

# Plan for your best health

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Aetna Health Exchange Plan

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## 2024 Pharmacy Drug Guide - Aetna Health Exchange Plan

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# How to use this guide

Your guide includes a list of commonly used drugs covered on your pharmacy plan. The amount you pay depends on the drug your doctor prescribes. It's either a flat fee or a percentage of the prescription's price after you meet your deductible, if applicable. Preferred generic drugs cost less. Preferred brand drugs will have a higher cost.

## Your plan includes

- Brand and generic drugs that are hand-picked for their quality and effectiveness
- A specialty pharmacy that fills specialty prescriptions (ones that are injected, infused or taken by mouth) — and provides services that include personal support, helpful resources and training, and free secure home delivery
- A home delivery pharmacy that delivers maintenance drugs to your home or wherever you choose (for drugs that are taken regularly to treat conditions like diabetes or asthma)

## What you can expect to pay

With your pharmacy plan, the amount you pay depends on the drug your doctor prescribes. It's either a flat fee or a percentage of the drug's/medicine's price.

Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are less expensive than brands.

Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth.

Covered services are based on the drugs listed in the drug guide. We exclude prescription drugs not in the drug guide unless we approve a medical exception. If it is medically necessary for you to use a prescription drug that is not in this drug guide, you or your provider must request a medical exception.

You're covered for all types of medicine — some more expensive, and some less.

- **Preferred generic:** the lowest cost
- **Preferred brand:** a slightly higher cost
- **Non-preferred brand and generic:** a higher cost
- **Preferred Specialty:** lower cost for specialty drugs
- **Non-preferred Specialty:** higher cost for non-preferred specialty drugs

Your pharmacy plan may not have all the coverage levels listed above so check your plan documents to see how much you will pay.

## For your exact coverage and cost, and to learn more about your plan

Visit the website that's on your member ID card. Then log in to your account, where you can:

- Find out the coverage\* and estimate of cost for specific drugs
- View your deductibles and plan limits
- Order medications
- Check your pharmacy order status
- Get a member ID card
- View your claims, Explanation of Benefits and more.

\* Check your plan documents for coverage information. Your plan may not cover certain drugs such as infertility, erectile dysfunction, and weight loss.

## Have more questions about your pharmacy benefits?

We're here to help. There are several ways you can learn more about your benefits:

- Check your Plan Design and Benefits Summary in your enrollment kit.
- Call the toll-free number on your member ID card.
- Review our pharmacy frequently asked questions (FAQs) and answers. Just visit the website that's on your member ID card to search for the "Pharmacy FAQ."

## Specialty Pharmacy Network

An in-network specialty pharmacy can fill your prescriptions for specialty drugs. These are the types of drugs that may be injected, infused or taken by mouth. They often need special storage and handling. And they need to be delivered quickly. A nurse or pharmacist may monitor you during your treatment, if needed. With this type of pharmacy, you can get this medicine sent right to your home.

## How to get started with a specialty pharmacy

Ordering your prescriptions through our specialty pharmacy is easy. And we typically offer a 30-day medicine supply.

- **To transfer your prescription**, just call us toll-free at [1-866-353-1892](tel:1-866-353-1892) (TTY: [711](tel:1-866-353-1892)).
- **For a new prescription**, your doctor can send it to us in one of four ways:
  - 1. Electronically:** Through e-prescribe
  - 2. Fax:** [1-800-323-2445](tel:1-800-323-2445)
  - 3. Phone:** [1-800-237-2767](tel:1-800-237-2767) (TTY: [711](tel:1-800-237-2767))

If you mail in your own prescription, please send it with a completed Patient Profile Form. To find this form, just visit the website that's on your member ID card, to search for the "Patient Profile Form."

## CVS Caremark Mail Service Pharmacy™

You can have maintenance drugs sent right to your home or anywhere else you choose by CVS Caremark Mail Service Pharmacy. These are drugs that are taken regularly for chronic conditions like diabetes or asthma. Depending on your plan, you can get up to a 90-day supply of medicine for less cost. It's fast and convenient, and standard shipping is always free.

## Get started right away

You can submit your order using one of these options:

- 1. Online** — Visit your secure member website and sign in to your account. There you can add or remove your prescriptions.
- 2. Phone** — Call us toll-free, 24/7 at [1-888-792-3862](tel:1-888-792-3862) (TTY: [711](tel:1-888-792-3862)). If you need the help of a telephone device for the hard of hearing, call [1-877-833-2779](tel:1-877-833-2779) (TTY: [711](tel:1-877-833-2779)).
- 3. Mail** — Get a new prescription from your doctor. Then mail it to us with a completed order form. You can find the form on your secure member website. The mailing address is on the form.

## Your doctor can submit your order using one of these options:

- 1. Online** — They can submit your prescriptions using the e-prescribe services on our provider website.
- 2. Fax** — They can fax your prescription to [1-877-270-3317](tel:1-877-270-3317). Make sure they include your member ID number, date of birth and mailing address on the fax cover sheet. Only a doctor may fax a prescription.

# Frequently asked questions

## How can I save on prescriptions?

Here are some tips to pay less out of pocket for your prescription drugs:

- Ask your doctor to consider prescribing drugs that are on the Pharmacy Drug Guide (formulary).
- Ask your doctor to consider prescribing generic drugs instead of brand-name drugs.
- Our home delivery pharmacy may save you money. For more information, visit the website on your member ID card and log in to your account.

## What are generic drugs?

Generic drugs are proven to be just as safe and effective as brand-name drugs. They contain the same active ingredients in the same amounts as the brand-name drugs and work the same way. So they have the same risks and benefits as brand-name drugs. However, they typically cost less.

When appropriate, your doctor may decide to prescribe a generic drug or allow the pharmacist to substitute a generic drug.

## What is precertification/prior authorization (PA)?

Precertification is one way that we can help you and your doctor find safe, appropriate drugs and keep costs down. Precertification means that you or your doctor need to get approval from the plan before certain drugs will be covered. Generally, precertification applies to drugs that:

- Are often taken in the wrong way
- Should only be used for certain conditions
- Often cost more than other drugs that are proven to be just as effective

Keep in mind that your doctor must contact us to request approval of coverage for these drugs.

## What is step therapy (ST)?

Some drugs require step therapy. This means that you must try one or more prerequisite drug(s) before a step therapy drug is covered.

The prerequisite drugs have U.S. Food and Drug Administration (FDA) approval and may cost less. They treat the same condition as the step therapy drug.

If you don't try the appropriate prerequisite drug first, you may need to pay full cost for the step-therapy drug.

## What are quantity limits (QL)?

Quantity limits help your doctor and pharmacist make sure that you use your drug correctly and safely. We use medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. The quantity limit program includes:

- **Dose efficiency edits** — Limits prescription coverage to one dose per day for drugs that have approval for once-daily dosing
- **Maximum daily dose** — If a prescription is lower than the minimum or higher than the maximum allowed dose, a message is sent to the pharmacy
- **Quantity limits over time** — Limits prescription coverage to a specific number of units over a specific amount of time

## What if I need a drug that requires an exception to the precertification, step therapy or quantity limits requirements? Or what if I need a drug that's not covered under my plan?

In certain cases, you or your prescriber can request a medical exception to the precertification, step therapy or quantity limits requirements or for a drug that's not covered on your plan. You can ask for your request to be expedited. Expedited coverage decisions are made within 24 hours.

We'll then contact you or your prescriber with our decision. All medically necessary outpatient prescription drugs will be covered. If a medical exception is approved, you only need to pay the copay after the deductible. This amount is based on your pharmacy plan design.

## How can your provider request a medical exception?

- Submit their request through our secure provider website on [www.availity.com](http://www.availity.com).
- Call the Aetna Pharmacy Precertification Unit: Non-Specialty **1-800-294-5979 (TTY: 711)** or Specialty **1-866-814-5506 (TTY: 711)**.
- Fax the completed request form to:  
Non-Specialty **1-888-836-0730** or  
Specialty **1-866-249-6155**.
- Mail the completed request form to:  
Medical Exception to Pharmacy Prior Authorization Unit  
1300 East Campbell Road Richardson, TX 75081

## Pharmacy and Therapeutics (P&T) committee

The services of an independent National Pharmacy and Therapeutics Committee (“P&T Committee”) are utilized to approve safe and clinically effective drug therapies. The P&T Committee is an external advisory body of clinical professionals from across the United States. The P&T Committee’s voting members include physicians, pharmacists, a pharmacoeconomist and a medical ethicist, all of whom have a broad background of clinical and academic expertise regarding prescription drugs. Voting members of the P&T Committee are not employees of CVS Caremark and must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

## Can the formulary change during the year?

The formulary can change throughout the year. Some reasons why it can change include:

- New drugs are approved.
- Existing drugs are removed from the market.
- Prescription drugs may become available over the counter (without a prescription). Over-the-counter drugs are not generally covered in a formulary.
- Brand-name drugs lose patent protection and generic versions become available. When this happens, the generic drug will be covered in place of the brand-name drug. The brand-name drug is likely to become non-formulary or covered at a higher cost. See the “What are generic drugs?” section above for more information.

## **Commercial 1557 Nondiscrimination Notice**

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

**1-800-648-7817 (TTY: 711)**,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705),

**CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019 (TTY: 711)**, **1-800-537-7697 (TDD) (TTY: 711)**.





Hawaiian	No ka wala'au 'ana me ka lawelawe 'olelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nọmba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤန့ၢ်ကိၣ်တၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်အိၣ်အဂီၢ်,ကိးဘၣ်လီၤတဖၣ်နီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၢ် (ID) အလီၤန့ၣ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بو دەسپێرێ ئاگهیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بو تو، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Nan bōk jipañ kōn kajin ilo an ejjelōk wōṇean ñan kwe, kwōn kallok nōm̄ba eo ilo kaat in ID eo am̄.
Micronesia-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowol doo búáh ílínígóó naaltsoos bee atah nílíggo nanitinígíí bee néého'dólzínígíí béésh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke cìn wëu kor keek tënɔŋ yin. Ke yin col ran ye koc kuony në namba de abac tō në ID kard duɔn de tīt de nyin de panakim kōu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.



## Remember to visit the website on your member ID card. Then sign in to your account for the most up-to-date information.

Please note that if your prescription drug benefits plan changes, the information here may no longer apply.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

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Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. To check coverage and copay information for a specific medicine, log into your member website. For questions, please call the toll-free number on the back of your member ID card.

The drugs on the Pharmacy Drug Guide (formulary), Formulary Exclusions, Precertification, and Quantity Limit Lists are subject to change. The quantity limits and step therapy drug coverage review programs are not available in all service areas. However, these programs are available to self-funded plans.

Information is subject to change. In accordance with state law or insurer policies, changes to drug coverage are not effective for commercial fully insured plans (including HMOs) in Louisiana, New York, Texas, and in most circumstances Connecticut and Vermont, until the plans' renewal date.

In accordance with state law, certain fully insured commercial California members (except Federal Employee Health Benefit Plan members) who obtained approval from an Aetna plan for coverage of drugs that are later added to the Preauthorization or Step Therapy Lists or removed from the Pharmacy Drug Guide will continue to have those drugs covered, for as long as the treating in-network provider continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Aetna reserves the right to periodically request clinical information from your provider to assess your medical condition and the appropriateness of your ongoing treatment. Failure to provide clinical information could result in subsequent denial of coverage for this medication.

In accordance with state law, fully insured Commercial Connecticut preferred provider organization (PPO) members (except Federal Employee Health Benefit Plan members) who are receiving coverage for drugs that are added to the Precertification or Step-Therapy Lists will continue to have those drugs covered for as long as the prescriber prescribes them, provided the drug is medically necessary and more medically beneficial than other covered drugs. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions.

In accordance with state law, commercial fully insured (including HMO) members in Connecticut, Louisiana, New Mexico and Texas (except Federal Employee Health Benefit Plan members) who are receiving coverage for drugs that are added or removed from the Pharmacy Drug Guide and Specialty Drug List will continue to have those drugs covered at the same benefit level until their plan's renewal date. In Texas, preauthorization approval is known as "preservice utilization review." It is not "verification" as defined by Texas law. Preauthorization means a determination that healthcare services proposed to be provided to a patient are medically necessary and appropriate.

In certain states, including Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Louisiana, Maryland, Minnesota, North Dakota, Pennsylvania and Texas, step therapy programs do not apply to fully insured members utilizing prescription drugs for the treatment of stage-four advanced, metastatic cancer.

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This material is for information only. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Information is subject to change. CVS Caremark Mail Service Pharmacy is part of the CVS Health family of companies.

	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
	<b>CE</b> = Copay Exception: Available to some members at no cost with a prescription from your provider when obtained at an in-network pharmacy. Certain limitations may apply.	<b>AL</b> = Age Limit
	<b>NP*</b> = Non Preferred	<b>IBC</b> = Indication Based Coverage
	<b>NPSP</b> = Non Preferred Specialty	<b>LGC</b> = Lowest Generic Copay applies to ME members only
<b>lowercase italics</b> = Generic drugs	<b>PB</b> = Preferred Brand	<b>N7</b> = Drug tier when CE does not apply
<b>UPPERCASE</b> = Brand name drugs	<b>PG</b> = Preferred Generic	<b>N8</b> = Drug Specific Coverage
	<b>PSP</b> = Preferred Specialty	<b>PA</b> = Prior Authorization
		<b>QL</b> = Quantity Limit
		<b>QLR</b> = QL Restriction based on Age:
		<b>ST</b> = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION</b>		
<b>COX-2 INHIBITORS</b>		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	NP*	
<b>GOUT</b>		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	PG	
<i>colchicine oral tablet 0.6 mg</i>	NP*	
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	PG	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	PG	ST
<i>probenecid oral tablet 500 mg</i>	PG	
<b>NSAIDS</b>		
<i>diclofenac potassium oral tablet 50 mg</i>	PG	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	PG	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	PG	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	PG	
<i>etodolac oral capsule 200 mg, 300 mg</i>	PG	

2024 Pharmacy Drug Guide - Aetna Health Exchange Plan

The formulary is updated the first week of each month.

TX Shoppers: To find TX plan consumer drug cost estimates go to <https://www.aetna.com/individuals-families/aca-texas-plans.html> or call us toll-free at 1-844-393-7139.

\*Check your plan documents for coverage information. Some plans may cover all generics, including nonpreferred generics, at the lowest cost tier.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>etodolac oral tablet 400 mg, 500 mg</i>	PG	
<i>fenoprofen calcium oral tablet 600 mg</i>	NP*	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	PG	
<i>ibuprofen oral suspension 100 mg/5ml</i>	PG	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	PG	
<i>ketorolac tromethamine oral tablet 10 mg</i>	NP*	QL (20 TABLETS per 30 days)
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	PG	
<i>mefenamic acid oral capsule 250 mg</i>	NP*	
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	PG	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	PG	N8 (Listing does not include certain NDCs)
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	PG	
<i>oxaprozin oral tablet 600 mg</i>	PG	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	PG	
<i>sulindac oral tablet 150 mg, 200 mg</i>	PG	
<i>tolmetin sodium oral capsule 400 mg</i>	PG	
<i>tolmetin sodium oral tablet 600 mg</i>	PG	
<b>NSAIDS, COMBINATIONS</b>		
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg</i>	PG	
<i>diclofenac-misoprostol oral tablet delayed release 75-0.2 mg</i>	NP*	
<b>OPIOID ANALGESICS</b>		
<i>acetaminophen-codeine #2 oral tablet 300-15 mg</i>	PG	ST; N8 (Subject to initial limit); QL (400 TABLETS per 30 days)
<i>acetaminophen-codeine #3 oral tablet 300-30 mg</i>	PG	ST; N8 (Subject to initial limit); QL (360 TABLETS per 30 days)

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\*Check your plan documents for coverage information. Some plans may cover all generics, including nonpreferred generics, at the lowest cost tier.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acetaminophen-codeine #4 oral tablet 300-60 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	PG	ST; N8 (Subject to initial limit); QL (2700 ML per 30 days)
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	PG	ST; N8 (Subject to initial limit); QL (300 CAPSULES per 30 DAYS)
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	NP*	QL (2 BOTTLES per 30 days)
<i>codeine sulfate oral tablet 30 mg</i>	PG	ST; N8 (Subject to initial limit); QL (42 TABLETS per 30 days)
<i>codeine sulfate oral tablet 60 mg</i>	NP*	ST; N8 (Subject to initial limit); QL (42 TABLETS per 30 days)
<i>oxycodone-acetaminophen (Endocet Oral Tablet 10-325 Mg)</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>oxycodone-acetaminophen (Endocet Oral Tablet 2.5-325 Mg, 5-325 Mg)</i>	PG	ST; N8 (Subject to initial limit); QL (360 TABLETS per 30 days)
<i>oxycodone-acetaminophen (Endocet Oral Tablet 7.5-325 Mg)</i>	PG	ST; N8 (Subject to initial limit); QL (240 TABLETS per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg</i>	NP*	PA; QL (120 LOZENGES per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	NP*	PA; ST
<i>fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr</i>	NP*	ST; QL (10 PATCHES per 30 days)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg</i>	PG	ST; QL (60 CAPSULES per 30 days)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 50 mg</i>	PG	PA; ST
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg</i>	PG	PA; ST
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	PG	ST; QL (30 TABLETS per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	NP*	ST; N8 (Subject to initial limit); QL (2700 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>hydrocodone-acetaminophen oral tablet 5-325 mg</i>	PG	ST; N8 (Subject to initial limit); QL (240 TABLETS per 30 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg</i>	PG	ST; N8 (Subject to initial limit); QL (50 TABLETS per 30 days)
<i>hydromorphone hcl er oral tablet extended release 24 hour 12 mg, 16 mg, 8 mg</i>	NP*	ST; QL (30 TABLETS per 30 days)
<i>hydromorphone hcl er oral tablet extended release 24 hour 32 mg</i>	NP*	PA; ST
<i>hydromorphone hcl oral tablet 2 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>hydromorphone hcl oral tablet 4 mg</i>	PG	ST; N8 (Subject to initial limit); QL (120 TABLETS per 30 days)
<i>hydromorphone hcl oral tablet 8 mg</i>	PG	ST; N8 (Subject to initial limit); QL (60 TABLETS per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levorphanol tartrate oral tablet 2 mg</i>	NP*	ST; N8 (Subject to initial limit); QL (120 TABLETS per 30 days)
<i>levorphanol tartrate oral tablet 3 mg</i>	NP*	ST; N8 (Subject to initial limit); QL (60 TABLETS per 30 days)
<i>methadone hcl</i> (Methadone Hcl Intensol Oral Concentrate 10 Mg/ML)	PG	ST; QL (45 ML per 30 days)
<i>methadone hcl oral concentrate 10 mg/ml</i>	PG	QL (30 ML per 30 days)
<i>methadone hcl oral solution 10 mg/5ml</i>	PG	ST; QL (225 ML per 30 days)
<i>methadone hcl oral solution 5 mg/5ml</i>	PG	ST; QL (450 ML per 30 days)
<i>methadone hcl oral tablet 10 mg</i>	PG	ST; QL (30 TABLETS per 30 days)
<i>methadone hcl oral tablet 5 mg</i>	PG	ST; QL (90 TABLETS per 30 days)
<i>methadone hcl oral tablet soluble 40 mg</i>	PG	QL (9 TABLETS per 30 days)
<i>methadone hcl</i> (Methadose Oral Tablet Soluble 40 Mg)	PG	QL (9 TABLETS per 30 days)
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml</i>	PG	ST; N8 (Subject to initial limit); QL (135 ML per 30 DAYS)
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg</i>	PG	PA; ST
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg</i>	PG	ST; QL (90 TABLETS per 30 days)
<i>morphine sulfate oral solution 10 mg/5ml</i>	PG	ST; N8 (Subject to initial limit); QL (900 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>morphine sulfate oral tablet 15 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>morphine sulfate oral tablet 30 mg</i>	PG	ST; N8 (Subject to initial limit); QL (90 TABLETS per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg</i>	PG	ST; QL (60 TABLETS per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 40 mg, 80 mg</i>	PG	PA; ST
<i>oxycodone hcl oral capsule 5 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 CAPSULES per 30 days)
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	PG	ST; N8 (Subject to initial limit); QL (90 ML per 30 days)
<i>oxycodone hcl oral solution 5 mg/5ml</i>	NP*	ST; N8 (Subject to initial limit); QL (900 ML per 30 days)
<i>oxycodone hcl oral tablet 10 mg, 5 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>oxycodone hcl oral tablet 15 mg</i>	PG	ST; N8 (Subject to initial limit); QL (120 TABLETS per 30 days)
<i>oxycodone hcl oral tablet 20 mg</i>	PG	ST; N8 (Subject to initial limit); QL (90 TABLETS per 30 days)
<i>oxycodone hcl oral tablet 30 mg</i>	PG	ST; N8 (Subject to initial limit); QL (60 TABLETS per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg</i>	PG	ST; N8 (Subject to initial limit); QL (360 TABLETS per 30 days)
<i>oxycodone-acetaminophen oral tablet 7.5-325 mg</i>	PG	ST; N8 (Subject to initial limit); QL (240 TABLETS per 30 days)
<i>oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg</i>	NP*	ST; QL (60 TABLETS per 30 days)
<i>oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg</i>	NP*	PA; ST
<i>oxymorphone hcl oral tablet 10 mg</i>	NP*	ST; N8 (Subject to initial limit); QL (90 TABLETS per 30 days)
<i>oxymorphone hcl oral tablet 5 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>tramadol hcl er oral tablet extended release 24 hour 100 mg</i>	NP*	ST; QL (30 TABLETS per 30 days)
<i>tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg</i>	NP*	PA; ST
<i>tramadol hcl oral tablet 50 mg</i>	PG	ST; N8 (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	PG	ST; N8 (Subject to initial limit); QL (40 TABLETS per 30 days)
<b>OPIOID PARTIAL AGONISTS</b>		
<i>buprenorphine transdermal patch weekly 10 mcg/1hr, 5 mcg/1hr, 7.5 mcg/1hr</i>	PG	ST; QL (4 PATCHES per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>buprenorphine transdermal patch weekly 15 mcg/1hr, 20 mcg/1hr</i>	PG	PA; ST
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML ( <i>buprenorphine</i> )	PSP	
<b>SALICYLATES</b>		
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay for members at risk for preeclampsia, otherwise not covered); QL (100 TABLETS per 30 days)
<i>diflunisal oral tablet 500 mg</i>	PG	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay for members at risk for preeclampsia, otherwise not covered); QL (100 TABLETS per 30 days)
<b>ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS</b>		
<b>ANTHELMINTICS - DRUGS FOR WORM INFECTION</b>		
<i>albendazole oral tablet 200 mg</i>	NP*	QL (336 TABLETS per 365 DAYS)
<i>benznidazole oral tablet 100 mg, 12.5 mg</i>	NP*	
EMVERM ORAL TABLET CHEWABLE 100 MG ( <i>mebendazole</i> )	NP*	QL (12 TABLETS per 365 DAYS)
<i>ivermectin oral tablet 3 mg</i>	PG	
<i>praziquantel oral tablet 600 mg</i>	PG	QL (24 TABLETS per 365 DAYS)
<b>ANTI-BACTERIALS - MISCELLANEOUS</b>		
<i>fosfomicin tromethamine oral packet 3 gm</i>	PG	
<i>neomycin sulfate oral tablet 500 mg</i>	PG	
<i>paromomycin sulfate oral capsule 250 mg</i>	PG	
<i>sulfadiazine oral tablet 500 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	PG	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	PG	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	NP*	
<b>ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS</b>		
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG ( <i>isavuconazonium sulfate</i> )	NP*	
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	PG	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	PG	
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	NP*	
<i>griseofulvin microsize oral tablet 500 mg</i>	NP*	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	NP*	
<i>itraconazole oral capsule 100 mg</i>	NP*	PA
<i>itraconazole oral solution 10 mg/ml</i>	NP*	PA
<i>nystatin oral tablet 500000 unit</i>	PG	
<i>posaconazole oral suspension 40 mg/ml</i>	PG	PA
<i>posaconazole oral tablet delayed release 100 mg</i>	NP*	PA
<i>terbinafine hcl oral tablet 250 mg</i>	PG	
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	NP*	PA
<i>voriconazole oral tablet 200 mg, 50 mg</i>	NP*	PA
<b>ANTIMALARIALS - DRUGS TO TREAT MALARIA</b>		
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	NP*	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	PG	
COARTEM ORAL TABLET 20-120 MG ( <i>artemether-lumefantrine</i> )	NP*	
<i>mefloquine hcl oral tablet 250 mg</i>	NP*	
<i>primaquine phosphate oral tablet 26.3 mg</i>	PG	
<i>quinine sulfate oral capsule 324 mg</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION</b>		
<i>abacavir sulfate oral solution 20 mg/ml</i>	PG	QL (900 ML per 30 DAYs)
<i>abacavir sulfate oral tablet 300 mg</i>	PG	QL (60 TABLETS per 30 DAYs)
APTIVUS ORAL CAPSULE 250 MG ( <i>tipranavir</i> )	PB	QL (120 CAPSULES per 30 DAYs)
<i>atazanavir sulfate oral capsule 150 mg, 300 mg</i>	PG	QL (30 CAPSULES per 30 DAYs)
<i>atazanavir sulfate oral capsule 200 mg</i>	PG	QL (60 CAPSULES per 30 DAYs)
<i>darunavir oral tablet 600 mg</i>	PG	QL (60 TABLETS per 30 days)
<i>darunavir oral tablet 800 mg</i>	PG	QL (30 TABLETS per 30 days)
EDURANT ORAL TABLET 25 MG ( <i>rilpivirine hcl</i> )	PB	QL (60 TABLETS per 30 DAYs)
<i>efavirenz oral tablet 600 mg</i>	PG	QL (30 TABLETS per 30 days)
<i>emtricitabine oral capsule 200 mg</i>	PG	QL (30 CAPSULES per 30 DAYs)
EMTRIVA ORAL SOLUTION 10 MG/ML ( <i>emtricitabine</i> )	PB	QL (680 ML per 28 days)
<i>etravirine oral tablet 100 mg</i>	PG	QL (120 TABLETS per 30 DAYs)
<i>etravirine oral tablet 200 mg</i>	PG	QL (60 TABLETS per 30 DAYs)
<i>fosamprenavir calcium oral tablet 700 mg</i>	PG	QL (120 TABLETS per 30 DAYs)
INTELENCE ORAL TABLET 25 MG ( <i>etravirine</i> )	PB	QL (120 TABLETS per 30 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ISENTRESS HD ORAL TABLET 600 MG ( <i>raltegravir potassium</i> )	PB	QL (60 TABLETS per 30 DAYs)
ISENTRESS ORAL PACKET 100 MG ( <i>raltegravir potassium</i> )	PB	QL (60 PACKETS per 30 DAYs)
ISENTRESS ORAL TABLET 400 MG ( <i>raltegravir potassium</i> )	PB	QL (120 TABLETS per 30 DAYs)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG ( <i>raltegravir potassium</i> )	PB	QL (180 TABLETS per 30 DAYs)
<i>lamivudine oral solution 10 mg/ml</i>	PG	QL (960 ML per 30 days)
<i>lamivudine oral tablet 150 mg</i>	PG	QL (60 TABLETS per 30 DAYs)
<i>lamivudine oral tablet 300 mg</i>	PG	QL (30 TABLETS per 30 DAYs)
<i>maraviroc oral tablet 150 mg</i>	PG	QL (60 TABLETS per 30 DAYs)
<i>maraviroc oral tablet 300 mg</i>	PG	QL (120 TABLETS per 30 DAYs)
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	PG	QL (30 TABLETS per 30 days)
<i>nevirapine oral suspension 50 mg/5ml</i>	PG	QL (1200 ML per 30 days)
<i>nevirapine oral tablet 200 mg</i>	PG	QL (60 TABLETS per 30 DAYs)
NORVIR ORAL PACKET 100 MG ( <i>ritonavir</i> )	PB	QL (360 PACKETS per 30 DAYs)
PREZISTA ORAL SUSPENSION 100 MG/ML ( <i>darunavir</i> )	PB	QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG ( <i>darunavir</i> )	PB	QL (180 TABLETS per 30 DAYs)
PREZISTA ORAL TABLET 75 MG ( <i>darunavir</i> )	PB	QL (300 TABLETS per 30 DAYs)
REYATAZ ORAL PACKET 50 MG ( <i>atazanavir sulfate</i> )	PB	QL (180 PACKETS per 30 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ritonavir oral tablet 100 mg</i>	PG	QL (360 TABLETS per 30 days)
SELZENTRY ORAL SOLUTION 20 MG/ML ( <i>maraviroc</i> )	PB	QL (1840 ML per 30 days)
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	PG	QL (30 TABLETS per 30 DAYs)
TIVICAY ORAL TABLET 50 MG ( <i>dolutegravir sodium</i> )	PB	QL (60 TABLETS per 30 DAYs)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG ( <i>dolutegravir sodium</i> )	PB	QL (360 TABLETS per 30 DAYs)
TYBOST ORAL TABLET 150 MG ( <i>cobicistat</i> )	PB	QL (30 TABLETS per 30 DAYs)
VIRACEPT ORAL TABLET 250 MG ( <i>nelfinavir mesylate</i> )	PB	QL (300 TABLETS per 30 DAYs)
VIRACEPT ORAL TABLET 625 MG ( <i>nelfinavir mesylate</i> )	PB	QL (120 TABLETS per 30 DAYs)
VIREAD ORAL POWDER 40 MG/GM ( <i>tenofovir disoproxil fumarate</i> )	PB	QL (240 GRAMS per 30 DAYs)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG ( <i>tenofovir disoproxil fumarate</i> )	PB	QL (30 TABLETS per 30 DAYs)
<i>zidovudine oral capsule 100 mg</i>	PG	QL (180 CAPSULES per 30 DAYs)
<i>zidovudine oral syrup 50 mg/5ml</i>	PG	QL (1920 ML per 30 days)
<i>zidovudine oral tablet 300 mg</i>	PG	QL (60 TABLETS per 30 DAYs)
<b>ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION</b>		
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	PG	QL (30 TABLETS per 30 days)
BIKTARVY ORAL TABLET 30-120-15 MG ( <i>bictegravir-emtricitab-tenofov</i> )	NP*	QL (30 TABLETS per 30 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIKTARVY ORAL TABLET 50-200-25 MG ( <i>bictegravir-emtricitab-tenofovir</i> )	NP*	QL (30 TABLETS per 30 days)
CIMDUO ORAL TABLET 300-300 MG ( <i>lamivudine-tenofovir</i> )	PB	QL (30 TABLETS per 30 DAYs)
DELSTRIGO ORAL TABLET 100-300-300 MG ( <i>doravirin-lamivudin-tenofovir df</i> )	NP*	QL (30 TABLETS per 30 DAYs)
DESCOVY ORAL TABLET 120-15 MG ( <i>emtricitabine-tenofovir af</i> )	PB	QL (30 TABLETS per 30 days)
DESCOVY ORAL TABLET 200-25 MG ( <i>emtricitabine-tenofovir af</i> )	PB	N8 (Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis); QL (30 TABLETS per 30 days)
DOVATO ORAL TABLET 50-300 MG ( <i>dolutegravir-lamivudine</i> )	PB	QL (30 TABLETS per 30 DAYs)
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	PG	QL (30 TABLETS per 30 Days)
<i>efavirenz-emtricitab-tenofovir oral tablet 600-200-300 mg</i>	PG	QL (30 TABLETS per 30 DAYs)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	PG	QL (30 TABLETS per 30 DAYs)
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	PG	QL (30 TABLETS per 30 DAYs)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	CE	N7 (PG); N8 (\$0 copay for pre-exposure prophylaxis); QL (30 TABLETS per 30 days)
EVOTAZ ORAL TABLET 300-150 MG ( <i>atazanavir-cobicistat</i> )	PB	QL (30 TABLETS per 30 DAYs)
GENVOYA ORAL TABLET 150-150-200-10 MG ( <i>elviteg-cobic-emtricit-tenofaf</i> )	PB	QL (30 TABLETS per 30 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	PG	QL (60 TABLETS per 30 days)
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	PG	QL (480 ML per 30 days)
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	PG	QL (300 TABLETS per 30 days)
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	PG	QL (120 TABLETS per 30 DAYs)
PREZCOBIX ORAL TABLET 800-150 MG ( <i>darunavir-cobicistat</i> )	PB	QL (30 TABLETS per 30 DAYs)
SYM TUZA ORAL TABLET 800-150-200-10 MG ( <i>darun-cobic-emtricit-tenofaf</i> )	NP*	QL (30 TABLETS per 30 DAYs)
TRIUMEQ ORAL TABLET 600-50-300 MG ( <i>abacavir-dolutegravir-lamivud</i> )	PB	QL (30 TABLETS per 30 DAYs)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG ( <i>abacavir-dolutegravir-lamivud</i> )	PB	QL (180 tablets per 30 days)
<b>ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS</b>		
<i>cycloserine oral capsule 250 mg</i>	NP*	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	PG	
<i>isoniazid oral syrup 50 mg/5ml</i>	PG	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	PG	
<i>pretomanid oral tablet 200 mg</i>	NP*	PA
PRIFTIN ORAL TABLET 150 MG ( <i>rifapentine</i> )	PB	
<i>pyrazinamide oral tablet 500 mg</i>	PG	
<i>rifabutin oral capsule 150 mg</i>	NP*	
<i>rifampin oral capsule 150 mg, 300 mg</i>	PG	
SIRTURO ORAL TABLET 100 MG, 20 MG ( <i>bedaquiline fumarate</i> )	NPSP	PA
TRECTOR ORAL TABLET 250 MG ( <i>ethionamide</i> )	PB	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS</b>		
<i>acyclovir oral capsule 200 mg</i>	PG	
<i>acyclovir oral suspension 200 mg/5ml</i>	PG	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	PG	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	NP*	
<i>oseltamivir phosphate oral capsule 30 mg</i>	PG	QL (40 CAPSULES per 90 DAYs)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	PG	QL (20 CAPSULES per 90 DAYs)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	PG	QL (360 ML per 90 DAYs)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG ( <i>nirmatrelvir-ritonavir</i> )	NP*	QL (40 TABLETS per 30 DAYs)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG ( <i>nirmatrelvir-ritonavir</i> )	NP*	QL (60 TABLETS per 30 DAYs)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT ( <i>zanamivir</i> )	PB	QL (2 INHALERS per 90 Days)
<i>ribavirin inhalation solution reconstituted 6 gm</i>	PG	
<i>rimantadine hcl oral tablet 100 mg</i>	PG	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	PG	
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	PSP	PA; QL (1000 ML per 30 DAYs)
<i>valganciclovir hcl oral tablet 450 mg</i>	PSP	PA; QL (120 TABLETS per 30 days)
<b>CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS</b>		
<i>cefaclor oral capsule 250 mg, 500 mg</i>	PG	
<i>cefaclor oral suspension reconstituted 250 mg/5ml</i>	PG	
<i>cefadroxil oral capsule 500 mg</i>	PG	
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	PG	
<i>cefadroxil oral tablet 1 gm</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefdinir oral capsule 300 mg</i>	PG	
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	PG	
<i>cefixime oral capsule 400 mg</i>	PG	
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	NP*	
<i>cefprozil proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	NP*	
<i>cefprozil proxetil oral tablet 100 mg, 200 mg</i>	NP*	
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	PG	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	PG	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	PG	
<i>cephalexin oral capsule 250 mg, 500 mg, 750 mg</i>	PG	
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	PG	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	PG	
<b>ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS</b>		
<i>azithromycin oral packet 1 gm</i>	PG	
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	PG	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	PG	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	PG	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	PG	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	PG	
<b>DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>fidaxomicin</i>)</b>	PB	PA
<b>DIFICID ORAL TABLET 200 MG (<i>fidaxomicin</i>)</b>	PB	PA
<i>erythromycin base (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg)</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ERYTHROCIN STEARATE ORAL TABLET 250 MG ( <i>erythromycin stearate</i> )	PG	
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	PG	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	PG	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	PG	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	PG	
<b>FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS</b>		
BAXDELA ORAL TABLET 450 MG ( <i>delafloxacin meglumine</i> )	NP*	
CIPRO ORAL SUSPENSION RECONSTITUTED 500 MG/5ML (10%) ( <i>ciprofloxacin</i> )	NP*	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	PG	
<i>levofloxacin oral solution 25 mg/ml</i>	PG	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	PG	
<i>moxifloxacin hcl oral tablet 400 mg</i>	NP*	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	PG	
<b>HEPATITIS B</b>		
<i>adefovir dipivoxil oral tablet 10 mg</i>	PSP	
BARACLUDGE ORAL SOLUTION 0.05 MG/ML ( <i>entecavir</i> )	PSP	PA; QL (630 ML per 30 days)
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	PSP	PA; QL (30 TABLETS per 30 days)
<i>lamivudine oral tablet 100 mg</i>	PG	
VEMLIDY ORAL TABLET 25 MG ( <i>tenofovir alafenamide fumarate</i> )	NP*	PA; QL (30 TABLETS per 30 DAYS)
<b>HEPATITIS C</b>		
EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG ( <i>sofosbuvir-velpatasvir</i> )	NP*	PA; QL (28 PELLETS per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG (sofosbuvir-velpatasvir)	NP*	PA; QL (28 TABLETS per 28 days)
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (ledipasvir-sofosbuvir)	NP*	PA; QL (28 PELLETS per 28 days)
HARVONI ORAL TABLET 45-200 MG, 90-400 MG (ledipasvir-sofosbuvir)	NP*	PA; QL (28 TABLETS per 28 days)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (peginterferon alfa-2a)	PSP	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (peginterferon alfa-2a)	PSP	PA
ribavirin oral capsule 200 mg	PG	PA
ribavirin oral tablet 200 mg	PG	PA
SOVALDI ORAL PACKET 150 MG, 200 MG (sofosbuvir)	NPSP	PA; ST; QL (28 PELLETS per 28 DAYS)
SOVALDI ORAL TABLET 200 MG, 400 MG (sofosbuvir)	NPSP	PA; ST; QL (28 TABLETS per 28 DAYS)
VOSEVI ORAL TABLET 400-100-100 MG (sofosbuv-velpatasv-voxilaprev)	NP*	PA; QL (28 TABLETS per 28 days)
<b>MISCELLANEOUS</b>		
ALINIA ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (nitazoxanide)	NP*	QL (540 ML per 30 days)
atovaquone oral suspension 750 mg/5ml	NP*	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	PG	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	PG	
dapsone oral tablet 100 mg, 25 mg	PG	
linezolid oral suspension reconstituted 100 mg/5ml	PG	
linezolid oral tablet 600 mg	PG	
methenamine hippurate oral tablet 1 gm	PG	
metronidazole oral capsule 375 mg	NP*	
metronidazole oral tablet 250 mg, 500 mg	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nitazoxanide oral tablet 500 mg</i>	PG	QL (20 TABLETS per 30 days)
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg</i>	PG	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	PG	PA; AL (Max 70 Years)
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	PG	PA; AL (Max 70 Years)
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	NP*	PA; AL (Max 70 Years)
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	PG	
<i>pyrimethamine oral tablet 25 mg</i>	NP*	PA
<i>trimethoprim oral tablet 100 mg</i>	PG	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	NP*	QL (80 CAPSULES per 10 DAYs)
XIFAXAN ORAL TABLET 200 MG ( <i>rifaximin</i> )	PB	QL (9 TABLETS per 30 days)
XIFAXAN ORAL TABLET 550 MG ( <i>rifaximin</i> )	PB	PA
<b>PENICILLINS - DRUGS TO TREAT INFECTIONS</b>		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	PG	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	PG	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	PG	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	PG	
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	PG	
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	PG	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</i>	PG	
<i>ampicillin oral capsule 500 mg</i>	PG	
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	PG	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	PG	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	PG	
<b>TETRACYCLINES - DRUGS TO TREAT INFECTIONS</b>		
<i>avidoxy oral tablet 100 mg</i>	PG	
<i>demeclocycline hcl oral tablet 150 mg, 300 mg</i>	NP*	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	PG	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	PG	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	PG	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	PG	
<i>doxycycline monohydrate oral tablet 150 mg, 50 mg, 75 mg</i>	PG	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	PG	
<i>minocycline hcl oral tablet 100 mg, 50 mg, 75 mg</i>	PG	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	PG	QL (120 CAPSULES per 30 days)
<b>ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER</b>		
<b>ALKYLATING AGENTS</b>		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	CE	N7 (PG)
EMCYT ORAL CAPSULE 140 MG ( <i>estramustine phosphate sodium</i> )	CE	N7 (PSP)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG ( <i>lomustine</i> )	CE	N7 (PSP)
LEUKERAN ORAL TABLET 2 MG ( <i>chlorambucil</i> )	CE	N7 (PB)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MATULANE ORAL CAPSULE 50 MG ( <i>procarbazine hcl</i> )	CE	N7 (PSP)
<i>melfhalan oral tablet 2 mg</i>	CE	N7 (PG)
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	CE	PA; N7 (PSP)
<b>ANTIMETABOLITES</b>		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	CE	PA; N7 (PSP)
<i>mercaptopurine oral tablet 50 mg</i>	CE	N7 (PG)
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	PG	
TABLOID ORAL TABLET 40 MG ( <i>thioguanine</i> )	CE	N7 (PB)
<b>ANTINEOPLASTIC, BCL-2 INHIBITORS</b>		
VENCLEXTA ORAL TABLET 10 MG, 50 MG ( <i>venetoclax</i> )	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYS)
VENCLEXTA ORAL TABLET 100 MG ( <i>venetoclax</i> )	CE	PA; N7 (PSP); QL (180 TABLETS per 30 DAYS)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG ( <i>venetoclax</i> )	CE	PA; N7 (PSP); QL (1 PACK per 28 days)
<b>BIOLOGIC RESPONSE MODIFIERS</b>		
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG ( <i>pomalidomide</i> )	CE	PA; N7 (PSP); QL (21 CAPSULES per 28 days)
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG ( <i>lenalidomide</i> )	CE	PA; N7 (PSP); QL (28 CAPSULES per 28 days)
REVLIMID ORAL CAPSULE 20 MG, 25 MG ( <i>lenalidomide</i> )	CE	PA; N7 (PSP); QL (21 CAPSULES per 28 days)
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML ( <i>rituximab-pvvr</i> )	NP*	PA
THALOMID ORAL CAPSULE 100 MG, 50 MG ( <i>thalidomide</i> )	PSP	PA; QL (28 CAPSULES per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG ( <i>thalidomide</i> )	PSP	PA; QL (56 CAPSULES per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HORMONAL ANTINEOPLASTIC AGENTS</b>		
<i>abiraterone acetate oral tablet 250 mg</i>	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYS)
<i>abiraterone acetate oral tablet 500 mg</i>	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYS)
<i>anastrozole oral tablet 1 mg</i>	CE	N7 (PG); N8 (\$0 copay for ages 35 and older for the primary prevention of breast cancer); AL (Min 35 Years)
<i>bicalutamide oral tablet 50 mg</i>	CE	N7 (PG)
ELIGARD SUBCUTANEOUS KIT 22.5 MG ( <i>leuprolide acetate (3 month)</i> )	PSP	PA
ELIGARD SUBCUTANEOUS KIT 30 MG ( <i>leuprolide acetate (4 month)</i> )	PSP	PA
ELIGARD SUBCUTANEOUS KIT 45 MG ( <i>leuprolide acetate (6 month)</i> )	PSP	PA
ELIGARD SUBCUTANEOUS KIT 7.5 MG ( <i>leuprolide acetate</i> )	PSP	PA
<i>exemestane oral tablet 25 mg</i>	CE	N7 (NP); N8 (\$0 copay for ages 35 and older for the primary prevention of breast cancer); AL (Min 35 Years)
<i>letrozole oral tablet 2.5 mg</i>	CE	N7 (PG)
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	PSP	PA
LYSODREN ORAL TABLET 500 MG ( <i>mitotane</i> )	CE	N7 (PB)
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	CE	N7 (PG)
NUBEQA ORAL TABLET 300 MG ( <i>darolutamide</i> )	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYS)
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	CE	N7 (PG); N8 (\$0 copay for ages 35 and older for the primary prevention of breast cancer); AL (Min 35 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>toremifene citrate oral tablet 60 mg</i>	CE	N7 (PG)
XTANDI ORAL CAPSULE 40 MG ( <i>enzalutamide</i> )	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 DAYs)
XTANDI ORAL TABLET 40 MG ( <i>enzalutamide</i> )	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYs)
XTANDI ORAL TABLET 80 MG ( <i>enzalutamide</i> )	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
<b>KINASE INHIBITORS</b>		
ALECENSA ORAL CAPSULE 150 MG ( <i>alectinib hcl</i> )	CE	PA; N7 (PSP); QL (240 CAPSULES per 30 DAYs)
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG ( <i>cabozantinib s-malate</i> )	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
CAPRELSA ORAL TABLET 100 MG ( <i>vandetanib</i> )	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
CAPRELSA ORAL TABLET 300 MG ( <i>vandetanib</i> )	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)
<i>erlotinib hcl oral tablet 25 mg</i>	CE	PA; N7 (PSP); QL (60 TABLETS per 30 days)
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
<i>everolimus oral tablet soluble 2 mg, 5 mg</i>	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
<i>everolimus oral tablet soluble 3 mg</i>	CE	PA; N7 (PSP); QL (90 TABLETS per 30 DAYs)
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG ( <i>palbociclib</i> )	CE	PA; N7 (PSP); QL (21 CAPSULES per 28 DAYs)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG ( <i>palbociclib</i> )	CE	PA; N7 (PSP); QL (21 TABLETS per 28 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>imatinib mesylate oral tablet 100 mg</i>	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
<i>imatinib mesylate oral tablet 400 mg</i>	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
IMBRUVICA ORAL CAPSULE 140 MG ( <i>ibrutinib</i> )	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 DAYs)
IMBRUVICA ORAL CAPSULE 70 MG ( <i>ibrutinib</i> )	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 DAYs)
IMBRUVICA ORAL SUSPENSION 70 MG/ML ( <i>ibrutinib</i> )	CE	PA; N7 (PSP); QL (216 ML per 36 DAYs)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG ( <i>ibrutinib</i> )	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
INLYTA ORAL TABLET 1 MG ( <i>axitinib</i> )	CE	PA; N7 (PSP); QL (240 TABLETS per 30 DAYs)
INLYTA ORAL TABLET 5 MG ( <i>axitinib</i> )	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYs)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG ( <i>ruxolitinib phosphate</i> )	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 DAYs)
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 DAYs)
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (60 CAPSULES per 30 DAYs)
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 DAYs)
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (60 CAPSULES per 30 DAYs)
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 DAYs)
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG ( <i>lenvatinib mesylate</i> )	CE	PA; N7 (PSP); QL (60 CAPSULES per 30 DAYs)
LORBRENA ORAL TABLET 100 MG ( <i>lorlatinib</i> )	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 DAYs)
LORBRENA ORAL TABLET 25 MG ( <i>lorlatinib</i> )	CE	PA; N7 (NPSP); QL (90 TABLETS per 30 DAYs)
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML ( <i>trametinib dimethyl sulfoxide</i> )	CE	PA; N7 (PSP); QL (12 BOTTLES per 28 DAYs)
MEKINIST ORAL TABLET 0.5 MG ( <i>trametinib dimethyl sulfoxide</i> )	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)
MEKINIST ORAL TABLET 2 MG ( <i>trametinib dimethyl sulfoxide</i> )	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
RYDAPT ORAL CAPSULE 25 MG ( <i>midostaurin</i> )	CE	PA; N7 (NPSP); QL (224 CAPSULES per 28 DAYs)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG ( <i>dasatinib</i> )	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
SPRYCEL ORAL TABLET 20 MG ( <i>dasatinib</i> )	CE	PA; N7 (PSP); QL (90 TABLETS per 30 DAYs)
STIVARGA ORAL TABLET 40 MG ( <i>regorafenib</i> )	CE	PA; N7 (PSP); QL (84 TABLETS per 28 DAYs)
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 DAYs)
TAFINLAR ORAL CAPSULE 50 MG, 75 MG ( <i>dabrafenib mesylate</i> )	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 DAYs)
TAFINLAR ORAL TABLET SOLUBLE 10 MG ( <i>dabrafenib mesylate</i> )	CE	PA; N7 (PSP); QL (4 BOTTLES per 28 DAYs)
TAGRISSE ORAL TABLET 40 MG, 80 MG ( <i>osimertinib mesylate</i> )	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
TUKYSA ORAL TABLET 150 MG, 50 MG ( <i>tucatinib</i> )	CE	PA; N7 (NPSP); QL (120 TABLETS per 30 DAYs)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG ( <i>abemaciclib</i> )	CE	PA; N7 (PSP); QL (56 TABLETS per 28 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITRAKVI ORAL CAPSULE 100 MG ( <i>larotrectinib sulfate</i> )	CE	PA; N7 (NPSP); QL (60 CAPSULES per 30 DAYs)
VITRAKVI ORAL CAPSULE 25 MG ( <i>larotrectinib sulfate</i> )	CE	PA; N7 (NPSP); QL (180 CAPSULES per 30 DAYs)
VITRAKVI ORAL SOLUTION 20 MG/ML ( <i>larotrectinib sulfate</i> )	CE	PA; N7 (NPSP); QL (300 ML per 30 DAYs)
<b>MISCELLANEOUS</b>		
<i>bexarotene oral capsule 75 mg</i>	CE	PA; N7 (PSP)
<i>hydroxyurea oral capsule 500 mg</i>	CE	N7 (PG)
LYNPARZA ORAL TABLET 100 MG, 150 MG ( <i>olaparib</i> )	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYs)
ODOMZO ORAL CAPSULE 200 MG ( <i>sonidegib phosphate</i> )	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 DAYs)
<i>tretinoin oral capsule 10 mg</i>	CE	N7 (PG)
VISTOGARD ORAL PACKET 10 GM ( <i>uridine triacetate</i> )	PSP	QL (20 PACKETS per 5 DAYs)
<b>PROTECTIVE AGENTS</b>		
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	CE	N7 (PG)
MESNEX ORAL TABLET 400 MG ( <i>mesna</i> )	CE	N7 (PSP)
<b>TOPOISOMERASE INHIBITORS</b>		
<i>etoposide oral capsule 50 mg</i>	CE	N7 (PG)
<b>CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS</b>		
<b>ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE</b>		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>benazepril-hydrochlorothiazide oral tablet 5-6.25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only)
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	PG	
<i>quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	PG	
<b>ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE</b>		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>lisinopril oral tablet 30 mg, 40 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only)
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	PG	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	PG	
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE</b>		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	NP*	
<b>ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE</b>		
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	PG	
<b>ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE</b>		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	NP*	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	PG	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	NP*	
<i>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</i>	NP*	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	NP*	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	PG	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE</b>		
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM</b>		
<i>amiodarone hcl oral tablet 200 mg, 400 mg</i>	PG	
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	PG	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	NP*	PA
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	PG	
<b>MULTAQ ORAL TABLET 400 MG (dronedarone hcl)</b>	NP*	PA
<b>NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (disopyramide phosphate)</b>	PB	
<i>amiodarone hcl (Pacerone Oral Tablet 100 Mg, 200 Mg)</i>	PG	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	NP*	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	PG	
<i>sotalol hcl (af) oral tablet 120 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>sotalol hcl (af) oral tablet 160 mg, 80 mg</i>	PG	
<i>sotalol hcl oral tablet 120 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>sotalol hcl oral tablet 160 mg, 240 mg</i>	PG	
<b>ANTILIPEMICS, BILE ACID RESINS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<i>cholestyramine light oral packet 4 gm</i>	PG	
<i>cholestyramine light oral powder 4 gm/dose</i>	PG	

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04/01/2024

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cholestyramine oral packet 4 gm</i>	PG	
<i>cholestyramine oral powder 4 gml/dose</i>	PG	
<i>colesevelam hcl oral packet 3.75 gm</i>	NP*	
<i>colestipol hcl oral granules 5 gm</i>	PG	
<i>colestipol hcl oral packet 5 gm</i>	PG	
<i>colestipol hcl oral tablet 1 gm</i>	PG	
<i>cholestyramine light (Prevalite Oral Powder 4 Gm/Dose)</i>	PG	
<b>ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<i>ezetimibe oral tablet 10 mg</i>	PG	
<b>ANTILIPEMICS, FIBRATES - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<i>fenofibrate micronized oral capsule 200 mg, 43 mg, 67 mg</i>	PG	
<i>fenofibrate oral capsule 134 mg, 150 mg</i>	PG	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	PG	
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	PG	
<i>gemfibrozil oral tablet 600 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	CE	LGC (Lowest Generic Copay applies to ME members only.); N7 (PG); AL (Min 40 Years and Max 75 Years)

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<i>atorvastatin calcium oral tablet 40 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.); N8 (Exception process available for \$0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease)
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	PG	
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	PG	
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	CE	LGC (Lowest Generic Copay applies to ME members only.); N7 (PG); AL (Min 40 Years and Max 75 Years)
<i>simvastatin oral tablet 80 mg</i>	PG	ST; LGC (Lowest Generic Copay applies to ME members only.); N8 (Exception process available for \$0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease)

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<b>ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	NP*	
<b>ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	PG	
<b>ANTILIPEMICS, OMEGA-3 FATTY ACIDS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<i>icosapent ethyl oral capsule 0.5 gm</i>	PG	
<i>icosapent ethyl oral capsule 1 gm</i>	PG	N8 (Only indicated as an adjunct to diet to reduce TG levels in adult patients with severe (greater than or equal to 500 mg/dL) hypertriglyceridemia)
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	NP*	
<b>ANTILIPEMICS, PCSK9 INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML ( <i>evolocumab</i> )	PSP	PA; QL (1 CARTRIDGE per 28 DAYs)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML ( <i>evolocumab</i> )	PSP	PA; QL (3 SYRINGES per 28 DAYs)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML ( <i>evolocumab</i> )	PSP	PA; QL (3 PENS per 28 DAYs)
<b>BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS</b>		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	PG	
<b>BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	PG	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	PG	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	PG	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	NP*	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	PG	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only)
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	PG	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	PG	
<i>pindolol oral tablet 10 mg, 5 mg</i>	PG	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	PG	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	PG	

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<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>propranolol hcl oral tablet 60 mg</i>	PG	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	PG	
<b>CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS</b>		
<i>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</i>	PG	
<b>CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS</b>		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)</i>	PG	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	PG	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	PG	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	PG	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg</i>	PG	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	PG	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	PG	

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<i>isradipine oral capsule 2.5 mg, 5 mg</i>	PG	
<i>diltiazem hcl (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)</i>	PG	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	PG	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	PG	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	PG	
<i>nimodipine oral capsule 30 mg</i>	PG	
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	PG	
<i>diltiazem hcl er beads (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)</i>	PG	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	PG	
<i>verapamil hcl er oral tablet extended release 120 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>verapamil hcl er oral tablet extended release 180 mg, 240 mg</i>	PG	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS</b>		
<i>digoxin oral solution 0.05 mg/ml</i>	PG	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	PG	
<b>DIRECT RENIN INHIBITORS/COMBINATIONS - DRUGS TO TREAT HEART CONDITIONS</b>		
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	PG	
<b>DIURETICS - DRUGS TO TREAT HEART CONDITIONS</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	PG	
<i>amiloride hcl oral tablet 5 mg</i>	PG	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	PG	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	PG	
DIURIL ORAL SUSPENSION 250 MG/5ML ( <i>chlorothiazide</i> )	NP*	
<i>ethacrynic acid oral tablet 25 mg</i>	NP*	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	PG	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>hydrochlorothiazide oral tablet 12.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only)
<i>hydrochlorothiazide oral tablet 25 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	PG	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	PG	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	PG	
<i>spironolactone oral tablet 100 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>spironolactone oral tablet 25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>spironolactone-hctz oral tablet 25-25 mg</i>	PG	
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	PG	
<i>triamterene oral capsule 100 mg, 50 mg</i>	PG	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>HEART FAILURE</b>		
CORLANOR ORAL SOLUTION 5 MG/5ML ( <i>ivabradine hcl</i> )	PB	
CORLANOR ORAL TABLET 5 MG, 7.5 MG ( <i>ivabradine hcl</i> )	PB	
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG ( <i>sacubitril-valsartan</i> )	PB	
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg</i>	PG	
<b>MISCELLANEOUS</b>		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	NP*	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	PG	
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 50 mg</i>	PG	
<i>hydralazine hcl oral tablet 25 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	PG	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	PG	
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	PSP	PA; QL (360 CAPSULES per 30 days)
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	PG	ST
<b>NITRATES - DRUGS TO TREAT HEART CONDITIONS</b>		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	PG	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	PG	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	PG	
NITRO-BID TRANSDERMAL OINTMENT 2% ( <i>nitroglycerin</i> )	NP*	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR ( <i>nitroglycerin</i> )	PB	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	PG	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/1hr, 0.2 mg/1hr, 0.4 mg/1hr, 0.6 mg/1hr</i>	PG	
<i>nitroglycerin translingual solution 0.4 mg/spray</i>	NP*	
<b>PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION</b>		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG ( <i>riociguat</i> )	NPSP	PA; QL (90 TABLETS per 30 DAYS)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	PSP	PA; QL (30 TABLETS per 30 DAYS)
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	PSP	PA; QL (60 TABLETS per 30 DAYS)
OPSUMIT ORAL TABLET 10 MG ( <i>macitentan</i> )	PSP	PA; QL (30 TABLETS per 30 DAYS)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	PSP	PA
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ( <i>treprostinil diolamine</i> )	PSP	PA
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG ( <i>treprostinil diolamine</i> )	PSP	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG ( <i>treprostinil diolamine</i> )	PSP	PA
REMODULIN INJECTION SOLUTION 100 MG/20ML, 20 MG/20ML, 200 MG/20ML, 50 MG/20ML ( <i>treprostinil</i> )	NPSP	PA
<i>sildenafil citrate oral tablet 20 mg</i>	PSP	PA; QL (360 TABLETS per 30 days)
<i>tadalafil (pah) oral tablet 20 mg</i>	NPSP	PA; QL (60 TABLETS per 30 DAYS)
TYVASO INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	PSP	PA; QL (28 AMPULES per 28 DAYS)
TYVASO REFILL INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	PSP	PA; QL (28 AMPULES per 28 DAYS)
TYVASO STARTER INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	PSP	PA; QL (28 AMPULES per 28 DAYS)
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML ( <i>iloprost</i> )	PSP	PA; QL (270 AMPULES per 30 DAYS)
<b>CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS</b>		
<b>ALCOHOL DETERRENTS</b>		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	NP*	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ANXIETY - DRUGS TO TREAT ANXIETY</b>		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML ( <i>alprazolam</i> )	PB	QL (300 ML per 30 days)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	PG	QL (150 TABLETS per 30 days)
<i>alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	PG	QL (150 TABLETS per 30 days)
<i>bupirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	PG	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	PG	QL (360 CAPSULES per 30 days)
<i>clomipramine hcl oral capsule 25 mg, 50 mg</i>	NP*	QL (150 CAPSULES per 30 days); AL (Max 65 Years)
<i>clomipramine hcl oral capsule 75 mg</i>	NP*	QL (90 CAPSULES per 30 days); AL (Max 65 Years)
<i>fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg</i>	PG	
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	PG	
<i>lorazepam oral concentrate 2 mg/ml</i>	PG	QL (150 ML per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	PG	QL (150 TABLETS per 30 days)
<i>meprobamate oral tablet 200 mg, 400 mg</i>	PG	
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	PG	QL (120 CAPSULES per 30 days)
<b>ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS</b>		
<i>donepezil hcl oral tablet 10 mg, 5 mg</i>	PG	
<i>donepezil hcl oral tablet 23 mg</i>	NP*	
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	PG	
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>galantamine hydrobromide oral solution 4 mg/ml</i>	NP*	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	NP*	
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	PG	PA; AL (Min 29 Years)
<i>memantine hcl oral solution 2 mg/ml</i>	PG	PA; AL (Min 29 Years)
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg &amp; 21 x 10 mg, 5 mg</i>	PG	PA; AL (Min 29 Years)
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	NP*	PA
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	NP*	PA
<b>ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION</b>		
<i>amitriptyline hcl oral tablet 10 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (150 TABLETS per 30 days); AL (Max 65 Years)
<i>amitriptyline hcl oral tablet 100 mg, 150 mg, 75 mg</i>	PG	AL (Max 65 Years)
<i>amitriptyline hcl oral tablet 25 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>amitriptyline hcl oral tablet 50 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (30 TABLETS per 30 days); AL (Max 65 Years)
<i>amoxapine oral tablet 100 mg, 25 mg, 50 mg</i>	PG	QL (90 TABLETS per 30 days); AL (Max 65 Years)
<i>amoxapine oral tablet 150 mg</i>	PG	QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	PG	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	PG	
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	NP*	
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>desipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (90 TABLETS per 30 days); AL (Max 65 Years)
<i>desipramine hcl oral tablet 100 mg, 150 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (30 TABLETS per 30 days); AL (Max 65 Years)
<i>desipramine hcl oral tablet 75 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	NP*	
<i>doxepin hcl oral capsule 10 mg, 25 mg, 50 mg</i>	PG	QL (90 CAPSULES per 30 days); AL (Max 65 Years)
<i>doxepin hcl oral capsule 100 mg, 150 mg</i>	PG	QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>doxepin hcl oral capsule 75 mg</i>	PG	QL (60 CAPSULES per 30 days); AL (Max 65 Years)
<i>doxepin hcl oral concentrate 10 mg/ml</i>	PG	QL (450 ML per 30 days); AL (Max 65 Years)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	PG	
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	PG	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG ( <i>levomilnacipran hcl</i> )	NP*	ST; QL (30 CAPSULES per 30 days)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ( <i>levomilnacipran hcl</i> )	NP*	ST; QL (30 CAPSULES per 30 days)
<i>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>fluoxetine hcl oral capsule delayed release 90 mg</i>	PG	
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	PG	
<i>fluoxetine hcl oral tablet 10 mg, 20 mg</i>	PG	
<i>imipramine hcl oral tablet 10 mg, 25 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (120 TABLETS per 30 days); AL (Max 65 Years)
<i>imipramine hcl oral tablet 50 mg</i>	PG	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>imipramine pamoate oral capsule 100 mg, 75 mg</i>	NP*	QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>imipramine pamoate oral capsule 125 mg, 150 mg</i>	NP*	AL (Max 65 Years)
MARPLAN ORAL TABLET 10 MG ( <i>isocarboxazid</i> )	NP*	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	PG	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	PG	
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	NP*	
<i>nortriptyline hcl oral capsule 10 mg</i>	PG	QL (150 CAPSULES per 30 days); AL (Max 65 Years)
<i>nortriptyline hcl oral capsule 25 mg</i>	PG	QL (60 CAPSULES per 30 days); AL (Max 65 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nortriptyline hcl oral capsule 50 mg</i>	PG	QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>nortriptyline hcl oral capsule 75 mg</i>	PG	AL (Max 65 Years)
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	PG	QL (750 ML per 30 days); AL (Max 65 Years)
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</i>	NP*	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>phenelzine sulfate oral tablet 15 mg</i>	PG	
<i>protriptyline hcl oral tablet 10 mg</i>	NP*	QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>protriptyline hcl oral tablet 5 mg</i>	NP*	QL (90 TABLETS per 30 days); AL (Max 65 Years)
<i>sertraline hcl oral concentrate 20 mg/ml</i>	PG	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>tranlycypromine sulfate oral tablet 10 mg</i>	NP*	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	PG	
<i>trimipramine maleate oral capsule 100 mg</i>	NP*	QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>trimipramine maleate oral capsule 25 mg, 50 mg</i>	NP*	QL (60 CAPSULES per 30 days); AL (Max 65 Years)
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG ( <i>vortioxetine hbr</i> )	NP*	ST
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	PG	
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	PG	
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	PG	
<b>ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE</b>		
<i>amantadine hcl oral capsule 100 mg</i>	PG	
<i>amantadine hcl oral solution 50 mg/5ml</i>	PG	
<i>amantadine hcl oral tablet 100 mg</i>	PG	
<b>APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (<i>apomorphine hcl</i>)</b>	NPSP	PA; QL (20 CARTRIDGES per 30 days)
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	PG	
<i>bromocriptine mesylate oral capsule 5 mg</i>	PG	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	PG	
<i>carbidopa oral tablet 25 mg</i>	PG	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	PG	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	PG	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	PG	
<i>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, 50-200-200 mg</i>	NP*	
<i>entacapone oral tablet 200 mg</i>	PG	
<b>NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (<i>rotigotine</i>)</b>	PB	
<b>ONGENTYS ORAL CAPSULE 25 MG, 50 MG (<i>opicapone</i>)</b>	NP*	
<i>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</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	PG	
<i>rasagiline mesylate oral tablet 0.5 mg</i>	PG	
<i>rasagiline mesylate oral tablet 1 mg</i>	NP*	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	PG	
<i>selegiline hcl oral capsule 5 mg</i>	PG	
<i>selegiline hcl oral tablet 5 mg</i>	PG	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	PG	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	PG	
<b>ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES</b>		
<i>aripiprazole oral solution 1 mg/ml</i>	PG	
<i>aripiprazole oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	PG	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	PG	
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	PG	
<i>chlorpromazine hcl oral tablet 10 mg, 200 mg, 50 mg</i>	PG	
<i>chlorpromazine hcl oral tablet 100 mg, 25 mg</i>	NP*	
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	PG	
<i>clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	PG	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	PG	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	PG	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	PG	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	PG	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	PG	
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	PG	
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	PG	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	PG	
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	NP*	
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg</i>	NP*	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	PG	
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	NP*	
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	PG	
<b>REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (brexpiprazole)</b>	NP*	ST
<i>risperidone oral solution 1 mg/ml</i>	PG	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	PG	
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	PG	
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	PG	
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	PG	
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	PG	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	PG	
<b>ANTISEIZURE AGENTS - DRUGS TO TREAT SEIZURES</b>		
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	PG	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	PG	
<i>carbamazepine oral suspension 100 mg/5ml</i>	PG	
<i>carbamazepine oral tablet 200 mg</i>	PG	
<i>carbamazepine oral tablet chewable 100 mg</i>	PG	
<i>clobazam oral suspension 2.5 mg/ml</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobazam oral tablet 10 mg, 20 mg</i>	PG	
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	PG	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	PG	QL (180 TABLETS per 30 days)
<i>diazepam (Diazepam Intensol Oral Concentrate 5 Mg/ML)</i>	PG	QL (240 ML per 30 days)
<i>diazepam oral solution 5 mg/5ml</i>	PG	QL (1200 ML per 30 days)
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	PG	QL (120 TABLETS per 30 days)
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	NP*	
<b>DILANTIN ORAL CAPSULE 30 MG</b> ( <i>phenytoin sodium extended</i> )	NP*	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	PG	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	PG	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	PG	
<b>EPIDIOLEX ORAL SOLUTION 100 MG/ML</b> ( <i>cannabidiol</i> )	PSP	PA; QL (800 ML per 30 days)
<i>carbamazepine (Eptol Oral Tablet 200 Mg)</i>	PG	
<i>ethosuximide oral capsule 250 mg</i>	PG	
<i>ethosuximide oral solution 250 mg/5ml</i>	PG	
<i>felbamate oral suspension 600 mg/5ml</i>	PG	
<i>felbamate oral tablet 400 mg, 600 mg</i>	NP*	
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	PG	QL (6 CAPSULES per 1 day)
<i>gabapentin oral solution 250 mg/5ml</i>	PG	QL (72 ML per 1 day)
<i>gabapentin oral tablet 600 mg</i>	PG	QL (6 TABLETS per 1 day)
<i>gabapentin oral tablet 800 mg</i>	PG	QL (4 TABLETS per 1 day)
<i>lacosamide oral solution 10 mg/ml</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	PG	
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	NP*	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	PG	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	NP*	
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	NP*	
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	PG	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</i>	PG	
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg &amp; 7 x 100 mg</i>	PG	
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	PG	
<i>levetiracetam oral solution 100 mg/ml</i>	PG	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	PG	
<i>methsuximide oral capsule 300 mg</i>	PG	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML ( <i>midazolam (anticonvulsant)</i> )	NP*	PA; QL (10 NASAL SPRAY UNITS per 30 days)
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	PG	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	PG	
<i>phenobarbital oral elixir 20 mg/5ml</i>	PG	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	PG	
<i>phenytoin (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)</i>	PG	
<i>phenytoin oral suspension 125 mg/5ml</i>	PG	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	PG	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	PG	ST
<i>pregabalin oral solution 20 mg/ml</i>	PG	ST

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>primidone oral tablet 250 mg, 50 mg</i>	PG	
<i>rufinamide oral suspension 40 mg/ml</i>	NP*	
<i>rufinamide oral tablet 200 mg, 400 mg</i>	NP*	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 4 mg</i>	PG	
<i>tiagabine hcl oral tablet 2 mg</i>	NP*	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	PG	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	PG	
<i>valproic acid oral capsule 250 mg</i>	PG	
<i>valproic acid oral solution 250 mg/5ml</i>	PG	
<i>vigabatrin oral packet 500 mg</i>	PSP	PA; QL (180 PACKETS per 30 days)
<i>vigabatrin oral tablet 500 mg</i>	PSP	PA; QL (180 TABLETS per 30 days)
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG ( <i>cenobamate</i> )	PB	
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG ( <i>cenobamate</i> )	PB	
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG ( <i>cenobamate</i> )	PB	
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 ( <i>cenobamate</i> )	PB	
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	PG	
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD</b>		
<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 10 mg, 5 mg</i>	PG	QL (90 CAPSULES per 30 days)
<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 15 mg, 20 mg, 25 mg, 30 mg</i>	PG	QL (30 CAPSULES per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 5 mg, 7.5 mg</i>	PG	QL (90 TABLETS per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 15 mg, 20 mg</i>	PG	QL (60 TABLETS per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 30 mg</i>	PG	QL (30 TABLETS per 30 days)
<i>atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg</i>	PG	QL (120 CAPSULES per 30 days)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	PG	QL (30 CAPSULES per 30 days)
<i>atomoxetine hcl oral capsule 40 mg</i>	PG	QL (60 CAPSULES per 30 days)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 5 mg</i>	NP*	QL (60 CAPSULES per 30 days)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg, 30 mg, 35 mg, 40 mg</i>	NP*	QL (30 CAPSULES per 30 days)
<i>dexmethylphenidate hcl oral tablet 10 mg</i>	PG	QL (60 TABLETS per 30 days)
<i>dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg</i>	PG	QL (120 TABLETS per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg</i>	NP*	QL (120 CAPSULES per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	NP*	QL (60 CAPSULES per 30 days)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	PG	QL (1200 ML per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	NP*	QL (120 TABLETS per 30 days)
<i>dextroamphetamine sulfate oral tablet 15 mg, 20 mg</i>	PG	QL (60 TABLETS per 30 DAYs)
<i>dextroamphetamine sulfate oral tablet 30 mg</i>	PG	QL (30 TABLETS per 30 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DYANA VEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML ( <i>amphetamine</i> )	NP*	QL (240 ML per 30 DAYs)
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	NP*	
<i>methamphetamine hcl oral tablet 5 mg</i>	NP*	QL (150 TABLETS per 30 days)
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg</i>	NP*	QL (60 CAPSULES per 30 days)
<i>methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg</i>	NP*	QL (30 CAPSULES per 30 days)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 30 mg</i>	NP*	QL (60 CAPSULES per 30 days)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg</i>	NP*	QL (30 CAPSULES per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 36 mg</i>	PG	QL (60 TABLETS per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 54 mg</i>	PG	QL (30 TABLETS per 30 days)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	PG	QL (90 TABLETS per 30 days)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	NP*	QL (900 ML per 30 days)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	NP*	QL (1800 ML per 30 days)
<i>methylphenidate hcl oral tablet 10 mg, 5 mg</i>	PG	QL (180 TABLETS per 30 days)
<i>methylphenidate hcl oral tablet 20 mg</i>	PG	QL (90 TABLETS per 30 days)
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	NP*	QL (180 CHEW TABLETS per 30 days)
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG ( <i>viloxazine hcl</i> )	NP*	PA; QL (90 CAPSULES per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dextroamphetamine sulfate</i> (Zenzedi Oral Tablet 2.5 Mg, 7.5 Mg)	PG	QL (120 TABLETS per 30 days)
<b>FIBROMYALGIA</b>		
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG ( <i>milnacipran hcl</i> )	NP*	ST
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG ( <i>milnacipran hcl</i> )	NP*	ST
<b>HYPNOTICS - DRUGS TO TREAT INSOMNIA</b>		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG ( <i>suvorexant</i> )	NP*	PA; QL (30 TABLETS per 30 days)
DAYVIGO ORAL TABLET 10 MG, 5 MG ( <i>lemborexant</i> )	NP*	PA; QL (30 TABLETS per 30 days)
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	NP*	QL (30 TABLETS per 30 days); AL (Max 65 Years)
<i>estazolam oral tablet 1 mg, 2 mg</i>	NP*	QL (15 TABLETS per 30 days)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	PG	QL (15 TABLETS per 30 days)
QUVIVIQ ORAL TABLET 25 MG, 50 MG ( <i>daridorexant hcl</i> )	NP*	PA; QL (30 TABLETS per 30 DAYS)
<i>ramelteon oral tablet 8 mg</i>	PG	QL (15 TABLETS per 30 days)
<i>sleep-aid oral tablet 25 mg</i>	PG	
<i>tasimelteon oral capsule 20 mg</i>	PSP	PA; QL (30 CAPSULES per 30 DAYS)
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	PG	QL (15 CAPSULES per 30 days)
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	NP*	QL (10 TABLETS per 30 days)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	PG	QL (15 CAPSULES per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	NP*	QL (15 TABLETS per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	PG	QL (15 TABLETS per 30 days)
<b>MIGRAINE - DRUGS TO TREAT SEVERE HEADACHES</b>		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML ( <i>erenumab-aooe</i> )	PB	ST; QL (1 INJECTION per 30 days)
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	NP*	QL (12 TABLETS per 30 days)
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	NP*	
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	NP*	QL (12 TABLETS per 30 days)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>galcanezumab-gnlm</i> )	PB	ST; QL (3 SYRINGES per 30 DAYS)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML ( <i>galcanezumab-gnlm</i> )	PB	ST; N8 (Quantity limit will be 2 syringes for the initial month); QL (1 SYRINGE per 30 DAYS)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML ( <i>galcanezumab-gnlm</i> )	PB	ST; N8 (Quantity limit will be 2 syringes for the initial month); QL (1 SYRINGE per 30 DAYS)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	NP*	
<i>frovatriptan succinate oral tablet 2.5 mg</i>	NP*	QL (18 TABLETS per 30 days)
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	PG	QL (12 TABLETS per 30 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	PG	QL (18 TABLETS per 30 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	PG	QL (18 TABLETS per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sumatriptan nasal solution 20 mg/lact</i>	NP*	QL (12 SPRAYS per 30 days)
<i>sumatriptan nasal solution 5 mg/lact</i>	NP*	QL (24 SPRAYS per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	PG	QL (12 TABLETS per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml</i>	NP*	QL (18 SYRINGES per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 6 mg/0.5ml</i>	NP*	QL (12 SOLUTION CARTRIDGE per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	NP*	QL (12 VIALS per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml</i>	NP*	QL (18 SYRINGES per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	NP*	QL (12 SOLUTION AUTO-INJECTOR per 30 days)
<i>sumatriptan-naproxen sodium oral tablet 85-500 mg</i>	NP*	ST; QL (9 TABLETS per 30 days)
UBRELVY ORAL TABLET 100 MG, 50 MG ( <i>ubrogepant</i> )	NP*	ST; QL (16 TABLETS per 30 DAYS)
<i>zolmitriptan nasal solution 5 mg</i>	PG	QL (12 SPRAYS per 30 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	PG	QL (12 TABLETS per 30 days)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	PG	QL (12 TABLETS per 30 days)
<b>MISCELLANEOUS</b>		
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML ( <i>risdiplam</i> )	NPSP	PA; QL (2 BOTTLES per 24 days)
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	PG	
<i>lithium carbonate oral tablet 300 mg</i>	PG	
<i>lithium oral solution 8 meq/5ml</i>	NP*	
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	PG	
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	PG	
<i>pyridostigmine bromide oral tablet 60 mg</i>	PG	
<i>riluzole oral tablet 50 mg</i>	PG	
<b>MOVEMENT DISORDERS</b>		
<i>tetrabenazine oral tablet 12.5 mg</i>	PSP	PA; QL (120 TABLETS per 30 DAYs)
<i>tetrabenazine oral tablet 25 mg</i>	PSP	PA; QL (60 TABLETS per 30 DAYs)
<b>MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS</b>		
<b>BETASERON SUBCUTANEOUS KIT 0.3 MG</b> ( <i>interferon beta-1b</i> )	PSP	PA; QL (14 INJECTIONS per 28 DAYs)
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	NPSP	PA; QL (60 TABLETS per 30 days)
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	PSP	PA; QL (14 CAPSULES per 28 DAYs)
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	PSP	PA; QL (60 CAPSULES per 30 DAYs)
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 &amp; 240 mg</i>	PSP	PA; QL (1 KIT per 30 days)
<i>fingolimod hcl oral capsule 0.5 mg</i>	PSP	PA; QL (30 CAPSULES per 30 DAYs)
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	NP*	PA; QL (12 SYRINGES per 28 days)
<i>glatiramer acetate</i> (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/MI)	NP*	PA; QL (30 INJECTIONS per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MUSCULOSKELETAL THERAPY AGENTS</b>		
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	PG	
<i>carisoprodol oral tablet 350 mg</i>	PG	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>chlorzoxazone oral tablet 500 mg</i>	PG	PA; AL (Max 70 Years)
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	PG	PA; AL (Max 70 Years)
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	PG	
<i>metaxalone oral tablet 800 mg</i>	NP*	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	PG	PA; AL (Max 70 Years)
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	PG	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	NP*	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>orphenadrine-aspirin-caffeine (Orphengesic Forte Oral Tablet 50-770-60 Mg)</i>	NP*	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	PG	
<b>NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS</b>		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	PG	PA; QL (30 TABLETS per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>armodafinil oral tablet 50 mg</i>	PG	PA; QL (60 TABLETS per 30 days)
<i>modafinil oral tablet 100 mg, 200 mg</i>	NP*	PA; QL (60 TABLETS per 30 days)
SUNOSI ORAL TABLET 150 MG, 75 MG ( <i>solriamfetol hcl</i> )	NP*	PA; QL (30 TABLETS per 30 days)
<b>OPIOID AGONIST/ANTAGONIST</b>		
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	PG	QL (2 FILM per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	PG	QL (3 FILM per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	CE	N7 (PG); QL (3 TABLETS per 1 day)
<b>OPIOID ANTAGONIST</b>		
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	PG	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	PG	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	PG	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	PG	QL (4 SPRAYS per 25 days)
<i>naltrexone hcl oral tablet 50 mg</i>	CE	N7 (PG)
NARCAN NASAL LIQUID 4 MG/0.1ML ( <i>naloxone hcl</i> )	PG	QL (4 SPRAYS per 25 DAYS)
<b>OPIOID PARTIAL AGONISTS</b>		
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	CE	N7 (PG); N8 (Must obtain approval after the first 30 day supply); QL (90 TABLETS per 30 days)
<b>PSYCHOTHERAPEUTIC-MISC</b>		
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg</i>	NP*	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>chlordiazepoxide-amitriptyline oral tablet 5-12.5 mg</i>	NP*	QLR (QL applies to members age 65 and older); QL (120 TABLETS per 30 days); AL (Max 65 Years)
<i>perphenazine-amitriptyline oral tablet 2-10 mg</i>	NP*	QLR (QL applies to members age 65 and older); QL (150 TABLET per 30 days); AL (Max 65 Years)
<i>perphenazine-amitriptyline oral tablet 2-25 mg, 4-25 mg</i>	NP*	QLR (QL applies to members age 65 and older); QL (60 TABLET per 30 days); AL (Max 65 Years)
<i>perphenazine-amitriptyline oral tablet 4-10 mg</i>	NP*	QLR (QL applies to members age 65 and older); QL (120 TABLET per 30 days); AL (Max 65 Years)
<i>perphenazine-amitriptyline oral tablet 4-50 mg</i>	NP*	QLR (QL applies to members age 65 and older); QL (30 TABLET per 30 days); AL (Max 65 Years)
<i>pimozide oral tablet 1 mg, 2 mg</i>	NP*	
<b>SMOKING DETERRENTS</b>		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>goodsense nicotine mouth/throat gum 4 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>nicotine polacrilex mouth/throat lozenge 2 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
NICOTROL INHALATION INHALER 10 MG ( <i>nicotine</i> )	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year); QL (168 DAYS OF TREATMENT per 365 days)
NICOTROL NS NASAL SOLUTION 10 MG/ML ( <i>nicotine</i> )	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year); QL (168 DAYS OF TREATMENT per 365 days)
<i>sm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 &amp; 1 mg x 42</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	CE	N7 (Not Covered); N8 (\$0 copay limited to 2 treatment cycles/year)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES</b>		
<b>ACROMEGALY - DRUGS TO TREAT CONDITIONS THAT CAUSE EXCESSIVE GROWTH</b>		
<i>octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	PSP	PA; QL (90 ML per 30 days)
<i>octreotide acetate injection solution 1000 mcg/ml</i>	PSP	PA; QL (45 ML per 30 days)
<i>octreotide acetate injection solution 200 mcg/ml</i>	PSP	PA; QL (225 ML per 30 days)
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	PSP	PA; QL (90 ML per 30 days)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML ( <i>lanreotide acetate</i> )	PSP	PA; QL (1 INJECTION per 28 days)
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG ( <i>pegvisomant</i> )	PSP	PA; QL (30 VIALS per 30 DAYS)
<b>ANDROGENS - DRUGS TO REGULATE MALE HORMONES</b>		
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	PG	PA
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	PG	PA
<i>testosterone transdermal gel 10 mg/lact (2%), 25 mg/2.5gm (1%)</i>	PG	PA
<b>ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS</b>		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	PG	
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	PG	
<b>ANTIDIABETICS, AMYLIN ANALOGS</b>		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML ( <i>pramlintide acetate</i> )	NP*	ST

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML ( <i>pramlintide acetate</i> )	NP*	ST
<b>ANTIDIABETICS, BIGUANIDE</b>		
<i>metformin hcl er oral tablet extended release 24 hour 500 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>metformin hcl er oral tablet extended release 24 hour 750 mg</i>	PG	
<i>metformin hcl oral tablet 1000 mg, 500 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>metformin hcl oral tablet 850 mg</i>	CE	LGC (Lowest Generic Copay applies to ME members only.); N7 (PG); AL (Min 35 Years and Max 70 Years)
<b>ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS</b>		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR COMBINATIONS</b>		
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i>	PG	ST
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	NP*	ST
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG ( <i>sitagliptin-metformin hcl</i> )	PB	ST
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG ( <i>sitagliptin-metformin hcl</i> )	PB	ST

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS</b>		
<i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	NP*	ST
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG ( <i>sitagliptin phosphate</i> )	PB	ST
<b>ANTIDIABETICS, INCRETIN MIMETIC AGENTS</b>		
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML ( <i>dulaglutide</i> )	PB	ST; QL (4 PENS per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML ( <i>liraglutide</i> )	NP*	ST; QL (3 PENS per 30 days)
<b>ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS</b>		
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML ( <i>insulin glargine-lixisenatide</i> )	PB	ST
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML ( <i>insulin degludec-liraglutide</i> )	NP*	ST
<b>ANTIDIABETICS, INSULIN</b>		
ADMELOG INJECTION SOLUTION 100 UNIT/ML ( <i>insulin lispro</i> )	NP*	
ADMELOG SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin lispro</i> )	NP*	
ADMELOG SUBCUTANEOUS SOLUTION 100 UNIT/ML ( <i>insulin lispro</i> )	NP*	
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin glargine</i> )	PB	
BASAGLAR TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin glargine</i> )	PB	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin aspart (w/niacinamide)</i> )	PB	
FIASP INJECTION SOLUTION 100 UNIT/ML ( <i>insulin aspart (w/niacinamide)</i> )	PB	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML ( <i>insulin aspart (w/niacinamide)</i> )	PB	
FIASP SUBCUTANEOUS SOLUTION 100 UNIT/ML ( <i>insulin aspart (w/niacinamide)</i> )	PB	
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML ( <i>insulin regular human</i> )	PB	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML ( <i>insulin regular human</i> )	PB	
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin detemir</i> )	PB	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML ( <i>insulin detemir</i> )	PB	
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	PB	N8 (RELION not covered)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	PB	N8 (RELION not covered)
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML ( <i>insulin nph human (isophane)</i> )	PB	N8 (RELION not covered)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML ( <i>insulin nph human (isophane)</i> )	PB	N8 (RELION not covered)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin regular human</i> )	PB	N8 (RELION not covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML ( <i>insulin regular human</i> )	PB	N8 (RELION not covered)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin aspart</i> )	PB	
NOVOLOG INJECTION SOLUTION 100 UNIT/ML ( <i>insulin aspart</i> )	PB	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin aspart prot &amp; aspart</i> )	PB	
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin aspart prot &amp; aspart</i> )	PB	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML ( <i>insulin aspart</i> )	PB	
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML ( <i>insulin degludec</i> )	PB	
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML ( <i>insulin degludec</i> )	PB	
<b>ANTIDIABETICS, INSULIN SENSITIZER</b>		
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION</b>		
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	PG	
<b>ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION</b>		
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	PG	
<b>ANTIDIABETICS, MEGLITINIDE</b>		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	NP*	
<b>ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS</b>		
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG ( <i>empagliflozin-metformin hcl</i> )	PB	ST
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG ( <i>empagliflozin-metformin hcl</i> )	PB	ST
<b>ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS</b>		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG ( <i>empagliflozin-linagliptin</i> )	PB	ST
<b>ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS</b>		
JARDIANCE ORAL TABLET 10 MG, 25 MG ( <i>empagliflozin</i> )	PB	ST
<b>ANTIDIABETICS, SULFONYLUREA</b>		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>glipizide oral tablet 10 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>CALCIUM RECEPTOR AGONISTS</b>		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	PSP	PA; QL (60 TABLETS per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cinacalcet hcl oral tablet 90 mg</i>	PSP	PA; QL (120 TABLETS per 30 days)
<b>CALCIUM REGULATORS, BISPHOSPHONATES</b>		
<i>alendronate sodium oral solution 70 mg/75ml</i>	PG	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	PG	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT ( <i>alendronate-cholecalciferol</i> )	NP*	ST
<i>ibandronate sodium oral tablet 150 mg</i>	NP*	
<i>risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg</i>	NP*	
<i>risedronate sodium oral tablet delayed release 35 mg</i>	NP*	
<b>CALCIUM REGULATORS, MISCELLANEOUS</b>		
<i>calcitonin (salmon) nasal solution 200 unit/lact</i>	PG	
<b>CALCIUM REGULATORS, PARATHYROID HORMONES</b>		
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML ( <i>abaloparatide</i> )	PSP	PA; QL (1 PEN per 30 DAYS)
<b>CHELATING AGENTS</b>		
CHEMET ORAL CAPSULE 100 MG ( <i>succimer</i> )	NP*	
<i>deferiprone oral tablet 1000 mg, 500 mg</i>	PSP	PA
FERRIPROX ORAL SOLUTION 100 MG/ML ( <i>deferiprone</i> )	PSP	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG ( <i>deferiprone</i> )	PSP	PA
<i>penicillamine oral tablet 250 mg</i>	PSP	PA
<b>CONTRACEPTIVES - PRODUCTS FOR BIRTH CONTROL</b>		
<i>levonorgestrel-ethinyl estrad (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)</i>	CE	N7 (Not Covered)
AFTERA ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
AFTERPILL ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad</i> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	CE	N7 (Not Covered)
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Amethia Oral Tablet 0.15-0.03 & 0.01 Mg)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Oral Tablet 90-20 Mcg)	CE	N7 (Not Covered)
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR ( <i>segesterone-ethinyl estradiol</i> )	CE	N7 (Not Covered); QL (1 RING per 300 DAYs)
<i>desogestrel-ethinyl estradiol</i> (Apri Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin-eth estrad triphasic</i> (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad</i> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (Not Covered)
<i>norethindrone-eth estradiol</i> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	CE	N7 (Not Covered)
<i>norethindrone</i> (Camila Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	CE	N7 (Not Covered)
CAYA VAGINAL DIAPHRAGM ( <i>diaphragm arc-spring</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYs)
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>condoms</i>	CE	N7 (Not Covered); QL (12 CONDOMS per 25 days)
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	CE	N7 (Not Covered)
CURAE ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desogestrel-ethinyl estradiol</i> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin-eth estrad triphasic</i> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	CE	N7 (Not Covered)
<i>norethindrone</i> (Deblitane Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Delyla Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (Not Covered)
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML ( <i>medroxyprogesterone acetate</i> )	CE	N7 (Not Covered); QL (4 INJECTIONS per 300 DAYs)
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg</i> (21/5)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Dolishale Oral Tablet 90-20 Mcg)	CE	N7 (Not Covered)
<i>drosipren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	CE	N7 (Not Covered)
<i>drosiprenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	CE	N7 (Not Covered)
ECONTRA ONE-STEP ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
<i>norgestrel-ethinyl estradiol</i> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	CE	N7 (Not Covered)
ELLA ORAL TABLET 30 MG ( <i>ulipristal acetate</i> )	CE	N7 (Not Covered)
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	CE	N7 (Not Covered); QL (13 RING per 300 days)
<i>etonogestrel-ethinyl estradiol</i> (Enilloring Vaginal Ring 0.12-0.015 Mg/24Hr)	CE	N7 (Not Covered); QL (13 RINGS per 300 DAYs)
<i>levonorg-eth estrad triphasic</i> (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	CE	N7 (Not Covered)

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<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone</i> (Errin Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	CE	N7 (Not Covered)
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	CE	N7 (Not Covered); QL (13 RING per 300 DAYs)
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (Not Covered)
FC2 FEMALE CONDOM ( <i>condoms - female</i> )	CE	N7 (Not Covered); QL (12 CONDOMS per 30 days)
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM ( <i>cervical caps</i> )	CE	N7 (Not Covered); QL (1 DEVICE per 300 DAYs)
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Gemmyly Oral Capsule 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	CE	N7 (Not Covered); QL (13 RING per 300 days)
<i>norethindrone</i> (Heather Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
HER STYLE ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estrad 91-day</i> (Iclevia Oral Tablet 0.15-0.03 Mg)	CE	N7 (Not Covered)
<i>norethindrone</i> (Incassia Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Introvale Oral Tablet 0.15-0.03 Mg)	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Oral Tablet 3-0.02 Mg)	CE	N7 (Not Covered)
<i>norethindrone</i> (Jencycla Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Jolessa Oral Tablet 0.15-0.03 Mg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad-fe bisg</i> (Joyeaux Oral Tablet 0.1-20 Mg-Mcg(21))	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)

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<i>desogestrel-ethinyl estradiol</i> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (Not Covered)
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered); QL (1 INTRAUTERINE DEVICE per 300 DAYs)
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin-eth estradiol-fe</i> (Layolis Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin-eth estrad triphasic</i> (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorg-eth estrad triphasic</i> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	CE	N7 (Not Covered)
<i>levonorgest-eth est &amp; eth est oral tablet 42-21-21-7 days</i>	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i>	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	CE	N7 (Not Covered)
<i>levonorgestrel oral tablet 1.5 mg</i>	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	CE	N7 (Not Covered)
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)</i>	CE	N7 (Not Covered)
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY ( <i>levonorgestrel</i> )	CE	N7 (Not Covered); QL (1 INTRAUTERINE DEVICE per 300 Days)
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG ( <i>norethin-eth estrad-fe biphas</i> )	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est (Loestrin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)</i>	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est (Loestrin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)</i>	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe (Loestrin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe (Loestrin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)</i>	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day (Lojaimiess Oral Tablet 0.1-0.02 &amp; 0.01 Mg)</i>	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol (Loryna Oral Tablet 3-0.02 Mg)</i>	CE	N7 (Not Covered)
<i>norgestrel-ethinyl estradiol (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)</i>	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol (Lo-Zumandimine Oral Tablet 3-0.02 Mg)</i>	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad (Lutera Oral Tablet 0.1-20 Mg-Mcg)</i>	CE	N7 (Not Covered)
<i>norethindrone (Lyleq Oral Tablet 0.35 Mg)</i>	CE	N7 (Not Covered)

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<i>norethindrone</i> (Lyza Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	CE	N7 (Not Covered)
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	CE	N7 (Not Covered); QL (4 INJECTIONS per 300 DAYS)
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	CE	N7 (Not Covered); QL (4 INJECTIONS per 300 DAYS)
<i>norethin ace-eth estrad-fe</i> (Merzee Oral Capsule 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Microgestin 24 Fe Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (Not Covered)
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY ( <i>levonorgestrel</i> )	CE	N7 (Not Covered); QL (1 INTRAUTERINE DEVICE per 300 Days)
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (Not Covered)
MY CHOICE ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
MY WAY ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG ( <i>estradiol valerate-dienogest</i> )	CE	N7 (Not Covered)
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	CE	N7 (Not Covered)
NEW DAY ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG ( <i>etonogestrel</i> )	CE	N7 (Not Covered); QL (1 IMPLANT per 300 days)
NEXTSTELLIS ORAL TABLET 3-14.2 MG ( <i>drospirenone-estetrol</i> )	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet 3-0.02 Mg)	CE	N7 (Not Covered)
<i>norethindrone</i> (Nora-Be Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	CE	N7 (Not Covered)
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	CE	N7 (Not Covered)
<i>norethindrone oral tablet 0.35 mg</i>	CE	N7 (Not Covered)
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	CE	N7 (Not Covered)
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	CE	N7 (Not Covered)
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	CE	N7 (Not Covered)
<i>norethindrone</i> (Norlyroc Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	CE	N7 (Not Covered)

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<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norgestimate-eth estradiol</i> (Nymyo Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol</i> (Ocella Oral Tablet 3-0.03 Mg)	CE	N7 (Not Covered)
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM ( <i>diaphragms</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYs)
OPCICON ONE-STEP ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
OPTION 2 ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE ( <i>copper</i> )	CE	N7 (Not Covered); QL (1 INTRAUTERINE DEVICE per 300 days)
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
REACT ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Oral Tablet 42-21-21-7 Days)	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet 0.15-0.03 Mg)	CE	N7 (Not Covered)
<i>norethindrone</i> (Sharobel Oral Tablet 0.35 Mg)	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (Not Covered)
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet 0.15-0.03 & 0.01 Mg)	CE	N7 (Not Covered)
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered); QL (1 INTRAUTERINE DEVICE per 300 DAYs)
SLYND ORAL TABLET 4 MG ( <i>drospirenone</i> )	CE	N7 (Not Covered)
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol</i> (Syeda Oral Tablet 3-0.03 Mg)	CE	N7 (Not Covered)
TAKE ACTION ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethin ace-eth estrad-fe</i> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	CE	N7 (Not Covered)
<i>norethindron-ethinyl estrad-fe</i> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (Not Covered)
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (Not Covered)

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<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Nymyo Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (Not Covered)
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (Not Covered)
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (Not Covered)
<i>norgestrel-ethinyl estradiol</i> (Turqoz Oral Tablet 0.3-30 Mg-Mcg)	CE	N7 (Not Covered)
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR ( <i>levonorgestrel-eth estradiol</i> )	CE	N7 (Not Covered)
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG ( <i>levonorgestrel-ethinyl estrad</i> )	CE	N7 (Not Covered)
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	CE	N7 (Not Covered)
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG ( <i>desogestrel-ethinyl estradiol</i> )	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	CE	N7 (Not Covered)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad</i> (Vienna Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (Not Covered)
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	CE	N7 (Not Covered)
<i>desogestrel-ethinyl estradiol</i> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (Not Covered)
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet 0.5-35 Mg-Mcg)	CE	N7 (Not Covered)
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYS)
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYS)
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYS)
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYS)
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYS)
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYS)
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYS)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % ( <i>diaphragm wide seal</i> )	CE	N7 (Not Covered); QL (1 DIAPHRAGM per 300 DAYs)
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>norelgestromin-eth estradiol</i> (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	CE	N7 (Not Covered)
<i>norelgestromin-eth estradiol</i> (Zafemy Transdermal Patch Weekly 150-35 Mcg/24Hr)	CE	N7 (Not Covered)
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	CE	N7 (Not Covered)
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Oral Tablet 3-0.03 Mg)	CE	N7 (Not Covered)
<b>DIABETIC SUPPLIES</b>		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP ( <i>glucose blood</i> )	PB	QL (150 TEST STRIPS per 30 days)
ACCU-CHEK GUIDE IN VITRO STRIP ( <i>glucose blood</i> )	PB	QL (150 TEST STRIPS per 30 days)
ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID ( <i>blood glucose calibration</i> )	PB	
ACCU-CHEK SMARTVIEW IN VITRO STRIP ( <i>glucose blood</i> )	PB	QL (150 TEST STRIPS per 30 days)
ACCU-CHEK SOFTCLIX LANCETS ( <i>lancets</i> )	PB	
<i>alcohol prep pad</i>	PB	
AUTOLET PLATFORMS ( <i>lancets misc.</i> )	PB	
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	PB	
CHEMSTRIP 9 IN VITRO STRIP ( <i>multiple urine tests</i> )	PB	
DEXCOM G6 RECEIVER DEVICE ( <i>continuous blood gluc receiver</i> )	PB	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEXCOM G6 SENSOR ( <i>continuous blood gluc sensor</i> )	PB	QL (3 SENSORS per 25 DAYS)
DEXCOM G6 TRANSMITTER ( <i>continuous blood gluc transmit</i> )	PB	
DEXCOM G7 RECEIVER DEVICE ( <i>continuous blood gluc receiver</i> )	PB	
DEXCOM G7 SENSOR ( <i>continuous blood gluc sensor</i> )	PB	QL (3 SENSORS per 25 days)
DIASTIX IN VITRO STRIP ( <i>glucose urine test-glucose ox</i> )	PB	
KETOSTIX IN VITRO STRIP ( <i>acetone (urine) test</i> )	PB	
<i>lancets</i>	PB	
<i>lancing device</i>	PB	
NOVOFINE 32G X 6 MM ( <i>insulin pen needle</i> )	PB	
NOVOFINE PEN NEEDLE 32G X 6 MM ( <i>insulin pen needle</i> )	PB	
OMNIPOD 5 G6 INTRO (GEN 5) KIT ( <i>insulin disposable pump</i> )	PB	
OMNIPOD 5 G6 PODS (GEN 5) ( <i>insulin disposable pump</i> )	PB	
OMNIPOD CLASSIC PODS (GEN 3) ( <i>insulin disposable pump</i> )	PB	
OMNIPOD DASH INTRO (GEN 4) KIT ( <i>insulin disposable pump</i> )	PB	
OMNIPOD DASH PDM (GEN 4) KIT ( <i>insulin disposable pump</i> )	PB	
OMNIPOD DASH PODS (GEN 4) ( <i>insulin disposable pump</i> )	PB	
PRECISION XTRA KETONE IN VITRO STRIP ( <i>ketone blood test</i> )	PB	
V-GO 20 KIT 20 UNIT/24HR ( <i>insulin disposable pump</i> )	PB	
V-GO 30 KIT 30 UNIT/24HR ( <i>insulin disposable pump</i> )	PB	
V-GO 40 KIT 40 UNIT/24HR ( <i>insulin disposable pump</i> )	PB	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENDOMETRIOSIS</b>		
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	PG	
ORLISSA ORAL TABLET 150 MG, 200 MG ( <i>elagolix sodium</i> )	PB	
<b>ENZYME REPLACEMENTS - DRUGS FOR REPLACEMENT, MODIFICATION, TREATMENT</b>		
<i>betaine oral powder</i>	PSP	PA
<i>carglumic acid oral tablet 200 mg</i>	PSP	PA
<i>carglumic acid oral tablet soluble 200 mg</i>	PSP	PA
CERDELGA ORAL CAPSULE 84 MG ( <i>eliglustat tartrate</i> )	PSP	PA; QL (56 CAPSULES per 28 days)
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG ( <i>metreleptin</i> )	PSP	PA; QL (30 VIALS per 30 DAYS)
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	PSP	PA
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	PSP	PA
<i>sodium phenylbutyrate oral powder 3 gmltsp</i>	PSP	PA; QL (798 GM per 30 days)
<i>sodium phenylbutyrate oral tablet 500 mg</i>	PSP	PA; QL (1200 TABLETS per 30 DAYS)
<b>ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES</b>		
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY ( <i>estradiol-levonorgestrel</i> )	PB	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML ( <i>estradiol cypionate</i> )	NP*	
DUAVEE ORAL TABLET 0.45-20 MG ( <i>conj estrogens-bazedoxifene</i> )	PB	
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) ( <i>estradiol</i> )	NP*	PA; AL (Max 70 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>estradiol oral tablet 0.5 mg, 2 mg</i>	PG	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>estradiol oral tablet 1 mg</i>	PG	PA; AL (Max 70 Years)
<i>estradiol transdermal gel 0.25 mg/0.25gm, 1.25 mg/1.25gm</i>	PG	PA; AL (Max 70 Years)
<i>estradiol transdermal gel 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm</i>	PG	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	PG	PA; AL (Max 70 Years)
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	PG	PA; AL (Max 70 Years)
<i>estradiol vaginal cream 0.1 mg/gm</i>	PG	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	PG	
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	PG	
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%) ( <i>estradiol</i> )	NP*	PA; AL (Max 70 Years)
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY ( <i>estradiol</i> )	NP*	PA; AL (Max 70 Years)
<i>norethindrone-eth estradiol (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg)</i>	NP*	
<i>norethindrone-eth estradiol (Jinteli Oral Tablet 1-5 Mg-Mcg)</i>	PG	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG ( <i>esterified estrogens</i> )	NP*	PA; AL (Max 70 Years)
<i>estradiol-norethindrone acet (Mimvey Oral Tablet 1-0.5 Mg)</i>	PG	
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	NP*	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG ( <i>estrogens conjugated</i> )	NP*	PA; AL (Max 70 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMARIN VAGINAL CREAM 0.625 MG/GM ( <i>estrogens, conjugated</i> )	NP*	
<i>estradiol</i> (Yuvaferm Vaginal Tablet 10 Mcg)	NP*	
<b>FERTILITY REGULATORS</b>		
<i>chorionic gonadotropin intramuscular solution reconstituted 10000 unit</i>	PSP	PA
<b>GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE</b>		
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML ( <i>dexamethasone</i> )	PB	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	PG	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	PG	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	PG	
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	PG	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	PG	
MEDROL ORAL TABLET 2 MG ( <i>methylprednisolone</i> )	PB	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	PG	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	PG	
<i>prednisolone oral solution 15 mg/5ml</i>	PG	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 6.7 (5 base) mg/5ml</i>	PG	
<i>prednisolone sodium phosphate oral solution 25 mg/5ml</i>	NP*	
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg</i>	NP*	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML ( <i>prednisone</i> )	PB	
<i>prednisone oral solution 5 mg/5ml</i>	PG	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	PG	
<b>GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR</b>		
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG ( <i>glucagon hcl (rdna)</i> )	PB	
<i>glucagon emergency injection kit 1 mg</i>	PG	
<b>HEREDITARY TYROSINEMIA TYPE 1 AGENTS - DRUGS FOR REPLACEMENT, MODIFICATION, TREATMENT</b>		
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	PSP	PA
ORFADIN ORAL CAPSULE 20 MG ( <i>nitisinone</i> )	PSP	PA
ORFADIN ORAL SUSPENSION 4 MG/ML ( <i>nitisinone</i> )	PSP	PA
<b>HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES</b>		
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 ( <i>somatropin</i> )	PSP	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG ( <i>somatropin</i> )	PSP	PA
NORDIPEN 5 INJECTION DEVICE ( <i>injection device</i> )	PB	
NORDIPEN DELIVERY SYSTEM ( <i>injection device</i> )	PB	
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML ( <i>somatropin</i> )	PSP	PA
<b>LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS</b>		
SYNAREL NASAL SOLUTION 2 MG/ML ( <i>nafarelin acetate</i> )	NPSP	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MINERALOCORTICOID RECEPTOR ANTAGONISTS - DRUGS TO TREAT CHRONIC KIDNEY DISEASE ASSOCIATED WITH TYPE 2 DIABETES</b>		
KERENDIA ORAL TABLET 10 MG, 20 MG ( <i>finerenone</i> )	NP*	PA
<b>MISCELLANEOUS</b>		
<i>cabergoline oral tablet 0.5 mg</i>	PG	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG ( <i>cysteamine bitartrate</i> )	PSP	PA
INTRAROSA VAGINAL INSERT 6.5 MG ( <i>prasterone</i> )	NP*	
MIFEPREX ORAL TABLET 200 MG ( <i>mifepristone</i> )	NP*	
<i>mifepristone oral tablet 200 mg</i>	PG	
OSPHENA ORAL TABLET 60 MG ( <i>ospemifene</i> )	NP*	PA
<i>raloxifene hcl oral tablet 60 mg</i>	CE	N7 (PG); N8 (\$0 copay for ages 35 and older for the primary prevention of breast cancer); AL (Min 35 Years)
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML ( <i>pasireotide diaspertate</i> )	NPSP	PA; QL (60 AMPULES per 30 DAYS)
<i>tolvaptan oral tablet 15 mg, 30 mg</i>	PSP	PA
<b>PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS</b>		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	PG	
<i>calcium acetate oral tablet 667 mg</i>	PG	
FOSRENOL ORAL PACKET 1000 MG, 750 MG ( <i>lanthanum carbonate</i> )	NP*	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	PG	
<i>sevelamer carbonate oral tablet 800 mg</i>	NP*	
VELPHORO ORAL TABLET CHEWABLE 500 MG ( <i>sucroferric oxyhydroxide</i> )	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM-REMOVING AGENTS</b>		
SPS ORAL SUSPENSION 15 GM/60ML ( <i>sodium polystyrene sulfonate</i> )	PG	
<b>PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES</b>		
CRINONE VAGINAL GEL 4 %, 8 % ( <i>progesterone</i> )	PB	
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	PG	
<i>megestrol acetate oral suspension 40 mg/ml</i>	CE	N7 (PG)
<i>megestrol acetate oral suspension 625 mg/5ml</i>	CE	N7 (NP)
<i>norethindrone acetate oral tablet 5 mg</i>	PG	
<i>progesterone oral capsule 100 mg, 200 mg</i>	PG	
<b>THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS</b>		
<i>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</i>	PG	
<i>levothyroxine sodium (Levoxyl Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)</i>	PG	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	PG	
<i>methimazole oral tablet 10 mg, 5 mg</i>	PG	
<i>propylthiouracil oral tablet 50 mg</i>	PG	
SYNTHROID 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 ( <i>levothyroxine sodium</i> )	PB	
<i>levothyroxine sodium (Unithroid Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES</b>		
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	PG	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	PG	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	NP*	
<b>GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS</b>		
<b>ANTICHOLINERGICS</b>		
<i>dicyclomine hcl oral capsule 10 mg</i>	PG	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	PG	
<i>dicyclomine hcl oral tablet 20 mg</i>	PG	
<i>glycopyrrolate oral solution 1 mg/5ml</i>	PG	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	NP*	
<i>methscopolamine bromide oral tablet 2.5 mg, 5 mg</i>	NP*	PA; AL (Max 70 Years)
<b>ANTIDIARRHEALS</b>		
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	PG	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	PG	
<i>loperamide hcl oral capsule 2 mg</i>	PG	
<b>MOTOFEN ORAL TABLET 1-0.025 MG (<i>difenoxin-atropine</i>)</b>	NP*	
<b>ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING</b>		
<b>AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)</b>	NP*	QL (2 CAPSULES per 28 days)
<i>aprepitant oral capsule 125 mg</i>	PG	QL (2 CAPSULES per 28 days)
<i>aprepitant oral capsule 40 mg</i>	PG	QL (3 CAPSULES per 180 DAYs)
<i>aprepitant oral capsule 80 &amp; 125 mg</i>	PG	QL (2 PACKS per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aprepitant oral capsule 80 mg</i>	PG	QL (4 CAPSULES per 28 days)
<i>prochlorperazine (Compro Rectal Suppository 25 Mg)</i>	PG	
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	NP*	QL (60 CAPSULES per 30 days)
<i>granisetron hcl oral tablet 1 mg</i>	NP*	QL (12 TABLETS per 28 days)
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	PG	
<i>metoclopramide hcl oral solution 10 mg/10ml</i>	PG	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	PG	
<i>metoclopramide hcl oral tablet dispersible 5 mg</i>	PG	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	PG	QL (200 ML per 28 days)
<i>ondansetron hcl oral tablet 24 mg</i>	PG	QL (2 TABLETS per 28 days)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	PG	QL (18 TABLETS per 28 days)
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	PG	QL (18 TABLETS per 28 days)
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	PG	
<i>prochlorperazine rectal suppository 25 mg</i>	PG	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	PG	PA; AL (Max 70 Years)
<i>promethazine hcl oral tablet 12.5 mg, 50 mg</i>	PG	PA; AL (Max 70 Years)
<i>promethazine hcl oral tablet 25 mg</i>	PG	PA; N8 (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	NP*	
<i>promethazine hcl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROMETHEGAN RECTAL SUPPOSITORY 50 MG ( <i>promethazine hcl</i> )	PG	
SANCUSO TRANSDERMAL PATCH 3.1 MG/24HR ( <i>granisetron</i> )	PB	QL (2 PATCHES per 28 days)
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	PG	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	PG	
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK 2 X 90 MG ( <i>rolapitant hcl</i> )	PB	
<b>H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	PG	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	PG	
<i>famotidine oral tablet 20 mg, 40 mg</i>	PG	
<i>nizatidine oral capsule 150 mg, 300 mg</i>	PG	
<b>INFLAMMATORY BOWEL DISEASE - BOWEL, INTESTINE, AND STOMACH CONDITION DRUGS</b>		
<i>balsalazide disodium oral capsule 750 mg</i>	PG	
<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	PG	
<i>budesonide oral capsule delayed release particles 3 mg</i>	NP*	
DIPENTUM ORAL CAPSULE 250 MG ( <i>olsalazine sodium</i> )	NP*	PA
<i>hydrocortisone rectal enema 100 mg/60ml</i>	PG	
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	PG	
<i>mesalamine oral capsule delayed release 400 mg</i>	PG	
<i>mesalamine oral tablet delayed release 1.2 gm, 800 mg</i>	NP*	
<i>mesalamine rectal enema 4 gm</i>	PG	
<i>mesalamine rectal suppository 1000 mg</i>	PG	
<i>mesalamine-cleanser rectal kit 4 gm</i>	PG	
<i>sulfasalazine oral tablet 500 mg</i>	PG	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRRITABLE BOWEL SYNDROME WITH CONSTIPATION</b>		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (linaclotide)	PB	PA
lubiprostone oral capsule 24 mcg, 8 mcg	PG	PA
<b>IRRITABLE BOWEL SYNDROME WITH DIARRHEA</b>		
alosetron hcl oral tablet 0.5 mg, 1 mg	NP*	PA
<b>LAXATIVES - DRUGS FOR CONSTIPATION</b>		
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM - GM/175ML (sod picosulfate-mag ox-cit acd)	CE	N7 (PB); N8 (\$0 copay for members age 45 through 75, Preferred Brand tier for all others); AL (Min 45 Years and Max 75 Years)
emulose oral solution 10 gm/15ml	PG	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (peg 3350-kcl-nabcb-nacl-nasulf)	PG	
peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)	PG	
generlac oral solution 10 gm/15ml	PG	
lactulose oral solution 10 gm/15ml	PG	
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	CE	N7 (PG); N8 (\$0 copay for members age 45 through 75, otherwise preferred generic); AL (Min 45 Years and Max 75 Years)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	PG	
peg-3350/electrolytes oral solution reconstituted 236 gm	PG	
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	CE	N7 (Not Covered); N8 (\$0 copay for members age 45 through 75, otherwise not covered); AL (Min 45 Years and Max 75 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEG-PREP ORAL KIT 5-210 MG-GM ( <i>bisacodyl-peg-kcl-nabicar-nacl</i> )	CE	N7 (Not Covered); N8 (\$0 copay for members age 45 through 75, otherwise not covered); AL (Min 45 Years and Max 75 Years)
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM ( <i>peg-kcl-nacl-nasulf-na asc-c</i> )	CE	N7 (Not Covered); N8 (\$0 copay for members age 45 through 75, otherwise not covered); AL (Min 45 Years and Max 75 Years)
<i>polyethylene glycol 3350 oral powder 17 gmlscoop</i>	PG	
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM ( <i>peg 3350-kcl-nacl-nasulf-mgsul</i> )	CE	N7 (Not Covered); N8 (\$0 copay for members age 45 through 75, otherwise not covered); AL (Min 45 Years and Max 75 Years)
SUTAB ORAL TABLET 1479-225-188 MG ( <i>sodium sulfate-mag sulfate-kcl</i> )	CE	N7 (Not Covered); N8 (\$0 copay for members age 45 through 75, otherwise not covered); AL (Min 45 Years and Max 75 Years)
<b>MISCELLANEOUS</b>		
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	NP*	
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	PG	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG ( <i>naloxegol oxalate</i> )	PB	
RELISTOR ORAL TABLET 150 MG ( <i>methylnaltrexone bromide</i> )	NP*	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML ( <i>methylnaltrexone bromide</i> )	NP*	PA
SUCRAID ORAL SOLUTION 8500 UNIT/ML ( <i>sacrosidase</i> )	NP*	PA; QL (354 ML per 30 days)
<i>sucralfate oral tablet 1 gm</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ursodiol oral capsule 300 mg</i>	PG	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	NP*	
<b>PANCREATIC ENZYMES</b>		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	PB	PA
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	PB	PA
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	PB	PA
<b>PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>esomeprazole magnesium oral capsule delayed release 20 mg</i>	PG	QL (90 CAPSULES per 365 DAYs)
<i>esomeprazole magnesium oral capsule delayed release 40 mg</i>	NP*	QL (90 CAPSULES per 365 DAYs)
<i>esomeprazole magnesium oral packet 10 mg</i>	PG	QL (90 PACKETS per 365 days); AL (Max 1 Years)
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg</i>	PG	QL (90 CAPSULES per 365 DAYs)
NEXIUM ORAL PACKET 2.5 MG, 5 MG ( <i>esomeprazole magnesium</i> )	NP*	QL (90 PACKETS per 365 days); AL (Max 1 Years)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	PG	QL (90 CAPSULES per 365 DAYs)
<i>omeprazole-sodium bicarbonate oral packet 20-1680 mg, 40-1680 mg</i>	NP*	QL (90 PACKETS per 365 DAYs)
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	PG	QL (90 TABLETS per 365 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	PG	QL (90 TABLETS per 365 days)
<b>RECTAL, CORTICOSTEROIDS</b>		
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	PG	
<i>hydrocortisone (Proctozone-Hc External Cream 2.5 %)</i>	PG	
<b>ULCER THERAPY COMBINATIONS</b>		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i>	NP*	
<b>GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS</b>		
<b>BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE</b>		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	PG	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG ( <i>doxazosin mesylate</i> )	NP*	ST
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	PG	
<i>dutasteride oral capsule 0.5 mg</i>	PG	
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	PG	
<i>finasteride oral tablet 5 mg</i>	PG	
<i>silodosin oral capsule 4 mg, 8 mg</i>	PG	
<i>tamsulosin hcl oral capsule 0.4 mg</i>	PG	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
<b>CONTRACEPTIVES - PRODUCTS FOR BIRTH CONTROL</b>		
ENCARE VAGINAL SUPPOSITORY 100 MG ( <i>nonoxynol-9</i> )	CE	N7 (Not Covered)
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % ( <i>nonoxynol-9</i> )	CE	N7 (Not Covered)

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PHEXXI VAGINAL GEL 1.8-1-0.4 % ( <i>lactic ac-citric ac-pot bitart</i> )	CE	N7 (Not Covered)
SHUR-SEAL CONTRACEPTIVE VAGINAL GEL 2 % ( <i>nonoxynol-9</i> )	CE	N7 (Not Covered)
TODAY SPONGE VAGINAL 1000 MG ( <i>nonoxynol-9</i> )	CE	N7 (Not Covered)
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % ( <i>nonoxynol-9</i> )	CE	N7 (Not Covered)
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % ( <i>nonoxynol-9</i> )	CE	N7 (Not Covered)
<b>ERECTILE DYSFUNCTION</b>		
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	PG	PA; QL (30 TABLETS per 30 days)
<b>MISCELLANEOUS</b>		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	PG	
ELMIRON ORAL CAPSULE 100 MG ( <i>pentosan polysulfate sodium</i> )	NP*	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	PG	
<i>urinary pain relief oral tablet 95 mg</i>	PG	
<b>URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE</b>		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	NP*	
<i>fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg</i>	PG	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML ( <i>mirabegron</i> )	PB	
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	PG	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	PG	
<i>oxybutynin chloride oral tablet 5 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	PG	
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	NP*	
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	PG	
<i>tropium chloride er oral capsule extended release 24 hour 60 mg</i>	NP*	
<i>tropium chloride oral tablet 20 mg</i>	PG	
<b>VAGINAL ANTI-INFECTIVES - DRUGS TO TREAT VAGINAL INFECTIONS</b>		
<b>CLEOCIN VAGINAL SUPPOSITORY 100 MG</b> <i>(clindamycin phosphate)</i>	PB	
<i>clindamycin phosphate vaginal cream 2 %</i>	NP*	
<b>GYNAZOLE-1 VAGINAL CREAM 2 %</b> <i>(butoconazole nitrate (1 dose))</i>	NP*	
<i>metronidazole vaginal gel 0.75 %</i>	PG	
<i>miconazole 3 vaginal suppository 200 mg</i>	PG	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	PG	
<i>terconazole vaginal suppository 80 mg</i>	NP*	
<b>HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS</b>		
<b>ANTICOAGULANTS - BLOOD THINNERS</b>		
<b>ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG</b> <i>(apixaban)</i>	PB	
<b>ELIQUIS ORAL TABLET 2.5 MG, 5 MG</b> <i>(apixaban)</i>	PB	
<i>enoxaparin sodium injection solution 150 mg/ml, 300 mg/3ml</i>	PG	
<i>enoxaparin sodium 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</i>	PG	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML ( <i>dalteparin sodium</i> )	NP*	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNIT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML ( <i>dalteparin sodium</i> )	NP*	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	PG	
<i>heparin sodium (porcine) pf injection solution 5000 unit/0.5ml</i>	PG	
<i>warfarin sodium</i> (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	PG	LGC (Lowest Generic Copay applies to ME members only.)
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	PG	LGC (Lowest Generic Copay applies to ME members only.)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML ( <i>rivaroxaban</i> )	PB	
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG ( <i>rivaroxaban</i> )	PB	
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG ( <i>rivaroxaban</i> )	PB	
<b>HEMATOPOIETIC GROWTH FACTORS</b>		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML ( <i>darbepoetin alfa</i> )	PSP	PA
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 ( <i>darbepoetin alfa</i> )	PSP	PA
DOPTELET TABLET 20 MG ORAL ( <i>avatrombopag maleate</i> )	NPSP	PA; QL (1 CARTON per 5 Days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DOPTELET TABLET 20 MG ORAL ( <i>avatrombopag maleate</i> )	NPSP	PA; QL (60 TABLETS per 30 Days)
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <i>pegfilgrastim-pbbk</i> )	PSP	PA; QL (2 INJECTIONS per 28 DAYs)
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 ( <i>methoxy peg-epoetin beta</i> )	PSP	PA
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML ( <i>filgrastim-aafi</i> )	PSP	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML ( <i>filgrastim-aafi</i> )	PSP	PA
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <i>pegfilgrastim-apgf</i> )	PSP	PA; QL (2 INJECTIONS per 28 DAYs)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	PSP	PA
<b>MISCELLANEOUS</b>		
<i>anagrelide hcl oral capsule 0.5 mg</i>	PG	
<i>anagrelide hcl oral capsule 1 mg</i>	NP*	
<i>cilostazol oral tablet 100 mg, 50 mg</i>	PG	
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG ( <i>hydroxyurea</i> )	PB	
<i>pentoxifylline er oral tablet extended release 400 mg</i>	PG	
<i>tranexamic acid oral tablet 650 mg</i>	PG	
<b>PLATELET AGGREGATION INHIBITORS - BLOOD THINNERS</b>		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	PG	
<i>clopidogrel bisulfate oral tablet 300 mg, 75 mg</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	PG	PA; AL (Max 70 Years)
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	NP*	
YOSPRALA ORAL TABLET DELAYED RELEASE 325-40 MG, 81-40 MG ( <i>aspirin-omeprazole</i> )	NP*	
ZONTIVITY ORAL TABLET 2.08 MG ( <i>vorapaxar sulfate</i> )	NP*	
<b>IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM</b>		
<b>AUTOIMMUNE AGENTS (SELF-ADMINISTERED)</b>		
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML ( <i>tocilizumab</i> )	NPSP	PA; QL (4 SYRINGES per 28 days)
<i>adalimumab-adaz subcutaneous solution auto-injector 40 mg/0.4ml</i>	PSP	PA; QL (4 PENS per 28 DAYs)
<i>adalimumab-adaz subcutaneous solution prefilled syringe 40 mg/0.4ml</i>	PSP	PA; QL (4 SYRINGES per 28 DAYs)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>secukinumab</i> )	PSP	PA; QL (300 MG per 28 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>secukinumab</i> )	PSP	PA; QL (300 MG per 28 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>secukinumab</i> )	PSP	PA; QL (1 PEN per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>secukinumab</i> )	PSP	PA; QL (1 SYRINGE per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML ( <i>secukinumab</i> )	PSP	PA; QL (1 SYRINGE per 28 DAYs)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML ( <i>secukinumab</i> )	PSP	PA; QL (1 PEN per 28 DAYs)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML ( <i>etanercept</i> )	PSP	PA; QL (4 CARTRIDGES per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML ( <i>etanercept</i> )	PSP	PA; QL (8 VIALS per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML ( <i>etanercept</i> )	PSP	PA; QL (8 SYRINGES per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML ( <i>etanercept</i> )	PSP	PA; QL (4 SYRINGES per 28 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML ( <i>etanercept</i> )	PSP	PA; QL (4 SYRINGES per 28 days)
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab</i> )	PSP	PA; QL (4 INJECTIONS per 28 DAYS)
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML ( <i>adalimumab</i> )	PSP	PA; QL (4 PENS per 28 Days)
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML ( <i>adalimumab</i> )	PSP	PA; QL (1 kit per 28 days)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML ( <i>adalimumab</i> )	PSP	PA; QL (2 INJECTIONS per 28 DAYs)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML ( <i>adalimumab</i> )	PSP	PA; QL (4 INJECTIONS per 28 days)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML ( <i>adalimumab</i> )	PSP	PA; QL (4 INJECTIONS per 28 DAYs)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML ( <i>adalimumab</i> )	PSP	PA; QL (4 INJECTIONS per 28 Days)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML ( <i>adalimumab</i> )	PSP	PA; QL (1 KIT per 28 days)
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	PSP	PA; QL (1 KIT per 28 days)
HUMIRA-PED>/=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML ( <i>adalimumab</i> )	PSP	PA; QL (1 KIT per 28 days)

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HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab</i> )	PSP	PA; QL (1 KIT per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML ( <i>adalimumab-adaz</i> )	PSP	PA; QL (4 PENS per 28 DAYs)
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML ( <i>adalimumab-adaz</i> )	PSP	PA; QL (2 PENS per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML ( <i>adalimumab-adaz</i> )	PSP	PA; QL (2 SYRINGES per 28 DAYs)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML ( <i>adalimumab-adaz</i> )	PSP	PA; QL (4 SYRINGES per 28 DAYs)
HYRIMOZ-CROHNS/UC STARTER SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML ( <i>adalimumab-adaz</i> )	PSP	PA; N8 (Starter pack - initial dose only); QL (1 KIT per 28 days)
HYRIMOZ-PED<40KG CROHN STARTER SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab-adaz</i> )	PSP	PA; N8 (Starter pack - initial dose only); QL (1 KIT per 28 DAYs)
HYRIMOZ-PED>/=40KG CROHN START SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML ( <i>adalimumab-adaz</i> )	PSP	PA; N8 (Starter pack - initial dose only); QL (1 KIT per 28 DAYs)
HYRIMOZ-PLAQUE PSORIASIS START SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML ( <i>adalimumab-adaz</i> )	PSP	PA; N8 (Starter pack - initial dose only); QL (1 KIT per 28 DAYs)
OTEZLA ORAL TABLET 30 MG ( <i>apremilast</i> )	PSP	PA; QL (60 TABLETS per 30 days)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG ( <i>apremilast</i> )	PSP	PA; QL (55 TABLETS per 28 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG ( <i>upadacitinib</i> )	PSP	PA; QL (30 TABLETS per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG ( <i>upadacitinib</i> )	PSP	PA; N8 (Use only for induction); QL (1 FILL per 1 INDUCTION PERIOD)
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML ( <i>risankizumab-rzaa</i> )	PSP	PA; QL (1 SYRINGE per 84 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML ( <i>risankizumab-rzaa</i> )	PSP	PA; QL (1 CARTRIDGE per 56 DAYS)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML ( <i>risankizumab-rzaa</i> )	PSP	PA; QL (1 SYRINGE per 84 days)
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML ( <i>ustekinumab</i> )	PSP	PA; QL (1 vial per 84 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML ( <i>ustekinumab</i> )	PSP	PA; QL (1 SYRINGE per 84 DAYS)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML ( <i>ustekinumab</i> )	PSP	PA; QL (1 SYRINGE per 56 DAYS)
<b>DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)</b>		
<i>methotrexate sodium oral tablet 2.5 mg</i>	CE	N7 (PG)
<b>DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) - DRUGS TO TREAT RHEUMATOID ARTHRITIS</b>		
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	PG	
<i>leflunomide oral tablet 10 mg, 20 mg</i>	PG	
<b>HEREDITARY ANGIOEDEMA</b>		
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT ( <i>c1 esterase inhibitor (human)</i> )	NPSP	PA; QL (20 VIALS per 30 DAYS)
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	PSP	PA; QL (45 SYRINGES per 90 days)

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<b>IMMUNOGLOBULIN</b>		
HYQVIA SUBCUTANEOUS KIT 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML ( <i>immune globulin-hyaluronidase</i> )	PSP	PA
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML ( <i>interferon gamma-1b</i> )	NPSP	PA
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG ( <i>rilonacept</i> )	PSP	PA; QL (8 VIALS per 28 days)
<b>IMMUNOSUPPRESSANTS</b>		
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	PG	
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	PG	
<i>cyclosporine modified oral solution 100 mg/ml</i>	PG	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	PG	
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	PG	
<i>cyclosporine modified (Gengraf Oral Capsule 100 Mg, 25 Mg)</i>	PG	
<i>cyclosporine modified (Gengraf Oral Solution 100 Mg/ML)</i>	PG	
<i>mycophenolate mofetil oral capsule 250 mg</i>	PG	
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	PG	
<i>mycophenolate mofetil oral tablet 500 mg</i>	PG	
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	PG	
SANDIMMUNE ORAL SOLUTION 100 MG/ML ( <i>cyclosporine</i> )	NP*	
<i>sirolimus oral solution 1 mg/ml</i>	PG	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	PG	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	PG	

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<b>NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS</b>		
<b>ELECTROLYTES</b>		
<i>potassium bicarbonate</i> (Effer-K Oral Tablet Effervescent 25 Meq)	PG	
<i>potassium chloride</i> (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	PG	
<i>potassium chloride crys er</i> (Klor-Con M15 Oral Tablet Extended Release 15 Meq)	PG	
<i>potassium chloride</i> (Klor-Con Oral Tablet Extended Release 8 Meq)	PG	
<i>potassium chloride crys er oral tablet extended release 10 meq, 20 meq</i>	PG	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	PG	
<i>potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq</i>	PG	
<i>potassium chloride oral solution 10 %</i>	NP*	
<i>potassium chloride oral solution 40 meq/15ml (20%)</i>	PG	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	CE	N7 (Not Covered); AL (Max 5 Years)
<i>sodium fluoride oral tablet 1.1 (0.5 f) mg</i>	CE	N7 (Not Covered); AL (Max 5 Years)
<i>sodium fluoride oral tablet 2.2 (1 f) mg</i>	PG	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg</i>	CE	N7 (Not Covered); AL (Max 5 Years)
<i>sodium fluoride oral tablet chewable 2.2 (1 f) mg</i>	PG	
<b>PRENATAL VITAMINS</b>		
ELITE-OB ORAL TABLET 50-1.25 MG ( <i>prenatal vit-iron carbonyl-fa</i> )	PG	

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<b>VITAMINS - VITAMINS AND SUPPLEMENTS</b>		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	PG	
<i>calcitriol oral solution 1 mcg/ml</i>	PG	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	PG	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	PG	
<i>folic acid oral capsule 0.8 mg</i>	CE	N7 (Not Covered); QL (100 CAPSULES per 30 DAYs); AL (Max 55 Years)
<i>folic acid oral tablet 1 mg</i>	PG	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	CE	N7 (Not Covered); QL (100 TABLETS per 30 DAYs); AL (Max 55 Years)
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	PG	
<i>vitamin d (ergocalciferol) oral capsule 50000 unit</i>	PG	
<i>westab max oral tablet 2.5-25-2 mg</i>	PG	
<b>OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS</b>		
<b>ANTIALLERGICS - DRUGS TO TREAT ALLERGIES</b>		
<i>ALOCRILOPHthalmic SOLUTION 2 % (nedocromil sodium)</i>	NP*	
<i>ALOMIDOPHthalmic SOLUTION 0.1 % (lodoxamide tromethamine)</i>	NP*	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	PG	
<i>bepotastine besilate ophthalmic solution 1.5 %</i>	PG	
<i>cromolyn sodium ophthalmic solution 4 %</i>	PG	
<i>epinastine hcl ophthalmic solution 0.05 %</i>	PG	
<i>olopatadine hcl ophthalmic solution 0.2 %</i>	PG	
<i>ZERVIAOPHthalmic SOLUTION 0.24 % (cetirizine hcl)</i>	NP*	

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<b>ANTIGLAUCOMA - DRUGS TO TREAT GLAUCOMA</b>		
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	PG	
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	PG	
BETIMOL OPHTHALMIC SOLUTION 0.25 %, 0.5 % ( <i>timolol hemihydrate</i> )	NP*	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % ( <i>betaxolol hcl</i> )	PB	
<i>brimonidine tartrate ophthalmic solution 0.1 %, 0.15 %, 0.2 %</i>	PG	
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	PG	
<i>brinzolamide ophthalmic suspension 1 %</i>	PG	
<i>carteolol hcl ophthalmic solution 1 %</i>	PG	
<i>dorzolamide hcl ophthalmic solution 2 %</i>	PG	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	PG	
IOPIDINE OPHTHALMIC SOLUTION 1 % ( <i>apraclonidine hcl</i> )	NP*	
<i>latanoprost ophthalmic solution 0.005 %</i>	PG	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	PG	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % ( <i>bimatoprost</i> )	PB	ST
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % ( <i>echothiophate iodide</i> )	NP*	
<i>pilocarpine hcl ophthalmic solution 1 %</i>	PG	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % ( <i>brinzolamide-brimonidine</i> )	PB	
<i>tafluprost (pf) ophthalmic solution 0.0015 %</i>	PG	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	NP*	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	NP*	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	PG	
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION</b>		
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	PG	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	PG	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	PG	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	NP*	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	PG	
<b>TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %</b> ( <i>tobramycin-dexamethasone</i> )	PB	
<b>TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 %</b> ( <i>tobramycin-dexamethasone</i> )	PB	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	NP*	
<b>ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS</b>		
<b>AZASITE OPHTHALMIC SOLUTION 1 %</b> ( <i>azithromycin</i> )	PB	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	NP*	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	PG	
<b>BESIVANCE OPHTHALMIC SUSPENSION 0.6 %</b> ( <i>besifloxacin hcl</i> )	NP*	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	PG	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	PG	
<i>gatifloxacin ophthalmic solution 0.5 %</i>	NP*	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	PG	QL (20 ML per 30 days)
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	PG	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	NP*	
<b>NATACYN OPHTHALMIC SUSPENSION 5 %</b> ( <i>natamycin</i> )	PB	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000</i>	PG	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	PG	
<i>ofloxacin ophthalmic solution 0.3 %</i>	PG	
<i>bacitracin-polymyxin b (Polycin Ophthalmic Ointment 500-10000 Unit/Gm)</i>	PG	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	PG	
<i>sulfacetamide sodium ophthalmic ointment 10 %</i>	PG	
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	PG	
<i>tobramycin ophthalmic solution 0.3 %</i>	PG	
<i>trifluridine ophthalmic solution 1 %</i>	NP*	
<b>ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION</b>		
<b>ACUVAIL OPHTHALMIC SOLUTION 0.45 % (ketorolac tromethamine)</b>	PB	
<i>bromfenac sodium (once-daily) ophthalmic solution 0.09 %</i>	NP*	
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	PG	
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	PG	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	PG	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	PG	
<b>ILEVRO OPHTHALMIC SUSPENSION 0.3 % (nepafenac)</b>	PB	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	PG	
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	PG	
<b>NEVANAC OPHTHALMIC SUSPENSION 0.1 % (nepafenac)</b>	PB	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	PG	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	PB	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRY EYE DISEASE</b>		
<i>cyclosporine emulsion 0.05 % ophthalmic</i>	PG	PA; QL (1 MULTI-USE VIAL per 28 Days)
<i>cyclosporine emulsion 0.05 % ophthalmic</i>	PG	PA; QL (60 SINGLE USE VIALS per 30 Days)
<b>MISCELLANEOUS</b>		
<i>atropine sulfate ophthalmic solution 1 %</i>	PG	
CYSTARAN OPHTHALMIC SOLUTION 0.44 % ( <i>cysteamine hcl</i> )	NPSP	PA; QL (4 BOTTLES per 28 days)
LACRISERT OPHTHALMIC INSERT 5 MG ( <i>artificial tear insert</i> )	NP*	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	PG	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	PG	
<i>tropicamide ophthalmic solution 0.5 %, 1 %</i>	PG	
<b>OTHER</b>		
<b>IRRIGATION SOLUTIONS</b>		
<i>irrigation solns physiological</i> (Physiolyte Irrigation Solution)	PG	
<i>irrigation solns physiological</i> (Physiosol Irrigation Irrigation Solution)	PG	
<i>ringers irrigation</i> (Tis-U-Sol Irrigation Solution)	PG	
<b>RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS</b>		
<b>ANAPHYLAXIS TREATMENT AGENTS</b>		
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	PG	QL (4 AUTO-INJECTORS per 30 days)
<b>ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD</b>		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT ( <i>umeclidinium-vilanterol</i> )	NP*	QL (1 PACKAGE per 30 Days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT ( <i>glycopyrrolate-formoterol</i> )	NP*	QL (1 PACKAGE per 30 days)
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	PG	QL (6 BOXES per 30 days)
<b>ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD</b>		
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	PB	QL (1 PACKAGE per 30 days)
<b>ANTICHOLINERGICS</b>		
<i>ipratropium bromide inhalation solution 0.02 %</i>	PG	QL (5 BOXES per 30 days)
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	PG	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT ( <i>tiotropium bromide monohydrate</i> )	PB	QL (1 PACKAGE per 30 days)
<i>tiotropium bromide monohydrate inhalation capsule 18 mcg</i>	PG	QL (1 PACKAGE per 30 DAYS)
<b>ANTI-HISTAMINE COMBINATIONS</b>		
<i>azelastine-fluticasone nasal suspension 137-50 mcg/lact</i>	PG	QL (1 PACKAGE per 30 days)
<b>ANTI-HISTAMINES - DRUGS TO TREAT ALLERGIES</b>		
<i>azelastine hcl nasal solution 0.1 %, 0.15 %</i>	PG	QL (2 BOTTLES per 30 days)
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	PG	
<i>carbinoxamine maleate oral tablet 4 mg</i>	PG	
<i>clemastine fumarate oral tablet 2.68 mg</i>	PG	PA; AL (Max 70 Years)
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	PG	
<i>cyproheptadine hcl oral tablet 4 mg</i>	PG	
<i>desloratadine oral tablet 5 mg</i>	PG	
<i>desloratadine oral tablet dispersible 2.5 mg, 5 mg</i>	NP*	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	PG	PA; AL (Max 70 Years)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	PG	PA; AL (Max 70 Years)
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	PG	PA; AL (Max 70 Years)
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	PG	PA; AL (Max 70 Years)
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</i>	PG	
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	PG	
<i>olopatadine hcl nasal solution 0.6 %</i>	NP*	QL (1 CONTAINER per 30 days)
<b>RYCLORA ORAL SOLUTION 2 MG/5ML</b> ( <i>dexchlorpheniramine maleate</i> )	NP*	PA; AL (Max 70 Years)
<b>BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD</b>		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/lact</i>	PG	QL (2 INHALERS per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml</i>	PG	QL (5 BOXES per 30 days)
<i>albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml</i>	PG	QL (60 ML per 30 DAYS)
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	PG	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	PG	
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	NP*	QL (60 VIALS per 30 days)
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	PG	QL (60 VIALS per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml</i>	NP*	QL (300 ML per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml</i>	NP*	QL (45 ML per 30 days)
<i>levalbuterol tartrate inhalation aerosol 45 mcg/lact</i>	NP*	QL (2 INHALERS per 30 days)
<b>SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT</b> ( <i>salmeterol xinafoate</i> )	NP*	QL (1 PACKAGE per 30 Days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT ( <i>olodaterol hcl</i> )	PB	QL (1 PACKAGE per 30 days)
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	PG	
<b>COLD/COUGH</b>		
<i>benzonatate oral capsule 100 mg, 200 mg</i>	PG	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml</i>	PG	N8 (Limited to 7 day supply per month); QL (60 ML per day for 7 days per 1 month)
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	PG	N8 (Limited to 7 day supply per month); QL (10 ML per 1 Day)
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	PG	N8 (Limited to 7 day supply per month); QL (30 ML per 1 Day)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	PG	N8 (Limited to 7 day supply per month); QL (6 TABLETS per 1 Day)
<i>hydromet oral solution 5-1.5 mg/5ml</i>	PG	N8 (Limited to 7 day supply per month); QL (30 ML per 1 Day)
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	PG	
<i>promethazine vclcodeine oral syrup 6.25-5-10 mg/5ml</i>	PG	N8 (Limited to 7 day supply per month); QL (30 ML per 1 DAY)
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	PG	N8 (Limited to 7 day supply per month); QL (30 ML per 1 day)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	PG	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	NP*	
<b>CYSTIC FIBROSIS</b>		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG ( <i>aztreonam lysine</i> )	PSP	PA; QL (84 VIALS per 28 DAYs)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	PSP	PA; QL (224 ML per 28 DAYs)
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	PSP	PA; QL (280 ML per 28 DAYs)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG ( <i>elexacaftor-tezacaftor-ivacafti</i> )	PSP	PA; QL (84 TABLETS per 28 DAYs)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG ( <i>elexacaftor-tezacaftor-ivacafti</i> )	PSP	PA; QL (56 PACKETS per 28 days)
<b>LEUKOTRIENE MODIFIERS</b>		
<i>zileuton er oral tablet extended release 12 hour 600 mg</i>	NP*	PA
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS TO TREAT ASTHMA AND ALLERGIES</b>		
<i>montelukast sodium oral packet 4 mg</i>	PG	
<i>montelukast sodium oral tablet 10 mg</i>	PG	
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	PG	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	PG	
<b>MAST CELL STABILIZERS - DRUGS TO TREAT ALLERGIES</b>		
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	PG	QL (2 BOXES per 30 days)
<b>MISCELLANEOUS</b>		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	PG	
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	PG	PA
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %</i>	PG	
<b>NASAL STEROIDS - DRUGS TO TREAT ALLERGIES</b>		
<i>flunisolide nasal solution 25 mcglact (0.025%)</i>	PG	QL (3 CONTAINERS per 30 days)
<i>fluticasone propionate nasal suspension 50 mcglact</i>	PG	QL (1 CONTAINER per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mometasone furoate nasal suspension 50 mcglact</i>	PG	QL (2 PACKAGES per 30 days)
OMNARIS NASAL SUSPENSION 50 MCG/ACT ( <i>ciclesonide</i> )	NP*	ST; QL (1 PACKAGE per 30 days)
<i>triamcinolone acetonide nasal aerosol 55 mcglact</i>	PG	QL (1 PACKAGE per 30 days)
<b>PULMONARY FIBROSIS AGENTS</b>		
OFEV ORAL CAPSULE 100 MG, 150 MG ( <i>nintedanib esylate</i> )	NPSP	PA; QL (60 CAPSULES per 30 DAYS)
<i>pirfenidone oral capsule 267 mg</i>	PSP	PA; QL (270 CAPSULES per 30 DAYS)
<i>pirfenidone oral tablet 267 mg</i>	PSP	PA; QL (270 TABLETS per 30 DAYS)
<i>pirfenidone oral tablet 801 mg</i>	PSP	PA; QL (90 TABLETS per 30 DAYS)
<b>RESPIRATORY THERAPY SUPPLIES</b>		
AEROCHAMBER PLUS FLOW VU ( <i>spacer/aero-holding chambers</i> )	PB	
CLEVER CHOICE HOLDING CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	PB	
FLEXICHAMBER CHILD MASK/SMALL ( <i>spacer/aero-hold chamber mask</i> )	PB	
PEDIATRIC PANDA MASK ( <i>spacer/aero-hold chamber mask</i> )	PB	
<b>SEVERE ASTHMA AGENTS</b>		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML ( <i>mepolizumab</i> )	PSP	PA; QL (3 INJECTIONS per 28 DAYS)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML ( <i>mepolizumab</i> )	PSP	PA; QL (3 SYRINGES per 28 days)

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<b>STEROID INHALANTS - DRUGS TO TREAT ASTHMA</b>		
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT ( <i>ciclesonide</i> )	NP*	QL (2 PACKAGES per 30 DAYs)
ALVESCO INHALATION AEROSOL SOLUTION 80 MCG/ACT ( <i>ciclesonide</i> )	NP*	QL (3 PACKAGES per 30 DAYs)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT ( <i>fluticasone furoate</i> )	NP*	QL (1 PACKAGE per 30 days)
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT ( <i>mometasone furoate</i> )	NP*	QL (1 PACKAGE per 30 Days)
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT ( <i>mometasone furoate</i> )	NP*	QL (2 PACKAGES per 30 Days)
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT ( <i>mometasone furoate</i> )	NP*	QL (4 PACKAGES per 30 Days)
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT ( <i>mometasone furoate</i> )	NP*	QL (2 PACKAGES per 30 Days)
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT ( <i>mometasone furoate</i> )	NP*	QL (1 PACKAGE per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml</i>	NP*	QL (3 BOXES per 30 days)
<i>budesonide inhalation suspension 0.5 mg/2ml</i>	NP*	QL (2 BOXES per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	NP*	QL (1 BOX per 30 days)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT ( <i>beclomethasone diprop hfa</i> )	PB	QL (2 PACKAGES per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD</b>		
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT ( <i>fluticasone furoate-vilanterol</i> )	PB	QL (1 PACKAGE per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH ( <i>fluticasone furoate-vilanterol</i> )	PB	QL (1 PACKAGE per 30 DAYs)
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcglact, 80-4.5 mcglact</i>	PG	N8 (Listing does not include certain NDCs); QL (3 PACKAGES per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcglact, 250-50 mcglact, 500-50 mcglact</i>	PG	QL (1 INHALER per 30 Days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose</i>	PG	QL (1 PACKAGE per 30 DAYs)
<b>XANTHINES - DRUGS TO TREAT COPD</b>		
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	PG	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	PG	
<i>theophylline oral elixir 80 mg/15ml</i>	PG	
<i>theophylline oral solution 80 mg/15ml</i>	PG	
<b>TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS</b>		
<b>DERMATOLOGY, ACNE</b>		
<i>adapalene external cream 0.1 %</i>	NP*	PA; QL (45 GM per 28 days); AL (Max 35 Years)
<i>adapalene external gel 0.1 %</i>	PG	PA; QL (45 GM per 28 days); AL (Max 35 Years)
<i>adapalene external gel 0.3 %</i>	NP*	PA; QL (45 GM per 28 days); AL (Max 35 Years)

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<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	NP*	
<i>adapalene-benzoyl peroxide external gel 0.3-2.5 %</i>	PG	
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	NP*	QL (47 GM per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	NP*	QL (45 GM per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %</i>	NP*	QL (50 GM per 30 days)
<i>clindamycin phosphate external foam 1 %</i>	NP*	
<i>clindamycin phosphate external gel 1 %</i>	NP*	QL (75 GM per 30 days)
<i>clindamycin phosphate external lotion 1 %</i>	NP*	QL (60 ML per 30 days)
<i>clindamycin phosphate external solution 1 %</i>	NP*	QL (60 ML per 30 days)
<i>clindamycin phosphate external swab 1 %</i>	PG	
<i>ery external pad 2 %</i>	PG	
<i>erythromycin external gel 2 %</i>	NP*	QL (60 GM per 30 days)
<i>erythromycin external solution 2 %</i>	PG	QL (60 ML per 30 days)
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	NP*	PA
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	PG	
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	PG	PA; AL (Max 35 Years)
<i>tretinoin external gel 0.01 %, 0.025 %</i>	PG	PA; AL (Max 35 Years)
<i>tretinoin external gel 0.05 %</i>	NP*	PA; AL (Max 35 Years)
<i>tretinoin microsphere external gel 0.1 %</i>	PG	PA; AL (Max 35 Years)
<i>tretinoin microsphere pump external gel 0.04 %</i>	PG	PA; AL (Max 35 Years)
<b>DERMATOLOGY, ACTINIC KERATOSIS</b>		
<i>fluorouracil external cream 5 %</i>	PG	
<i>fluorouracil external solution 2 %, 5 %</i>	PG	
<i>imiquimod external cream 5 %</i>	NP*	
<b>DERMATOLOGY, ANTIBIOTICS</b>		
<b>ALTABAX EXTERNAL OINTMENT 1 % (retapamulin)</b>	NP*	
<i>gentamicin sulfate external cream 0.1 %</i>	PG	QL (120 GM per 30 days)
<i>gentamicin sulfate external ointment 0.1 %</i>	PG	QL (120 GM per 30 days)

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<i>mupirocin external ointment 2 %</i>	PG	QL (30 GM per 30 days)
<i>silver sulfadiazine external cream 1 %</i>	PG	
<i>silver sulfadiazine (Ssd External Cream 1 %)</i>	PG	
SULFAMYLYON EXTERNAL CREAM 85 MG/GM ( <i>mafenide acetate</i> )	NP*	
XEPI EXTERNAL CREAM 1 % ( <i>ozenoxacin</i> )	NP*	PA; QL (30 GM per 30 days)
<b>DERMATOLOGY, ANTIFUNGALS</b>		
<i>butenafine hcl external cream 1 %</i>	PG	
<i>ciclopirox external gel 0.77 %</i>	NP*	QL (120 GM per 30 days)
<i>ciclopirox external shampoo 1 %</i>	NP*	QL (120 ML per 30 days)
<i>ciclopirox olamine external cream 0.77 %</i>	PG	QL (120 GM per 30 days)
<i>ciclopirox olamine external suspension 0.77 %</i>	PG	QL (120 ML per 30 days)
<i>clotrimazole external cream 1 %</i>	PG	QL (120 GM per 30 days)
<i>clotrimazole external solution 1 %</i>	PG	QL (120 ML per 30 days)
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	PG	QL (60 GM per 30 days)
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	PG	QL (60 ML per 30 days)
<i>econazole nitrate external cream 1 %</i>	NP*	QL (60 GM per 30 days)
ERTACZO EXTERNAL CREAM 2 % ( <i>sertaconazole nitrate</i> )	NP*	QL (60 GM per 30 days)
<i>keconazole external cream 2 %</i>	PG	QL (120 GM per 30 days)
<i>luliconazole external cream 1 %</i>	NP*	QL (60 GM per 30 days)
<i>naftifine hcl external cream 1 %, 2 %</i>	NP*	QL (60 GM per 30 days)
<i>nystatin (Nyamyc External Powder 100000 Unit/Gm)</i>	PG	QL (120 GM per 30 days)
<i>nystatin external cream 100000 unit/gm</i>	PG	QL (120 GM per 30 days)
<i>nystatin external ointment 100000 unit/gm</i>	PG	QL (120 GM per 30 days)
<i>nystatin external powder 100000 unit/gm</i>	PG	QL (120 GM per 30 days)
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	NP*	QL (60 GM per 30 days)
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	NP*	QL (60 GM per 30 days)

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<i>nystatin</i> (Nystop External Powder 100000 Unit/Gm)	PG	QL (120 GM per 30 days)
<i>oxiconazole nitrate external cream 1 %</i>	NP*	QL (60 GM per 30 days)
<i>sulconazole nitrate external cream 1 %</i>	PG	QL (60 GM per 30 days)
<i>sulconazole nitrate external solution 1 %</i>	PG	QL (60 ML per 30 days)
<b>DERMATOLOGY, ANTIPRURITIC</b>		
<i>doxepin hcl external cream 5 %</i>	NP*	ST; QL (45 GM per 30 days)
<b>DERMATOLOGY, ANTIPSORIATICS</b>		
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	NP*	
<i>calcipotriene external solution 0.005 %</i>	NP*	ST; QL (60 ML per 30 days)
<i>calcipotriene-betameth diprop external ointment 0.005-0.064 %</i>	NP*	ST; QL (60 GM per 30 days)
<i>calcitriol external ointment 3 mcg/gm</i>	NP*	ST; QL (100 GM per 30 days)
<i>methoxsalen rapid oral capsule 10 mg</i>	PG	
<i>tazarotene external cream 0.1 %</i>	NP*	PA
<i>tazarotene external gel 0.05 %, 0.1 %</i>	PG	PA
TAZORAC EXTERNAL CREAM 0.05 % ( <i>tazarotene</i> )	PB	PA
<b>DERMATOLOGY, ANTISEBORRHEICS</b>		
<i>ketoconazole external shampoo 2 %</i>	PG	QL (120 ML per 30 days)
<i>selenium sulfide external lotion 2.5 %</i>	PG	
<b>DERMATOLOGY, CORTICOSTEROIDS</b>		
<i>ala-cort external cream 1 %</i>	PG	QL (120 GM per 30 days)
<i>alclometasone dipropionate external cream 0.05 %</i>	PG	QL (120 GM per 30 days)
<i>alclometasone dipropionate external ointment 0.05 %</i>	PG	QL (120 GM per 30 days)
<i>amcinonide external lotion 0.1 %</i>	NP*	QL (120 ML per 30 days)
<i>amcinonide external ointment 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>betamethasone dipropionate aug external cream 0.05 %</i>	PG	QL (120 GM per 30 days)
<i>betamethasone dipropionate aug external gel 0.05 %</i>	PG	QL (120 GM per 30 days)
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	PG	QL (120 ML per 30 days)

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<i>betamethasone dipropionate aug external ointment 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>betamethasone dipropionate external cream 0.05 %</i>	PG	QL (120 GM per 30 days)
<i>betamethasone dipropionate external lotion 0.05 %</i>	PG	QL (120 ML per 30 days)
<i>betamethasone valerate external cream 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>betamethasone valerate external foam 0.12 %</i>	NP*	QL (120 GM per 30 days)
<i>betamethasone valerate external lotion 0.1 %</i>	NP*	QL (120 ML per 30 days)
<i>betamethasone valerate external ointment 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>clobetasol prop emollient base external cream 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>clobetasol propionate external cream 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>clobetasol propionate external foam 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>clobetasol propionate external gel 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>clobetasol propionate external liquid 0.05 %</i>	NP*	QL (120 ML per 30 days)
<i>clobetasol propionate external lotion 0.05 %</i>	NP*	QL (120 ML per 30 days)
<i>clobetasol propionate external ointment 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>clobetasol propionate external shampoo 0.05 %</i>	NP*	QL (120 ML per 30 days)
<i>clobetasol propionate external solution 0.05 %</i>	NP*	QL (120 ML per 30 days)
<i>clocortolone pivalate external cream 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>desonide external cream 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>desonide external lotion 0.05 %</i>	NP*	QL (120 ML per 30 days)
<i>desonide external ointment 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	NP*	QL (120 GM per 30 days)
<i>desoximetasone external gel 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>desoximetasone external liquid 0.25 %</i>	NP*	QL (120 ML per 30 DAYs)
<i>desoximetasone external ointment 0.25 %</i>	NP*	QL (120 GM per 30 days)
<i>diflorasone diacetate external cream 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>diflorasone diacetate external ointment 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>fluocinolone acetonide body external oil 0.01 %</i>	NP*	QL (120 ML per 30 days)
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	NP*	QL (120 GM per 30 days)

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<i>fluocinolone acetonide external ointment 0.025 %</i>	NP*	QL (120 GM per 30 days)
<i>fluocinolone acetonide external solution 0.01 %</i>	NP*	QL (120 ML per 30 days)
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	NP*	QL (120 ML per 30 days)
<i>fluocinonide external cream 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>fluocinonide external gel 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>fluocinonide external ointment 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>fluocinonide external solution 0.05 %</i>	PG	QL (120 ML per 30 days)
<i>fluticasone propionate external cream 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>fluticasone propionate external lotion 0.05 %</i>	NP*	QL (120 ML per 30 days)
<i>fluticasone propionate external ointment 0.005 %</i>	PG	QL (120 GM per 30 days)
<i>halcinonide external cream 0.1 %</i>	PG	QL (120 GM per 30 DAYs)
<i>halobetasol propionate external cream 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>halobetasol propionate external ointment 0.05 %</i>	NP*	QL (120 GM per 30 days)
<i>hydrocortisone butyrate external cream 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>hydrocortisone butyrate external ointment 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>hydrocortisone butyrate external solution 0.1 %</i>	PG	QL (120 ML per 30 days)
<i>hydrocortisone external cream 1 %</i>	PG	QL (120 grams per 30 days)
<i>hydrocortisone external cream 2.5 %</i>	PG	QL (120 GM per 30 days)
<i>hydrocortisone external lotion 2.5 %</i>	PG	QL (120 ML per 30 days)
<i>hydrocortisone external ointment 2.5 %</i>	PG	QL (120 GM per 30 days)
<i>hydrocortisone valerate external cream 0.2 %</i>	NP*	QL (120 GM per 30 days)
<i>hydrocortisone valerate external ointment 0.2 %</i>	NP*	QL (120 GM per 30 days)
<i>mometasone furoate external cream 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>mometasone furoate external ointment 0.1 %</i>	NP*	QL (120 GM per 30 days)
<i>mometasone furoate external solution 0.1 %</i>	PG	QL (120 ML per 30 days)
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	PG	QL (120 GM per 30 days)
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	PG	QL (120 ML per 30 days)

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<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	PG	QL (120 GM per 30 days)
<b>DERMATOLOGY, LOCAL ANESTHETICS</b>		
<i>lidocaine external ointment 5 %</i>	NP*	QL (50 GM per 30 days)
<i>lidocaine external patch 5 %</i>	PG	PA; QL (90 PATCHES per 30 days)
<i>lidocaine hcl external solution 4 %</i>	PG	QL (50 ML per 30 days)
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	PG	QL (60 ML per 30 days)
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	PG	QL (30 GM per 30 days)
<b>DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE</b>		
<i>acyclovir external cream 5 %</i>	NP*	
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML ( <i>interferon alfa-n3</i> )	PSP	
AMELUZ EXTERNAL GEL 10 % ( <i>aminolevulinic acid hcl</i> )	NP*	
<i>ammonium lactate external cream 12 %</i>	PG	
<i>ammonium lactate external lotion 12 %</i>	PG	
<i>bexarotene external gel 1 %</i>	PSP	PA
CONDYLOX EXTERNAL GEL 0.5 % ( <i>podofilox</i> )	NP*	
<i>diclofenac sodium external gel 1 %</i>	PG	QL (300 GM per 30 days)
EUCRISA EXTERNAL OINTMENT 2 % ( <i>crisaborole</i> )	NP*	ST; QL (60 GM per 30 days)
<i>penciclovir external cream 1 %</i>	PG	
<i>pimecrolimus external cream 1 %</i>	NP*	PA
<i>podofilox external gel 0.5 %</i>	PG	
<i>podofilox external solution 0.5 %</i>	PG	
RECTIV RECTAL OINTMENT 0.4 % ( <i>nitroglycerin</i> )	NP*	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	NP*	
VOLTAREN EXTERNAL GEL 1 % ( <i>diclofenac sodium</i> )	PG	QL (300 GM per 30 days)

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<b>DERMATOLOGY, ROSACEA</b>		
<i>azelaic acid external gel 15 %</i>	NP*	
<i>brimonidine tartrate external gel 0.33 %</i>	PG	PA
FINACEA EXTERNAL FOAM 15 % ( <i>azelaic acid</i> )	PB	
<i>ivermectin external cream 1 %</i>	NP*	PA
<i>metronidazole external cream 0.75 %</i>	NP*	QL (60 GM per 30 days)
<i>metronidazole external gel 0.75 %, 1 %</i>	NP*	QL (60 GM per 30 days)
<i>metronidazole external lotion 0.75 %</i>	PG	QL (60 ML per 30 days)
<b>DERMATOLOGY, SCABICIDES AND PEDICULICIDES</b>		
CROTAN EXTERNAL LOTION 10 % ( <i>crotamiton</i> )	PG	
<i>cvs ivermectin lice treatment external lotion 0.5 %</i>	PG	
<i>cvs lice treatment external liquid 1 %</i>	PG	
<i>lice treatment external lotion 1 %</i>	PG	
<i>malathion external lotion 0.5 %</i>	NP*	ST
<i>permethrin external cream 5 %</i>	NP*	
<i>spinosad external suspension 0.9 %</i>	NP*	ST
<b>DERMATOLOGY, WOUND CARE AGENTS</b>		
REGANEX EXTERNAL GEL 0.01 % ( <i>becaplermin</i> )	NP*	PA; QL (30 GM per 30 days)
<i>sodium chloride irrigation solution 0.9 %</i>	PG	
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<i>cevimeline hcl oral capsule 30 mg</i>	NP*	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	PG	
<i>clotrimazole mouth/throat troche 10 mg</i>	PG	QL (90 LOZENGES per 30 days)
<i>lidocaine hcl mouth/throat solution 4 %</i>	PG	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	PG	
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	PG	

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<i>triamcinolone acetonide</i> (Oralene Mouth/Throat Paste 0.1 %)	PG	
ORAVIG BUCCAL TABLET 50 MG ( <i>miconazole</i> )	NP*	QL (14 TABLETS per 30 days)
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	PG	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	PG	
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	PG	
<b>OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR</b>		
<i>acetic acid otic solution 2 %</i>	PG	
<i>ciprofloxacin hcl otic solution 0.2 %</i>	PG	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	PG	
<i>ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %</i>	NP*	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML ( <i>neomycin-colist-hc-thonzonium</i> )	NP*	
<i>fluocinolone acetonide otic oil 0.01 %</i>	NP*	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	PG	
<i>neomycin-polymyxin-hc otic solution 1 %</i>	PG	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	PG	
<i>ofloxacin otic solution 0.3 %</i>	NP*	

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