NOT COVERED PA Required	
TRILEPTAL ORAL TABLET 300 MG (*oxcarbazepine*)	NOT COVERED PA Required	QL (8 EA per 1 day)
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (*topiramate*)	NOT COVERED PA Required	
valproic acid oral capsule 250 mg	COVERED - sPDL	QL (20 EA per 1 day)
valproic acid oral solution 250 mg/5ml	COVERED - sPDL	QL (100 ML per 1 day)
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (*diazepam*)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 6 Years)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML (*diazepam*)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 6 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML (*diazepam*)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 6 Years)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (*diazepam*)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 6 Years)
vigabatrin oral packet 500 mg	NOT COVERED PA Required	
vigabatrin oral tablet 500 mg	NOT COVERED PA Required	QL (6 EA per 1 day)
vigabatrin (Vigadrone Oral Packet 500 Mg)	NOT COVERED PA Required	QL (6 EA per 1 day)
vigabatrin (Vigadrone Oral Tablet 500 Mg)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
vigabatrin (Vigpoder Oral Packet 500 Mg)	COVERED with Clinical Criteria	PA
VIMPAT ORAL SOLUTION 10 MG/ML (*lacosamide*)	NOT COVERED PA Required	
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (*lacosamide*)	COVERED with Clinical Criteria	PA
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG (*cenobamate*)	NOT COVERED PA Required	
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG (*cenobamate*)	NOT COVERED PA Required	
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*cenobamate*)	NOT COVERED PA Required	
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG (*cenobamate*)	NOT COVERED PA Required	
ZARONTIN ORAL CAPSULE 250 MG (*ethosuximide*)	NOT COVERED PA Required	
ZARONTIN ORAL SOLUTION 250 MG/5ML (*ethosuximide*)	NOT COVERED PA Required	
ZONISADE ORAL SUSPENSION 100 MG/5ML (*zonisamide*)	NOT COVERED PA Required	
zonisamide oral capsule 100 mg	COVERED - sPDL	QL (6 EA per 1 day)
zonisamide oral capsule 25 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day)
ZTALMY ORAL SUSPENSION 50 MG/ML (*ganaxolone*)	NOT COVERED PA Required	
ANTIDEPRESSANTS		
amitriptyline hcl oral tablet 10 mg, 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years); 90DS
amitriptyline hcl oral tablet 100 mg, 150 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Max 64 Years); 90DS
amitriptyline hcl oral tablet 50 mg, 75 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Max 64 Years); 90DS
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 174 MG, 348 MG, 522 MG (*bupropion hbr*)	NOT COVERED PA Required	
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (*dextromethorphan-bupropion*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 200 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg	COVERED - sPDL	QL (3 EA per 1 day); 90DS
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg	COVERED - sPDL	
bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg	NOT COVERED PA Required	
bupropion hcl oral tablet 100 mg, 75 mg	COVERED - sPDL	QL (4 EA per 1 day); 90DS
CELEXA ORAL TABLET 10 MG, 20 MG, 40 MG (*citalopram hydrobromide*)	NOT COVERED PA Required	
citalopram hydrobromide oral capsule 30 mg	NOT COVERED PA Required	
citalopram hydrobromide oral solution 10 mg/5ml	COVERED - sPDL	QL (20 ML per 1 day); 90DS
citalopram hydrobromide oral tablet 10 mg	COVERED - sPDL	QL (1.5 EA per 1 day); 90DS
citalopram hydrobromide oral tablet 20 mg, 40 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
clomipramine hcl oral capsule 25 mg	COVERED - cDL	QL (6 EA per 1 day); 90DS
clomipramine hcl oral capsule 50 mg, 75 mg	COVERED - cDL	QL (4 EA per 1 day); 90DS
desipramine hcl oral tablet 10 mg, 50 mg	COVERED - cDL	QL (6 EA per 1 day); 90DS
desipramine hcl oral tablet 100 mg	COVERED - cDL	QL (3 EA per 1 day); 90DS
desipramine hcl oral tablet 150 mg	COVERED - cDL	QL (2 EA per 1 day); 90DS
desipramine hcl oral tablet 25 mg, 75 mg	COVERED - cDL	QL (4 EA per 1 day); 90DS
desvenlafaxine er oral tablet extended release 24 hour 100 mg, 50 mg	NOT COVERED PA Required	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	COVERED - sPDL	
doxepin hcl oral capsule 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Max 64 Years); 90DS
doxepin hcl oral capsule 150 mg	COVERED - cDL	QL (2 EA per 1 day); AGE (Max 64 Years); 90DS
doxepin hcl oral concentrate 10 mg/ml	COVERED - cDL	QL (30 ML per 1 day); AGE (Max 64 Years); 90DS

Drug Name	Drug Tier	Requirements/Limits
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG (*duloxetine hcl*)	NOT COVERED PA Required	
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
duloxetine hcl oral capsule delayed release particles 40 mg	NOT COVERED PA Required	
EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 150 MG, 37.5 MG, 75 MG (*venlafaxine hcl*)	NOT COVERED PA Required	
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (*selegiline*)	NOT COVERED PA Required	
escitalopram oxalate oral solution 5 mg/5ml	NOT COVERED PA Required	90DS
escitalopram oxalate oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (1.5 EA per 1 day); 90DS
escitalopram oxalate oral tablet 20 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (*levomilnacipran hcl*)	NOT COVERED PA Required	
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (*levomilnacipran hcl*)	NOT COVERED PA Required	
fluoxetine hcl oral capsule 10 mg	COVERED - sPDL	QL (3 EA per 1 day); 90DS
fluoxetine hcl oral capsule 20 mg	COVERED - sPDL	QL (4 EA per 1 day); 90DS
fluoxetine hcl oral capsule 40 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
fluoxetine hcl oral capsule delayed release 90 mg	NOT COVERED PA Required	
fluoxetine hcl oral solution 20 mg/5ml	COVERED - sPDL	90DS
fluoxetine hcl oral tablet 10 mg, 20 mg	COVERED - sPDL	
fluoxetine hcl oral tablet 60 mg	NOT COVERED PA Required	
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	NOT COVERED PA Required	
fluvoxamine maleate oral tablet 100 mg	COVERED - sPDL	QL (3 EA per 1 day); 90DS
fluvoxamine maleate oral tablet 25 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS

Drug Name	Drug Tier	Requirements/Limits
FORFIVO XL ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG (*bupropion hcl*)	NOT COVERED PA Required	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	COVERED - cDL	QL (6 EA per 1 day); 90DS
LEXAPRO ORAL TABLET 10 MG, 20 MG, 5 MG (*escitalopram oxalate*)	NOT COVERED PA Required	
MARPLAN ORAL TABLET 10 MG (*isocarboxazid*)	NOT COVERED PA Required	
mirtazapine oral tablet 15 mg, 45 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
mirtazapine oral tablet 30 mg	COVERED - sPDL	QL (4 EA per 1 day); 90DS
mirtazapine oral tablet 7.5 mg	COVERED - sPDL	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	COVERED - sPDL	
NARDIL ORAL TABLET 15 MG (*phenelzine sulfate*)	NOT COVERED PA Required	
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	COVERED - sPDL	
nortriptyline hcl oral capsule 10 mg, 25 mg	COVERED - cDL	QL (6 EA per 1 day); 90DS
nortriptyline hcl oral capsule 50 mg	COVERED - cDL	QL (4 EA per 1 day); 90DS
nortriptyline hcl oral capsule 75 mg	COVERED - cDL	QL (2 EA per 1 day); 90DS
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	NOT COVERED PA Required	
paroxetine hcl oral suspension 10 mg/5ml	NOT COVERED PA Required	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG (*paroxetine hcl*)	NOT COVERED PA Required	
PAXIL ORAL SUSPENSION 10 MG/5ML (*paroxetine hcl*)	NOT COVERED PA Required	
PAXIL ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG (*paroxetine hcl*)	NOT COVERED PA Required	
phenelzine sulfate oral tablet 15 mg	COVERED - sPDL	QL (6 EA per 1 day); 90DS

Drug Name	Drug Tier	Requirements/Limits
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 25 MG, 50 MG (*desvenlafaxine succinate*)	NOT COVERED PA Required	
protriptyline hcl oral tablet 10 mg, 5 mg	COVERED - cDL	QL (8 EA per 1 day); 90DS
PROZAC ORAL CAPSULE 10 MG, 20 MG, 40 MG (*fluoxetine hcl*)	NOT COVERED PA Required	
REMERON ORAL TABLET 15 MG, 30 MG (*mirtazapine*)	NOT COVERED PA Required	
REMERON SOLTAB ORAL TABLET DISPERSIBLE 15 MG, 30 MG, 45 MG (*mirtazapine*)	NOT COVERED PA Required	
sertraline hcl oral capsule 150 mg, 200 mg	NOT COVERED PA Required	
sertraline hcl oral concentrate 20 mg/ml	COVERED - sPDL	90DS
sertraline hcl oral tablet 100 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
sertraline hcl oral tablet 25 mg	COVERED - sPDL	QL (1.5 EA per 1 day); 90DS
tranylcypromine sulfate oral tablet 10 mg	NOT COVERED PA Required	
trazodone hcl oral tablet 100 mg, 150 mg, 50 mg	COVERED - sPDL	90DS
trazodone hcl oral tablet 300 mg	COVERED - sPDL	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (*vortioxetine hbr*)	NOT COVERED PA Required	
venlafaxine besylate er oral tablet extended release 24 hour 112.5 mg	NOT COVERED PA Required	
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
venlafaxine hcl er oral capsule extended release 24 hour 75 mg	COVERED - sPDL	QL (3 EA per 1 day); 90DS
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg, 37.5 mg, 75 mg	NOT COVERED PA Required	
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	COVERED - sPDL	QL (3 EA per 1 day); 90DS
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (*vilazodone hcl*)	COVERED - sPDL	
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
WELLBUTRIN SR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 150 MG, 200 MG (*bupropion hcl*)	NOT COVERED PA Required	
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG (*bupropion hcl*)	NOT COVERED PA Required	
ZOLOFT ORAL CONCENTRATE 20 MG/ML (*sertraline hcl*)	NOT COVERED PA Required	
ZOLOFT ORAL TABLET 100 MG, 25 MG, 50 MG (*sertraline hcl*)	NOT COVERED PA Required	
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG (*zuranolone*)	NOT COVERED PA Required	
ANTIDIABETICS		
acarbose oral tablet 100 mg	COVERED - sPDL	QL (4 EA per 1 day)
acarbose oral tablet 25 mg, 50 mg	COVERED - sPDL	QL (3 EA per 1 day)
ACTOPLUS MET ORAL TABLET 15-850 MG (*pioglitazone hcl-metformin hcl*)	NOT COVERED PA Required	
ACTOS ORAL TABLET 15 MG, 30 MG, 45 MG (*pioglitazone hcl*)	NOT COVERED PA Required	
ADMELOG INJECTION SOLUTION 100 UNIT/ML (*insulin lispro*)	NOT COVERED PA Required	QL (30 ML per 25 days)
ADMELOG SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	NOT COVERED PA Required	
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60X4 &60X8 & 60X12 UNIT, 8 UNIT, 90 X 4 UNIT & 90X8 UNIT, 90 X 8 UNIT & 90X12 UNIT (*insulin regular human*)	NOT COVERED PA Required	
alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg	NOT COVERED PA Required	ST; QL (1 EA per 1 day); PRIOR USE OF METFORMIN
alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg	NOT COVERED PA Required	ST; QL (2 EA per 1 day); PRIOR USE OF METFORMIN AND SULFON
alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg	NOT COVERED PA Required	ST; QL (1 EA per 1 day); PRIOR USE OF METFORMIN AND SULFON
APIDRA INJECTION SOLUTION 100 UNIT/ML (*insulin glulisine*)	NOT COVERED PA Required	
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glulisine*)	COVERED - sPDL	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (*glucagon*)	COVERED - cDL	QL (2 EA per 25 days)

Drug Name	Drug Tier	Requirements/Limits
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	NOT COVERED PA Required	QL (30 ML per 25 days)
BASAGLAR TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	NOT COVERED PA Required	
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML (*exenatide*)	NOT COVERED PA Required	
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML (*exenatide*)	NOT COVERED PA Required	
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML (*exenatide*)	NOT COVERED PA Required	
dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg, 5-1000 mg	NOT COVERED PA Required	
dapagliflozin propanediol oral tablet 10 mg, 5 mg	NOT COVERED PA Required	
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (*pioglitazone hcl-glimepiride*)	NOT COVERED PA Required	
FARXIGA ORAL TABLET 10 MG, 5 MG (*dapagliflozin propanediol*)	COVERED - sPDL	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	NOT COVERED PA Required	
FIASP INJECTION SOLUTION 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	NOT COVERED PA Required	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	NOT COVERED PA Required	
glimepiride oral tablet 1 mg, 4 mg	COVERED - sPDL	QL (3 EA per 1 day)
glimepiride oral tablet 2 mg	COVERED - sPDL	QL (4 EA per 1 day)
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	COVERED - sPDL	QL (2 EA per 1 day)
glipizide oral tablet 10 mg	COVERED - sPDL	QL (4 EA per 1 day)
glipizide oral tablet 2.5 mg	COVERED - sPDL	
glipizide oral tablet 5 mg	COVERED - sPDL	QL (8 EA per 1 day)
glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	NOT COVERED PA Required	
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG (*glucagon hcl (rdna)*)	COVERED - cDL	QL (2 EA per 25 days)
glucagon emergency injection kit 1 mg	COVERED - cDL	QL (2 EA per 25 days)
glucose instant energy oral tablet chewable 4-6 gm-mg	COVERED - cDL	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 5 MG (*glipizide*)	NOT COVERED PA Required	
GLUMETZA ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG, 500 MG (*metformin hcl*)	NOT COVERED PA Required	
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	COVERED - sPDL	QL (4 EA per 1 day)
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	COVERED - sPDL	QL (4 EA per 1 day)
glyburide-metformin oral tablet 1.25-250 mg	COVERED - sPDL	QL (2 EA per 1 day)
glyburide-metformin oral tablet 2.5-500 mg	COVERED - sPDL	
glyburide-metformin oral tablet 5-500 mg	COVERED - sPDL	QL (4 EA per 1 day)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (*empagliflozin-linagliptin*)	NOT COVERED PA Required	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (*glucagon*)	COVERED - cDL	QL (2 ML per 25 days)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (*glucagon*)	COVERED - cDL	QL (0.4 ML per 25 days)
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (*glucagon*)	COVERED - cDL	QL (0.4 ML per 25 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (*glucagon*)	COVERED - cDL	QL (0.4 ML per 25 days)
HUMALOG INJECTION SOLUTION 100 UNIT/ML (*insulin lispro*)	COVERED - sPDL	
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	COVERED - sPDL	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin lispro*)	COVERED - sPDL	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (*insulin lispro prot & lispro*)	COVERED - sPDL	
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML (*insulin lispro prot & lispro*)	COVERED - sPDL	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	COVERED - sPDL	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin lispro*)	COVERED - sPDL	
HUMALOG TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	COVERED - sPDL	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	COVERED - sPDL	
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	COVERED - sPDL	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	NOT COVERED PA Required	
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	NOT COVERED PA Required	
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	COVERED - sPDL	
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML (*insulin regular human*)	COVERED - sPDL	QL (20 ML per 25 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (*insulin regular human*)	COVERED - sPDL	QL (18 ML per 25 days)
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	COVERED - sPDL	QL (30 ML per 25 days)
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	COVERED - sPDL	
insulin aspart injection solution 100 unit/ml	COVERED - sPDL	
insulin aspart penfill subcutaneous solution cartridge 100 unit/ml	COVERED - sPDL	
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	COVERED - sPDL	QL (30 ML per 25 days)
insulin degludec flextouch subcutaneous solution pen-injector 100 unit/ml, 200 unit/ml	NOT COVERED PA Required	
insulin degludec subcutaneous solution 100 unit/ml	NOT COVERED PA Required	
insulin glargine max solostar subcutaneous solution pen-injector 300 unit/ml	NOT COVERED PA Required	
insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml, 300 unit/ml	NOT COVERED PA Required	
insulin glargine subcutaneous solution 100 unit/ml	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
insulin glargine-yfgn subcutaneous solution 100 unit/ml	NOT COVERED PA Required	QL (30 ML per 25 days)
insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml	NOT COVERED PA Required	QL (30 ML per 25 days)
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	COVERED - sPDL	
insulin lispro injection solution 100 unit/ml	COVERED - sPDL	
insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml	COVERED - sPDL	
insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml	COVERED - sPDL	QL (30 ML per 25 days)
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (*canagliflozin-metformin hcl*)	COVERED - sPDL	
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (*canagliflozin-metformin hcl*)	NOT COVERED PA Required	
INVOKANA ORAL TABLET 100 MG, 300 MG (*canagliflozin*)	COVERED - sPDL	
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (*sitagliptin-metformin hcl*)	COVERED - sPDL	
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (*sitagliptin-metformin hcl*)	NOT COVERED PA Required	
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (*sitagliptin phosphate*)	COVERED - sPDL	
JARDIANCE ORAL TABLET 10 MG, 25 MG (*empagliflozin*)	COVERED - sPDL	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (*linagliptin-metformin hcl*)	COVERED - sPDL	
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG (*linagliptin-metformin hcl*)	NOT COVERED PA Required	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	COVERED - sPDL	
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin glargine*)	COVERED - sPDL	
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin detemir*)	COVERED - sPDL	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin detemir*)	COVERED - sPDL	
LYUMJEV INJECTION SOLUTION 100 UNIT/ML (*insulin lispro-aabc*)	NOT COVERED PA Required	
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin lispro-aabc*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
LYUMJEV TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro-aabc*)	NOT COVERED PA Required	
metformin hcl er (mod) oral tablet extended release 24 hour 1000 mg, 500 mg	NOT COVERED PA Required	
metformin hcl er (osm) oral tablet extended release 24 hour 1000 mg, 500 mg	NOT COVERED PA Required	
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	COVERED - sPDL	QL (4 EA per 1 day)
metformin hcl oral solution 500 mg/5ml	NOT COVERED PA Required	
metformin hcl oral tablet 1000 mg	COVERED - sPDL	QL (2 EA per 1 day)
metformin hcl oral tablet 500 mg	COVERED - sPDL	QL (5 EA per 1 day)
metformin hcl oral tablet 625 mg	NOT COVERED PA Required	
metformin hcl oral tablet 850 mg	COVERED - sPDL	QL (3 EA per 1 day)
miglitol oral tablet 100 mg, 25 mg, 50 mg	NOT COVERED PA Required	
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide*)	NOT COVERED PA Required	
nateglinide oral tablet 120 mg, 60 mg	COVERED - sPDL	QL (3 EA per 1 day)
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	NOT COVERED PA Required	
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	NOT COVERED PA Required	QL (30 ML per 25 days)
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	NOT COVERED PA Required	
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	NOT COVERED PA Required	QL (30 ML per 25 days)
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	NOT COVERED PA Required	
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	NOT COVERED PA Required	QL (30 ML per 25 days)

Drug Name	Drug Tier	Requirements/Limits
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	NOT COVERED PA Required	
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	NOT COVERED PA Required	QL (30 ML per 25 days)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin regular human*)	NOT COVERED PA Required	
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin regular human*)	NOT COVERED PA Required	
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	NOT COVERED PA Required	QL (30 ML per 25 days)
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	NOT COVERED PA Required	
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	COVERED - sPDL	
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart*)	COVERED - sPDL	
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart*)	COVERED - sPDL	
NOVOLOG INJECTION SOLUTION 100 UNIT/ML (*insulin aspart*)	COVERED - sPDL	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	COVERED - sPDL	
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	COVERED - sPDL	
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	COVERED - sPDL	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin aspart*)	COVERED - sPDL	
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML (*insulin aspart*)	COVERED - sPDL	
ONGLYZA ORAL TABLET 5 MG (*saxagliptin hcl*)	NOT COVERED PA Required	
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (*semaglutide*)	COVERED - sPDL	ST; QL (3 ML per 25 days); PRIOR USE OF METFORMIN
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (*semaglutide*)	COVERED - sPDL	ST; QL (3 ML per 25 days); PRIOR USE OF METFORMIN
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (*semaglutide*)	COVERED - sPDL	ST; QL (3 ML per 25 days); PRIOR USE OF METFORMIN
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	COVERED - sPDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	NOT COVERED PA Required	
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	NOT COVERED PA Required	
QTERN ORAL TABLET 10-5 MG, 5-5 MG (*dapagliflozin-saxagliptin*)	NOT COVERED PA Required	
repaglinide oral tablet 0.5 mg, 2 mg	NOT COVERED PA Required	QL (6 EA per 1 day)
repaglinide oral tablet 1 mg	NOT COVERED PA Required	
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine-aglr*)	NOT COVERED PA Required	
RIOMET ORAL SOLUTION 500 MG/5ML (*metformin hcl*)	NOT COVERED PA Required	
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (*semaglutide*)	COVERED - sPDL	ST; QL (1 EA per 1 day); PRIOR USE OF METFORMIN
saxagliptin hcl oral tablet 2.5 mg, 5 mg	NOT COVERED PA Required	
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg, 5-1000 mg, 5-500 mg	NOT COVERED PA Required	
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG (*ertugliflozin-metformin hcl*)	NOT COVERED PA Required	ST; PRIOR USE OF METFORMIN
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin glargine-yfgn*)	NOT COVERED PA Required	
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine-yfgn*)	NOT COVERED PA Required	
sitagliptin oral tablet 100 mg, 25 mg, 50 mg	NOT COVERED PA Required	
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (*insulin glargine-lixisenatide*)	NOT COVERED PA Required	
STEGLATRO ORAL TABLET 15 MG, 5 MG (*ertugliflozin l-pyroglutamicac*)	NOT COVERED PA Required	ST; PRIOR USE OF METFORMIN
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG (*ertugliflozin-sitagliptin*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML (*pramlintide acetate*)	COVERED - sPDL	
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML (*pramlintide acetate*)	COVERED - sPDL	
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (*empagliflozin-metformin hcl*)	NOT COVERED PA Required	
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG (*empagliflozin-metformin hcl*)	NOT COVERED PA Required	
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*)	NOT COVERED PA Required	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*)	NOT COVERED PA Required	
TRADJENTA ORAL TABLET 5 MG (*linagliptin*)	COVERED - sPDL	
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin degludec*)	NOT COVERED PA Required	
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin degludec*)	NOT COVERED PA Required	
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 12.5-2.5-1000 MG, 25-5-1000 MG, 5-2.5-1000 MG (*empagliflozin-linaglip-metform*)	NOT COVERED PA Required	
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML (*dulaglutide*)	COVERED - sPDL	ST; QL (2 ML per 25 days); PRIOR USE OF METFORMIN
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide*)	COVERED - sPDL	ST; PRIOR USE OF METFORMIN
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG (*dapagliflozin prop-metformin*)	COVERED - sPDL	
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML (*insulin degludec-liraglutide*)	NOT COVERED PA Required	
zituvio oral tablet 100 mg, 25 mg, 50 mg	NOT COVERED PA Required	
ANTIDIARRHEAL/PROBIOTIC AGENTS		
bismatrol oral suspension 262 mg/15ml	COVERED - cDL	
bismuth subsalicylate oral tablet chewable 262 mg	COVERED - cDL	
cvs anti-diarrheal oral suspension 262 mg/15ml	COVERED - cDL	
cvs stomach relief max st oral suspension 525 mg/15ml	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
cvs stomach relief oral suspension 525 mg/15ml, 525 mg/30ml	COVERED - cDL	
diarrhea oral suspension 262 mg/15ml	COVERED - cDL	
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	COVERED - cDL	QL (40 ML per 1 day)
diphenoxylate-atropine oral tablet 2.5-0.025 mg	COVERED - cDL	QL (8 EA per 1 day)
eq stomach relief oral suspension 262 mg/15ml	COVERED - cDL	
eql stomach relief max st oral suspension 525 mg/15ml	COVERED - cDL	
eql stomach relief oral suspension 262 mg/15ml	COVERED - cDL	
ft stomach relief oral suspension 525 mg/30ml	COVERED - cDL	
gnp pink bismuth ultra str oral suspension 525 mg/15ml	COVERED - cDL	
gnp stomach relief oral suspension 525 mg/30ml	COVERED - cDL	
goodsense stomach relief oral suspension 1050 mg/30ml, 525 mg/30ml	COVERED - cDL	
KAOPECTATE EXTRA STRENGTH ORAL SUSPENSION 525 MG/15ML (*bismuth subsalicylate*)	COVERED - cDL	
KAOPECTATE ORAL SUSPENSION 262 MG/15ML (*bismuth subsalicylate*)	COVERED - cDL	
loperamide hcl oral capsule 2 mg	COVERED - cDL	QL (8 EA per 1 day)
loperamide hcl oral tablet 2 mg	COVERED - cDL	QL (8 EA per 1 day)
PEPTO-BISMOL MAX STRENGTH ORAL SUSPENSION 525 MG/15ML (*bismuth subsalicylate*)	COVERED - cDL	
PEPTO-BISMOL ORAL SUSPENSION 262 MG/15ML (*bismuth subsalicylate*)	COVERED - cDL	
pink bismuth maximum strength oral suspension 525 mg/15ml	COVERED - cDL	
pink bismuth oral suspension 262 mg/15ml	COVERED - cDL	
qc diarrhea relief oral suspension 262 mg/15ml	COVERED - cDL	
qc pink bismuth oral suspension 262 mg/15ml, 525 mg/15ml	COVERED - cDL	
qc stomach relief oral suspension 525 mg/30ml	COVERED - cDL	
qc stomach relief ultra oral suspension 525 mg/15ml	COVERED - cDL	
ra stomach relief oral suspension 262 mg/15ml	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
sm stomach relief oral suspension 262 mg/15ml	COVERED - cDL	
SOOTHE MAXIMUM STRENGTH ORAL SUSPENSION 525 MG/15ML (*bismuth subsalicylate*)	COVERED - cDL	
SOOTHE ORAL SUSPENSION 262 MG/15ML, 525 MG/30ML (*bismuth subsalicylate*)	COVERED - cDL	
stomach relief extra strength oral suspension 525 mg/15ml	COVERED - cDL	
stomach relief oral suspension 525 mg/15ml, 525 mg/30ml, 527 mg/30ml	COVERED - cDL	
stomach relief oral tablet 262 mg	COVERED - cDL	
stomach relief plus oral suspension 525 mg/15ml	COVERED - cDL	
stomach relief ultra oral suspension 525 mg/15ml	COVERED - cDL	
ANTIDOTES AND SPECIFIC ANTAGONISTS		
KLOXXADO NASAL LIQUID 8 MG/0.1ML (*naloxone hcl*)	NOT COVERED PA Required	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	COVERED - sPDL	
naloxone hcl injection solution cartridge 0.4 mg/ml	COVERED - sPDL	
naloxone hcl injection solution prefilled syringe 2 mg/2ml	COVERED - sPDL	
naloxone hcl nasal liquid 4 mg/0.1ml	NOT COVERED PA Required	
naltrexone hcl oral tablet 50 mg	COVERED - cDL	QL (2 EA per 1 day)
NARCAN NASAL LIQUID 4 MG/0.1ML (*naloxone hcl*)	COVERED - sPDL	
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (*nalmefene hcl*)	NOT COVERED PA Required	
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (*naloxone hcl*)	NOT COVERED PA Required	
ANTIEMETICS		
AKYNZEO ORAL CAPSULE 300-0.5 MG (*netupitant-palonosetron*)	NOT COVERED PA Required	
anti-nausea oral solution 1.87-1.87-21.5	COVERED - cDL	
ANTIVERT ORAL TABLET 50 MG (*meclizine hcl*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
ANTIVERT ORAL TABLET CHEWABLE 25 MG (*meclizine hcl*)	NOT COVERED PA Required	
ANZEMET ORAL TABLET 50 MG (*dolasetron mesylate*)	NOT COVERED PA Required	
aprepitant oral 80 & 125 mg	NOT COVERED PA Required	
aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg	NOT COVERED PA Required	
BONJESTA ORAL TABLET EXTENDED RELEASE 20-20 MG (*doxylamine-pyridoxine*)	NOT COVERED PA Required	
DICLEGIS ORAL TABLET DELAYED RELEASE 10-10 MG (*doxylamine-pyridoxine*)	NOT COVERED PA Required	
doxylamine-pyridoxine oral tablet delayed release 10-10 mg	NOT COVERED PA Required	
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	NOT COVERED PA Required	
EMEND ORAL CAPSULE 80 MG (*aprepitant*)	COVERED - sPDL	
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (*aprepitant*)	NOT COVERED PA Required	
EMEND TRI-PACK ORAL CAPSULE 80 & 125 MG (*aprepitant*)	COVERED - sPDL	
granisetron hcl oral tablet 1 mg	NOT COVERED PA Required	ST; QL (2 EA per 1 day); PRIOR USE OF ONDANSETRON
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (*dronabinol*)	NOT COVERED PA Required	
meclizine hcl oral tablet 12.5 mg	COVERED - sPDL	QL (4 EA per 1 day)
meclizine hcl oral tablet 25 mg	NOT COVERED PA Required	QL (4 EA per 1 day)
meclizine hcl oral tablet 50 mg	NOT COVERED PA Required	
motion sickness relief oral tablet chewable 25 mg	COVERED - sPDL	QL (4 EA per 1 day)
ondansetron hcl oral solution 4 mg/5ml	COVERED - sPDL	PA
ondansetron hcl oral tablet 4 mg, 8 mg	COVERED - sPDL	QL (90 EA per 25 days)

Drug Name	Drug Tier	Requirements/Limits
ondansetron oral tablet dispersible 4 mg, 8 mg	COVERED - sPDL	QL (90 EA per 25 days)
SANCUSO TRANSDERMAL PATCH 3.1 MG/24HR (*granisetron*)	NOT COVERED PA Required	
scopolamine transdermal patch 72 hour 1 mg/3days	NOT COVERED PA Required	QL (0.34 EA per 1 day)
TRANSDERM-SCOP TRANSDERMAL PATCH 72 HOUR 1 MG/3DAYS (*scopolamine base*)	COVERED - sPDL	
trimethobenzamide hcl oral capsule 300 mg	NOT COVERED PA Required	
ANTIFUNGALS		
BREXAFEMME ORAL TABLET 150 MG (*ibrexafungerp citrate*)	NOT COVERED PA Required	
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (*isavuconazonium sulfate*)	NOT COVERED PA Required	
DIFLUCAN ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fluconazole*)	NOT COVERED PA Required	
DIFLUCAN ORAL TABLET 100 MG, 200 MG (*fluconazole*)	NOT COVERED PA Required	
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	NOT COVERED PA Required	QL (35 ML per 25 days); AGE (Max 12 Years)
fluconazole oral tablet 100 mg, 200 mg	COVERED - cDL	QL (21 EA per 25 days)
fluconazole oral tablet 150 mg	COVERED - cDL	QL (2 EA per 25 days)
fluconazole oral tablet 50 mg	COVERED - cDL	QL (2 EA per 1 day)
griseofulvin microsize oral suspension 125 mg/5ml	COVERED - sPDL	QL (40 ML per 1 day)
griseofulvin microsize oral tablet 500 mg	NOT COVERED PA Required	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	COVERED - sPDL	
itraconazole oral capsule 100 mg	NOT COVERED PA Required	QL (4 EA per 1 day); AGE (Min 18 Years)
itraconazole oral solution 10 mg/ml	NOT COVERED PA Required	
ketoconazole oral tablet 200 mg	NOT COVERED PA Required	QL (2 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
nystatin oral tablet 500000 unit	NOT COVERED PA Required	QL (8 EA per 1 day)
SPORANOX ORAL CAPSULE 100 MG (*itraconazole*)	NOT COVERED PA Required	
SPORANOX ORAL SOLUTION 10 MG/ML (*itraconazole*)	NOT COVERED PA Required	
terbinafine hcl oral tablet 250 mg	COVERED - sPDL	QL (1 EA per 1 day)
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*voriconazole*)	NOT COVERED PA Required	
VFEND ORAL TABLET 200 MG, 50 MG (*voriconazole*)	NOT COVERED PA Required	
voriconazole oral suspension reconstituted 40 mg/ml	NOT COVERED PA Required	
voriconazole oral tablet 200 mg, 50 mg	NOT COVERED PA Required	
ANTIHISTAMINES		
allergy (cetirizine) oral tablet 10 mg	COVERED - cDL	QL (1 EA per 1 day)
allergy relief (loratadine) oral tablet 10 mg	COVERED - sPDL	
allergy relief childrens oral tablet dispersible 12.5 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
allergy relief oral capsule 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
allergy relief oral tablet 10 mg, 5 mg	COVERED - sPDL	
BENADRYL ALLERGY EXTRA STR ORAL TABLET 50 MG (*diphenhydramine hcl*)	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
carbinoxamine maleate oral solution 4 mg/5ml	COVERED - cDL	
carbinoxamine maleate oral tablet 4 mg	COVERED - cDL	
cetirizine hcl childrens oral solution 5 mg/5ml	COVERED - sPDL	QL (10 ML per 1 day); AGE (Max 12 Years)
cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml	COVERED - sPDL	
cetirizine hcl oral tablet 5 mg	COVERED - cDL	QL (1 EA per 1 day)
chlorpheniramine maleate er oral tablet extended release 12 mg	COVERED - cDL	QL (2 EA per 1 day)
chlorpheniramine maleate oral tablet 4 mg	COVERED - cDL	QL (6 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
CLARINEX ORAL TABLET 5 MG (*desloratadine*)	NOT COVERED PA Required	
clemastine fumarate oral tablet 2.68 mg	COVERED - cDL	QL (3 EA per 1 day)
cyproheptadine hcl oral syrup 2 mg/5ml	COVERED - cDL	QL (20 ML per 1 day); AGE (Max 64 Years)
cyproheptadine hcl oral tablet 4 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
desloratadine oral tablet 5 mg	NOT COVERED PA Required	
desloratadine oral tablet dispersible 2.5 mg, 5 mg	NOT COVERED PA Required	
DIABETIC TUSSIN ALLERGY ORAL SYRUP 2 MG/5ML (*chlorpheniramine maleate*)	COVERED - cDL	QL (5 ML per 1 day)
diphenhydramine hcl childrens oral liquid 12.5 mg/5ml	COVERED - cDL	QL (80 ML per 1 day); AGE (Max 12 Years)
diphenhydramine hcl injection solution 50 mg/ml	COVERED - cDL	AGE (Max 64 Years)
diphenhydramine hcl oral capsule 50 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
diphenhydramine hcl oral elixir 12.5 mg/5ml	COVERED - cDL	QL (80 ML per 1 day); AGE (Max 12 Years)
diphenhydramine hcl oral tablet chewable 12.5 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 12 Years)
ed chlorped jr oral syrup 2 mg/5ml	COVERED - cDL	QL (5 ML per 1 day)
ft all day allergy relief oral tablet 10 mg	COVERED - sPDL	
ft allergy relief childrens oral tablet chewable 5 mg	COVERED - sPDL	
ft allergy relief loratadine oral tablet 10 mg	COVERED - sPDL	
gnp allergy relief 24 hr oral tablet 5 mg	COVERED - sPDL	
gnp loratadine oral tablet 10 mg	COVERED - sPDL	
gnp loratadine oral tablet dispersible 10 mg	COVERED - sPDL	
goodsense allergy relief oral tablet 10 mg	COVERED - sPDL	
hm loratadine oral tablet 10 mg	COVERED - sPDL	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	NOT COVERED PA Required	
levocetirizine dihydrochloride oral tablet 5 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
loratadine childrens oral solution 5 mg/5ml	COVERED - cDL	QL (10 ML per 1 day); AGE (Max 12 Years)
loratadine childrens oral tablet chewable 5 mg	COVERED - sPDL	
loratadine oral tablet 10 mg	COVERED - sPDL	QL (1 EA per 1 day)
loratadine oral tablet dispersible 10 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Max 12 Years)
promethazine hcl injection solution 25 mg/ml	COVERED - cDL	QL (100 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
promethazine hcl injection solution 50 mg/ml	COVERED - cDL	QL (50 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
promethazine hcl oral solution 6.25 mg/5ml	COVERED - sPDL	
promethazine hcl oral tablet 12.5 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
promethazine hcl oral tablet 25 mg	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
promethazine hcl rectal suppository 12.5 mg, 25 mg	COVERED - sPDL	
promethazine hcl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	COVERED - sPDL	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (*promethazine hcl*)	COVERED - sPDL	
sm all day allergy relief oral tablet 10 mg	COVERED - sPDL	
sm loratadine oral tablet 10 mg	COVERED - sPDL	
ANTIHYPERLIPIDEMICS		
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HOUR 20 MG, 40 MG, 60 MG (*lovastatin*)	NOT COVERED PA Required	
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (*atorvastatin calcium*)	NOT COVERED PA Required	
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
cholestyramine light oral packet 4 gm	NOT COVERED PA Required	
cholestyramine light oral powder 4 gm/dose	COVERED - sPDL	QL (8 GM per 1 day)
cholestyramine oral packet 4 gm	COVERED - sPDL	
cholestyramine oral powder 4 gm/dose	COVERED - sPDL	QL (48 GM per 1 day)

Drug Name	Drug Tier	Requirements/Limits
colesevelam hcl oral packet 3.75 gm	NOT COVERED PA Required	
colesevelam hcl oral tablet 625 mg	NOT COVERED PA Required	
COLESTID ORAL GRANULES 5 GM (*colestipol hcl*)	NOT COVERED PA Required	
COLESTID ORAL TABLET 1 GM (*colestipol hcl*)	NOT COVERED PA Required	
colestipol hcl oral granules 5 gm	COVERED - sPDL	
colestipol hcl oral packet 5 gm	COVERED - sPDL	
colestipol hcl oral tablet 1 gm	COVERED - sPDL	QL (16 EA per 1 day)
CRESTOR ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (*rosuvastatin calcium*)	NOT COVERED PA Required	
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (*rosuvastatin calcium*)	NOT COVERED PA Required	
ezetimibe oral tablet 10 mg	COVERED - sPDL	QL (1 EA per 1 day)
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	NOT COVERED PA Required	
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg	NOT COVERED PA Required	
fenofibrate oral capsule 134 mg, 150 mg, 200 mg, 50 mg, 67 mg	NOT COVERED PA Required	
fenofibrate oral tablet 120 mg, 40 mg	NOT COVERED PA Required	
fenofibrate oral tablet 145 mg, 48 mg	COVERED - sPDL	QL (1 EA per 1 day)
fenofibrate oral tablet 160 mg, 54 mg	NOT COVERED PA Required	QL (1 EA per 1 day)
fenofibric acid oral capsule delayed release 135 mg, 45 mg	NOT COVERED PA Required	
fenofibric acid oral tablet 105 mg, 35 mg	NOT COVERED PA Required	

Drug Name	**Drug Tier**	**Requirements/Limits**
FENOGLIDE ORAL TABLET 120 MG, 40 MG (*fenofibrate*)	NOT COVERED PA Required	
FIBRICOR ORAL TABLET 105 MG, 35 MG (*fenofibric acid*)	NOT COVERED PA Required	
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	NOT COVERED PA Required	
fluvastatin sodium oral capsule 20 mg, 40 mg	COVERED - sPDL	
gemfibrozil oral tablet 600 mg	COVERED - sPDL	QL (4 EA per 1 day)
icosapent ethyl oral capsule 0.5 gm, 1 gm	NOT COVERED PA Required	
LESCOL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 80 MG (*fluvastatin sodium*)	NOT COVERED PA Required	
LIPITOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG (*atorvastatin calcium*)	NOT COVERED PA Required	
LIPOFEN ORAL CAPSULE 150 MG, 50 MG (*fenofibrate*)	NOT COVERED PA Required	
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (*pitavastatin calcium*)	NOT COVERED PA Required	
LOPID ORAL TABLET 600 MG (*gemfibrozil*)	NOT COVERED PA Required	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
LOVAZA ORAL CAPSULE 1 GM (*omega-3-acid ethyl esters*)	NOT COVERED PA Required	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	NOT COVERED PA Required	
omega-3-acid ethyl esters oral capsule 1 gm	COVERED - sPDL	
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	NOT COVERED PA Required	
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
cholestyramine light (Prevalite Oral Packet 4 Gm)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
cholestyramine light (Prevalite Oral Powder 4 Gm/Dose)	NOT COVERED PA Required	
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (*cholestyramine light*)	NOT COVERED PA Required	
QUESTRAN ORAL PACKET 4 GM (*cholestyramine*)	COVERED - sPDL	
QUESTRAN ORAL POWDER 4 GM/DOSE (*cholestyramine*)	NOT COVERED PA Required	
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (*evolocumab*)	COVERED - cDL	PA; QL (3.5 ML per 25 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (*evolocumab*)	COVERED - cDL	PA; QL (2 ML per 24 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (*evolocumab*)	COVERED - cDL	PA; QL (2 ML per 24 days)
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day); 90DS
simvastatin oral tablet 80 mg	COVERED - sPDL	
TRICOR ORAL TABLET 145 MG, 48 MG (*fenofibrate*)	NOT COVERED PA Required	
TRILIPIX ORAL CAPSULE DELAYED RELEASE 135 MG, 45 MG (*choline fenofibrate*)	NOT COVERED PA Required	
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM (*icosapent ethyl*)	COVERED - sPDL	
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG (*ezetimibe-simvastatin*)	NOT COVERED PA Required	
WELCHOL ORAL PACKET 3.75 GM (*colesevelam hcl*)	NOT COVERED PA Required	
WELCHOL ORAL TABLET 625 MG (*colesevelam hcl*)	NOT COVERED PA Required	
ZETIA ORAL TABLET 10 MG (*ezetimibe*)	NOT COVERED PA Required	
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG (*simvastatin*)	NOT COVERED PA Required	
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (*pitavastatin magnesium*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
ANTIHYPERTENSIVES		
ACCUPRIL ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (*quinapril hcl*)	NOT COVERED PA Required	
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG (*quinapril-hydrochlorothiazide*)	NOT COVERED PA Required	
aliskiren fumarate oral tablet 150 mg, 300 mg	NOT COVERED PA Required	
ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG, 5 MG (*ramipril*)	NOT COVERED PA Required	
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-10 mg, 5-20 mg, 5-40 mg	COVERED - sPDL	QL (1 EA per 1 day)
amlodipine besy-benazepril hcl oral capsule 2.5-10 mg	COVERED - sPDL	
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	COVERED - sPDL	QL (1 EA per 1 day)
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	NOT COVERED PA Required	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	NOT COVERED PA Required	
ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (*candesartan cilexetil-hctz*)	NOT COVERED PA Required	
ATACAND ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG (*candesartan cilexetil*)	NOT COVERED PA Required	
atenolol-chlorthalidone oral tablet 100-25 mg	COVERED - sPDL	QL (1 EA per 1 day)
atenolol-chlorthalidone oral tablet 50-25 mg	COVERED - sPDL	QL (2 EA per 1 day)
AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (*irbesartan-hydrochlorothiazide*)	NOT COVERED PA Required	
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG (*irbesartan*)	NOT COVERED PA Required	
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG (*amlodipine-olmesartan*)	NOT COVERED PA Required	
benazepril hcl oral tablet 10 mg, 20 mg, 5 mg	COVERED - sPDL	QL (1.5 EA per 1 day)
benazepril hcl oral tablet 40 mg	COVERED - sPDL	QL (2 EA per 1 day)
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	COVERED - sPDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG (*olmesartan medoxomil-hctz*)	COVERED - sPDL	
BENICAR ORAL TABLET 20 MG, 40 MG, 5 MG (*olmesartan medoxomil*)	NOT COVERED PA Required	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg	COVERED - sPDL	QL (4 EA per 1 day)
bisoprolol-hydrochlorothiazide oral tablet 2.5-6.25 mg, 5-6.25 mg	COVERED - sPDL	QL (3 EA per 1 day)
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	NOT COVERED PA Required	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	NOT COVERED PA Required	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	COVERED - sPDL	QL (3 EA per 1 day)
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	NOT COVERED PA Required	
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (*doxazosin mesylate*)	NOT COVERED PA Required	
clonidine hcl er oral tablet extended release 24 hour 0.17 mg	NOT COVERED PA Required	
clonidine hcl oral tablet 0.1 mg, 0.2 mg	COVERED - sPDL	QL (6 EA per 1 day)
clonidine hcl oral tablet 0.3 mg	COVERED - sPDL	QL (4 EA per 1 day)
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	NOT COVERED PA Required	
COZAAR ORAL TABLET 100 MG, 25 MG, 50 MG (*losartan potassium*)	NOT COVERED PA Required	
DIOVAN HCT ORAL TABLET 160-12.5 MG, 160-25 MG, 320-12.5 MG, 320-25 MG, 80-12.5 MG (*valsartan-hydrochlorothiazide*)	NOT COVERED PA Required	
DIOVAN ORAL TABLET 160 MG, 320 MG, 40 MG, 80 MG (*valsartan*)	NOT COVERED PA Required	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg	COVERED - sPDL	QL (1 EA per 1 day)
doxazosin mesylate oral tablet 8 mg	COVERED - sPDL	QL (2 EA per 1 day)
EDARBI ORAL TABLET 40 MG, 80 MG (*azilsartan medoxomil*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (*azilsartan-chlorthalidone*)	NOT COVERED PA Required	
enalapril maleate oral solution 1 mg/ml	NOT COVERED PA Required	AGE (Max 12 Years)
enalapril maleate oral tablet 10 mg, 2.5 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
enalapril maleate oral tablet 20 mg	COVERED - sPDL	QL (2 EA per 1 day)
enalapril-hydrochlorothiazide oral tablet 10-25 mg	COVERED - sPDL	
enalapril-hydrochlorothiazide oral tablet 5-12.5 mg	COVERED - sPDL	QL (2 EA per 1 day)
EPANED ORAL SOLUTION 1 MG/ML (*enalapril maleate*)	NOT COVERED PA Required	
EXFORGE HCT ORAL TABLET 10-160-12.5 MG, 10-160-25 MG, 10-320-25 MG, 5-160-12.5 MG, 5-160-25 MG (*amlodipine-valsartan-hctz*)	COVERED - sPDL	
EXFORGE ORAL TABLET 10-160 MG, 10-320 MG, 5-160 MG, 5-320 MG (*amlodipine besylate-valsartan*)	NOT COVERED PA Required	
fosinopril sodium oral tablet 10 mg	NOT COVERED PA Required	QL (1 EA per 1 day)
fosinopril sodium oral tablet 20 mg, 40 mg	COVERED - sPDL	QL (1 EA per 1 day)
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	NOT COVERED PA Required	QL (1 EA per 1 day)
guanfacine hcl oral tablet 1 mg	COVERED - sPDL	QL (4 EA per 1 day)
guanfacine hcl oral tablet 2 mg	COVERED - sPDL	QL (2 EA per 1 day)
hydralazine hcl oral tablet 10 mg	COVERED - cDL	QL (10 EA per 1 day)
hydralazine hcl oral tablet 100 mg	COVERED - cDL	QL (3 EA per 1 day)
hydralazine hcl oral tablet 25 mg	COVERED - cDL	QL (4 EA per 1 day)
hydralazine hcl oral tablet 50 mg	COVERED - cDL	QL (8 EA per 1 day)
HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (*losartan potassium-hctz*)	NOT COVERED PA Required	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	COVERED - sPDL	QL (1 EA per 1 day)
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	COVERED - sPDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
lisinopril oral tablet 30 mg, 40 mg	COVERED - sPDL	QL (2 EA per 1 day)
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	COVERED - sPDL	QL (2 EA per 1 day)
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	COVERED - sPDL	QL (1 EA per 1 day)
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	COVERED - sPDL	QL (1 EA per 1 day)
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (*benazepril-hydrochlorothiazide*)	NOT COVERED PA Required	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (*benazepril hcl*)	NOT COVERED PA Required	
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (*amlodipine besy-benazepril hcl*)	NOT COVERED PA Required	
methyldopa oral tablet 250 mg, 500 mg	COVERED - sPDL	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	NOT COVERED PA Required	
MICARDIS HCT ORAL TABLET 40-12.5 MG, 80-12.5 MG, 80-25 MG (*telmisartan-hctz*)	NOT COVERED PA Required	
MICARDIS ORAL TABLET 20 MG, 40 MG, 80 MG (*telmisartan*)	NOT COVERED PA Required	
minoxidil oral tablet 10 mg, 2.5 mg	COVERED - cDL	QL (5 EA per 1 day)
moexipril hcl oral tablet 15 mg, 7.5 mg	NOT COVERED PA Required	
NEXICLON XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.17 MG (*clonidine hcl*)	NOT COVERED PA Required	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	COVERED - sPDL	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	NOT COVERED PA Required	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	NOT COVERED PA Required	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	NOT COVERED PA Required	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	COVERED - cDL	QL (6 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
QBRELIS ORAL SOLUTION 1 MG/ML (*lisinopril*)	NOT COVERED PA Required	AGE (Min 6 Years and Max 12 Years)
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	NOT COVERED PA Required	QL (1 EA per 1 day)
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg	NOT COVERED PA Required	
quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg	NOT COVERED PA Required	QL (1 EA per 1 day)
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
TEKTURNA ORAL TABLET 150 MG, 300 MG (*aliskiren fumarate*)	COVERED - sPDL	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	COVERED - sPDL	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	NOT COVERED PA Required	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	COVERED - sPDL	
TENORETIC 100 ORAL TABLET 100-25 MG (*atenolol-chlorthalidone*)	NOT COVERED PA Required	
TENORETIC 50 ORAL TABLET 50-25 MG (*atenolol-chlorthalidone*)	NOT COVERED PA Required	
terazosin hcl oral capsule 1 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
terazosin hcl oral capsule 10 mg, 2 mg	COVERED - sPDL	QL (2 EA per 1 day)
trandolapril oral tablet 1 mg, 2 mg, 4 mg	COVERED - sPDL	QL (1 EA per 1 day)
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	COVERED - sPDL	
TRIBENZOR ORAL TABLET 20-5-12.5 MG, 40-10-12.5 MG, 40-10-25 MG, 40-5-12.5 MG, 40-5-25 MG (*olmesartan-amlodipine-hctz*)	NOT COVERED PA Required	
valsartan oral solution 4 mg/ml	NOT COVERED PA Required	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	NOT COVERED PA Required	QL (2 EA per 1 day)
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	COVERED - sPDL	QL (1 EA per 1 day)
VASERETIC ORAL TABLET 10-25 MG (*enalapril-hydrochlorothiazide*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
VASOTEC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (*enalapril maleate*)	NOT COVERED PA Required	
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (*lisinopril-hydrochlorothiazide*)	NOT COVERED PA Required	
ZESTRIL ORAL TABLET 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG (*lisinopril*)	NOT COVERED PA Required	
ANTI-INFECTIVE AGENTS - MISC.		
AEMCOLO ORAL TABLET DELAYED RELEASE 194 MG (*rifamycin sodium*)	NOT COVERED PA Required	
atovaquone oral suspension 750 mg/5ml	COVERED - cDL	PA; 90
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (*aztreonam lysine*)	NOT COVERED PA Required	
clindamycin hcl oral capsule 150 mg	COVERED - cDL	QL (8 EA per 1 day)
clindamycin hcl oral capsule 300 mg	COVERED - cDL	QL (6 EA per 1 day)
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	COVERED - cDL	AGE (Max 18 Years)
dapsone oral tablet 100 mg	COVERED - cDL	QL (3 EA per 1 day)
dapsone oral tablet 25 mg	COVERED - cDL	QL (4 EA per 1 day)
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (*vancomycin hcl*)	COVERED - sPDL	
FLAGYL ORAL CAPSULE 375 MG (*metronidazole*)	NOT COVERED PA Required	
LIKMEZ ORAL SUSPENSION 500 MG/5ML (*metronidazole*)	NOT COVERED PA Required	
linezolid oral suspension reconstituted 100 mg/5ml	COVERED - cDL	PA
linezolid oral tablet 600 mg	COVERED - cDL	PA
metronidazole oral capsule 375 mg	NOT COVERED PA Required	
metronidazole oral tablet 250 mg	COVERED - sPDL	QL (8 EA per 1 day)
metronidazole oral tablet 500 mg	COVERED - sPDL	QL (4 EA per 1 day)
nitazoxanide oral tablet 500 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
nitrofurantoin macrocrystal oral capsule 100 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Max 64 Years)
nitrofurantoin macrocrystal oral capsule 50 mg	COVERED - cDL	QL (2 EA per 1 day); AGE (Max 64 Years)
nitrofurantoin monohyd macro oral capsule 100 mg	COVERED - cDL	QL (2 EA per 1 day); AGE (Max 64 Years)
nitrofurantoin oral suspension 25 mg/5ml	COVERED - cDL	QL (40 ML per 1 day); AGE (Max 12 Years)
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	COVERED - cDL	QL (40 ML per 1 day)
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	COVERED - cDL	QL (4 EA per 1 day)
tinidazole oral tablet 250 mg, 500 mg	NOT COVERED PA Required	
trimethoprim oral tablet 100 mg	COVERED - cDL	QL (6 EA per 1 day)
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (*vancomycin hcl*)	NOT COVERED PA Required	
vancomycin hcl oral capsule 125 mg, 250 mg	COVERED - sPDL	
vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml	NOT COVERED PA Required	QL (40 ML per 1 day)
vancomycin hcl oral solution reconstituted 250 mg/5ml	NOT COVERED PA Required	
XIFAXAN ORAL TABLET 200 MG, 550 MG (*rifaximin*)	NOT COVERED PA Required	
ANTIMALARIALS		
chloroquine phosphate oral tablet 250 mg	COVERED - cDL	QL (10 EA per 3 days)
chloroquine phosphate oral tablet 500 mg	COVERED - cDL	QL (5 EA per 3 days)
hydroxychloroquine sulfate oral tablet 200 mg	COVERED - cDL	QL (4 EA per 1 day)
mefloquine hcl oral tablet 250 mg	COVERED - cDL	QL (4 EA per 1 day)
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine bromide oral tablet 60 mg	COVERED - cDL	QL (6 EA per 1 day)
ANTIMYCOBACTERIAL AGENTS		
ethambutol hcl oral tablet 100 mg, 400 mg	COVERED - cDL	QL (5 EA per 1 day)
isoniazid oral syrup 50 mg/5ml	COVERED - cDL	QL (30 ML per 1 day)

Drug Name	Drug Tier	Requirements/Limits
isoniazid oral tablet 100 mg	COVERED - cDL	QL (6 EA per 1 day)
isoniazid oral tablet 300 mg	COVERED - cDL	QL (3 EA per 1 day)
PRIFTIN ORAL TABLET 150 MG (*rifapentine*)	COVERED - cDL	QL (1.143 EA per 1 day)
pyrazinamide oral tablet 500 mg	COVERED - cDL	QL (6 EA per 1 day)
rifampin oral capsule 150 mg, 300 mg	COVERED - cDL	QL (8 EA per 1 day)
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
abiraterone acetate oral tablet 250 mg	COVERED - cDL	PA; QL (4 EA per 1 day)
ALECENSA ORAL CAPSULE 150 MG (*alectinib hcl*)	COVERED - cDL	PA; QL (8 EA per 1 day)
anastrozole oral tablet 1 mg	COVERED - cDL	QL (1 EA per 1 day)
bicalutamide oral tablet 50 mg	COVERED - cDL	QL (3 EA per 1 day)
BRUKINSA ORAL CAPSULE 80 MG (*zanubrutinib*)	COVERED - cDL	PA; QL (4 EA per 1 day)
capecitabine oral tablet 150 mg, 500 mg	COVERED - cDL	PA
cyclophosphamide oral capsule 25 mg, 50 mg	COVERED - cDL	QL (16 EA per 1 day)
ELIGARD SUBCUTANEOUS KIT 22.5 MG (*leuprolide acetate (3 month)*)	COVERED - cDL	PA
ELIGARD SUBCUTANEOUS KIT 30 MG (*leuprolide acetate (4 month)*)	COVERED - cDL	PA
ELIGARD SUBCUTANEOUS KIT 45 MG (*leuprolide acetate (6 month)*)	COVERED - cDL	PA
ELIGARD SUBCUTANEOUS KIT 7.5 MG (*leuprolide acetate*)	COVERED - cDL	PA
erlotinib hcl oral tablet 100 mg, 150 mg	COVERED - cDL	PA; QL (1 EA per 1 day)
erlotinib hcl oral tablet 25 mg	COVERED - cDL	PA; QL (3 EA per 1 day)
etoposide oral capsule 50 mg	COVERED - cDL	PA
EULEXIN ORAL CAPSULE 125 MG (*flutamide*)	COVERED - cDL	QL (6 EA per 1 day)
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG (*lomustine*)	COVERED - cDL	QL (1.34 EA per 1 day)
GLEOSTINE ORAL CAPSULE 100 MG (*lomustine*)	COVERED - cDL	QL (1 EA per 1 day)
hydroxyurea oral capsule 500 mg	COVERED - cDL	
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (*palbociclib*)	COVERED - cDL	PA; QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (*palbociclib*)	COVERED - cDL	PA; QL (1 EA per 1 day)
imatinib mesylate oral tablet 100 mg	COVERED - cDL	PA; QL (3 EA per 1 day)
imatinib mesylate oral tablet 400 mg	COVERED - cDL	PA; QL (2 EA per 1 day)
IMBRUVICA ORAL CAPSULE 140 MG (*ibrutinib*)	COVERED - cDL	PA; QL (3 EA per 1 day)
IMBRUVICA ORAL TABLET 420 MG (*ibrutinib*)	COVERED - cDL	PA; QL (1 EA per 1 day)
JYLAMVO ORAL SOLUTION 2 MG/ML (*methotrexate*)	NOT COVERED PA Required	
letrozole oral tablet 2.5 mg	COVERED - cDL	QL (1 EA per 1 day)
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	COVERED - cDL	
LEUKERAN ORAL TABLET 2 MG (*chlorambucil*)	COVERED - cDL	QL (8 EA per 1 day)
leuprolide acetate injection kit 1 mg/0.2ml	COVERED - cDL	PA
LYSODREN ORAL TABLET 500 MG (*mitotane*)	COVERED - cDL	
MATULANE ORAL CAPSULE 50 MG (*procarbazine hcl*)	COVERED - cDL	PA
megestrol acetate oral suspension 40 mg/ml	COVERED - sPDL	QL (40 ML per 1 day)
megestrol acetate oral suspension 400 mg/10ml, 800 mg/20ml	COVERED - sPDL	
megestrol acetate oral tablet 20 mg	COVERED - cDL	QL (40 EA per 1 day)
megestrol acetate oral tablet 40 mg	COVERED - cDL	QL (20 EA per 1 day)
mercaptopurine oral tablet 50 mg	COVERED - cDL	QL (4 EA per 1 day)
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	COVERED - sPDL	QL (10 ML per 25 days)
methotrexate sodium injection solution 1000 mg/40ml	COVERED - sPDL	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	COVERED - sPDL	QL (10 ML per 25 days)
methotrexate sodium injection solution reconstituted 1 gm	COVERED - sPDL	
methotrexate sodium oral tablet 2.5 mg	COVERED - sPDL	
sorafenib tosylate oral tablet 200 mg	COVERED - cDL	PA; QL (4 EA per 1 day)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG (*dasatinib*)	COVERED - cDL	PA; QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
SPRYCEL ORAL TABLET 20 MG (*dasatinib*)	COVERED - cDL	PA; QL (3 EA per 1 day)
sunitinib malate oral capsule 12.5 mg	COVERED - cDL	PA; QL (4 EA per 1 day)
sunitinib malate oral capsule 25 mg	COVERED - cDL	PA; QL (2 EA per 1 day)
sunitinib malate oral capsule 37.5 mg, 50 mg	COVERED - cDL	PA; QL (1 EA per 1 day)
TAGRISSO ORAL TABLET 40 MG, 80 MG (*osimertinib mesylate*)	COVERED - cDL	PA; QL (1 EA per 1 day)
tamoxifen citrate oral tablet 10 mg, 20 mg	COVERED - cDL	QL (2 EA per 1 day)
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	COVERED - cDL	PA
tretinoin oral capsule 10 mg	COVERED - cDL	PA
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*)	NOT COVERED PA Required	
TYKERB ORAL TABLET 250 MG (*lapatinib ditosylate*)	COVERED - cDL	PA; QL (6 EA per 1 day)
XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*)	NOT COVERED PA Required	
ANTIPARKINSON AND RELATED THERAPY AGENTS		
amantadine hcl oral capsule 100 mg	COVERED - cDL	QL (4 EA per 1 day)
amantadine hcl oral solution 50 mg/5ml	COVERED - cDL	QL (1 ML per 1 day)
benztropine mesylate oral tablet 0.5 mg	COVERED - cDL	QL (5 EA per 1 day); AGE (Max 64 Years)
benztropine mesylate oral tablet 1 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
benztropine mesylate oral tablet 2 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Max 64 Years)
bromocriptine mesylate oral capsule 5 mg	COVERED - cDL	QL (6 EA per 1 day)
bromocriptine mesylate oral tablet 2.5 mg	COVERED - cDL	QL (6 EA per 1 day)
carbidopa-levodopa er oral tablet extended release 25-100 mg	COVERED - cDL	QL (4 EA per 1 day)
carbidopa-levodopa er oral tablet extended release 50-200 mg	COVERED - cDL	QL (8 EA per 1 day)
carbidopa-levodopa oral tablet 10-100 mg, 25-250 mg	COVERED - cDL	QL (8 EA per 1 day)
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg	COVERED - cDL	ST; QL (8 EA per 1 day); prior use of LEVODOPA/CARBIDOPA

Drug Name	Drug Tier	Requirements/Limits
carbidopa-levodopa-entacapone oral tablet 50-200-200 mg	COVERED - cDL	ST; QL (6 EA per 1 day); prior use of LEVODOPA/CARBIDOPA
entacapone oral tablet 200 mg	COVERED - cDL	ST; QL (8 EA per 1 day); prior use of LEVODOPA/CARBIDOPA
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR 0.375 MG, 0.75 MG, 2.25 MG, 3 MG, 3.75 MG, 4.5 MG (*pramipexole dihydrochloride*)	NOT COVERED PA Required	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (*rotigotine*)	NOT COVERED PA Required	
OSMOLEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR 129 MG, 193 MG (*amantadine hcl*)	NOT COVERED PA Required	
pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg	NOT COVERED PA Required	
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 1.5 mg	COVERED - sPDL	QL (3 EA per 1 day)
pramipexole dihydrochloride oral tablet 0.75 mg	COVERED - sPDL	QL (6 EA per 1 day)
ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	NOT COVERED PA Required	
ropinirole hcl oral tablet 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	COVERED - sPDL	QL (12 EA per 1 day)
ropinirole hcl oral tablet 0.5 mg	COVERED - sPDL	QL (6 EA per 1 day)
selegiline hcl oral capsule 5 mg	COVERED - cDL	QL (2 EA per 1 day); 90DS
selegiline hcl oral tablet 5 mg	COVERED - cDL	QL (2 EA per 1 day); 90DS
trihexyphenidyl hcl oral solution 0.4 mg/ml	COVERED - cDL	PA
trihexyphenidyl hcl oral tablet 2 mg	COVERED - cDL	QL (12 EA per 1 day); AGE (Max 64 Years)
trihexyphenidyl hcl oral tablet 5 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Max 64 Years)
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML, 960 MG/3.2ML (*aripiprazole*)	NOT COVERED PA Required	
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG (*aripiprazole*)	COVERED - sPDL	QL (1 EA per 25 days); AGE (Min 18 Years); 90DS
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG (*aripiprazole*)	COVERED - sPDL	QL (1 EA per 25 days); AGE (Min 18 Years); 90DS
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (*aripiprazole w/ sens-strip-pod*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
ABILIFY MYCITE STARTER KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (*aripiprazole w/ sens-strip-pod*)	NOT COVERED PA Required	
ABILIFY ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (*aripiprazole*)	NOT COVERED PA Required	
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG (*loxapine*)	NOT COVERED PA Required	
aripiprazole oral solution 1 mg/ml	NOT COVERED PA Required	AGE (Min 6 Years); 90DS
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years); 90DS
aripiprazole oral tablet dispersible 10 mg, 15 mg	COVERED - sPDL	PA; QL (1 EA per 1 day); AGE (Min 6 Years); 90DS
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML (*aripiprazole lauroxil*)	COVERED - sPDL	
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML (*aripiprazole lauroxil*)	COVERED - sPDL	QL (3.9 ML per 50 days); AGE (Min 18 Years); 90DS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML (*aripiprazole lauroxil*)	COVERED - sPDL	QL (1.6 ML per 25 days); AGE (Min 18 Years); 90DS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML (*aripiprazole lauroxil*)	COVERED - sPDL	QL (2.4 ML per 25 days); AGE (Min 18 Years); 90DS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML (*aripiprazole lauroxil*)	COVERED - sPDL	QL (3.2 ML per 25 days); AGE (Min 18 Years); 90DS
asenapine maleate sublingual tablet sublingual 10 mg, 5 mg	NOT COVERED PA Required	90DS
asenapine maleate sublingual tablet sublingual 2.5 mg	NOT COVERED PA Required	
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (*lumateperone tosylate*)	NOT COVERED PA Required	
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	COVERED - cDL	QL (12 EA per 1 day); AGE (Min 6 Years); 90DS
clozapine oral tablet 100 mg, 200 mg, 25 mg	COVERED - sPDL	AGE (Min 6 Years); 90DS
clozapine oral tablet 50 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years); 90DS
clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg	NOT COVERED PA Required	
CLOZARIL ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (*clozapine*)	NOT COVERED PA Required	
prochlorperazine (Compro Rectal Suppository 25 Mg)	NOT COVERED PA Required	QL (12 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine (antipsychotic)*)	NOT COVERED PA Required	
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*iloperidone*)	NOT COVERED PA Required	
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG (*iloperidone*)	NOT COVERED PA Required	
fluphenazine decanoate injection solution 25 mg/ml	COVERED - cDL	90DS
fluphenazine hcl injection solution 2.5 mg/ml	COVERED - cDL	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 6 Years); 90DS
GEODON ORAL CAPSULE 20 MG, 40 MG, 60 MG, 80 MG (*ziprasidone hcl*)	NOT COVERED PA Required	
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml	COVERED - cDL	AGE (Min 6 Years); 90DS
haloperidol lactate injection solution 5 mg/ml	COVERED - cDL	AGE (Min 6 Years)
haloperidol lactate oral concentrate 2 mg/ml	COVERED - cDL	AGE (Min 6 Years); 90DS
haloperidol oral tablet 0.5 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Min 6 Years); 90DS
haloperidol oral tablet 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	COVERED - cDL	QL (5 EA per 1 day); AGE (Min 6 Years); 90DS
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML (*paliperidone palmitate*)	COVERED - sPDL	
INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 3 MG, 6 MG, 9 MG (*paliperidone*)	NOT COVERED PA Required	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML (*paliperidone palmitate*)	COVERED - sPDL	QL (0.75 ML per 25 days); AGE (Min 18 Years); 90DS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML (*paliperidone palmitate*)	COVERED - sPDL	QL (1 ML per 25 days); AGE (Min 18 Years); 90DS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML (*paliperidone palmitate*)	COVERED - sPDL	QL (1.5 ML per 25 days); AGE (Min 18 Years); 90DS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML (*paliperidone palmitate*)	COVERED - sPDL	QL (0.25 ML per 25 days); AGE (Min 18 Years); 90DS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML (*paliperidone palmitate*)	COVERED - sPDL	QL (0.5 ML per 25 days); AGE (Min 18 Years); 90DS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML (*paliperidone palmitate*)	COVERED - sPDL	QL (0.88 ML per 71 days); AGE (Min 18 Years and Max 1 Years); 90DS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML (*paliperidone palmitate*)	COVERED - sPDL	QL (1.32 ML per 71 days); AGE (Min 18 Years and Max 1 Years); 90DS

Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML (*paliperidone palmitate*)	COVERED - sPDL	QL (1.75 ML per 71 days); AGE (Min 18 Years); 90DS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML (*paliperidone palmitate*)	COVERED - sPDL	QL (2.65 ML per 71 days); AGE (Min 18 Years and Max 1 Years); 90DS
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG (*lurasidone hcl*)	COVERED - sPDL	
lithium carbonate er oral tablet extended release 300 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Min 6 Years)
lithium carbonate er oral tablet extended release 450 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 6 Years)
lithium carbonate oral capsule 150 mg	COVERED - cDL	QL (12 EA per 1 day); AGE (Min 6 Years)
lithium carbonate oral capsule 300 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Min 6 Years)
lithium carbonate oral capsule 600 mg	COVERED - cDL	QL (3 EA per 1 day)
lithium carbonate oral tablet 300 mg	COVERED - cDL	QL (6 EA per 1 day)
lithium oral solution 8 meq/5ml	COVERED - cDL	
loxapine succinate oral capsule 10 mg, 5 mg, 50 mg	COVERED - cDL	QL (15 EA per 1 day); AGE (Min 6 Years); 90DS
loxapine succinate oral capsule 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Min 6 Years); 90DS
lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg	NOT COVERED PA Required	
NUPLAZID ORAL CAPSULE 34 MG (*pimavanserin tartrate*)	NOT COVERED PA Required	
NUPLAZID ORAL TABLET 10 MG (*pimavanserin tartrate*)	NOT COVERED PA Required	
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	COVERED - sPDL	ST; QL (1 EA per 1 day); PRIOR USE RISPERIDONE or QUETIAPINE or CLOZAPINE, 90DS
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	NOT COVERED PA Required	
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg	NOT COVERED PA Required	AGE (Min 6 Years); 90DS
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Min 6 Years); 90DS
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG (*risperidone*)	COVERED - sPDL	
prochlorperazine maleate oral tablet 10 mg	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 6 Years); 90DS

Drug Name	Drug Tier	Requirements/Limits
prochlorperazine maleate oral tablet 5 mg	COVERED - sPDL	QL (10 EA per 1 day); AGE (Min 6 Years); 90DS
prochlorperazine rectal suppository 25 mg	COVERED - sPDL	
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	COVERED - sPDL	PA; QL (1 EA per 1 day); AGE (Min 6 Years); 90DS
quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years); 90DS
quetiapine fumarate oral tablet 150 mg	COVERED - sPDL	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (*brexpiprazole*)	NOT COVERED PA Required	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG, 50 MG (*risperidone microspheres*)	COVERED - sPDL	AGE (Min 18 Years); 90DS
RISPERDAL ORAL SOLUTION 1 MG/ML (*risperidone*)	NOT COVERED PA Required	
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (*risperidone*)	NOT COVERED PA Required	
risperidone oral solution 1 mg/ml	COVERED - sPDL	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 5 Years); 90DS
risperidone oral tablet 4 mg	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 5 Years); 90DS
risperidone oral tablet dispersible 0.25 mg, 1 mg, 2 mg, 3 mg	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 5 Years); 90DS
risperidone oral tablet dispersible 0.5 mg	COVERED - sPDL	
risperidone oral tablet dispersible 4 mg	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 5 Years); 90DS
RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG (*risperidone*)	NOT COVERED PA Required	
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG, 2.5 MG, 5 MG (*asenapine maleate*)	COVERED - sPDL	
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR (*asenapine*)	NOT COVERED PA Required	
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG (*quetiapine fumarate*)	NOT COVERED PA Required	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG (*quetiapine fumarate*)	NOT COVERED PA Required	
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Max 64 Years); 90DS

Drug Name	Drug Tier	Requirements/Limits
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Min 6 Years); 90DS
trifluoperazine hcl oral tablet 1 mg, 2 mg, 5 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Min 6 Years); 90DS
trifluoperazine hcl oral tablet 10 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 6 Years); 90DS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML, 125 MG/0.35ML, 150 MG/0.42ML, 200 MG/0.56ML, 250 MG/0.7ML, 50 MG/0.14ML, 75 MG/0.21ML (*risperidone*)	NOT COVERED PA Required	
VERSACLOZ ORAL SUSPENSION 50 MG/ML (*clozapine*)	NOT COVERED PA Required	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (*cariprazine hcl*)	COVERED - sPDL	PA; AGE (Min 6 Years); 90DS
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
ziprasidone mesylate intramuscular solution reconstituted 20 mg	NOT COVERED PA Required	
ZYPREXA INTRAMUSCULAR SOLUTION RECONSTITUTED 10 MG (*olanzapine*)	NOT COVERED PA Required	
ZYPREXA ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG, 5 MG, 7.5 MG (*olanzapine*)	NOT COVERED PA Required	
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG (*olanzapine pamoate*)	NOT COVERED PA Required	AGE (Min 18 Years); 90DS
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG (*olanzapine pamoate*)	NOT COVERED PA Required	QL (1 EA per 25 days); AGE (Min 18 Years); 90DS
ZYPREXA ZYDIS ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 20 MG, 5 MG (*olanzapine*)	NOT COVERED PA Required	
ANTIVIRALS		
abacavir sulfate oral solution 20 mg/ml	COVERED - cDL	QL (30 ML per 1 day)
abacavir sulfate oral tablet 300 mg	COVERED - cDL	QL (2 EA per 1 day)
abacavir sulfate-lamivudine oral tablet 600-300 mg	COVERED - cDL	QL (1 EA per 1 day)
acyclovir oral capsule 200 mg	COVERED - sPDL	QL (5 EA per 1 day)
acyclovir oral suspension 200 mg/5ml	COVERED - sPDL	QL (25 ML per 1 day)
acyclovir oral tablet 400 mg, 800 mg	COVERED - sPDL	QL (5 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
adefovir dipivoxil oral tablet 10 mg	NOT COVERED PA Required	QL (1 EA per 1 day)
APTIVUS ORAL CAPSULE 250 MG (*tipranavir*)	COVERED - cDL	QL (4 EA per 1 day)
atazanavir sulfate oral capsule 150 mg	COVERED - cDL	QL (2 EA per 1 day)
BARACLUDE ORAL SOLUTION 0.05 MG/ML (*entecavir*)	COVERED - sPDL	
BARACLUDE ORAL TABLET 0.5 MG, 1 MG (*entecavir*)	NOT COVERED PA Required	
BIKTARVY ORAL TABLET 30-120-15 MG (*bictegravir-emtricitab-tenofov*)	COVERED - cDL	QL (1 EA per 1 day); AGE (Min 12 Years and Max 12 Years)
BIKTARVY ORAL TABLET 50-200-25 MG (*bictegravir-emtricitab-tenofov*)	COVERED - cDL	QL (1 EA per 1 day)
CIMDUO ORAL TABLET 300-300 MG (*lamivudine-tenofovir*)	COVERED - cDL	QL (1 EA per 1 day)
COMPLERA ORAL TABLET 200-25-300 MG (*emtricitab-rilpivir-tenofovir*)	COVERED - cDL	QL (1 EA per 1 day)
DELSTRIGO ORAL TABLET 100-300-300 MG (*doravirin-lamivudin-tenofov df*)	COVERED - cDL	QL (1 EA per 1 day)
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG (*emtricitabine-tenofovir af*)	COVERED - cDL	ST; QL (1 EA per 1 day); Prior Use of Truvada
DOVATO ORAL TABLET 50-300 MG (*dolutegravir-lamivudine*)	COVERED - cDL	QL (1 EA per 1 day)
EDURANT ORAL TABLET 25 MG (*rilpivirine hcl*)	COVERED - cDL	QL (1 EA per 1 day)
efavirenz oral capsule 200 mg	COVERED - cDL	QL (3 EA per 1 day)
efavirenz oral capsule 50 mg	COVERED - cDL	QL (12 EA per 1 day)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	COVERED - cDL	QL (1 EA per 1 day)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	COVERED - cDL	QL (1 EA per 1 day)
emtricitabine-tenofovir df oral tablet 200-300 mg	COVERED - cDL	QL (1 EA per 1 day)
EMTRIVA ORAL CAPSULE 200 MG (*emtricitabine*)	COVERED - cDL	QL (1 EA per 1 day)
EMTRIVA ORAL SOLUTION 10 MG/ML (*emtricitabine*)	COVERED - cDL	QL (20 ML per 1 day)
entecavir oral tablet 0.5 mg, 1 mg	COVERED - sPDL	QL (1 EA per 1 day)
EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG (*sofosbuvir-velpatasvir*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG (*sofosbuvir-velpatasvir*)	NOT COVERED PA Required	
etravirine oral tablet 100 mg	COVERED - cDL	QL (4 EA per 1 day)
etravirine oral tablet 200 mg	COVERED - cDL	QL (2 EA per 1 day)
EVOTAZ ORAL TABLET 300-150 MG (*atazanavir-cobicistat*)	COVERED - cDL	QL (1 EA per 1 day)
famciclovir oral tablet 125 mg, 250 mg, 500 mg	NOT COVERED PA Required	QL (3 EA per 1 day)
fosamprenavir calcium oral tablet 700 mg	COVERED - cDL	QL (4 EA per 1 day)
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (*enfuvirtide*)	COVERED - cDL	PA
GENVOYA ORAL TABLET 150-150-200-10 MG (*elviteg-cobic-emtricit-tenofaf*)	COVERED - cDL	QL (1 EA per 1 day)
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (*ledipasvir-sofosbuvir*)	NOT COVERED PA Required	
HARVONI ORAL TABLET 45-200 MG, 90-400 MG (*ledipasvir-sofosbuvir*)	NOT COVERED PA Required	
INTELENCE ORAL TABLET 25 MG (*etravirine*)	COVERED - cDL	QL (4 EA per 1 day)
ISENTRESS HD ORAL TABLET 600 MG (*raltegravir potassium*)	COVERED - cDL	QL (2 EA per 1 day)
ISENTRESS ORAL PACKET 100 MG (*raltegravir potassium*)	COVERED - cDL	QL (12 EA per 1 day)
ISENTRESS ORAL TABLET 400 MG (*raltegravir potassium*)	COVERED - cDL	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 100 MG (*raltegravir potassium*)	COVERED - cDL	QL (12 EA per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 25 MG (*raltegravir potassium*)	COVERED - cDL	QL (2 EA per 1 day)
JULUCA ORAL TABLET 50-25 MG (*dolutegravir-rilpivirine*)	COVERED - cDL	QL (1 EA per 1 day)
KALETRA ORAL SOLUTION 400-100 MG/5ML (*lopinavir-ritonavir*)	COVERED - cDL	QL (16 ML per 1 day)
KALETRA ORAL TABLET 100-25 MG (*lopinavir-ritonavir*)	COVERED - cDL	QL (8 EA per 1 day)
KALETRA ORAL TABLET 200-50 MG (*lopinavir-ritonavir*)	COVERED - cDL	QL (4 EA per 1 day)
lamivudine oral solution 10 mg/ml	COVERED - cDL	QL (30 ML per 1 day)
lamivudine oral tablet 100 mg	COVERED - sPDL	QL (3 EA per 1 day)
lamivudine oral tablet 150 mg	COVERED - cDL	QL (2 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
lamivudine oral tablet 300 mg	COVERED - cDL	QL (1 EA per 1 day)
lamivudine-zidovudine oral tablet 150-300 mg	COVERED - cDL	QL (2 EA per 1 day)
ledipasvir-sofosbuvir oral tablet 90-400 mg	NOT COVERED PA Required	
maraviroc oral tablet 150 mg, 300 mg	COVERED - cDL	QL (2 EA per 1 day)
MAVYRET ORAL PACKET 50-20 MG (*glecaprevir-pibrentasvir*)	COVERED with Clinical Criteria	PA
MAVYRET ORAL TABLET 100-40 MG (*glecaprevir-pibrentasvir*)	COVERED with Clinical Criteria	PA
nevirapine er oral tablet extended release 24 hour 400 mg	COVERED - cDL	QL (1 EA per 1 day)
nevirapine oral suspension 50 mg/5ml	COVERED - cDL	QL (40 ML per 1 day)
nevirapine oral tablet 200 mg	COVERED - cDL	QL (2 EA per 1 day)
ODEFSEY ORAL TABLET 200-25-25 MG (*emtricitab-rilpivir-tenofov af*)	COVERED - cDL	QL (1 EA per 1 day)
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	COVERED - cDL	QL (10 EA per 5 days)
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	COVERED - cDL	QL (180 ML per 5 days); AGE (Max 12 Years)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	COVERED - cDL	QL (30 EA per 5 days); AGE (Min 18 Years); Max 5 day supply
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	COVERED - cDL	QL (30 EA per 5 days); AGE (Min 18 Years); Max 5 day supply
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (*peginterferon alfa-2a*)	NOT COVERED PA Required	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (*peginterferon alfa-2a*)	NOT COVERED PA Required	
PIFELTRO ORAL TABLET 100 MG (*doravirine*)	COVERED - cDL	QL (1 EA per 1 day)
PREZCOBIX ORAL TABLET 800-150 MG (*darunavir-cobicistat*)	COVERED - cDL	QL (1 EA per 1 day)
PREZISTA ORAL SUSPENSION 100 MG/ML (*darunavir*)	COVERED - cDL	QL (8 ML per 1 day)
PREZISTA ORAL TABLET 150 MG (*darunavir*)	COVERED - cDL	QL (8 EA per 1 day)
PREZISTA ORAL TABLET 600 MG (*darunavir*)	COVERED - cDL	QL (2 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
PREZISTA ORAL TABLET 75 MG (*darunavir*)	COVERED - cDL	QL (16 EA per 1 day)
PREZISTA ORAL TABLET 800 MG (*darunavir*)	COVERED - cDL	QL (1 EA per 1 day)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (*zanamivir*)	COVERED - cDL	MAX QTY 20.00
RETROVIR ORAL CAPSULE 100 MG (*zidovudine*)	COVERED - cDL	QL (6 EA per 1 day)
RETROVIR ORAL SYRUP 50 MG/5ML (*zidovudine*)	COVERED - cDL	QL (60 ML per 1 day)
REYATAZ ORAL CAPSULE 200 MG (*atazanavir sulfate*)	COVERED - cDL	QL (2 EA per 1 day)
REYATAZ ORAL CAPSULE 300 MG (*atazanavir sulfate*)	COVERED - cDL	QL (1 EA per 1 day)
ribavirin oral capsule 200 mg	NOT COVERED PA Required	
ribavirin oral tablet 200 mg	NOT COVERED PA Required	
rimantadine hcl oral tablet 100 mg	COVERED - cDL	QL (2 EA per 1 day)
ritonavir oral tablet 100 mg	COVERED - cDL	QL (12 EA per 1 day)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (*fostemsavir tromethamine*)	COVERED - cDL	QL (2 EA per 1 day)
SELZENTRY ORAL SOLUTION 20 MG/ML (*maraviroc*)	COVERED - cDL	QL (30 ML per 1 day)
SITAVIG BUCCAL TABLET 50 MG (*acyclovir*)	NOT COVERED PA Required	
sofosbuvir-velpatasvir oral tablet 400-100 mg	COVERED - sPDL	PA; QL (1 EA per 1 day)
SOVALDI ORAL PACKET 150 MG, 200 MG (*sofosbuvir*)	NOT COVERED PA Required	
SOVALDI ORAL TABLET 200 MG (*sofosbuvir*)	NOT COVERED PA Required	
SOVALDI ORAL TABLET 400 MG (*sofosbuvir*)	NOT COVERED PA Required	QL (1 EA per 1 day)
STRIBILD ORAL TABLET 150-150-200-300 MG (*elviteg-cobic-emtricit-tenofdf*)	COVERED - cDL	QL (1 EA per 1 day)
SUSTIVA ORAL TABLET 600 MG (*efavirenz*)	COVERED - cDL	QL (1 EA per 1 day)
SYMTUZA ORAL TABLET 800-150-200-10 MG (*darun-cobic-emtricit-tenofaf*)	COVERED - cDL	QL (1 EA per 1 day)
tenofovir disoproxil fumarate oral tablet 300 mg	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
TIVICAY ORAL TABLET 50 MG (*dolutegravir sodium*)	COVERED - cDL	QL (2 EA per 1 day)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (*dolutegravir sodium*)	COVERED - cDL	QL (6 EA per 1 day)
TRIUMEQ ORAL TABLET 600-50-300 MG (*abacavir-dolutegravir-lamivud*)	COVERED - cDL	QL (1 EA per 1 day)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG (*abacavir-dolutegravir-lamivud*)	COVERED - cDL	QL (1 EA per 1 day)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (*emtricitabine-tenofovir df*)	COVERED - cDL	QL (1 EA per 1 day)
TYBOST ORAL TABLET 150 MG (*cobicistat*)	COVERED - cDL	QL (1 EA per 1 day)
valacyclovir hcl oral tablet 1 gm, 500 mg	COVERED - sPDL	QL (8 EA per 1 day)
valganciclovir hcl oral solution reconstituted 50 mg/ml	COVERED - cDL	PA
valganciclovir hcl oral tablet 450 mg	COVERED - cDL	PA
VALTREX ORAL TABLET 1 GM, 500 MG (*valacyclovir hcl*)	NOT COVERED PA Required	
VEKLURY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*remdesivir*)	COVERED - cDL	
VEMLIDY ORAL TABLET 25 MG (*tenofovir alafenamide fumarate*)	NOT COVERED PA Required	
VIRACEPT ORAL TABLET 250 MG (*nelfinavir mesylate*)	COVERED - cDL	QL (10 EA per 1 day)
VIRACEPT ORAL TABLET 625 MG (*nelfinavir mesylate*)	COVERED - cDL	QL (4 EA per 1 day)
VIREAD ORAL POWDER 40 MG/GM (*tenofovir disoproxil fumarate*)	COVERED - cDL	QL (7.5 GM per 1 day)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (*tenofovir disoproxil fumarate*)	COVERED - cDL	QL (1 EA per 1 day)
VOSEVI ORAL TABLET 400-100-100 MG (*sofosbuv-velpatasv-voxilaprev*)	COVERED - sPDL	PA; QL (1 EA per 1 day)
ZEPATIER ORAL TABLET 50-100 MG (*elbasvir-grazoprevir*)	NOT COVERED PA Required	QL (1 EA per 1 day)
zidovudine oral tablet 300 mg	COVERED - cDL	QL (2 EA per 1 day)
BETA BLOCKERS		
acebutolol hcl oral capsule 200 mg, 400 mg	COVERED - sPDL	QL (16 EA per 1 day)
atenolol oral tablet 100 mg, 25 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day)
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl*)	NOT COVERED PA Required	
betaxolol hcl oral tablet 10 mg, 20 mg	NOT COVERED PA Required	
bisoprolol fumarate oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (2 EA per 1 day)
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (*nebivolol hcl*)	NOT COVERED PA Required	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	COVERED - sPDL	QL (2 EA per 1 day)
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	NOT COVERED PA Required	
COREG CR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 40 MG, 80 MG (*carvedilol phosphate*)	NOT COVERED PA Required	
COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (*carvedilol*)	NOT COVERED PA Required	
CORGARD ORAL TABLET 20 MG, 40 MG (*nadolol*)	NOT COVERED PA Required	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*)	NOT COVERED PA Required	
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (*propranolol hcl*)	NOT COVERED PA Required	
INDERAL XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (*propranolol hcl sr beads*)	NOT COVERED PA Required	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (*propranolol hcl sr beads*)	NOT COVERED PA Required	
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*)	NOT COVERED PA Required	
labetalol hcl oral tablet 100 mg, 200 mg	COVERED - sPDL	QL (4 EA per 1 day)
labetalol hcl oral tablet 300 mg	COVERED - sPDL	QL (8 EA per 1 day)
LOPRESSOR ORAL TABLET 100 MG, 50 MG (*metoprolol tartrate*)	NOT COVERED PA Required	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 25 mg	COVERED - sPDL	QL (3 EA per 1 day)
metoprolol succinate er oral tablet extended release 24 hour 200 mg	COVERED - sPDL	QL (2 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
metoprolol succinate er oral tablet extended release 24 hour 50 mg	COVERED - sPDL	QL (4 EA per 1 day)
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	COVERED - sPDL	QL (3 EA per 1 day)
metoprolol tartrate oral tablet 37.5 mg, 75 mg	COVERED - sPDL	
nadolol oral tablet 20 mg, 40 mg	COVERED - sPDL	QL (3 EA per 1 day)
nadolol oral tablet 80 mg	COVERED - sPDL	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	NOT COVERED PA Required	
pindolol oral tablet 10 mg, 5 mg	NOT COVERED PA Required	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 60 mg	COVERED - sPDL	QL (3 EA per 1 day)
propranolol hcl er oral capsule extended release 24 hour 160 mg	COVERED - sPDL	QL (2 EA per 1 day)
propranolol hcl er oral capsule extended release 24 hour 80 mg	COVERED - sPDL	QL (4 EA per 1 day)
propranolol hcl oral solution 20 mg/5ml	COVERED - sPDL	QL (20 ML per 1 day)
propranolol hcl oral solution 40 mg/5ml	COVERED - sPDL	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	COVERED - sPDL	QL (6 EA per 1 day)
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	COVERED - sPDL	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	COVERED - sPDL	QL (2 EA per 1 day)
SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*)	NOT COVERED PA Required	
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG (*atenolol*)	NOT COVERED PA Required	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	NOT COVERED PA Required	
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*)	NOT COVERED PA Required	
CALCIUM CHANNEL BLOCKERS		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
CARDIZEM CD ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG (*diltiazem hcl coated beads*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl*)	NOT COVERED PA Required	
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG (*diltiazem hcl*)	NOT COVERED PA Required	
diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	COVERED - sPDL	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	COVERED - sPDL	QL (2 EA per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 240 mg, 300 mg	COVERED - sPDL	QL (1 EA per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg	COVERED - sPDL	QL (2 EA per 1 day)
diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg	COVERED - sPDL	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	COVERED - sPDL	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	COVERED - sPDL	QL (2 EA per 1 day)
diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	COVERED - sPDL	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	COVERED - sPDL	QL (4 EA per 1 day)
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	COVERED - sPDL	
felodipine er oral tablet extended release 24 hour 10 mg	COVERED - sPDL	QL (2 EA per 1 day)
felodipine er oral tablet extended release 24 hour 2.5 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
isradipine oral capsule 2.5 mg, 5 mg	COVERED - sPDL	
KATERZIA ORAL SUSPENSION 1 MG/ML (*amlodipine benzoate*)	NOT COVERED PA Required	AGE (Min 6 Years and Max 12 Years)
levamlodipine maleate oral tablet 2.5 mg, 5 mg	NOT COVERED PA Required	
diltiazem hcl (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	NOT COVERED PA Required	
nicardipine hcl oral capsule 20 mg, 30 mg	COVERED - sPDL	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg	COVERED - sPDL	QL (1 EA per 1 day)
nifedipine er oral tablet extended release 24 hour 90 mg	COVERED - sPDL	QL (2 EA per 1 day)
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	COVERED - sPDL	QL (2 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
nifedipine oral capsule 10 mg, 20 mg	NOT COVERED PA Required	QL (4 EA per 1 day); AGE (Max 64 Years)
nimodipine oral capsule 30 mg	NOT COVERED PA Required	
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg	NOT COVERED PA Required	
NORLIQVA ORAL SOLUTION 1 MG/ML (*amlodipine besylate*)	NOT COVERED PA Required	AGE (Min 6 Years and Max 12 Years)
NORVASC ORAL TABLET 10 MG, 2.5 MG, 5 MG (*amlodipine besylate*)	NOT COVERED PA Required	
NYMALIZE ORAL SOLUTION 6 MG/ML (*nimodipine*)	NOT COVERED PA Required	
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (*nifedipine*)	NOT COVERED PA Required	
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (*nisoldipine*)	NOT COVERED PA Required	
diltiazem hcl er beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	COVERED - sPDL	
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG (*diltiazem hcl er beads*)	NOT COVERED PA Required	QL (2 EA per 1 day)
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 360 MG, 420 MG (*diltiazem hcl er beads*)	NOT COVERED PA Required	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	NOT COVERED PA Required	
verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg	COVERED - sPDL	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	COVERED - sPDL	QL (3 EA per 1 day)
verapamil hcl oral tablet 120 mg	COVERED - sPDL	QL (3 EA per 1 day)
verapamil hcl oral tablet 40 mg, 80 mg	COVERED - sPDL	QL (4 EA per 1 day)
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (*verapamil hcl*)	NOT COVERED PA Required	
CARDIOTONICS		
digoxin oral solution 0.05 mg/ml	COVERED - cDL	AGE (Max 12 Years)

Drug Name	Drug Tier	Requirements/Limits
digoxin oral tablet 125 mcg, 250 mcg	COVERED - cDL	QL (1 EA per 1 day)
CARDIOVASCULAR AGENTS - MISC.		
ADCIRCA ORAL TABLET 20 MG (*tadalafil (pah)*)	COVERED with Clinical Criteria	PA
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (*riociguat*)	NOT COVERED PA Required	
tadalafil (pah) (Alyq Oral Tablet 20 Mg)	NOT COVERED PA Required	
ambrisentan oral tablet 10 mg, 5 mg	NOT COVERED PA Required	QL (1 EA per 1 day)
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	NOT COVERED PA Required	
bosentan oral tablet 125 mg, 62.5 mg	NOT COVERED PA Required	QL (2 EA per 1 day)
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG (*amlodipine-atorvastatin*)	NOT COVERED PA Required	
CORLANOR ORAL TABLET 5 MG, 7.5 MG (*ivabradine hcl*)	COVERED - cDL	PA
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (*sacubitril-valsartan*)	COVERED - sPDL	PA
INPEFA ORAL TABLET 200 MG, 400 MG (*sotagliflozin*)	NOT COVERED PA Required	
LETAIRIS ORAL TABLET 10 MG, 5 MG (*ambrisentan*)	NOT COVERED PA Required	
LIQREV ORAL SUSPENSION 10 MG/ML (*sildenafil citrate*)	NOT COVERED PA Required	
niacin flush free oral capsule 500 mg	COVERED - cDL	
OPSUMIT ORAL TABLET 10 MG (*macitentan*)	NOT COVERED PA Required	QL (1 EA per 1 day)
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG (*macitentan-tadalafil*)	NOT COVERED PA Required	
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	NOT COVERED PA Required	
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (*treprostinil diolamine*)	NOT COVERED PA Required	
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (*treprostinil diolamine*)	NOT COVERED PA Required	
REVATIO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (*sildenafil citrate*)	NOT COVERED PA Required	
REVATIO ORAL TABLET 20 MG (*sildenafil citrate*)	NOT COVERED PA Required	
sildenafil citrate oral suspension reconstituted 10 mg/ml	NOT COVERED PA Required	
sildenafil citrate oral tablet 20 mg	COVERED - sPDL	PA
tadalafil (pah) oral tablet 20 mg	NOT COVERED PA Required	
TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*)	NOT COVERED PA Required	
TRACLEER ORAL TABLET 125 MG, 62.5 MG (*bosentan*)	COVERED - sPDL	
TRACLEER ORAL TABLET SOLUBLE 32 MG (*bosentan*)	NOT COVERED PA Required	
treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml	COVERED - cDL	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (*selexipag*)	NOT COVERED PA Required	QL (2 EA per 1 day)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (*selexipag*)	NOT COVERED PA Required	
CEPHALOSPORINS		
cefaclor er oral tablet extended release 12 hour 500 mg	NOT COVERED PA Required	
cefaclor oral capsule 250 mg, 500 mg	NOT COVERED PA Required	
cefadroxil oral capsule 500 mg	NOT COVERED PA Required	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	NOT COVERED PA Required	AGE (Max 12 Years)

Drug Name	Drug Tier	Requirements/Limits
cefadroxil oral tablet 1 gm	NOT COVERED PA Required	
cefdinir oral capsule 300 mg	COVERED - sPDL	QL (2 EA per 1 day)
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	COVERED - sPDL	AGE (Max 12 Years)
cefixime oral capsule 400 mg	NOT COVERED PA Required	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	NOT COVERED PA Required	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	NOT COVERED PA Required	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	NOT COVERED PA Required	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	COVERED - sPDL	AGE (Max 12 Years)
cefprozil oral tablet 250 mg, 500 mg	COVERED - sPDL	
cefuroxime axetil oral tablet 250 mg, 500 mg	COVERED - sPDL	QL (2 EA per 1 day); 10
cephalexin oral capsule 250 mg, 500 mg	COVERED - cDL	QL (6 EA per 1 day)
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	COVERED - cDL	AGE (Max 12 Years)
CHEMICALS		
acesulfame potassium powder	COVERED - cDL	
benzyl benzoate liquid	COVERED - cDL	AGE (Min 16 Years and Max 60 Years)
budesonide powder	COVERED - cDL	
ethyl oleate liquid	COVERED - cDL	
hydroxyurea powder	COVERED - cDL	
progesterone micronized powder	COVERED - cDL	
sesame oil oil	COVERED - cDL	
stevia extract powder	COVERED - cDL	
CONTRACEPTIVES		
norethindrone-eth estradiol (Balziva Oral Tablet 0.4-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
levonorgest-eth estrad 91-day (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	COVERED - cDL	QL (1.08 EA per 1 day)
levonorgest-eth estrad 91-day (Camrese Oral Tablet 0.15-0.03 &0.01 Mg)	COVERED - cDL	QL (1.08 EA per 1 day)
norgestrel-ethinyl estradiol (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (*medroxyprogesterone acetate*)	COVERED - cDL	QL (1 ML per 1 day)
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	COVERED - cDL	QL (1.34 EA per 1 day)
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg	COVERED - cDL	QL (1.34 EA per 1 day)
ELLA ORAL TABLET 30 MG (*ulipristal acetate*)	COVERED - cDL	QL (1 EA per 1 day)
levonorg-eth estrad triphasic (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
norgestimate-eth estradiol (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg	COVERED - cDL	QL (1.34 EA per 1 day)
ethynodiol diac-eth estradiol (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (*levonorgestrel*)	COVERED - cDL	QL (1 EA per 1 day)
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	COVERED - cDL	QL (1.08 EA per 1 day)
levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg	COVERED - cDL	QL (1.34 EA per 1 day)
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (*levonorgestrel*)	COVERED - cDL	QL (1 EA per 1 day)
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	COVERED - cDL	QL (4 ML per 310 days)
norgestimate-eth estradiol (Mili Oral Tablet 0.25-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (*levonorgestrel*)	COVERED - cDL	QL (1 EA per 1 day)
norgestimate-eth estradiol (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	COVERED - cDL	QL (1.34 EA per 1 day)
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	COVERED - cDL	QL (1.34 EA per 1 day)
norethindrone oral tablet 0.35 mg	COVERED - cDL	QL (1.34 EA per 1 day)
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	COVERED - cDL	QL (1.34 EA per 1 day)
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	COVERED - cDL	QL (1.35 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
norethindrone-eth estradiol (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
norethindrone-eth estradiol (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
norethin-eth estrad triphasic (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
NUVARING VAGINAL RING 0.12-0.015 MG/24HR (*etonogestrel-ethinyl estradiol*)	COVERED - cDL	QL (0.05 EA per 1 day)
norgestimate-eth estradiol (Nymyo Oral Tablet 0.25-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
OPTION 2 ORAL TABLET 1.5 MG (*levonorgestrel*)	COVERED - cDL	QL (12 EA per 310 days)
levonorgestrel-ethinyl estrad (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
desogestrel-ethinyl estradiol (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (*levonorgestrel*)	COVERED - cDL	QL (1 EA per 1 day)
norgestimate-eth estradiol (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
norgestim-eth estrad triphasic (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
norgestim-eth estrad triphasic (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
norgestim-eth estrad triphasic (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
norgestim-eth estrad triphasic (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
norgestim-eth estrad triphasic (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
norgestim-eth estrad triphasic (Trinessa (28) Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
norgestim-eth estrad triphasic (Tri-Nymyo Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
norgestim-eth estrad triphasic (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
norgestim-eth estrad triphasic (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - cDL	QL (1.35 EA per 1 day)
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (*desogestrel-ethinyl estradiol*)	COVERED - cDL	QL (1.34 EA per 1 day)
drospirenone-ethinyl estradiol (Vestura Oral Tablet 3-0.02 Mg)	COVERED - cDL	QL (1.34 EA per 1 day)
norgestimate-eth estradiol (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	COVERED - cDL	QL (1.34 EA per 1 day)
norelgestromin-eth estradiol (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	COVERED - cDL	QL (0.143 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
CORTICOSTEROIDS		
AGAMREE ORAL SUSPENSION 40 MG/ML (*vamorolone*)	NOT COVERED PA Required	
ALKINDI SPRINKLE ORAL CAPSULE SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG (*hydrocortisone*)	NOT COVERED PA Required	
budesonide er oral tablet extended release 24 hour 9 mg	NOT COVERED PA Required	
budesonide oral capsule delayed release particles 3 mg	COVERED - sPDL	
CORTEF ORAL TABLET 10 MG (*hydrocortisone*)	NOT COVERED PA Required	QL (12 EA per 1 day)
CORTEF ORAL TABLET 20 MG (*hydrocortisone*)	NOT COVERED PA Required	QL (6 EA per 1 day)
CORTEF ORAL TABLET 5 MG (*hydrocortisone*)	NOT COVERED PA Required	QL (24 EA per 1 day)
cortisone acetate oral tablet 25 mg	COVERED - sPDL	
deflazacort oral tablet 18 mg, 30 mg, 6 mg	NOT COVERED PA Required	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML (*dexamethasone*)	NOT COVERED PA Required	
dexamethasone oral elixir 0.5 mg/5ml	COVERED - sPDL	QL (60 ML per 1 day)
dexamethasone oral solution 0.5 mg/5ml	COVERED - sPDL	
dexamethasone oral tablet 0.5 mg	COVERED - sPDL	QL (12 EA per 1 day)
dexamethasone oral tablet 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	COVERED - sPDL	QL (10 EA per 1 day)
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	COVERED - sPDL	
EMFLAZA ORAL SUSPENSION 22.75 MG/ML (*deflazacort*)	NOT COVERED PA Required	
EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG (*deflazacort*)	NOT COVERED PA Required	
EOHILIA ORAL SUSPENSION 2 MG/10ML (*budesonide*)	NOT COVERED PA Required	
fludrocortisone acetate oral tablet 0.1 mg	COVERED - cDL	QL (5 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
HEMADY ORAL TABLET 20 MG (*dexamethasone*)	NOT COVERED PA Required	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	COVERED - sPDL	
MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG (*methylprednisolone*)	NOT COVERED PA Required	
MEDROL ORAL TABLET THERAPY PACK 4 MG (*methylprednisolone*)	NOT COVERED PA Required	
methylprednisolone oral tablet 16 mg	COVERED - sPDL	QL (4 EA per 1 day)
methylprednisolone oral tablet 32 mg	COVERED - sPDL	QL (2 EA per 1 day)
methylprednisolone oral tablet 4 mg	COVERED - sPDL	QL (12 EA per 1 day)
methylprednisolone oral tablet 8 mg	COVERED - sPDL	QL (6 EA per 1 day)
methylprednisolone oral tablet therapy pack 4 mg	COVERED - sPDL	QL (12 EA per 1 day)
prednisolone oral solution 15 mg/5ml	COVERED - sPDL	
prednisolone oral tablet 5 mg	NOT COVERED PA Required	
prednisolone sodium phosphate oral solution 10 mg/5ml, 15 mg/5ml, 20 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml	COVERED - sPDL	
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	COVERED - sPDL	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML (*prednisone*)	NOT COVERED PA Required	
prednisone oral solution 5 mg/5ml	COVERED - sPDL	QL (60 ML per 1 day)
prednisone oral tablet 1 mg	COVERED - sPDL	QL (10 EA per 1 day)
prednisone oral tablet 10 mg	COVERED - sPDL	QL (9 EA per 1 day)
prednisone oral tablet 2.5 mg	COVERED - sPDL	QL (8 EA per 1 day)
prednisone oral tablet 20 mg	COVERED - sPDL	QL (6 EA per 1 day)
prednisone oral tablet 5 mg	COVERED - sPDL	QL (16 EA per 1 day)
prednisone oral tablet 50 mg	COVERED - sPDL	QL (3 EA per 1 day)
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
RAYOS ORAL TABLET DELAYED RELEASE 1 MG, 2 MG, 5 MG (*prednisone*)	NOT COVERED PA Required	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (*dexamethasone*)	NOT COVERED PA Required	
dexamethasone (Taperdex 6-Day Oral Tablet Therapy Pack 1.5 Mg, 1.5 Mg (21))	NOT COVERED PA Required	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (*dexamethasone*)	NOT COVERED PA Required	
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (*budesonide*)	NOT COVERED PA Required	
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (*budesonide*)	NOT COVERED PA Required	
COUGH/COLD/ALLERGY		
acetylcysteine inhalation solution 20 %	COVERED - cDL	QL (120 ML per 1 day)
allergy/congestion relief oral tablet extended release 12 hour 5-120 mg	COVERED - cDL	QL (2 EA per 1 day)
altarussin dm oral syrup 100-10 mg/5ml	COVERED - cDL	
altarussin oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
BENADRYL ALLERGY CON ULTRATABS ORAL TABLET 25-10 MG (*diphenhydramine-phenylephrine*)	COVERED - cDL	
benzonatate oral capsule 100 mg	COVERED - cDL	QL (6 EA per 1 day)
benzonatate oral capsule 200 mg	COVERED - cDL	QL (5 EA per 1 day)
BUCKLEYS CHEST CONGESTION ORAL LIQUID 100 MG/5ML (*guaifenesin*)	COVERED - cDL	QL (4 ML per 1 day)
cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg	COVERED - cDL	QL (2 EA per 1 day)
chest congestion relief child oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
chest congestion relief dm oral syrup 10-100 mg/5ml	COVERED - cDL	
chest congestion relief oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
chest congestion relief oral tablet 400 mg	COVERED - cDL	AGE (Min 4 Years)
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (*desloratadine-pseudoephedrine*)	NOT COVERED PA Required	
cvs mucus d extended release oral tablet extended release 12 hour 60-600 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 4 Years)

Drug Name	Drug Tier	Requirements/Limits
cvs tussin adult chest congest oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
cvs tussin long-acting oral liquid 15 mg/5ml	COVERED - cDL	QL (1 ML per 1 day)
dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml, 20-200 mg/10ml	COVERED - cDL	
DIABETIC TUSSIN DM MAX ST ORAL LIQUID 10-200 MG/5ML (*dextromethorphan-guaifenesin*)	COVERED - cDL	
DIABETIC TUSSIN EX ORAL LIQUID 100 MG/5ML (*guaifenesin*)	COVERED - cDL	QL (4 ML per 1 day)
DIMETAPP NIGHT COLD/CONGESTION ORAL LIQUID 6.25-2.5 MG/5ML (*diphenhydramine-phenylephrine*)	COVERED - cDL	QL (180 ML per 25 days)
eq tussin dm cough/chest oral syrup 10-100 mg/5ml	COVERED - cDL	
eql tussin dm cough/chest cong oral syrup 100-10 mg/5ml	COVERED - cDL	
eql tussin mucus/chest congest oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
ft mucus relief d 12 hour oral tablet extended release 12 hour 60-600 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 4 Years)
ft tussin adult oral liquid 200 mg/10ml	COVERED - cDL	QL (4 ML per 1 day)
geri-tussin dm oral syrup 10-100 mg/5ml	COVERED - cDL	
geri-tussin oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
geri-tussin oral syrup 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
GILTUSS HONEY DM CHILDRENS ORAL LIQUID 15 MG/5ML (*dextromethorphan hbr*)	COVERED - cDL	QL (1 ML per 1 day)
GILTUSS HONEY DM ORAL LIQUID 30 MG/10ML (*dextromethorphan hbr*)	COVERED - cDL	QL (1 ML per 1 day)
gnp tussin mucus & chest cong oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
guaifenesin er oral tablet extended release 12 hour 600 mg	COVERED - cDL	QL (2 EA per 1 day)
guaifenesin oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
guaifenesin oral tablet 200 mg	COVERED - cDL	AGE (Min 4 Years)
guaifenesin-codeine oral solution 100-10 mg/5ml	COVERED - cDL	QL (60 ML per 1 day); AGE (Min 2 Years)
guaifenesin-dm oral syrup 100-10 mg/5ml	COVERED - cDL	
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	COVERED - cDL	QL (1 ML per 1 day)
loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
MAX TUSSIN MUCUS & CHEST CONG ORAL LIQUID 200 MG/10ML (*guaifenesin*)	COVERED - cDL	QL (4 ML per 1 day)
maxi-tuss gmx oral liquid 10-200 mg/5ml	COVERED - cDL	
medi-tussin dm oral syrup 100-10 mg/5ml	COVERED - cDL	
MUCINEX D ORAL TABLET EXTENDED RELEASE 12 HOUR 60-600 MG (*pseudoephedrine-guaifenesin*)	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 4 Years)
MUCINEX FAST-MAX CHEST CONG MS ORAL LIQUID 400 MG/20ML (*guaifenesin*)	COVERED - cDL	QL (4 ML per 1 day)
mucus & chest congestion oral liquid 200 mg/10ml	COVERED - cDL	QL (4 ML per 1 day)
mucus relief chest congestion oral liquid 400 mg/20ml	COVERED - cDL	QL (4 ML per 1 day)
mucus relief d 12hr er oral tablet extended release 12 hour 60-600 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 4 Years)
mucus relief d oral tablet extended release 12 hour 60-600 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 4 Years)
mucus relief dm oral tablet extended release 12 hour 30-600 mg	COVERED - cDL	QL (2 EA per 1 day)
mucus+chest congestion oral liquid 200 mg/10ml	COVERED - cDL	QL (4 ML per 1 day)
promethazine vc oral syrup 6.25-5 mg/5ml	COVERED - cDL	QL (60 ML per 1 day); AGE (Max 64 Years)
promethazine-codeine oral syrup 6.25-10 mg/5ml	COVERED - cDL	QL (240 ML per 25 days); AGE (Min 2 Years and Max 64 Years)
promethazine-dm oral syrup 6.25-15 mg/5ml	COVERED - cDL	QL (180 ML per 25 days); AGE (Min 4 Years)
pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml	COVERED - cDL	QL (60 ML per 1 day)
pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 60-600 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 4 Years)
qc cough relief oral liquid 15 mg/5ml	COVERED - cDL	QL (1 ML per 1 day)
qc medifin mucus relief child oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
qc mucus relief childrens oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
qc tussin expectorant adult oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
qc tussin mucus/congestion oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
q-tussin dm oral syrup 10-100 mg/5ml	COVERED - cDL	
ra mucus relief d oral tablet extended release 12 hour 60-600 mg, 600-60 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Min 4 Years)
ra tussin chest congestion oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)

Drug Name	Drug Tier	Requirements/Limits
ra tussin cough dm sugar free oral syrup 100-10 mg/5ml	COVERED - cDL	
ra tussin cough/chest dm max oral liquid 10-200 mg/5ml	COVERED - cDL	
ra tussin oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
robafen dm clear oral syrup 100-10 mg/5ml	COVERED - cDL	
ROBAFEN DM COUGH CLEAR ORAL SYRUP 100-10 MG/5ML (*dextromethorphan-guaifenesin*)	COVERED - cDL	
ROBAFEN MUCUS/CHEST CONGESTION ORAL LIQUID 200 MG/10ML (*guaifenesin*)	COVERED - cDL	QL (4 ML per 1 day)
rynex pse oral liquid 1-15 mg/5ml	COVERED - cDL	
sb cough control oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
scot-tussin expectorant oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
siltussin sa oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
sm cold & allergy childrens oral elixir 1-15 mg/5ml	COVERED - cDL	
sm mucus relief childrens oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
sm tussin cough/chest congest oral syrup 100-10 mg/5ml	COVERED - cDL	
sm tussin dm oral syrup 100-10 mg/5ml	COVERED - cDL	
sm tussin mucus+chest congest oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
sodium chloride inhalation nebulization solution 0.9 %, 3 %, 7 %	COVERED - cDL	
TUSNEL-EX ORAL LIQUID 100 MG/5ML (*guaifenesin*)	COVERED - cDL	QL (4 ML per 1 day)
tussin dm oral syrup 10-100 mg/5ml, 100-10 mg/5ml	COVERED - cDL	
tussin mucus & chest congest oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
tussin mucus+chest congestion oral liquid 100 mg/5ml	COVERED - cDL	QL (4 ML per 1 day)
wal-tap cold/allergy oral elixir 1-15 mg/5ml	COVERED - cDL	
WAL-TUSSIN CHEST CONGESTION ORAL LIQUID 100 MG/5ML (*guaifenesin*)	COVERED - cDL	QL (4 ML per 1 day)
WAL-TUSSIN COUGH LONG ACTING ORAL LIQUID 15 MG/5ML (*dextromethorphan hbr*)	COVERED - cDL	QL (1 ML per 1 day)
WAL-TUSSIN COUGH/CHEST DM ORAL SYRUP 100-10 MG/5ML (*dextromethorphan-guaifenesin*)	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGICALS		
ABREVA EXTERNAL CREAM 10 % (*docosanol*)	COVERED - sPDL	
ACANYA EXTERNAL GEL 1.2-2.5 % (*clindamycin phos-benzoyl perox*)	NOT COVERED PA Required	
acne medication 10 external lotion 10 %	COVERED - cDL	
acne medication 2.5 external gel 2.5 %	COVERED - cDL	QL (60 GM per 25 days)
acne medication 5 external lotion 5 %	COVERED - cDL	
acyclovir external cream 5 %	NOT COVERED PA Required	
acyclovir external ointment 5 %	NOT COVERED PA Required	
adapalene external cream 0.1 %	NOT COVERED PA Required	
adapalene external gel 0.1 %	COVERED - cDL	QL (45 GM per 25 days)
adapalene external gel 0.3 %	NOT COVERED PA Required	
adapalene-benzoyl peroxide external gel 0.1-2.5 %, 0.3-2.5 %	NOT COVERED PA Required	
alclometasone dipropionate external cream 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
alclometasone dipropionate external ointment 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
ALOE VESTA ANTIFUNGAL EXTERNAL OINTMENT 2 % (*miconazole nitrate*)	COVERED - cDL	QL (113 GM per 30 days)
ALTRENO EXTERNAL LOTION 0.05 % (*tretinoin*)	NOT COVERED PA Required	
ammonium lactate external cream 12 %	COVERED - cDL	QL (280 GM per 25 days)
anti-dandruff external shampoo 1 %	COVERED - cDL	
antifungal (clotrimazole) external cream 1 %	COVERED - sPDL	QL (60 GM per 25 days)
antifungal (tolnaftate) external cream 1 %	COVERED - cDL	QL (60 GM per 25 days)
antifungal external powder 2 %	COVERED - cDL	QL (90 GM per 30 days)
anti-itch maximum strength external cream 1 %	COVERED - sPDL	QL (60 GM per 25 days)

Drug Name	Drug Tier	Requirements/Limits
APEXICON E EXTERNAL CREAM 0.05 % (*diflorasone diacet emoll base*)	NOT COVERED PA Required	
ARAZLO EXTERNAL LOTION 0.045 % (*tazarotene*)	NOT COVERED PA Required	
arthritis pain reliever external gel 1 %	COVERED - sPDL	
arthritis pain relieving external cream 0.075 %	COVERED - cDL	
athletes foot powder spray external aerosol powder 2 %	COVERED - cDL	QL (133 GM per 30 days)
ATRALIN EXTERNAL GEL 0.05 % (*tretinoin*)	NOT COVERED PA Required	
sulfacetamide sodium-sulfur (Avar Cleanser External Liquid 10-5 %)	NOT COVERED PA Required	
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (*sulfacetamide sodium-sulfur*)	NOT COVERED PA Required	
sulfacetamide sodium-sulfur (Avar-E Emollient External Cream 10-5 %)	NOT COVERED PA Required	
sulfacetamide sodium-sulfur (Avar-E Green External Cream 10-5 %)	NOT COVERED PA Required	
AVAR-E LS EXTERNAL CREAM 10-2 % (*sulfacetamide sodium-sulfur*)	NOT COVERED PA Required	
azelaic acid external gel 15 %	NOT COVERED PA Required	
bacitracin external ointment 500 unit/gm	COVERED - cDL	
bacitracin zinc external ointment 500 unit/gm	COVERED - cDL	
bensal hp external ointment 3 %	NOT COVERED PA Required	
BENZAMYCIN EXTERNAL GEL 5-3 % (*benzoyl peroxide-erythromycin*)	NOT COVERED PA Required	
benzoyl peroxide external gel 10 %, 5 %	COVERED - cDL	
benzoyl peroxide external liquid 10 %	COVERED - sPDL	
benzoyl peroxide wash external liquid 10 %, 5 %	COVERED - sPDL	QL (240 ML per 25 days)

Drug Name	Drug Tier	Requirements/Limits
benzoyl peroxide-erythromycin external gel 5-3 %	NOT COVERED PA Required	
betamethasone dipropionate aug external cream 0.05 %	COVERED - sPDL	QL (50 GM per 25 days)
betamethasone dipropionate aug external gel 0.05 %	COVERED - sPDL	QL (50 GM per 25 days)
betamethasone dipropionate aug external lotion 0.05 %	NOT COVERED PA Required	QL (60 ML per 25 days)
betamethasone dipropionate aug external ointment 0.05 %	NOT COVERED PA Required	QL (50 GM per 25 days)
betamethasone dipropionate external cream 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
betamethasone dipropionate external lotion 0.05 %	COVERED - sPDL	QL (60 ML per 25 days)
betamethasone dipropionate external ointment 0.05 %	NOT COVERED PA Required	QL (45 GM per 25 days)
betamethasone valerate external cream 0.1 %	COVERED - sPDL	QL (45 GM per 25 days)
betamethasone valerate external foam 0.12 %	NOT COVERED PA Required	
betamethasone valerate external lotion 0.1 %	COVERED - sPDL	QL (60 ML per 25 days)
betamethasone valerate external ointment 0.1 %	NOT COVERED PA Required	QL (45 GM per 25 days)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (*bimekizumab-bkzx*)	NOT COVERED PA Required	
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (*bimekizumab-bkzx*)	NOT COVERED PA Required	
BLIS-TO-SOL EXTERNAL LIQUID 1 % (*tolnaftate*)	COVERED - cDL	QL (151 ML per 30 days)
bp 10-1 external emulsion 10-1 %	NOT COVERED PA Required	
brimonidine tartrate external gel 0.33 %	NOT COVERED PA Required	
BRYHALI EXTERNAL LOTION 0.01 % (*halobetasol propionate*)	NOT COVERED PA Required	
CABTREO EXTERNAL GEL 0.15-3.1-1.2 % (*adapalene-benzoyl per-clindamy*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
calcipotriene external cream 0.005 %	COVERED - sPDL	PA
calcipotriene external foam 0.005 %	NOT COVERED PA Required	
calcipotriene external ointment 0.005 %	COVERED - sPDL	PA
calcipotriene external solution 0.005 %	COVERED - sPDL	PA
calcipotriene-betameth diprop external ointment 0.005-0.064 %	NOT COVERED PA Required	
calcipotriene-betameth diprop external suspension 0.005-0.064 %	NOT COVERED PA Required	
calcitriol external ointment 3 mcg/gm	NOT COVERED PA Required	
capsaicin external cream 0.025 %, 0.1 %	COVERED - cDL	
CAPZASIN-P EXTERNAL CREAM 0.035 % (*capsaicin*)	COVERED - cDL	
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*)	NOT COVERED PA Required	
ciclopirox (Ciclodan External Solution 8 %)	NOT COVERED PA Required	
ciclopirox external gel 0.77 %	NOT COVERED PA Required	
ciclopirox external shampoo 1 %	NOT COVERED PA Required	
ciclopirox external solution 8 %	NOT COVERED PA Required	
ciclopirox olamine external cream 0.77 %	COVERED - sPDL	QL (20 GM per 1 day)
ciclopirox olamine external suspension 0.77 %	COVERED - sPDL	QL (60 ML per 25 days)
ciclopirox treatment external kit 8 %	NOT COVERED PA Required	
CIRCATA EXTERNAL CREAM 0.05 % (*capsaicin*)	COVERED - cDL	
CLEOCIN-T EXTERNAL LOTION 1 % (*clindamycin phosphate*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
clindamycin phosphate (Clindacin Etz External Swab 1 %)	NOT COVERED PA Required	
clindamycin phosphate (Clindacin External Foam 1 %)	NOT COVERED PA Required	
clindamycin phosphate (Clindacin-P External Swab 1 %)	NOT COVERED PA Required	
CLINDAGEL EXTERNAL GEL 1 % (*clindamycin phosphate*)	NOT COVERED PA Required	
clindamycin phos-benzoyl perox external gel 1.2-5 %	COVERED - sPDL	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	NOT COVERED PA Required	
clindamycin phosphate external foam 1 %	NOT COVERED PA Required	
clindamycin phosphate external gel 1 %	NOT COVERED PA Required	ST; QL (60 GM per 25 days); PRIOR USE DIFFERIN OTC AND CLINDA SOLN
clindamycin phosphate external lotion 1 %	NOT COVERED PA Required	ST; QL (10 ML per 1 day); PRIOR USE DIFFERIN OTC AND CLINDA SOLN
clindamycin phosphate external solution 1 %	COVERED - sPDL	QL (60 ML per 25 days)
clindamycin phosphate external swab 1 %	NOT COVERED PA Required	
clindamycin-tretinoin external gel 1.2-0.025 %	NOT COVERED PA Required	
clobetasol propionate e external cream 0.05 %	COVERED - sPDL	
clobetasol propionate emulsion external foam 0.05 %	NOT COVERED PA Required	
clobetasol propionate external cream 0.05 %	COVERED - sPDL	
clobetasol propionate external foam 0.05 %	NOT COVERED PA Required	
clobetasol propionate external gel 0.05 %	COVERED - sPDL	
clobetasol propionate external liquid 0.05 %	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
clobetasol propionate external lotion 0.05 %	NOT COVERED PA Required	
clobetasol propionate external ointment 0.05 %	COVERED - sPDL	
clobetasol propionate external shampoo 0.05 %	NOT COVERED PA Required	
clobetasol propionate external solution 0.05 %	COVERED - sPDL	QL (50 ML per 25 days)
clocortolone pivalate external cream 0.1 %	NOT COVERED PA Required	
clobetasol propionate (Clodan External Shampoo 0.05 %)	NOT COVERED PA Required	
CLODERM EXTERNAL CREAM 0.1 % (*clocortolone pivalate*)	NOT COVERED PA Required	
clotrimazole external cream 1 %	COVERED - sPDL	
clotrimazole external solution 1 %	COVERED - sPDL	QL (60 ML per 25 days)
clotrimazole-betamethasone external cream 1-0.05 %	COVERED - sPDL	
clotrimazole-betamethasone external lotion 1-0.05 %	COVERED - sPDL	
CONDYLOX EXTERNAL GEL 0.5 % (*podofilox*)	NOT COVERED PA Required	
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*)	NOT COVERED PA Required	QL (2 ML per 24 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	NOT COVERED PA Required	QL (2 ML per 24 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	NOT COVERED PA Required	QL (1 ML per 24 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*)	NOT COVERED PA Required	QL (1 ML per 24 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*secukinumab*)	NOT COVERED PA Required	QL (0.5 ML per 24 days)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*secukinumab*)	NOT COVERED PA Required	
CROTAN EXTERNAL LOTION 10 % (*crotamiton*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
cvs athletes foot (tolnaftate) external aerosol powder 1 %	COVERED - cDL	QL (133 GM per 30 days)
cvs cortisone maximum strength external gel 1 %	COVERED - cDL	
dapsone external gel 5 %, 7.5 %	NOT COVERED PA Required	
DENAVIR EXTERNAL CREAM 1 % (*penciclovir*)	NOT COVERED PA Required	
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	NOT COVERED PA Required	
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	NOT COVERED PA Required	
desonide external cream 0.05 %	COVERED - sPDL	ST; QL (60 GM per 25 days); REQ TRY ANY 3 PREFERRED LOW POTENCY
desonide external lotion 0.05 %	COVERED - sPDL	
desonide external ointment 0.05 %	COVERED - sPDL	ST; QL (60 GM per 25 days); REQ TRY ANY 3 PREFERRED LOW POTENCY
desoximetasone external cream 0.05 %, 0.25 %	NOT COVERED PA Required	
desoximetasone external gel 0.05 %	NOT COVERED PA Required	
desoximetasone external liquid 0.25 %	NOT COVERED PA Required	
desoximetasone external ointment 0.05 %, 0.25 %	NOT COVERED PA Required	
dibucaine external ointment 1 %	COVERED - cDL	
diclofenac epolamine external patch 1.3 %	NOT COVERED PA Required	
diclofenac sodium external gel 1 %	COVERED - sPDL	QL (200 GM per 25 days)
diclofenac sodium external solution 1.5 %, 2 %	NOT COVERED PA Required	
diflorasone diacetate external cream 0.05 %	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
diflorasone diacetate external ointment 0.05 %	NOT COVERED PA Required	
DIPROLENE EXTERNAL OINTMENT 0.05 % (*betamethasone dipropionate aug*)	NOT COVERED PA Required	
doxycycline oral capsule delayed release 40 mg	NOT COVERED PA Required	
DRYSOL EXTERNAL SOLUTION 20 % (*aluminum chloride*)	COVERED - cDL	
DUOBRII EXTERNAL LOTION 0.01-0.045 % (*halobetasol prop-tazarotene*)	NOT COVERED PA Required	
econazole nitrate external cream 1 %	COVERED - sPDL	
EFUDEX EXTERNAL CREAM 5 % (*fluorouracil*)	COVERED - cDL	
ELIDEL EXTERNAL CREAM 1 % (*pimecrolimus*)	COVERED - sPDL	
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (*calcipotriene-betameth diprop*)	NOT COVERED PA Required	
ERTACZO EXTERNAL CREAM 2 % (*sertaconazole nitrate*)	NOT COVERED PA Required	
ery external pad 2 %	COVERED - sPDL	
ERYGEL EXTERNAL GEL 2 % (*erythromycin*)	NOT COVERED PA Required	
erythromycin external gel 2 %	NOT COVERED PA Required	
erythromycin external solution 2 %	COVERED - sPDL	QL (15 ML per 1 day)
EUCRISA EXTERNAL OINTMENT 2 % (*crisaborole*)	NOT COVERED PA Required	
FABIOR EXTERNAL FOAM 0.1 % (*tazarotene*)	NOT COVERED PA Required	
FINACEA EXTERNAL FOAM 15 % (*azelaic acid*)	NOT COVERED PA Required	
FINACEA EXTERNAL GEL 15 % (*azelaic acid*)	COVERED - sPDL	
FLECTOR EXTERNAL PATCH 1.3 % (*diclofenac epolamine*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
fluocinolone acetonide body external oil 0.01 %	COVERED - sPDL	QL (120 ML per 25 days)
fluocinolone acetonide external cream 0.01 %	NOT COVERED PA Required	
fluocinolone acetonide external cream 0.025 %	NOT COVERED PA Required	QL (60 GM per 25 days)
fluocinolone acetonide external ointment 0.025 %	NOT COVERED PA Required	ST; QL (60 GM per 25 days); PRIOR USE MOMETASONE AND FLUOCINOLONE CREAM
fluocinolone acetonide external solution 0.01 %	NOT COVERED PA Required	
fluocinolone acetonide scalp external oil 0.01 %	COVERED - sPDL	QL (120 ML per 25 days)
fluocinonide emulsified base external cream 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
fluocinonide external cream 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
fluocinonide external cream 0.1 %	COVERED - sPDL	
fluocinonide external gel 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
fluocinonide external ointment 0.05 %	NOT COVERED PA Required	ST; QL (60 GM per 25 days); PRIOR USE MOMETASONE AND FLUOCINOLONE CRE
fluocinonide external solution 0.05 %	COVERED - sPDL	QL (60 ML per 25 days)
flurandrenolide external cream 0.05 %	NOT COVERED PA Required	
flurandrenolide external lotion 0.05 %	NOT COVERED PA Required	
fluticasone propionate external cream 0.05 %	NOT COVERED PA Required	QL (60 GM per 25 days)
fluticasone propionate external lotion 0.05 %	NOT COVERED PA Required	
fluticasone propionate external ointment 0.005 %	NOT COVERED PA Required	QL (60 GM per 25 days)
ft arthritis pain external gel 1 %	COVERED - sPDL	
gentamicin sulfate external cream 0.1 %	COVERED - cDL	QL (30 GM per 25 days)

Drug Name	Drug Tier	Requirements/Limits
gentamicin sulfate external ointment 0.1 %	COVERED - cDL	QL (30 GM per 25 days)
lidocaine hcl (Glydo External Prefilled Syringe 2 %)	COVERED - cDL	
gnp arthritis pain external gel 1 %	COVERED - sPDL	
gnp diclofenac sodium external gel 1 %	COVERED - sPDL	
gnp lice treatment external liquid 1 %	COVERED - sPDL	
goodsense arthritis pain external gel 1 %	COVERED - sPDL	
goodsense lice killing external liquid 1 %	COVERED - sPDL	
halcinonide external cream 0.1 %	NOT COVERED PA Required	
halobetasol propionate external cream 0.05 %	COVERED - sPDL	QL (50 GM per 25 days)
halobetasol propionate external foam 0.05 %	NOT COVERED PA Required	
halobetasol propionate external ointment 0.05 %	COVERED - sPDL	QL (50 GM per 25 days)
HALOG EXTERNAL CREAM 0.1 % (*halcinonide*)	NOT COVERED PA Required	
HALOG EXTERNAL OINTMENT 0.1 % (*halcinonide*)	NOT COVERED PA Required	
HALOG EXTERNAL SOLUTION 0.1 % (*halcinonide*)	NOT COVERED PA Required	
hydrocortisone acetate external cream 1 %	COVERED - cDL	
hydrocortisone butyrate external cream 0.1 %	NOT COVERED PA Required	
hydrocortisone butyrate external lotion 0.1 %	NOT COVERED PA Required	
hydrocortisone butyrate external ointment 0.1 %	COVERED - sPDL	
hydrocortisone butyrate external solution 0.1 %	COVERED - sPDL	
hydrocortisone external cream 0.5 %	COVERED - cDL	QL (60 GM per 25 days)
hydrocortisone external cream 1 %	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
hydrocortisone external cream 2.5 %	COVERED - sPDL	QL (60 GM per 25 days)
hydrocortisone external lotion 1 %	COVERED - cDL	
hydrocortisone external lotion 2.5 %	COVERED - sPDL	QL (60 ML per 25 days)
hydrocortisone external ointment 0.5 %	COVERED - cDL	QL (60 GM per 25 days)
hydrocortisone external ointment 1 %, 2.5 %	COVERED - sPDL	QL (60 GM per 25 days)
hydrocortisone valerate external cream 0.2 %	COVERED - sPDL	
hydrocortisone valerate external ointment 0.2 %	NOT COVERED PA Required	
HYDROLATUM EXTERNAL OINTMENT (*emollient*)	COVERED - cDL	
HYDROXYM EXTERNAL GEL 2 % (*hydrocortisone*)	NOT COVERED PA Required	
HYFTOR EXTERNAL GEL 0.2 % (*sirolimus*)	NOT COVERED PA Required	
imiquimod external cream 3.75 %	NOT COVERED PA Required	
imiquimod external cream 5 %	COVERED - sPDL	PA; QL (24 EA per 25 days)
imiquimod pump external cream 3.75 %	NOT COVERED PA Required	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	COVERED - cDL	PA
ivermectin external cream 1 %	NOT COVERED PA Required	
JUBLIA EXTERNAL SOLUTION 10 % (*efinaconazole*)	NOT COVERED PA Required	
ketoconazole external cream 2 %	COVERED - sPDL	QL (60 GM per 25 days)
ketoconazole external foam 2 %	NOT COVERED PA Required	
ketoconazole external shampoo 2 %	COVERED - sPDL	QL (120 ML per 25 days)
ketoconazole (Ketodan External Foam 2 %)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
KLARON EXTERNAL LOTION 10 % (*sulfacetamide sodium (acne)*)	NOT COVERED PA Required	
nystatin (Klayesta External Powder 100000 Unit/Gm)	COVERED - sPDL	
LEXETTE EXTERNAL FOAM 0.05 % (*halobetasol propionate*)	NOT COVERED PA Required	
LICART EXTERNAL PATCH 24 HOUR 1.3 % (*diclofenac epolamine*)	NOT COVERED PA Required	
lice killing maximum strength external shampoo 0.33-4 %	COVERED - cDL	
lidocaine external cream 4 %	COVERED - cDL	
lidocaine external patch 5 %	COVERED - cDL	PA; QL (3 EA per 1 day)
lidocaine hcl external solution 4 %	COVERED - cDL	
lidocaine pain relief max st external patch 4 %	COVERED - cDL	QL (1 EA per 1 day)
lidocaine-prilocaine external cream 2.5-2.5 %	COVERED - cDL	QL (60 GM per 25 days)
lintera wash external foam 10 %	COVERED - sPDL	
LITFULO ORAL CAPSULE 50 MG (*ritlecitinib tosylate*)	NOT COVERED PA Required	
LOCOID EXTERNAL LOTION 0.1 % (*hydrocortisone butyrate*)	NOT COVERED PA Required	
LOCOID LIPOCREAM EXTERNAL CREAM 0.1 % (*hydrocortisone butyr lipo base*)	NOT COVERED PA Required	
luliconazole external cream 1 %	NOT COVERED PA Required	
malathion external lotion 0.5 %	NOT COVERED PA Required	
metronidazole external cream 0.75 %	COVERED - sPDL	
metronidazole external gel 0.75 %, 1 %	COVERED - sPDL	
metronidazole external lotion 0.75 %	COVERED - sPDL	
miconazole antifungal external cream 2 %	COVERED - cDL	QL (150 GM per 25 days)

Drug Name	Drug Tier	Requirements/Limits
miconazole-zinc oxide-petrolat external ointment 0.25-15-81.35 %	NOT COVERED PA Required	
MINERIN CREME EXTERNAL CREAM (*skin protectants, misc.*)	COVERED - cDL	
mometasone furoate external cream 0.1 %	COVERED - sPDL	QL (45 GM per 25 days)
mometasone furoate external ointment 0.1 %	COVERED - sPDL	QL (45 GM per 25 days)
mometasone furoate external solution 0.1 %	COVERED - sPDL	QL (60 ML per 25 days)
mupirocin calcium external cream 2 %	NOT COVERED PA Required	
mupirocin external ointment 2 %	COVERED - sPDL	QL (44 GM per 25 days)
naftifine hcl external cream 1 %, 2 %	NOT COVERED PA Required	
naftifine hcl external gel 2 %	NOT COVERED PA Required	
NAFTIN EXTERNAL GEL 2 % (*naftifine hcl*)	NOT COVERED PA Required	
NATROBA EXTERNAL SUSPENSION 0.9 % (*spinosad*)	COVERED - sPDL	
clindamycin-benzoyl per (refr) (Neuac External Gel 1.2-5 %)	NOT COVERED PA Required	
NORITATE EXTERNAL CREAM 1 % (*metronidazole*)	NOT COVERED PA Required	
nystatin (Nyamyc External Powder 100000 Unit/Gm)	COVERED - sPDL	
nystatin external cream 100000 unit/gm	COVERED - sPDL	QL (90 GM per 25 days)
nystatin external ointment 100000 unit/gm	COVERED - sPDL	QL (90 GM per 25 days)
nystatin external powder 100000 unit/gm	COVERED - sPDL	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	COVERED - sPDL	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	COVERED - sPDL	
nystatin (Nystop External Powder 100000 Unit/Gm)	COVERED - sPDL	QL (30 GM per 25 days)
ONEXTON EXTERNAL GEL 1.2-3.75 % (*clindamycin phos-benzoyl perox*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
OPZELURA EXTERNAL CREAM 1.5 % (*ruxolitinib phosphate*)	NOT COVERED PA Required	
OVACE PLUS EXTERNAL CREAM 10 % (*sulfacetamide sodium*)	NOT COVERED PA Required	
OVACE PLUS EXTERNAL LOTION 9.8 % (*sulfacetamide sodium*)	NOT COVERED PA Required	
OVACE PLUS EXTERNAL SHAMPOO 10 % (*sulfacetamide sodium*)	NOT COVERED PA Required	
OVACE PLUS WASH EXTERNAL GEL 10 % (*sulfacetamide sodium*)	NOT COVERED PA Required	
OVACE PLUS WASH EXTERNAL LIQUID 10 % (*sulfacetamide sodium*)	NOT COVERED PA Required	
OVACE WASH EXTERNAL LIQUID 10 % (*sulfacetamide sodium*)	NOT COVERED PA Required	
OVIDE EXTERNAL LOTION 0.5 % (*malathion*)	NOT COVERED PA Required	QL (59 ML per 25 days)
oxiconazole nitrate external cream 1 %	NOT COVERED PA Required	
OXISTAT EXTERNAL LOTION 1 % (*oxiconazole nitrate*)	NOT COVERED PA Required	
PANDEL EXTERNAL CREAM 0.1 % (*hydrocortisone probutate*)	NOT COVERED PA Required	
penciclovir external cream 1 %	NOT COVERED PA Required	
PENNSAID EXTERNAL SOLUTION 2 % (*diclofenac sodium*)	NOT COVERED PA Required	
permethrin external cream 5 %	COVERED - sPDL	
pimecrolimus external cream 1 %	NOT COVERED PA Required	QL (2 GM per 1 day)
podofilox external gel 0.5 %	NOT COVERED PA Required	
podofilox external solution 0.5 %	NOT COVERED PA Required	QL (7 ML per 180 days)

Drug Name	Drug Tier	Requirements/Limits
POLYSPORIN EXTERNAL OINTMENT 500-10000 UNIT/GM (*bacitracin-polymyxin b*)	COVERED - cDL	
lidocaine hcl (Proxivol External Gel 2 %)	COVERED - cDL	
RETIN-A EXTERNAL CREAM 0.025 %, 0.05 %, 0.1 % (*tretinoin*)	COVERED - sPDL	
RETIN-A EXTERNAL GEL 0.01 %, 0.025 % (*tretinoin*)	COVERED - sPDL	
RETIN-A MICRO EXTERNAL GEL 0.04 %, 0.1 % (*tretinoin microsphere*)	NOT COVERED PA Required	
RETIN-A MICRO PUMP EXTERNAL GEL 0.04 %, 0.06 %, 0.08 %, 0.1 % (*tretinoin microsphere*)	NOT COVERED PA Required	
RHOFADE EXTERNAL CREAM 1 % (*oxymetazoline hcl*)	NOT COVERED PA Required	
salicylic acid external ointment 3 %	NOT COVERED PA Required	
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (*collagenase*)	COVERED - cDL	PA; QL (2 GM per 1 day)
selenium sulfide external lotion 2.5 %	COVERED - cDL	
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML (*brodalumab*)	NOT COVERED PA Required	
silver sulfadiazine external cream 1 %	COVERED - cDL	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*risankizumab-rzaa*)	NOT COVERED PA Required	
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*risankizumab-rzaa*)	NOT COVERED PA Required	
sm arthritis pain external gel 1 %	COVERED - sPDL	
sm lice treatment external liquid 1 %	COVERED - sPDL	
sodium sulfacetamide external shampoo 10 %	NOT COVERED PA Required	
sodium sulfacetamide wash external liquid 10 %	NOT COVERED PA Required	
SORILUX EXTERNAL FOAM 0.005 % (*calcipotriene*)	NOT COVERED PA Required	
SOTYKTU ORAL TABLET 6 MG (*deucravacitinib*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*spesolimab-sbzo*)	NOT COVERED PA Required	
spinosad external suspension 0.9 %	NOT COVERED PA Required	QL (120 ML per 25 days)
sss 10-5 external cream 10-5 %	NOT COVERED PA Required	
sss 10-5 external foam 10-5 %	NOT COVERED PA Required	
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab*)	NOT COVERED PA Required	
stop lice aerosol 0.5 %	COVERED - cDL	
stop lice complete treatment combination kit 0.33-4-0.5 %	COVERED - cDL	
stop lice maximum strength external liquid 0.33-4 %	COVERED - cDL	
sulfacetamide sodium (acne) external lotion 10 %	NOT COVERED PA Required	QL (118 ML per 25 days)
sulfacetamide sodium (cleans) external gel 10 %	NOT COVERED PA Required	
sulfacetamide sodium external liquid 10 %	NOT COVERED PA Required	
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	NOT COVERED PA Required	
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9-4.5 %, 9.8-4.8 %	NOT COVERED PA Required	
sulfacetamide sodium-sulfur external lotion 10-5 %	NOT COVERED PA Required	
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	NOT COVERED PA Required	
sulfacetamide sod-sulfur wash external liquid 9-4.5 %	NOT COVERED PA Required	
sulfacetamide-sulfur in urea external emulsion 10-5 %	NOT COVERED PA Required	
SUMADAN EXTERNAL KIT 9-4.5 % (*sulfacetamide-sulfur-cleanser*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
SUMADAN WASH EXTERNAL LIQUID 9-4.5 % (*sulfacetamide sodium-sulfur*)	NOT COVERED PA Required	
SUMAXIN CP EXTERNAL KIT 10-4 % (*sulfacetamide-sulfur-cleanser*)	NOT COVERED PA Required	
SUMAXIN EXTERNAL PAD 10-4 % (*sulfacetamide sodium-sulfur*)	NOT COVERED PA Required	
SYNALAR EXTERNAL CREAM 0.025 % (*fluocinolone acetonide*)	NOT COVERED PA Required	
SYNALAR EXTERNAL OINTMENT 0.025 % (*fluocinolone acetonide*)	NOT COVERED PA Required	
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (*calcipotriene-betameth diprop*)	NOT COVERED PA Required	
tacrolimus external ointment 0.03 %, 0.1 %	NOT COVERED PA Required	QL (30 GM per 25 days)
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML (*ixekizumab*)	NOT COVERED PA Required	
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML (*ixekizumab*)	NOT COVERED PA Required	
tavaborole external solution 5 %	NOT COVERED PA Required	
tazarotene external cream 0.1 %	NOT COVERED PA Required	
tazarotene external foam 0.1 %	NOT COVERED PA Required	
tazarotene external gel 0.05 %, 0.1 %	NOT COVERED PA Required	
terbinafine hcl external cream 1 %	COVERED - cDL	QL (30 GM per 25 days)
TEXACORT EXTERNAL SOLUTION 2.5 % (*hydrocortisone*)	NOT COVERED PA Required	
tolnaftate external powder 1 %	COVERED - cDL	QL (67.5 GM per 30 days)
TOPICORT EXTERNAL CREAM 0.05 %, 0.25 % (*desoximetasone*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
TOPICORT EXTERNAL GEL 0.05 % (*desoximetasone*)	NOT COVERED PA Required	
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (*desoximetasone*)	NOT COVERED PA Required	
TOPICORT SPRAY EXTERNAL LIQUID 0.25 % (*desoximetasone*)	NOT COVERED PA Required	
clobetasol propionate emulsion (Tovet External Foam 0.05 %)	NOT COVERED PA Required	
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (*guselkumab*)	NOT COVERED PA Required	
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*guselkumab*)	NOT COVERED PA Required	
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	NOT COVERED PA Required	ST; QL (45 GM per 25 days); AGE (Max 35 Years); Requires trial of clindamycin soln AND DIFFERIN OTC or erythromycin topical AND DIFFERIN OTC
tretinoin external gel 0.01 %	NOT COVERED PA Required	ST; QL (45 GM per 25 days); AGE (Max 35 Years); Requires trial of clindamycin soln AND DIFFERIN OTC or erythromycin topical AND DIFFERIN OTC
tretinoin external gel 0.025 %, 0.05 %	NOT COVERED PA Required	
tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %	NOT COVERED PA Required	
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	NOT COVERED PA Required	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	COVERED - sPDL	
triamcinolone acetonide external lotion 0.025 %, 0.1 %	COVERED - sPDL	
triamcinolone acetonide external ointment 0.025 %, 0.05 %, 0.1 %, 0.5 %	COVERED - sPDL	
triamcinolone acetonide powder	COVERED - cDL	
triamcinolone in absorbase external ointment 0.05 %	COVERED - sPDL	
triple antibiotic external ointment	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
triple antibiotic pain relief external ointment 1 %	COVERED - cDL	
ULTRAVATE EXTERNAL LOTION 0.05 % (*halobetasol propionate*)	NOT COVERED PA Required	
VANOS EXTERNAL CREAM 0.1 % (*fluocinonide*)	NOT COVERED PA Required	
VEREGEN EXTERNAL OINTMENT 15 % (*sinecatechins*)	NOT COVERED PA Required	
VTAMA EXTERNAL CREAM 1 % (*tapinarof*)	NOT COVERED PA Required	
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (*miconazole-zinc oxide-petrolat*)	NOT COVERED PA Required	
WINLEVI EXTERNAL CREAM 1 % (*clascoterone*)	NOT COVERED PA Required	
XEPI EXTERNAL CREAM 1 % (*ozenoxacin*)	NOT COVERED PA Required	
XERESE EXTERNAL CREAM 5-1 % (*acyclovir-hydrocortisone*)	NOT COVERED PA Required	
ZIANA EXTERNAL GEL 1.2-0.025 % (*clindamycin-tretinoin*)	NOT COVERED PA Required	
ZINC-OXYDE PLUS EXTERNAL OINTMENT 0.44-20 % (*menthol-zinc oxide*)	COVERED - cDL	
ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*)	NOT COVERED PA Required	
ZORYVE EXTERNAL FOAM 0.3 % (*roflumilast (antiseborrheic)*)	NOT COVERED PA Required	
ZOSTRIX NATURAL PAIN RELIEF EXTERNAL CREAM 0.033 % (*capsaicin*)	COVERED - cDL	
ZOVIRAX EXTERNAL CREAM 5 % (*acyclovir*)	NOT COVERED PA Required	
ZOVIRAX EXTERNAL OINTMENT 5 % (*acyclovir*)	NOT COVERED PA Required	
ZYCLARA EXTERNAL CREAM 3.75 % (*imiquimod*)	NOT COVERED PA Required	
ZYCLARA PUMP EXTERNAL CREAM 2.5 %, 3.75 % (*imiquimod*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
DIAGNOSTIC PRODUCTS		
BD VERITOR SYSTEM SARS-COV-2 IN VITRO KIT (*covid-19 antigen test*)	COVERED - cDL	QL (2 EA per 28 days)
COBAS LIAT SARS-COV-2 CONTROL IN VITRO KIT (*covid-19 control test*)	COVERED - cDL	
covid-19 at-home test in vitro kit	COVERED - cDL	QL (2 EA per 28 days)
covid-19 testing by pharmacist kit	COVERED - cDL	QL (2 EA per 28 days)
CUE COVID-19 TEST IN VITRO CARTRIDGE (*covid-19 at home test*)	COVERED - cDL	QL (2 EA per 28 days)
CUE HEALTH MONITORING SYSTEM IN VITRO (*covid-19 at home test*)	COVERED - cDL	QL (2 EA per 28 days)
ID NOW COVID-19 2.0 CONTROL IN VITRO KIT (*covid-19 control test*)	COVERED - cDL	
ID NOW COVID-19 2.0 TEST IN VITRO KIT (*covid-19 test*)	COVERED - cDL	QL (2 EA per 28 days)
ID NOW COVID-19 CONTROL IN VITRO KIT (*covid-19 control test*)	COVERED - cDL	
ID NOW COVID-19 IN VITRO KIT (*covid-19 test*)	COVERED - cDL	QL (2 EA per 28 days)
KETOSTIX IN VITRO STRIP (*acetone (urine) test*)	COVERED - cDL	
LUCIRA COVID-19 ALL-IN-ONE IN VITRO KIT (*covid-19 at home test*)	COVERED - cDL	QL (2 EA per 28 days)
PIXEL COVID-19 PCR HOME TEST IN VITRO KIT (*covid-19 home test*)	COVERED - cDL	QL (2 EA per 28 days)
RAPID RESPONSE COVID-19 IN VITRO KIT (*covid-19 antibody test*)	COVERED - cDL	QL (2 EA per 28 days)
RELION TRUE METRIX TEST STRIPS IN VITRO STRIP (*glucose blood*)	COVERED - sPDL	PA; Max of #100/month for non-insulin users. Max of #200/month for insulin users and pregnant members filling prenatal vitamins
THYROGEN INTRAMUSCULAR SOLUTION RECONSTITUTED 0.9 MG (*thyrotropin alfa*)	COVERED - cDL	PA
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	COVERED - sPDL	PA; Max of #100/month for non-insulin users. Max of #200/month for insulin users and pregnant members filling prenatal vitamins
DIGESTIVE AIDS		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (*pancrelipase (lip-prot-amyl)*)	COVERED - sPDL	QL (6 EA per 1 day)
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (*pancrelipase (lip-prot-amyl)*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (*pancrelipase (lip-prot-amyl)*)	NOT COVERED PA Required	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 60000-189600 UNIT (*pancrelipase (lip-prot-amyl)*)	COVERED - sPDL	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT (*pancrelipase (lip-prot-amyl)*)	COVERED - sPDL	QL (6 EA per 1 day)
DIURETICS		
acetazolamide er oral capsule extended release 12 hour 500 mg	COVERED - cDL	QL (4 EA per 1 day)
acetazolamide oral tablet 125 mg, 250 mg	COVERED - cDL	QL (4 EA per 1 day)
ALDACTONE ORAL TABLET 100 MG (*spironolactone*)	COVERED - cDL	QL (2 EA per 1 day)
ALDACTONE ORAL TABLET 25 MG (*spironolactone*)	COVERED - cDL	QL (8 EA per 1 day)
ALDACTONE ORAL TABLET 50 MG (*spironolactone*)	COVERED - cDL	QL (4 EA per 1 day)
amiloride hcl oral tablet 5 mg	COVERED - cDL	QL (4 EA per 1 day)
amiloride-hydrochlorothiazide oral tablet 5-50 mg	COVERED - cDL	QL (2 EA per 1 day)
bumetanide oral tablet 0.5 mg, 1 mg	COVERED - cDL	QL (2 EA per 1 day)
bumetanide oral tablet 2 mg	COVERED - cDL	QL (5 EA per 1 day)
chlorthalidone oral tablet 25 mg, 50 mg	COVERED - cDL	QL (4 EA per 1 day)
furosemide oral solution 10 mg/ml, 8 mg/ml	COVERED - cDL	AGE (Max 12 Years)
furosemide oral tablet 20 mg, 40 mg, 80 mg	COVERED - cDL	QL (6 EA per 1 day)
hydrochlorothiazide oral capsule 12.5 mg	COVERED - cDL	QL (2 EA per 1 day)
hydrochlorothiazide oral tablet 25 mg	COVERED - cDL	QL (8 EA per 1 day)
hydrochlorothiazide oral tablet 50 mg	COVERED - cDL	QL (4 EA per 1 day)
indapamide oral tablet 1.25 mg, 2.5 mg	COVERED - cDL	QL (2 EA per 1 day)
metolazone oral tablet 10 mg	COVERED - cDL	QL (2 EA per 1 day)
metolazone oral tablet 2.5 mg, 5 mg	COVERED - cDL	QL (4 EA per 1 day)
spironolactone-hctz oral tablet 25-25 mg	COVERED - cDL	QL (4 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
torsemide oral tablet 10 mg, 20 mg	COVERED - cDL	QL (4 EA per 1 day)
torsemide oral tablet 100 mg, 5 mg	COVERED - cDL	QL (2 EA per 1 day)
triamterene-hctz oral capsule 37.5-25 mg	COVERED - cDL	QL (2 EA per 1 day)
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ACTONEL ORAL TABLET 150 MG, 35 MG (*risedronate sodium*)	NOT COVERED PA Required	
alendronate sodium oral solution 70 mg/75ml	NOT COVERED PA Required	
alendronate sodium oral tablet 10 mg	COVERED - sPDL	QL (1 EA per 1 day)
alendronate sodium oral tablet 35 mg	COVERED - sPDL	QL (0.1429 EA per 1 day)
alendronate sodium oral tablet 5 mg	COVERED - cDL	QL (1 EA per 1 day)
alendronate sodium oral tablet 70 mg	COVERED - sPDL	
ATELVIA ORAL TABLET DELAYED RELEASE 35 MG (*risedronate sodium*)	NOT COVERED PA Required	
BINOSTO ORAL TABLET EFFERVESCENT 70 MG (*alendronate sodium*)	NOT COVERED PA Required	
cabergoline oral tablet 0.5 mg	COVERED - cDL	
calcitonin (salmon) nasal solution 200 unit/act	COVERED - sPDL	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	COVERED - cDL	QL (4 EA per 1 day)
desmopressin ace spray refrig nasal solution 0.01 %	COVERED - cDL	PA
desmopressin acetate nasal solution 1.5 mg/ml	COVERED - cDL	QL (34 EA per 1 day)
desmopressin acetate oral tablet 0.1 mg	COVERED - cDL	QL (4 EA per 1 day)
desmopressin acetate oral tablet 0.2 mg	COVERED - cDL	QL (5 EA per 1 day)
desmopressin acetate spray nasal solution 0.01 %	COVERED - cDL	PA
ELAPRASE INTRAVENOUS SOLUTION 6 MG/3ML (*idursulfase*)	COVERED - cDL	PA
EVISTA ORAL TABLET 60 MG (*raloxifene hcl*)	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 50 Years)

Drug Name	Drug Tier	Requirements/Limits
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 600 MCG/2.4ML (*teriparatide (recombinant)*)	NOT COVERED PA Required	
FOSAMAX ORAL TABLET 70 MG (*alendronate sodium*)	COVERED - sPDL	QL (0.1429 EA per 1 day)
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (*alendronate-cholecalciferol*)	NOT COVERED PA Required	
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG (*somatropin*)	COVERED with Clinical Criteria	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG (*somatropin*)	COVERED with Clinical Criteria	PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG (*somatropin*)	NOT COVERED PA Required	
ibandronate sodium oral tablet 150 mg	COVERED - sPDL	
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (*mecasermin*)	COVERED - cDL	PA
levocarnitine oral solution 1 gm/10ml	COVERED - cDL	QL (60 ML per 1 day)
levocarnitine oral tablet 330 mg	COVERED - cDL	QL (18 EA per 1 day)
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (*leuprolide acetate*)	COVERED - cDL	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG (*leuprolide acetate (3 month)*)	COVERED - cDL	PA
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML (*somatrogon-ghla*)	NOT COVERED PA Required	
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML (*somatropin*)	COVERED with Clinical Criteria	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (*somatropin*)	NOT COVERED PA Required	
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML (*somatropin*)	NOT COVERED PA Required	
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML (*somatropin*)	NOT COVERED PA Required	
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml	COVERED - cDL	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML (*somatropin*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab*)	NOT COVERED PA Required	
raloxifene hcl oral tablet 60 mg	NOT COVERED PA Required	
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	NOT COVERED PA Required	
risedronate sodium oral tablet delayed release 35 mg	NOT COVERED PA Required	
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML (*octreotide acetate*)	COVERED - cDL	PA
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 20 MG, 30 MG (*octreotide acetate*)	COVERED - cDL	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (*somatropin (non-refrigerated)*)	NOT COVERED PA Required	
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (*lonapegsomatropin-tcgd*)	NOT COVERED PA Required	
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (*somapacitan-beco*)	NOT COVERED PA Required	
SYNAREL NASAL SOLUTION 2 MG/ML (*nafarelin acetate*)	COVERED - cDL	PA
teriparatide (recombinant) subcutaneous solution pen-injector 600 mcg/2.4ml, 620 mcg/2.48ml	COVERED - sPDL	
teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml	COVERED - sPDL	
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (*abaloparatide*)	NOT COVERED PA Required	
XPHOZAH ORAL TABLET 20 MG, 30 MG (*tenapanor hcl (ckd)*)	NOT COVERED PA Required	
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG (*somatropin*)	NOT COVERED PA Required	
ESTROGENS		
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	COVERED - cDL	AGE (Max 64 Years)
norethindrone-eth estradiol (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg)	COVERED - cDL	QL (1 EA per 1 day)
norethindrone-eth estradiol (Jinteli Oral Tablet 1-5 Mg-Mcg)	COVERED - cDL	QL (1 EA per 1 day)
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
FLUOROQUINOLONES		
BAXDELA ORAL TABLET 450 MG (*delafloxacin meglumine*)	NOT COVERED PA Required	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (*ciprofloxacin*)	NOT COVERED PA Required	
CIPRO ORAL TABLET 250 MG, 500 MG (*ciprofloxacin hcl*)	NOT COVERED PA Required	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	COVERED - sPDL	QL (2 EA per 1 day)
levofloxacin oral solution 25 mg/ml	NOT COVERED PA Required	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	COVERED - sPDL	QL (1 EA per 1 day); 10
moxifloxacin hcl oral tablet 400 mg	NOT COVERED PA Required	
ofloxacin oral tablet 300 mg, 400 mg	NOT COVERED PA Required	
GASTROINTESTINAL AGENTS - MISC.		
alosetron hcl oral tablet 0.5 mg, 1 mg	NOT COVERED PA Required	
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (*lubiprostone*)	COVERED - sPDL	
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (*mesalamine*)	COVERED - sPDL	
AURYXIA ORAL TABLET 1 GM 210 MG(FE) (*ferric citrate*)	NOT COVERED PA Required	
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (*sulfasalazine*)	NOT COVERED PA Required	
AZULFIDINE ORAL TABLET 500 MG (*sulfasalazine*)	NOT COVERED PA Required	
balsalazide disodium oral capsule 750 mg	COVERED - sPDL	
calcium acetate (phos binder) oral capsule 667 mg	COVERED - sPDL	
calcium acetate (phos binder) oral tablet 667 mg	COVERED - sPDL	
calcium acetate oral tablet 667 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
CALPHRON ORAL TABLET 667 MG (*calcium acetate (phos binder)*)	NOT COVERED PA Required	
CANASA RECTAL SUPPOSITORY 1000 MG (*mesalamine*)	COVERED - sPDL	
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*)	NOT COVERED PA Required	
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML (*certolizumab pegol*)	NOT COVERED PA Required	
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG (*certolizumab pegol*)	NOT COVERED PA Required	
COLAZAL ORAL CAPSULE 750 MG (*balsalazide disodium*)	NOT COVERED PA Required	
cvs gas relief infants oral suspension 20 mg/0.3ml	COVERED - cDL	
cvs infants gas relief oral suspension 20 mg/0.3ml	COVERED - cDL	
DELZICOL ORAL CAPSULE DELAYED RELEASE 400 MG (*mesalamine*)	NOT COVERED PA Required	
DIPENTUM ORAL CAPSULE 250 MG (*olsalazine sodium*)	NOT COVERED PA Required	
ENTYVIO SUBCUTANEOUS SOLUTION PEN-INJECTOR 108 MG/0.68ML (*vedolizumab*)	NOT COVERED PA Required	
enulose oral solution 10 gm/15ml	COVERED - sPDL	
eq infants gas relief oral suspension 20 mg/0.3ml, 40 mg/0.6ml	COVERED - cDL	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (*lanthanum carbonate*)	NOT COVERED PA Required	
FOSRENOL ORAL TABLET CHEWABLE 1000 MG, 500 MG, 750 MG (*lanthanum carbonate*)	NOT COVERED PA Required	
ft gas relief infants oral suspension 20 mg/0.3ml	COVERED - cDL	
gas relief infants oral liquid 40 mg/0.6ml	COVERED - cDL	
gas relief infants oral suspension 20 mg/0.3ml, 40 mg/0.6ml	COVERED - cDL	
gas relief oral liquid 40 mg/0.6ml	COVERED - cDL	
GAS-X INFANT DROPS ORAL LIQUID 20 MG/0.3ML (*simethicone*)	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
generlac oral solution 10 gm/15ml	COVERED - sPDL	
GIMOTI NASAL SOLUTION 15 MG/ACT (*metoclopramide hcl*)	NOT COVERED PA Required	
gnp infant gas relief oral suspension 20 mg/0.3ml	COVERED - cDL	
IBSRELA ORAL TABLET 50 MG (*tenapanor hcl*)	NOT COVERED PA Required	
infants gas relief oral suspension 20 mg/0.3ml, 40 mg/0.6ml	COVERED - cDL	
lactulose encephalopathy oral solution 10 gm/15ml	COVERED - sPDL	QL (180 ML per 1 day)
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	NOT COVERED PA Required	
LIALDA ORAL TABLET DELAYED RELEASE 1.2 GM (*mesalamine*)	NOT COVERED PA Required	
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (*linaclotide*)	COVERED - sPDL	
LITTLE REMEDIES GAS RELIEF ORAL SUSPENSION 20 MG/0.3ML (*simethicone*)	COVERED - cDL	
LOTRONEX ORAL TABLET 0.5 MG, 1 MG (*alosetron hcl*)	NOT COVERED PA Required	
lubiprostone oral capsule 24 mcg, 8 mcg	NOT COVERED PA Required	
mesalamine er oral capsule extended release 24 hour 0.375 gm	NOT COVERED PA Required	QL (4 EA per 1 day)
mesalamine er oral capsule extended release 500 mg	NOT COVERED PA Required	
mesalamine oral capsule delayed release 400 mg	NOT COVERED PA Required	
mesalamine oral tablet delayed release 1.2 gm, 800 mg	NOT COVERED PA Required	
mesalamine rectal enema 4 gm	COVERED - sPDL	
mesalamine rectal suppository 1000 mg	NOT COVERED PA Required	
mesalamine-cleanser rectal kit 4 gm	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml	COVERED - sPDL	
metoclopramide hcl oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (6 EA per 1 day)
MOMMY'S BLISS GAS RELIEF DROPS ORAL SUSPENSION 20 MG/0.3ML (*simethicone*)	COVERED - cDL	
MOTEGRITY ORAL TABLET 1 MG, 2 MG (*prucalopride succinate*)	NOT COVERED PA Required	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (*naloxegol oxalate*)	COVERED - sPDL	
MYLICON INFANTS GAS RELIEF ORAL SUSPENSION 20 MG/0.3ML (*simethicone*)	COVERED - cDL	
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*mirikizumab-mrkz*)	NOT COVERED PA Required	
PEDIACARE INFANTS GAS RELIEF ORAL SUSPENSION 20 MG/0.3ML (*simethicone*)	COVERED - cDL	
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG, 500 MG (*mesalamine*)	COVERED - sPDL	
PHAZYME ORAL TABLET CHEWABLE 125 MG (*simethicone*)	COVERED - cDL	
qc gas relief infants oral suspension 20 mg/0.3ml	COVERED - cDL	
REGLAN ORAL TABLET 10 MG, 5 MG (*metoclopramide hcl*)	NOT COVERED PA Required	
RELISTOR ORAL TABLET 150 MG (*methylnaltrexone bromide*)	NOT COVERED PA Required	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML (*methylnaltrexone bromide*)	NOT COVERED PA Required	
RENAGEL ORAL TABLET 800 MG (*sevelamer hcl*)	NOT COVERED PA Required	
RENVELA ORAL PACKET 0.8 GM, 2.4 GM (*sevelamer carbonate*)	NOT COVERED PA Required	
RENVELA ORAL TABLET 800 MG (*sevelamer carbonate*)	NOT COVERED PA Required	
ROWASA RECTAL KIT 4 GM (*mesalamine-cleanser*)	NOT COVERED PA Required	
sb gas relief oral suspension 40 mg/0.6ml	COVERED - cDL	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
sevelamer carbonate oral tablet 800 mg	COVERED - sPDL	ST; PRIOR USE OF calcium acetate
sevelamer hcl oral tablet 400 mg, 800 mg	NOT COVERED PA Required	
SFROWASA RECTAL ENEMA 4 GM/60ML (*mesalamine*)	NOT COVERED PA Required	
simeped oral suspension 40 mg/0.6ml	COVERED - cDL	
simethicone drops infants oral suspension 20 mg/0.3ml	COVERED - cDL	
simethicone extra strength oral capsule 125 mg	COVERED - cDL	
simethicone oral suspension 40 mg/0.6ml	COVERED - cDL	
simethicone oral tablet chewable 80 mg	COVERED - cDL	
simethicone ultra strength oral capsule 180 mg	COVERED - cDL	
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML (*risankizumab-rzaa*)	NOT COVERED PA Required	
sm gas relief infants drops oral suspension 40 mg/0.6ml	COVERED - cDL	
sm gas relief infants oral suspension 20 mg/0.3ml	COVERED - cDL	
sulfasalazine oral tablet 500 mg	COVERED - sPDL	QL (10 EA per 1 day)
sulfasalazine oral tablet delayed release 500 mg	COVERED - sPDL	QL (8 EA per 1 day)
SYMPROIC ORAL TABLET 0.2 MG (*naldemedine tosylate*)	NOT COVERED PA Required	
teeny tummy gas relief drops oral suspension 20 mg/0.3ml	COVERED - cDL	
TRULANCE ORAL TABLET 3 MG (*plecanatide*)	NOT COVERED PA Required	
ursodiol oral capsule 300 mg	COVERED - cDL	
ursodiol oral tablet 250 mg	COVERED - cDL	QL (4 EA per 1 day)
ursodiol oral tablet 500 mg	COVERED - cDL	QL (2 EA per 1 day)
VELPHORO ORAL TABLET CHEWABLE 500 MG (*sucroferric oxyhydroxide*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
VELSIPITY ORAL TABLET 2 MG (*etrasimod arginine*)	NOT COVERED PA Required	
VIBERZI ORAL TABLET 100 MG, 75 MG (*eluxadoline*)	NOT COVERED PA Required	
ZYMFENTRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 120 MG/ML (*infliximab-dyyb*)	NOT COVERED PA Required	
ZYMFENTRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 120 MG/ML (*infliximab-dyyb*)	NOT COVERED PA Required	
ZYMFENTRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 120 MG/ML (*infliximab-dyyb*)	NOT COVERED PA Required	
GENITOURINARY AGENTS - MISCELLANEOUS		
acetic acid irrigation solution 0.25 %	COVERED - cDL	
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	COVERED - sPDL	QL (1 EA per 1 day)
AVODART ORAL CAPSULE 0.5 MG (*dutasteride*)	NOT COVERED PA Required	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (*doxazosin mesylate*)	NOT COVERED PA Required	
dutasteride oral capsule 0.5 mg	COVERED - sPDL	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	NOT COVERED PA Required	
ENTADFI ORAL CAPSULE 5-5 MG (*finasteride-tadalafil*)	NOT COVERED PA Required	
finasteride oral tablet 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
FLOMAX ORAL CAPSULE 0.4 MG (*tamsulosin hcl*)	NOT COVERED PA Required	
phenazopyridine hcl oral tablet 100 mg, 200 mg	COVERED - cDL	QL (3 EA per 1 day)
potassium citrate-citric acid oral solution 1100-334 mg/5ml	COVERED - cDL	
PROSCAR ORAL TABLET 5 MG (*finasteride*)	NOT COVERED PA Required	
RAPAFLO ORAL CAPSULE 4 MG, 8 MG (*silodosin*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
silodosin oral capsule 4 mg, 8 mg	NOT COVERED PA Required	
sod citrate-citric acid oral solution 500-334 mg/5ml	COVERED - cDL	
sodium chloride irrigation solution 0.9 %	COVERED - cDL	QL (10000 ML per 25 days)
tamsulosin hcl oral capsule 0.4 mg	COVERED - sPDL	QL (2 EA per 1 day)
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (*potassium citrate*)	COVERED - cDL	QL (3 EA per 1 day)
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (*potassium citrate*)	COVERED - cDL	QL (4 EA per 1 day)
UROCIT-K 5 ORAL TABLET EXTENDED RELEASE 5 MEQ (540 MG) (*potassium citrate*)	COVERED - cDL	QL (3 EA per 1 day)
GOUT AGENTS		
allopurinol oral tablet 100 mg	COVERED - sPDL	QL (6 EA per 1 day)
allopurinol oral tablet 200 mg	NOT COVERED PA Required	
allopurinol oral tablet 300 mg	COVERED - sPDL	QL (4 EA per 1 day)
colchicine oral capsule 0.6 mg	NOT COVERED PA Required	
colchicine oral tablet 0.6 mg	COVERED - sPDL	QL (30 EA per 90 days)
colchicine-probenecid oral tablet 0.5-500 mg	COVERED - sPDL	QL (3 EA per 1 day)
febuxostat oral tablet 40 mg, 80 mg	NOT COVERED PA Required	
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (*colchicine*)	NOT COVERED PA Required	
MITIGARE ORAL CAPSULE 0.6 MG (*colchicine*)	NOT COVERED PA Required	
probenecid oral tablet 500 mg	COVERED - sPDL	QL (3 EA per 1 day)
ULORIC ORAL TABLET 40 MG, 80 MG (*febuxostat*)	NOT COVERED PA Required	
HEMATOLOGICAL AGENTS - MISC.		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT, 4000 UNIT (*antihemophil factor (rahf-pfm)*)	COVERED - cDL	PA
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*)	COVERED - cDL	PA
BRILINTA ORAL TABLET 60 MG, 90 MG (*ticagrelor*)	COVERED - sPDL	
cilostazol oral tablet 100 mg, 50 mg	COVERED - cDL	QL (2 EA per 1 day)
clopidogrel bisulfate oral tablet 300 mg	COVERED - sPDL	
clopidogrel bisulfate oral tablet 75 mg	COVERED - sPDL	QL (1 EA per 1 day)
dipyridamole oral tablet 25 mg	NOT COVERED PA Required	QL (10 EA per 1 day)
dipyridamole oral tablet 50 mg	NOT COVERED PA Required	QL (8 EA per 1 day)
dipyridamole oral tablet 75 mg	NOT COVERED PA Required	QL (4 EA per 1 day)
EFFIENT ORAL TABLET 10 MG, 5 MG (*prasugrel hcl*)	NOT COVERED PA Required	
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 500-1200 UNIT (*antihemophilic factor-vwf*)	COVERED - cDL	PA
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 250 UNIT, 500 UNIT (*antihem factor recomb (rfviii)*)	COVERED - cDL	PA
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*)	COVERED - cDL	PA
NUWIQ INTRAVENOUS KIT 1000 UNIT, 250 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,sim)*)	COVERED - cDL	PA
pentoxifylline er oral tablet extended release 400 mg	COVERED - cDL	QL (4 EA per 1 day)
PLAVIX ORAL TABLET 75 MG (*clopidogrel bisulfate*)	NOT COVERED PA Required	
prasugrel hcl oral tablet 10 mg, 5 mg	COVERED - sPDL	
rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit	COVERED - cDL	PA
TAVNEOS ORAL CAPSULE 10 MG (*avacopan*)	NOT COVERED PA Required	
HEMATOPOIETIC AGENTS		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (*darbepoetin alfa*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML (*darbepoetin alfa*)	NOT COVERED PA Required	
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (*epoetin alfa*)	COVERED - sPDL	
FERATE ORAL TABLET 240 (27 FE) MG (*ferrous gluconate*)	COVERED - cDL	
FER-IN-SOL ORAL SOLUTION 75 (15 FE) MG/ML (*ferrous sulfate*)	COVERED - cDL	
FERROCITE ORAL TABLET 324 MG (*ferrous fumarate*)	COVERED - cDL	
ferrous gluconate oral tablet 324 (37.5 fe) mg, 324 (38 fe) mg	COVERED - cDL	
ferrous sulfate oral tablet delayed release 324 (65 fe) mg, 325 (65 fe) mg	COVERED - cDL	
folic acid oral tablet 1 mg, 400 mcg, 800 mcg	COVERED - cDL	QL (5 EA per 1 day)
foltrin oral capsule	COVERED - cDL	QL (2 EA per 1 day)
HEMATOGEN ORAL CAPSULE (*iron combinations*)	COVERED - cDL	QL (2 EA per 1 day)
iron (ferrous sulfate) oral tablet 325 (65 fe) mg	COVERED - cDL	QL (3 EA per 1 day)
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG, 8 MG (*daprodustat*)	NOT COVERED PA Required	
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 120 MCG/0.3ML, 150 MCG/0.3ML, 200 MCG/0.3ML, 30 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML (*methoxy peg-epoetin beta*)	NOT COVERED PA Required	
NU-IRON ORAL CAPSULE 150 MG (*polysaccharide iron complex*)	COVERED - cDL	QL (2 EA per 1 day)
polysaccharide iron forte oral capsule 150-25-1 mg-mcg-mg	COVERED - cDL	QL (2 EA per 1 day)
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (*epoetin alfa*)	NOT COVERED PA Required	
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (*epoetin alfa-epbx*)	COVERED - sPDL	PA
slow release iron oral tablet extended release 45 mg, 50 mg	COVERED - cDL	
vitamin b-12 er oral tablet extended release 1000 mcg	COVERED - cDL	
vitamin b-12 oral tablet 100 mcg, 1000 mcg, 250 mcg, 500 mcg	COVERED - cDL	
vitamin b-12 sublingual tablet sublingual 1000 mcg, 2500 mcg, 500 mcg	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-sndz*)	COVERED - cDL	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-bmez*)	COVERED - cDL	PA; QL (0.6 ML per 11 days)
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
AMBIEN CR ORAL TABLET EXTENDED RELEASE 12.5 MG, 6.25 MG (*zolpidem tartrate*)	NOT COVERED PA Required	
AMBIEN ORAL TABLET 10 MG, 5 MG (*zolpidem tartrate*)	NOT COVERED PA Required	
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (*suvorexant*)	NOT COVERED PA Required	
cvs sleep aid nighttime oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
cvs sleep aid oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
DAYVIGO ORAL TABLET 10 MG, 5 MG (*lemborexant*)	NOT COVERED PA Required	
diphenhydramine hcl (sleep) oral tablet 50 mg	COVERED - cDL	QL (1 EA per 1 day)
DORAL ORAL TABLET 15 MG (*quazepam*)	NOT COVERED PA Required	
doxepin hcl oral tablet 3 mg, 6 mg	NOT COVERED PA Required	
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (*zolpidem tartrate*)	NOT COVERED PA Required	
eql nighttime sleep aid oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
estazolam oral tablet 1 mg, 2 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 18 Years)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	NOT COVERED PA Required	
flurazepam hcl oral capsule 15 mg, 30 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 15 Years)
ft nighttime sleep aid oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
gnp sleep aid nighttime oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
HALCION ORAL TABLET 0.25 MG (*triazolam*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (*tasimelteon*)	NOT COVERED PA Required	
HETLIOZ ORAL CAPSULE 20 MG (*tasimelteon*)	NOT COVERED PA Required	
IGALMI SUBLINGUAL FILM 120 MCG, 180 MCG (*dexmedetomidine hcl*)	NOT COVERED PA Required	
LUNESTA ORAL TABLET 1 MG, 2 MG, 3 MG (*eszopiclone*)	NOT COVERED PA Required	
night time sleep aid oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
nighttime sleep aid oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
NYTOL QUICKCAPS ORAL TABLET 25 MG (*diphenhydramine hcl (sleep)*)	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
phenobarbital oral elixir 20 mg/5ml	COVERED - cDL	QL (50 ML per 1 day); AGE (Max 12 Years)
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 97.2 mg	COVERED - cDL	QL (2 EA per 1 day)
phenobarbital oral tablet 64.8 mg	COVERED - cDL	QL (3 EA per 1 day)
qc rest simply oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
quazepam oral tablet 15 mg	NOT COVERED PA Required	
QUVIVIQ ORAL TABLET 25 MG, 50 MG (*daridorexant hcl*)	NOT COVERED PA Required	
ra nighttime sleep aid oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
ra sleep aid (diphenhydramine) oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
ramelteon oral tablet 8 mg	NOT COVERED PA Required	
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (*temazepam*)	NOT COVERED PA Required	
ROZEREM ORAL TABLET 8 MG (*ramelteon*)	NOT COVERED PA Required	
sb sleep oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
SIMPLY SLEEP ORAL TABLET 25 MG (*diphenhydramine hcl (sleep)*)	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)

Drug Name	Drug Tier	Requirements/Limits
sleep aid (diphenhydramine) oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
sleep aid oral tablet 25 mg	COVERED - cDL	QL (1 EA per 1 day)
sleep tabs oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
sleep-tabs oral tablet 25 mg	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
SOMINEX NIGHTTIME SLEEP-AID ORAL TABLET 25 MG (*diphenhydramine hcl (sleep)*)	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
SOMINEX ORAL TABLET 25 MG (*diphenhydramine hcl (sleep)*)	COVERED - cDL	QL (6 EA per 1 day); AGE (Max 64 Years)
tasimelteon oral capsule 20 mg	NOT COVERED PA Required	
temazepam oral capsule 15 mg, 30 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 18 Years)
temazepam oral capsule 22.5 mg, 7.5 mg	COVERED - sPDL	
triazolam oral tablet 0.125 mg	NOT COVERED PA Required	QL (1 EA per 1 day); AGE (Min 18 Years)
triazolam oral tablet 0.25 mg	NOT COVERED PA Required	QL (2 EA per 1 day); AGE (Min 18 Years)
zaleplon oral capsule 10 mg, 5 mg	NOT COVERED PA Required	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	NOT COVERED PA Required	
zolpidem tartrate oral capsule 7.5 mg	NOT COVERED PA Required	
zolpidem tartrate oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 18 Years)
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	NOT COVERED PA Required	
LAXATIVES		
BENEFIBER DRINK MIX ORAL PACKET (*wheat dextrin*)	COVERED - cDL	
BENEFIBER FOR CHILDREN ORAL POWDER (*wheat dextrin*)	COVERED - cDL	
bisacodyl oral tablet delayed release 5 mg	COVERED - cDL	QL (3 EA per 1 day)
CITRUCEL ORAL TABLET 500 MG (*methylcellulose (laxative)*)	COVERED - cDL	
CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
constulose oral solution 10 gm/15ml	COVERED - sPDL	
cvs chocolate laxative pieces oral tablet chewable 15 mg	COVERED - cDL	
cvs daily fiber oral capsule 0.52 gm	COVERED - cDL	
cvs daily fiber oral packet 58.6 %	COVERED - cDL	
cvs fiber oral capsule 0.52 gm	COVERED - cDL	
cvs laxative pills max st oral tablet 25 mg	COVERED - cDL	
cvs natural fiber supplement oral powder 100 %	COVERED - cDL	
cvs stool softener oral capsule 50 mg	COVERED - cDL	QL (2 EA per 1 day)
docusate calcium oral capsule 240 mg	COVERED - cDL	QL (2 EA per 1 day)
docusate sodium oral capsule 250 mg	COVERED - cDL	QL (6 EA per 1 day)
docusate sodium oral liquid 50 mg/5ml	COVERED - cDL	QL (30 ML per 1 day)
docusate sodium oral syrup 60 mg/15ml	COVERED - cDL	
DOK ORAL TABLET 100 MG (*docusate sodium*)	COVERED - cDL	QL (6 EA per 1 day)
easy-lax plus oral tablet 8.6-50 mg	COVERED - cDL	QL (6 EA per 1 day)
enema mineral oil rectal enema	COVERED - cDL	
eq fiber therapy oral capsule 0.52 gm	COVERED - cDL	
eql laxative maximum strength oral tablet 25 mg	COVERED - cDL	
EVAC ORAL POWDER (*psyllium*)	COVERED - cDL	
EX-LAX MAXIMUM STRENGTH ORAL TABLET 25 MG (*sennosides*)	COVERED - cDL	
fiber (corn dextrin) oral powder	COVERED - cDL	
FIBERCON ORAL TABLET 625 MG (*calcium polycarbophil*)	COVERED - cDL	
FLEET ENEMA RECTAL ENEMA 7-19 GM/118ML (*sodium phosphates*)	COVERED - cDL	
FLEET PEDIATRIC RECTAL ENEMA 3.5-9.5 GM/59ML (*sodium phosphates*)	COVERED - cDL	
ft clearlax oral powder 17 gm/scoop	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
ft magnesium citrate oral solution 1.745 gm/30ml	COVERED - sPDL	
ft stool softener oral tablet 100 mg	COVERED - cDL	QL (6 EA per 1 day)
gavilax oral powder 17 gm/scoop	COVERED - sPDL	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (*peg 3350-kcl-nabcb-nacl-nasulf*)	COVERED - sPDL	
peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)	COVERED - sPDL	
gentle laxative rectal suppository 10 mg	COVERED - cDL	QL (1 EA per 1 day)
glycerin (adult) rectal suppository 2 gm, 2.1 gm	COVERED - cDL	
glycerin (pediatric) rectal suppository 1.2 gm	COVERED - cDL	
GNP CLEARLAX ORAL PACKET 17 GM (*polyethylene glycol 3350*)	COVERED - sPDL	
GNP CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	COVERED - sPDL	
gnp magnesium citrate oral solution 1.745 gm/30ml	COVERED - sPDL	
gnp natural fiber oral capsule 0.52 gm	COVERED - cDL	
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM (*peg 3350-kcl-nabcb-nacl-nasulf*)	NOT COVERED PA Required	
GOODSENSE CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	COVERED - sPDL	
goodsense laxative pills oral tablet 25 mg	COVERED - cDL	
HEALTHY MAMA MOVE IT ALONG ORAL TABLET 100 MG (*docusate sodium*)	COVERED - cDL	QL (6 EA per 1 day)
HEALTHYLAX ORAL PACKET 17 GM (*polyethylene glycol 3350*)	COVERED - sPDL	
HM CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	COVERED - sPDL	
HYDROCIL ORAL POWDER 95 % (*psyllium*)	COVERED - cDL	
konsyl daily fiber oral packet 100 %	COVERED - cDL	
KRISTALOSE ORAL PACKET 10 GM, 20 GM (*lactulose*)	NOT COVERED PA Required	
lactulose oral solution 10 gm/15ml	COVERED - sPDL	QL (180 ML per 1 day)
lactulose oral solution 20 gm/30ml	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
laxative max str oral tablet 25 mg	COVERED - cDL	
magnesium citrate oral solution 1.745 gm/30ml	COVERED - sPDL	
MEDI-MUCIL ORAL CAPSULE 0.52 GM (*psyllium*)	COVERED - cDL	
METAMUCIL ORAL WAFER (*psyllium*)	COVERED - cDL	
milk of magnesia concentrate oral suspension 2400 mg/10ml	COVERED - cDL	
milk of magnesia oral suspension 1200 mg/15ml	COVERED - cDL	
mineral oil oral oil	COVERED - cDL	
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (*peg-kcl-nacl-nasulf-na asc-c*)	NOT COVERED PA Required	
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	NOT COVERED PA Required	
natural fiber oral powder 58.6 %	COVERED - cDL	
natural psyllium seed oral powder 100 %	COVERED - cDL	
PEDIA-LAX ORAL LIQUID 50 MG/15ML (*docusate sodium*)	COVERED - cDL	QL (30 ML per 1 day)
peg 3350 oral packet 17 gm	COVERED - sPDL	
peg 3350 oral powder 17 gm/scoop	COVERED - sPDL	QL (34 GM per 1 day)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	NOT COVERED PA Required	QL (4000 ML per 1 day)
peg-3350/electrolytes oral solution reconstituted 236 gm	COVERED - sPDL	QL (4000 ML per 1 day)
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	NOT COVERED PA Required	
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	NOT COVERED PA Required	
PEG-PREP ORAL KIT 5-210 MG-GM (*bisacodyl-peg-kcl-nabicar-nacl*)	COVERED - cDL	QL (1 EA per 1 day)
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (*peg-kcl-nacl-nasulf-na asc-c*)	NOT COVERED PA Required	
polyethylene glycol 3350 oral packet 17 gm	COVERED - sPDL	
polyethylene glycol 3350 oral powder 17 gm/scoop	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
PROMOLAXIN ORAL TABLET 100 MG (*docusate sodium*)	COVERED - cDL	QL (6 EA per 1 day)
psyllium fiber oral capsule 0.52 gm	COVERED - cDL	
qc fiber laxative oral capsule 0.52 gm	COVERED - cDL	
ra glycerin adult rectal suppository 80.7 %	COVERED - cDL	
REGULOID ORAL CAPSULE 0.52 GM (*psyllium*)	COVERED - cDL	
sb fib lax orange oral powder 33 %	COVERED - cDL	
senna oral syrup 8.8 mg/5ml	COVERED - cDL	
SM CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	COVERED - sPDL	
sm magnesium citrate oral solution 1.745 gm/30ml	COVERED - sPDL	
sm stool softener oral tablet 100 mg	COVERED - cDL	QL (6 EA per 1 day)
stool softener oral capsule 100 mg	COVERED - cDL	QL (6 EA per 1 day)
stool softener oral tablet 100 mg	COVERED - cDL	QL (6 EA per 1 day)
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (*peg 3350-kcl-nacl-nasulf-mgsul*)	NOT COVERED PA Required	
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML (*na sulfate-k sulfate-mg sulf*)	NOT COVERED PA Required	
SUTAB ORAL TABLET 1479-225-188 MG (*sodium sulfate-mag sulfate-kcl*)	NOT COVERED PA Required	
UNIFIBER ORAL POWDER (*cellulose*)	COVERED - cDL	
WAL-MUCIL ORAL CAPSULE 0.52 GM (*psyllium*)	COVERED - cDL	
WAL-MUCIL ORAL POWDER 100 % (*psyllium*)	COVERED - cDL	
MACROLIDES		
azithromycin oral packet 1 gm	COVERED - sPDL	
azithromycin oral suspension reconstituted 100 mg/5ml	COVERED - sPDL	QL (20 ML per 1 day); AGE (Max 12 Years)
azithromycin oral suspension reconstituted 200 mg/5ml	COVERED - sPDL	QL (30 ML per 1 day); AGE (Max 12 Years)
azithromycin oral tablet 250 mg	COVERED - sPDL	QL (12 EA per 25 days)

Drug Name	Drug Tier	Requirements/Limits
azithromycin oral tablet 500 mg	COVERED - sPDL	QL (6 EA per 25 days)
azithromycin oral tablet 600 mg	COVERED - sPDL	QL (1 EA per 1 day)
clarithromycin er oral tablet extended release 24 hour 500 mg	NOT COVERED PA Required	
clarithromycin oral suspension reconstituted 125 mg/5ml	COVERED - sPDL	AGE (Max 12 Years)
clarithromycin oral suspension reconstituted 250 mg/5ml	COVERED - sPDL	
clarithromycin oral tablet 250 mg, 500 mg	COVERED - sPDL	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fidaxomicin*)	NOT COVERED PA Required	
DIFICID ORAL TABLET 200 MG (*fidaxomicin*)	NOT COVERED PA Required	
E.E.S. 400 ORAL TABLET 400 MG (*erythromycin ethylsuccinate*)	NOT COVERED PA Required	
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*)	NOT COVERED PA Required	
ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*)	NOT COVERED PA Required	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (*erythromycin ethylsuccinate*)	NOT COVERED PA Required	
erythromycin base (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg)	NOT COVERED PA Required	
ERYTHROCIN STEARATE ORAL TABLET 250 MG (*erythromycin stearate*)	COVERED - sPDL	
erythromycin base oral capsule delayed release particles 250 mg	NOT COVERED PA Required	
erythromycin base oral tablet 250 mg, 500 mg	NOT COVERED PA Required	
erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg	NOT COVERED PA Required	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	COVERED - sPDL	AGE (Max 12 Years)
erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
erythromycin ethylsuccinate oral tablet 400 mg	NOT COVERED PA Required	
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	NOT COVERED PA Required	
ZITHROMAX ORAL PACKET 1 GM (*azithromycin*)	NOT COVERED PA Required	
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML (*azithromycin*)	NOT COVERED PA Required	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (*azithromycin*)	NOT COVERED PA Required	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (*azithromycin*)	NOT COVERED PA Required	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (*azithromycin*)	NOT COVERED PA Required	
MEDICAL DEVICES AND SUPPLIES		
AEROECLIPSE II NEBULIZER (*nebulizers*)	COVERED - cDL	
aimsco lubricated	COVERED - cDL	QL (12 EA per 1 day)
alcohol swabs pad 70 %	COVERED - cDL	QL (200 EA per 25 days)
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (*insulin syringe/needle u-500*)	COVERED - cDL	QL (5 EA per 1 day)
condoms	COVERED - cDL	QL (12 EA per 1 day)
DEXCOM G6 RECEIVER DEVICE (*continuous glucose receiver*)	COVERED - sPDL	PA; QL (1 EA per 310 days); (except ages 2-18 with history of insulin)
DEXCOM G6 SENSOR (*continuous glucose sensor*)	COVERED - cDL	PA; QL (3 EA per 23 days); (except ages 2-18 with history of insulin)
DEXCOM G6 TRANSMITTER (*continuous glucose transmitter*)	COVERED - cDL	PA; QL (1 EA per 76 days); (except ages 2-18 with history of insulin)
DEXCOM G7 RECEIVER DEVICE (*continuous glucose receiver*)	COVERED - sPDL	PA; QL (1 EA per 310 days); (except ages 2-18 with history of insulin)
DEXCOM G7 SENSOR (*continuous glucose sensor*)	COVERED - cDL	PA; QL (3 EA per 23 days); (except ages 2-18 with history of insulin)
DUREX EXTRA SENSITIVE THIN DEVICE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
essentra wipes 9x9" sheet 70 %	COVERED - cDL	QL (200 EA per 25 days)

Drug Name	Drug Tier	Requirements/Limits
FANTASY LUBRICATED (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
FANTASY LUBRICATED/SPERMICIDE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
FREESTYLE LIBRE 14 DAY READER DEVICE (*continuous glucose receiver*)	COVERED - sPDL	PA; QL (1 EA per 310 days); (except ages 2-18 with history of insulin)
FREESTYLE LIBRE 14 DAY SENSOR (*continuous glucose sensor*)	COVERED - cDL	PA; QL (2 EA per 23 days); (except ages 2-18 with history of insulin)
FREESTYLE LIBRE 2 READER DEVICE (*continuous glucose receiver*)	COVERED - sPDL	PA; QL (1 EA per 310 days); (except ages 2-18 with history of insulin)
FREESTYLE LIBRE 2 SENSOR (*continuous glucose sensor*)	COVERED - cDL	PA; QL (2 EA per 23 days); (except ages 2-18 with history of insulin)
FREESTYLE LIBRE 3 SENSOR (*continuous glucose sensor*)	COVERED - cDL	PA; QL (2 EA per 23 days); (except ages 2-18 with history of insulin)
FREESTYLE LIBRE READER DEVICE (*continuous glucose receiver*)	COVERED - sPDL	PA; QL (1 EA per 310 days); (except ages 2-18 with history of insulin)
INSPIREASE (*spacer/aero-holding chambers*)	COVERED - cDL	QL (2 EA per 365 days)
KAMELEON LUBRICATED (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
kimono	COVERED - cDL	QL (12 EA per 1 day)
KIMONO COLORS DEVICE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
KIMONO MAXX-LARGE FLARE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
kimono micro thin plus	COVERED - cDL	QL (12 EA per 1 day)
kimono plus	COVERED - cDL	QL (12 EA per 1 day)
kimono ps	COVERED - cDL	QL (12 EA per 1 day)
kimono ps plus	COVERED - cDL	QL (12 EA per 1 day)
kimono sensation	COVERED - cDL	QL (12 EA per 1 day)
kimono sensation plus	COVERED - cDL	QL (12 EA per 1 day)
KIMONO SPECIAL DEVICE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
lancets thin	COVERED - cDL	
maxx	COVERED - cDL	QL (12 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
maxx plus	COVERED - cDL	QL (12 EA per 1 day)
MONOJECT HYPODERMIC NEEDLE 18G X 1-1/2" (*needle (disp)*)	COVERED - cDL	
MONOJECT SYRINGE 22G X 1" 3 ML, 25G X 1" 3 ML (*syringe/needle (disp)*)	COVERED - cDL	
MONOJECT SYRINGE REGULAR TIP 3 ML (*syringe (disposable)*)	COVERED - cDL	
PEDIATRIC PANDA MASK (*spacer/aero-hold chamber mask*)	COVERED - cDL	QL (1 EA per 365 days)
REALITY LATEX CONDOMS (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
REALITY LATEX/ULTRA TEXTURED DEVICE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
REALITY LATEX/ULTRA THIN DEVICE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
techlite insulin syringe 30g x 1/2" 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	COVERED - cDL	QL (5 EA per 1 day)
TECHLITE PEN NEEDLES 31G X 8 MM , 32G X 6 MM (*insulin pen needle*)	COVERED - cDL	QL (200 EA per 25 days)
true cover device	COVERED - cDL	QL (12 EA per 1 day)
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (*insulin pen needle*)	COVERED - cDL	QL (200 EA per 25 days)
TRUEPLUS 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 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*)	COVERED - cDL	QL (5 EA per 1 day)
TRUSTEX COLOR CONDOMS + LUBE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX LUB/RIBBED/STUDDED (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX LUB/SPERMICIDE EX ST (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX LUB/SPERMICIDE XL (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX LUBRICATED (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX LUBRICATED EX LARGE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX LUBRICATED EXTRA ST (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX LUBRICATED/SPERMICIDE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX NATURAL CONDOMS + LUBE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
TRUSTEX RIA LUB/SPERMICIDE (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX RIA LUBRICATED (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX RIA NON-LUBRICATED (*condoms latex non-lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUSTEX-NONOXYNOL-9/RIB/STUD (*condoms latex lubricated*)	COVERED - cDL	QL (12 EA per 1 day)
TRUZONE PEAK FLOW METER DEVICE (*peak flow meter*)	COVERED - cDL	QL (1 EA per 365 days)
MIGRAINE PRODUCTS		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (*erenumab-aooe*)	NOT COVERED PA Required	
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML (*fremanezumab-vfrm*)	NOT COVERED PA Required	
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (*fremanezumab-vfrm*)	NOT COVERED PA Required	
almotriptan malate oral tablet 12.5 mg, 6.25 mg	NOT COVERED PA Required	
eletriptan hydrobromide oral tablet 20 mg, 40 mg	NOT COVERED PA Required	
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*galcanezumab-gnlm*)	NOT COVERED PA Required	
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (*galcanezumab-gnlm*)	COVERED with Clinical Criteria	PA
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*galcanezumab-gnlm*)	COVERED with Clinical Criteria	PA
FROVA ORAL TABLET 2.5 MG (*frovatriptan succinate*)	NOT COVERED PA Required	
frovatriptan succinate oral tablet 2.5 mg	NOT COVERED PA Required	
IMITREX ORAL TABLET 100 MG, 25 MG, 50 MG (*sumatriptan succinate*)	NOT COVERED PA Required	
IMITREX STATDOSE REFILL SUBCUTANEOUS SOLUTION CARTRIDGE 4 MG/0.5ML, 6 MG/0.5ML (*sumatriptan succinate*)	NOT COVERED PA Required	
IMITREX STATDOSE SYSTEM SUBCUTANEOUS SOLUTION AUTO-INJECTOR 4 MG/0.5ML, 6 MG/0.5ML (*sumatriptan succinate*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
MAXALT ORAL TABLET 10 MG (*rizatriptan benzoate*)	NOT COVERED PA Required	
MAXALT-MLT ORAL TABLET DISPERSIBLE 10 MG (*rizatriptan benzoate*)	NOT COVERED PA Required	
naratriptan hcl oral tablet 1 mg, 2.5 mg	NOT COVERED PA Required	QL (9 EA per 25 days)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (*rimegepant sulfate*)	NOT COVERED PA Required	
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (*atogepant*)	NOT COVERED PA Required	
RELPAX ORAL TABLET 20 MG, 40 MG (*eletriptan hydrobromide*)	COVERED - sPDL	
rizatriptan benzoate oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (12 EA per 25 days)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	COVERED - sPDL	QL (12 EA per 25 days)
sumatriptan nasal solution 20 mg/act, 5 mg/act	NOT COVERED PA Required	
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	COVERED - sPDL	QL (9 EA per 25 days)
sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml	COVERED - sPDL	
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	COVERED - sPDL	
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml	COVERED - sPDL	
sumatriptan-naproxen sodium oral tablet 85-500 mg	NOT COVERED PA Required	
TOSYMRA NASAL SOLUTION 10 MG/ACT (*sumatriptan*)	NOT COVERED PA Required	
UBRELVY ORAL TABLET 100 MG, 50 MG (*ubrogepant*)	COVERED with Clinical Criteria	PA
ZAVZPRET NASAL SOLUTION 10 MG/ACT (*zavegepant hcl*)	NOT COVERED PA Required	
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (*sumatriptan succinate*)	NOT COVERED PA Required	
zolmitriptan nasal solution 5 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
zolmitriptan oral tablet 2.5 mg, 5 mg	NOT COVERED PA Required	
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	NOT COVERED PA Required	
ZOMIG NASAL SOLUTION 5 MG (*zolmitriptan*)	NOT COVERED PA Required	
ZOMIG ORAL TABLET 5 MG (*zolmitriptan*)	NOT COVERED PA Required	
MINERALS & ELECTROLYTES		
calcium 500 + d oral tablet 500-3.125 mg-mcg	COVERED - cDL	
calcium 600 oral tablet 1500 (600 ca) mg, 600 mg	COVERED - cDL	
calcium 600/vitamin d oral tablet chewable 600-10 mg-mcg	COVERED - cDL	
calcium 600+d oral tablet 600-10 mg-mcg, 600-5 mg-mcg	COVERED - cDL	
calcium carb-cholecalciferol oral tablet 600-5 mg-mcg	COVERED - cDL	
calcium carb-cholecalciferol oral tablet chewable 500-10 mg-mcg	COVERED - cDL	
calcium carbonate oral tablet 1250 (500 ca) mg, 1500 (600 ca) mg	COVERED - cDL	
calcium citrate + d oral tablet 250-5 mg-mcg	COVERED - cDL	
calcium citrate + d3 oral tablet 315-6.25 mg-mcg	COVERED - cDL	
calcium citrate oral tablet 950 (200 ca) mg	COVERED - cDL	
calcium citrate-vitamin d oral tablet 315-5 mg-mcg	COVERED - cDL	
calcium high potency oral tablet 1500 (600 ca) mg	COVERED - cDL	
calcium oyster shell oral tablet 500 mg	COVERED - cDL	
calcium-magnesium-zinc oral tablet 333.33-133.33-5 mg	COVERED - cDL	
calcium-vitamin d oral tablet 600-3.125 mg-mcg	COVERED - cDL	
calcium-vitamin d3 oral tablet 250-3.125 mg-mcg	COVERED - cDL	
CALTRATE 600+D3 ORAL TABLET 600-20 MG-MCG (*calcium carb-cholecalciferol*)	COVERED - cDL	
citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
gnp calcium oral tablet 1500 (600 ca) mg	COVERED - cDL	
potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	COVERED - cDL	QL (4 EA per 1 day)
potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)	COVERED - cDL	QL (4 EA per 1 day)
potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)	COVERED - cDL	QL (5 EA per 1 day)
potassium chloride (Klor-Con Oral Tablet Extended Release 8 Meq)	COVERED - cDL	QL (4 EA per 1 day)
potassium bicarbonate (Klor-Con/Ef Oral Tablet Effervescent 25 Meq)	COVERED - cDL	QL (2 EA per 1 day)
K-PHOS-NEUTRAL ORAL TABLET 155-852-130 MG (*k phos mono-sod phos di & mono*)	COVERED - cDL	QL (4 EA per 1 day)
K-TAB ORAL TABLET EXTENDED RELEASE 20 MEQ (*potassium chloride*)	COVERED - cDL	QL (5 EA per 1 day)
liquid calcium/vitamin d oral capsule 600-5 mg-mcg	COVERED - cDL	
MAGDELAY ORAL TABLET DELAYED RELEASE 64 MG (*magnesium chloride*)	COVERED - cDL	
mag-g oral tablet 500 (27 mg) mg	COVERED - cDL	
MAGNEBIND 400 ORAL TABLET 80-115 MG (*calcium carb-magnesium carb*)	NOT COVERED PA Required	
magnesium gluconate oral tablet 27.5 mg	COVERED - cDL	
magnesium oral tablet 250 mg, 400 mg	COVERED - cDL	
magnesium oxide -mg supplement oral capsule 500 mg	COVERED - cDL	
magnesium oxide -mg supplement oral tablet 250 mg, 400 (240 mg) mg, 500 mg	COVERED - cDL	
OS-CAL CALCIUM + D3 ORAL TABLET 500-5 MG-MCG (*calcium carb-cholecalciferol*)	COVERED - cDL	
OS-CAL ORAL TABLET CHEWABLE 500-15 MG-MCG (*calcium carb-cholecalciferol*)	COVERED - cDL	
oyster shell calcium oral tablet 500 mg	COVERED - cDL	
oyster shell calcium/d oral tablet 250-3.125 mg-mcg, 500-10 mg-mcg, 500-5 mg-mcg	COVERED - cDL	
potassium chloride er oral capsule extended release 10 meq, 8 meq	COVERED - cDL	QL (4 EA per 1 day)
potassium chloride er oral tablet extended release 10 meq, 8 meq	COVERED - cDL	QL (4 EA per 1 day)
potassium chloride oral solution 10 %, 40 meq/15ml (20%)	COVERED - cDL	
pure calcium carbonate oral tablet 1500 (600 ca) mg	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
qc calcium fast dissolution oral tablet 1500 (600 ca) mg	COVERED - cDL	
ra calcium 600 oral tablet 1500 (600 ca) mg	COVERED - cDL	
ra calcium 600/vit d/minerals oral tablet chewable 600-400 mg-unit	COVERED - cDL	
REHYDRALYTE ORAL SOLUTION (*oral electrolytes*)	COVERED - cDL	
risacal-d oral tablet 105-81-120 mg-mg-unit	COVERED - cDL	
sb oyster shell calcium oral tablet 500 mg	COVERED - cDL	
sodium chloride oral tablet 1 gm	COVERED - cDL	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	COVERED - cDL	QL (1.67 ML per 1 day)
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg	COVERED - cDL	QL (1 EA per 1 day)
sodium fluoride oral tablet chewable 2.2 (1 f) mg	COVERED - cDL	
super calcium oral tablet 1500 (600 ca) mg	COVERED - cDL	
zinc sulfate oral capsule 220 (50 zn) mg	COVERED - cDL	
MISCELLANEOUS THERAPEUTIC CLASSES		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG (*tacrolimus*)	NOT COVERED PA Required	
azathioprine (Azasan Oral Tablet 100 Mg, 75 Mg)	NOT COVERED PA Required	
azathioprine oral tablet 100 mg, 75 mg	COVERED - sPDL	
azathioprine oral tablet 50 mg	COVERED - sPDL	QL (8 EA per 1 day)
CELLCEPT ORAL CAPSULE 250 MG (*mycophenolate mofetil*)	COVERED - sPDL	
CELLCEPT ORAL SUSPENSION RECONSTITUTED 200 MG/ML (*mycophenolate mofetil*)	NOT COVERED PA Required	
CELLCEPT ORAL TABLET 500 MG (*mycophenolate mofetil*)	COVERED - sPDL	
cyclosporine modified oral capsule 100 mg, 25 mg	COVERED - sPDL	
cyclosporine modified oral capsule 50 mg	COVERED - sPDL	QL (15 EA per 1 day)
cyclosporine modified oral solution 100 mg/ml	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
cyclosporine oral capsule 100 mg	COVERED - sPDL	QL (5 EA per 1 day)
cyclosporine oral capsule 25 mg	COVERED - sPDL	QL (16 EA per 1 day)
DEPEN TITRATABS ORAL TABLET 250 MG (*penicillamine*)	COVERED - cDL	PA
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*satralizumab-mwge*)	NOT COVERED PA Required	
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG (*tacrolimus*)	NOT COVERED PA Required	
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	NOT COVERED PA Required	
cyclosporine modified (Gengraf Oral Capsule 100 Mg)	COVERED - sPDL	QL (10 EA per 1 day)
cyclosporine modified (Gengraf Oral Capsule 25 Mg)	COVERED - sPDL	QL (15 EA per 1 day)
cyclosporine modified (Gengraf Oral Solution 100 Mg/Ml)	COVERED - sPDL	QL (10 ML per 1 day)
IMURAN ORAL TABLET 50 MG (*azathioprine*)	NOT COVERED PA Required	
lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg	COVERED - cDL	PA; QL (1 EA per 1 day)
LOKELMA ORAL PACKET 10 GM, 5 GM (*sodium zirconium cyclosilicate*)	COVERED - cDL	QL (3 EA per 1 day)
mycophenolate mofetil oral capsule 250 mg	COVERED - sPDL	QL (12 EA per 1 day)
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	COVERED - sPDL	
mycophenolate mofetil oral tablet 500 mg	COVERED - sPDL	QL (8 EA per 1 day)
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	COVERED - sPDL	
mycophenolic acid oral tablet delayed release 180 mg, 360 mg	COVERED - sPDL	
MYFORTIC ORAL TABLET DELAYED RELEASE 180 MG, 360 MG (*mycophenolate sodium*)	NOT COVERED PA Required	
NEORAL ORAL CAPSULE 100 MG, 25 MG (*cyclosporine modified*)	NOT COVERED PA Required	
NEORAL ORAL SOLUTION 100 MG/ML (*cyclosporine modified*)	NOT COVERED PA Required	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (*tacrolimus*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
PROGRAF ORAL PACKET 0.2 MG, 1 MG (*tacrolimus*)	NOT COVERED PA Required	
RAPAMUNE ORAL SOLUTION 1 MG/ML (*sirolimus*)	COVERED - sPDL	
RAPAMUNE ORAL TABLET 0.5 MG, 1 MG, 2 MG (*sirolimus*)	COVERED - sPDL	
REZUROCK ORAL TABLET 200 MG (*belumosudil mesylate*)	NOT COVERED PA Required	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (*cyclosporine*)	COVERED - sPDL	
SANDIMMUNE ORAL SOLUTION 100 MG/ML (*cyclosporine*)	COVERED - sPDL	
sirolimus oral solution 1 mg/ml	COVERED - sPDL	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	COVERED - sPDL	
sodium polystyrene sulfonate oral powder	COVERED - cDL	
SPS ORAL SUSPENSION 15 GM/60ML (*sodium polystyrene sulfonate*)	COVERED - cDL	
sterile water for irrigation irrigation solution	COVERED - cDL	
tacrolimus oral capsule 0.5 mg	COVERED - sPDL	QL (2 EA per 1 day)
tacrolimus oral capsule 1 mg	NOT COVERED PA Required	QL (14 EA per 1 day)
tacrolimus oral capsule 5 mg	COVERED - sPDL	
THALOMID ORAL CAPSULE 100 MG (*thalidomide*)	COVERED - cDL	PA; QL (1 EA per 1 day)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (*patiromer sorbitex calcium*)	COVERED - cDL	QL (1 EA per 1 day)
ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG, 1 MG (*everolimus*)	NOT COVERED PA Required	
MOUTH/THROAT/DENTAL AGENTS		
chlorhexidine gluconate mouth/throat solution 0.12 %	COVERED - cDL	
clotrimazole mouth/throat troche 10 mg	COVERED - cDL	QL (5 EA per 1 day)
lidocaine viscous hcl mouth/throat solution 2 %	COVERED - cDL	
nystatin mouth/throat suspension 100000 unit/ml	COVERED - cDL	QL (120 ML per 1 day)
pilocarpine hcl oral tablet 5 mg, 7.5 mg	COVERED - cDL	

Drug Name	Drug Tier	Requirements/Limits
sf dental gel 1.1 %	COVERED - cDL	
sodium fluoride 5000 plus dental cream 1.1 %	COVERED - cDL	
MULTIVITAMINS		
activite oral tablet 1 mg	COVERED - cDL	
ALIVE MULTI-VITAMIN ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
b-complex/vitamin c oral tablet	COVERED - cDL	
BPROTECTED MULTI-VITE ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
BRAINSTRONG PRENATAL ORAL 33-0.8 & 350 MG (*prenatal mv-min-fe cbn-fa-dha*)	COVERED - cDL	QL (1 EA per 1 day)
BURIED TREASURE ACTIVE 55 PLUS ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
CENTRUM ADULT ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
CENTRUM KIDS ORAL TABLET CHEWABLE (*pediatric multivit-minerals*)	COVERED - cDL	QL (1 EA per 1 day)
CENTRUM ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
CENTRUM SPECIALIST PRENATAL ORAL 27-0.8 & 200 MG (*prenatal mv-min-fe fum-fa-dha*)	COVERED - cDL	QL (1 EA per 1 day)
CERTA-VITE ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
childrens chew multivitamin oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
childrens chewable vitamins oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
complete multivitamin/mineral oral liquid	COVERED - cDL	QL (1 ML per 1 day)
completenate oral tablet chewable 29-1 mg	COVERED - cDL	QL (1 EA per 1 day)
CO-NATAL FA ORAL TABLET (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
CULTURELLE KIDS COMPLETE ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
CULTURELLE KIDS PROBIOTIC-MV ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
cvs chewable childrens vitamin oral tablet chewable 18 mg	COVERED - cDL	
cvs one daily mens 50+ adv oral tablet	COVERED - cDL	QL (1 EA per 1 day)
cvs prenatal gummy oral tablet chewable 0.4-113.5 mg	COVERED - cDL	QL (1 EA per 1 day)
daily vitamin/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
daily vite multivitamin/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
daily-vite oral tablet	COVERED - cDL	QL (1 EA per 1 day)
b complex-c-folic acid (Dialyvite Oral Tablet)	COVERED - cDL	
FLINSTONES GUMMIES OMEGA-3 DHA ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
FLINTSTONES MULTIVITAMIN ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
FLINTSTONES PLUS CALCIUM ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
folbee plus oral tablet	COVERED - cDL	
folika-bc oral tablet 1 mg	COVERED - cDL	
fruity chews oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
fruity chews/iron oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
gnp childrens chewables/ex c oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
gnp childrens chewables/iron oral tablet chewable 15 mg	COVERED - cDL	QL (1 EA per 1 day)
gnp little ones childrens oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
HEALTHY MAMA BE WELL ROUNDED ORAL THERAPY PACK 28-0.8 & 450 MG (*prenatal-fe bisgly-fa-omega 3*)	COVERED - cDL	QL (1 EA per 1 day)
ICAPS ORAL CAPSULE (*multiple vitamins-minerals*)	COVERED - cDL	
INATAL GT ORAL TABLET (*prenatal vit-dss-fe cbn-fa*)	COVERED - cDL	QL (1 EA per 1 day)
kpn prenatal oral tablet 0.1 mg	COVERED - cDL	QL (1 EA per 1 day)
LAND BEFORE TIME MULTIVITAMIN ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
LAND BEFORE TIME MULTIVITAMIN ORAL TABLET CHEWABLE 15 MG (*pediatric multivitamins-iron*)	COVERED - cDL	QL (1 EA per 1 day)
little animals oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
LIVITA ADULTS ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
LYSIPLEX PLUS ORAL LIQUID (*multiple vitamins-minerals*)	COVERED - cDL	QL (1 ML per 1 day)
m-natal plus oral tablet 27-1 mg	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
multiple vitamins/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
multiple vitamins-iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
multiple vitamins-iron oral tablet chewable 15 mg	COVERED - cDL	QL (1 EA per 1 day)
multivit/multimineral adult oral liquid	COVERED - cDL	QL (1 ML per 1 day)
multivitamin childrens (w/ fa) oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
multivitamin childrens oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
multivitamin oral liquid	COVERED - cDL	QL (1 ML per 1 day)
multivitamin plus iron adult oral tablet	COVERED - cDL	QL (1 EA per 1 day)
multivitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	COVERED - cDL	QL (1.67 ML per 1 day)
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg	COVERED - cDL	QL (1 EA per 1 day)
multivitamin/fluoride oral tablet chewable 1 mg	COVERED - cDL	QL (2 EA per 1 day)
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	COVERED - cDL	QL (1.67 ML per 1 day)
multi-vitamin/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
multi-vite oral liquid	COVERED - cDL	QL (1 ML per 1 day)
multi-vit-flor oral tablet chewable 0.5 mg	COVERED - cDL	QL (1 EA per 1 day)
MVW COMPLETE FORMULATION ORAL SOLUTION (*pediatric multivit-minerals*)	COVERED - cDL	
NATALVIT ORAL TABLET (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
nat-rul daily-vite+iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
neonatal complete oral tablet 27-1 mg	COVERED - cDL	QL (1 EA per 1 day)
NEONATAL PLUS ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
b complex-c-folic acid (Nephronex Oral Tablet)	COVERED - cDL	
NEPHRO-VITE ORAL TABLET 0.8 MG (*b complex-c-folic acid*)	COVERED - cDL	
NIVA-PLUS ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
one daily multivitamin/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
one vite womens plus oral tablet 27-1 mg	COVERED - cDL	QL (1 EA per 1 day)
ONE-A-DAY VITACRAVES+OMEGA-3 ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
ONE-A-DAY WOMENS PRENATAL ORAL 28-0.8 & 223 MG (*prenatal vit-fe fum-fa-omega*)	COVERED - cDL	QL (1 EA per 1 day)
one-daily multi-vitamin/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
one-daily/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
pnv prenatal plus multivitamin oral tablet 27-1 mg	COVERED - cDL	QL (1 EA per 1 day)
POLY-VI-SOL ORAL SOLUTION (*pediatric multiple vitamins*)	COVERED - cDL	QL (50 ML per 25 days)
POLY-VI-SOL/IRON ORAL SOLUTION 11 MG/ML (*pediatric multivitamins-iron*)	COVERED - cDL	QL (50 ML per 25 days)
poly-vitamin/iron oral solution 10 mg/ml	COVERED - cDL	QL (50 ML per 25 days)
PRENATABS RX ORAL TABLET 29-1 MG (*prenatal vit-iron carbonyl-fa*)	COVERED - cDL	QL (1 EA per 1 day)
prenatal (w/iron & fa) oral tablet 27-0.8 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal + complete multi oral therapy pack 0.267 & 373 mg	COVERED - cDL	QL (2 EA per 1 day)
prenatal complete oral tablet 14-0.4 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal formula a-free oral tablet 9-0.267 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal formula oral capsule 28-0.8-235 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal multi +dha oral capsule 27-0.8-228 mg, 27-0.8-250 mg	COVERED - cDL	QL (1 EA per 1 day)
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG (*prenatal mv-min-fe fum-fa-dha*)	COVERED - cDL	QL (2 EA per 1 day)
prenatal oral tablet 27-0.8 mg, 27-1 mg, 6.75-0.2 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal plus oral tablet 27-1 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal plus vitamin/mineral oral tablet 27-1 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal vitamin and mineral oral tablet 28-0.8 mg	COVERED - cDL	QL (1 EA per 1 day)
prenatal+dha oral 28-0.975 & 200 mg	COVERED - cDL	QL (1 EA per 1 day)
PRENATRIX ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
PRENATRYL ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
qc childrens vitamins/extra c oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
qc childrens vitamins/iron oral tablet chewable 15 mg	COVERED - cDL	QL (1 EA per 1 day)
qc daily multivitamins/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
rena-vite rx oral tablet 1 mg	COVERED - cDL	
se-natal 19 oral tablet 29-1 mg	COVERED - cDL	QL (1 EA per 1 day)
sm animal shapes kids first oral tablet chewable	COVERED - cDL	QL (1 EA per 1 day)
sm multiple vitamins/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
sm one daily prenatal oral 28-0.8 & 440 mg	COVERED - cDL	QL (1 EA per 1 day)
stress b complex/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
stress formula/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
support oral liquid	COVERED - cDL	QL (1 ML per 1 day)
tab-a-vite/iron oral tablet	COVERED - cDL	QL (1 EA per 1 day)
TAB-A-VITE/IRON/BETA CAROTENE ORAL TABLET (*multiple vitamins-iron*)	COVERED - cDL	QL (1 EA per 1 day)
THERANATAL CORE NUTRITION ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
thrivite rx oral tablet 29-1 mg	COVERED - cDL	QL (1 EA per 1 day)
tm-vite rx oral tablet 1 mg	COVERED - cDL	
TRICARE ORAL TABLET (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
trinatal rx 1 oral tablet 60-1 mg	COVERED - cDL	QL (1 EA per 1 day)
triphrocaps oral capsule 1 mg	COVERED - cDL	QL (2 EA per 1 day)
TRI-VI-SOL A/C/D ORAL SOLUTION 250-50-10 (*pediatric vitamins adc*)	COVERED - cDL	QL (50 ML per 25 days)
tri-vite pediatric oral solution 750-400-35 unit-mg/ml	COVERED - cDL	QL (50 ML per 25 days)
tri-vite/fluoride oral solution 0.5 mg/ml	COVERED - cDL	QL (1.67 ML per 1 day)
tronvite oral tablet 1 mg	COVERED - cDL	
tropical liquid nutrition oral liquid	COVERED - cDL	QL (1 ML per 1 day)

Drug Name	Drug Tier	Requirements/Limits
VINATE II ORAL TABLET 29-1 MG (*prenatal vit w/ fe bisg-fa*)	COVERED - cDL	QL (1 EA per 1 day)
VITAFOL-OB ORAL TABLET (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
vitasure oral tablet 1 mg	COVERED - cDL	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	COVERED - cDL	QL (1 EA per 1 day)
westab plus oral tablet 27-1 mg	COVERED - cDL	QL (1 EA per 1 day)
ZELDANA ORAL CAPSULE (*multiple vitamin*)	COVERED - cDL	QL (1 EA per 1 day)
ZOO FRIENDS/EXTRA C ORAL TABLET CHEWABLE (*pediatric multiple vitamins*)	COVERED - cDL	QL (1 EA per 1 day)
MUSCULOSKELETAL THERAPY AGENTS		
AMRIX ORAL CAPSULE EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (*cyclobenzaprine hcl*)	NOT COVERED PA Required	
baclofen oral solution 10 mg/5ml, 5 mg/5ml	NOT COVERED PA Required	
baclofen oral suspension 25 mg/5ml	NOT COVERED PA Required	
baclofen oral tablet 10 mg	COVERED - sPDL	QL (3 EA per 1 day)
baclofen oral tablet 15 mg	COVERED - sPDL	
baclofen oral tablet 20 mg, 5 mg	COVERED - sPDL	QL (4 EA per 1 day)
carisoprodol oral tablet 250 mg, 350 mg	NOT COVERED PA Required	
chlorzoxazone oral tablet 250 mg, 375 mg, 750 mg	COVERED - sPDL	
chlorzoxazone oral tablet 500 mg	COVERED - sPDL	QL (6 EA per 1 day)
cyclobenzaprine hcl er oral capsule extended release 24 hour 15 mg, 30 mg	NOT COVERED PA Required	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (3 EA per 1 day)
cyclobenzaprine hcl oral tablet 7.5 mg	COVERED - sPDL	
DANTRIUM ORAL CAPSULE 25 MG (*dantrolene sodium*)	NOT COVERED PA Required	
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	COVERED - cDL	PA; QL (6 ML per 180 days)
cyclobenzaprine hcl (Fexmid Oral Tablet 7.5 Mg)	NOT COVERED PA Required	
FLEQSUVY ORAL SUSPENSION 25 MG/5ML (*baclofen*)	NOT COVERED PA Required	
chlorzoxazone (Lorzone Oral Tablet 375 Mg, 750 Mg)	NOT COVERED PA Required	
LYVISPAH ORAL PACKET 10 MG, 20 MG, 5 MG (*baclofen*)	NOT COVERED PA Required	
metaxalone oral tablet 400 mg, 800 mg	NOT COVERED PA Required	
methocarbamol oral tablet 500 mg	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
methocarbamol oral tablet 750 mg	COVERED - sPDL	QL (10 EA per 1 day); AGE (Max 64 Years)
norgesic forte oral tablet 50-770-60 mg	NOT COVERED PA Required	
orphenadrine-aspirin-caffeine (Norgesic Oral Tablet 25-385-30 Mg)	NOT COVERED PA Required	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	COVERED - sPDL	QL (2 EA per 1 day)
orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg	NOT COVERED PA Required	
orphenadrine-aspirin-caffeine (Orphengesic Forte Oral Tablet 50-770-60 Mg)	NOT COVERED PA Required	
SOMA ORAL TABLET 250 MG, 350 MG (*carisoprodol*)	NOT COVERED PA Required	
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg	NOT COVERED PA Required	
tizanidine hcl oral tablet 2 mg	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
tizanidine hcl oral tablet 4 mg	COVERED - sPDL	QL (9 EA per 1 day); AGE (Max 64 Years)
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG (*tizanidine hcl*)	NOT COVERED PA Required	
ZANAFLEX ORAL TABLET 4 MG (*tizanidine hcl*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
NASAL AGENTS - SYSTEMIC AND TOPICAL		
12 hour nasal decongestant nasal solution 0.05 %	COVERED - cDL	
AFRIN SALINE NASAL MIST NASAL SOLUTION 0.65 % (*saline*)	COVERED - cDL	QL (1 ML per 1 day)
altamist spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
AYR NASAL SOLUTION 0.65 % (*saline*)	COVERED - cDL	QL (1 ML per 1 day)
azelastine hcl nasal solution 0.1 %	COVERED - sPDL	QL (30 ML per 25 days)
azelastine hcl nasal solution 0.15 %	NOT COVERED PA Required	
azelastine hcl nasal solution 137 mcg/spray	COVERED - sPDL	
azelastine-fluticasone nasal suspension 137-50 mcg/act	NOT COVERED PA Required	
BABY AYR SALINE NASAL SOLUTION 0.65 % (*saline*)	COVERED - cDL	QL (1 ML per 1 day)
budesonide nasal suspension 32 mcg/act	COVERED - cDL	QL (8.43 ML per 25 days); AGE (Min 6 Years)
cvs saline nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
deep sea nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
DYMISTA NASAL SUSPENSION 137-50 MCG/ACT (*azelastine-fluticasone*)	NOT COVERED PA Required	
eq saline nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
eql saline nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
flunisolide nasal solution 25 mcg/act (0.025%)	NOT COVERED PA Required	
fluticasone propionate nasal suspension 50 mcg/act	COVERED - sPDL	QL (16 GM per 25 days); AGE (Min 4 Years)
gnp nasal moisturizing nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
ipratropium bromide nasal solution 0.03 %, 0.06 %	COVERED - sPDL	
meijer saline nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
mometasone furoate nasal suspension 50 mcg/act	COVERED - sPDL	
NASAL MOIST NASAL SOLUTION 0.65 % (*saline*)	COVERED - cDL	QL (1 ML per 1 day)

Drug Name	Drug Tier	Requirements/Limits
nasal moisturizing spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
NASALCROM NASAL AEROSOL SOLUTION 5.2 MG/ACT (*cromolyn sodium*)	COVERED - cDL	QL (52 ML per 25 days)
NOZIN NASAL SANITIZER NASAL KIT 62 % (*alcohol*)	COVERED - cDL	QL (1 ML per 1 day)
NOZIN NASAL SANITIZER POPSWAB NASAL SWAB (*alcohol*)	COVERED - cDL	QL (1 EA per 1 day)
OCEAN FOR KIDS NASAL SOLUTION 0.65 % (*saline*)	COVERED - cDL	QL (1 ML per 1 day)
OCEAN NASAL SPRAY NASAL SOLUTION 0.65 % (*saline*)	COVERED - cDL	QL (1 ML per 1 day)
olopatadine hcl nasal solution 0.6 %	NOT COVERED PA Required	
OMNARIS NASAL SUSPENSION 50 MCG/ACT (*ciclesonide*)	NOT COVERED PA Required	
phenylephrine hcl oral tablet 10 mg	COVERED - cDL	
pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg	COVERED - cDL	QL (2 EA per 1 day)
pseudoephedrine hcl oral tablet 30 mg, 60 mg	COVERED - cDL	QL (6 EA per 1 day)
qc saline nasal relief nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
qc saline nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (*beclomethasone diprop (nasal)*)	NOT COVERED PA Required	
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (*beclomethasone diprop (nasal)*)	NOT COVERED PA Required	
ra saline nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (*olopatadine-mometasone*)	NOT COVERED PA Required	
saline mist spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
saline nasal spray nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
sb saline nose nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
sm nasal spray saline nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
sodium chloride nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)

Drug Name	Drug Tier	Requirements/Limits
SUDAFED CHILDRENS ORAL LIQUID 15 MG/5ML (*pseudoephedrine hcl*)	COVERED - cDL	QL (1 ML per 1 day)
SUDAFED PE CHILDRENS ORAL SOLUTION 2.5 MG/5ML (*phenylephrine hcl*)	COVERED - cDL	
triamcinolone acetonide nasal aerosol 55 mcg/act	COVERED - cDL	QL (17 ML per 25 days); AGE (Min 2 Years)
true nasal moisturizing nasal solution 0.65 %	COVERED - cDL	QL (1 ML per 1 day)
XHANCE NASAL EXHALER SUSPENSION 93 MCG/ACT (*fluticasone propionate*)	NOT COVERED PA Required	
ZETONNA NASAL AEROSOL SOLUTION 37 MCG/ACT (*ciclesonide*)	NOT COVERED PA Required	
NUTRIENTS		
dha complete oral capsule 200 mg	COVERED - cDL	QL (1 EA per 1 day)
fish oil extra strength oral capsule 1200 mg	COVERED - cDL	
fish oil oral capsule 500 mg	COVERED - cDL	
fish oil oral capsule delayed release 1200 mg	COVERED - cDL	
odorless coated fish oil oral capsule delayed release 1000 mg	COVERED - cDL	
omega-3 fish oil oral capsule 1000 mg	COVERED - cDL	
OPHTHALMIC AGENTS		
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (*ketorolac tromethamine*)	NOT COVERED PA Required	
ACULAR OPHTHALMIC SOLUTION 0.5 % (*ketorolac tromethamine*)	NOT COVERED PA Required	
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (*ketorolac tromethamine*)	NOT COVERED PA Required	
ALAWAY CHILDRENS ALLERGY OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	COVERED - sPDL	
ALAWAY OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	COVERED - sPDL	
ALOCRIL OPHTHALMIC SOLUTION 2 % (*nedocromil sodium*)	COVERED - sPDL	
ALOMIDE OPHTHALMIC SOLUTION 0.1 % (*lodoxamide tromethamine*)	COVERED - sPDL	
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %, 0.15 % (*brimonidine tartrate*)	COVERED - sPDL	
ALREX OPHTHALMIC SUSPENSION 0.2 % (*loteprednol etabonate*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
apraclonidine hcl ophthalmic solution 0.5 %	NOT COVERED PA Required	
artificial tears ophthalmic solution 0.1-0.3 %, 0.5-0.6 %	COVERED - cDL	
artificial tears pf ophthalmic solution 0.1-0.3 %	COVERED - cDL	
atropine sulfate ophthalmic solution 1 %	COVERED - cDL	
AZASITE OPHTHALMIC SOLUTION 1 % (*azithromycin*)	NOT COVERED PA Required	
azelastine hcl ophthalmic solution 0.05 %	NOT COVERED PA Required	QL (6 ML per 25 days)
AZOPT OPHTHALMIC SUSPENSION 1 % (*brinzolamide*)	COVERED - sPDL	
bacitracin ophthalmic ointment 500 unit/gm	COVERED - cDL	
bepotastine besilate ophthalmic solution 1.5 %	NOT COVERED PA Required	
BEPREVE OPHTHALMIC SOLUTION 1.5 % (*bepotastine besilate*)	NOT COVERED PA Required	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (*besifloxacin hcl*)	NOT COVERED PA Required	
betaxolol hcl ophthalmic solution 0.5 %	COVERED - sPDL	
BETIMOL OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol hemihydrate*)	NOT COVERED PA Required	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (*betaxolol hcl*)	NOT COVERED PA Required	
bimatoprost ophthalmic solution 0.03 %	NOT COVERED PA Required	ST; Please use Latanoprost
brimonidine tartrate ophthalmic solution 0.1 %	NOT COVERED PA Required	
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	COVERED - sPDL	
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	NOT COVERED PA Required	
brinzolamide ophthalmic suspension 1 %	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	NOT COVERED PA Required	
bromfenac sodium ophthalmic solution 0.07 %, 0.075 %	NOT COVERED PA Required	
BROMSITE OPHTHALMIC SOLUTION 0.075 % (*bromfenac sodium*)	NOT COVERED PA Required	
carteolol hcl ophthalmic solution 1 %	COVERED - sPDL	QL (15 ML per 25 days)
CEQUA OPHTHALMIC SOLUTION 0.09 % (*cyclosporine*)	NOT COVERED PA Required	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (*ciprofloxacin hcl*)	NOT COVERED PA Required	
ciprofloxacin hcl ophthalmic solution 0.3 %	COVERED - sPDL	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (*brimonidine tartrate-timolol*)	COVERED - sPDL	
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (*dorzolamide hcl-timolol mal*)	NOT COVERED PA Required	
COSOPT PF OPHTHALMIC SOLUTION 2-0.5 % (*dorzolamide hcl-timolol mal*)	NOT COVERED PA Required	
cromolyn sodium ophthalmic solution 4 %	COVERED - sPDL	
cyclopentolate hcl ophthalmic solution 1 %	COVERED - cDL	QL (15 ML per 25 days)
cyclosporine ophthalmic emulsion 0.05 %	NOT COVERED PA Required	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	COVERED - cDL	
diclofenac sodium ophthalmic solution 0.1 %	COVERED - sPDL	
dorzolamide hcl ophthalmic solution 2 %	COVERED - sPDL	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	COVERED - sPDL	QL (10 ML per 25 days)
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	NOT COVERED PA Required	
dry eye relief drops ophthalmic solution 0.2-0.2-1 %	COVERED - cDL	
epinastine hcl ophthalmic solution 0.05 %	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
erythromycin ophthalmic ointment 5 mg/gm	COVERED - cDL	
eye itch relief ophthalmic solution 0.035 %	COVERED - sPDL	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (*loteprednol etabonate*)	NOT COVERED PA Required	
fluorometholone ophthalmic suspension 0.1 %	COVERED - cDL	QL (15 ML per 25 days)
flurbiprofen sodium ophthalmic solution 0.03 %	COVERED - sPDL	
gatifloxacin ophthalmic solution 0.5 %	NOT COVERED PA Required	
gentamicin sulfate ophthalmic solution 0.3 %	COVERED - cDL	QL (10 ML per 30 days)
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (*nepafenac*)	NOT COVERED PA Required	
IOPIDINE OPHTHALMIC SOLUTION 1 % (*apraclonidine hcl*)	NOT COVERED PA Required	
ISTALOL OPHTHALMIC SOLUTION 0.5 % (*timolol maleate*)	NOT COVERED PA Required	
IYUZEH OPHTHALMIC SOLUTION 0.005 % (*latanoprost*)	NOT COVERED PA Required	
ketorolac tromethamine ophthalmic solution 0.5 %	COVERED - sPDL	QL (10 ML per 25 days)
ketotifen fumarate ophthalmic solution 0.035 %	COVERED - sPDL	
latanoprost ophthalmic solution 0.005 %	COVERED - sPDL	QL (5 ML per 25 days)
levobunolol hcl ophthalmic solution 0.5 %	COVERED - sPDL	QL (15 ML per 25 days)
loteprednol etabonate ophthalmic suspension 0.2 %	NOT COVERED PA Required	
lubricant eye drops (pf) ophthalmic solution 0.4-0.3 %	COVERED - cDL	
lubricant eye drops ophthalmic solution 0.4-0.3 %, 0.5 %	COVERED - cDL	
lubricant eye drops pf ophthalmic solution 0.5 %	COVERED - cDL	
lubricant pm ophthalmic ointment	COVERED - cDL	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (*bimatoprost*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (*perfluorohexyloctane*)	NOT COVERED PA Required	
MOISTURE EYES OPHTHALMIC SOLUTION 1-0.3 % (*propylene glycol-glycerin*)	COVERED - cDL	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	NOT COVERED PA Required	
moxifloxacin hcl ophthalmic solution 0.5 %	NOT COVERED PA Required	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	COVERED - cDL	
neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %	COVERED - cDL	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	COVERED - cDL	
bacitracin-polymyx-neo-hc (Neo-Polycin Hc Ophthalmic Ointment 1 %)	COVERED - cDL	
neomycin-bacitracin zn-polymyx (Neo-Polycin Ophthalmic Ointment 3.5-400-10000)	COVERED - cDL	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (*nepafenac*)	COVERED - sPDL	
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (*ofloxacin*)	NOT COVERED PA Required	
ofloxacin ophthalmic solution 0.3 %	NOT COVERED PA Required	
olopatadine hcl ophthalmic solution 0.1 %	COVERED - sPDL	QL (5 ML per 30 days)
olopatadine hcl ophthalmic solution 0.2 %	COVERED - sPDL	QL (2.5 ML per 30 days)
bacitracin-polymyxin b (Polycin Ophthalmic Ointment 500-10000 Unit/Gm)	COVERED - cDL	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	COVERED - cDL	
polyvinyl alcohol ophthalmic solution 1.4 %	COVERED - cDL	
prednisolone acetate ophthalmic suspension 1 %	COVERED - cDL	
PROLENSA OPHTHALMIC SOLUTION 0.07 % (*bromfenac sodium*)	NOT COVERED PA Required	
proparacaine hcl ophthalmic solution 0.5 %	COVERED - cDL	
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	COVERED - sPDL	
RESTASIS OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (*brinzolamide-brimonidine*)	NOT COVERED PA Required	
sodium chloride (hypertonic) ophthalmic ointment 5 %	COVERED - cDL	
sodium chloride (hypertonic) ophthalmic solution 5 %	COVERED - cDL	
sulfacetamide sodium ophthalmic solution 10 %	COVERED - cDL	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	COVERED - cDL	
SYSTANE CONTACTS OPHTHALMIC SOLUTION (*artificial tear solution*)	COVERED - cDL	
tafluprost (pf) ophthalmic solution 0.0015 %	NOT COVERED PA Required	
timolol maleate (once-daily) ophthalmic solution 0.5 %	COVERED - sPDL	
timolol maleate (Timolol Maleate Ocudose Ophthalmic Solution 0.5 %)	COVERED - sPDL	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	COVERED - sPDL	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	COVERED - sPDL	
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	COVERED - sPDL	
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol maleate*)	NOT COVERED PA Required	
tobramycin ophthalmic solution 0.3 %	NOT COVERED PA Required	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	COVERED - cDL	
TOBREX OPHTHALMIC OINTMENT 0.3 % (*tobramycin*)	NOT COVERED PA Required	
TRAVATAN Z OPHTHALMIC SOLUTION 0.004 % (*travoprost*)	COVERED - sPDL	
travoprost (bak free) ophthalmic solution 0.004 %	NOT COVERED PA Required	
trifluridine ophthalmic solution 1 %	COVERED - cDL	QL (7.5 ML per 25 days)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (*varenicline tartrate*)	NOT COVERED PA Required	
VERKAZIA OPHTHALMIC EMULSION 0.1 % (*cyclosporine*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
VEVYE OPHTHALMIC SOLUTION 0.1 % (*cyclosporine*)	NOT COVERED PA Required	
VIGAMOX OPHTHALMIC SOLUTION 0.5 % (*moxifloxacin hcl*)	COVERED - sPDL	
VYZULTA OPHTHALMIC SOLUTION 0.024 % (*latanoprostene bunod*)	NOT COVERED PA Required	
XALATAN OPHTHALMIC SOLUTION 0.005 % (*latanoprost*)	NOT COVERED PA Required	
XELPROS OPHTHALMIC EMULSION 0.005 % (*latanoprost*)	NOT COVERED PA Required	
XIIDRA OPHTHALMIC SOLUTION 5 % (*lifitegrast*)	COVERED - sPDL	
ZADITOR OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	COVERED - sPDL	
ZERVIATE OPHTHALMIC SOLUTION 0.24 % (*cetirizine hcl*)	NOT COVERED PA Required	
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (*tafluprost*)	NOT COVERED PA Required	
OTIC AGENTS		
acetic acid otic solution 2 %	COVERED - cDL	QL (20 ML per 25 days)
CIPRO HC OTIC SUSPENSION 0.2-1 % (*ciprofloxacin-hydrocortisone*)	NOT COVERED PA Required	
ciprofloxacin hcl otic solution 0.2 %	NOT COVERED PA Required	QL (14 EA per 25 days)
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	COVERED - sPDL	
ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %	NOT COVERED PA Required	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (*neomycin-colist-hc-thonzonium*)	NOT COVERED PA Required	
ear drops otic solution 6.5 %	COVERED - cDL	
hydrocortisone-acetic acid otic solution 1-2 %	COVERED - cDL	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	COVERED - sPDL	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
ofloxacin otic solution 0.3 %	COVERED - sPDL	QL (5 ML per 25 days)
ra ear drying agent otic liquid 95-5 %	COVERED - cDL	
OXYTOCICS		
methylergonovine maleate oral tablet 0.2 mg	COVERED - cDL	QL (7 EA per 1 day)
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
MICRHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 250 UNIT (*rho d immune globulin*)	COVERED - cDL	
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT (*rho d immune globulin*)	COVERED - cDL	
RHOPHYLAC INJECTION SOLUTION PREFILLED SYRINGE 1500 UNIT/2ML (*rho d immune globulin*)	COVERED - cDL	
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML (*palivizumab*)	COVERED - cDL	PA
PENICILLINS		
amoxicillin oral capsule 250 mg, 500 mg	COVERED - cDL	QL (8 EA per 1 day)
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	COVERED - cDL	
amoxicillin oral tablet 500 mg	COVERED - cDL	QL (5 EA per 1 day)
amoxicillin oral tablet 875 mg	COVERED - cDL	QL (4 EA per 1 day)
amoxicillin oral tablet chewable 125 mg	COVERED - cDL	QL (6 EA per 1 day)
amoxicillin oral tablet chewable 250 mg	COVERED - cDL	QL (8 EA per 1 day)
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	COVERED - cDL	AGE (Max 12 Years)
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	COVERED - cDL	QL (2 EA per 1 day); 10
amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg	COVERED - cDL	QL (3 EA per 1 day); AGE (Max 12 Years)
amoxicillin-pot clavulanate oral tablet chewable 400-57 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Max 12 Years)
ampicillin oral capsule 500 mg	COVERED - cDL	QL (8 EA per 1 day)
dicloxacillin sodium oral capsule 250 mg	COVERED - cDL	QL (8 EA per 1 day)
dicloxacillin sodium oral capsule 500 mg	COVERED - cDL	QL (6 EA per 1 day)
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	COVERED - cDL	QL (40 ML per 1 day)
penicillin v potassium oral tablet 250 mg, 500 mg	COVERED - cDL	QL (8 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
PHARMACEUTICAL ADJUVANTS		
banana cream flavor liquid	COVERED - cDL	
benzyl alcohol liquid	COVERED - cDL	AGE (Min 16 Years and Max 60 Years)
cherry oral syrup	COVERED - cDL	
flavor sweet oral syrup	COVERED - cDL	
methylparaben powder	COVERED - cDL	
propylparaben powder	COVERED - cDL	
simple syrup oral syrup	COVERED - cDL	
sterile water for injection injection solution	COVERED - cDL	
PROGESTINS		
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	COVERED - cDL	QL (2 EA per 1 day)
megestrol acetate oral suspension 625 mg/5ml	NOT COVERED PA Required	
norethindrone acetate oral tablet 5 mg	COVERED - cDL	QL (1 EA per 1 day)
progesterone oral capsule 100 mg	COVERED - cDL	QL (1 EA per 1 day)
progesterone oral capsule 200 mg	COVERED - cDL	QL (2 EA per 1 day)
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
acamprosate calcium oral tablet delayed release 333 mg	COVERED - cDL	
ADLARITY TRANSDERMAL PATCH WEEKLY 10 MG/DAY, 5 MG/DAY (*donepezil hcl*)	NOT COVERED PA Required	
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HOUR 10 MG (*dalfampridine*)	NOT COVERED PA Required	
ARICEPT ORAL TABLET 10 MG, 23 MG, 5 MG (*donepezil hcl*)	NOT COVERED PA Required	
AUBAGIO ORAL TABLET 14 MG, 7 MG (*teriflunomide*)	NOT COVERED PA Required	
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (*deutetrabenazine*)	COVERED - sPDL	
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 24 MG, 6 MG (*deutetrabenazine*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 6 & 12 & 24 MG (*deutetrabenazine*)	NOT COVERED PA Required	
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (*interferon beta-1a*)	COVERED - sPDL	PA
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (*interferon beta-1a*)	COVERED - sPDL	PA
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (*monomethyl fumarate*)	NOT COVERED PA Required	
BETASERON SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*)	COVERED - sPDL	
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	COVERED - sPDL	QL (2 EA per 1 day); 90DS
CHANTIX ORAL TABLET 1 MG (*varenicline tartrate*)	COVERED - sPDL	
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (*glatiramer acetate*)	COVERED - sPDL	
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (*glatiramer acetate*)	NOT COVERED PA Required	
dalfampridine er oral tablet extended release 12 hour 10 mg	NOT COVERED PA Required	
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	COVERED - sPDL	PA; QL (2 EA per 1 day)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	COVERED with Clinical Criteria	PA
disulfiram oral tablet 250 mg, 500 mg	COVERED - cDL	QL (1 EA per 1 day)
donepezil hcl oral tablet 10 mg, 5 mg	COVERED - sPDL	QL (1 EA per 1 day)
donepezil hcl oral tablet 23 mg	NOT COVERED PA Required	
donepezil hcl oral tablet dispersible 10 mg	COVERED - sPDL	QL (1 EA per 1 day)
donepezil hcl oral tablet dispersible 5 mg	COVERED - sPDL	QL (2 EA per 1 day)
EXELON TRANSDERMAL PATCH 24 HOUR 13.3 MG/24HR, 4.6 MG/24HR, 9.5 MG/24HR (*rivastigmine*)	COVERED - sPDL	
EXTAVIA SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*)	NOT COVERED PA Required	
fingolimod hcl oral capsule 0.5 mg	NOT COVERED PA Required	
fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	
ft nicotine mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	
gabapentin (once-daily) oral tablet 300 mg, 600 mg	NOT COVERED PA Required	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	NOT COVERED PA Required	
galantamine hydrobromide oral solution 4 mg/ml	NOT COVERED PA Required	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	NOT COVERED PA Required	
GILENYA ORAL CAPSULE 0.25 MG, 0.5 MG (*fingolimod hcl*)	NOT COVERED PA Required	
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml	NOT COVERED PA Required	
glatiramer acetate (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/Ml, 40 Mg/Ml)	NOT COVERED PA Required	
gnp nicotine mini mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	
gnp nicotine mouth/throat gum 2 mg, 4 mg	COVERED - sPDL	
gnp nicotine polacrilex mouth/throat gum 2 mg, 4 mg	COVERED - sPDL	
gnp nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	
gnp nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	COVERED - sPDL	
goodsense nicotine mouth/throat gum 2 mg, 4 mg	COVERED - sPDL	
goodsense nicotine mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	
GRALISE ORAL 300 (9) & 600(24) MG (*gabapentin (once-daily)*)	NOT COVERED PA Required	
GRALISE ORAL TABLET 300 MG, 450 MG, 600 MG, 750 MG, 900 MG (*gabapentin (once-daily)*)	NOT COVERED PA Required	
hm nicotine polacrilex mouth/throat gum 2 mg	COVERED - sPDL	
hm nicotine polacrilex mouth/throat lozenge 2 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG, 600 MG (*gabapentin enacarbil*)	NOT COVERED PA Required	
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (*valbenazine tosylate*)	COVERED - sPDL	
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (*valbenazine tosylate*)	COVERED - sPDL	
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (*ofatumumab*)	NOT COVERED PA Required	
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (*olanzapine-samidorphan*)	NOT COVERED PA Required	
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 165 MG, 330 MG, 82.5 MG (*pregabalin*)	NOT COVERED PA Required	
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NOT COVERED PA Required	
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NOT COVERED PA Required	
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NOT COVERED PA Required	
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NOT COVERED PA Required	
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NOT COVERED PA Required	
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NOT COVERED PA Required	
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NOT COVERED PA Required	
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG (*siponimod fumarate*)	NOT COVERED PA Required	
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG, 7 X 0.25 MG (*siponimod fumarate*)	NOT COVERED PA Required	
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	NOT COVERED PA Required	
memantine hcl oral solution 2 mg/ml	COVERED - sPDL	
memantine hcl oral tablet 10 mg, 5 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg	NOT COVERED PA Required	
NAMENDA TITRATION PAK ORAL TABLET 28 X 5 MG & 21 X 10 MG (*memantine hcl*)	NOT COVERED PA Required	
NAMENDA XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14 MG, 21 MG, 28 MG (*memantine hcl*)	NOT COVERED PA Required	
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG (*memantine hcl-donepezil hcl*)	NOT COVERED PA Required	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (*memantine hcl-donepezil hcl*)	NOT COVERED PA Required	
nicotine mini mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	
nicotine polacrilex mini mouth/throat lozenge 2 mg	COVERED - sPDL	
nicotine polacrilex mouth/throat gum 2 mg	COVERED - sPDL	QL (8 EA per 1 day); MAX 3 FILLS/365 DAYS
nicotine polacrilex mouth/throat gum 4 mg	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 18 Years); MAX 3 FILLS/365 DAYS
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	QL (8 EA per 1 day); MAX 3 FILLS/365 DAYS
nicotine step 1 transdermal patch 24 hour 21 mg/24hr	COVERED - sPDL	
nicotine step 2 transdermal patch 24 hour 14 mg/24hr	COVERED - sPDL	
nicotine step 3 transdermal patch 24 hour 7 mg/24hr	COVERED - sPDL	
nicotine transdermal kit 21-14-7 mg/24hr	COVERED - sPDL	
nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	COVERED - sPDL	QL (1 EA per 1 day)
NICOTROL INHALATION INHALER 10 MG (*nicotine*)	COVERED - sPDL	QL (16 EA per 1 day)
NICOTROL NS NASAL SOLUTION 10 MG/ML (*nicotine*)	COVERED - sPDL	QL (4 ML per 1 day); AGE (Min 18 Years)
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	NOT COVERED PA Required	
paroxetine mesylate oral capsule 7.5 mg	NOT COVERED PA Required	
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	NOT COVERED PA Required	
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	NOT COVERED PA Required	
PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR 125 MCG/0.5ML (*peginterferon beta-1a*)	NOT COVERED PA Required	
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	NOT COVERED PA Required	
PONVORY ORAL TABLET 20 MG (*ponesimod*)	NOT COVERED PA Required	
PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG (*ponesimod*)	NOT COVERED PA Required	
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	NOT COVERED PA Required	
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML (*interferon beta-1a*)	NOT COVERED PA Required	
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG (*interferon beta-1a*)	NOT COVERED PA Required	
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (*interferon beta-1a*)	NOT COVERED PA Required	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (*interferon beta-1a*)	NOT COVERED PA Required	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	COVERED - sPDL	
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	NOT COVERED PA Required	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (*milnacipran hcl*)	NOT COVERED PA Required	
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (*milnacipran hcl*)	NOT COVERED PA Required	
sm nicotine mouth/throat gum 4 mg	COVERED - sPDL	
sm nicotine mouth/throat lozenge 2 mg	COVERED - sPDL	
sm nicotine polacrilex mouth/throat gum 2 mg, 4 mg	COVERED - sPDL	

Drug Name	Drug Tier	Requirements/Limits
sm nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	COVERED - sPDL	
sm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	COVERED - sPDL	
sodium oxybate oral solution 500 mg/ml	COVERED - cDL	PA
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (*olanzapine-fluoxetine hcl*)	NOT COVERED PA Required	
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG, 0.5 MG (*fingolimod lauryl sulfate*)	NOT COVERED PA Required	
TECFIDERA ORAL CAPSULE DELAYED RELEASE 120 MG, 240 MG (*dimethyl fumarate*)	NOT COVERED PA Required	
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG (*dimethyl fumarate*)	NOT COVERED PA Required	
teriflunomide oral tablet 14 mg, 7 mg	NOT COVERED PA Required	
tetrabenazine oral tablet 12.5 mg, 25 mg	COVERED - sPDL	PA
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	NOT COVERED PA Required	
varenicline tartrate oral tablet 0.5 mg, 1 mg	NOT COVERED PA Required	
varenicline tartrate(continue) oral tablet 1 mg	NOT COVERED PA Required	
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG (*diroximel fumarate*)	NOT COVERED PA Required	
XENAZINE ORAL TABLET 12.5 MG, 25 MG (*tetrabenazine*)	NOT COVERED PA Required	
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (*ozanimod hcl*)	NOT COVERED PA Required	
ZEPOSIA ORAL CAPSULE 0.92 MG (*ozanimod hcl*)	NOT COVERED PA Required	
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (*ozanimod hcl*)	NOT COVERED PA Required	
RESPIRATORY AGENTS - MISC.		
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (*ivacaftor*)	COVERED - cDL	PA

Drug Name	Drug Tier	Requirements/Limits
KALYDECO ORAL TABLET 150 MG (*ivacaftor*)	COVERED - cDL	PA
ORKAMBI ORAL PACKET 150-188 MG (*lumacaftor-ivacaftor*)	COVERED - cDL	PA
ORKAMBI ORAL TABLET 100-125 MG (*lumacaftor-ivacaftor*)	COVERED - cDL	PA; QL (4 EA per 1 day); AGE (Min 6 Years and Max 11 Years)
ORKAMBI ORAL TABLET 200-125 MG (*lumacaftor-ivacaftor*)	COVERED - cDL	PA; QL (4 EA per 1 day); AGE (Min 11 Years)
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML (*alpha1-proteinase inhibitor*)	COVERED - cDL	PA
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (*dornase alfa*)	COVERED - cDL	PA; QL (1 ML per 1 day)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (*tezacaftor-ivacaftor*)	COVERED - cDL	PA
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG (*elexacaftor-tezacaftor-ivacaft*)	COVERED - cDL	PA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG (*alpha1-proteinase inhibitor*)	COVERED - cDL	PA
TETRACYCLINES		
demeclocycline hcl oral tablet 150 mg, 300 mg	NOT COVERED PA Required	
DORYX MPC ORAL TABLET DELAYED RELEASE 120 MG, 60 MG (*doxycycline hyclate*)	NOT COVERED PA Required	
doxycycline hyclate oral capsule 100 mg, 50 mg	COVERED - sPDL	
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 50 mg, 75 mg	COVERED - sPDL	
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg, 80 mg	NOT COVERED PA Required	
doxycycline monohydrate oral capsule 100 mg, 50 mg	COVERED - sPDL	
doxycycline monohydrate oral capsule 150 mg, 75 mg	NOT COVERED PA Required	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	NOT COVERED PA Required	
doxycycline monohydrate oral tablet 100 mg	NOT COVERED PA Required	QL (3 EA per 1 day)
doxycycline monohydrate oral tablet 150 mg, 50 mg, 75 mg	NOT COVERED PA Required	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
minocycline hcl oral capsule 100 mg, 50 mg	COVERED - sPDL	QL (2 EA per 1 day)
minocycline hcl oral capsule 75 mg	COVERED - sPDL	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	COVERED - sPDL	
MINOLIRA ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG, 135 MG (*minocycline hcl*)	NOT COVERED PA Required	
NUZYRA ORAL TABLET 150 MG (*omadacycline tosylate*)	NOT COVERED PA Required	
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HOUR 105 MG, 55 MG, 65 MG, 80 MG (*minocycline hcl*)	NOT COVERED PA Required	
tetracycline hcl oral capsule 250 mg, 500 mg	COVERED - sPDL	
tetracycline hcl oral tablet 250 mg, 500 mg	COVERED - sPDL	
VIBRAMYCIN ORAL CAPSULE 100 MG (*doxycycline hyclate*)	NOT COVERED PA Required	
THYROID AGENTS		
adthyza oral tablet 130 mg, 16.25 mg, 32.5 mg, 65 mg, 97.5 mg	COVERED - cDL	QL (1 EA per 1 day); AGE (Max 64 Years)
ARMOUR THYROID ORAL TABLET 180 MG, 240 MG, 300 MG (*thyroid*)	COVERED - cDL	QL (1 EA per 1 day); AGE (Max 64 Years)
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	COVERED - cDL	QL (2 EA per 1 day)
methimazole oral tablet 10 mg, 5 mg	COVERED - cDL	QL (6 EA per 1 day)
propylthiouracil oral tablet 50 mg	COVERED - cDL	QL (20 EA per 1 day)
thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	COVERED - cDL	QL (1 EA per 1 day); AGE (Max 64 Years)
TOXOIDS		
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML (*tetanus-diphtheria toxoids td*)	COVERED - cDL	
tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml	COVERED - cDL	
VAXELIS INTRAMUSCULAR SUSPENSION (*dtap-ipv-hib-hepatitis b recmb*)	COVERED - cDL	
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-ipv-hib-hepatitis b recmb*)	COVERED - cDL	
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
acid reducer maximum strength oral tablet 20 mg	COVERED - sPDL	QL (2 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
acid reducer oral tablet 10 mg	COVERED - cDL	QL (2 EA per 1 day)
ACIPHEX ORAL TABLET DELAYED RELEASE 20 MG (*rabeprazole sodium*)	NOT COVERED PA Required	
cimetidine 200 oral tablet 200 mg	COVERED - sPDL	QL (4 EA per 1 day)
cimetidine oral tablet 200 mg	NOT COVERED PA Required	
cimetidine oral tablet 300 mg, 400 mg, 800 mg	NOT COVERED PA Required	QL (2 EA per 1 day)
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG (*dexlansoprazole*)	COVERED - sPDL	
dexlansoprazole oral capsule delayed release 30 mg, 60 mg	NOT COVERED PA Required	
dicyclomine hcl oral capsule 10 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Max 64 Years)
dicyclomine hcl oral solution 10 mg/5ml	COVERED - cDL	QL (80 ML per 1 day); AGE (Max 64 Years)
dicyclomine hcl oral tablet 20 mg	COVERED - cDL	QL (8 EA per 1 day); AGE (Max 64 Years)
esomeprazole magnesium oral capsule delayed release 20 mg	NOT COVERED PA Required	QL (2 EA per 1 day)
esomeprazole magnesium oral capsule delayed release 40 mg	NOT COVERED PA Required	
esomeprazole magnesium oral packet 10 mg, 20 mg, 40 mg	NOT COVERED PA Required	
famotidine oral suspension reconstituted 40 mg/5ml	COVERED - sPDL	QL (5 ML per 1 day); AGE (Max 6 Years)
famotidine oral tablet 20 mg	COVERED - sPDL	
famotidine oral tablet 40 mg	COVERED - sPDL	QL (2 EA per 1 day)
glycopyrrolate oral solution 1 mg/5ml	COVERED - cDL	PA
glycopyrrolate oral tablet 1 mg, 2 mg	COVERED - cDL	
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	COVERED - cDL	QL (4 EA per 1 day); AGE (Max 64 Years)
hyoscyamine sulfate oral elixir 0.125 mg/5ml	COVERED - cDL	QL (60 ML per 1 day); AGE (Max 64 Years)
hyoscyamine sulfate oral solution 0.125 mg/ml	COVERED - cDL	QL (60 ML per 1 day); AGE (Max 64 Years)

Drug Name	Drug Tier	Requirements/Limits
hyoscyamine sulfate oral tablet 0.125 mg	COVERED - cDL	QL (12 EA per 1 day); AGE (Max 64 Years)
hyoscyamine sulfate oral tablet dispersible 0.125 mg	COVERED - cDL	QL (12 EA per 1 day); AGE (Max 64 Years)
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	COVERED - cDL	QL (12 EA per 1 day); AGE (Max 64 Years)
KONVOMEP ORAL SUSPENSION RECONSTITUTED 2-84 MG/ML (*omeprazole-sodium bicarbonate*)	NOT COVERED PA Required	
lansoprazole oral capsule delayed release 15 mg	NOT COVERED PA Required	QL (2 EA per 1 day)
lansoprazole oral capsule delayed release 30 mg	NOT COVERED PA Required	
lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg	COVERED - sPDL	
misoprostol oral tablet 100 mcg, 200 mcg	COVERED - cDL	QL (4 EA per 1 day)
NEXIUM ORAL CAPSULE DELAYED RELEASE 20 MG, 40 MG (*esomeprazole magnesium*)	NOT COVERED PA Required	
NEXIUM ORAL PACKET 10 MG, 2.5 MG, 20 MG, 40 MG, 5 MG (*esomeprazole magnesium*)	COVERED - sPDL	
nizatidine oral capsule 150 mg	NOT COVERED PA Required	ST; QL (4 EA per 1 day); T/F of Famotidine
nizatidine oral capsule 300 mg	NOT COVERED PA Required	
omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg	COVERED - cDL	QL (1 EA per 1 day)
omeprazole magnesium oral tablet delayed release 20 mg	COVERED - cDL	QL (3 EA per 1 day)
omeprazole oral capsule delayed release 10 mg, 20 mg	COVERED - sPDL	QL (3 EA per 1 day)
omeprazole oral capsule delayed release 40 mg	COVERED - sPDL	QL (1 EA per 1 day)
omeprazole oral tablet delayed release 20 mg	COVERED - cDL	QL (3 EA per 1 day)
omeprazole-sodium bicarbonate oral capsule 20-1100 mg, 40-1100 mg	NOT COVERED PA Required	
omeprazole-sodium bicarbonate oral packet 20-1680 mg, 40-1680 mg	NOT COVERED PA Required	
pantoprazole sodium oral packet 40 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
pantoprazole sodium oral tablet delayed release 20 mg	COVERED - sPDL	QL (1 EA per 1 day)
pantoprazole sodium oral tablet delayed release 40 mg	COVERED - sPDL	QL (3 EA per 1 day)
PEPCID ORAL TABLET 20 MG, 40 MG (*famotidine*)	NOT COVERED PA Required	
PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG (*lansoprazole*)	NOT COVERED PA Required	
PREVACID SOLUTAB ORAL TABLET DELAYED RELEASE DISPERSIBLE 15 MG, 30 MG (*lansoprazole*)	NOT COVERED PA Required	
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (*omeprazole magnesium*)	NOT COVERED PA Required	
PROTONIX ORAL PACKET 40 MG (*pantoprazole sodium*)	COVERED - sPDL	
PROTONIX ORAL TABLET DELAYED RELEASE 20 MG, 40 MG (*pantoprazole sodium*)	NOT COVERED PA Required	
rabeprazole sodium oral tablet delayed release 20 mg	NOT COVERED PA Required	
sucralfate oral suspension 1 gm/10ml	COVERED - cDL	QL (40 ML per 1 day); AGE (Max 18 Years)
sucralfate oral tablet 1 gm	COVERED - cDL	QL (4 EA per 1 day)
ZEGERID ORAL CAPSULE 20-1100 MG, 40-1100 MG (*omeprazole-sodium bicarbonate*)	NOT COVERED PA Required	
ZEGERID ORAL PACKET 20-1680 MG, 40-1680 MG (*omeprazole-sodium bicarbonate*)	NOT COVERED PA Required	
URINARY ANTISPASMODICS		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	COVERED - cDL	QL (4 EA per 1 day)
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	NOT COVERED PA Required	
DETROL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 2 MG, 4 MG (*tolterodine tartrate*)	NOT COVERED PA Required	
DETROL ORAL TABLET 1 MG, 2 MG (*tolterodine tartrate*)	NOT COVERED PA Required	
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
flavoxate hcl oral tablet 100 mg	NOT COVERED PA Required	QL (4 EA per 1 day)
GELNIQUE TRANSDERMAL GEL 10 % (*oxybutynin chloride*)	NOT COVERED PA Required	
GEMTESA ORAL TABLET 75 MG (*vibegron*)	NOT COVERED PA Required	
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	NOT COVERED PA Required	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML (*mirabegron*)	NOT COVERED PA Required	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG (*mirabegron*)	NOT COVERED PA Required	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	COVERED - sPDL	ST; QL (1 EA per 1 day); Prior use of oxybutynin required
oxybutynin chloride oral solution 5 mg/5ml	COVERED - sPDL	QL (20 ML per 1 day)
oxybutynin chloride oral tablet 2.5 mg	NOT COVERED PA Required	
oxybutynin chloride oral tablet 5 mg	COVERED - sPDL	QL (3 EA per 1 day)
OXYTROL TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR (*oxybutynin*)	NOT COVERED PA Required	
solifenacin succinate oral tablet 10 mg, 5 mg	COVERED - sPDL	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	NOT COVERED PA Required	
tolterodine tartrate oral tablet 1 mg, 2 mg	NOT COVERED PA Required	ST; QL (2 EA per 1 day); Prior use of oxybutynin required
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (*fesoterodine fumarate*)	COVERED - sPDL	
trospium chloride er oral capsule extended release 24 hour 60 mg	NOT COVERED PA Required	
trospium chloride oral tablet 20 mg	NOT COVERED PA Required	ST; QL (2 EA per 1 day); Prior use of oxybutynin required
VESICARE LS ORAL SUSPENSION 5 MG/5ML (*solifenacin succinate*)	NOT COVERED PA Required	

Drug Name	Drug Tier	Requirements/Limits
VESICARE ORAL TABLET 10 MG, 5 MG (*solifenacin succinate*)	NOT COVERED PA Required	
VAGINAL AND RELATED PRODUCTS		
clindamycin phosphate vaginal cream 2 %	COVERED - cDL	
clotrimazole 3 vaginal cream 2 %	COVERED - cDL	
clotrimazole-7 vaginal cream 1 %	COVERED - cDL	
estradiol vaginal cream 0.1 mg/gm	COVERED - cDL	QL (1.42 GM per 1 day)
estradiol vaginal tablet 10 mcg	COVERED - cDL	
metronidazole vaginal gel 0.75 %	COVERED - cDL	QL (70 GM per 5 days)
miconazole 3 combo-supp vaginal kit 200 & 2 mg-% (9gm)	COVERED - cDL	
miconazole 7 vaginal cream 2 %	COVERED - cDL	
miconazole 7 vaginal suppository 100 mg	COVERED - cDL	
MONISTAT 3 VAGINAL CREAM 4 % (*miconazole nitrate*)	COVERED - cDL	
qc 3 day vaginal cream 4 %	COVERED - cDL	
ra miconazole 3 combo pack app vaginal kit 200 & 2 mg-% (9gm)	COVERED - cDL	
terconazole vaginal cream 0.4 %, 0.8 %	COVERED - cDL	
terconazole vaginal suppository 80 mg	COVERED - cDL	QL (1 EA per 1 day)
tioconazole-1 vaginal ointment 6.5 %	COVERED - cDL	
VASOPRESSORS		
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML (*epinephrine*)	NOT COVERED PA Required	
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	NOT COVERED PA Required	
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (*epinephrine*)	COVERED - sPDL	
EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML (*epinephrine*)	COVERED - sPDL	
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	COVERED - cDL	QL (3 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
VITAMINS		
ascorbic acid oral tablet 500 mg	COVERED - cDL	
d 10000 oral capsule 250 mcg (10000 ut)	COVERED - cDL	QL (1 EA per 1 day)
d3-1000 oral capsule 25 mcg (1000 ut)	COVERED - cDL	QL (1 EA per 1 day)
D3-50 ORAL CAPSULE 1.25 MG (50000 UT) (*cholecalciferol*)	COVERED - cDL	QL (1 EA per 1 day)
D-VI-SOL ORAL LIQUID 10 MCG/ML (*cholecalciferol*)	COVERED - cDL	QL (6 ML per 1 day)
natural vitamin d-3 oral tablet 125 mcg (5000 ut)	COVERED - cDL	QL (6 EA per 1 day)
niacin er oral capsule extended release 250 mg, 500 mg	COVERED - cDL	
niacin er oral tablet extended release 250 mg, 500 mg, 750 mg	COVERED - cDL	
niacin oral tablet 100 mg, 250 mg, 50 mg, 500 mg	COVERED - cDL	
niacinamide oral tablet 500 mg	COVERED - cDL	
phytonadione oral tablet 5 mg	COVERED - cDL	QL (5 EA per 1 day)
pyridoxine hcl oral tablet 50 mg	COVERED - cDL	QL (4 EA per 1 day)
thiamine hcl oral tablet 100 mg	COVERED - cDL	QL (1 EA per 1 day)
true vitamin b3 oral tablet 50 mg	COVERED - cDL	
vitamin b-1 oral tablet 100 mg	COVERED - cDL	QL (1 EA per 1 day)
vitamin b-1 oral tablet 50 mg	COVERED - cDL	QL (2 EA per 1 day)
vitamin b-2 oral tablet 100 mg	COVERED - cDL	
vitamin b-6 er oral tablet extended release 200 mg	COVERED - cDL	
vitamin b-6 oral tablet 100 mg	COVERED - cDL	QL (4 EA per 1 day)
vitamin b-6 oral tablet 25 mg	COVERED - cDL	QL (2 EA per 1 day)
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	COVERED - cDL	QL (6 EA per 1 day)
vitamin d oral tablet 25 mcg (1000 ut), 50 mcg (2000 ut)	COVERED - cDL	QL (6 EA per 1 day)
vitamin d3 extra strength oral tablet chewable 25 mcg (1000 ut)	COVERED - cDL	QL (1 EA per 1 day); AGE (Max 1 Years)
vitamin d3 oral capsule 125 mcg (5000 ut), 50 mcg (2000 ut)	COVERED - cDL	QL (1 EA per 1 day)

Drug Name	Drug Tier	Requirements/Limits
vitamin d3 oral liquid 125 mcg/ml	COVERED - cDL	
vitamin d3 oral tablet 10 mcg (400 unit)	COVERED - cDL	QL (6 EA per 1 day)
vitamin d3 oral tablet chewable 10 mcg (400 unit)	COVERED - cDL	QL (1 EA per 1 day)

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