2024 Aetna Pharmacy Drug Guide

Standard Opt Out Plan - Aetna: California

Visit **www.aetna.com/formulary** for the most up-to-date information. For a summary of your coverage or benefits plan log in to your secure member site. Or call the toll-free number on your member ID card.

The formulary is updated the first week of each month. The formulary is subject to change. Previous versions are no longer in effect.

The Medical plan names to which this document applies to in the state of California are listed below:

Plan Name

Aetna Value Network HMO
Aetna Value Network HMO HDHP
Aetna Value Network OA Elect Choice® EPO
Aetna Value Network OA Managed Choice® POS
Aetna Value Network OA Managed Choice® POS HDHP
Aexcel® OA Managed Choice® POS
Aexcel® Plus Managed Choice® POS HDHP Tiered
Aexcel® Plus OA Managed Choice® POS HDHP Tiered
Aexcel® Plus OA Managed Choice® POS Tiered
Aexcel® Plus Open Choice® PPO HDHP Tiered
Aexcel® Plus Open Choice® PPO Tiered
AHF Aetna Value Network OA Managed Choice® POS
AHF AWH MemorialCare OA Managed Choice® POS
AHF AWH PrimeCare OA Managed Choice® POS
AHF AWH Providence OA Elect Choice® EPO
AHF AWH Providence OA Managed Choice® POS
AHF AWH Sharp OA Managed Choice® POS
AHF AWH Southern CA OA Managed Choice® POS
AHF AWH Southern CA OA Managed Choice® POS HDHP
AHF HMO
AHF HMO Basic POS
AHF HMO Basic PPO
AHF HMO Deductible
AHF HMO Deductible HDHP
AHF HMO Deductible POS
AHF HMO Deductible PPO
AHF OA Elect Choice® EPO
AHF OA Managed Choice® POS
AHF OA Managed Choice® POS HDHP
AHF Open Choice® PPO
AHF Open Choice® PPO HDHP
AHF Savings Plus OA Managed Choice® POS
AHF Savings Plus OA Managed Choice® POS HDHP
AHF Sutter Health OA Elect Choice® EPO
AHF Sutter Health OA Managed Choice® POS
AHF Sutter Health OA Managed Choice® POS HDHP
AWH MemorialCare Managed Choice® POS
AWH MemorialCare OA Elect Choice® EPO
AWH MemorialCare OA Elect Choice® EPO HDHP
AWH MemorialCare OA Managed Choice® POS
AWH MemorialCare OA Managed Choice® POS HDHP
AWH PrimeCare HMO
AWH PrimeCare OA Elect Choice® EPO
AWH PrimeCare OA Elect Choice® EPO HDHP
AWH PrimeCare OA Managed Choice® POS
AWH PrimeCare OA Managed Choice® POS HDHP

Plan Name

AWH PrimeCare OA Managed Choice® POS HDHP Tiered
AWH PrimeCare OA Managed Choice® POS Tiered AWH Providence Managed Choice® POS
AWH Providence OA Elect Choice® EPO
AWH Providence OA Elect Choice® EPO HDHP
AWH Providence OA Managed Choice® POS
AWH Providence OA Managed Choice® POS HDHP AWH
SCCIPA OA Elect Choice® EPO
AWH SCCIPA OA Elect Choice® EPO HDHP
AWH SCCIPA OA Managed Choice® POS
AWH Sharp OA Elect Choice® EPO
AWH Sharp OA Managed Choice® POS
AWH Sharp OA Managed Choice® POS HDHP
AWH Southern CA HMO
AWH Southern CA HMO HDHP
AWH Southern CA Managed Choice® POS
AWH Southern CA OA Elect Choice® EPO
AWH Southern CA OA Elect Choice® EPO HDHP
AWH Southern CA OA Managed Choice® POS
AWH Southern CA OA Managed Choice® POS HDHP
Elect Choice® EPO
HMO
HMO Basic
HMO Basic EPO
HMO Basic HDHP
HMO Basic POS
HMO Basic POS HDHP
HMO Basic PPO
HMO Basic PPO HDHP
HMO Deductible
HMO Deductible EPO
HMO Deductible HDHP
HMO Deductible POS
HMO Deductible POS HDHP
HMO Deductible PPO
HMO Deductible PPO HDHP
HMO HDHP
Managed Choice® POS
Managed Choice® POS HDHP
OA Elect Choice® EPO
OA Elect Choice® EPO HDHP
OA Managed Choice® POS
OA Managed Choice® POS HDHP
Open Choice® PPO
Open Choice® PPO HDHP
QPOS
QPOS HDHP
Savings Plus OA Managed Choice® POS
Savings Plus OA Managed Choice® POS HDHP

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Definitions

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

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

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

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

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

Enrollee is a person enrolled in a health plan who is entitled to receive services from the plan.

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

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

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

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

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

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

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

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

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

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

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

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

Subscriber means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

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.

Refer to the Summary of Benefits for differences and information about the prescription drugs covered under your Outpatient prescription drugs and medical benefit in your plan.

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

If a generic equivalent for a brand name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

- A drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs;
- The generic name for a brand name drug is included after the brand name in parentheses and all lowercase italicized letters. (For example: COREG (*carvedilol*))
- If a generic equivalent for a brand name drug is both available and covered, the generic drug will be listed separately from the brand name drug in all lowercase italicized letters; and (For example: *carvedilol*)
- If a generic drug is marketed under a proprietary, trademark-protected brand name, the brand name will be listed after the generic name in parentheses and regular typeface with the first letter of each word capitalized. (For example: *desogestrel-ethinyl estradiol* (Azurette)).
- Inclusion of a prescription drug on the formulary does not guarantee that your provider will prescribe the drug for a particular medical condition.'
- Therapeutic categories and classes are based on the Medispan therapeutic classification system.

Your plan includes

- Brand and generic drugs that are hand-picked for their quality and effectiveness
- A specialty pharmacy fills specialty drug 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 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.

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

- **Generic – G (tier 1):** the lowest cost share
- **Preferred brand – PB (tier 2)**: a slightly higher cost share
- **Non-preferred brand – NP (tier 3):** a higher cost share
- **Preferred Specialty – PSP (tier 4):** lower cost share for specialty drugs
- **Non-preferred Specialty – NPS (tier 5):** higher cost share for non-preferred specialty drugs
- **Copay Exception – CE:** Available to some members at no cost with a prescription from your provider when obtained at an in-network pharmacy. Certain limitations may apply.

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 example your copayments and maximum dollar amounts.

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

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 your treatment, if needed. With this type of pharmacy, you can get this medicine sent right to our mailbox.

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 (TTY: 711)**.
- **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**
  3. **Phone: 1-800-237-2767 (TTY: 711)**

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 with 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 (TTY: 711)**. If you need the help of a telephone device for the hard of hearing, call **1-877-833-2779 (TTY: 711)**.
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**. 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 service 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)?

Prior authorization is one way that we can help you and your doctor find safe, appropriate drugs and keep costs down. Prior authorization means that you or your doctor need to get approval from the plan before certain drugs will be covered. Generally, Prior authorization 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(s) 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 prior authorization, 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 prior authorization, step therapy or quantity limits requirement or for a drug that's not covered on your plan. Coverage determinations will be made within 72 hours of receiving non-urgent requests. 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.

Medical exceptions which are approved for non-urgent requests will cover the duration of the prescription, including refills. Approved medical exceptions for exigent circumstances will provide coverage for the duration of the exigency.

If your request is denied you have the right to file an appeal using the process described in the notification letter.

If a determination is not made for a prior authorization or step therapy exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed approved and we may not deny the request thereafter.

In accordance with state law, members who are covered under small group health insurance policies and who have previously received approval from us for coverage of medications for the members' medical conditions will continue to have those medications covered, for as long as the prescriber continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the member's medical condition.

How can your provider request a medical exception?

The following options will provide detail to help request a medical exception.

- Submit their request through our secure provider website on **www.availity.com**.
- Call the Aetna Pharmacy prior authorization 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

Can the formulary change during the year?

The formulary can change throughout the year. Some reasons why they 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.

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.

How do you find a pharmacy?

You can find a pharmacy in two ways:

- **Online:** By logging onto your secure member website at **Aetna.com**.
- **By phone:** Call the toll-free number on your ID card. During regular business hours, a representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-802-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation 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 race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator
P.O. Box 24030, Fresno, CA 93779
1-800-648-7817 (TTY: 711), Fax: 860-262-7705
CRCoordinator@aetna.com.

You can also file a complaint with the California Department of Insurance at **www.insurance.ca.gov**, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at **1-800-927-HELP (4357) (TTY: 711)**, **TDD: 1-800-482-4TDD (4833) (TTY: 711)**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. You can 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)**.

TTY:711

English	**To access language services at no cost to you, call the number on your ID card.**
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የ ቋንቋ አገ ልግሎቶችን ያለክፍያ ለማግኘት፣ በሚታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ፡ ፡
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով անվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով
Bantu-Kirundi	Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။
Catalan	Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.
Cebuano	Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	ᏩᎩᏍᏗ ᏕᏫᏂᏱᏍᏗ ᎢᏳᎾᏛᏁᏗ Ꮭ ᎠᎱᏍᏗ ᏗᏟᎬᏔᏁᏗ ᏜᎩ, ᏑᎫᏱᏏᎳᏛᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᏚᎪᏪᎵ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏤᎵᎢ.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Choctaw	Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Dutch	Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.

Hawaiian	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo 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 obụla, kpọọ nọmba nọ na kaadi njirimara gị
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	လၢတၢ်ကမၤန့ၢ်ကျိာ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ် လၢတအိဉ်ဒီးအပှၤလၢနကဘဉ်ဟ့ဉ်အီၤအဂီၢ်,ကိးဘဉ်လိတဲစိနိဉ်ဂံၢ်လၢအအိဉ်လၢနခိဉ်ဂီၤ (ID) အလိၤန့ဉ်တက့ၢ်.
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	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی(ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Ṇan bōk jipañ kōn kajin ilo an ejjeḷọk wōṇean ñan kwe, kwōn kallok nōṃba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajį’ hólne’.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kɔɔr yïn ran de wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke yïn cɔl ran ye kɔc kuɔny në namba de abac tɔ në ID kard duɔ̈n de tïït de nyin de panakim kɔ̈u.
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.

Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian	Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Sudanic Fulfulde	Heeɓa a naasta nder ekkitol jaangirde woldeji walla yobugo, ewnu lamba je ɗon windi ha do ɗerowol maaɗa.
Swahili	Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho.
Syriac-Assyrian	ܟܝ ܡܣܒܩܐ ܡܠܘܟ ܥܠ ܝܠܦܢܘܬܐ ܕܡܫܘܕܥܬܐ ܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܝܒܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܡܫܘܕܥܢܘܬܐ ܕܝܘܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Telugu	బాష సేవలను మీకు ఖర్చు లేకుండా అందుకునేందుకు, మీ ఐడి కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Tongan	Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika ‘oku hā atu ‘i ho’o ID kaati.
Turkish	Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.
Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Urdu	لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Yiddish	צו באקומען שפראך סערוויסעס פריי פון אפצאל, רופט דעם נומער אויף אייער ID קארטל.
Yoruba	Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.

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.

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lowercase italics = Generic drugs
UPPERCASE = Brand name drugs

Drug Tier
CE = 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.
NF = Non-formulary, not covered unless exception request granted
Tier 1 (G) = Generic
Tier 2 (PB) = Preferred Brand
Tier 3 (NPB) = Non-Preferred Brand
Tier 4 (PSP) = Preferred Specialty
Tier 5 (NPSP) = Non-Preferred Specialty

Coverage Requirements and Limits
AL = Age Limit
IBC = Indication Based Coverage
LGC = Lowest Generic Copay
N10 = Drug Coverage for Student Health members.
N7 = Drug tier when CE does not apply
N8 = Drug Specific Coverage
PA = Prior Authorization
QL = Quantity Limit
Select OTC = Select OTC Program if your pharmacy plan includes this program you may have coverage for products noted with a doctors prescription. Please see your plan benefit information for specific coverage details.
SPC = Select Plan Coverage: Only available for select plans. Refer to member plan documents for coverage.
ST = Step Therapy
STX = Safer and/or more effective treatments are available

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION		
COX-2 INHIBITORS		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	Tier 1 (G)	
GOUT		
allopurinol oral tablet 100 mg, 300 mg	Tier 1 (G)	
colchicine oral capsule 0.6 mg	Tier 1 (G)	
colchicine oral tablet 0.6 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
colchicine-probenecid oral tablet 0.5-500 mg	Tier 1 (G)	
febuxostat oral tablet 40 mg, 80 mg	Tier 1 (G)	
KRYSTEXXA INTRAVENOUS SOLUTION 8 MG/ML (*pegloticase*)	Tier 5 (NPSP)	PA
probenecid oral tablet 500 mg	Tier 1 (G)	
MISCELLANEOUS		
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 500 MCG/20ML, 500 MCG/5ML (*ziconotide acetate*)	Tier 5 (NPSP)	
NON-OPIOID ANALGESICS		
ALLZITAL ORAL TABLET 25-325 MG (*butalbital-acetaminophen*)	Tier 3 (NPB)	STX; QL (96 TABLETS per 25 days)
butalbital-apap-caffeine (Bac Oral Tablet 50-325-40 Mg)	Tier 1 (G)	STX; QL (48 tablets per 25 days)
butalbital-acetaminophen oral capsule 50-300 mg	NF	
butalbital-acetaminophen oral tablet 50-300 mg	NF	
butalbital-acetaminophen oral tablet 50-325 mg	Tier 1 (G)	STX; QL (48 TABLETS per 25 DAYs)
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	Tier 1 (G)	STX; QL (48 CAPSULES per 25 DAYs)
butalbital-apap-caffeine oral tablet 50-325-40 mg	Tier 1 (G)	STX; QL (48 TABLETS per 25 days)
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	Tier 1 (G)	STX; QL (48 CAPSULES per 25 DAYs)
ESGIC ORAL TABLET 50-325-40 MG (*butalbital-apap-caffeine*)	Tier 3 (NPB)	STX; QL (48 TABLETS per 25 days)
FIORICET ORAL CAPSULE 50-300-40 MG (*butalbital-apap-caffeine*)	Tier 3 (NPB)	STX; QL (48 CAPSULES per 25 DAYs)
NSAIDS		
diclofenac epolamine external patch 1.3 %	Tier 1 (G)	STX; QL (30 PATCHES per 25 days)
diclofenac potassium oral capsule 25 mg	NF	
diclofenac potassium oral tablet 25 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diclofenac potassium oral tablet 50 mg	Tier 1 (G)	
diclofenac potassium(migraine) oral packet 50 mg	NF	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	Tier 1 (G)	
diclofenac sodium external gel 3 %	Tier 1 (G)	PA; QL (100 G per 25 days)
diclofenac sodium external solution 1.5 %	Tier 1 (G)	
diclofenac sodium external solution 2 %	NF	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	Tier 1 (G)	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	Tier 1 (G)	
etodolac oral capsule 200 mg, 300 mg	Tier 1 (G)	
etodolac oral tablet 400 mg, 500 mg	Tier 1 (G)	
fenoprofen calcium oral capsule 200 mg	NF	
fenoprofen calcium oral capsule 400 mg	Tier 1 (G)	N8 (Listing does not include certain NDCs)
fenoprofen calcium oral tablet 600 mg	NF	
FLECTOR EXTERNAL PATCH 1.3 % (*diclofenac epolamine*)	Tier 3 (NPB)	STX; QL (30 PATCHES per 25 days)
flurbiprofen oral tablet 100 mg, 50 mg	Tier 1 (G)	
ibuprofen (Ibu Oral Tablet 600 Mg)	Tier 1 (G)	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	Tier 1 (G)	
INDOCIN ORAL SUSPENSION 25 MG/5ML (*indomethacin*)	NF	
indomethacin oral capsule 25 mg, 50 mg	Tier 1 (G)	STX
indomethacin rectal suppository 50 mg	NF	
ketoprofen er oral capsule extended release 24 hour 200 mg	NF	
ketoprofen oral capsule 25 mg	NF	
ketoprofen oral capsule 50 mg	Tier 1 (G)	
ketorolac tromethamine oral tablet 10 mg	Tier 1 (G)	QL (20 TABLETS per 25 DAYs)
LICART EXTERNAL PATCH 24 HOUR 1.3 % (*diclofenac epolamine*)	Tier 3 (NPB)	STX; QL (15 PATCHES per 25 days)

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diclofenac potassium (Lofena Oral Tablet 25 Mg)	NF	
meclofenamate sodium oral capsule 100 mg, 50 mg	Tier 1 (G)	
mefenamic acid oral capsule 250 mg	Tier 1 (G)	N8 (Listing does not include certain NDCs)
meloxicam oral capsule 10 mg, 5 mg	NF	
meloxicam oral tablet 15 mg, 7.5 mg	Tier 1 (G)	
nabumetone oral tablet 500 mg, 750 mg	Tier 1 (G)	
NAPRELAN ORAL TABLET EXTENDED RELEASE 24 HOUR 375 MG, 500 MG (*naproxen sodium*)	NF	
NAPROSYN ORAL TABLET 500 MG (*naproxen*)	Tier 3 (NPB)	
naproxen oral suspension 125 mg/5ml	NF	
naproxen oral tablet 250 mg, 375 mg, 500 mg	Tier 1 (G)	
naproxen oral tablet delayed release 375 mg, 500 mg	Tier 1 (G)	
naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg	NF	
naproxen sodium oral tablet 275 mg, 550 mg	Tier 1 (G)	
oxaprozin oral tablet 600 mg	Tier 1 (G)	
piroxicam oral capsule 10 mg, 20 mg	Tier 1 (G)	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (*ketorolac tromethamine*)	NF	
sulindac oral tablet 150 mg, 200 mg	Tier 1 (G)	
NSAIDS, COMBINATIONS		
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	Tier 1 (G)	
naproxen-esomeprazole mg oral tablet delayed release 375-20 mg, 500-20 mg	NF	
OPIOID ANALGESICS		
acetaminophen-codeine oral solution 120-12 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (2700 ML per 25 days)
acetaminophen-codeine oral solution 300-30 mg/12.5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (2700 ML per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
acetaminophen-codeine oral tablet 300-15 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (400 TABLETS per 25 DAYs)
acetaminophen-codeine oral tablet 300-30 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (360 TABLETS per 25 Days)
acetaminophen-codeine oral tablet 300-60 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 Days)
APADAZ ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG (*benzhydrocodone-acetaminophen*)	Tier 3 (NPB)	STX; N8 (Subject to initial limit.); QL (168 TABLETS per 25 days)
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (300 CAPSULES per 25 days)
benzhydrocodone-acetaminophen oral tablet 4.08-325 mg, 6.12-325 mg, 8.16-325 mg	Tier 3 (NPB)	STX; N8 (Subject to initial limit.); QL (168 TABLETS per 25 days)
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	Tier 1 (G)	STX; QL (48 CAPSULES per 25 DAYs)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	Tier 1 (G)	STX; QL (48 CAPSULES per 25 days)
butorphanol tartrate nasal solution 10 mg/ml	Tier 1 (G)	QL (2 BOTTLES per 25 DAYs)
codeine sulfate oral tablet 30 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (42 TABLETS per 25 days)
codeine sulfate oral tablet 60 mg	Tier 3 (NPB)	N8 (Subject to initial limit); QL (42 TABLETS per 25 days)
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (*tramadol hcl*)	Tier 3 (NPB)	ST; QL (30 CAPSULES per 25 DAYs)
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG, 300 MG (*tramadol hcl*)	Tier 3 (NPB)	ST

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DILAUDID ORAL LIQUID 1 MG/ML (*hydromorphone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (480 ML per 25 days)
DILAUDID ORAL TABLET 2 MG (*hydromorphone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
DILAUDID ORAL TABLET 4 MG (*hydromorphone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
DILAUDID ORAL TABLET 8 MG (*hydromorphone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
fentanyl citrate buccal lozenge on a handle 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	Tier 1 (G)	PA; QL (120 LOZENGES per 25 days)
fentanyl citrate buccal tablet 200 mcg, 400 mcg, 600 mcg, 800 mcg	Tier 1 (G)	PA; QL (120 TABLETS per 25 DAYs)
fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr	Tier 1 (G)	ST
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr	Tier 1 (G)	ST; QL (10 PATCHES per 25 DAYs)
FIORICET/CODEINE ORAL CAPSULE 50-300-40-30 MG (*butalbital-apap-caff-cod*)	Tier 3 (NPB)	STX; QL (48 CAPSULES per 25 DAYs)
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg	Tier 1 (G)	ST; QL (60 CAPSULES per 25 days)
hydrocodone bitartrate er oral capsule extended release 12 hour 50 mg	Tier 1 (G)	ST
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	Tier 1 (G)	ST
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	Tier 1 (G)	ST; QL (30 TABLETS per 25 DAYs)
hydrocodone-acetaminophen oral solution 10-325 mg/15ml	Tier 1 (G)	N8 (Subject to initial limit); QL (2700 ML per 25 DAYs)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	Tier 1 (G)	N8 (Subject to initial limit); QL (2700 ML per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrocodone-acetaminophen oral tablet 10-300 mg, 7.5-300 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 DAYs)
hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
hydrocodone-acetaminophen oral tablet 5-300 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (240 TABLETS per 25 DAYs)
hydrocodone-acetaminophen oral tablet 5-325 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (50 TABLETS per 25 days)
hydromorphone hcl er oral tablet extended release 24 hour 12 mg, 16 mg, 8 mg	Tier 1 (G)	ST; QL (30 TABLETS per 25 DAYs)
hydromorphone hcl er oral tablet extended release 24 hour 32 mg	Tier 1 (G)	ST
hydromorphone hcl oral liquid 1 mg/ml	Tier 1 (G)	N8 (Subject to initial limit); QL (480 ML per 25 days)
hydromorphone hcl oral tablet 2 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
hydromorphone hcl oral tablet 4 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
hydromorphone hcl oral tablet 8 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG, 120 MG (*hydrocodone bitartrate*)	Tier 3 (NPB)	ST
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 20 MG, 30 MG, 40 MG, 60 MG, 80 MG (*hydrocodone bitartrate*)	Tier 3 (NPB)	ST; QL (30 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levorphanol tartrate oral tablet 2 mg, 3 mg	NF	
meperidine hcl oral solution 50 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (90 ML per 25 days)
meperidine hcl oral tablet 50 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (18 TABLETS per 25 days)
methadone hcl (Methadone Hcl Intensol Oral Concentrate 10 Mg/Ml)	Tier 1 (G)	ST; QL (45 ML per 25 days)
methadone hcl oral concentrate 10 mg/ml	Tier 1 (G)	QL (30 ML per 25 DAYs)
methadone hcl oral solution 10 mg/5ml	Tier 1 (G)	ST; QL (225 ML per 25 days)
methadone hcl oral solution 5 mg/5ml	Tier 1 (G)	ST; QL (450 ML per 25 DAYs)
methadone hcl oral tablet 10 mg	Tier 1 (G)	ST; QL (30 TABLETS per 25 days)
methadone hcl oral tablet 5 mg	Tier 1 (G)	ST; QL (90 TABLETS per 25 days)
methadone hcl oral tablet soluble 40 mg	Tier 1 (G)	QL (9 TABLETS per 25 DAYs)
METHADOSE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*)	Tier 3 (NPB)	QL (30 ML per 25 DAYs)
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*)	Tier 3 (NPB)	QL (30 ML per 25 DAYs)
morphine sulfate (concentrate) oral solution 100 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (135 ML per 25 days)
morphine sulfate er beads oral capsule extended release 24 hour 120 mg	Tier 1 (G)	ST
morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	Tier 1 (G)	ST; QL (30 CAPSULES per 25 DAYs)
morphine sulfate er oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg	Tier 1 (G)	ST; QL (60 CAPSULES per 25 days)
morphine sulfate er oral capsule extended release 24 hour 100 mg	Tier 1 (G)	ST
morphine sulfate er oral capsule extended release 24 hour 50 mg, 60 mg, 80 mg	Tier 1 (G)	ST; QL (30 CAPSULES per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg	Tier 1 (G)	ST
morphine sulfate er oral tablet extended release 15 mg, 30 mg	Tier 1 (G)	ST; QL (90 TABLETS per 25 DAYs)
morphine sulfate oral solution 10 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (900 ML per 25 days)
morphine sulfate oral solution 20 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (675 ML per 25 DAYs)
morphine sulfate oral tablet 15 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
morphine sulfate oral tablet 30 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 200 MG, 60 MG (*morphine sulfate*)	Tier 3 (NPB)	ST
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG (*morphine sulfate*)	Tier 3 (NPB)	ST; QL (90 TABLETS per 25 DAYs)
nalocet oral tablet 2.5-300 mg	Tier 3 (NPB)	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 50 MG (*tapentadol hcl*)	Tier 3 (NPB)	ST; QL (60 TABLETS per 25 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (*tapentadol hcl*)	Tier 3 (NPB)	ST
NUCYNTA ORAL TABLET 100 MG (*tapentadol hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
NUCYNTA ORAL TABLET 50 MG (*tapentadol hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
NUCYNTA ORAL TABLET 75 MG (*tapentadol hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxycodone hcl oral capsule 5 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 CAPSULES per 25 days)
oxycodone hcl oral concentrate 100 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (90 ML per 25 days)
oxycodone hcl oral solution 5 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (900 ML per 25 days)
oxycodone hcl oral tablet 10 mg, 5 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
oxycodone hcl oral tablet 15 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
oxycodone hcl oral tablet 20 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)
oxycodone hcl oral tablet 30 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
oxycodone hcl oral tablet abuse-deterrent 15 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
oxycodone hcl oral tablet abuse-deterrent 30 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (60 TABLETS per 25 DAYs)
oxycodone hcl oral tablet abuse-deterrent 5 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 DAYs)
oxycodone-acetaminophen oral solution 10-300 mg/5ml	Tier 3 (NPB)	N8 (Subject to initial limit); QL (900 ML per 25 days)
oxycodone-acetaminophen oral solution 5-325 mg/5ml	Tier 1 (G)	N8 (Subject to initial limit); QL (1800 ML per 25 days)
oxycodone-acetaminophen oral tablet 10-300 mg	Tier 3 (NPB)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxycodone-acetaminophen oral tablet 10-325 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 2.5-300 mg, 5-300 mg	Tier 3 (NPB)	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 7.5-300 mg	Tier 3 (NPB)	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 7.5-325 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG, 15 MG, 20 MG, 30 MG (*oxycodone hcl*)	Tier 3 (NPB)	ST; QL (60 TABLETS per 25 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 40 MG, 60 MG, 80 MG (*oxycodone hcl*)	Tier 3 (NPB)	ST
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg	Tier 1 (G)	ST; QL (60 TABLETS per 25 days)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg	Tier 1 (G)	ST
oxymorphone hcl oral tablet 10 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)
oxymorphone hcl oral tablet 5 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
PERCOCET ORAL TABLET 10-325 MG (*oxycodone-acetaminophen*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
PERCOCET ORAL TABLET 2.5-325 MG, 5-325 MG (*oxycodone-acetaminophen*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)

The formulary is updated the first week of each month.

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PERCOCET ORAL TABLET 7.5-325 MG (*oxycodone-acetaminophen*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
PROLATE ORAL SOLUTION 10-300 MG/5ML (*oxycodone-acetaminophen*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (900 ML per 25 DAYs)
PROLATE ORAL TABLET 10-300 MG (*oxycodone-acetaminophen*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
PROLATE ORAL TABLET 5-300 MG (*oxycodone-acetaminophen*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
PROLATE ORAL TABLET 7.5-300 MG (*oxycodone-acetaminophen*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
QDOLO ORAL SOLUTION 5 MG/ML (*tramadol hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (1800 ML per 25 DAYs)
ROXICODONE ORAL TABLET 15 MG (*oxycodone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
ROXICODONE ORAL TABLET 30 MG (*oxycodone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 15 MG (*oxycodone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (120 TABLETS per 25 DAYs)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 30 MG (*oxycodone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (60 TABLETS per 25 DAYs)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 5 MG (*oxycodone hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (180 TABLETS per 25 DAYs)
SEGLENTIS ORAL TABLET 56-44 MG (*celecoxib-tramadol hcl*)	Tier 3 (NPB)	N8 (Subject to initial limit); QL (120 TABLETS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tramadol hcl (er biphasic) oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	NF	
tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg	Tier 1 (G)	ST; QL (30 TABLETS per 25 days)
tramadol hcl (er biphasic) oral tablet extended release 24 hour 200 mg, 300 mg	Tier 1 (G)	ST
tramadol hcl er oral tablet extended release 24 hour 100 mg	Tier 1 (G)	ST; QL (30 TABLETS per 25 days)
tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg	Tier 1 (G)	ST
tramadol hcl oral tablet 100 mg	NF	
tramadol hcl oral tablet 25 mg	Tier 1 (G)	QL (120 TABLETS per 25 days)
tramadol hcl oral tablet 50 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
tramadol hcl solution 5 mg/ml oral	Tier 1 (G)	N8 (Subject to initial limit); QL (1800 ML per 25 Days)
tramadol hcl solution 5 mg/ml oral	Tier 3 (NPB)	N8 (Subject to initial limit); QL (1800 ML per 25 Days)
tramadol-acetaminophen oral tablet 37.5-325 mg	Tier 1 (G)	N8 (Subject to initial limit); QL (40 TABLETS per 25 days)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 9 MG (*oxycodone*)	Tier 2 (PB)	ST; QL (60 CAPSULES per 25 days)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (*oxycodone*)	Tier 2 (PB)	ST
OPIOID PARTIAL AGONISTS		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 75 MCG (*buprenorphine hcl*)	Tier 2 (PB)	ST; QL (60 FILMS per 25 DAYs)
BELBUCA BUCCAL FILM 600 MCG, 750 MCG, 900 MCG (*buprenorphine hcl*)	Tier 2 (PB)	ST

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
buprenorphine transdermal patch weekly 10 mcg/hr, 5 mcg/hr, 7.5 mcg/hr	Tier 1 (G)	ST; QL (4 PATCHES per 25 DAYs)
buprenorphine transdermal patch weekly 15 mcg/hr, 20 mcg/hr	Tier 1 (G)	ST
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HR, 5 MCG/HR, 7.5 MCG/HR (*buprenorphine*)	Tier 3 (NPB)	ST; QL (4 PATCH WEEKLY per 25 days)
BUTRANS TRANSDERMAL PATCH WEEKLY 15 MCG/HR, 20 MCG/HR (*buprenorphine*)	Tier 3 (NPB)	ST
pentazocine-naloxone hcl oral tablet 50-0.5 mg	Tier 1 (G)	STX; N8 (Subject to initial limit.); QL (120 TABLETS per 25 days)
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML (*buprenorphine*)	Tier 4 (PSP)	
SALICYLATES		
aspirin childrens oral tablet chewable 81 mg	CE	N7 (Not Covered); QL (100 TABLETS per 30 DAYs); AL (Min 12 Years and Max 59 Years)
aspirin oral tablet delayed release 81 mg	CE	N7 (Not Covered); QL (100 TABLETS per 30 Days); AL (Min 12 Years and Max 59 Years)
diflunisal oral tablet 500 mg	Tier 1 (G)	
VISCOSUPPLEMENTS		
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE 60 MG/3ML (*sodium hyaluronate (viscosup)*)	Tier 4 (PSP)	PA
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	Tier 4 (PSP)	PA
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE 30 MG/3ML (*cross-linked hyaluronate*)	NF	
GELSYN-3 INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 16.8 MG/2ML (*sodium hyaluronate (viscosup)*)	Tier 4 (PSP)	PA
GENVISC 850 INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 25 MG/2.5ML (*sodium hyaluronate (viscosup)*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYALGAN INTRA-ARTICULAR SOLUTION 20 MG/2ML (*sodium hyaluronate (viscosup)*)	NF	
HYALGAN INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	NF	
HYMOVIS INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 24 MG/3ML (*hyaluronan*)	NF	
MONOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 88 MG/4ML (*hyaluronan*)	NF	
ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 30 MG/2ML (*hyaluronan*)	NF	
SUPARTZ FX INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 25 MG/2.5ML (*sodium hyaluronate (viscosup)*)	Tier 4 (PSP)	PA
SYNOJOYNT INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	NF	
SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 16 MG/2ML (*hylan g-f 20*)	NF	
SYNVISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 48 MG/6ML (*hylan g-f 20*)	NF	
TRILURON INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	NF	
TRIVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 25 MG/2.5ML (*sodium hyaluronate (viscosup)*)	NF	
VISCO-3 INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 25 MG/2.5ML (*sodium hyaluronate (viscosup)*)	NF	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
ANTHELMINTICS - DRUGS FOR WORM INFECTION		
albendazole oral tablet 200 mg	Tier 1 (G)	QL (336 TABLETS per 365 DAYs)
BILTRICIDE ORAL TABLET 600 MG (*praziquantel*)	Tier 3 (NPB)	QL (24 TABLETS per 365 DAYs)
EMVERM ORAL TABLET CHEWABLE 100 MG (*mebendazole*)	Tier 2 (PB)	QL (12 TABLETS per 365 DAYs)
ivermectin oral tablet 3 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
praziquantel oral tablet 600 mg	Tier 1 (G)	QL (24 TABLETS per 365 DAYs)
ANTI-BACTERIALS - MISCELLANEOUS		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (*amikacin sulfate liposome*)	Tier 5 (NPSP)	PA
neomycin sulfate oral tablet 500 mg	Tier 1 (G)	
tinidazole oral tablet 250 mg, 500 mg	Tier 1 (G)	
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	Tier 1 (G)	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	Tier 1 (G)	
flucytosine oral capsule 500 mg	NF	
griseofulvin microsize oral suspension 125 mg/5ml	Tier 1 (G)	
griseofulvin microsize oral tablet 500 mg	Tier 1 (G)	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	Tier 1 (G)	
itraconazole oral capsule 100 mg	Tier 1 (G)	
itraconazole oral solution 10 mg/ml	Tier 1 (G)	
ketoconazole oral tablet 200 mg	Tier 1 (G)	STX
nystatin oral tablet 500000 unit	Tier 1 (G)	
posaconazole oral tablet delayed release 100 mg	Tier 1 (G)	
terbinafine hcl oral tablet 250 mg	Tier 1 (G)	
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*voriconazole*)	Tier 2 (PB)	
VFEND ORAL TABLET 50 MG (*voriconazole*)	Tier 2 (PB)	
voriconazole oral suspension reconstituted 40 mg/ml	Tier 1 (G)	
voriconazole oral tablet 200 mg, 50 mg	Tier 1 (G)	
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	Tier 1 (G)	
chloroquine phosphate oral tablet 250 mg, 500 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (*atovaquone-proguanil hcl*)	Tier 2 (PB)	
mefloquine hcl oral tablet 250 mg	Tier 1 (G)	
primaquine phosphate oral tablet 26.3 (15 base) mg	Tier 1 (G)	
quinine sulfate oral capsule 324 mg	Tier 1 (G)	
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate oral solution 20 mg/ml	Tier 1 (G)	QL (900 ML per 30 DAYs)
abacavir sulfate oral tablet 300 mg	Tier 1 (G)	QL (60 TABLETS per 30 DAYs)
APTIVUS ORAL CAPSULE 250 MG (*tipranavir*)	NF	
atazanavir sulfate oral capsule 150 mg, 300 mg	Tier 1 (G)	QL (30 CAPSULES per 30 DAYs)
atazanavir sulfate oral capsule 200 mg	Tier 1 (G)	QL (60 CAPSULES per 30 DAYs)
darunavir oral tablet 600 mg	Tier 1 (G)	QL (60 TABLETS per 30 DAYs)
darunavir oral tablet 800 mg	Tier 1 (G)	QL (30 TABLETS per 30 DAYs)
EDURANT ORAL TABLET 25 MG (*rilpivirine hcl*)	Tier 3 (NPB)	QL (60 TABLETS per 30 days)
efavirenz oral tablet 600 mg	Tier 1 (G)	QL (30 TABLETS per 30 days)
emtricitabine oral capsule 200 mg	Tier 1 (G)	QL (30 TABLETS per 30 DAYs)
EMTRIVA ORAL CAPSULE 200 MG (*emtricitabine*)	Tier 2 (PB)	QL (30 CAPSULES per 30 DAYs)
EMTRIVA ORAL SOLUTION 10 MG/ML (*emtricitabine*)	Tier 2 (PB)	QL (680 ML per 28 DAYs)
EPIVIR ORAL SOLUTION 10 MG/ML (*lamivudine*)	Tier 3 (NPB)	QL (900 mls per 30 days)
EPIVIR ORAL TABLET 150 MG (*lamivudine*)	Tier 3 (NPB)	QL (60 tablets per 30 days)
EPIVIR ORAL TABLET 300 MG (*lamivudine*)	Tier 3 (NPB)	QL (30 tablets per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
etravirine oral tablet 100 mg	Tier 1 (G)	QL (120 TABLETS per 30 DAYs)
etravirine oral tablet 200 mg	Tier 1 (G)	QL (60 TABLETS per 30 DAYs)
fosamprenavir calcium oral tablet 700 mg	Tier 1 (G)	QL (120 TABLETS per 30 DAYs)
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (*enfuvirtide*)	Tier 4 (PSP)	QL (60 VIALS per 30 days)
INTELENCE ORAL TABLET 100 MG, 200 MG, 25 MG (*etravirine*)	NF	
ISENTRESS HD ORAL TABLET 600 MG (*raltegravir potassium*)	Tier 2 (PB)	QL (60 TABLETS per 30 DAYs)
ISENTRESS ORAL PACKET 100 MG (*raltegravir potassium*)	Tier 2 (PB)	QL (60 PACKETS per 30 days)
ISENTRESS ORAL TABLET 400 MG (*raltegravir potassium*)	Tier 2 (PB)	QL (120 TABLETS per 30 DAYs)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (*raltegravir potassium*)	Tier 2 (PB)	QL (180 TABLETS per 30 DAYs)
lamivudine oral solution 10 mg/ml	Tier 1 (G)	QL (900 ML per 30 DAYs)
lamivudine oral tablet 150 mg	Tier 1 (G)	QL (60 TABLETS per 30 DAYs)
lamivudine oral tablet 300 mg	Tier 1 (G)	QL (30 TABLETS per 30 DAYs)
LEXIVA ORAL TABLET 700 MG (*fosamprenavir calcium*)	NF	
maraviroc oral tablet 150 mg	Tier 1 (G)	QL (60 TABLETS per 30 DAYs)
maraviroc oral tablet 300 mg	Tier 1 (G)	QL (120 TABLETS per 30 DAYs)
nevirapine er oral tablet extended release 24 hour 400 mg	Tier 1 (G)	QL (30 TABLETS per 30 DAYs)
nevirapine oral suspension 50 mg/5ml	Tier 1 (G)	QL (1200 ML per 30 days)
nevirapine oral tablet 200 mg	Tier 1 (G)	QL (60 TABLETS per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NORVIR ORAL PACKET 100 MG (*ritonavir*)	NF	
NORVIR ORAL TABLET 100 MG (*ritonavir*)	NF	
PIFELTRO ORAL TABLET 100 MG (*doravirine*)	NF	
PREZISTA ORAL SUSPENSION 100 MG/ML (*darunavir*)	NF	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG (*darunavir*)	NF	
RETROVIR ORAL CAPSULE 100 MG (*zidovudine*)	Tier 3 (NPB)	QL (180 CAPSULES per 30 DAYs)
RETROVIR ORAL SYRUP 50 MG/5ML (*zidovudine*)	Tier 3 (NPB)	QL (1800 ML per 30 DAYs)
REYATAZ ORAL CAPSULE 200 MG, 300 MG (*atazanavir sulfate*)	NF	
REYATAZ ORAL PACKET 50 MG (*atazanavir sulfate*)	NF	
ritonavir oral tablet 100 mg	Tier 1 (G)	QL (360 TABLETS per 30 days)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (*fostemsavir tromethamine*)	Tier 3 (NPB)	QL (60 TABLETS per 30 days)
SELZENTRY ORAL SOLUTION 20 MG/ML (*maraviroc*)	NF	
SELZENTRY ORAL TABLET 150 MG, 300 MG (*maraviroc*)	NF	
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (*lenacapavir sodium*)	Tier 5 (NPSP)	QL (4 TABLETS per 2 days)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (*lenacapavir sodium*)	Tier 5 (NPSP)	QL (5 TABLETS per 8 days)
tenofovir disoproxil fumarate oral tablet 300 mg	Tier 1 (G)	QL (30 TABLETS per 30 DAYs)
TIVICAY ORAL TABLET 50 MG (*dolutegravir sodium*)	Tier 2 (PB)	QL (60 TABLETS per 30 DAYs)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (*dolutegravir sodium*)	Tier 2 (PB)	QL (360 TABLETS per 30 days)
TYBOST ORAL TABLET 150 MG (*cobicistat*)	Tier 3 (NPB)	QL (30 TABLETS per 30 DAYs)
VIRACEPT ORAL TABLET 250 MG, 625 MG (*nelfinavir mesylate*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIREAD ORAL POWDER 40 MG/GM (*tenofovir disoproxil fumarate*)	Tier 3 (NPB)	QL (240 G per 30 days)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG, 300 MG (*tenofovir disoproxil fumarate*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)
ZIAGEN ORAL SOLUTION 20 MG/ML (*abacavir sulfate*)	Tier 3 (NPB)	QL (900 mls per 30 days)
zidovudine oral capsule 100 mg	Tier 1 (G)	QL (180 CAPSULES per 30 days)
zidovudine oral syrup 50 mg/5ml	Tier 1 (G)	QL (1800 ML per 30 DAYs)
zidovudine oral tablet 300 mg	Tier 1 (G)	QL (60 TABLETS per 30 days)
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine oral tablet 600-300 mg	Tier 1 (G)	QL (30 TABLETS per 30 days)
BIKTARVY ORAL TABLET 30-120-15 MG (*bictegravir-emtricitab-tenofov*)	Tier 2 (PB)	QL (30 TABLETS per 30 days)
BIKTARVY ORAL TABLET 50-200-25 MG (*bictegravir-emtricitab-tenofov*)	Tier 2 (PB)	QL (30 TABLETS per 30 DAYs)
CIMDUO ORAL TABLET 300-300 MG (*lamivudine-tenofovir*)	Tier 2 (PB)	QL (30 TABLETS per 30 DAYs)
COMPLERA ORAL TABLET 200-25-300 MG (*emtricitab-rilpivir-tenofovir*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)
DELSTRIGO ORAL TABLET 100-300-300 MG (*doravirin-lamivudin-tenofov df*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)
DESCOVY ORAL TABLET 120-15 MG (*emtricitabine-tenofovir af*)	Tier 2 (PB)	QL (30 TABLETS per 30 days)
DESCOVY ORAL TABLET 200-25 MG (*emtricitabine-tenofovir af*)	CE	N7 (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 (*dolutegravir-lamivudine*)	Tier 2 (PB)	QL (30 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	Tier 1 (G)	QL (30 TABLETS per 30 Days)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	Tier 1 (G)	QL (30 TABLETS per 30 DAYs)
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	Tier 1 (G)	QL (30 TABLETS per 30 DAYs)
emtricitabine-tenofovir df oral tablet 200-300 mg	CE	N7 (G); N8 ($0 copay applies for pre-exposure prophylaxis only); QL (30 TABLETS per 30 days)
EVOTAZ ORAL TABLET 300-150 MG (*atazanavir-cobicistat*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)
GENVOYA ORAL TABLET 150-150-200-10 MG (*elviteg-cobic-emtricit-tenofaf*)	Tier 2 (PB)	QL (30 TABLETS per 30 DAYs)
JULUCA ORAL TABLET 50-25 MG (*dolutegravir-rilpivirine*)	Tier 3 (NPB)	QL (30 TABLETS per 30 DAYs)
KALETRA ORAL SOLUTION 400-100 MG/5ML (*lopinavir-ritonavir*)	NF	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (*lopinavir-ritonavir*)	NF	
lamivudine-zidovudine oral tablet 150-300 mg	Tier 1 (G)	QL (60 TABLETS per 30 DAYs)
lopinavir-ritonavir oral solution 400-100 mg/5ml	Tier 1 (G)	QL (480 ML per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg	Tier 1 (G)	QL (300 TABLETS per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	Tier 1 (G)	QL (120 TABLETS per 30 DAYs)
ODEFSEY ORAL TABLET 200-25-25 MG (*emtricitab-rilpivir-tenofov af*)	Tier 2 (PB)	QL (30 TABLETS per 30 DAYs)
PREZCOBIX ORAL TABLET 800-150 MG (*darunavir-cobicistat*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG (*elviteg-cobic-emtricit-tenofdf*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMFI LO ORAL TABLET 400-300-300 MG (*efavirenz-lamivudine-tenofovir*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)
SYMFI ORAL TABLET 600-300-300 MG (*efavirenz-lamivudine-tenofovir*)	Tier 3 (NPB)	QL (30 TABLETS per 30 days)
SYMTUZA ORAL TABLET 800-150-200-10 MG (*darun-cobic-emtricit-tenofaf*)	Tier 2 (PB)	QL (30 TABLETS per 30 days)
TRIUMEQ ORAL TABLET 600-50-300 MG (*abacavir-dolutegravir-lamivud*)	Tier 2 (PB)	QL (30 TABLETS per 30 DAYs)
triumeq pd oral tablet soluble 60-5-30 mg	Tier 2 (PB)	QL (180 TABLETS per 30 days)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG, 200-300 MG (*emtricitabine-tenofovir df*)	NF	
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
cycloserine oral capsule 250 mg	Tier 1 (G)	
ethambutol hcl oral tablet 100 mg, 400 mg	Tier 1 (G)	
isoniazid oral syrup 50 mg/5ml	Tier 1 (G)	
isoniazid oral tablet 100 mg, 300 mg	Tier 1 (G)	
pyrazinamide oral tablet 500 mg	Tier 1 (G)	
rifabutin oral capsule 150 mg	Tier 1 (G)	
rifampin oral capsule 150 mg, 300 mg	Tier 1 (G)	
SIRTURO ORAL TABLET 100 MG, 20 MG (*bedaquiline fumarate*)	Tier 5 (NPSP)	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
acyclovir oral capsule 200 mg	Tier 1 (G)	
acyclovir oral suspension 200 mg/5ml	Tier 1 (G)	
acyclovir oral tablet 400 mg, 800 mg	Tier 1 (G)	
cidofovir intravenous solution 75 mg/ml	Tier 1 (G)	
famciclovir oral tablet 125 mg, 250 mg, 500 mg	Tier 1 (G)	
LAGEVRIO ORAL CAPSULE 200 MG (*molnupiravir*)	CE	N7 (NPB)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIVTENCITY ORAL TABLET 200 MG (*maribavir*)	Tier 5 (NPSP)	PA; QL (120 TABLETS per 30 days)
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	Tier 1 (G)	
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	Tier 1 (G)	
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	CE	N7 (PB)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	CE	N7 (PB)
PREVYMIS ORAL TABLET 240 MG, 480 MG (*letermovir*)	Tier 3 (NPB)	QL (1 TABLET per 1 DAY)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (*zanamivir*)	Tier 2 (PB)	
rimantadine hcl oral tablet 100 mg	Tier 1 (G)	
valacyclovir hcl oral tablet 1 gm, 500 mg	Tier 1 (G)	
VALCYTE ORAL SOLUTION RECONSTITUTED 50 MG/ML (*valganciclovir hcl*)	Tier 3 (NPB)	PA; QL (1000 ML per 30 days)
VALCYTE ORAL TABLET 450 MG (*valganciclovir hcl*)	Tier 3 (NPB)	PA; QL (120 TABLETS per 30 days)
valganciclovir hcl oral solution reconstituted 50 mg/ml	Tier 1 (G)	PA; QL (1000 ML per 30 days)
valganciclovir hcl oral tablet 450 mg	Tier 1 (G)	PA; QL (120 TABLETS per 30 days)
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
cefaclor oral capsule 250 mg, 500 mg	Tier 1 (G)	
cefaclor oral suspension reconstituted 250 mg/5ml	Tier 1 (G)	
cefadroxil oral capsule 500 mg	Tier 1 (G)	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	Tier 1 (G)	
cefadroxil oral tablet 1 gm	Tier 1 (G)	
cefdinir oral capsule 300 mg	Tier 1 (G)	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Tier 1 (G)	
cefixime oral capsule 400 mg	Tier 1 (G)	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	Tier 1 (G)	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	Tier 1 (G)	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Tier 1 (G)	
cefprozil oral tablet 250 mg, 500 mg	Tier 1 (G)	
cefuroxime axetil oral tablet 250 mg, 500 mg	Tier 1 (G)	
cephalexin oral capsule 250 mg, 500 mg, 750 mg	Tier 1 (G)	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Tier 1 (G)	
cephalexin oral tablet 250 mg, 500 mg	Tier 1 (G)	
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
azithromycin oral packet 1 gm	Tier 1 (G)	
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	Tier 1 (G)	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	Tier 1 (G)	
clarithromycin er oral tablet extended release 24 hour 500 mg	Tier 1 (G)	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Tier 1 (G)	
clarithromycin oral tablet 250 mg, 500 mg	Tier 1 (G)	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fidaxomicin*)	Tier 2 (PB)	
DIFICID ORAL TABLET 200 MG (*fidaxomicin*)	Tier 2 (PB)	
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*)	NF	
ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*)	NF	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (*erythromycin ethylsuccinate*)	NF	
erythromycin base (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg)	Tier 1 (G)	
erythromycin base oral capsule delayed release particles 250 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
erythromycin base oral tablet 250 mg, 500 mg	Tier 1 (G)	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml	Tier 1 (G)	
erythromycin ethylsuccinate oral tablet 400 mg	Tier 1 (G)	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	Tier 1 (G)	
levofloxacin oral solution 25 mg/ml	Tier 1 (G)	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	Tier 1 (G)	
moxifloxacin hcl oral tablet 400 mg	Tier 1 (G)	
HEPATITIS B		
adefovir dipivoxil oral tablet 10 mg	Tier 1 (G)	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (*entecavir*)	Tier 5 (NPSP)	PA; QL (630 ML per 30 days)
BARACLUDE ORAL TABLET 0.5 MG, 1 MG (*entecavir*)	NF	
entecavir oral tablet 0.5 mg, 1 mg	Tier 1 (G)	QL (30 TABLETS per 30 days)
lamivudine oral tablet 100 mg	Tier 1 (G)	
VEMLIDY ORAL TABLET 25 MG (*tenofovir alafenamide fumarate*)	Tier 4 (PSP)	QL (30 TABLETS per 30 days)
HEPATITIS C		
EPCLUSA ORAL PACKET 150-37.5 MG (*sofosbuvir-velpatasvir*)	Tier 2 (PB)	PA; IBC (Preferred for all genotypes); QL (28 PELLETS per 28 days)
EPCLUSA ORAL PACKET 200-50 MG (*sofosbuvir-velpatasvir*)	Tier 2 (PB)	PA; IBC (Preferred for all genotypes); QL (56 PELLETS per 28 days)
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG (*sofosbuvir-velpatasvir*)	Tier 2 (PB)	PA; IBC (Preferred for all genotypes); QL (28 TABLETS per 28 days)
HARVONI ORAL PACKET 33.75-150 MG (*ledipasvir-sofosbuvir*)	Tier 4 (PSP)	PA; QL (28 PACKET per 28 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HARVONI ORAL PACKET 45-200 MG (*ledipasvir-sofosbuvir*)	Tier 4 (PSP)	PA; QL (56 PELLETS per 28 days)
HARVONI ORAL TABLET 45-200 MG, 90-400 MG (*ledipasvir-sofosbuvir*)	Tier 4 (PSP)	PA; IBC (Preferred for genotypes 1,4,5,6); QL (28 TABLETS per 28 days)
ledipasvir-sofosbuvir oral tablet 90-400 mg	NF	
MAVYRET ORAL PACKET 50-20 MG (*glecaprevir-pibrentasvir*)	NF	
MAVYRET ORAL TABLET 100-40 MG (*glecaprevir-pibrentasvir*)	NF	
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (*peginterferon alfa-2a*)	NF	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (*peginterferon alfa-2a*)	NF	
ribavirin oral capsule 200 mg	Tier 1 (G)	PA
ribavirin oral tablet 200 mg	Tier 1 (G)	PA
sofosbuvir-velpatasvir oral tablet 400-100 mg	NF	
SOVALDI ORAL PACKET 150 MG (*sofosbuvir*)	Tier 5 (NPSP)	PA; QL (28 PELLETS per 28 days)
SOVALDI ORAL PACKET 200 MG (*sofosbuvir*)	Tier 5 (NPSP)	PA; QL (56 PELLETS per 28 days)
SOVALDI ORAL TABLET 200 MG, 400 MG (*sofosbuvir*)	Tier 5 (NPSP)	PA; QL (28 TABLETS per 28 days)
VOSEVI ORAL TABLET 400-100-100 MG (*sofosbuv-velpatasv-voxilaprev*)	Tier 4 (PSP)	PA; IBC (Preferred for all genotypes); QL (28 TABLETS per 28 days)
ZEPATIER ORAL TABLET 50-100 MG (*elbasvir-grazoprevir*)	NF	
MISCELLANEOUS		
atovaquone oral suspension 750 mg/5ml	Tier 1 (G)	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG, 75 MG (*clindamycin hcl*)	Tier 2 (PB)	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (*clindamycin palmitate hcl*)	Tier 2 (PB)	

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	Tier 1 (G)	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	Tier 1 (G)	
colistimethate sodium (cba) injection solution reconstituted 150 mg	Tier 1 (G)	
dapsone oral tablet 100 mg, 25 mg	Tier 1 (G)	
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (*vancomycin hcl*)	Tier 3 (NPB)	QL (450 ML per 10 DAYs)
linezolid oral suspension reconstituted 100 mg/5ml	Tier 1 (G)	
linezolid oral tablet 600 mg	Tier 1 (G)	
MACROBID ORAL CAPSULE 100 MG (*nitrofurantoin monohyd macro*)	Tier 2 (PB)	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (*nitrofurantoin macrocrystal*)	NF	
methenamine hippurate oral tablet 1 gm	Tier 1 (G)	
methenamine mandelate oral tablet 0.5 gm, 1 gm	Tier 1 (G)	
metronidazole oral capsule 375 mg	Tier 1 (G)	
metronidazole oral tablet 250 mg, 500 mg	Tier 1 (G)	
nitazoxanide oral tablet 500 mg	Tier 1 (G)	QL (20 TABLETS per 25 DAYs); AL (Min 12 Years)
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	Tier 1 (G)	
nitrofurantoin monohyd macro oral capsule 100 mg	Tier 1 (G)	
nitrofurantoin oral suspension 25 mg/5ml	Tier 1 (G)	N8 (Listing does not include certain NDCs)
pentamidine isethionate inhalation solution reconstituted 300 mg	Tier 1 (G)	
pyrimethamine oral tablet 25 mg	Tier 1 (G)	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	Tier 1 (G)	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	Tier 1 (G)	
VANCOCIN ORAL CAPSULE 125 MG (*vancomycin hcl*)	Tier 2 (PB)	QL (80 CAPSULES per 10 Days)
VANCOCIN ORAL CAPSULE 250 MG (*vancomycin hcl*)	Tier 2 (PB)	QL (80 capsules per 10 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
vancomycin hcl oral capsule 125 mg	Tier 1 (G)	QL (80 CAPSULES per 10 DAYs)
vancomycin hcl oral capsule 250 mg	Tier 1 (G)	QL (80 CAPSULES per 10 days)
vancomycin hcl oral solution reconstituted 50 mg/ml	Tier 1 (G)	QL (450 ML per 10 DAYs)
XIFAXAN ORAL TABLET 550 MG (*rifaximin*)	Tier 2 (PB)	
PENICILLINS - DRUGS TO TREAT INFECTIONS		
amoxicillin oral capsule 250 mg, 500 mg	Tier 1 (G)	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	Tier 1 (G)	
amoxicillin oral tablet 500 mg, 875 mg	Tier 1 (G)	
amoxicillin oral tablet chewable 125 mg, 250 mg	Tier 1 (G)	
amoxicillin suspension reconstituted 400 mg/5ml oral	NF	
amoxicillin suspension reconstituted 400 mg/5ml oral	Tier 1 (G)	
amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg	Tier 1 (G)	
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	Tier 1 (G)	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	Tier 1 (G)	
amoxicillin-pot clavulanate oral tablet chewable 400-57 mg	Tier 1 (G)	
ampicillin oral capsule 500 mg	Tier 1 (G)	
dicloxacillin sodium oral capsule 250 mg, 500 mg	Tier 1 (G)	
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	Tier 1 (G)	
penicillin v potassium oral tablet 250 mg, 500 mg	Tier 1 (G)	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
demeclocycline hcl oral tablet 150 mg, 300 mg	Tier 1 (G)	
doxycycline hyclate oral capsule 100 mg, 50 mg	Tier 1 (G)	
doxycycline hyclate oral tablet 100 mg, 20 mg	Tier 1 (G)	
doxycycline hyclate oral tablet 150 mg, 50 mg, 75 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
doxycycline hyclate oral tablet delayed release 100 mg, 150 mg, 200 mg, 50 mg, 75 mg, 80 mg	NF	
doxycycline monohydrate oral capsule 100 mg, 50 mg	Tier 1 (G)	
doxycycline monohydrate oral capsule 150 mg, 75 mg	NF	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	Tier 1 (G)	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	Tier 1 (G)	
minocycline hcl er oral tablet extended release 24 hour 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg	NF	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	Tier 1 (G)	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	Tier 1 (G)	
NUZYRA ORAL TABLET 150 MG (*omadacycline tosylate*)	Tier 5 (NPSP)	
doxycycline hyclate (Targadox Oral Tablet 50 Mg)	NF	
tetracycline hcl oral capsule 250 mg, 500 mg	Tier 1 (G)	
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
cyclophosphamide oral capsule 25 mg, 50 mg	CE	N7 (G)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (*lomustine*)	CE	N7 (NPSP)
LEUKERAN ORAL TABLET 2 MG (*chlorambucil*)	CE	N7 (PB)
MATULANE ORAL CAPSULE 50 MG (*procarbazine hcl*)	CE	N7 (PSP)
MYLERAN ORAL TABLET 2 MG (*busulfan*)	CE	N7 (PB)
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	CE	PA; N7 (G)
ANTIMETABOLITES		
capecitabine oral tablet 150 mg, 500 mg	CE	PA; N7 (G)
INQOVI ORAL TABLET 35-100 MG (*decitabine-cedazuridine*)	CE	PA; N7 (NPSP); QL (5 TABLETS per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LONSURF ORAL TABLET 15-6.14 MG (*trifluridine-tipiracil*)	CE	PA; N7 (PSP); QL (100 TABLETS per 30 days)
LONSURF ORAL TABLET 20-8.19 MG (*trifluridine-tipiracil*)	CE	PA; N7 (PSP); QL (80 TABLETS per 30 days)
mercaptopurine oral tablet 50 mg	CE	N7 (G)
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	Tier 1 (G)	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	Tier 1 (G)	
methotrexate sodium injection solution reconstituted 1 gm	Tier 1 (G)	
ONUREG ORAL TABLET 200 MG, 300 MG (*azacitidine*)	CE	PA; N7 (NPSP); QL (14 TABLETS per 28 days)
PURIXAN ORAL SUSPENSION 2000 MG/100ML (*mercaptopurine*)	CE	PA; N7 (NPSP)
TABLOID ORAL TABLET 40 MG (*thioguanine*)	CE	N7 (PB)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*)	CE	N7 (PB)
XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*)	CE	N7 (NPSP)
XELODA ORAL TABLET 150 MG, 500 MG (*capecitabine*)	CE	PA; ST; N7 (NPSP)
ANTINEOPLASTIC, BCL-2 INHIBITORS		
VENCLEXTA ORAL TABLET 10 MG, 50 MG (*venetoclax*)	CE	PA; N7 (NPSP); QL (120 TABLETS per 30 days)
VENCLEXTA ORAL TABLET 100 MG (*venetoclax*)	CE	PA; N7 (NPSP); QL (180 TABLETS per 30 days)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (*venetoclax*)	CE	PA; N7 (NPSP); QL (1 TABLET THERAPY PACK per 28 days)
BIOLOGIC RESPONSE MODIFIERS		
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (*ropeginterferon alfa-2b-njft*)	Tier 4 (PSP)	PA; QL (2 SYRINGES per 28 days)
DAURISMO ORAL TABLET 100 MG, 25 MG (*glasdegib maleate*)	CE	N7 (NF)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ERIVEDGE ORAL CAPSULE 150 MG (*vismodegib*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (*pomalidomide*)	CE	PA; N7 (NPSP); QL (21 CAPSULES per 28 days)
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (*lenalidomide*)	CE	PA; N7 (PSP); QL (28 CAPSULES per 28 days)
REVLIMID ORAL CAPSULE 20 MG, 25 MG (*lenalidomide*)	CE	PA; N7 (PSP); QL (21 CAPSULES per 28 days)
THALOMID ORAL CAPSULE 100 MG (*thalidomide*)	Tier 4 (PSP)	PA; QL (112 CAPSULES per 28 days)
THALOMID ORAL CAPSULE 50 MG (*thalidomide*)	Tier 4 (PSP)	PA; QL (28 CAPSULES per 28 days)
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate oral tablet 250 mg	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
abiraterone acetate oral tablet 500 mg	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (*niraparib-abiraterone acetate*)	CE	N7 (NF)
anastrozole oral tablet 1 mg	CE	N7 (G); AL (Min 35 Years)
ARIMIDEX ORAL TABLET 1 MG (*anastrozole*)	CE	N7 (PB)
AROMASIN ORAL TABLET 25 MG (*exemestane*)	CE	N7 (PB)
bicalutamide oral tablet 50 mg	CE	N7 (G)
ELIGARD SUBCUTANEOUS KIT 22.5 MG (*leuprolide acetate (3 month)*)	Tier 4 (PSP)	PA
ELIGARD SUBCUTANEOUS KIT 30 MG (*leuprolide acetate (4 month)*)	Tier 4 (PSP)	PA
ELIGARD SUBCUTANEOUS KIT 45 MG (*leuprolide acetate (6 month)*)	Tier 4 (PSP)	PA
ELIGARD SUBCUTANEOUS KIT 7.5 MG (*leuprolide acetate*)	Tier 4 (PSP)	PA
ERLEADA ORAL TABLET 240 MG (*apalutamide*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ERLEADA ORAL TABLET 60 MG (*apalutamide*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
exemestane oral tablet 25 mg	CE	N7 (G); AL (Min 35 Years)
FASLODEX INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 250 MG/5ML (*fulvestrant*)	Tier 5 (NPSP)	PA
FEMARA ORAL TABLET 2.5 MG (*letrozole*)	CE	N7 (PB)
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL (*degarelix acetate*)	NF	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (*degarelix acetate*)	NF	
fulvestrant intramuscular solution prefilled syringe 250 mg/5ml	Tier 4 (PSP)	PA
letrozole oral tablet 2.5 mg	CE	N7 (G)
leuprolide acetate injection kit 1 mg/0.2ml	Tier 4 (PSP)	PA
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG (*leuprolide acetate*)	Tier 5 (NPSP)	PA
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 7.5 MG (*leuprolide acetate*)	NF	
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (*leuprolide acetate (3 month)*)	Tier 5 (NPSP)	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 22.5 MG (*leuprolide acetate (3 month)*)	NF	
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG (*leuprolide acetate (4 month)*)	NF	
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG (*leuprolide acetate (6 month)*)	NF	
LYSODREN ORAL TABLET 500 MG (*mitotane*)	CE	N7 (PSP)
megestrol acetate oral tablet 20 mg, 40 mg	CE	N7 (G)
NILANDRON ORAL TABLET 150 MG (*nilutamide*)	CE	N7 (NF)
nilutamide oral tablet 150 mg	CE	N7 (G)
NUBEQA ORAL TABLET 300 MG (*darolutamide*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORGOVYX ORAL TABLET 120 MG (*relugolix*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 days)
ORSERDU ORAL TABLET 345 MG, 86 MG (*elacestrant hydrochloride*)	CE	N7 (NF)
tamoxifen citrate oral tablet 10 mg, 20 mg	CE	N7 (G); AL (Min 35 Years)
toremifene citrate oral tablet 60 mg	CE	N7 (G)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG (*triptorelin pamoate*)	NF	
XTANDI ORAL CAPSULE 40 MG (*enzalutamide*)	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
XTANDI ORAL TABLET 40 MG (*enzalutamide*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYs)
XTANDI ORAL TABLET 80 MG (*enzalutamide*)	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
YONSA ORAL TABLET 125 MG (*abiraterone acetate micronized*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
ZYTIGA ORAL TABLET 250 MG, 500 MG (*abiraterone acetate*)	CE	N7 (NF)
KINASE INHIBITORS		
AFINITOR DISPERZ ORAL TABLET SOLUBLE 2 MG, 3 MG, 5 MG (*everolimus*)	CE	N7 (Not Covered)
AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG (*everolimus*)	CE	N7 (NF)
ALECENSA ORAL CAPSULE 150 MG (*alectinib hcl*)	CE	PA; N7 (PSP); QL (240 CAPSULES per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG (*brigatinib*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)
ALUNBRIG ORAL TABLET 30 MG (*brigatinib*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG (*brigatinib*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUGTYRO ORAL CAPSULE 40 MG (*repotrectinib*)	CE	PA; N7 (PSP); QL (240 CAPSULES per 30 days)
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (*avapritinib*)	CE	N7 (NF)
BALVERSA ORAL TABLET 3 MG (*erdafitinib*)	CE	PA; N7 (NPSP); QL (84 TABLETS per 28 DAYs)
BALVERSA ORAL TABLET 4 MG (*erdafitinib*)	CE	PA; N7 (NPSP); QL (56 TABLETS per 28 DAYs)
BALVERSA ORAL TABLET 5 MG (*erdafitinib*)	CE	PA; N7 (NPSP); QL (28 TABLETS per 28 DAYs)
BOSULIF ORAL CAPSULE 100 MG (*bosutinib*)	CE	PA; N7 (PSP); QL (300 CAPSULES per 30 DAYs)
BOSULIF ORAL CAPSULE 50 MG (*bosutinib*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 DAYs)
BOSULIF ORAL TABLET 100 MG (*bosutinib*)	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG (*bosutinib*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG (*encorafenib*)	CE	PA; N7 (PSP); QL (180 CAPSULES per 30 days)
BRUKINSA ORAL CAPSULE 80 MG (*zanubrutinib*)	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (*cabozantinib s-malate*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)
CALQUENCE ORAL TABLET 100 MG (*acalabrutinib maleate*)	CE	PA; N7 (PSP); QL (60 TABLETS per 30 days)
CAPRELSA ORAL TABLET 100 MG (*vandetanib*)	CE	PA; N7 (NPSP); QL (60 TABLETS per 30 days)
CAPRELSA ORAL TABLET 300 MG (*vandetanib*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 days)
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG (*cabozantinib s-malate*)	CE	PA; N7 (NPSP); QL (56 CAPSULES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG (*cabozantinib s-malate*)	CE	PA; N7 (NPSP); QL (112 CAPSULES per 28 days)
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG (*cabozantinib s-malate*)	CE	PA; N7 (NPSP); QL (1 KIT per 28 days)
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (*duvelisib*)	CE	PA; N7 (PSP); QL (56 CAPSULES per 28 days)
COTELLIC ORAL TABLET 20 MG (*cobimetinib fumarate*)	CE	PA; N7 (PSP); QL (63 TABLETS per 21 days)
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
dasatinib oral tablet 20 mg	CE	PA; N7 (PSP); QL (90 TABLETS per 30 DAYs)
erlotinib hcl oral tablet 100 mg, 150 mg	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
erlotinib hcl oral tablet 25 mg	CE	PA; N7 (PSP); QL (60 TABLETS per 30 days)
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
everolimus oral tablet soluble 2 mg, 5 mg	CE	PA; N7 (PSP); QL (60 TABLETS per 30 DAYs)
everolimus oral tablet soluble 3 mg	CE	PA; N7 (PSP); QL (90 TABLETS per 30 DAYs)
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (*tivozanib hcl*)	CE	N7 (NF)
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG (*fruquintinib*)	CE	N7 (NF)
GAVRETO ORAL CAPSULE 100 MG (*pralsetinib*)	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
gefitinib oral tablet 250 mg	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (*afatinib dimaleate*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 days)
GLEEVEC ORAL TABLET 100 MG, 400 MG (*imatinib mesylate*)	CE	N7 (NF)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (*palbociclib*)	CE	PA; N7 (PSP); QL (21 CAPSULES per 28 days)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (*palbociclib*)	CE	PA; N7 (PSP); QL (21 TABLETS per 28 days)
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG (*ponatinib hcl*)	CE	N7 (NF)
imatinib mesylate oral tablet 100 mg	CE	PA; N7 (G); QL (120 TABLETS per 30 days)
imatinib mesylate oral tablet 400 mg	CE	PA; N7 (G); QL (60 TABLETS per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG (*ibrutinib*)	CE	N7 (NF)
IMBRUVICA ORAL SUSPENSION 70 MG/ML (*ibrutinib*)	CE	N7 (NF)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG (*ibrutinib*)	CE	N7 (NF)
INLYTA ORAL TABLET 1 MG (*axitinib*)	CE	PA; N7 (PSP); QL (240 TABLETS per 30 days)
INLYTA ORAL TABLET 5 MG (*axitinib*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
INREBIC ORAL CAPSULE 100 MG (*fedratinib hcl*)	CE	N7 (NF)
IRESSA ORAL TABLET 250 MG (*gefitinib*)	CE	N7 (NF)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (*ruxolitinib phosphate*)	CE	PA; IBC (Not covered for polycythemia vera); N7 (NPSP); QL (60 TABLETS per 30 days)
JAYPIRCA ORAL TABLET 100 MG, 50 MG (*pirtobrutinib*)	CE	N7 (NF)
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (*ribociclib succinate*)	CE	PA; N7 (PSP); QL (21 TABLETS per 28 days)
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (*ribociclib succinate*)	CE	PA; N7 (PSP); QL (42 TABLETS per 28 days)
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG (*ribociclib succinate*)	CE	PA; N7 (PSP); QL (63 TABLETS per 28 days)
KOSELUGO ORAL CAPSULE 10 MG (*selumetinib sulfate*)	CE	PA; N7 (PSP); QL (240 CAPSULES per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KOSELUGO ORAL CAPSULE 25 MG (*selumetinib sulfate*)	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
lapatinib ditosylate oral tablet 250 mg	CE	PA; N7 (PSP); QL (180 TABLETS per 30 DAYs)
LAZCLUZE ORAL TABLET 240 MG, 80 MG (*lazertinib mesylate*)	CE	N7 (NF)
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG (*lenvatinib mesylate*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG (*lenvatinib mesylate*)	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 days)
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG (*lenvatinib mesylate*)	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 (*lenvatinib mesylate*)	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 days)
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG (*lenvatinib mesylate*)	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 (*lenvatinib mesylate*)	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 days)
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG (*lenvatinib mesylate*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG (*lenvatinib mesylate*)	CE	PA; N7 (PSP); QL (60 CAPSULES per 30 days)
LORBRENA ORAL TABLET 100 MG, 25 MG (*lorlatinib*)	CE	N7 (NF)
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (*futibatinib*)	CE	N7 (NF)
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (*futibatinib*)	CE	N7 (NF)
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG (*futibatinib*)	CE	N7 (NF)
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (*trametinib dimethyl sulfoxide*)	CE	PA; N7 (NPSP); QL (1080 ML per 28 days)
MEKINIST ORAL TABLET 0.5 MG, 2 MG (*trametinib dimethyl sulfoxide*)	CE	N7 (NF)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEKTOVI ORAL TABLET 15 MG (*binimetinib*)	CE	PA; N7 (PSP); QL (180 TABLETS per 30 days)
NERLYNX ORAL TABLET 40 MG (*neratinib maleate*)	CE	PA; N7 (NPSP); QL (180 TABLETS per 30 days)
NEXAVAR ORAL TABLET 200 MG (*sorafenib tosylate*)	CE	N7 (NF)
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML (*tovorafenib*)	CE	N7 (NF)
OJEMDA ORAL TABLET 100 MG (*tovorafenib*)	CE	N7 (NF)
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (*momelotinib dihydrochloride*)	NF	
pazopanib hcl oral tablet 200 mg	CE	PA; N7 (PSP); QL (120 TABLETS per 30 Days)
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (*pemigatinib*)	CE	N7 (NF)
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG (*alpelisib*)	CE	PA; N7 (NPSP); QL (28 TABLETS per 28 days)
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG (*alpelisib*)	CE	PA; N7 (NPSP); QL (56 TABLETS per 28 days)
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG (*alpelisib*)	CE	PA; N7 (NPSP); QL (56 TABLETS per 28 days)
QINLOCK ORAL TABLET 50 MG (*ripretinib*)	CE	N7 (NF)
RETEVMO ORAL CAPSULE 40 MG (*selpercatinib*)	CE	PA; N7 (PSP); QL (60 TABLETS per 30 days)
RETEVMO ORAL CAPSULE 80 MG (*selpercatinib*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
RETEVMO ORAL TABLET 120 MG, 160 MG (*selpercatinib*)	CE	PA; N7 (PSP); QL (60 TABLETS per 30 days)
RETEVMO ORAL TABLET 40 MG (*selpercatinib*)	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)
RETEVMO ORAL TABLET 80 MG (*selpercatinib*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
ROZLYTREK ORAL CAPSULE 100 MG (*entrectinib*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROZLYTREK ORAL CAPSULE 200 MG (*entrectinib*)	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 days)
ROZLYTREK ORAL PACKET 50 MG (*entrectinib*)	CE	PA; N7 (PSP); QL (8 CARTONS per 28 days)
RYDAPT ORAL CAPSULE 25 MG (*midostaurin*)	CE	PA; N7 (PSP); QL (224 CAPSULES per 28 days)
SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG (*asciminib hcl*)	CE	N7 (NF)
sorafenib tosylate oral tablet 200 mg	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYs)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG (*dasatinib*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)
SPRYCEL ORAL TABLET 20 MG (*dasatinib*)	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)
STIVARGA ORAL TABLET 40 MG (*regorafenib*)	CE	PA; N7 (PSP); QL (84 TABLETS per 28 days)
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 DAYs)
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG (*sunitinib malate*)	CE	N7 (NF)
TABRECTA ORAL TABLET 150 MG, 200 MG (*capmatinib hcl*)	CE	N7 (NF)
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (*dabrafenib mesylate*)	CE	N7 (Not Covered)
TAFINLAR ORAL TABLET SOLUBLE 10 MG (*dabrafenib mesylate*)	CE	PA; N7 (NPSP); QL (840 TABLETS per 28 days)
TAGRISSO ORAL TABLET 40 MG, 80 MG (*osimertinib mesylate*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)
TARCEVA ORAL TABLET 100 MG, 150 MG (*erlotinib hcl*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 days)
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG (*nilotinib hcl*)	CE	N7 (NF)
TEPMETKO ORAL TABLET 225 MG (*tepotinib hcl*)	CE	N7 (NF)

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUQAP ORAL TABLET 160 MG, 200 MG (*capivasertib*)	CE	N7 (NF)
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (*capivasertib*)	CE	N7 (NF)
TUKYSA ORAL TABLET 150 MG, 50 MG (*tucatinib*)	CE	PA; N7 (NPSP); QL (120 TABLETS per 30 days)
TURALIO ORAL CAPSULE 125 MG (*pexidartinib hcl*)	CE	N7 (NF)
TYKERB ORAL TABLET 250 MG (*lapatinib ditosylate*)	CE	PA; N7 (NPSP); QL (180 TABLETS per 30 days)
VANFLYTA ORAL TABLET 17.7 MG (*quizartinib dihydrochloride*)	CE	PA; N7 (NPSP); QL (28 TABLETS per 28 days)
VANFLYTA ORAL TABLET 26.5 MG (*quizartinib dihydrochloride*)	CE	PA; N7 (NPSP); QL (56 TABLETS per 28 days)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (*abemaciclib*)	CE	PA; N7 (NPSP); QL (56 TABLETS per 28 days)
VITRAKVI ORAL CAPSULE 100 MG (*larotrectinib sulfate*)	CE	PA; N7 (PSP); QL (60 CAPSULES per 30 days)
VITRAKVI ORAL CAPSULE 25 MG (*larotrectinib sulfate*)	CE	PA; N7 (PSP); QL (180 CAPSULES per 30 days)
VITRAKVI ORAL SOLUTION 20 MG/ML (*larotrectinib sulfate*)	CE	PA; N7 (PSP); QL (300 ML per 30 days)
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (*dacomitinib*)	CE	N7 (NF)
VONJO ORAL CAPSULE 100 MG (*pacritinib citrate*)	CE	PA; N7 (NPSP); QL (120 CAPSULES per 30 days)
VOTRIENT ORAL TABLET 200 MG (*pazopanib hcl*)	CE	N7 (NF)
XALKORI ORAL CAPSULE 200 MG, 250 MG (*crizotinib*)	CE	N7 (NF)
XALKORI ORAL CAPSULE SPRINKLE 150 MG (*crizotinib*)	CE	PA; N7 (NPSP); QL (180 CAPSULES per 30 days)
XALKORI ORAL CAPSULE SPRINKLE 20 MG, 50 MG (*crizotinib*)	CE	PA; N7 (NPSP); QL (120 CAPSULES per 30 days)
XOSPATA ORAL TABLET 40 MG (*gilteritinib fumarate*)	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZELBORAF ORAL TABLET 240 MG (*vemurafenib*)	CE	PA; N7 (PSP); QL (240 TABLETS per 30 days)
ZYDELIG ORAL TABLET 100 MG, 150 MG (*idelalisib*)	CE	PA; N7 (PSP); QL (60 TABLETS per 30 days)
ZYKADIA ORAL TABLET 150 MG (*ceritinib*)	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)
MISCELLANEOUS		
bexarotene oral capsule 75 mg	CE	PA; N7 (PSP)
HYDREA ORAL CAPSULE 500 MG (*hydroxyurea*)	CE	N7 (PB)
hydroxyurea oral capsule 500 mg	CE	N7 (G)
IDHIFA ORAL TABLET 100 MG, 50 MG (*enasidenib mesylate*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 days)
IWILFIN ORAL TABLET 192 MG (*eflornithine hcl*)	CE	PA; N7 (NPSP); QL (240 TABLETS per 30 days)
KRAZATI ORAL TABLET 200 MG (*adagrasib*)	CE	PA; N7 (PSP); QL (180 TABLETS per 30 days)
LUMAKRAS ORAL TABLET 120 MG (*sotorasib*)	CE	PA; N7 (PSP); QL (240 TABLETS per 30 days)
LUMAKRAS ORAL TABLET 320 MG (*sotorasib*)	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)
LYNPARZA ORAL TABLET 100 MG, 150 MG (*olaparib*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
ODOMZO ORAL CAPSULE 200 MG (*sonidegib phosphate*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG (*nirogacestat hydrobromide*)	CE	N7 (NF)
REZLIDHIA ORAL CAPSULE 150 MG (*olutasidenib*)	CE	N7 (NF)
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (*rucaparib camsylate*)	CE	N7 (NF)
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (*talazoparib tosylate*)	CE	N7 (NF)
TARGRETIN ORAL CAPSULE 75 MG (*bexarotene*)	CE	N7 (NF)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAZVERIK ORAL TABLET 200 MG (*tazemetostat hbr*)	CE	N7 (NF)
TIBSOVO ORAL TABLET 250 MG (*ivosidenib*)	CE	PA; N7 (NPSP); QL (60 TABLETS per 30 days)
tretinoin oral capsule 10 mg	CE	N7 (G)
VISTOGARD ORAL PACKET 10 GM (*uridine triacetate*)	Tier 4 (PSP)	QL (20 PACKETS per 5 DAYs)
VORANIGO ORAL TABLET 10 MG (*vorasidenib*)	CE	PA; N7 (NPSP); QL (60 TABLETS per 30 DAYs)
VORANIGO ORAL TABLET 40 MG (*vorasidenib*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 DAYs)
WELIREG ORAL TABLET 40 MG (*belzutifan*)	CE	N7 (NF)
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (8 TABLETS per 28 days)
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (4 TABLETS per 28 days)
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (8 TABLETS per 28 days)
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (4 TABLETS per 28 days)
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (24 TABLETS per 28 days)
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (8 TABLETS per 28 days)
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (32 TABLETS per 28 days)
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG (*niraparib tosylate*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
ZOLINZA ORAL CAPSULE 100 MG (*vorinostat*)	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
PROTEASOME INHIBITORS		
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (*ixazomib citrate*)	CE	PA; N7 (PSP); QL (3 CAPSULES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTECTIVE AGENTS		
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	CE	N7 (G)
TOPOISOMERASE INHIBITORS		
etoposide oral capsule 50 mg	CE	N7 (G)
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG (*topotecan hcl*)	CE	PA; N7 (NPSP)
CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
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	Tier 1 (G)	LGC
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	Tier 1 (G)	LGC
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	Tier 1 (G)	LGC
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	Tier 1 (G)	LGC
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Tier 1 (G)	LGC
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (*amlodipine besy-benazepril hcl*)	Tier 2 (PB)	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Tier 1 (G)	LGC
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg	Tier 1 (G)	
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Tier 1 (G)	LGC
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
enalapril maleate oral solution 1 mg/ml	Tier 1 (G)	
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Tier 1 (G)	LGC
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	Tier 1 (G)	LGC
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	Tier 1 (G)	LGC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
moexipril hcl oral tablet 15 mg, 7.5 mg	Tier 1 (G)	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	Tier 1 (G)	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Tier 1 (G)	LGC
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	LGC
trandolapril oral tablet 1 mg, 2 mg, 4 mg	Tier 1 (G)	LGC
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (*spironolactone*)	Tier 2 (PB)	
eplerenone oral tablet 25 mg, 50 mg	Tier 1 (G)	
INSPRA ORAL TABLET 25 MG, 50 MG (*eplerenone*)	Tier 2 (PB)	
KERENDIA ORAL TABLET 10 MG, 20 MG (*finerenone*)	Tier 2 (PB)	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	Tier 1 (G)	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	Tier 1 (G)	LGC
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	Tier 1 (G)	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	Tier 1 (G)	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	Tier 1 (G)	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	Tier 1 (G)	LGC
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	Tier 1 (G)	LGC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	Tier 1 (G)	
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	Tier 1 (G)	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	Tier 1 (G)	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	Tier 1 (G)	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	Tier 1 (G)	LGC
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	Tier 1 (G)	LGC
irbesartan oral tablet 150 mg, 300 mg, 75 mg	Tier 1 (G)	LGC
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	Tier 1 (G)	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	Tier 1 (G)	LGC
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	Tier 1 (G)	LGC
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg	Tier 1 (G)	
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*)	NF	
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl*)	NF	
disopyramide phosphate oral capsule 100 mg, 150 mg	Tier 1 (G)	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	Tier 4 (PSP)	PA
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	Tier 1 (G)	
MULTAQ ORAL TABLET 400 MG (*dronedarone hcl*)	Tier 2 (PB)	
propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg	Tier 1 (G)	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sotalol hcl (af) oral tablet 120 mg	Tier 1 (G)	LGC
sotalol hcl (af) oral tablet 160 mg, 80 mg	Tier 1 (G)	
sotalol hcl oral tablet 120 mg, 80 mg	Tier 1 (G)	LGC
sotalol hcl oral tablet 160 mg, 240 mg	Tier 1 (G)	
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (*dofetilide*)	Tier 5 (NPSP)	PA; ST
ANTILIPEMICS, ACL INHIBITORS/COMBINATIONS - DRUGS TO TREAT HIGH CHOLESTEROL		
NEXLETOL ORAL TABLET 180 MG (*bempedoic acid*)	Tier 2 (PB)	
NEXLIZET ORAL TABLET 180-10 MG (*bempedoic acid-ezetimibe*)	Tier 2 (PB)	
ANTILIPEMICS, BILE ACID RESINS - DRUGS TO TREAT HIGH CHOLESTEROL		
cholestyramine light oral packet 4 gm	Tier 1 (G)	
cholestyramine light oral powder 4 gm/dose	Tier 1 (G)	
cholestyramine oral packet 4 gm	Tier 1 (G)	
cholestyramine oral powder 4 gm/dose	Tier 1 (G)	
colesevelam hcl oral packet 3.75 gm	Tier 1 (G)	
colesevelam hcl oral tablet 625 mg	Tier 1 (G)	
colestipol hcl oral granules 5 gm	Tier 1 (G)	
colestipol hcl oral packet 5 gm	Tier 1 (G)	
colestipol hcl oral tablet 1 gm	Tier 1 (G)	
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR - DRUGS TO TREAT HIGH CHOLESTEROL		
ezetimibe oral tablet 10 mg	Tier 1 (G)	
ANTILIPEMICS, FIBRATES - DRUGS TO TREAT HIGH CHOLESTEROL		
fenofibrate micronized oral capsule 130 mg	NF	
fenofibrate micronized oral capsule 134 mg, 43 mg, 67 mg	Tier 1 (G)	
fenofibrate oral capsule 150 mg, 200 mg	Tier 1 (G)	
fenofibrate oral capsule 50 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fenofibrate oral tablet 120 mg, 40 mg	NF	
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	Tier 1 (G)	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	Tier 1 (G)	
fenofibric acid oral tablet 105 mg, 35 mg	Tier 1 (G)	
FENOGLIDE ORAL TABLET 120 MG (*fenofibrate*)	NF	
gemfibrozil oral tablet 600 mg	Tier 1 (G)	LGC
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
atorvastatin calcium oral tablet 10 mg, 20 mg	CE	LGC; N7 (G); AL (Min 40 Years and Max 75 Years)
atorvastatin calcium oral tablet 40 mg, 80 mg	Tier 1 (G)	LGC; N8 (Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease)
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	Tier 1 (G)	
fluvastatin sodium oral capsule 20 mg, 40 mg	Tier 1 (G)	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	Tier 1 (G)	LGC
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	Tier 1 (G)	LGC
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Tier 1 (G)	LGC
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	CE	LGC; N7 (G); AL (Min 40 Years and Max 75 Years)
simvastatin oral tablet 80 mg	Tier 1 (G)	LGC; N8 (Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS - DRUGS TO TREAT HIGH CHOLESTEROL		
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	Tier 1 (G)	
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG (*lomitapide mesylate*)	NF	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	Tier 1 (G)	
NIACOR ORAL TABLET 500 MG (*niacin (antihyperlipidemic)*)	NF	
ANTILIPEMICS, OMEGA-3 FATTY ACIDS - DRUGS TO TREAT HIGH CHOLESTEROL		
icosapent ethyl oral capsule 0.5 gm, 1 gm	Tier 1 (G)	
omega-3-acid ethyl esters oral capsule 1 gm	Tier 1 (G)	
ANTILIPEMICS, PCSK9 INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML (*alirocumab*)	NF	
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (*evolocumab*)	Tier 2 (PB)	QL (1 CARTRIDGE per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (*evolocumab*)	Tier 2 (PB)	QL (3 SYRINGES per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (*evolocumab*)	Tier 2 (PB)	QL (3 PENS per 28 days)
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	Tier 1 (G)	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	Tier 1 (G)	LGC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	Tier 1 (G)	
BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
acebutolol hcl oral capsule 200 mg, 400 mg	Tier 1 (G)	
atenolol oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
betaxolol hcl oral tablet 10 mg, 20 mg	Tier 1 (G)	
bisoprolol fumarate oral tablet 10 mg, 5 mg	Tier 1 (G)	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	Tier 1 (G)	LGC
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	Tier 1 (G)	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	Tier 1 (G)	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
metoprolol tartrate oral tablet 37.5 mg, 75 mg	Tier 1 (G)	
nadolol oral tablet 20 mg, 40 mg, 80 mg	Tier 1 (G)	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Tier 1 (G)	
pindolol oral tablet 10 mg, 5 mg	Tier 1 (G)	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	Tier 1 (G)	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	Tier 1 (G)	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 80 mg	Tier 1 (G)	LGC
propranolol hcl oral tablet 60 mg	Tier 1 (G)	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	Tier 1 (G)	
CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
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	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	LGC
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	Tier 1 (G)	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	Tier 1 (G)	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	Tier 1 (G)	
diltiazem hcl er oral tablet extended release 24 hour 120 mg	Tier 1 (G)	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	Tier 1 (G)	LGC
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	Tier 1 (G)	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	
isradipine oral capsule 2.5 mg, 5 mg	Tier 1 (G)	
diltiazem hcl (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Tier 1 (G)	
nicardipine hcl oral capsule 20 mg, 30 mg	Tier 1 (G)	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	Tier 1 (G)	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	Tier 1 (G)	
nimodipine oral capsule 30 mg	Tier 1 (G)	
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg	Tier 1 (G)	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg	Tier 1 (G)	
verapamil hcl er oral tablet extended release 120 mg	Tier 1 (G)	LGC
verapamil hcl er oral tablet extended release 180 mg, 240 mg	Tier 1 (G)	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	Tier 1 (G)	LGC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS		
digoxin oral solution 0.05 mg/ml	Tier 1 (G)	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	Tier 1 (G)	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (*digoxin*)	NF	
DIRECT RENIN INHIBITORS/COMBINATIONS - DRUGS TO TREAT HEART CONDITIONS		
aliskiren fumarate oral tablet 150 mg, 300 mg	Tier 1 (G)	
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
acetazolamide er oral capsule extended release 12 hour 500 mg	Tier 1 (G)	
acetazolamide oral tablet 125 mg, 250 mg	Tier 1 (G)	
amiloride hcl oral tablet 5 mg	Tier 1 (G)	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	Tier 1 (G)	LGC
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	
chlorthalidone oral tablet 25 mg, 50 mg	Tier 1 (G)	
dichlorphenamide oral tablet 50 mg	Tier 4 (PSP)	PA; QL (120 TABLETS per 30 DAYs)
DYRENIUM ORAL CAPSULE 100 MG, 50 MG (*triamterene*)	NF	
ethacrynic acid oral tablet 25 mg	Tier 1 (G)	
furosemide oral tablet 20 mg, 40 mg, 80 mg	Tier 1 (G)	LGC
hydrochlorothiazide oral capsule 12.5 mg	Tier 1 (G)	LGC
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
indapamide oral tablet 1.25 mg, 2.5 mg	Tier 1 (G)	
KEVEYIS ORAL TABLET 50 MG (*dichlorphenamide*)	Tier 5 (NPSP)	PA; QL (120 TABLETS per 30 days)
methazolamide oral tablet 25 mg, 50 mg	Tier 1 (G)	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	
spironolactone-hctz oral tablet 25-25 mg	Tier 1 (G)	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	Tier 1 (G)	
triamterene oral capsule 100 mg, 50 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
triamterene-hctz oral capsule 37.5-25 mg	Tier 1 (G)	LGC
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	Tier 1 (G)	LGC
HEART FAILURE		
CORLANOR ORAL TABLET 5 MG, 7.5 MG (*ivabradine hcl*)	Tier 2 (PB)	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG (*sacubitril-valsartan*)	Tier 2 (PB)	
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (*sacubitril-valsartan*)	Tier 2 (PB)	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	Tier 1 (G)	
ivabradine hcl oral tablet 5 mg, 7.5 mg	Tier 1 (G)	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (*vericiguat*)	Tier 2 (PB)	
MISCELLANEOUS		
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (*mavacamten*)	Tier 5 (NPSP)	PA; QL (30 CAPSULES per 30 days)
CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY 0.1 MG/24HR (*clonidine*)	Tier 2 (PB)	
CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY 0.2 MG/24HR (*clonidine*)	Tier 2 (PB)	
CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY 0.3 MG/24HR (*clonidine*)	Tier 2 (PB)	
clonidine er oral tablet extended release 24 hour 0.17 mg	Tier 1 (G)	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	Tier 1 (G)	LGC
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	Tier 1 (G)	
DEMSER ORAL CAPSULE 250 MG (*metyrosine*)	Tier 5 (NPSP)	PA; QL (480 CAPSULES per 30 DAYs)
DIBENZYLINE ORAL CAPSULE 10 MG (*phenoxybenzamine hcl*)	Tier 3 (NPB)	
droxidopa oral capsule 100 mg, 200 mg, 300 mg	Tier 4 (PSP)	PA; QL (180 CAPSULES per 30 days)
guanfacine hcl oral tablet 1 mg, 2 mg	Tier 1 (G)	
hydralazine hcl oral tablet 10 mg, 100 mg, 50 mg	Tier 1 (G)	

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydralazine hcl oral tablet 25 mg	Tier 1 (G)	LGC
metyrosine oral capsule 250 mg	Tier 4 (PSP)	PA; QL (480 CAPSULES per 30 days)
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	
minoxidil oral tablet 10 mg, 2.5 mg	Tier 1 (G)	
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG (*droxidopa*)	NF	
phenoxybenzamine hcl oral capsule 10 mg	Tier 1 (G)	
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	Tier 1 (G)	
VECAMYL ORAL TABLET 2.5 MG (*mecamylamine hcl*)	Tier 3 (NPB)	
VYNDAMAX ORAL CAPSULE 61 MG (*tafamidis*)	Tier 5 (NPSP)	PA; QL (30 CAPSULES per 30 days)
VYNDAQEL ORAL CAPSULE 20 MG (*tafamidis meglumine (cardiac)*)	NF	
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	Tier 1 (G)	
isosorbide dinitrate oral tablet 40 mg	NF	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	Tier 1 (G)	
isosorbide mononitrate oral tablet 10 mg, 20 mg	Tier 1 (G)	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR (*nitroglycerin*)	Tier 2 (PB)	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	Tier 1 (G)	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	Tier 1 (G)	
nitroglycerin translingual solution 0.4 mg/spray	Tier 1 (G)	
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADCIRCA ORAL TABLET 20 MG (*tadalafil (pah)*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (*riociguat*)	Tier 4 (PSP)	PA; QL (90 TABLETS per 30 days)
tadalafil (pah) (Alyq Oral Tablet 20 Mg)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
ambrisentan oral tablet 10 mg, 5 mg	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 DAYs)
bosentan oral tablet 125 mg, 62.5 mg	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
epoprostenol sodium intravenous solution reconstituted 0.5 mg, 1.5 mg	Tier 4 (PSP)	PA
FLOLAN INTRAVENOUS SOLUTION RECONSTITUTED 0.5 MG, 1.5 MG (*epoprostenol sodium*)	Tier 5 (NPSP)	PA
LETAIRIS ORAL TABLET 10 MG, 5 MG (*ambrisentan*)	NF	
OPSUMIT ORAL TABLET 10 MG (*macitentan*)	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 days)
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	Tier 4 (PSP)	PA
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	Tier 4 (PSP)	PA
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (*treprostinil diolamine*)	Tier 4 (PSP)	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (*treprostinil diolamine*)	Tier 4 (PSP)	PA
REMODULIN INJECTION SOLUTION 100 MG/20ML, 20 MG/20ML, 200 MG/20ML, 50 MG/20ML (*treprostinil*)	NF	
REVATIO ORAL TABLET 20 MG (*sildenafil citrate*)	NF	
sildenafil citrate oral suspension reconstituted 10 mg/ml	Tier 4 (PSP)	PA; QL (784 ML per 30 days)
sildenafil citrate oral tablet 20 mg	Tier 1 (G)	PA; QL (360 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tadalafil (pah) oral tablet 20 mg	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*)	Tier 4 (PSP)	PA; QL (300 ML per 30 days)
TRACLEER ORAL TABLET 125 MG, 62.5 MG (*bosentan*)	NF	
TRACLEER ORAL TABLET SOLUBLE 32 MG (*bosentan*)	NF	
treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml	Tier 4 (PSP)	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (*selexipag*)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
UPTRAVI ORAL TABLET 200 MCG (*selexipag*)	Tier 4 (PSP)	PA; QL (140 TABLETS per 28 days)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (*selexipag*)	Tier 4 (PSP)	PA; QL (1 TABLET THERAPY PACK per 28 days)
VELETRI INTRAVENOUS SOLUTION RECONSTITUTED 0.5 MG, 1.5 MG (*epoprostenol sodium*)	Tier 5 (NPSP)	PA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (*iloprost*)	Tier 5 (NPSP)	PA; QL (270 ML per 30 days)
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG (*sotatercept-csrk*)	NF	
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ALCOHOL DETERRENTS		
acamprosate calcium oral tablet delayed release 333 mg	Tier 1 (G)	
disulfiram oral tablet 250 mg	Tier 1 (G)	
AMYOTROPHIC LATERAL SCLEROSIS (ALS) - DRUGS TO TREAT ALS		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (*edaravone*)	Tier 4 (PSP)	PA; QL (50 ML per 28 days)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (*edaravone*)	Tier 4 (PSP)	PA; QL (70 ML per 28 days)
riluzole oral tablet 50 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	QL (150 TABLETS per 25 DAYs)
alprazolam er oral tablet extended release 24 hour 3 mg	Tier 1 (G)	QL (90 TABLETS per 25 DAYs)
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (*alprazolam*)	Tier 3 (NPB)	QL (300 ML per 25 days)
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	QL (150 TABLETS per 25 days)
alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	QL (150 TABLETS per 25 days)
ANAFRANIL ORAL CAPSULE 25 MG, 50 MG, 75 MG (*clomipramine hcl*)	Tier 2 (PB)	
ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG (*lorazepam*)	Tier 3 (NPB)	QL (150 TABLETS per 25 days)
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	Tier 1 (G)	
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	Tier 1 (G)	QL (360 CAPSULES per 25 DAYs)
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	Tier 1 (G)	
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	Tier 1 (G)	
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	
lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/Ml)	Tier 1 (G)	QL (150 ML per 25 DAYs)
lorazepam oral tablet 0.5 mg, 1 mg	Tier 1 (G)	QL (150 TABLETS per 25 days)
lorazepam oral tablet 2 mg	Tier 1 (G)	QL (150 TABLETS per 25 DAYs)
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG (*lorazepam*)	Tier 3 (NPB)	QL (150 CAPSULES per 25 DAYs)
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 3 MG (*lorazepam*)	Tier 3 (NPB)	QL (90 CAPSULES per 25 DAYs)
oxazepam oral capsule 10 mg, 15 mg, 30 mg	Tier 1 (G)	QL (120 CAPSULES per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG (*alprazolam*)	Tier 3 (NPB)	QL (150 TABLETS per 25 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 2 MG (*alprazolam*)	Tier 3 (NPB)	QL (150 TABLETS per 25 DAYs)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HOUR 3 MG (*alprazolam*)	Tier 3 (NPB)	QL (90 TABLETS per 25 DAYs)
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hcl oral tablet 10 mg, 23 mg, 5 mg	Tier 1 (G)	
donepezil hcl oral tablet dispersible 10 mg, 5 mg	Tier 1 (G)	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	Tier 1 (G)	
galantamine hydrobromide oral solution 4 mg/ml	Tier 1 (G)	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	Tier 1 (G)	
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	Tier 1 (G)	
memantine hcl oral solution 2 mg/ml	Tier 1 (G)	
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	Tier 1 (G)	
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG (*memantine hcl-donepezil hcl*)	Tier 2 (PB)	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (*memantine hcl-donepezil hcl*)	Tier 2 (PB)	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	Tier 1 (G)	
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	Tier 1 (G)	
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Tier 1 (G)	
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	Tier 1 (G)	
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	Tier 1 (G)	
bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg	NF	
bupropion hcl oral tablet 100 mg, 75 mg	Tier 1 (G)	
citalopram hydrobromide oral solution 10 mg/5ml	Tier 1 (G)	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	Tier 1 (G)	LGC
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Tier 1 (G)	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	Tier 1 (G)	
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Tier 1 (G)	
doxepin hcl oral concentrate 10 mg/ml	Tier 1 (G)	
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	Tier 1 (G)	
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (*selegiline*)	Tier 3 (NPB)	
escitalopram oxalate oral solution 5 mg/5ml	Tier 1 (G)	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	Tier 1 (G)	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (*levomilnacipran hcl*)	Tier 2 (PB)	
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (*levomilnacipran hcl*)	Tier 2 (PB)	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	Tier 1 (G)	LGC
fluoxetine hcl oral capsule delayed release 90 mg	Tier 1 (G)	
fluoxetine hcl oral solution 20 mg/5ml	Tier 1 (G)	
fluoxetine hcl oral tablet 10 mg, 20 mg	Tier 1 (G)	
fluoxetine hcl oral tablet 60 mg	NF	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	Tier 1 (G)	
imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg	Tier 1 (G)	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	Tier 1 (G)	
NARDIL ORAL TABLET 15 MG (*phenelzine sulfate*)	Tier 2 (PB)	
NORPRAMIN ORAL TABLET 10 MG, 25 MG (*desipramine hcl*)	Tier 2 (PB)	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	Tier 1 (G)	
nortriptyline hcl oral solution 10 mg/5ml	Tier 1 (G)	
PAMELOR ORAL CAPSULE 10 MG, 25 MG, 50 MG, 75 MG (*nortriptyline hcl*)	Tier 2 (PB)	
PARNATE ORAL TABLET 10 MG (*tranylcypromine sulfate*)	Tier 2 (PB)	
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	Tier 1 (G)	
paroxetine hcl oral suspension 10 mg/5ml	Tier 1 (G)	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	Tier 1 (G)	LGC
phenelzine sulfate oral tablet 15 mg	Tier 1 (G)	
protriptyline hcl oral tablet 10 mg, 5 mg	Tier 1 (G)	
sertraline hcl oral concentrate 20 mg/ml	Tier 1 (G)	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	LGC
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*)	Tier 5 (NPSP)	PA
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*)	Tier 5 (NPSP)	PA
tranylcypromine sulfate oral tablet 10 mg	Tier 1 (G)	
trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg	Tier 1 (G)	
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	Tier 1 (G)	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (*vortioxetine hbr*)	Tier 2 (PB)	
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	Tier 1 (G)	
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg, 37.5 mg, 75 mg	Tier 1 (G)	
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	Tier 1 (G)	

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (*vilazodone hcl*)	Tier 2 (PB)	
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	Tier 1 (G)	
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
amantadine hcl oral capsule 100 mg	Tier 1 (G)	
amantadine hcl oral solution 50 mg/5ml	Tier 1 (G)	
amantadine hcl oral tablet 100 mg	Tier 1 (G)	
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (*apomorphine hcl*)	NF	
apomorphine hcl subcutaneous solution cartridge 30 mg/3ml	NF	
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	
bromocriptine mesylate oral capsule 5 mg	Tier 1 (G)	
bromocriptine mesylate oral tablet 2.5 mg	Tier 1 (G)	
carbidopa oral tablet 25 mg	Tier 1 (G)	
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	Tier 1 (G)	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	Tier 1 (G)	
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	Tier 1 (G)	
CREXONT ORAL CAPSULE EXTENDED RELEASE 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG (*carbidopa-levodopa*)	Tier 3 (NPB)	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (*carbidopa-levodopa*)	Tier 5 (NPSP)	PA
entacapone oral tablet 200 mg	Tier 1 (G)	
INBRIJA INHALATION CAPSULE 42 MG (*levodopa*)	Tier 4 (PSP)	PA; QL (300 CAPSULES per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (*rotigotine*)	Tier 2 (PB)	
NOURIANZ ORAL TABLET 20 MG, 40 MG (*istradefylline*)	Tier 5 (NPSP)	
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	Tier 1 (G)	
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	Tier 1 (G)	
rasagiline mesylate oral tablet 0.5 mg, 1 mg	Tier 1 (G)	
ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	Tier 1 (G)	
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	Tier 1 (G)	
RYTARY ORAL CAPSULE EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG (*carbidopa-levodopa*)	Tier 2 (PB)	
selegiline hcl oral capsule 5 mg	Tier 1 (G)	
selegiline hcl oral tablet 5 mg	Tier 1 (G)	
trihexyphenidyl hcl oral solution 0.4 mg/ml	Tier 1 (G)	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	Tier 1 (G)	
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML, 960 MG/3.2ML (*aripiprazole*)	Tier 3 (NPB)	
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG (*aripiprazole*)	Tier 2 (PB)	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG (*aripiprazole*)	Tier 2 (PB)	
aripiprazole oral solution 1 mg/ml	Tier 1 (G)	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	Tier 1 (G)	
aripiprazole oral tablet dispersible 10 mg, 15 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML (*aripiprazole lauroxil*)	Tier 2 (PB)	
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML (*aripiprazole lauroxil*)	Tier 2 (PB)	
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	Tier 1 (G)	
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	Tier 1 (G)	
clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg	Tier 1 (G)	
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*iloperidone*)	NF	
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG (*iloperidone*)	NF	
fluphenazine hcl oral concentrate 5 mg/ml	Tier 1 (G)	
fluphenazine hcl oral elixir 2.5 mg/5ml	Tier 1 (G)	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	
haloperidol lactate oral concentrate 2 mg/ml	Tier 1 (G)	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	Tier 1 (G)	
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	Tier 1 (G)	
lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg	Tier 1 (G)	
NUPLAZID ORAL CAPSULE 34 MG (*pimavanserin tartrate*)	Tier 5 (NPSP)	PA; QL (30 CAPSULES per 30 days)
NUPLAZID ORAL TABLET 10 MG (*pimavanserin tartrate*)	Tier 5 (NPSP)	PA; QL (30 TABLETS per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	Tier 1 (G)	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	Tier 1 (G)	
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg	Tier 1 (G)	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	Tier 1 (G)	
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	Tier 1 (G)	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG, 50 MG (*risperidone microspheres*)	Tier 2 (PB)	
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg	Tier 1 (G)	
risperidone oral solution 1 mg/ml	Tier 1 (G)	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Tier 1 (G)	
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Tier 1 (G)	
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	Tier 1 (G)	
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	Tier 1 (G)	
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	Tier 1 (G)	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (*cariprazine hcl*)	Tier 2 (PB)	
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	Tier 1 (G)	
ziprasidone mesylate intramuscular solution reconstituted 20 mg	Tier 1 (G)	
ANTISEIZURE AGENTS - DRUGS TO TREAT SEIZURES		
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	Tier 1 (G)	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	Tier 1 (G)	
carbamazepine oral suspension 100 mg/5ml	Tier 1 (G)	
carbamazepine oral tablet 200 mg	Tier 1 (G)	
carbamazepine oral tablet chewable 100 mg	Tier 1 (G)	
clobazam oral suspension 2.5 mg/ml	Tier 1 (G)	
clobazam oral tablet 10 mg, 20 mg	Tier 1 (G)	
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	QL (300 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	QL (300 TABLETS per 25 days)
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	Tier 1 (G)	QL (180 TABLETS per 25 days)
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (*stiripentol*)	NF	
DIACOMIT ORAL PACKET 250 MG, 500 MG (*stiripentol*)	NF	
diazepam (Diazepam Intensol Oral Concentrate 5 Mg/Ml)	Tier 1 (G)	QL (240 ML per 25 days)
diazepam oral solution 5 mg/5ml	Tier 1 (G)	QL (1200 ML per 25 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	Tier 1 (G)	QL (120 TABLETS per 25 days)
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	Tier 1 (G)	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	Tier 1 (G)	
divalproex sodium oral capsule delayed release sprinkle 125 mg	Tier 1 (G)	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	Tier 1 (G)	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (*cannabidiol*)	Tier 5 (NPSP)	PA; QL (800 ML per 30 days)
ethosuximide oral capsule 250 mg	Tier 1 (G)	
ethosuximide oral solution 250 mg/5ml	Tier 1 (G)	
felbamate oral suspension 600 mg/5ml	Tier 1 (G)	
felbamate oral tablet 400 mg, 600 mg	Tier 1 (G)	
FINTEPLA ORAL SOLUTION 2.2 MG/ML (*fenfluramine hcl*)	NF	
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (*perampanel*)	Tier 2 (PB)	
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*perampanel*)	Tier 2 (PB)	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	Tier 1 (G)	
gabapentin oral solution 250 mg/5ml, 300 mg/6ml	Tier 1 (G)	
gabapentin oral tablet 600 mg, 800 mg	Tier 1 (G)	
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG (*clonazepam*)	Tier 3 (NPB)	QL (300 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lacosamide oral solution 10 mg/ml	Tier 1 (G)	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	Tier 1 (G)	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	Tier 1 (G)	
lamotrigine oral kit 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	Tier 1 (G)	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	Tier 1 (G)	
lamotrigine oral tablet chewable 25 mg, 5 mg	Tier 1 (G)	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	Tier 1 (G)	
lamotrigine starter kit-blue oral kit 35 x 25 mg	Tier 1 (G)	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	Tier 1 (G)	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	Tier 1 (G)	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	Tier 1 (G)	
levetiracetam oral solution 100 mg/ml	Tier 1 (G)	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	Tier 1 (G)	
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG (*diazepam*)	Tier 3 (NPB)	QL (10 POUCHES per 25 DAYs)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (*pregabalin*)	Tier 3 (NPB)	
LYRICA ORAL SOLUTION 20 MG/ML (*pregabalin*)	Tier 3 (NPB)	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (*midazolam (anticonvulsant)*)	Tier 3 (NPB)	QL (10 SOLUTION per 25 days)
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (*gabapentin*)	Tier 3 (NPB)	
NEURONTIN ORAL SOLUTION 250 MG/5ML (*gabapentin*)	Tier 3 (NPB)	
NEURONTIN ORAL TABLET 600 MG, 800 MG (*gabapentin*)	Tier 3 (NPB)	
oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg, 600 mg	Tier 1 (G)	
oxcarbazepine oral suspension 300 mg/5ml	Tier 1 (G)	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG, 600 MG (*oxcarbazepine*)	Tier 2 (PB)	
phenobarbital oral elixir 20 mg/5ml	Tier 1 (G)	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	Tier 1 (G)	
phenytoin oral suspension 125 mg/5ml	Tier 1 (G)	
phenytoin oral tablet chewable 50 mg	Tier 1 (G)	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	Tier 1 (G)	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	Tier 1 (G)	
pregabalin oral solution 20 mg/ml	Tier 1 (G)	
primidone oral tablet 125 mg, 250 mg, 50 mg	Tier 1 (G)	
rufinamide oral suspension 40 mg/ml	Tier 1 (G)	
SABRIL ORAL PACKET 500 MG (*vigabatrin*)	NF	
SABRIL ORAL TABLET 500 MG (*vigabatrin*)	NF	
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	Tier 1 (G)	
topiramate er oral capsule er 24 hour sprinkle 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	NF	
topiramate er oral capsule extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	Tier 1 (G)	
topiramate oral capsule sprinkle 15 mg, 25 mg	Tier 1 (G)	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	Tier 1 (G)	
VALIUM ORAL TABLET 10 MG, 2 MG, 5 MG (*diazepam*)	Tier 3 (NPB)	QL (120 TABLETS per 25 days)
valproic acid oral capsule 250 mg	Tier 1 (G)	
valproic acid oral solution 250 mg/5ml	Tier 1 (G)	
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (*diazepam*)	Tier 3 (NPB)	QL (10 BLISTER per 25 days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML (*diazepam*)	Tier 3 (NPB)	QL (10 BLISTER per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML (*diazepam*)	Tier 3 (NPB)	QL (10 BLISTER per 25 days)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (*diazepam*)	Tier 3 (NPB)	QL (10 BLISTER per 25 days)
vigabatrin oral packet 500 mg	Tier 4 (PSP)	PA; QL (180 PACKETS per 30 days)
vigabatrin oral tablet 500 mg	Tier 4 (PSP)	PA; QL (180 TABLETS per 30 days)
vigabatrin (Vigadrone Oral Packet 500 Mg)	Tier 4 (PSP)	PA; QL (180 PACKETS per 30 days)
VIGAFYDE ORAL SOLUTION 100 MG/ML (*vigabatrin*)	NF	
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG (*cenobamate*)	Tier 2 (PB)	
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG (*cenobamate*)	Tier 2 (PB)	
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*cenobamate*)	Tier 2 (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 (*cenobamate*)	Tier 2 (PB)	
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (*zonisamide*)	NF	
zonisamide oral capsule 100 mg, 25 mg, 50 mg	Tier 1 (G)	
ZTALMY ORAL SUSPENSION 50 MG/ML (*ganaxolone*)	NF	
ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD		
ADDERALL ORAL TABLET 10 MG, 12.5 MG, 5 MG, 7.5 MG (*amphetamine-dextroamphetamine*)	Tier 3 (NPB)	QL (90 TABLETS per 25 DAYs)
ADDERALL ORAL TABLET 15 MG, 20 MG (*amphetamine-dextroamphetamine*)	Tier 3 (NPB)	QL (60 TABLETS per 25 DAYs)
ADDERALL ORAL TABLET 30 MG (*amphetamine-dextroamphetamine*)	Tier 3 (NPB)	QL (30 TABLETS per 25 DAYs)
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 5 MG (*amphetamine-dextroamphetamine*)	Tier 3 (NPB)	QL (90 CAPSULES per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 15 MG, 20 MG, 25 MG, 30 MG (*amphetamine-dextroamphetamine*)	Tier 3 (NPB)	QL (30 CAPSULES per 25 DAYs)
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG (*amphetamine*)	Tier 3 (NPB)	QL (30 TABLETS per 25 DAYs)
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 3.1 MG, 6.3 MG, 9.4 MG (*amphetamine*)	Tier 3 (NPB)	QL (60 TABLETS per 25 DAYs)
amphetamine sulfate oral tablet 10 mg, 5 mg	Tier 1 (G)	STX; QL (120 TABLETS per 25 days)
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 5 mg	Tier 1 (G)	QL (90 CAPSULES per 25 days)
amphetamine-dextroamphet er oral capsule extended release 24 hour 15 mg, 20 mg, 25 mg, 30 mg	Tier 1 (G)	QL (30 CAPSULES per 25 days)
amphetamine-dextroamphetamine oral tablet 10 mg	Tier 1 (G)	QL (90 TABLETS per 25 DAYs)
amphetamine-dextroamphetamine oral tablet 12.5 mg, 5 mg, 7.5 mg	Tier 1 (G)	QL (90 TABLETS per 25 days)
amphetamine-dextroamphetamine oral tablet 15 mg	Tier 1 (G)	QL (60 TABLETS per 25 days)
amphetamine-dextroamphetamine oral tablet 20 mg	Tier 1 (G)	QL (60 TABLETS per 25 DAYs)
amphetamine-dextroamphetamine oral tablet 30 mg	Tier 1 (G)	QL (30 TABLETS per 25 days)
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg	Tier 1 (G)	QL (60 CAPSULES per 25 DAYs)
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 37.5 mg, 50 mg	Tier 1 (G)	QL (30 CAPSULES per 25 DAYs)
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 30 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (60 CAPSULES per 25 DAYs)
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 40 MG, 50 MG, 60 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 CAPSULES per 25 DAYs)
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (*serdexmethylphen-dexmethylphen*)	Tier 2 (PB)	QL (30 CAPSULES per 25 days)
CONCERTA ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 36 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (60 TABLETS per 25 DAYs)
CONCERTA ORAL TABLET EXTENDED RELEASE 54 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 TABLETS per 25 DAYs)
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG (*methylphenidate*)	Tier 3 (NPB)	QL (60 TABLETS per 25 DAYs)
DAYTRANA TRANSDERMAL PATCH 10 MG/9HR, 15 MG/9HR, 20 MG/9HR, 30 MG/9HR (*methylphenidate*)	Tier 3 (NPB)	QL (30 PATCHES per 25 DAYs)
DESOXYN ORAL TABLET 5 MG (*methamphetamine hcl*)	Tier 3 (NPB)	QL (150 TABLETS per 25 days)
DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG (*dextroamphetamine sulfate*)	Tier 3 (NPB)	QL (120 CAPSULES per 25 DAYs)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 5 mg	Tier 1 (G)	QL (60 CAPSULES per 25 DAYs)
dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg, 30 mg, 35 mg, 40 mg	Tier 1 (G)	QL (30 CAPSULES per 25 DAYs)
dexmethylphenidate hcl oral tablet 10 mg	Tier 1 (G)	QL (60 TABLETS per 25 days)
dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg	Tier 1 (G)	QL (120 TABLETS per 25 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg	Tier 1 (G)	QL (120 CAPSULES per 25 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	Tier 1 (G)	QL (60 CAPSULES per 25 days)
dextroamphetamine sulfate oral solution 5 mg/5ml	Tier 1 (G)	QL (1200 ML per 25 DAYs)
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	Tier 1 (G)	QL (120 TABLETS per 25 DAYs)
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (*amphetamine*)	Tier 3 (NPB)	QL (240 ML per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 10 MG, 5 MG (*amphetamine*)	Tier 3 (NPB)	QL (60 TABLETS per 25 days)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 15 MG, 20 MG (*amphetamine*)	Tier 3 (NPB)	QL (30 TABLETS per 25 days)
EVEKEO ORAL TABLET 10 MG, 5 MG (*amphetamine sulfate*)	Tier 3 (NPB)	STX; QL (120 TABLETS per 25 days)
FOCALIN ORAL TABLET 10 MG (*dexmethylphenidate hcl*)	Tier 3 (NPB)	QL (60 TABLETS per 25 days)
FOCALIN ORAL TABLET 2.5 MG, 5 MG (*dexmethylphenidate hcl*)	Tier 3 (NPB)	QL (120 TABLETS per 25 DAYs)
FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 5 MG (*dexmethylphenidate hcl*)	Tier 3 (NPB)	QL (60 CAPSULES per 25 DAYs)
FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 25 MG, 30 MG, 35 MG, 40 MG (*dexmethylphenidate hcl*)	Tier 3 (NPB)	QL (30 CAPSULES per 25 DAYs)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	Tier 1 (G)	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 60 MG, 80 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 CAPSULES per 25 DAYs)
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 20 MG, 40 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (60 CAPSULES per 25 DAYs)
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	Tier 1 (G)	QL (60 CAPSULES per 25 DAYs)
lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	Tier 1 (G)	QL (30 CAPSULES per 25 DAYs)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	Tier 1 (G)	QL (60 TABLETS per 25 DAYs)
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	Tier 1 (G)	QL (30 TABLETS per 25 DAYs)
METADATE CD ORAL CAPSULE EXTENDED RELEASE 10 MG, 20 MG, 30 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (60 CAPSULES per 25 DAYs)
METADATE CD ORAL CAPSULE EXTENDED RELEASE 40 MG, 50 MG, 60 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 CAPSULES per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methamphetamine hcl oral tablet 5 mg	Tier 1 (G)	STX; QL (150 TABLETS per 25 days)
METHYLIN ORAL SOLUTION 10 MG/5ML (*methylphenidate hcl*)	Tier 3 (NPB)	QL (900 ML per 25 DAYs)
METHYLIN ORAL SOLUTION 5 MG/5ML (*methylphenidate hcl*)	Tier 3 (NPB)	QL (1800 ML per 25 DAYs)
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg	Tier 1 (G)	QL (60 CAPSULES per 25 DAYs)
methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg	Tier 1 (G)	QL (30 CAPSULES per 25 days)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg	Tier 1 (G)	QL (60 CAPSULES per 25 DAYs)
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 30 mg	Tier 1 (G)	QL (60 CAPSULES per 25 days)
methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg	Tier 1 (G)	QL (30 CAPSULES per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 18 mg	Tier 1 (G)	QL (60 TABLETS per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 27 mg, 36 mg	Tier 1 (G)	QL (60 tablets per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 45 mg, 63 mg, 72 mg	Tier 1 (G)	QL (30 TABLETS per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 54 mg	Tier 1 (G)	QL (30 tablets per 25 days)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg	Tier 1 (G)	QL (60 CAPSULES per 25 DAYs)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 40 mg, 50 mg, 60 mg	Tier 1 (G)	QL (30 CAPSULES per 25 DAYs)
methylphenidate hcl er oral tablet extended release 10 mg, 20 mg	Tier 1 (G)	QL (90 TABLETS per 25 DAYs)
methylphenidate hcl er oral tablet extended release 24 hour 18 mg	Tier 1 (G)	QL (60 TABLETS per 25 DAYs)
methylphenidate hcl er oral tablet extended release 24 hour 27 mg, 36 mg	Tier 1 (G)	QL (60 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methylphenidate hcl er oral tablet extended release 24 hour 54 mg	Tier 1 (G)	QL (30 TABLETS per 25 days)
methylphenidate hcl oral solution 10 mg/5ml	Tier 1 (G)	QL (900 ML per 25 DAYs)
methylphenidate hcl oral solution 5 mg/5ml	Tier 1 (G)	QL (1800 ML per 25 DAYs)
methylphenidate hcl oral tablet 10 mg, 5 mg	Tier 1 (G)	QL (180 TABLETS per 25 DAYs)
methylphenidate hcl oral tablet 20 mg	Tier 1 (G)	QL (90 TABLETS per 25 DAYs)
methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	QL (180 TABLETS per 25 DAYs)
methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr, 30 mg/9hr	Tier 1 (G)	QL (30 PATCHES per 25 DAYs)
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG (*amphetamine-dextroamphetamine*)	Tier 3 (NPB)	QL (60 CAPSULES per 25 days)
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG, 50 MG (*amphetamine-dextroamphetamine*)	Tier 3 (NPB)	QL (30 CAPSULES per 25 days)
dextroamphetamine sulfate (Procentra Oral Solution 5 Mg/5Ml)	Tier 1 (G)	QL (1200 ML per 25 days)
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (*viloxazine hcl*)	Tier 2 (PB)	QL (90 CAPSULES per 25 days)
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (60 TABLETS per 25 DAYs)
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 40 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 TABLETS per 25 DAYs)
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML (*methylphenidate hcl*)	Tier 3 (NPB)	QL (360 ML per 25 days)
RELEXXII ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 36 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (60 TABLETS per 25 DAYs)
RELEXXII ORAL TABLET EXTENDED RELEASE 45 MG, 63 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 TABLETS per 25 days)
RELEXXII ORAL TABLET EXTENDED RELEASE 54 MG, 72 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 TABLETS per 25 DAYs)
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 30 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (60 CAPSULES per 25 DAYs)

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 40 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (30 CAPSULES per 25 DAYs)
RITALIN ORAL TABLET 10 MG, 5 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (180 TABLETS per 25 DAYs)
RITALIN ORAL TABLET 20 MG (*methylphenidate hcl*)	Tier 3 (NPB)	QL (90 TABLETS per 25 DAYs)
STRATTERA ORAL CAPSULE 10 MG, 100 MG, 18 MG, 25 MG, 40 MG, 60 MG, 80 MG (*atomoxetine hcl*)	Tier 3 (NPB)	
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG (*lisdexamfetamine dimesylate*)	Tier 2 (PB)	QL (60 CAPSULES per 25 DAYs)
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG (*lisdexamfetamine dimesylate*)	Tier 2 (PB)	QL (30 CAPSULES per 25 DAYs)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG (*lisdexamfetamine dimesylate*)	Tier 2 (PB)	QL (60 TABLETS per 25 DAYs)
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG (*lisdexamfetamine dimesylate*)	Tier 2 (PB)	QL (30 TABLETS per 25 DAYs)
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (*dextroamphetamine*)	Tier 3 (NPB)	QL (30 PATCHES per 25 DAYs)
dextroamphetamine sulfate (Zenzedi Oral Tablet 15 Mg, 20 Mg)	Tier 1 (G)	QL (60 TABLETS per 25 days)
dextroamphetamine sulfate (Zenzedi Oral Tablet 2.5 Mg, 7.5 Mg)	Tier 1 (G)	QL (120 TABLETS per 25 days)
dextroamphetamine sulfate (Zenzedi Oral Tablet 30 Mg)	Tier 1 (G)	QL (30 TABLETS per 25 days)
BOTULINUM TOXINS		
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT (*onabotulinumtoxina*)	NF	
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT (*abobotulinumtoxina*)	Tier 4 (PSP)	PA
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT (*incobotulinumtoxina*)	Tier 4 (PSP)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIBROMYALGIA		
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (*milnacipran hcl*)	Tier 2 (PB)	
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (*milnacipran hcl*)	Tier 2 (PB)	
HYPNOTICS - DRUGS TO TREAT INSOMNIA		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (*suvorexant*)	Tier 2 (PB)	
DAYVIGO ORAL TABLET 10 MG, 5 MG (*lemborexant*)	Tier 2 (PB)	
doxepin hcl oral tablet 3 mg, 6 mg	Tier 1 (G)	
estazolam oral tablet 1 mg, 2 mg	Tier 1 (G)	
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	Tier 1 (G)	
flurazepam hcl oral capsule 15 mg, 30 mg	Tier 1 (G)	STX
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (*tasimelteon*)	Tier 5 (NPSP)	PA; QL (158 ML per 30 days)
HETLIOZ ORAL CAPSULE 20 MG (*tasimelteon*)	Tier 5 (NPSP)	PA; QL (30 CAPSULES per 30 days)
midazolam hcl oral syrup 2 mg/ml	Tier 1 (G)	
quazepam oral tablet 15 mg	NF	
QUVIVIQ ORAL TABLET 25 MG, 50 MG (*daridorexant hcl*)	Tier 2 (PB)	
ramelteon oral tablet 8 mg	Tier 1 (G)	
tasimelteon oral capsule 20 mg	Tier 4 (PSP)	PA; QL (30 CAPSULES per 30 DAYs)
temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg	Tier 1 (G)	
triazolam oral tablet 0.125 mg, 0.25 mg	Tier 1 (G)	
zaleplon oral capsule 10 mg, 5 mg	Tier 1 (G)	
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	Tier 1 (G)	
zolpidem tartrate oral tablet 10 mg, 5 mg	Tier 1 (G)	
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIGRAINE - ERGOTAMINE DERIVATIVES - DRUGS TO TREAT SEVERE HEADACHES		
dihydroergotamine mesylate injection solution 1 mg/ml	Tier 1 (G)	
dihydroergotamine mesylate nasal solution 4 mg/ml	NF	
ergotamine-caffeine oral tablet 1-100 mg	NF	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (*ergotamine-caffeine*)	NF	
MIGRANAL NASAL SOLUTION 4 MG/ML (*dihydroergotamine mesylate*)	Tier 3 (NPB)	QL (8 SOLUTION per 25 days)
TRUDHESA NASAL AEROSOL SOLUTION 0.725 MG/ACT (*dihydroergotamine mesylate hfa*)	NF	
MIGRAINE - MISCELLANEOUS - DRUGS TO TREAT SEVERE HEADACHES		
NURTEC ORAL TABLET DISPERSIBLE 75 MG (*rimegepant sulfate*)	Tier 2 (PB)	
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (*atogepant*)	Tier 2 (PB)	
UBRELVY ORAL TABLET 100 MG, 50 MG (*ubrogepant*)	Tier 2 (PB)	
MIGRAINE - MONOCLONAL ANTIBODIES - DRUGS TO TREAT SEVERE HEADACHES		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (*erenumab-aooe*)	Tier 2 (PB)	
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML (*fremanezumab-vfrm*)	Tier 2 (PB)	
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (*fremanezumab-vfrm*)	Tier 2 (PB)	
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*galcanezumab-gnlm*)	Tier 2 (PB)	
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (*galcanezumab-gnlm*)	Tier 2 (PB)	
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*galcanezumab-gnlm*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIGRAINE - TRIPTANS AND COMBINATIONS - DRUGS TO TREAT SEVERE HEADACHES		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	Tier 1 (G)	
eletriptan hydrobromide oral tablet 20 mg, 40 mg	Tier 1 (G)	
frovatriptan succinate oral tablet 2.5 mg	Tier 1 (G)	
naratriptan hcl oral tablet 1 mg, 2.5 mg	Tier 1 (G)	
ONZETRA XSAIL NASAL EXHALER POWDER 11 MG/NOSEPC (*sumatriptan succinate*)	Tier 2 (PB)	
rizatriptan benzoate oral tablet 10 mg, 5 mg	Tier 1 (G)	
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	Tier 1 (G)	
sumatriptan nasal solution 20 mg/act, 5 mg/act	Tier 1 (G)	
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	
sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml	Tier 1 (G)	
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	Tier 1 (G)	
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml	Tier 1 (G)	
sumatriptan-naproxen sodium oral tablet 85-500 mg	NF	
TREXIMET ORAL TABLET 85-500 MG (*sumatriptan-naproxen sodium*)	NF	
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (*sumatriptan succinate*)	Tier 2 (PB)	
zolmitriptan nasal solution 2.5 mg, 5 mg	Tier 1 (G)	
zolmitriptan oral tablet 2.5 mg, 5 mg	Tier 1 (G)	
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	Tier 1 (G)	
MISCELLANEOUS		
DAYBUE ORAL SOLUTION 200 MG/ML (*trofinetide*)	Tier 5 (NPSP)	PA; QL (3600 ML per 30 days)
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*satralizumab-mwge*)	Tier 4 (PSP)	PA; QL (1 SYRINGE per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (*risdiplam*)	Tier 5 (NPSP)	PA; QL (2 BOTTLES per 24 days)
FIRDAPSE ORAL TABLET 10 MG (*amifampridine phosphate*)	Tier 5 (NPSP)	PA; QL (300 TABLETS per 30 days)
SKYCLARYS ORAL CAPSULE 50 MG (*omaveloxolone*)	Tier 5 (NPSP)	PA; QL (90 CAPSULES per 30 days)
ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML, 23 MG/0.574ML, 32.4 MG/0.81ML (*zilucoplan sodium*)	NF	
MOOD STABILIZERS - DRUG TO TREAT MOOD DISORDERS		
lithium carbonate er oral tablet extended release 300 mg, 450 mg	Tier 1 (G)	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	Tier 1 (G)	
lithium carbonate oral tablet 300 mg	Tier 1 (G)	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (*lithium carbonate*)	Tier 2 (PB)	
MOVEMENT DISORDERS		
AUSTEDO ORAL TABLET 12 MG, 9 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (120 TABLETS per 30 days)
AUSTEDO ORAL TABLET 6 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (120 TABLETS per 30 DAYs)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 18 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 DAYs)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 DAYs)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 36 MG, 42 MG, 48 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 6 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (90 TABLETS per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (*deutetrabenazine*)	Tier 4 (PSP)	PA; QL (28 TABLETS per 28 DAYs)
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (*valbenazine tosylate*)	Tier 4 (PSP)	PA; QL (30 CAPSULES per 30 days)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (*valbenazine tosylate*)	Tier 4 (PSP)	PA; QL (30 CAPSULES per 30 DAYs)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (*valbenazine tosylate*)	Tier 4 (PSP)	PA; QL (1 PACK (28 capsules) per 28 days)
tetrabenazine oral tablet 12.5 mg	Tier 4 (PSP)	PA; QL (240 TABLETS per 30 days)
tetrabenazine oral tablet 25 mg	Tier 4 (PSP)	PA; QL (120 TABLETS per 30 days)
XENAZINE ORAL TABLET 12.5 MG, 25 MG (*tetrabenazine*)	NF	
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HOUR 10 MG (*dalfampridine*)	Tier 5 (NPSP)	PA; ST; QL (60 TABLETS per 30 days)
AUBAGIO ORAL TABLET 14 MG, 7 MG (*teriflunomide*)	NF	
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (*interferon beta-1a*)	Tier 4 (PSP)	PA; QL (4 SYRINGES per 28 days)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (*interferon beta-1a*)	Tier 4 (PSP)	PA; QL (4 SYRINGES per 28 days)
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (*monomethyl fumarate*)	NF	
BETASERON SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*)	Tier 4 (PSP)	PA; QL (14 INJECTIONS per 28 days)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (*glatiramer acetate*)	NF	
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (*glatiramer acetate*)	Tier 4 (PSP)	PA; QL (12 ML per 28 days)
dalfampridine er oral tablet extended release 12 hour 10 mg	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dimethyl fumarate oral capsule delayed release 120 mg	Tier 4 (PSP)	PA; QL (14 CAPSULES per 28 DAYs)
dimethyl fumarate oral capsule delayed release 240 mg	Tier 4 (PSP)	PA; QL (60 CAPSULES per 30 DAYs)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	Tier 4 (PSP)	PA; QL (1 KIT per 30 DAYs)
EXTAVIA SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*)	NF	
fingolimod hcl oral capsule 0.5 mg	Tier 4 (PSP)	PA; QL (30 CAPSULES per 30 DAYs)
GILENYA ORAL CAPSULE 0.25 MG, 0.5 MG (*fingolimod hcl*)	NF	
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	Tier 4 (PSP)	PA; QL (30 ML per 30 days)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	Tier 4 (PSP)	PA; QL (12 ML per 28 days)
glatiramer acetate (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/Ml)	Tier 4 (PSP)	PA; QL (30 ML per 30 days)
glatiramer acetate (Glatopa Subcutaneous Solution Prefilled Syringe 40 Mg/Ml)	Tier 4 (PSP)	PA; QL (12 ML per 28 days)
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (*ofatumumab*)	Tier 4 (PSP)	PA; QL (1 PEN per 28 days)
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Tier 5 (NPSP)	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Tier 5 (NPSP)	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Tier 5 (NPSP)	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Tier 5 (NPSP)	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Tier 5 (NPSP)	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Tier 5 (NPSP)	PA; QL (20 TABLETS per 270 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Tier 5 (NPSP)	PA; QL (20 TABLETS per 270 days)
MAYZENT ORAL TABLET 0.25 MG (*siponimod fumarate*)	Tier 4 (PSP)	PA; QL (12 TABLETS per 5 days)
MAYZENT ORAL TABLET 1 MG (*siponimod fumarate*)	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 days)
MAYZENT ORAL TABLET 2 MG (*siponimod fumarate*)	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 DAYs)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (*siponimod fumarate*)	Tier 4 (PSP)	PA; QL (12 TABLETS per 5 Days)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (*siponimod fumarate*)	Tier 4 (PSP)	PA; QL (7 TABLETS per 4 days)
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	Tier 5 (NPSP)	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	Tier 5 (NPSP)	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	Tier 5 (NPSP)	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (*peginterferon beta-1a*)	Tier 5 (NPSP)	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	Tier 5 (NPSP)	PA; QL (2 INJECTIONS per 28 days)
PONVORY ORAL TABLET 20 MG (*ponesimod*)	Tier 5 (NPSP)	PA; QL (30 TABLETS per 30 days)
PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG (*ponesimod*)	Tier 5 (NPSP)	PA; QL (14 TABLETS per 14 days)
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML (*interferon beta-1a*)	Tier 4 (PSP)	PA; QL (12 PENS per 28 days)
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG (*interferon beta-1a*)	Tier 4 (PSP)	PA; QL (1 ML per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (*interferon beta-1a*)	Tier 4 (PSP)	PA; QL (12 SYRINGES per 28 DAYs)
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (*interferon beta-1a*)	Tier 4 (PSP)	PA; QL (1 ML per 28 days)
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG, 0.5 MG (*fingolimod lauryl sulfate*)	Tier 5 (NPSP)	PA; QL (30 TABLETS per 30 days)
TECFIDERA ORAL CAPSULE DELAYED RELEASE 120 MG, 240 MG (*dimethyl fumarate*)	NF	
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG (*dimethyl fumarate*)	NF	
teriflunomide oral tablet 14 mg, 7 mg	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 DAYs)
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML (*natalizumab*)	Tier 4 (PSP)	PA; QL (1 ML per 28 days)
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG (*diroximel fumarate*)	Tier 4 (PSP)	PA; QL (120 CAPSULES per 30 days)
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (*ozanimod hcl*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Ulcerative Colitis); QL (1 PACK per 7 days)
ZEPOSIA ORAL CAPSULE 0.92 MG (*ozanimod hcl*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Ulcerative Colitis); QL (30 CAPSULES per 30 days)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (*ozanimod hcl*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Ulcerative Colitis); QL (1 KIT per 28 days)
MUSCULOSKELETAL THERAPY AGENTS		
baclofen oral tablet 10 mg, 20 mg, 5 mg	Tier 1 (G)	
carisoprodol oral tablet 250 mg	NF	
carisoprodol oral tablet 350 mg	Tier 1 (G)	QL (84 TABLETS per 28 days)
chlorzoxazone oral tablet 250 mg, 375 mg, 750 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
chlorzoxazone oral tablet 500 mg	Tier 1 (G)	N8 (Listing does not include certain NDCs)
cyclobenzaprine hcl er oral capsule extended release 24 hour 15 mg, 30 mg	NF	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	Tier 1 (G)	
cyclobenzaprine hcl oral tablet 7.5 mg	NF	
DANTRIUM ORAL CAPSULE 25 MG (*dantrolene sodium*)	Tier 2 (PB)	
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	Tier 1 (G)	
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (*givinostat hcl*)	NF	
LYVISPAH ORAL PACKET 10 MG, 20 MG, 5 MG (*baclofen*)	Tier 2 (PB)	
metaxalone oral tablet 400 mg	NF	
metaxalone oral tablet 800 mg	Tier 1 (G)	
methocarbamol oral tablet 500 mg, 750 mg	Tier 1 (G)	N8 (Listing does not include certain NDCs)
norgesic forte oral tablet 50-770-60 mg	NF	
orphenadrine-aspirin-caffeine (Norgesic Oral Tablet 25-385-30 Mg)	NF	
orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg	NF	
orphenadrine-aspirin-caffeine (Orphengesic Forte Oral Tablet 50-770-60 Mg)	NF	
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (*palovarotene*)	NF	
SOMA ORAL TABLET 250 MG, 350 MG (*carisoprodol*)	Tier 3 (NPB)	QL (84 TABLETS per 28 DAYs)
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg	Tier 1 (G)	
tizanidine hcl oral tablet 2 mg, 4 mg	Tier 1 (G)	
MYASTHENIA GRAVIS - DRUGS TO TREAT MYASTHENIA GRAVIS		
pyridostigmine bromide er oral tablet extended release 180 mg	Tier 1 (G)	
pyridostigmine bromide oral solution 60 mg/5ml	Tier 1 (G)	
pyridostigmine bromide oral tablet 30 mg, 60 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	Tier 1 (G)	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (*sodium oxybate*)	Tier 4 (PSP)	PA; QL (30 PACKETS per 30 days)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (*sodium oxybate*)	Tier 4 (PSP)	PA
modafinil oral tablet 100 mg, 200 mg	Tier 1 (G)	
sodium oxybate oral solution 500 mg/ml	NF	
SUNOSI ORAL TABLET 150 MG, 75 MG (*solriamfetol hcl*)	Tier 2 (PB)	
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (*pitolisant hcl*)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
XYREM ORAL SOLUTION 500 MG/ML (*sodium oxybate*)	NF	
XYWAV ORAL SOLUTION 500 MG/ML (*ca, mg, k, and na oxybates*)	Tier 4 (PSP)	PA; QL (540 ML per 30 days)
OPIOID AGONIST/ANTAGONIST		
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	Tier 1 (G)	QL (60 FILM per 25 days)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg	Tier 1 (G)	QL (90 FILM per 25 days)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	CE	QL (90 TABLETS per 25 DAYs)
SUBOXONE SUBLINGUAL FILM 12-3 MG (*buprenorphine hcl-naloxone hcl*)	Tier 3 (NPB)	QL (60 FILMS per 25 DAYs)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG (*buprenorphine hcl-naloxone hcl*)	Tier 3 (NPB)	QL (90 FILM per 25 days)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 2.9-0.71 MG, 5.7-1.4 MG (*buprenorphine hcl-naloxone hcl*)	Tier 2 (PB)	QL (90 TABLETS per 25 DAYs)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG (*buprenorphine hcl-naloxone hcl*)	Tier 2 (PB)	QL (30 TABLETS per 25 DAYs)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG (*buprenorphine hcl-naloxone hcl*)	Tier 2 (PB)	QL (60 TABLETS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONIST		
KLOXXADO NASAL LIQUID 8 MG/0.1ML (*naloxone hcl*)	Tier 2 (PB)	QL (4 SPRAYS per 25 days)
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	Tier 1 (G)	
naloxone hcl injection solution cartridge 0.4 mg/ml	Tier 1 (G)	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	Tier 1 (G)	
naloxone hcl nasal liquid 4 mg/0.1ml	Tier 1 (G)	QL (4 SPRAYS per 25 days)
naltrexone hcl oral tablet 50 mg	CE	
NARCAN NASAL LIQUID 4 MG/0.1ML (*naloxone hcl*)	Tier 3 (NPB)	QL (4 SPRAYS per 25 days)
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (*nalmefene hcl*)	Tier 3 (NPB)	QL (4 SPRAYS per 25 days)
REXTOVY NASAL LIQUID 4 MG/0.25ML (*naloxone hcl*)	Tier 3 (NPB)	QL (4 SPRAYS per 25 DAYs)
RIVIVE NASAL LIQUID 3 MG/0.1ML (*naloxone hcl*)	Tier 3 (NPB)	QL (4 SPRAYS per 25 DAYs)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (*naltrexone*)	Tier 5 (NPSP)	QL (380 MG per 28 days)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (*naloxone hcl*)	Tier 3 (NPB)	QL (4 SYRINGES per 25 days)
OPIOID PARTIAL AGONISTS		
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	CE	QL (90 TABLETS per 25 DAYs)
POSTHERPETIC NEURALGIA (PHN)		
gabapentin (once-daily) oral tablet 300 mg, 600 mg	Tier 1 (G)	
GRALISE ORAL TABLET 300 MG, 450 MG, 600 MG, 750 MG, 900 MG (*gabapentin (once-daily)*)	Tier 2 (PB)	
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	Tier 1 (G)	
PSYCHOTHERAPEUTIC-MISC		
ADDYI ORAL TABLET 100 MG (*flibanserin*)	Tier 3 (NPB)	SPC
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	Tier 1 (G)	
fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lofexidine hcl oral tablet 0.18 mg	Tier 1 (G)	
LUCEMYRA ORAL TABLET 0.18 MG (*lofexidine hcl*)	Tier 3 (NPB)	
NUEDEXTA ORAL CAPSULE 20-10 MG (*dextromethorphan-quinidine*)	Tier 2 (PB)	
paroxetine mesylate oral capsule 7.5 mg	NF	
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	Tier 1 (G)	
pimozide oral tablet 1 mg, 2 mg	Tier 1 (G)	
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (*bremelanotide acetate*)	Tier 3 (NPB)	SPC
SMOKING DETERRENTS		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	CE	N7 (G); N8 ($0 copay limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 days)
cvs nicotine mouth/throat gum 4 mg	CE	N7 (G); N8 ($0 limited to 2 treatment cycles/year); QL (2 treatment cycles per 365 days)
cvs nicotine polacrilex mouth/throat gum 2 mg	CE	N7 (G); N8 ($0 copay limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 days)
cvs nicotine polacrilex mouth/throat gum 4 mg	CE	N7 (G); N8 ($0 limited to 2 treatment cycles/year); QL (2 treatment cycles per 365 days)
cvs nicotine polacrilex mouth/throat lozenge 2 mg	CE	N7 (G); N8 ($0 copay limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 days)
cvs nicotine polacrilex mouth/throat lozenge 4 mg	CE	N7 (G); N8 ($0 copay limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cvs nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr	CE	N7 (G); N8 ($0 copay limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 DAYs)
cvs nicotine transdermal patch 24 hour 7 mg/24hr	CE	N7 (G); N8 ($0 copay limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 days)
NICOTROL INHALATION INHALER 10 MG (*nicotine*)	CE	N7 (NPB); N8 ($0 copay limited to 2 treatment cycles/year); QL (168 DAYS OF TREATMENT per 365 days)
NICOTROL NS NASAL SOLUTION 10 MG/ML (*nicotine*)	CE	N7 (NPB); N8 ($0 copay limited to 2 treatment cycles/year); QL (168 DAYS OF TREATMENT per 365 days)
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	CE	N7 (G); N8 ($0 limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 Days)
varenicline tartrate oral tablet 0.5 mg, 1 mg	CE	N7 (G); N8 ($0 limited to 2 treatment cycles/year); QL (2 TREATMENT CYCLES per 365 days)
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ACROMEGALY - DRUGS TO TREAT CONDITIONS THAT CAUSE EXCESSIVE GROWTH		
MYCAPSSA ORAL CAPSULE DELAYED RELEASE 20 MG (*octreotide acetate*)	NF	
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	Tier 1 (G)	PA; QL (90 ML per 30 days)
octreotide acetate injection solution 1000 mcg/ml	Tier 1 (G)	PA; QL (45 ML per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
octreotide acetate injection solution 200 mcg/ml	Tier 1 (G)	PA; QL (225 ML per 30 days)
octreotide acetate intramuscular kit 20 mg, 30 mg	NF	
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	Tier 1 (G)	PA; QL (90 ML per 30 days)
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML (*octreotide acetate*)	Tier 5 (NPSP)	PA; QL (90 ML per 30 DAYs)
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 20 MG, 30 MG (*octreotide acetate*)	NF	
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML (*lanreotide acetate*)	Tier 4 (PSP)	PA; QL (1 INJECTION per 28 days)
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (*pegvisomant*)	NF	
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%) (*testosterone*)	Tier 3 (NPB)	PA
AVEED INTRAMUSCULAR SOLUTION 750 MG/3ML (*testosterone undecanoate*)	Tier 5 (NPSP)	PA
JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG (*testosterone undecanoate*)	Tier 3 (NPB)	PA
KYZATREX ORAL CAPSULE 100 MG, 150 MG, 200 MG (*testosterone undecanoate*)	Tier 3 (NPB)	PA
methitest oral tablet 10 mg	Tier 3 (NPB)	PA; STX
methyltestosterone oral capsule 10 mg	Tier 1 (G)	PA; STX
NATESTO NASAL GEL 5.5 MG/ACT (*testosterone*)	Tier 2 (PB)	PA
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	Tier 3 (NPB)	PA
testosterone cypionate injection solution 200 mg/ml	Tier 3 (NPB)	PA
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	Tier 1 (G)	PA
testosterone enanthate intramuscular solution 200 mg/ml	Tier 1 (G)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
testosterone transdermal gel 1.62 %, 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	Tier 1 (G)	PA
testosterone transdermal solution 30 mg/act	Tier 1 (G)	PA
TLANDO ORAL CAPSULE 112.5 MG (*testosterone undecanoate*)	Tier 3 (NPB)	PA
VOGELXO PUMP TRANSDERMAL GEL 12.5 MG/ACT (1%) (*testosterone*)	Tier 3 (NPB)	PA
VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	Tier 3 (NPB)	PA
XYOSTED SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/0.5ML, 50 MG/0.5ML, 75 MG/0.5ML (*testosterone enanthate*)	Tier 2 (PB)	PA
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	
miglitol oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	
ANTIDIABETICS, AMYLIN ANALOGS		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML (*pramlintide acetate*)	Tier 2 (PB)	
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML (*pramlintide acetate*)	Tier 2 (PB)	
ANTIDIABETICS, BIGUANIDE		
GLUMETZA ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG, 500 MG (*metformin hcl*)	NF	
metformin hcl er (mod) oral tablet extended release 24 hour 1000 mg, 500 mg	NF	
metformin hcl er (osm) oral tablet extended release 24 hour 1000 mg, 500 mg	NF	
metformin hcl er oral tablet extended release 24 hour 500 mg	Tier 1 (G)	LGC
metformin hcl er oral tablet extended release 24 hour 750 mg	Tier 1 (G)	
metformin hcl oral solution 500 mg/5ml	Tier 1 (G)	
metformin hcl oral tablet 1000 mg, 500 mg	Tier 1 (G)	LGC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
metformin hcl oral tablet 850 mg	CE	LGC; N7 (G); AL (Min 35 Years and Max 70 Years)
ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS		
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	Tier 1 (G)	LGC
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR COMBINATIONS		
alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg	Tier 1 (G)	
alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg	Tier 1 (G)	
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (*sitagliptin-metformin hcl*)	Tier 2 (PB)	
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (*sitagliptin-metformin hcl*)	Tier 2 (PB)	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (*linagliptin-metformin hcl*)	Tier 2 (PB)	
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG (*linagliptin-metformin hcl*)	Tier 2 (PB)	
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 12.5-2.5-1000 MG, 25-5-1000 MG, 5-2.5-1000 MG (*empagliflozin-linaglip-metform*)	Tier 2 (PB)	
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg	Tier 1 (G)	
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (*sitagliptin phosphate*)	Tier 2 (PB)	
TRADJENTA ORAL TABLET 5 MG (*linagliptin*)	Tier 2 (PB)	
ANTIDIABETICS, INCRETIN MIMETIC AGENTS		
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML (*exenatide*)	Tier 3 (NPB)	ST

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML (*exenatide*)	Tier 3 (NPB)	ST
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML (*exenatide*)	Tier 3 (NPB)	ST
liraglutide subcutaneous solution pen-injector 18 mg/3ml	Tier 1 (G)	ST
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide*)	Tier 2 (PB)	ST
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (*semaglutide*)	Tier 2 (PB)	ST
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (*semaglutide*)	Tier 2 (PB)	ST
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (*semaglutide*)	Tier 2 (PB)	ST
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (*semaglutide*)	Tier 2 (PB)	ST
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML (*dulaglutide*)	Tier 2 (PB)	ST
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide*)	Tier 2 (PB)	ST
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (*insulin glargine-lixisenatide*)	Tier 2 (PB)	
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML (*insulin degludec-liraglutide*)	Tier 2 (PB)	
ANTIDIABETICS, INSULIN		
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	Tier 2 (PB)	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIASP INJECTION SOLUTION 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	Tier 2 (PB)	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	Tier 2 (PB)	
HUMALOG INJECTION SOLUTION 100 UNIT/ML (*insulin lispro*)	Tier 2 (PB)	
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	Tier 3 (NPB)	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin lispro*)	Tier 2 (PB)	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (*insulin lispro prot & lispro*)	Tier 2 (PB)	
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML (*insulin lispro prot & lispro*)	Tier 2 (PB)	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	Tier 2 (PB)	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	Tier 2 (PB)	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin lispro*)	Tier 2 (PB)	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Tier 2 (PB)	
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Tier 2 (PB)	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	Tier 2 (PB)	
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	Tier 2 (PB)	
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML (*insulin regular human*)	Tier 2 (PB)	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (*insulin regular human*)	Tier 2 (PB)	
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	Tier 2 (PB)	
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	Tier 2 (PB)	
insulin aspart injection solution 100 unit/ml	Tier 2 (PB)	
insulin aspart penfill subcutaneous solution cartridge 100 unit/ml	Tier 2 (PB)	
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	Tier 2 (PB)	
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	Tier 2 (PB)	
insulin lispro injection solution 100 unit/ml	Tier 2 (PB)	
insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml	Tier 2 (PB)	
insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml	Tier 2 (PB)	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	Tier 2 (PB)	
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin glargine*)	Tier 2 (PB)	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin detemir*)	Tier 2 (PB)	
LYUMJEV INJECTION SOLUTION 100 UNIT/ML (*insulin lispro-aabc*)	Tier 2 (PB)	
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin lispro-aabc*)	Tier 2 (PB)	
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Tier 2 (PB)	
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	Tier 2 (PB)	
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	Tier 2 (PB)	
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin regular human*)	Tier 2 (PB)	
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	Tier 2 (PB)	
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	Tier 3 (NPB)	
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart*)	Tier 2 (PB)	
NOVOLOG INJECTION SOLUTION 100 UNIT/ML (*insulin aspart*)	Tier 2 (PB)	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	Tier 2 (PB)	
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	Tier 2 (PB)	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin aspart*)	Tier 2 (PB)	
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*)	Tier 2 (PB)	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*)	Tier 2 (PB)	
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin degludec*)	Tier 2 (PB)	
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin degludec*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIABETICS, INSULIN SENSITIZER		
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	Tier 1 (G)	LGC
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	Tier 1 (G)	
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	Tier 1 (G)	
ANTIDIABETICS, MEGLITINIDE		
nateglinide oral tablet 120 mg, 60 mg	Tier 1 (G)	LGC
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	
ANTIDIABETICS, MISCELLANEOUS		
KORLYM ORAL TABLET 300 MG (*mifepristone*)	NF	
mifepristone oral tablet 300 mg	NF	
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS		
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (*canagliflozin-metformin hcl*)	Tier 2 (PB)	
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (*canagliflozin-metformin hcl*)	Tier 2 (PB)	
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (*empagliflozin-metformin hcl*)	Tier 2 (PB)	
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG (*empagliflozin-metformin hcl*)	Tier 2 (PB)	
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG (*dapagliflozin prop-metformin*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (*empagliflozin-linagliptin*)	Tier 2 (PB)	
QTERN ORAL TABLET 10-5 MG, 5-5 MG (*dapagliflozin-saxagliptin*)	Tier 2 (PB)	
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS		
FARXIGA ORAL TABLET 10 MG, 5 MG (*dapagliflozin propanediol*)	Tier 2 (PB)	
JARDIANCE ORAL TABLET 10 MG, 25 MG (*empagliflozin*)	Tier 2 (PB)	
ANTIDIABETICS, SULFONYLUREA		
glimepiride oral tablet 1 mg, 2 mg, 4 mg	Tier 1 (G)	LGC
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	LGC
glipizide oral tablet 10 mg, 5 mg	Tier 1 (G)	LGC
glipizide oral tablet 2.5 mg	Tier 1 (G)	
glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	LGC
ANTIOBESITY		
ADIPEX-P ORAL TABLET 37.5 MG (*phentermine hcl*)	Tier 3 (NPB)	PA; SPC; QL (30 TABLETS per 25 DAYs)
benzphetamine hcl oral tablet 50 mg	Tier 1 (G)	PA; SPC; QL (90 TABLETS per 25 days)
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (*naltrexone-bupropion hcl*)	Tier 3 (NPB)	PA; SPC; QL (120 TABLETS per 25 days)
diethylpropion hcl er oral tablet extended release 24 hour 75 mg	Tier 1 (G)	PA; SPC; QL (30 TABLETS per 25 days)
diethylpropion hcl oral tablet 25 mg	Tier 1 (G)	PA; SPC; QL (90 TABLETS per 25 days)
LOMAIRA ORAL TABLET 8 MG (*phentermine hcl*)	Tier 3 (NPB)	PA; SPC; QL (90 TABLETS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
orlistat oral capsule 120 mg	Tier 1 (G)	PA; SPC; QL (90 CAPSULES per 25 days)
phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg	Tier 3 (NPB)	PA; SPC; QL (30 CAPSULES per 25 DAYs)
phendimetrazine tartrate oral tablet 35 mg	Tier 1 (G)	PA; SPC; QL (180 TABLETS per 25 days)
phentermine hcl oral capsule 15 mg	Tier 1 (G)	PA; SPC; QL (60 CAPSULES per 25 days)
phentermine hcl oral capsule 30 mg, 37.5 mg	Tier 1 (G)	PA; SPC; QL (30 CAPSULES per 25 days)
phentermine hcl oral tablet 37.5 mg	Tier 1 (G)	PA; SPC; QL (30 TABLETS per 25 days)
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (*phentermine-topiramate*)	Tier 2 (PB)	PA; SPC; QL (30 CAPSULES per 25 days)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide -weight management*)	Tier 2 (PB)	PA; SPC; QL (5 PENS per 25 days)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML (*semaglutide-weight management*)	Tier 2 (PB)	PA; SPC; QL (4 PENS per 21 days)
XENICAL ORAL CAPSULE 120 MG (*orlistat*)	Tier 3 (NPB)	PA; SPC; QL (90 CAPSULES per 25 DAYs)
ZEPBOUND SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML, 5 MG/0.5ML (*tirzepatide-weight management*)	Tier 3 (NPB)	PA; SPC; QL (4 VIALS per 21 DAYs)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide-weight management*)	Tier 2 (PB)	PA; SPC; QL (4 PENS per 21 days)
CALCIUM RECEPTOR AGONISTS		
cinacalcet hcl oral tablet 30 mg, 60 mg	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
cinacalcet hcl oral tablet 90 mg	Tier 4 (PSP)	PA; QL (120 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARSABIV INTRAVENOUS SOLUTION 10 MG/2ML, 2.5 MG/0.5ML, 5 MG/ML (*etelcalcetide hcl*)	NF	
SENSIPAR ORAL TABLET 30 MG, 60 MG (*cinacalcet hcl*)	Tier 5 (NPSP)	PA; QL (60 TABLETS per 30 days)
SENSIPAR ORAL TABLET 90 MG (*cinacalcet hcl*)	Tier 5 (NPSP)	PA; QL (120 TABLETS per 30 days)
CALCIUM REGULATORS, BISPHOSPHONATES - DRUGS TO TREAT BONE LOSS		
alendronate sodium oral solution 70 mg/75ml	Tier 1 (G)	
alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg	Tier 1 (G)	
ibandronate sodium intravenous solution 3 mg/3ml	Tier 1 (G)	
ibandronate sodium oral tablet 150 mg	Tier 1 (G)	
pamidronate disodium intravenous solution 30 mg/10ml, 90 mg/10ml	Tier 1 (G)	
pamidronate disodium intravenous solution 6 mg/ml	Tier 5 (NPSP)	
RECLAST INTRAVENOUS SOLUTION 5 MG/100ML (*zoledronic acid*)	Tier 5 (NPSP)	PA
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	Tier 1 (G)	
risedronate sodium oral tablet delayed release 35 mg	Tier 1 (G)	
zoledronic acid intravenous concentrate 4 mg/5ml	Tier 1 (G)	PA
zoledronic acid intravenous solution 4 mg/100ml	Tier 5 (NPSP)	PA
zoledronic acid intravenous solution 5 mg/100ml	Tier 1 (G)	PA
CALCIUM REGULATORS, MISCELLANEOUS		
calcitonin (salmon) nasal solution 200 unit/act	Tier 1 (G)	
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab*)	Tier 4 (PSP)	PA; QL (60 MG per 168 days)
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab*)	Tier 5 (NPSP)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM REGULATORS, PARATHYROID HORMONES		
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 600 MCG/2.4ML (*teriparatide*)	Tier 5 (NPSP)	PA; QL (1 PEN per 28 days)
teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml	Tier 4 (PSP)	PA; QL (1 PEN per 28 DAYs)
teriparatide subcutaneous solution pen-injector 620 mcg/2.48ml	NF	
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (*abaloparatide*)	Tier 4 (PSP)	PA; QL (1 PEN per 30 days)
YORVIPATH SUBCUTANEOUS SOLUTION PEN-INJECTOR 168 MCG/0.56ML, 294 MCG/0.98ML, 420 MCG/1.4ML (*palopegteriparatide*)	NF	
CARNITINE DEFICIENCY AGENTS		
CARNITOR ORAL SOLUTION 1 GM/10ML (*levocarnitine*)	NF	
CARNITOR ORAL TABLET 330 MG (*levocarnitine*)	NF	
CARNITOR SF ORAL SOLUTION 1 GM/10ML (*levocarnitine*)	NF	
levocarnitine oral solution 1 gm/10ml	Tier 1 (G)	
levocarnitine oral tablet 330 mg	Tier 1 (G)	
CENTRAL PRECOCIOUS PUBERTY - DRUGS TO SUPPRESS PITUITARY HORMONES		
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (*leuprolide acetate*)	Tier 4 (PSP)	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG (*leuprolide acetate (3 month)*)	Tier 4 (PSP)	PA
TRIPTODUR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 22.5 MG (*triptorelin pamoate*)	NF	
CHELATING AGENTS		
CUPRIMINE ORAL CAPSULE 250 MG (*penicillamine*)	NF	
CUVRIOR ORAL TABLET 300 MG (*trientine tetrahydrochloride*)	NF	
deferasirox granules oral packet 180 mg, 360 mg, 90 mg	Tier 4 (PSP)	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	Tier 4 (PSP)	PA
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	Tier 4 (PSP)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
deferiprone oral tablet 1000 mg, 500 mg	Tier 4 (PSP)	PA
deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg	Tier 4 (PSP)	PA
DESFERAL INJECTION SOLUTION RECONSTITUTED 500 MG (*deferoxamine mesylate*)	NF	
EXJADE ORAL TABLET SOLUBLE 125 MG, 250 MG, 500 MG (*deferasirox*)	NF	
FERRIPROX ORAL SOLUTION 100 MG/ML (*deferiprone*)	NF	
FERRIPROX ORAL TABLET 1000 MG, 500 MG (*deferiprone*)	NF	
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG (*deferiprone*)	NF	
JADENU ORAL TABLET 180 MG, 360 MG, 90 MG (*deferasirox*)	NF	
JADENU SPRINKLE ORAL PACKET 180 MG, 360 MG, 90 MG (*deferasirox*)	NF	
penicillamine oral capsule 250 mg	Tier 4 (PSP)	
penicillamine oral tablet 250 mg	Tier 1 (G)	
SYPRINE ORAL CAPSULE 250 MG (*trientine hcl*)	NF	
trientine hcl oral capsule 250 mg, 500 mg	Tier 4 (PSP)	
CONTRACEPTIVES - PRODUCTS FOR BIRTH CONTROL		
levonorgestrel-ethinyl estrad (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
AFTERA ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
AFTERPILL ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
levonorgestrel-ethinyl estrad (Altavera Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
alyacen 1/35 oral tablet 1-35 mg-mcg	CE	N7 (G)
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	CE	N7 (G)
levonorgestrel-ethinyl estrad (Amethyst Oral Tablet 90-20 Mcg)	CE	N7 (G)
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (*segesterone-ethinyl estradiol*)	CE	N7 (PB); QL (1 RING per 300 days)

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desogestrel-ethinyl estradiol (Apri Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
norethin-eth estrad triphasic (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Ashlyna Oral Tablet 0.15-0.03 &0.01 Mg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin ace-eth estrad-fe (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Aviane Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
desogestrel-ethinyl estradiol (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (G)
norethindrone-eth estradiol (Balziva Oral Tablet 0.4-35 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin ace-eth estrad-fe (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
briellyn oral tablet 0.4-35 mg-mcg	CE	N7 (G)
norethindrone (Camila Oral Tablet 0.35 Mg)	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levonorgest-eth estrad 91-day (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Camrese Oral Tablet 0.15-0.03 &0.01 Mg)	CE	N7 (G)
CAYA VAGINAL DIAPHRAGM (*diaphragm arc-spring*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
norethin ace-eth estrad-fe (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	CE	N7 (G)
levonorgestrel-ethinyl estrad (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
condoms	CE	N7 (Not Covered)
norgestrel-ethinyl estradiol (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	CE	N7 (G)
CURAE ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
desogestrel-ethinyl estradiol (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
norethindrone-eth estradiol (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	CE	N7 (G)
norethin-eth estrad triphasic (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Daysee Oral Tablet 0.15-0.03 &0.01 Mg)	CE	N7 (G)
norethindrone (Deblitane Oral Tablet 0.35 Mg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Delyla Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (*medroxyprogesterone acetate*)	Tier 2 (PB)	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (*medroxyprogesterone acetate*)	Tier 2 (PB)	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (*medroxyprogesterone acetate*)	CE	N7 (PB); QL (4 ML per 300 days)
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levonorgestrel-ethinyl estrad (Dolishale Oral Tablet 90-20 Mcg)	CE	N7 (G)
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	CE	N7 (G)
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	CE	N7 (G)
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
norgestrel-ethinyl estradiol (Elinest Oral Tablet 0.3-30 Mg-Mcg)	CE	N7 (G)
ELLA ORAL TABLET 30 MG (*ulipristal acetate*)	CE	N7 (NPB)
norethindrone (Emzahh Oral Tablet 0.35 Mg)	CE	N7 (G)
levonorg-eth estrad triphasic (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	CE	N7 (G)
desogestrel-ethinyl estradiol (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
norethindrone (Errin Oral Tablet 0.35 Mg)	CE	N7 (G)
norgestimate-eth estradiol (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (G)
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	CE	N7 (G)
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	CE	N7 (G); QL (13 RING per 300 days)
levonorgestrel-ethinyl estrad (Falmina Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
FC2 FEMALE CONDOM (*condoms - female*)	CE	N7 (NPB)
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (*cervical caps*)	CE	N7 (NPB); QL (1 DEVICE per 300 days)
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (*norethindrone acet-ethinyl est*)	CE	N7 (NPB)
norethin ace-eth estrad-fe (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin ace-eth estrad-fe (Gemmily Oral Capsule 1-20 Mg-Mcg(24))	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acet-ethinyl est (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin ace-eth estrad-fe (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
etonogestrel-ethinyl estradiol (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	CE	N7 (G); QL (13 RING per 300 DAYs)
norethindrone (Heather Oral Tablet 0.35 Mg)	CE	N7 (G)
HER STYLE ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
levonorgest-eth estrad 91-day (Iclevia Oral Tablet 0.15-0.03 Mg)	CE	N7 (G)
norethindrone (Incassia Oral Tablet 0.35 Mg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Introvale Oral Tablet 0.15-0.03 Mg)	CE	N7 (G)
desogestrel-ethinyl estradiol (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Jaimiess Oral Tablet 0.15-0.03 &0.01 Mg)	CE	N7 (G)
drospirenone-ethinyl estradiol (Jasmiel Oral Tablet 3-0.02 Mg)	CE	N7 (G)
norethindrone (Jencycla Oral Tablet 0.35 Mg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Jolessa Oral Tablet 0.15-0.03 Mg)	CE	N7 (G)
levonorgest-eth estrad-fe bisg (Joyeaux Oral Tablet 0.1-20 Mg-Mcg(21))	CE	N7 (G)
desogestrel-ethinyl estradiol (Juleber Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethin ace-eth estrad-fe (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin-eth estradiol-fe (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	CE	N7 (G)
desogestrel-ethinyl estradiol (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
desogestrel-ethinyl estradiol (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (G)
ethynodiol diac-eth estradiol (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	CE	N7 (G)
ethynodiol diac-eth estradiol (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (*levonorgestrel*)	CE	N7 (PB); QL (1 INTRAUTERINE DEVICE per 300 days)
norethindrone acet-ethinyl est (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin ace-eth estrad-fe (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norethin-eth estradiol-fe (Layolis Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethin-eth estrad triphasic (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Lessina Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
levonorg-eth estrad triphasic (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	CE	N7 (G)
levonorgest-eth est & eth est oral tablet 42-21-21-7 days	CE	N7 (G)
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 &0.01 mg, 0.15-0.03 mg	CE	N7 (G)
levonorgestrel oral tablet 1.5 mg	CE	N7 (Not Covered)
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg	CE	N7 (G)
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	CE	N7 (G)
levonorgestrel-ethinyl estrad (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (*levonorgestrel*)	CE	N7 (NF)
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (*norethin-eth estrad-fe biphas*)	CE	N7 (PB)
norethindrone acet-ethinyl est (Loestrin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Loestrin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Loestrin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Loestrin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	CE	N7 (G)
drospirenone-ethinyl estradiol (Loryna Oral Tablet 3-0.02 Mg)	CE	N7 (G)
norgestrel-ethinyl estradiol (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
drospirenone-ethinyl estradiol (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Lutera Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
norethindrone (Lyleq Oral Tablet 0.35 Mg)	CE	N7 (G)
norethindrone (Lyza Oral Tablet 0.35 Mg)	CE	N7 (G)
marlissa oral tablet 0.15-30 mg-mcg	CE	N7 (G)
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	CE	N7 (G); QL (4 ML per 300 days)
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	CE	N7 (G); QL (4 ML per 300 days)
norethin ace-eth estrad-fe (Merzee Oral Capsule 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin ace-eth estrad-fe (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	CE	N7 (G)
norethindrone acet-ethinyl est (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norgestimate-eth estradiol (Mili Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (G)
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (*levonorgestrel*)	CE	N7 (PB); QL (1 INTRAUTERINE DEVICE per 300 Days)
norgestimate-eth estradiol (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (G)
MY CHOICE ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
MY WAY ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (*estradiol valerate-dienogest*)	CE	N7 (PB)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone-eth estradiol (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	CE	N7 (G)
NEW DAY ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG (*etonogestrel*)	CE	N7 (NPB); QL (1 IMPLANT per 300 days)
NEXTSTELLIS ORAL TABLET 3-14.2 MG (*drospirenone-estetrol*)	CE	N7 (NPB)
drospirenone-ethinyl estradiol (Nikki Oral Tablet 3-0.02 Mg)	CE	N7 (G)
norethindrone (Nora-Be Oral Tablet 0.35 Mg)	CE	N7 (G)
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	CE	N7 (G)
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	CE	N7 (G)
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	CE	N7 (G)
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	CE	N7 (G)
norethindrone oral tablet 0.35 mg	CE	N7 (G)
norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg	CE	N7 (G)
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg	CE	N7 (G)
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	CE	N7 (G)
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg	CE	N7 (G)
norethindrone (Norlyroc Oral Tablet 0.35 Mg)	CE	N7 (G)
norethindrone-eth estradiol (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	CE	N7 (G)
norethindrone-eth estradiol (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	CE	N7 (G)
norethin-eth estrad triphasic (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	CE	N7 (G)
NUVARING VAGINAL RING 0.12-0.015 MG/24HR (*etonogestrel-ethinyl estradiol*)	Tier 3 (NPB)	QL (13 RING per 300 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone-eth estradiol (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	CE	N7 (G)
norethin-eth estrad triphasic (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	CE	N7 (G)
drospirenone-ethinyl estradiol (Ocella Oral Tablet 3-0.03 Mg)	CE	N7 (G)
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (*diaphragms*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
OPCICON ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
OPILL ORAL TABLET 0.075 MG (*norgestrel*)	CE	N7 (Not Covered)
OPTION 2 ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (*copper*)	CE	N7 (NPB); QL (1 INTRAUTERINE DEVICE per 300 days)
norethindrone-eth estradiol (Philith Oral Tablet 0.4-35 Mg-Mcg)	CE	N7 (G)
desogestrel-ethinyl estradiol (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (G)
norethin-eth estrad triphasic (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
REACT ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
desogestrel-ethinyl estradiol (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
levonorgest-eth estrad 91-day (Rivelsa Oral Tablet 42-21-21-7 Days)	CE	N7 (G)
levonorgest-eth estrad 91-day (Setlakin Oral Tablet 0.15-0.03 Mg)	CE	N7 (G)
norethindrone (Sharobel Oral Tablet 0.35 Mg)	CE	N7 (G)
desogestrel-ethinyl estradiol (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (G)
levonorgest-eth estrad 91-day (Simpesse Oral Tablet 0.15-0.03 &0.01 Mg)	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (*levonorgestrel*)	CE	N7 (PB); QL (1 INTRAUTERINE DEVICE per 300 days)
SLYND ORAL TABLET 4 MG (*drospirenone*)	CE	N7 (NPB)
norgestimate-eth estradiol (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
drospirenone-ethinyl estradiol (Syeda Oral Tablet 3-0.03 Mg)	CE	N7 (G)
TAKE ACTION ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
norethin ace-eth estrad-fe (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	CE	N7 (G)
norethin ace-eth estrad-fe (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	CE	N7 (G)
norethindron-ethinyl estrad-fe (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (G)
norethindron-ethinyl estrad-fe (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norgestim-eth estrad triphasic (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (G)
levonorg-eth estrad triphasic (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	CE	N7 (G)
norgestim-eth estrad triphasic (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	CE	N7 (G)
norgestrel-ethinyl estradiol (Turqoz Oral Tablet 0.3-30 Mg-Mcg)	CE	N7 (G)
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (*levonorgestrel-eth estradiol*)	CE	N7 (NPB)
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (*levonorgestrel-ethinyl estrad*)	CE	N7 (NPB)
drospiren-eth estrad-levomefol (Tydemy Oral Tablet 3-0.03-0.451 Mg)	CE	N7 (G)
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (*desogestrel-ethinyl estradiol*)	CE	N7 (G)
drospirenone-ethinyl estradiol (Vestura Oral Tablet 3-0.02 Mg)	CE	N7 (G)
levonorgestrel-ethinyl estrad (Vienva Oral Tablet 0.1-20 Mg-Mcg)	CE	N7 (G)
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	CE	N7 (G)
desogestrel-ethinyl estradiol (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (G)
norethindrone-eth estradiol (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	CE	N7 (G)
norgestimate-eth estradiol (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	CE	N7 (G)
norethindrone-eth estradiol (Wera Oral Tablet 0.5-35 Mg-Mcg)	CE	N7 (G)
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % (*diaphragm wide seal*)	CE	N7 (NPB); QL (1 DIAPHRAGM per 300 days)
norethin-eth estradiol-fe (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	CE	N7 (G)
norelgestromin-eth estradiol (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	CE	N7 (G)
norelgestromin-eth estradiol (Zafemy Transdermal Patch Weekly 150-35 Mcg/24Hr)	CE	N7 (G)
ethynodiol diac-eth estradiol (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	CE	N7 (G)
drospirenone-ethinyl estradiol (Zumandimine Oral Tablet 3-0.03 Mg)	CE	N7 (G)
CORTISOL SYNTHESIS INHIBITORS		
ISTURISA ORAL TABLET 1 MG, 5 MG (*osilodrostat phosphate*)	NF	
RECORLEV ORAL TABLET 150 MG (*levoketoconazole*)	NF	
DIABETIC SUPPLIES		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP (*glucose blood*)	Tier 2 (PB)	QL (150 TEST STRIPS per 25 days)
ACCU-CHEK FASTCLIX LANCET KIT (*lancets misc.*)	Tier 2 (PB)	
ACCU-CHEK FASTCLIX LANCETS (*lancets*)	Tier 2 (PB)	
ACCU-CHEK GUIDE TEST IN VITRO STRIP (*glucose blood*)	Tier 2 (PB)	QL (150 TEST STRIPS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCU-CHEK SAFE-T PRO LANCETS (*lancets*)	Tier 2 (PB)	
ACCU-CHEK SMARTVIEW IN VITRO STRIP (*glucose blood*)	Tier 2 (PB)	QL (150 TEST STRIPS per 25 days)
ACCU-CHEK SOFTCLIX LANCET DEV KIT (*lancets misc.*)	Tier 2 (PB)	
ACCU-CHEK SOFTCLIX LANCETS (*lancets*)	Tier 2 (PB)	
ACCUTREND GLUCOSE IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
ADVANCE MICRO-DRAW TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
alcohol swabs pad	Tier 3 (NPB)	
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (*insulin syringe/needle u-500*)	Tier 2 (PB)	N8 (BD syringes and needles are the only preferred options)
BD PEN NEEDLE MICRO U/F 32G X 6 MM (*insulin pen needle*)	Tier 2 (PB)	N8 (BD syringes and needles are the only preferred options)
BD PEN NEEDLE MINI U/F 31G X 5 MM (*insulin pen needle*)	Tier 2 (PB)	N8 (BD syringes and needles are the only preferred options)
BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM (*insulin pen needle*)	Tier 2 (PB)	N8 (BD syringes and needles are the only preferred options)
BD PEN NEEDLE NANO U/F 32G X 4 MM (*insulin pen needle*)	Tier 2 (PB)	N8 (BD syringes and needles are the only preferred options)
BD PEN NEEDLE ORIGINAL U/F 29G X 12.7MM (*insulin pen needle*)	Tier 2 (PB)	N8 (BD syringes and needles are the only preferred options)
BD PEN NEEDLE SHORT U/F 31G X 8 MM (*insulin pen needle*)	Tier 2 (PB)	N8 (BD syringes and needles are the only preferred options)
CARETOUCH TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
CONTOUR NEXT TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
CONTOUR TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
CVS ADVANCED GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
D-CARE BLOOD GLUCOSE IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
DEXCOM G6 RECEIVER DEVICE (*continuous glucose receiver*)	Tier 2 (PB)	
DEXCOM G6 SENSOR (*continuous glucose sensor*)	Tier 2 (PB)	QL (3 SENSORS per 25 days)
DEXCOM G6 TRANSMITTER (*continuous glucose transmitter*)	Tier 2 (PB)	
DEXCOM G7 RECEIVER DEVICE (*continuous glucose receiver*)	Tier 2 (PB)	
DEXCOM G7 SENSOR (*continuous glucose sensor*)	Tier 2 (PB)	QL (3 SENSORS per 25 days)
EASY TOUCH TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
EASYMAX 15 TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
EASYMAX TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
EMBRACE BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
EMBRACE WAVE BLOOD GLUCOSE IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 test strips per 25 days)
ENLITE GLUCOSE SENSOR (*continuous glucose sensor*)	Tier 3 (NPB)	QL (5 SENSORS per 25 DAYs)
eq blood glucose test in vitro strip	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
EVERSENSE 365 SENSOR/HOLDER (*continuous glucose sensor*)	Tier 3 (NPB)	
EVERSENSE 365 SMART TRANSMIT (*continuous glucose transmitter*)	Tier 3 (NPB)	
EVERSENSE SENSOR/HOLDER (*continuous glucose sensor*)	Tier 3 (NPB)	QL (1 SENSOR per 75 DAYs)
FORA 6 CONNECT/GTEL TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 DAYs)
FREESTYLE LIBRE 14 DAY SENSOR (*continuous glucose sensor*)	Tier 2 (PB)	QL (2 SENSORS per 21 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 2 SENSOR (*continuous glucose sensor*)	Tier 2 (PB)	QL (2 SENSORS per 21 DAYs)
FREESTYLE LIBRE 3 PLUS SENSOR (*continuous glucose sensor*)	Tier 3 (NPB)	QL (2 SENSORS per 25 DAYs)
FREESTYLE LIBRE 3 READER DEVICE (*continuous glucose receiver*)	Tier 2 (PB)	
FREESTYLE LIBRE 3 SENSOR (*continuous glucose sensor*)	Tier 2 (PB)	QL (2 SENSORS per 21 days)
FREESTYLE LIBRE READER DEVICE (*continuous glucose receiver*)	Tier 2 (PB)	
FREESTYLE PRECISION NEO TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
glucose control in vitro solution	Tier 3 (NPB)	
GOJJI BLOOD TEST STRIP/LANCETS IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
GUARDIAN 4 GLUCOSE SENSOR (*continuous glucose sensor*)	Tier 3 (NPB)	QL (5 SENSORS per 21 DAYs)
GUARDIAN 4 TRANSMITTER (*continuous glucose transmitter*)	Tier 3 (NPB)	
GUARDIAN SENSOR (3) (*continuous glucose sensor*)	Tier 3 (NPB)	QL (5 SENSORS per 21 DAYs)
guardian sensor 3	Tier 3 (NPB)	QL (5 SENSORS per 21 DAYs)
LIBERTY GLUCOSE CONTROL IN VITRO SOLUTION HIGH (*blood glucose calibration*)	Tier 3 (NPB)	
liberty test in vitro strip	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
MICRODOT TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
NEUTEK 2TEK TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (*insulin disposable pump*)	Tier 2 (PB)	
OMNIPOD 5 DEXG7G6 PODS GEN 5 (*insulin disposable pump*)	Tier 2 (PB)	
OMNIPOD CLASSIC PODS (GEN 3) (*insulin disposable pump*)	Tier 2 (PB)	

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CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMNIPOD DASH INTRO (GEN 4) KIT (*insulin disposable pump*)	Tier 2 (PB)	
OMNIPOD DASH PDM (GEN 4) KIT (*insulin disposable pump*)	Tier 2 (PB)	
OMNIPOD DASH PODS (GEN 4) (*insulin disposable pump*)	Tier 2 (PB)	
OMNIPOD GO KIT 10 UNIT/24HR, 15 UNIT/24HR, 20 UNIT/24HR, 25 UNIT/24HR, 30 UNIT/24HR, 35 UNIT/24HR, 40 UNIT/24HR (*insulin disposable pump*)	Tier 3 (NPB)	
ONETOUCH DELICA PLUS LANCET30G (*lancets*)	Tier 2 (PB)	
ONETOUCH DELICA PLUS LANCET33G (*lancets*)	Tier 2 (PB)	
ONETOUCH DELICA PLUS LANCING (*lancet devices*)	Tier 2 (PB)	
ONETOUCH ULTRA TEST IN VITRO STRIP (*glucose blood*)	Tier 2 (PB)	QL (150 TEST STRIPS per 25 Days)
ONETOUCH ULTRASOFT 2 LANCETS (*lancets*)	Tier 2 (PB)	
ONETOUCH VERIO IN VITRO STRIP (*glucose blood*)	Tier 2 (PB)	QL (150 TEST STRIPS per 25 days)
OPTIUMEZ TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
PRECISION XTRA BLOOD GLUCOSE IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
premium blood glucose test in vitro strip	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
QUINTET AC BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
QUINTET BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
RELION ULTIMA TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
SUPREME TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
true focus blood glucose strip in vitro strip	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUETEST TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
TRUETRACK TEST IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
UNISTRIP CONTROL IN VITRO SOLUTION LOW (*blood glucose calibration*)	Tier 3 (NPB)	
UNISTRIP1 GENERIC IN VITRO STRIP (*glucose blood*)	Tier 3 (NPB)	QL (150 TEST STRIPS per 25 days)
V-GO 20 KIT 20 UNIT/24HR (*insulin disposable pump*)	Tier 2 (PB)	
V-GO 30 KIT 30 UNIT/24HR (*insulin disposable pump*)	Tier 2 (PB)	
V-GO 40 KIT 40 UNIT/24HR (*insulin disposable pump*)	Tier 2 (PB)	
ENDOMETRIOSIS		
danazol oral capsule 100 mg, 200 mg, 50 mg	Tier 1 (G)	
ORILISSA ORAL TABLET 150 MG, 200 MG (*elagolix sodium*)	Tier 2 (PB)	
SYNAREL NASAL SOLUTION 2 MG/ML (*nafarelin acetate*)	Tier 3 (NPB)	PA
FERTILITY REGULATORS		
cetrorelix acetate subcutaneous kit 0.25 mg	Tier 4 (PSP)	PA; SPC
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (*cetrorelix acetate*)	NF	
chorionic gonadotropin intramuscular solution reconstituted 10000 unit	NF	
CLOMID ORAL TABLET 50 MG (*clomiphene citrate*)	Tier 1 (G)	SPC
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML, 600 UNT/0.72ML, 900 UNT/1.08ML (*follitropin beta*)	Tier 4 (PSP)	PA; SPC
ganirelix acetate (Fyremadel Subcutaneous Solution Prefilled Syringe 250 Mcg/0.5Ml)	NF	
ganirelix acetate solution prefilled syringe 250 mcg/0.5ml subcutaneous	NF	
ganirelix acetate solution prefilled syringe 250 mcg/0.5ml subcutaneous	Tier 4 (PSP)	PA; SPC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GONAL-F INJECTION SOLUTION RECONSTITUTED 1050 UNIT, 450 UNIT (*follitropin alfa*)	NF	
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/0.5ML, 450 UNT/0.75ML, 900 UNIT/1.5ML (*follitropin alfa*)	NF	
GONAL-F RFF SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (*follitropin alfa*)	NF	
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (*menotropins*)	Tier 4 (PSP)	PA; SPC
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (*chorionic gonadotropin*)	NF	
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (*choriogonadotropin alfa*)	Tier 4 (PSP)	PA
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (*chorionic gonadotropin*)	NF	
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
AGAMREE ORAL SUSPENSION 40 MG/ML (*vamorolone*)	NF	
ALKINDI SPRINKLE ORAL CAPSULE SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG (*hydrocortisone*)	Tier 3 (NPB)	
deflazacort oral suspension 22.75 mg/ml	NF	
deflazacort oral tablet 18 mg, 30 mg, 36 mg, 6 mg	NF	
dexamethasone oral elixir 0.5 mg/5ml	Tier 1 (G)	
dexamethasone oral solution 0.5 mg/5ml	Tier 1 (G)	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	Tier 1 (G)	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	Tier 1 (G)	
EMFLAZA ORAL SUSPENSION 22.75 MG/ML (*deflazacort*)	NF	
EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG (*deflazacort*)	NF	
fludrocortisone acetate oral tablet 0.1 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dexamethasone (Hidex 6-Day Oral Tablet Therapy Pack 1.5 Mg (21))	Tier 1 (G)	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	Tier 1 (G)	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	Tier 1 (G)	
methylprednisolone oral tablet therapy pack 4 mg	Tier 1 (G)	
prednisolone oral solution 15 mg/5ml	Tier 1 (G)	
prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml	NF	
prednisolone sodium phosphate oral solution 15 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml	Tier 1 (G)	
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	Tier 1 (G)	
prednisone oral solution 5 mg/5ml	Tier 1 (G)	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	Tier 1 (G)	
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	Tier 1 (G)	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (*dexamethasone*)	Tier 1 (G)	
dexamethasone (Taperdex 6-Day Oral Tablet Therapy Pack 1.5 Mg, 1.5 Mg (21))	NF	
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (*dexamethasone*)	Tier 1 (G)	
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (*glucagon*)	Tier 2 (PB)	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (*glucagon*)	Tier 2 (PB)	
BD GLUCOSE ORAL TABLET CHEWABLE 5 GM (*dextrose (diabetic use)*)	Tier 3 (NPB)	
diazoxide oral suspension 50 mg/ml	Tier 1 (G)	
glucagon emergency injection kit 1 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
glucose oral tablet chewable 4 gm	Tier 3 (NPB)	
gnp glucose gummies oral tablet chewable 2 gm	Tier 1 (G)	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (*glucagon*)	Tier 2 (PB)	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (*glucagon*)	Tier 2 (PB)	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (*glucagon*)	Tier 2 (PB)	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (*glucagon*)	Tier 2 (PB)	
lanreotide acetate solution 120 mg/0.5ml subcutaneous	NF	
lanreotide acetate solution 120 mg/0.5ml subcutaneous	Tier 4 (PSP)	PA; QL (1 INJECTION per 28 days)
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (*dasiglucagon hcl*)	Tier 2 (PB)	
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (*dasiglucagon hcl*)	Tier 2 (PB)	
GROWTH IMPROVEMENT AGENTS - DRUGS TO PROMOTE GROWTH		
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (*vosoritide*)	Tier 5 (NPSP)	PA; QL (30 VIALS per 30 days)
HEREDITARY TYROSINEMIA TYPE 1 AGENTS - DRUGS FOR REPLACEMENT, MODIFICATION, TREATMENT		
nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg	Tier 4 (PSP)	PA
NITYR ORAL TABLET 10 MG, 2 MG, 5 MG (*nitisinone*)	NF	
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (*nitisinone*)	Tier 4 (PSP)	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (*nitisinone*)	Tier 4 (PSP)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG (*somatropin*)	NF	
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG (*somatropin*)	NF	
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG (*somatropin*)	Tier 4 (PSP)	PA
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML (*somatrogon-ghla*)	NF	
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML (*somatropin*)	Tier 4 (PSP)	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (*somatropin*)	NF	
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML (*somatropin*)	NF	
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML (*somatropin*)	NF	
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML (*somatropin*)	NF	
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (*somatropin*)	NF	
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (*somatropin (non-refrigerated)*)	Tier 5 (NPSP)	PA
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (*lonapegsomatropin-tcgd*)	NF	
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (*somapacitan-beco*)	Tier 4 (PSP)	PA; QL (4 PENS per 28 days)
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG (*somatropin*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LYSOSOMAL STORAGE DISORDERS - DRUGS TO TREAT LYSOSOMAL STORAGE DISORDERS		
ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5ML (*laronidase*)	Tier 5 (NPSP)	PA
AQNEURSA ORAL PACKET 1 GM (*levacetylleucine*)	NF	
ELAPRASE INTRAVENOUS SOLUTION 6 MG/3ML (*idursulfase*)	Tier 5 (NPSP)	PA
KANUMA INTRAVENOUS SOLUTION 20 MG/10ML (*sebelipase alfa*)	Tier 5 (NPSP)	PA
LUMIZYME INTRAVENOUS SOLUTION RECONSTITUTED 50 MG (*alglucosidase alfa*)	Tier 5 (NPSP)	PA
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (*arimoclomol citrate*)	NF	
NAGLAZYME INTRAVENOUS SOLUTION 1 MG/ML (*galsulfase*)	Tier 5 (NPSP)	PA
OPFOLDA ORAL CAPSULE 65 MG (*miglustat (gaa deficiency)*)	NF	
VIMIZIM INTRAVENOUS SOLUTION 5 MG/5ML (*elosulfase alfa*)	Tier 5 (NPSP)	PA
LYSOSOMAL STORAGE DISORDERS - FABRY DISEASE - DRUGS TO TREAT FABRY DISEASE		
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 35 MG, 5 MG (*agalsidase beta*)	Tier 4 (PSP)	PA
GALAFOLD ORAL CAPSULE 123 MG (*migalastat hcl*)	Tier 4 (PSP)	PA
LYSOSOMAL STORAGE DISORDERS - GAUCHER DISEASE - DRUGS TO TREAT GAUCHER DISEASE		
CERDELGA ORAL CAPSULE 84 MG (*eliglustat tartrate*)	Tier 4 (PSP)	PA; QL (56 CAPSULES per 28 days)
CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT (*imiglucerase*)	Tier 4 (PSP)	PA; QL (15 VIALS per 14 days)
ELELYSO INTRAVENOUS SOLUTION RECONSTITUTED 200 UNIT (*taliglucerase alfa*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
miglustat oral capsule 100 mg	Tier 4 (PSP)	PA; QL (90 CAPSULES per 30 days)
VPRIV INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT (*velaglucerase alfa*)	NF	
ZAVESCA ORAL CAPSULE 100 MG (*miglustat*)	Tier 5 (NPSP)	PA; QL (90 CAPSULES per 30 days)
MENOPAUSAL SYMPTOM AGENTS - DRUGS TO TREAT MENOPAUSE		
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (*estradiol-levonorgestrel*)	Tier 2 (PB)	
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (*estradiol-norethindrone acet*)	Tier 2 (PB)	
DUAVEE ORAL TABLET 0.45-20 MG (*conj estrogens-bazedoxifene*)	Tier 2 (PB)	
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	
estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm	Tier 1 (G)	
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	Tier 1 (G)	
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	Tier 1 (G)	
estradiol vaginal cream 0.1 mg/gm	Tier 1 (G)	
estradiol vaginal tablet 10 mcg	Tier 1 (G)	
estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml	Tier 1 (G)	
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	Tier 1 (G)	
ESTRING VAGINAL RING 7.5 MCG/24HR (*estradiol*)	Tier 2 (PB)	
norethindrone-eth estradiol (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg, 1-5 Mg-Mcg)	Tier 1 (G)	
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG (*estradiol*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (*estradiol*)	Tier 2 (PB)	
norethindrone-eth estradiol (Jinteli Oral Tablet 1-5 Mg-Mcg)	Tier 1 (G)	
estradiol-norethindrone acet (Mimvey Oral Tablet 1-0.5 Mg)	Tier 1 (G)	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (*estrogens conjugated*)	Tier 2 (PB)	
PREMARIN VAGINAL CREAM 0.625 MG/GM (*estrogens, conjugated*)	Tier 2 (PB)	
PREMPHASE ORAL TABLET 0.625-5 MG (*conj estrog-medroxyprogest ace*)	Tier 2 (PB)	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (*conj estrog-medroxyprogest ace*)	Tier 2 (PB)	
MISCELLANEOUS		
ACTHAR GEL SUBCUTANEOUS AUTO-INJECTOR 40 UNIT/0.5ML, 80 UNIT/ML (*corticotropin*)	Tier 5 (NPSP)	PA; QL (28 PENS per 28 days)
ACTHAR INJECTION GEL 80 UNIT/ML (*corticotropin*)	Tier 5 (NPSP)	PA; QL (35 ML per 21 days)
betaine oral powder	Tier 4 (PSP)	PA
cabergoline oral tablet 0.5 mg	Tier 1 (G)	
CORTROPHIN INJECTION GEL 80 UNIT/ML (*corticotropin*)	Tier 5 (NPSP)	PA; QL (35 ML per 21 days)
CYSTADANE ORAL POWDER (*betaine*)	NF	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (*cysteamine bitartrate*)	Tier 4 (PSP)	PA
EVENITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 105 MG/1.17ML (*romosozumab-aqqg*)	NF	
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (*setmelanotide acetate*)	NF	
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (*mecasermin*)	Tier 5 (NPSP)	PA
JYNARQUE ORAL TABLET 15 MG, 30 MG (*tolvaptan*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JYNARQUE ORAL TABLET THERAPY PACK 15 MG, 30 & 15 MG, 45 & 15 MG, 60 & 30 MG, 90 & 30 MG (*tolvaptan*)	NF	
KUVAN ORAL PACKET 100 MG, 500 MG (*sapropterin dihydrochloride*)	NF	
KUVAN ORAL TABLET 100 MG (*sapropterin dihydrochloride*)	NF	
methylergonovine maleate (Methergine Oral Tablet 0.2 Mg)	Tier 1 (G)	
methylergonovine maleate oral tablet 0.2 mg	Tier 1 (G)	
mifepristone oral tablet 200 mg	Tier 1 (G)	N7 (G); N8 (Available at $0 copay)
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (*metreleptin*)	Tier 5 (NPSP)	PA; QL (30 VIALS per 30 days)
OSPHENA ORAL TABLET 60 MG (*ospemifene*)	Tier 2 (PB)	
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 2.5 MG/0.5ML, 20 MG/ML (*pegvaliase-pqpz*)	NF	
raloxifene hcl oral tablet 60 mg	CE	N7 (G); AL (Min 35 Years)
SAMSCA ORAL TABLET 15 MG, 30 MG (*tolvaptan*)	Tier 5 (NPSP)	PA
sapropterin dihydrochloride oral packet 100 mg, 500 mg	Tier 4 (PSP)	PA
sapropterin dihydrochloride oral tablet 100 mg	Tier 4 (PSP)	PA
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 10 MG, 20 MG, 30 MG, 40 MG, 60 MG (*pasireotide pamoate*)	NF	
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (*pasireotide diaspartate*)	Tier 5 (NPSP)	PA; QL (60 ML per 30 days)
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML (*asfotase alfa*)	Tier 5 (NPSP)	PA
tolvaptan oral tablet 15 mg, 30 mg	Tier 4 (PSP)	PA
VIJOICE ORAL PACKET 50 MG (*alpelisib*)	NF	
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 200 & 50 MG, 50 MG (*alpelisib*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XURIDEN ORAL PACKET 2 GM (*uridine triacetate*)	Tier 5 (NPSP)	QL (4 PACKETS per 1 DAY)
ZOKINVY ORAL CAPSULE 50 MG, 75 MG (*lonafarnib*)	Tier 5 (NPSP)	PA; QL (120 CAPSULES per 30 days)
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
AURYXIA ORAL TABLET 1 GM 210 MG(FE) (*ferric citrate*)	Tier 2 (PB)	
calcium acetate (phos binder) oral capsule 667 mg	Tier 1 (G)	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	NF	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	Tier 1 (G)	
sevelamer carbonate oral tablet 800 mg	Tier 1 (G)	
sevelamer hcl oral tablet 400 mg, 800 mg	Tier 1 (G)	
POLYNEUROPATHY		
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (*eplontersen sodium*)	NF	
POTASSIUM-REMOVING AGENTS - DRUGS TO REGULATE POTASSIUM		
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (*sodium polystyrene sulfonate*)	Tier 1 (G)	
POTASSIUM-REMOVING AGENTS - DRUGS TO REGULATE POTASSIUM LEVELS		
LOKELMA ORAL PACKET 10 GM, 5 GM (*sodium zirconium cyclosilicate*)	Tier 2 (PB)	
sodium polystyrene sulfonate oral powder	Tier 1 (G)	
sodium polystyrene sulfonate (Sps (Sodium Polystyrene Sulf) Combination Suspension 15 Gm/60Ml)	Tier 1 (G)	
VELTASSA ORAL PACKET 1 GM, 16.8 GM, 25.2 GM, 8.4 GM (*patiromer sorbitex calcium*)	Tier 2 (PB)	
PROGESTINS - DRUGS TO REGULATE PROGESTIN		
CRINONE VAGINAL GEL 4 %, 8 % (*progesterone*)	Tier 2 (PB)	
ENDOMETRIN VAGINAL INSERT 100 MG (*progesterone*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml	CE	N7 (G)
norethindrone acetate oral tablet 5 mg	Tier 1 (G)	
progesterone oral capsule 100 mg, 200 mg	Tier 1 (G)	
PROMETRIUM ORAL CAPSULE 100 MG, 200 MG (*progesterone*)	NF	
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
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	Tier 1 (G)	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	Tier 1 (G)	
methimazole oral tablet 10 mg, 5 mg	Tier 1 (G)	
propylthiouracil oral tablet 50 mg	Tier 1 (G)	
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 (*levothyroxine sodium*)	Tier 2 (PB)	
UREA CYCLE DISORDER - DRUGS TO TREAT UREA CYCLE DISORDER		
BUPHENYL ORAL POWDER 3 GM/TSP (*sodium phenylbutyrate*)	NF	
BUPHENYL ORAL TABLET 500 MG (*sodium phenylbutyrate*)	NF	
CARBAGLU ORAL TABLET SOLUBLE 200 MG (*carglumic acid*)	NF	
carglumic acid oral tablet soluble 200 mg	Tier 4 (PSP)	PA
OLPRUVA (2 GM DOSE) ORAL THERAPY PACK 2 GM (*sodium phenylbutyrate*)	NF	
OLPRUVA (3 GM DOSE) ORAL THERAPY PACK 3 GM (*sodium phenylbutyrate*)	NF	
OLPRUVA (4 GM DOSE) ORAL THERAPY PACK 2 & 2 GM (*sodium phenylbutyrate*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OLPRUVA (5 GM DOSE) ORAL THERAPY PACK 2 & 3 GM (*sodium phenylbutyrate*)	NF	
OLPRUVA (6 GM DOSE) ORAL THERAPY PACK 3 & 3 GM (*sodium phenylbutyrate*)	NF	
OLPRUVA (6.67 GM DOSE) ORAL THERAPY PACK 3 & 3.67 GM (*sodium phenylbutyrate*)	NF	
PHEBURANE ORAL PELLET 483 MG/GM (*sodium phenylbutyrate*)	Tier 4 (PSP)	PA; QL (672 G per 30 days)
RAVICTI ORAL LIQUID 1.1 GM/ML (*glycerol phenylbutyrate*)	NF	
sodium phenylbutyrate oral powder 3 gm/tsp	Tier 4 (PSP)	PA; QL (798 G per 30 days)
sodium phenylbutyrate oral tablet 500 mg	Tier 4 (PSP)	PA; QL (1200 TABLETS per 30 days)
UTERINE FIBROIDS - DRUGS TO TREAT UTERINE FIBROIDS		
MYFEMBREE ORAL TABLET 40-1-0.5 MG (*relugolix-estradiol-norethind*)	Tier 2 (PB)	
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (*elagolix-estradiol-norethind*)	Tier 2 (PB)	
VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES		
desmopressin ace spray refrig nasal solution 0.01 %	Tier 1 (G)	
desmopressin acetate nasal solution 1.5 mg/ml	Tier 5 (NPSP)	PA
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	Tier 1 (G)	
desmopressin acetate spray nasal solution 0.01 %	Tier 1 (G)	
VITAMIN D ANALOGS		
calcitriol oral capsule 0.25 mcg, 0.5 mcg	Tier 1 (G)	
calcitriol oral solution 1 mcg/ml	Tier 1 (G)	
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	Tier 1 (G)	
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	Tier 1 (G)	
ROCALTROL ORAL CAPSULE 0.25 MCG, 0.5 MCG (*calcitriol*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROCALTROL ORAL SOLUTION 1 MCG/ML (*calcitriol*)	Tier 2 (PB)	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (*paricalcitol*)	Tier 2 (PB)	
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTICHOLINERGICS		
dicyclomine hcl oral capsule 10 mg	Tier 1 (G)	
dicyclomine hcl oral tablet 20 mg	Tier 1 (G)	
GLYCATE ORAL TABLET 1.5 MG (*glycopyrrolate*)	NF	
glycopyrrolate oral solution 1 mg/5ml	Tier 1 (G)	
glycopyrrolate oral tablet 1 mg, 2 mg	Tier 1 (G)	
glycopyrrolate oral tablet 1.5 mg	NF	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	Tier 1 (G)	
ANTIDIARRHEALS		
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	Tier 1 (G)	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	Tier 1 (G)	
LOMOTIL ORAL TABLET 2.5-0.025 MG (*diphenoxylate-atropine*)	Tier 2 (PB)	
MYTESI ORAL TABLET DELAYED RELEASE 125 MG (*crofelemer*)	NF	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg	Tier 1 (G)	
prochlorperazine (Compro Rectal Suppository 25 Mg)	Tier 1 (G)	
doxylamine-pyridoxine oral tablet delayed release 10-10 mg	Tier 1 (G)	
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	Tier 1 (G)	
granisetron hcl oral tablet 1 mg	Tier 1 (G)	
metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml	Tier 1 (G)	
metoclopramide hcl oral tablet 10 mg, 5 mg	Tier 1 (G)	
metoclopramide hcl oral tablet dispersible 5 mg	Tier 1 (G)	
ondansetron hcl oral solution 4 mg/5ml	Tier 1 (G)	
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ondansetron oral tablet dispersible 4 mg, 8 mg	Tier 1 (G)	
prochlorperazine maleate oral tablet 10 mg, 5 mg	Tier 1 (G)	
promethazine hcl oral solution 6.25 mg/5ml	Tier 1 (G)	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	Tier 1 (G)	
promethazine hcl rectal suppository 12.5 mg, 25 mg	Tier 1 (G)	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (*promethazine hcl*)	Tier 1 (G)	
SANCUSO TRANSDERMAL PATCH 3.1 MG/24HR (*granisetron*)	Tier 2 (PB)	
scopolamine transdermal patch 72 hour 1 mg/3days	Tier 1 (G)	
trimethobenzamide hcl oral capsule 300 mg	Tier 1 (G)	
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK 2 X 90 MG (*rolapitant hcl*)	Tier 2 (PB)	
ANTISPASMODICS - DRUGS FOR MUSCLE SPASM		
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	Tier 1 (G)	N8 (Listing does not include certain NDCs)
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
cimetidine oral tablet 300 mg, 400 mg, 800 mg	Tier 1 (G)	
famotidine oral tablet 40 mg	Tier 1 (G)	
nizatidine oral capsule 150 mg, 300 mg	Tier 1 (G)	
INFLAMMATORY BOWEL DISEASE - BOWEL, INTESTINE, AND STOMACH CONDITION DRUGS		
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (*mesalamine*)	Tier 3 (NPB)	
balsalazide disodium oral capsule 750 mg	Tier 1 (G)	
budesonide er oral tablet extended release 24 hour 9 mg	Tier 1 (G)	
budesonide oral capsule delayed release particles 3 mg	Tier 1 (G)	
COLAZAL ORAL CAPSULE 750 MG (*balsalazide disodium*)	NF	
CORTIFOAM EXTERNAL FOAM 10 % (*hydrocortisone acetate*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
mesalamine er oral capsule extended release 24 hour 0.375 gm	Tier 1 (G)	
mesalamine er oral capsule extended release 500 mg	Tier 1 (G)	
mesalamine oral capsule delayed release 400 mg	Tier 1 (G)	
mesalamine oral tablet delayed release 1.2 gm, 800 mg	Tier 1 (G)	
mesalamine rectal enema 4 gm	Tier 1 (G)	
mesalamine rectal suppository 1000 mg	Tier 1 (G)	
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG, 500 MG (*mesalamine*)	Tier 2 (PB)	
sulfasalazine oral tablet 500 mg	Tier 1 (G)	
sulfasalazine oral tablet delayed release 500 mg	Tier 1 (G)	
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (*linaclotide*)	Tier 2 (PB)	
lubiprostone oral capsule 24 mcg, 8 mcg	Tier 1 (G)	
IRRITABLE BOWEL SYNDROME WITH DIARRHEA		
alosetron hcl oral tablet 0.5 mg, 1 mg	Tier 1 (G)	
VIBERZI ORAL TABLET 100 MG, 75 MG (*eluxadoline*)	Tier 2 (PB)	
LAXATIVES - DRUGS FOR CONSTIPATION		
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/175ML (*sod picosulfate-mag ox-cit acd*)	CE	N7 (NPB); N8 ($0 copay for members age 45 through 75); AL (Min 45 Years and Max 75 Years)
enulose oral solution 10 gm/15ml	Tier 1 (G)	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (*peg 3350-kcl-nabcb-nacl-nasulf*)	Tier 1 (G)	
peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)	Tier 1 (G)	
KRISTALOSE ORAL PACKET 10 GM (*lactulose*)	Tier 3 (NPB)	
lactulose oral packet 10 gm	NF	
lactulose oral solution 10 gm/15ml	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (*peg-kcl-nacl-nasulf-na asc-c*)	Tier 3 (NPB)	
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	CE	N7 (G); N8 ($0 copay for members age 45 through 75); AL (Min 45 Years and Max 75 Years)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	Tier 1 (G)	
peg-3350/electrolytes oral solution reconstituted 236 gm	Tier 1 (G)	
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	CE	N7 (NF)
PEG-PREP ORAL KIT 5-210 MG-GM (*bisacodyl-peg-kcl-nabicar-nacl*)	CE	N7 (NPB); N8 ($0 copay for members age 45 through 75); AL (Min 45 Years and Max 75 Years)
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (*peg-kcl-nacl-nasulf-na asc-c*)	CE	N7 (NPB); N8 ($0 copay for members age 45 through 75); AL (Min 45 Years and Max 75 Years)
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (*peg 3350-kcl-nacl-nasulf-mgsul*)	CE	N7 (NPB); N8 ($0 copay for members age 45 through 75); AL (Min 45 Years and Max 75 Years)
SUTAB ORAL TABLET 1479-225-188 MG (*sodium sulfate-mag sulfate-kcl*)	CE	N7 (NPB); N8 ($0 copay for members age 45 through 75); AL (Min 45 Years and Max 75 Years)
MISCELLANEOUS		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG, 600 MCG (*odevixibat*)	NF	
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG (*odevixibat*)	NF	
CHENODAL ORAL TABLET 250 MG (*chenodiol*)	Tier 5 (NPSP)	PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (*cholic acid*)	Tier 5 (NPSP)	PA
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (*misoprostol*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GATTEX SUBCUTANEOUS KIT 5 MG (*teduglutide (rdna)*)	Tier 5 (NPSP)	PA; QL (1 KIT per 30 days)
IQIRVO ORAL TABLET 80 MG (*elafibranor*)	NF	
LIVDELZI ORAL CAPSULE 10 MG (*seladelpar lysine*)	NF	
LIVMARLI ORAL SOLUTION 19 MG/ML (*maralixibat chloride*)	Tier 5 (NPSP)	PA; QL (60 ML per 30 DAYs)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (*maralixibat chloride*)	Tier 5 (NPSP)	PA; QL (90 ML per 30 days)
misoprostol oral tablet 100 mcg, 200 mcg	CE	N7 (G); N8 (Available at $0 copay)
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (*naloxegol oxalate*)	Tier 2 (PB)	
OCALIVA ORAL TABLET 10 MG, 5 MG (*obeticholic acid*)	Tier 5 (NPSP)	PA; QL (30 TABLETS per 30 days)
SUCRAID ORAL SOLUTION 8500 UNIT/ML (*sacrosidase*)	Tier 5 (NPSP)	
sucralfate oral suspension 1 gm/10ml	NF	
sucralfate oral tablet 1 gm	Tier 1 (G)	
SYMPROIC ORAL TABLET 0.2 MG (*naldemedine tosylate*)	Tier 2 (PB)	
URSO FORTE ORAL TABLET 500 MG (*ursodiol*)	Tier 2 (PB)	
ursodiol oral capsule 300 mg	Tier 1 (G)	
ursodiol oral tablet 250 mg, 500 mg	Tier 1 (G)	
VOWST ORAL CAPSULE (*fecal microb spores, live-brpk*)	Tier 5 (NPSP)	PA; QL (12 CAPSULES per 30 DAYs)
XERMELO ORAL TABLET 250 MG (*telotristat etiprate*)	Tier 5 (NPSP)	PA; QL (84 TABLETS per 28 days)
PANCREATIC ENZYMES		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (*pancrelipase (lip-prot-amyl)*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (*pancrelipase (lip-prot-amyl)*)	Tier 2 (PB)	
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 (*pancrelipase (lip-prot-amyl)*)	Tier 2 (PB)	
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
ACIPHEX ORAL TABLET DELAYED RELEASE 20 MG (*rabeprazole sodium*)	Tier 3 (NPB)	QL (90 TABLETS per 365 days)
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG (*dexlansoprazole*)	Tier 3 (NPB)	QL (90 CAPSULES per 365 days)
dexlansoprazole oral capsule delayed release 30 mg, 60 mg	Tier 1 (G)	QL (90 CAPSULES per 365 days)
esomeprazole magnesium oral capsule delayed release 20 mg	Tier 1 (G)	QL (90 CAPSULES per 365 DAYs)
esomeprazole magnesium oral capsule delayed release 40 mg	Tier 1 (G)	QL (90 CAPSULES per 365 days)
esomeprazole magnesium oral packet 10 mg, 20 mg, 40 mg	Tier 1 (G)	QL (90 PACKET per 365 days)
esomeprazole magnesium oral tablet delayed release 20 mg	Tier 1 (G)	Select OTC; QL (90 TABLETS per 365 DAYs)
KONVOMEP ORAL SUSPENSION RECONSTITUTED 2-84 MG/ML (*omeprazole-sodium bicarbonate*)	Tier 3 (NPB)	QL (1800 ML per 365 DAYs)
lansoprazole oral capsule delayed release 30 mg	Tier 1 (G)	QL (90 CAPSULES per 365 DAYs)
lansoprazole oral tablet delayed release dispersible 30 mg	NF	
NEXIUM 24HR ORAL TABLET DELAYED RELEASE 20 MG (*esomeprazole magnesium*)	Tier 1 (G)	Select OTC; QL (90 tablets per 365 days)
NEXIUM ORAL CAPSULE DELAYED RELEASE 40 MG (*esomeprazole magnesium*)	Tier 3 (NPB)	QL (90 CAPSULES per 365 DAYs)
NEXIUM ORAL PACKET 10 MG, 2.5 MG, 20 MG, 40 MG, 5 MG (*esomeprazole magnesium*)	Tier 3 (NPB)	QL (90 PACKETS per 365 DAYs)

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg	Tier 1 (G)	Select OTC; QL (90 CAPSULES per 365 days)
omeprazole magnesium oral tablet delayed release 20 mg	Tier 1 (G)	Select OTC; QL (90 TABLETS per 365 DAYs)
omeprazole oral capsule delayed release 10 mg, 40 mg	Tier 1 (G)	QL (90 CAPSULES per 365 days)
omeprazole oral capsule delayed release 20 mg	Tier 1 (G)	Select OTC; QL (90 CAPSULES per 365 days)
omeprazole-sodium bicarbonate oral capsule 20-1100 mg	Tier 1 (G)	QL (90 CAPSULES per 365 DAYs)
omeprazole-sodium bicarbonate oral capsule 40-1100 mg	NF	
omeprazole-sodium bicarbonate oral packet 20-1680 mg, 40-1680 mg	NF	
pantoprazole sodium oral packet 40 mg	NF	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	Tier 1 (G)	QL (90 TABLETS per 365 days)
PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG (*lansoprazole*)	Tier 3 (NPB)	QL (90 CAPSULES per 365 DAYs)
PREVACID SOLUTAB ORAL TABLET DELAYED RELEASE DISPERSIBLE 30 MG (*lansoprazole*)	Tier 3 (NPB)	QL (90 TABLETS per 365 DAYs)
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (*omeprazole magnesium*)	NF	
PRILOSEC OTC ORAL TABLET DELAYED RELEASE 20 MG (*omeprazole magnesium*)	Tier 1 (G)	Select OTC; QL (90 TABLETS per 365 DAYs)
PROTONIX ORAL PACKET 40 MG (*pantoprazole sodium*)	Tier 3 (NPB)	QL (90 PACKETS per 365 DAYs)
PROTONIX ORAL TABLET DELAYED RELEASE 20 MG, 40 MG (*pantoprazole sodium*)	Tier 3 (NPB)	QL (90 TABLETS per 365 DAYs)
qc lansoprazole oral capsule delayed release 15 mg	Tier 1 (G)	Select OTC; QL (90 CAPSULES per 365 DAYs)
ra omeprazole oral tablet delayed release 20 mg	Tier 1 (G)	Select OTC; QL (90 TABLETS per 365 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
rabeprazole sodium oral capsule sprinkle 10 mg	Tier 3 (NPB)	QL (90 CAPSULES per 365 DAYs)
rabeprazole sodium oral tablet delayed release 20 mg	Tier 1 (G)	QL (90 TABLETS per 365 days)
ZEGERID ORAL CAPSULE 40-1100 MG (*omeprazole-sodium bicarbonate*)	NF	
ZEGERID ORAL PACKET 20-1680 MG, 40-1680 MG (*omeprazole-sodium bicarbonate*)	NF	
RECTAL, CORTICOSTEROIDS		
ANUSOL-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*)	Tier 2 (PB)	
hydrocortisone (perianal) external cream 2.5 %	Tier 1 (G)	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (*hydrocortisone ace-pramoxine*)	Tier 2 (PB)	
hydrocortisone (Proctozone-Hc External Cream 2.5 %)	Tier 1 (G)	
ULCER THERAPY COMBINATIONS		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	Tier 1 (G)	
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	Tier 1 (G)	
TALICIA ORAL CAPSULE DELAYED RELEASE 250-12.5-10 MG (*amoxicill-rifabutin-omeprazole*)	Tier 2 (PB)	
GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	Tier 1 (G)	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	Tier 1 (G)	
dutasteride oral capsule 0.5 mg	Tier 1 (G)	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	Tier 1 (G)	
finasteride oral tablet 5 mg	Tier 1 (G)	
silodosin oral capsule 4 mg, 8 mg	Tier 1 (G)	
tamsulosin hcl oral capsule 0.4 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	Tier 1 (G)	LGC
UROXATRAL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG (*alfuzosin hcl*)	NF	
CONTRACEPTIVES - PRODUCTS FOR BIRTH CONTROL		
ENCARE VAGINAL SUPPOSITORY 100 MG (*nonoxynol-9*)	CE	N7 (Not Covered)
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (*nonoxynol-9*)	CE	N7 (Not Covered)
PHEXXI VAGINAL GEL 1.8-1-0.4 % (*lactic ac-citric ac-pot bitart*)	CE	N7 (NPB)
TODAY SPONGE VAGINAL 1000 MG (*nonoxynol-9*)	CE	N7 (Not Covered)
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (*nonoxynol-9*)	CE	N7 (Not Covered)
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (*nonoxynol-9*)	CE	N7 (Not Covered)
ERECTILE DYSFUNCTION		
bi-mix intracavernosal solution reconstituted 150-5 mg	Tier 3 (NPB)	SPC
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (*alprostadil (vasodilator)*)	Tier 3 (NPB)	SPC
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 40 MCG (*alprostadil (vasodilator)*)	Tier 3 (NPB)	SPC
CIALIS ORAL TABLET 10 MG, 20 MG, 5 MG (*tadalafil*)	Tier 3 (NPB)	SPC
EDEX INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG (*alprostadil (vasodilator)*)	Tier 3 (NPB)	SPC
quad-mix intracavernosal solution reconstituted 150-10-0.1-1 mg	Tier 3 (NPB)	SPC
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	Tier 1 (G)	SPC
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (*avanafil*)	NF	
super bi-mix intracavernosal solution reconstituted 150-10 mg	Tier 3 (NPB)	SPC
super quad-mix intracavernosal solution reconstituted 150-20-0.2-2 mg	Tier 3 (NPB)	SPC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
super tri-mix intracavernosal solution reconstituted 150-10-100 mg-mg-mcg	Tier 3 (NPB)	SPC
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Tier 1 (G)	SPC
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Tier 1 (G)	SPC
vardenafil hcl oral tablet dispersible 10 mg	Tier 1 (G)	SPC
VIAGRA ORAL TABLET 100 MG, 25 MG, 50 MG (*sildenafil citrate*)	Tier 3 (NPB)	SPC
MISCELLANEOUS		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	Tier 1 (G)	
ELMIRON ORAL CAPSULE 100 MG (*pentosan polysulfate sodium*)	Tier 3 (NPB)	QL (90 CAPSULES per 25 days)
FILSPARI ORAL TABLET 200 MG, 400 MG (*sparsentan*)	NF	
pot & sod cit-cit ac oral solution 550-500-334 mg/5ml	Tier 1 (G)	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	Tier 1 (G)	
PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG, 75 MG (*cysteamine bitartrate*)	NF	
PROCYSBI ORAL PACKET 300 MG, 75 MG (*cysteamine bitartrate*)	NF	
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5ML (*nedosiran sodium*)	NF	
RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML, 160 MG/ML (*nedosiran sodium*)	NF	
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (*budesonide*)	NF	
THIOLA EC ORAL TABLET DELAYED RELEASE 100 MG, 300 MG (*tiopronin*)	NF	
THIOLA ORAL TABLET 100 MG (*tiopronin*)	NF	
tiopronin oral tablet 100 mg	Tier 4 (PSP)	PA
tiopronin oral tablet delayed release 100 mg, 300 mg	NF	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (*potassium citrate*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (*potassium citrate*)	Tier 2 (PB)	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	Tier 1 (G)	
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	Tier 1 (G)	
flavoxate hcl oral tablet 100 mg	Tier 1 (G)	
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	Tier 1 (G)	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML (*mirabegron*)	Tier 2 (PB)	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG (*mirabegron*)	Tier 2 (PB)	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	Tier 1 (G)	
oxybutynin chloride oral solution 5 mg/5ml	Tier 1 (G)	
oxybutynin chloride oral tablet 5 mg	Tier 1 (G)	
solifenacin succinate oral tablet 10 mg, 5 mg	Tier 1 (G)	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	Tier 1 (G)	
tolterodine tartrate oral tablet 1 mg, 2 mg	Tier 1 (G)	
trospium chloride er oral capsule extended release 24 hour 60 mg	Tier 1 (G)	
trospium chloride oral tablet 20 mg	Tier 1 (G)	
VAGINAL ANTI-INFECTIVES - DRUGS TO TREAT VAGINAL INFECTIONS		
CLEOCIN VAGINAL CREAM 2 % (*clindamycin phosphate*)	Tier 2 (PB)	
clindamycin phosphate vaginal cream 2 %	Tier 1 (G)	
metronidazole vaginal gel 0.75 %	Tier 1 (G)	
miconazole 3 vaginal suppository 200 mg	Tier 1 (G)	
terconazole vaginal cream 0.4 %, 0.8 %	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
terconazole vaginal suppository 80 mg	Tier 1 (G)	
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
ARIXTRA SUBCUTANEOUS SOLUTION 10 MG/0.8ML, 2.5 MG/0.5ML, 5 MG/0.4ML, 7.5 MG/0.6ML (*fondaparinux sodium*)	Tier 2 (PB)	
dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg	Tier 1 (G)	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (*apixaban*)	Tier 2 (PB)	
ELIQUIS ORAL TABLET 2.5 MG, 5 MG (*apixaban*)	Tier 2 (PB)	
enoxaparin sodium injection solution 300 mg/3ml	Tier 1 (G)	
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	Tier 1 (G)	
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	Tier 1 (G)	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (*dalteparin sodium*)	Tier 2 (PB)	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (*dalteparin sodium*)	Tier 2 (PB)	
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml	Tier 1 (G)	
heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml	Tier 1 (G)	
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	Tier 1 (G)	LGC
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (*rivaroxaban*)	Tier 2 (PB)	
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG (*rivaroxaban*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (*rivaroxaban*)	Tier 2 (PB)	
BLEEDING DISORDERS AGENTS		
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor-vwf*)	Tier 5 (NPSP)	PA
CABLIVI INJECTION KIT 11 MG (*caplacizumab-yhdp*)	NF	
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (*coagulation factor x (human)*)	Tier 5 (NPSP)	PA
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (*factor xiii concentrate human*)	Tier 5 (NPSP)	PA
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (*antiinhibitor coagulant cmplx*)	NF	
FIBRYGA INTRAVENOUS SOLUTION RECONSTITUTED (*fibrinogen concentrate (human)*)	Tier 5 (NPSP)	PA
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (*antihemophilic factor-vwf*)	Tier 5 (NPSP)	PA
KCENTRA INTRAVENOUS KIT 1000 UNIT, 500 UNIT (*prothrombin complex conc human*)	Tier 5 (NPSP)	
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (*coagulation factor viia recomb*)	Tier 4 (PSP)	PA
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED (*fibrinogen concentrate (human)*)	Tier 5 (NPSP)	PA
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 5 MG (*coagulation factor viia-jncw*)	Tier 4 (PSP)	PA
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (*coagulation factor xiii a-sub*)	Tier 5 (NPSP)	PA
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (*von willebrand factor (recomb)*)	NF	
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (*antihemophilic factor-vwf*)	Tier 5 (NPSP)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMATOPOIETIC GROWTH FACTORS		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (*darbepoetin alfa*)	Tier 4 (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 (*darbepoetin alfa*)	Tier 4 (PSP)	PA
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (*epoetin alfa*)	NF	
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-jmdb*)	NF	
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-pbbk*)	Tier 4 (PSP)	PA; QL (2 SYRINGES per 28 days)
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML, 480 MCG/1.6ML (*tbo-filgrastim*)	NF	
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*tbo-filgrastim*)	NF	
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG, 8 MG (*daprodustat*)	NF	
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (*sargramostim*)	NF	
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 120 MCG/0.3ML, 150 MCG/0.3ML, 200 MCG/0.3ML, 30 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML (*methoxy peg-epoetin beta*)	NF	
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML (*pegfilgrastim*)	NF	
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim*)	NF	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (*filgrastim*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim*)	NF	
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (*filgrastim-aafi*)	Tier 4 (PSP)	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-aafi*)	Tier 4 (PSP)	PA
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-apgf*)	Tier 4 (PSP)	PA; QL (2 SYRINGES per 28 days)
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (*epoetin alfa*)	Tier 4 (PSP)	PA
releuko subcutaneous solution prefilled syringe 300 mcg/0.5ml, 480 mcg/0.8ml	NF	
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (*epoetin alfa-epbx*)	Tier 4 (PSP)	PA
ROLVEDON SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 13.2 MG/0.6ML (*eflapegrastim-xnst*)	NF	
STIMUFEND SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-fpgk*)	NF	
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (*pegfilgrastim-cbqv*)	NF	
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-cbqv*)	NF	
VAFSEO ORAL TABLET 150 MG, 300 MG (*vadadustat*)	NF	
XOLREMDI ORAL CAPSULE 100 MG (*mavorixafor*)	NF	
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-sndz*)	NF	
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-bmez*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMOPHILIA A AGENTS		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*)	Tier 4 (PSP)	PA
adynovate intravenous solution reconstituted 1000 unit, 1500 unit, 2000 unit, 250 unit, 3000 unit, 500 unit, 750 unit	Tier 4 (PSP)	PA
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact single chain*)	Tier 4 (PSP)	PA
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact fc-vwf-xten-ehtl*)	NF	
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (*antihem fact (bdd-rfviiifc)*)	Tier 4 (PSP)	PA
ESPEROCT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (*antihemoph fact rcmb gpeg-exei*)	Tier 4 (PSP)	PA
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 12 MG/0.4ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML (*emicizumab-kxwh*)	Tier 5 (NPSP)	PA
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*)	Tier 5 (NPSP)	PA
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (*ahf (bdd-rfviii peg-aucl)*)	Tier 4 (PSP)	PA
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*)	Tier 5 (NPSP)	PA
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 500 UNIT (*antihemophilic factor*)	Tier 5 (NPSP)	PA
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihem factor recomb (rfviii)*)	Tier 4 (PSP)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*)	Tier 4 (PSP)	PA
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact bd truncated*)	Tier 4 (PSP)	PA
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,sim)*)	Tier 4 (PSP)	PA
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,sim)*)	Tier 4 (PSP)	PA
obizur intravenous solution reconstituted 500 unit	Tier 5 (NPSP)	PA
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (*antihem factor recomb (rfviii)*)	Tier 5 (NPSP)	PA
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*)	Tier 4 (PSP)	PA
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*)	Tier 4 (PSP)	PA
HEMOPHILIA B AGENTS		
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*coagulation factor ix*)	Tier 5 (NPSP)	PA
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*coagulation factor ix (rfixfc)*)	Tier 4 (PSP)	PA
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*)	NF	
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (*coagulation factor ix (rix-fp)*)	Tier 5 (NPSP)	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IXINITY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*)	NF	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*factor ix complex*)	Tier 5 (NPSP)	PA
REBINYN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix glycopeg*)	Tier 4 (PSP)	PA
rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit	NF	
MISCELLANEOUS		
AGRYLIN ORAL CAPSULE 0.5 MG (*anagrelide hcl*)	Tier 2 (PB)	
aminocaproic acid oral solution 0.25 gm/ml	Tier 1 (G)	
aminocaproic acid oral tablet 1000 mg, 500 mg	Tier 1 (G)	
anagrelide hcl oral capsule 0.5 mg, 1 mg	Tier 1 (G)	
cilostazol oral tablet 100 mg, 50 mg	Tier 1 (G)	
pentoxifylline er oral tablet extended release 400 mg	Tier 1 (G)	
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (*mitapivat sulfate*)	NF	
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG, 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG (*mitapivat sulfate*)	NF	
TAVNEOS ORAL CAPSULE 10 MG (*avacopan*)	Tier 5 (NPSP)	PA; QL (180 CAPSULES per 30 days)
tranexamic acid oral tablet 650 mg	Tier 1 (G)	
PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) AGENTS		
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (*pegcetacoplan*)	Tier 4 (PSP)	PA; QL (10 VIALS per 30 days)
FABHALTA ORAL CAPSULE 200 MG (*iptacopan hcl*)	Tier 5 (NPSP)	PA; QL (60 CAPSULES per 30 days)
VOYDEYA ORAL TABLET 100 MG (*danicopan*)	NF	

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VOYDEYA ORAL TABLET THERAPY PACK 50 & 100 MG (*danicopan*)	NF	
PLATELET AGGREGATION INHIBITORS - BLOOD THINNERS		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	Tier 1 (G)	
BRILINTA ORAL TABLET 60 MG, 90 MG (*ticagrelor*)	Tier 2 (PB)	
clopidogrel bisulfate oral tablet 300 mg, 75 mg	Tier 1 (G)	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	Tier 1 (G)	
prasugrel hcl oral tablet 10 mg, 5 mg	Tier 1 (G)	
SICKLE CELL DISEASE		
ENDARI ORAL PACKET 5 GM (*glutamine (sickle cell)*)	Tier 4 (PSP)	PA; QL (180 PACKETS per 30 days)
l-glutamine oral packet 5 gm	Tier 4 (PSP)	PA; QL (180 PACKETS per 30 DAYs)
SIKLOS ORAL TABLET 100 MG, 1000 MG (*hydroxyurea*)	Tier 2 (PB)	
THROMBOCYTOPENIA AGENTS - DRUGS TO TREAT PLATELET DISORDERS		
DOPTELET ORAL TABLET 20 MG (*avatrombopag maleate*)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
MULPLETA ORAL TABLET 3 MG (*lusutrombopag*)	Tier 5 (NPSP)	PA; QL (7 TABLETS per 14 days)
NPLATE SUBCUTANEOUS SOLUTION RECONSTITUTED 125 MCG, 250 MCG, 500 MCG (*romiplostim*)	NF	
PROMACTA ORAL PACKET 12.5 MG (*eltrombopag olamine*)	Tier 4 (PSP)	PA; QL (120 PACKETS per 30 days)
PROMACTA ORAL PACKET 25 MG (*eltrombopag olamine*)	Tier 4 (PSP)	PA; QL (180 PACKETS per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 75 MG (*eltrombopag olamine*)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
PROMACTA ORAL TABLET 25 MG, 50 MG (*eltrombopag olamine*)	Tier 4 (PSP)	PA; QL (90 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAVALISSE ORAL TABLET 100 MG, 150 MG (*fostamatinib disodium*)	Tier 4 (PSP)	PA; QL (60 TABLETS per 30 days)
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (*timothy grass pollen allergen*)	Tier 2 (PB)	
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (*grass mix pollens allergen ext*)	Tier 4 (PSP)	PA
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (*short ragweed pollen ext*)	Tier 2 (PB)	
AUTOIMMUNE AGENTS (PHYSICIAN-ADMINISTERED)		
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (*tocilizumab*)	NF	
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-axxq*)	Tier 4 (PSP)	PA; ST; QL (5 VIALS per 42 days)
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (*vedolizumab*)	NF	IBC (Available as NPSP with PA for Ulcerative Colitis)
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*tildrakizumab-asmn*)	Tier 4 (PSP)	PA; QL (1 SYRINGE per 90 days)
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-dyyb*)	NF	
infliximab intravenous solution reconstituted 100 mg	NF	
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG (*abatacept*)	NF	
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab*)	Tier 4 (PSP)	PA; QL (5 VIALS per 42 days)
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-abda*)	NF	
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML (*golimumab*)	Tier 4 (PSP)	PA; QL (4 VIALS per 56 days)
TOFIDENCE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (*tocilizumab-bavi*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYENNE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (*tocilizumab-aazg*)	NF	
AUTOIMMUNE AGENTS (SELF-ADMINISTERED)		
ABRILADA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-afzb*)	NF	
ABRILADA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-afzb*)	NF	
ABRILADA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (*adalimumab-afzb*)	NF	
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab*)	NF	
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab*)	NF	
adalimumab-aacf (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	NF	
adalimumab-aacf (2 syringe) subcutaneous prefilled syringe kit 40 mg/0.8ml	NF	
adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 80 mg/0.8ml	NF	
adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml	NF	
adalimumab-adaz subcutaneous solution auto-injector 40 mg/0.4ml	Tier 4 (PSP)	PA; ST; QL (4 PENS per 28 days)
adalimumab-adaz subcutaneous solution prefilled syringe 40 mg/0.4ml	Tier 4 (PSP)	PA; ST; QL (4 SYRINGES per 28 days)
adalimumab-adbm (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	NF	
adalimumab-adbm (2 syringe) subcutaneous prefilled syringe kit 10 mg/0.2ml, 20 mg/0.4ml, 40 mg/0.4ml, 40 mg/0.8ml	NF	
adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.8ml	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml	NF	
adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	NF	
adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml	NF	
adalimumab-ryvk (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml	NF	
adalimumab-ryvk (2 syringe) subcutaneous prefilled syringe kit 40 mg/0.4ml	NF	
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (*adalimumab-atto*)	NF	
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-atto*)	NF	
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML (*adalimumab-atto*)	NF	
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 20 MG/0.4ML (*adalimumab-atto*)	NF	
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (*bimekizumab-bkzx*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis after the failure of two preferred agents); QL (2 INJECTIONS per 56 days)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (*bimekizumab-bkzx*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis after the failure of two preferred agents); QL (2 INJECTIONS per 56 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Non-radiographical Axial Spondyloarthritis and preferred agent for Ankylosing Spondylitis, Crohn's, Psoriasis, Psoriatic Arthritis, and Rheumatoid Arthritis after the failure of two preferred agents.); QL (2 KITS per 28 Days)
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Non-radiographical Axial Spondyloarthritis and preferred agent for Ankylosing Spondylitis, Crohn's, Psoriasis, Psoriatic Arthritis, and Rheumatoid Arthritis after the failure of two preferred agents.); QL (1 KIT per 28 days)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis and Non-radiographical Axial Spondyloarthritis. Not covered for Psoriasis); QL (2 SYRINGES per 28 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis and Non-radiographical Axial Spondyloarthritis. Not covered for Psoriasis); QL (2 PENS per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis and Non-radiographical Axial Spondyloarthritis. Not covered for Psoriasis); QL (1 PEN per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML (*secukinumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis and Non-radiographical Axial Spondyloarthritis. Not covered for Psoriasis); QL (1 SYRINGE per 28 days)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*secukinumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis and Non-radiographical Axial Spondyloarthritis. Not covered for Psoriasis); QL (1 PEN per 28 days)
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	NF	
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	NF	
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (*etanercept*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for all conditions except Psoriasis); QL (4 CARTRIDGES per 28 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (*etanercept*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for all conditions except Psoriasis); QL (8 VIALS per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (*etanercept*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for all conditions except Psoriasis); QL (8 SYRINGES per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (*etanercept*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for all conditions except Psoriasis); QL (4 SYRINGES per 28 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (*etanercept*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for all conditions except Psoriasis); QL (4 SYRINGES per 28 days)
ENTYVIO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 108 MG/0.68ML (*vedolizumab*)	NF	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-bwwd*)	NF	
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-bwwd*)	NF	
HULIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-fkjp*)	NF	
HULIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (*adalimumab-fkjp*)	NF	
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (*adalimumab*)	NF	
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab*)	NF	
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (*adalimumab*)	NF	
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (*adalimumab*)	NF	
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adaz*)	Tier 4 (PSP)	PA; ST; QL (4 PENS per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*adalimumab-adaz*)	Tier 4 (PSP)	PA; ST; QL (2 PENS per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML (*adalimumab-adaz*)	Tier 4 (PSP)	PA; ST; QL (2 SYRINGES per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adaz*)	Tier 4 (PSP)	PA; ST; QL (4 SYRINGES per 28 days)
HYRIMOZ-PED<40KG CROHN STARTER SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML (*adalimumab-adaz*)	Tier 4 (PSP)	PA; ST; QL (1 KIT per 28 days)
HYRIMOZ-PED>/=40KG CROHN START SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML (*adalimumab-adaz*)	Tier 4 (PSP)	PA; ST; QL (1 KIT per 28 days)
HYRIMOZ-PLAQUE PSORIASIS START SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML (*adalimumab-adaz*)	Tier 4 (PSP)	PA; ST; QL (1 KIT per 28 days)
IDACIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-aacf*)	NF	
IDACIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (*adalimumab-aacf*)	NF	
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis); QL (2 PENS per 28 days)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis); QL (2 SYRINGES per 28 days)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*anakinra*)	NF	
LITFULO ORAL CAPSULE 50 MG (*ritlecitinib tosylate*)	Tier 5 (NPSP)	PA; QL (28 CAPSULES per 28 DAYs)
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (*baricitinib*)	NF	
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*mirikizumab-mrkz*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*mirikizumab-mrkz*)	NF	
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (*abatacept*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis. Not covered for other conditions); QL (4 SYRINGES per 28 days)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML (*abatacept*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis. Not covered for other conditions); QL (4 SYRINGES per 28 days)
OTEZLA ORAL TABLET 20 MG (*apremilast*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (60 TABLETS per 30 DAYs)
OTEZLA ORAL TABLET 30 MG (*apremilast*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (60 TABLETS per 30 days)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (*apremilast*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (55 TABLETS per 28 days)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (*apremilast*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (55 TABLETS per 28 DAYs)
RINVOQ LQ ORAL SOLUTION 1 MG/ML (*upadacitinib*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriatic Arthritis); QL (2 BOTTLES per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG (*upadacitinib*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Atopic Dermatitis, Ankylosing Spondylitis, Ulcerative Colitis, Non-radiographical Axial Spondyloarthritis, and Crohn's Disease); QL (30 TABLETS per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG (*upadacitinib*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Atopic Dermatitis, Ulcerative Colitis, and Crohn's Disease); QL (30 TABLETS per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (*upadacitinib*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Ulcerative Colitis and Crohn's Disease); QL (1 FILL per 1 INDUCTION PERIOD)
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML (*brodalumab*)	NF	
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-ryvk*)	NF	
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (*golimumab*)	NF	
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (*golimumab*)	NF	
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*risankizumab-rzaa*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (1 SYRINGE per 84 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML (*risankizumab-rzaa*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Crohn's Disease and Ulcerative Colitis); QL (1 CARTRIDGE per 56 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (*risankizumab-rzaa*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Crohn's Disease and Ulcerative Colitis); QL (1 CARTRIDGE per 56 days)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*risankizumab-rzaa*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (1 SYRINGE per 84 days)
SOTYKTU ORAL TABLET 6 MG (*deucravacitinib*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis); QL (30 TABLETS per 30 DAYs)
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 SYRINGE per 84 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (*ustekinumab*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 SYRINGE per 84 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (*ustekinumab*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 SYRINGE per 56 days)
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML (*ixekizumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Psoriasis. Not covered for Psoriatic Arthritis, Non-Radiographic Axial Spondyloarthritis or Ankylosing Spondylitis); QL (1 INJECTION per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML, 80 MG/ML (*ixekizumab*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Psoriasis. Not covered for Psoriatic Arthritis, Non-Radiographic Axial Spondyloarthritis or Ankylosing Spondylitis); QL (1 INJECTION per 28 days)
TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*guselkumab*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (1 SYRINGE per 56 days)
TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*guselkumab*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*guselkumab*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (1 ML per 56 days)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (*guselkumab*)	Tier 4 (PSP)	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis)
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab-aazg*)	NF	
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab-aazg*)	NF	
XELJANZ ORAL SOLUTION 1 MG/ML (*tofacitinib citrate*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis, Ulcerative Colitis. Not covered for Psoriatic Arthritis, Ankylosing Spondylitis); QL (240 ML per 24 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XELJANZ ORAL TABLET 10 MG, 5 MG (*tofacitinib citrate*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis, Ulcerative Colitis. Not covered for Psoriatic Arthritis, Ankylosing Spondylitis); QL (60 TABLETS per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (*tofacitinib citrate*)	Tier 4 (PSP)	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis, Ulcerative Colitis. Not covered for Psoriatic Arthritis, Ankylosing Spondylitis); QL (30 TABLETS per 30 days)
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML (*adalimumab-aaty*)	NF	
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML (*adalimumab-aaty*)	NF	
YUSIMRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (*adalimumab-aqvh*)	NF	
ZYMFENTRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 120 MG/ML (*infliximab-dyyb*)	NF	
ZYMFENTRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 120 MG/ML (*infliximab-dyyb*)	NF	
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) - DRUGS TO TREAT RHEUMATOID ARTHRITIS		
ARAVA ORAL TABLET 10 MG, 20 MG (*leflunomide*)	Tier 2 (PB)	
hydroxychloroquine sulfate oral tablet 200 mg	Tier 1 (G)	
leflunomide oral tablet 10 mg, 20 mg	Tier 1 (G)	
methotrexate sodium oral tablet 2.5 mg	CE	N7 (G)
OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 17.5 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML (*methotrexate (anti-rheumatic)*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLAQUENIL ORAL TABLET 200 MG (*hydroxychloroquine sulfate*)	Tier 2 (PB)	
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML (*methotrexate (anti-rheumatic)*)	Tier 4 (PSP)	PA; QL (4 ML per 28 days)
HEREDITARY ANGIOEDEMA		
BERINERT INTRAVENOUS KIT 500 UNIT (*c1 esterase inhibitor (human)*)	NF	
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT (*c1 esterase inhibitor (human)*)	NF	
FIRAZYR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML (*icatibant acetate*)	NF	
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (*c1 esterase inhibitor (human)*)	Tier 5 (NPSP)	PA; QL (20 VIALS per 30 days)
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	Tier 4 (PSP)	PA; QL (45 SYRINGES per 90 days)
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML (*ecallantide*)	Tier 5 (NPSP)	PA; QL (30 ML per 90 days)
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (*berotralstat hcl*)	Tier 4 (PSP)	PA; QL (28 CAPSULES per 28 days)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (*c1 esterase inhibitor (recomb)*)	Tier 4 (PSP)	PA; QL (60 VIALS per 90 days)
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (*lanadelumab-flyo*)	Tier 4 (PSP)	PA; QL (2 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML (*lanadelumab-flyo*)	Tier 4 (PSP)	PA; QL (2 SYRINGES per 28 DAYs)
IMMUNOGLOBULIN		
ALYGLO INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 5 GM/50ML (*immune globulin (human)-stwk*)	NF	
ASCENIV INTRAVENOUS SOLUTION 5 GM/50ML (*immune globulin (human)-slra*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML, 5 GM/50ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
CUTAQUIG SUBCUTANEOUS SOLUTION 1 GM/6ML, 1.65 GM/10ML, 2 GM/12ML, 3.3 GM/20ML, 4 GM/24ML, 8 GM/48ML (*immune globulin (human)-hipp*)	Tier 4 (PSP)	PA
CUVITRU SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML, 8 GM/40ML (*immune globulin (human)*)	NF	
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 GM/200ML, 20 GM/400ML, 5 GM/100ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM (*immune globulin (human)*)	Tier 5 (NPSP)	PA
GAMMAKED INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
HIZENTRA SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
HIZENTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
HYPERRHO S/D INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT, 250 UNIT (*rho d immune globulin*)	Tier 5 (NPSP)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERTET INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 250 UNIT/ML (*tetanus immune globulin*)	Tier 5 (NPSP)	
HYQVIA SUBCUTANEOUS KIT 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML (*immune globulin-hyaluronidase*)	NF	
IMOGAM RABIES-HT INJECTION SOLUTION 300 UNIT/2ML (*rabies immune globulin*)	Tier 5 (NPSP)	
kedrab injection solution 1500 unit/10ml, 300 unit/2ml	Tier 5 (NPSP)	
MICRHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 250 UNIT (*rho d immune globulin*)	Tier 5 (NPSP)	
OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 10 GM/100ML, 10 GM/200ML, 2 GM/20ML, 2.5 GM/50ML, 20 GM/200ML, 30 GM/300ML, 5 GM/100ML, 5 GM/50ML (*immune globulin (human)*)	NF	
PANZYGA INTRAVENOUS SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML (*immune globulin (human)-ifas*)	NF	
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML (*immune globulin (human)*)	Tier 5 (NPSP)	PA
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT (*rho d immune globulin*)	Tier 5 (NPSP)	
RHOPHYLAC INJECTION SOLUTION PREFILLED SYRINGE 1500 UNIT/2ML (*rho d immune globulin*)	Tier 5 (NPSP)	
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML (*varicella-zoster immune glob*)	Tier 5 (NPSP)	
WINRHO SDF INJECTION SOLUTION 1500 UNIT/1.3ML, 15000 UNIT/13ML, 2500 UNIT/2.2ML, 5000 UNIT/4.4ML (*rho d immune globulin*)	Tier 5 (NPSP)	
XEMBIFY SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML (*immune globulin (human)-klhw*)	Tier 5 (NPSP)	PA

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOMODULATORS		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (*interferon gamma-1b*)	Tier 5 (NPSP)	PA
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (*rilonacept*)	NF	
JOENJA ORAL TABLET 70 MG (*leniolisib phosphate*)	NF	
IMMUNOSUPPRESSANTS		
azathioprine oral tablet 100 mg, 50 mg, 75 mg	Tier 1 (G)	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (*belimumab*)	Tier 5 (NPSP)	PA; QL (4 INJECTIONS per 28 days)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (*belimumab*)	Tier 5 (NPSP)	PA; QL (4 INJECTIONS per 28 days)
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	Tier 1 (G)	
cyclosporine modified oral solution 100 mg/ml	Tier 1 (G)	
cyclosporine oral capsule 100 mg, 25 mg	Tier 1 (G)	
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	Tier 1 (G)	
cyclosporine modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	Tier 1 (G)	
cyclosporine modified (Gengraf Oral Solution 100 Mg/Ml)	Tier 1 (G)	
IMURAN ORAL TABLET 50 MG (*azathioprine*)	Tier 2 (PB)	
LUPKYNIS ORAL CAPSULE 7.9 MG (*voclosporin*)	NF	
mycophenolate mofetil oral capsule 250 mg	Tier 1 (G)	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	Tier 1 (G)	
mycophenolate mofetil oral tablet 500 mg	Tier 1 (G)	
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	Tier 1 (G)	
NEORAL ORAL CAPSULE 100 MG, 25 MG (*cyclosporine modified*)	Tier 5 (NPSP)	
NEORAL ORAL SOLUTION 100 MG/ML (*cyclosporine modified*)	Tier 5 (NPSP)	
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML (*tacrolimus*)	Tier 5 (NPSP)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REZUROCK ORAL TABLET 200 MG (*belumosudil mesylate*)	NF	
SANDIMMUNE INTRAVENOUS SOLUTION 50 MG/ML (*cyclosporine*)	Tier 5 (NPSP)	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (*cyclosporine*)	Tier 5 (NPSP)	
sirolimus oral solution 1 mg/ml	Tier 1 (G)	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1 (G)	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	Tier 1 (G)	
MISCELLANEOUS		
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML (*canakinumab*)	Tier 5 (NPSP)	PA
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML (*palivizumab*)	Tier 5 (NPSP)	PA
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS		
ELECTROLYTES		
potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	Tier 1 (G)	
potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)	Tier 1 (G)	
potassium chloride crys er (Klor-Con M15 Oral Tablet Extended Release 15 Meq)	Tier 1 (G)	
potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)	Tier 1 (G)	
potassium chloride (Klor-Con Oral Packet 20 Meq)	Tier 1 (G)	
potassium chloride (Klor-Con Oral Tablet Extended Release 8 Meq)	Tier 1 (G)	
potassium chloride crys er oral tablet extended release 10 meq, 20 meq	Tier 1 (G)	
potassium chloride er oral capsule extended release 10 meq, 8 meq	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq	Tier 1 (G)	
potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)	Tier 1 (G)	
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	CE	N7 (Not Covered); AL (Max 5 Years)
sodium fluoride oral tablet 1.1 (0.5 f) mg	CE	N7 (Not Covered); AL (Max 5 Years)
sodium fluoride oral tablet 2.2 (1 f) mg	Tier 1 (G)	
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg	CE	N7 (Not Covered); AL (Max 5 Years)
sodium fluoride oral tablet chewable 2.2 (1 f) mg	Tier 1 (G)	
PRENATAL VITAMINS		
azesco oral tablet 13-1 mg	NF	
INATAL GT ORAL TABLET (*prenatal vit-dss-fe cbn-fa*)	Tier 1 (G)	
pnv-dha oral capsule 27-0.6-0.4-300 mg	Tier 1 (G)	
TRINATE ORAL TABLET (*prenatal vit-fe fumarate-fa*)	Tier 1 (G)	
zalvit oral tablet 13-1 mg	NF	
VITAMINS - VITAMINS AND SUPPLEMENTS		
cyanocobalamin injection solution 1000 mcg/ml	Tier 1 (G)	
b complex-c-folic acid (Dexifol Oral Tablet 5 Mg)	NF	
FA-8 ORAL CAPSULE 0.8 MG (*folic acid*)	CE	N7 (Not Covered); QL (100 CAPSULES per 30 DAYs); AL (Max 55 Years)
folbee plus oral tablet	Tier 1 (G)	
folic acid oral tablet 400 mcg	CE	N7 (Not Covered); QL (100 tablets per 30 days); AL (Max 55 Years)
folic acid oral tablet 800 mcg	CE	N7 (Not Covered); QL (100 TABLETS per 30 DAYs); AL (Max 55 Years)
na ferric gluc cplx in sucrose intravenous solution 12.5 mg/ml	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NICOMIDE ORAL TABLET 750-27-2-0.5 MG (*niacinamide-zn-cu-methfo-se-cr*)	NF	
nicotinamide oral tablet 750-27-2-0.5 mg	Tier 1 (G)	
phytonadione oral tablet 5 mg	Tier 1 (G)	
reno caps oral capsule 1 mg	Tier 1 (G)	Select OTC
VENOFER INTRAVENOUS SOLUTION 20 MG/ML (*iron sucrose*)	Tier 5 (NPSP)	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	Tier 1 (G)	
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
azelastine hcl ophthalmic solution 0.05 %	Tier 1 (G)	
bepotastine besilate ophthalmic solution 1.5 %	Tier 1 (G)	
cromolyn sodium ophthalmic solution 4 %	Tier 1 (G)	
epinastine hcl ophthalmic solution 0.05 %	Tier 1 (G)	
ketotifen fumarate ophthalmic solution 0.035 %	Tier 1 (G)	Select OTC
ZADITOR OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	Tier 1 (G)	Select OTC
ZERVIATE OPHTHALMIC SOLUTION 0.24 % (*cetirizine hcl*)	Tier 2 (PB)	
ANTIGLAUCOMA BETA-BLOCKERS - DRUGS TO TREAT GLAUCOMA		
betaxolol hcl ophthalmic solution 0.5 %	Tier 1 (G)	
BETIMOL OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol hemihydrate*)	Tier 2 (PB)	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (*betaxolol hcl*)	Tier 2 (PB)	
carteolol hcl ophthalmic solution 1 %	Tier 1 (G)	
levobunolol hcl ophthalmic solution 0.5 %	Tier 1 (G)	
timolol maleate (once-daily) ophthalmic solution 0.5 %	Tier 1 (G)	
timolol maleate (Timolol Maleate Ocudose Ophthalmic Solution 0.5 %)	Tier 1 (G)	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
timolol maleate ophthalmic solution 0.25 %, 0.5 %	Tier 1 (G)	
timolol maleate pf ophthalmic solution 0.25 %	Tier 1 (G)	
ANTIGLAUCOMA COMBINATION AGENTS - DRUGS TO TREAT GLAUCOMA		
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	Tier 1 (G)	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	Tier 1 (G)	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	Tier 1 (G)	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (*netarsudil-latanoprost*)	Tier 2 (PB)	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (*brinzolamide-brimonidine*)	Tier 2 (PB)	
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	Tier 1 (G)	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	Tier 1 (G)	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	Tier 1 (G)	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (*tobramycin-dexamethasone*)	Tier 2 (PB)	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (*tobramycin-dexamethasone*)	Tier 2 (PB)	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	Tier 1 (G)	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (*loteprednol-tobramycin*)	Tier 3 (NPB)	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
bacitracin ophthalmic ointment 500 unit/gm	Tier 1 (G)	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	Tier 1 (G)	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (*besifloxacin hcl*)	Tier 2 (PB)	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (*ciprofloxacin hcl*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ciprofloxacin hcl ophthalmic solution 0.3 %	Tier 1 (G)	
erythromycin ophthalmic ointment 5 mg/gm	Tier 1 (G)	
gatifloxacin ophthalmic solution 0.5 %	Tier 1 (G)	
gentamicin sulfate ophthalmic solution 0.3 %	Tier 1 (G)	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	Tier 1 (G)	
moxifloxacin hcl ophthalmic solution 0.5 %	Tier 1 (G)	
ofloxacin ophthalmic solution 0.3 %	Tier 1 (G)	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	Tier 1 (G)	
sulfacetamide sodium ophthalmic ointment 10 %	Tier 1 (G)	
sulfacetamide sodium ophthalmic solution 10 %	Tier 1 (G)	
tobramycin ophthalmic solution 0.3 %	Tier 1 (G)	
trifluridine ophthalmic solution 1 %	Tier 1 (G)	
ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION		
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (*ketorolac tromethamine*)	Tier 2 (PB)	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	Tier 1 (G)	
bromfenac sodium ophthalmic solution 0.07 %, 0.075 %	Tier 1 (G)	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	Tier 1 (G)	
diclofenac sodium ophthalmic solution 0.1 %	Tier 1 (G)	
difluprednate ophthalmic emulsion 0.05 %	Tier 1 (G)	
FLAREX OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone acetate*)	Tier 3 (NPB)	
fluorometholone ophthalmic suspension 0.1 %	Tier 1 (G)	
flurbiprofen sodium ophthalmic solution 0.03 %	Tier 1 (G)	
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (*fluorometholone*)	Tier 2 (PB)	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone*)	NF	
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (*nepafenac*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	Tier 1 (G)	
loteprednol etabonate ophthalmic gel 0.5 %	Tier 1 (G)	
loteprednol etabonate ophthalmic suspension 0.2 %, 0.5 %	Tier 1 (G)	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (*dexamethasone*)	Tier 2 (PB)	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (*nepafenac*)	Tier 2 (PB)	
PRED FORTE OPHTHALMIC SUSPENSION 1 % (*prednisolone acetate*)	NF	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (*prednisolone acetate*)	Tier 2 (PB)	
prednisolone acetate ophthalmic suspension 1 %	Tier 1 (G)	
CARBONIC ANHYDRASE INHIBITORS - DRUGS TO TREAT GLAUCOMA		
brinzolamide ophthalmic suspension 1 %	Tier 1 (G)	
dorzolamide hcl ophthalmic solution 2 %	Tier 1 (G)	
DRY EYE DISEASE		
cyclosporine ophthalmic emulsion 0.05 %	Tier 1 (G)	
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	Tier 2 (PB)	
RESTASIS OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	Tier 2 (PB)	
XIIDRA OPHTHALMIC SOLUTION 5 % (*lifitegrast*)	Tier 2 (PB)	
MISCELLANEOUS		
atropine sulfate ophthalmic solution 1 %	Tier 1 (G)	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (*cysteamine hcl*)	NF	
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (*cysteamine hcl*)	Tier 5 (NPSP)	PA; QL (4 BOTTLES per 28 days)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (*cenegermin-bkbj*)	Tier 5 (NPSP)	PA; QL (2 ML per 7 DAYs)
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	Tier 1 (G)	
tropicamide ophthalmic solution 0.5 %, 1 %	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VISUDYNE INTRAVENOUS SOLUTION RECONSTITUTED 15 MG (*verteporfin*)	Tier 5 (NPSP)	PA
PROSTAGLANDINS - DRUGS TO TREAT GLAUCOMA		
bimatoprost ophthalmic solution 0.03 %	Tier 1 (G)	
latanoprost ophthalmic solution 0.005 %	Tier 1 (G)	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (*bimatoprost*)	Tier 2 (PB)	
tafluprost (pf) ophthalmic solution 0.0015 %	Tier 1 (G)	
travoprost (bak free) ophthalmic solution 0.004 %	Tier 1 (G)	
RETINAL DISORDERS		
BYOOVIZ INTRAVITREAL SOLUTION 0.5 MG/0.05ML (*ranibizumab-nuna*)	Tier 4 (PSP)	PA
CIMERLI INTRAVITREAL SOLUTION 0.3 MG/0.05ML, 0.5 MG/0.05ML (*ranibizumab-eqrn*)	Tier 4 (PSP)	PA
EYLEA INTRAVITREAL SOLUTION 2 MG/0.05ML (*aflibercept*)	NF	
EYLEA INTRAVITREAL SOLUTION PREFILLED SYRINGE 2 MG/0.05ML (*aflibercept*)	NF	
LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE 0.3 MG/0.05ML, 0.5 MG/0.05ML (*ranibizumab*)	NF	
RHO KINASE INHIBITORS - DRUGS TO TREAT EYE CONDITIONS		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (*netarsudil dimesylate*)	Tier 2 (PB)	
SYMPATHOMIMETICS - DRUGS TO TREAT GLAUCOMA		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %, 0.15 % (*brimonidine tartrate*)	Tier 2 (PB)	
brimonidine tartrate ophthalmic solution 0.1 %, 0.15 %, 0.2 %	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ALPHA-1 ANTITRYPSIN DEFICIENCY AGENTS - DRUGS FOR REPLACEMENT, MODIFICATION, TREATMENT		
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG (*alpha1-proteinase inhibitor*)	NF	
GLASSIA INTRAVENOUS SOLUTION 1000 MG/50ML (*alpha1-proteinase inhibitor*)	NF	
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML (*alpha1-proteinase inhibitor*)	Tier 4 (PSP)	PA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 4000 MG, 5000 MG (*alpha1-proteinase inhibitor*)	Tier 4 (PSP)	PA
ANAPHYLAXIS TREATMENT AGENTS		
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML (*epinephrine*)	Tier 2 (PB)	QL (4 INJECTIONS per 25 days)
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml	Tier 1 (G)	QL (4 INJECTIONS per 25 DAYs)
epinephrine injection solution auto-injector 0.3 mg/0.3ml	Tier 1 (G)	QL (4 INJECTION per 25 days)
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (*epinephrine*)	Tier 3 (NPB)	QL (4 INJECTION per 25 days)
EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML (*epinephrine*)	Tier 3 (NPB)	QL (4 INJECTION per 25 days)
NEFFY NASAL SOLUTION 2 MG/0.1ML (*epinephrine*)	Tier 3 (NPB)	
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (*umeclidinium-vilanterol*)	Tier 2 (PB)	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (*glycopyrrolate-formoterol*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (*ipratropium-albuterol*)	Tier 3 (NPB)	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	Tier 1 (G)	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (*tiotropium bromide-olodaterol*)	Tier 2 (PB)	
ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*)	Tier 2 (PB)	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*)	Tier 2 (PB)	
ANTICHOLINERGICS		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (*ipratropium bromide hfa*)	Tier 2 (PB)	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (*umeclidinium bromide*)	Tier 2 (PB)	
ipratropium bromide inhalation solution 0.02 %	Tier 1 (G)	
ipratropium bromide nasal solution 0.03 %, 0.06 %	Tier 1 (G)	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (*tiotropium bromide monohydrate*)	Tier 2 (PB)	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (*tiotropium bromide monohydrate*)	Tier 2 (PB)	
YUPELRI INHALATION SOLUTION 175 MCG/3ML (*revefenacin*)	Tier 2 (PB)	
ANTIHISTAMINE COMBINATIONS		
azelastine-fluticasone nasal suspension 137-50 mcg/act	Tier 1 (G)	
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
ALLEGRA ALLERGY CHILDRENS ORAL SUSPENSION 30 MG/5ML (*fexofenadine hcl*)	Tier 1 (G)	Select OTC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLEGRA ALLERGY CHILDRENS ORAL TABLET DISPERSIBLE 30 MG (*fexofenadine hcl*)	Tier 1 (G)	Select OTC
ALLEGRA ALLERGY ORAL TABLET 180 MG, 60 MG (*fexofenadine hcl*)	Tier 1 (G)	Select OTC
allergy rel child (cetirizine) oral tablet dispersible 10 mg	Tier 1 (G)	Select OTC
allergy relief (cetirizine) oral capsule 10 mg	Tier 1 (G)	
azelastine hcl nasal solution 137 mcg/spray	Tier 1 (G)	
carbinoxamine maleate oral tablet 4 mg	Tier 1 (G)	
carbinoxamine maleate oral tablet 6 mg	NF	
cetirizine hcl allergy child oral solution 5 mg/5ml	Tier 1 (G)	Select OTC
cetirizine hcl oral tablet 10 mg, 5 mg	Tier 1 (G)	Select OTC
cetirizine hcl oral tablet chewable 10 mg, 5 mg	Tier 1 (G)	Select OTC
CLARITIN ALLERGY CHILDRENS ORAL SOLUTION 5 MG/5ML (*loratadine*)	Tier 1 (G)	Select OTC
CLARITIN ORAL CAPSULE 10 MG (*loratadine*)	Tier 1 (G)	Select OTC
CLARITIN ORAL TABLET 10 MG (*loratadine*)	Tier 1 (G)	Select OTC
CLARITIN ORAL TABLET CHEWABLE 10 MG (*loratadine*)	Tier 1 (G)	LGC; Select OTC
CLARITIN ORAL TABLET CHEWABLE 5 MG (*loratadine*)	Tier 1 (G)	Select OTC
CLARITIN REDITABS ORAL TABLET DISPERSIBLE 10 MG, 5 MG (*loratadine*)	Tier 1 (G)	Select OTC
cvs allergy relief childrens oral suspension 30 mg/5ml	Tier 1 (G)	Select OTC
cyproheptadine hcl oral syrup 2 mg/5ml	Tier 1 (G)	
cyproheptadine hcl oral tablet 4 mg	Tier 1 (G)	
desloratadine oral tablet 5 mg	Tier 1 (G)	
desloratadine oral tablet dispersible 2.5 mg, 5 mg	Tier 1 (G)	
eq loratadine childrens oral tablet chewable 5 mg	Tier 1 (G)	Select OTC
fexofenadine hcl oral tablet 180 mg	Tier 1 (G)	Select OTC
hydroxyzine hcl oral syrup 10 mg/5ml	Tier 1 (G)	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	Tier 1 (G)	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
kp fexofenadine hcl oral tablet 60 mg	Tier 1 (G)	Select OTC
levocetirizine dihydrochloride oral tablet 5 mg	Tier 1 (G)	Select OTC
loratadine oral capsule 10 mg	Tier 1 (G)	Select OTC
loratadine oral tablet 10 mg	Tier 1 (G)	Select OTC
olopatadine hcl nasal solution 0.6 %	Tier 1 (G)	
RYCLORA ORAL SOLUTION 2 MG/5ML (*dexchlorpheniramine maleate*)	NF	
sm loratadine allergy relief oral tablet dispersible 10 mg	Tier 1 (G)	Select OTC
sm loratadine oral solution 5 mg/5ml	Tier 1 (G)	Select OTC
XYZAL ALLERGY 24HR ORAL TABLET 5 MG (*levocetirizine dihydrochloride*)	Tier 1 (G)	Select OTC
ZYRTEC ALLERGY CHILDRENS ORAL TABLET DISPERSIBLE 10 MG (*cetirizine hcl*)	Tier 1 (G)	Select OTC
ZYRTEC ALLERGY ORAL CAPSULE 10 MG (*cetirizine hcl*)	Tier 1 (G)	Select OTC
ZYRTEC ALLERGY ORAL TABLET 10 MG (*cetirizine hcl*)	Tier 1 (G)	Select OTC
ZYRTEC CHILDRENS ALLERGY ORAL SOLUTION 1 MG/ML (*cetirizine hcl*)	Tier 1 (G)	Select OTC
ZYRTEC CHILDRENS ALLERGY ORAL TABLET CHEWABLE 10 MG (*cetirizine hcl*)	Tier 1 (G)	Select OTC
ZYRTEC CHILDRENS ALLERGY ORAL TABLET CHEWABLE 2.5 MG (*cetirizine hcl*)	Tier 1 (G)	LGC; Select OTC
ZYRTEC ORAL TABLET CHEWABLE 10 MG (*cetirizine hcl*)	Tier 1 (G)	Select OTC
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	Tier 1 (G)	
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	Tier 1 (G)	
albuterol sulfate oral syrup 2 mg/5ml	Tier 1 (G)	
albuterol sulfate oral tablet 2 mg, 4 mg	Tier 1 (G)	
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	Tier 1 (G)	
levalbuterol tartrate inhalation aerosol 45 mcg/act	Tier 1 (G)	
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (*albuterol sulfate*)	Tier 3 (NPB)	
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*salmeterol xinafoate*)	Tier 2 (PB)	
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (*olodaterol hcl*)	Tier 2 (PB)	
terbutaline sulfate oral tablet 2.5 mg, 5 mg	Tier 1 (G)	
COLD/COUGH		
ALLEGRA-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 12 HOUR 60-120 MG (*fexofenadine-pseudoephedrine*)	Tier 1 (G)	Select OTC
ALLEGRA-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 24 HOUR 180-240 MG (*fexofenadine-pseudoephedrine*)	Tier 1 (G)	Select OTC
benzonatate oral capsule 100 mg, 150 mg, 200 mg	Tier 1 (G)	
cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg	Tier 1 (G)	Select OTC
CLARITIN-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG (*loratadine-pseudoephedrine*)	Tier 1 (G)	Select OTC
CLARITIN-D 24 HOUR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-240 MG (*loratadine-pseudoephedrine*)	Tier 1 (G)	Select OTC
coditussin ac oral liquid 200-10 mg/5ml	Tier 1 (G)	Select OTC; QL (60 ML per 1 day)
fexofenadine-pseudoephed er oral tablet extended release 12 hour 60-120 mg	Tier 1 (G)	Select OTC
fexofenadine-pseudoephed er oral tablet extended release 24 hour 180-240 mg	Tier 1 (G)	Select OTC
HYCODAN ORAL SOLUTION 5-1.5 MG/5ML (*hydrocodone bit-homatrop mbr*)	Tier 3 (NPB)	QL (30 ML per 1 day)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYCODAN ORAL TABLET 5-1.5 MG (*hydrocodone bit-homatrop mbr*)	Tier 3 (NPB)	QL (6 TABLETS per 1 DAY)
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	Tier 1 (G)	
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	Tier 1 (G)	QL (30 ML per 1 day)
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	Tier 1 (G)	QL (6 TABLETS per 1 day)
loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg	Tier 1 (G)	Select OTC
promethazine vc oral syrup 6.25-5 mg/5ml	Tier 1 (G)	
promethazine-codeine oral solution 6.25-10 mg/5ml	Tier 1 (G)	QL (30 ML per 1 DAY)
promethazine-dm oral syrup 6.25-15 mg/5ml	Tier 1 (G)	
sm loratadine d 12hr oral tablet extended release 12 hour 5-120 mg	Tier 1 (G)	Select OTC
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (*chlorpheniramine-codeine*)	Tier 3 (NPB)	QL (2 TABLETS per 1 DAY)
ZYRTEC-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG (*cetirizine-pseudoephedrine*)	Tier 1 (G)	Select OTC
CYSTIC FIBROSIS		
BETHKIS INHALATION NEBULIZATION SOLUTION 300 MG/4ML (*tobramycin*)	NF	
BRONCHITOL INHALATION CAPSULE 40 MG (*mannitol (cystic fibrosis)*)	NF	
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (*aztreonam lysine*)	Tier 5 (NPSP)	PA; QL (84 VIALS per 28 days)
KALYDECO ORAL PACKET 13.4 MG, 5.8 MG (*ivacaftor*)	Tier 5 (NPSP)	PA; QL (56 PACKETS per 28 DAYs)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (*ivacaftor*)	Tier 5 (NPSP)	PA; QL (56 PACKET per 28 days)
KALYDECO ORAL TABLET 150 MG (*ivacaftor*)	Tier 5 (NPSP)	PA; QL (1 CARTONS per 28 days)
KITABIS PAK INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (*lumacaftor-ivacaftor*)	Tier 5 (NPSP)	PA; QL (56 PACKET per 28 days)
ORKAMBI ORAL PACKET 75-94 MG (*lumacaftor-ivacaftor*)	Tier 5 (NPSP)	PA; QL (56 PACKETS per 28 DAYs)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (*lumacaftor-ivacaftor*)	Tier 5 (NPSP)	PA; QL (112 TABLETS per 28 days)
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (*dornase alfa*)	Tier 5 (NPSP)	PA; QL (150 ML per 30 Days)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (*tezacaftor-ivacaftor*)	Tier 5 (NPSP)	PA; QL (56 TABLETS per 28 days)
TOBI INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*)	NF	
TOBI PODHALER INHALATION CAPSULE 28 MG (*tobramycin*)	NF	
tobramycin inhalation nebulization solution 300 mg/4ml	Tier 4 (PSP)	PA; QL (224 ML per 28 DAYs)
tobramycin inhalation nebulization solution 300 mg/5ml	Tier 3 (NPB)	PA; QL (280 ML per 28 days)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG (*elexacaftor-tezacaftor-ivacaft*)	Tier 3 (NPB)	PA; QL (84 TABLETS per 28 days)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (*elexacaftor-tezacaftor-ivacaft*)	Tier 3 (NPB)	PA; QL (56 PACKETS per 28 days)
LEUKOTRIENE MODIFIERS		
zileuton er oral tablet extended release 12 hour 600 mg	NF	
LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS TO TREAT ASTHMA AND ALLERGIES		
montelukast sodium oral packet 4 mg	Tier 1 (G)	
montelukast sodium oral tablet 10 mg	Tier 1 (G)	
montelukast sodium oral tablet chewable 4 mg, 5 mg	Tier 1 (G)	
zafirlukast oral tablet 10 mg, 20 mg	Tier 1 (G)	
MAST CELL STABILIZERS - DRUGS TO TREAT ALLERGIES		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MISCELLANEOUS		
acetylcysteine inhalation solution 10 %, 20 %	Tier 1 (G)	
roflumilast oral tablet 250 mcg, 500 mcg	Tier 1 (G)	
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
budesonide nasal suspension 32 mcg/act	Tier 1 (G)	Select OTC
FLONASE ALLERGY RELIEF NASAL SUSPENSION 50 MCG/ACT (*fluticasone propionate*)	Tier 1 (G)	Select OTC
flunisolide nasal solution 25 mcg/act (0.025%)	Tier 1 (G)	
fluticasone propionate nasal suspension 50 mcg/act	Tier 1 (G)	Select OTC
NASACORT ALLERGY 24HR NASAL AEROSOL 55 MCG/ACT (*triamcinolone acetonide*)	Tier 1 (G)	Select OTC
triamcinolone acetonide nasal aerosol 55 mcg/act	Tier 1 (G)	Select OTC
PULMONARY FIBROSIS AGENTS		
ESBRIET ORAL CAPSULE 267 MG (*pirfenidone*)	NF	
ESBRIET ORAL TABLET 267 MG, 801 MG (*pirfenidone*)	NF	
OFEV ORAL CAPSULE 100 MG, 150 MG (*nintedanib esylate*)	Tier 4 (PSP)	PA; QL (60 CAPSULES per 30 days)
pirfenidone oral capsule 267 mg	Tier 4 (PSP)	PA; QL (270 CAPSULES per 30 DAYs)
pirfenidone oral tablet 267 mg	Tier 4 (PSP)	PA; QL (270 TABLETS per 30 Days)
pirfenidone oral tablet 534 mg	NF	
pirfenidone oral tablet 801 mg	Tier 4 (PSP)	PA; QL (90 TABLETS per 30 Days)
SEVERE ASTHMA AGENTS		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (*dupilumab*)	Tier 2 (PB)	PA; IBC (Indicated for Asthma and Atopic Dermatitis); QL (2 PENS per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*dupilumab*)	Tier 2 (PB)	PA; IBC (Indicated for Asthma and Atopic Dermatitis); QL (4 PENS per 28 days)
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (*benralizumab*)	Tier 2 (PB)	PA; QL (1 PEN per 28 days)
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (*benralizumab*)	Tier 2 (PB)	PA; QL (1 SYRINGE per 56 days)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*mepolizumab*)	Tier 2 (PB)	PA; QL (3 INJECTIONS per 28 days)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*mepolizumab*)	Tier 2 (PB)	PA; QL (3 INJECTIONS per 28 days)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (*mepolizumab*)	Tier 2 (PB)	PA; QL (1 SYRINGE per 28 days)
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG (*mepolizumab*)	NF	
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (*tezepelumab-ekko*)	Tier 2 (PB)	PA; QL (1 PEN per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*omalizumab*)	Tier 2 (PB)	PA; QL (8 INJECTIONS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*omalizumab*)	Tier 2 (PB)	PA; QL (4 INJECTIONS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (*omalizumab*)	Tier 2 (PB)	PA; QL (2 INJECTIONS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*omalizumab*)	Tier 2 (PB)	PA; QL (8 SYRINGES per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*omalizumab*)	Tier 2 (PB)	PA; QL (4 SYRINGES per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*omalizumab*)	Tier 2 (PB)	PA; QL (2 SYRINGES per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (*omalizumab*)	Tier 2 (PB)	PA; QL (8 VIALS per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT (*fluticasone furoate*)	Tier 2 (PB)	
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml	Tier 1 (G)	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (*budesonide*)	Tier 2 (PB)	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (*beclomethasone diprop hfa*)	Tier 2 (PB)	
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*)	Tier 2 (PB)	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (*fluticasone furoate-vilanterol*)	Tier 2 (PB)	
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	Tier 1 (G)	
fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act	Tier 1 (G)	
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 113-14 mcg/act, 232-14 mcg/act, 250-50 mcg/act, 500-50 mcg/act, 55-14 mcg/act	Tier 1 (G)	
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (*budesonide-formoterol fumarate*)	Tier 2 (PB)	
fluticasone-salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	Tier 1 (G)	
XANTHINES - DRUGS TO TREAT COPD		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (*theophylline*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	Tier 1 (G)	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	Tier 1 (G)	
theophylline oral elixir 80 mg/15ml	Tier 1 (G)	
theophylline oral solution 80 mg/15ml	Tier 1 (G)	
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS		
DERMATOLOGY, ACNE		
ABSORICA LD ORAL CAPSULE 16 MG, 24 MG, 32 MG, 8 MG (*isotretinoin micronized*)	Tier 3 (NPB)	PA
ABSORICA ORAL CAPSULE 10 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG (*isotretinoin*)	Tier 2 (PB)	PA
ACANYA EXTERNAL GEL 1.2-2.5 % (*clindamycin phos-benzoyl perox*)	Tier 3 (NPB)	
isotretinoin (Accutane Oral Capsule 20 Mg, 30 Mg, 40 Mg)	Tier 1 (G)	PA
adapalene external cream 0.1 %	Tier 1 (G)	PA; AL (Max 35 Years)
adapalene external gel 0.1 %	Tier 1 (G)	PA; Select OTC; AL (Max 35 Years)
adapalene external gel 0.3 %	Tier 1 (G)	PA; AL (Max 35 Years)
adapalene external pad 0.1 %	NF	
adapalene-benzoyl peroxide external gel 0.1-2.5 %, 0.3-2.5 %	Tier 1 (G)	PA; AL (Max 35 Years)
AKLIEF EXTERNAL CREAM 0.005 % (*trifarotene*)	Tier 2 (PB)	
isotretinoin (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	Tier 1 (G)	PA
ARAZLO EXTERNAL LOTION 0.045 % (*tazarotene*)	Tier 2 (PB)	PA; AL (Max 35 Years)
benzoyl peroxide-erythromycin external gel 5-3 %	Tier 1 (G)	
isotretinoin (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1 (G)	PA
clindamycin phosphate (Clindacin-P External Swab 1 %)	Tier 1 (G)	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %, 1.2-5 %	Tier 1 (G)	
clindamycin phosphate external foam 1 %	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clindamycin phosphate external gel 1 %	Tier 1 (G)	N8 (Listing does not include certain NDCs)
clindamycin phosphate external lotion 1 %	Tier 1 (G)	
clindamycin phosphate external solution 1 %	Tier 1 (G)	
clindamycin-tretinoin external gel 1.2-0.025 %	Tier 1 (G)	PA; AL (Max 35 Years)
dapsone external gel 5 %, 7.5 %	Tier 1 (G)	
DIFFERIN EXTERNAL GEL 0.1 % (*adapalene*)	Tier 1 (G)	PA; Select OTC; AL (Max 35 Years)
EPIDUO EXTERNAL GEL 0.1-2.5 % (*adapalene-benzoyl peroxide*)	Tier 2 (PB)	PA; AL (Max 35 Years)
EPIDUO FORTE EXTERNAL GEL 0.3-2.5 % (*adapalene-benzoyl peroxide*)	Tier 2 (PB)	PA; AL (Max 35 Years)
ery external pad 2 %	Tier 1 (G)	
erythromycin external solution 2 %	Tier 1 (G)	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	Tier 1 (G)	PA
isotretinoin oral capsule 25 mg, 35 mg	NF	
RETIN-A MICRO EXTERNAL GEL 0.04 %, 0.1 % (*tretinoin microsphere*)	Tier 3 (NPB)	PA; AL (Max 35 Years)
RETIN-A MICRO PUMP EXTERNAL GEL 0.04 %, 0.06 %, 0.08 %, 0.1 % (*tretinoin microsphere*)	Tier 3 (NPB)	PA; AL (Max 35 Years)
sulfacetamide sodium (acne) external lotion 10 %	Tier 1 (G)	
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	Tier 1 (G)	PA; AL (Max 35 Years)
tretinoin external gel 0.01 %, 0.025 %, 0.05 %	Tier 1 (G)	PA; AL (Max 35 Years)
tretinoin microsphere external gel 0.04 %, 0.1 %	Tier 1 (G)	PA; AL (Max 35 Years)
tretinoin microsphere pump external gel 0.08 %	Tier 1 (G)	PA; AL (Max 35 Years)
TWYNEO EXTERNAL CREAM 0.1-3 % (*tretinoin-benzoyl peroxide*)	Tier 2 (PB)	
WINLEVI EXTERNAL CREAM 1 % (*clascoterone*)	Tier 2 (PB)	
isotretinoin (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1 (G)	PA
ZIANA EXTERNAL GEL 1.2-0.025 % (*clindamycin-tretinoin*)	Tier 3 (NPB)	PA; AL (Max 35 Years)

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DERMATOLOGY, ACTINIC KERATOSIS		
fluorouracil external cream 5 %	Tier 1 (G)	
fluorouracil external solution 2 %, 5 %	Tier 1 (G)	
imiquimod external cream 5 %	Tier 1 (G)	
imiquimod pump external cream 3.75 %	Tier 1 (G)	
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate external cream 0.1 %	Tier 1 (G)	
gentamicin sulfate external ointment 0.1 %	Tier 1 (G)	
mafenide acetate external packet 5 %	Tier 1 (G)	
mupirocin calcium external cream 2 %	NF	
mupirocin external ointment 2 %	Tier 1 (G)	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (*neomycin-fluocinolone*)	NF	
SILVADENE EXTERNAL CREAM 1 % (*silver sulfadiazine*)	Tier 2 (PB)	
silver sulfadiazine external cream 1 %	Tier 1 (G)	
silver sulfadiazine (Ssd External Cream 1 %)	Tier 1 (G)	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox external gel 0.77 %	Tier 1 (G)	
ciclopirox external shampoo 1 %	Tier 1 (G)	
ciclopirox external solution 8 %	Tier 1 (G)	STX
ciclopirox olamine external cream 0.77 %	Tier 1 (G)	
ciclopirox olamine external suspension 0.77 %	Tier 1 (G)	
clotrimazole-betamethasone external cream 1-0.05 %	Tier 1 (G)	STX; QL (60 G per 25 days)
clotrimazole-betamethasone external lotion 1-0.05 %	Tier 1 (G)	STX; QL (60 ML per 25 days)
econazole nitrate external cream 1 %	Tier 1 (G)	
JUBLIA EXTERNAL SOLUTION 10 % (*efinaconazole*)	Tier 3 (NPB)	QL (4 ML per 21 days)
ketoconazole external cream 2 %	Tier 1 (G)	
ketoconazole external foam 2 %	NF	
luliconazole external cream 1 %	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
miconazole-zinc oxide-petrolat external ointment 0.25-15-81.35 %	Tier 1 (G)	
naftifine hcl external cream 1 %, 2 %	Tier 1 (G)	
naftifine hcl external gel 2 %	Tier 1 (G)	
NAFTIN EXTERNAL GEL 2 % (*naftifine hcl*)	Tier 2 (PB)	
nystatin external cream 100000 unit/gm	Tier 1 (G)	
nystatin external ointment 100000 unit/gm	Tier 1 (G)	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	Tier 1 (G)	STX; QL (60 G per 25 days)
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	Tier 1 (G)	STX; QL (60 G per 25 days)
oxiconazole nitrate external cream 1 %	Tier 1 (G)	N8 (Listing does not include certain NDCs); QL (60 G per 25 days)
OXISTAT EXTERNAL LOTION 1 % (*oxiconazole nitrate*)	Tier 3 (NPB)	QL (60 ML per 25 days)
sulconazole nitrate external cream 1 %	Tier 1 (G)	
sulconazole nitrate external solution 1 %	Tier 1 (G)	
tavaborole external solution 5 %	NF	
DERMATOLOGY, ANTIPRURITIC		
doxepin hcl external cream 5 %	NF	
PRUDOXIN EXTERNAL CREAM 5 % (*doxepin hcl (antipruritic)*)	Tier 3 (NPB)	QL (45 G per 25 days)
ZONALON EXTERNAL CREAM 5 % (*doxepin hcl (antipruritic)*)	Tier 3 (NPB)	QL (45 G per 25 days)
DERMATOLOGY, ANTIPSORIATICS		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	Tier 1 (G)	
calcipotriene external cream 0.005 %	NF	
calcipotriene external ointment 0.005 %	Tier 1 (G)	
calcipotriene external solution 0.005 %	Tier 1 (G)	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	NF	
calcipotriene-betameth diprop external suspension 0.005-0.064 %	NF	
calcitriol external ointment 3 mcg/gm	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (*calcipotriene-betameth diprop*)	Tier 2 (PB)	
methoxsalen rapid oral capsule 10 mg	Tier 1 (G)	
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*spesolimab-sbzo*)	Tier 5 (NPSP)	PA; QL (2 SYRINGES per 28 days)
tazarotene external cream 0.05 %	Tier 1 (G)	
tazarotene external cream 0.1 %	Tier 1 (G)	PA; AL (Max 35 Years)
tazarotene external gel 0.05 %, 0.1 %	Tier 1 (G)	
VECTICAL EXTERNAL OINTMENT 3 MCG/GM (*calcitriol*)	NF	
VTAMA EXTERNAL CREAM 1 % (*tapinarof*)	Tier 2 (PB)	
ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*)	Tier 2 (PB)	
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole external shampoo 2 %	Tier 1 (G)	
ZORYVE EXTERNAL FOAM 0.3 % (*roflumilast (antiseborrheic)*)	Tier 2 (PB)	
DERMATOLOGY, ATOPIC DERMATITIS		
ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*tralokinumab-ldrm*)	Tier 4 (PSP)	PA; QL (2 PENS per 28 days)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*tralokinumab-ldrm*)	Tier 4 (PSP)	PA; QL (4 SYRINGES per 28 days)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*)	Tier 4 (PSP)	PA; QL (30 TABLETS per 30 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (*dupilumab*)	Tier 2 (PB)	PA; IBC (Indicated for Asthma and Atopic Dermatitis); QL (2 SYRINGES per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*dupilumab*)	Tier 2 (PB)	PA; IBC (Indicated for Asthma and Atopic Dermatitis); QL (4 SYRINGES per 28 days)
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (*lebrikizumab-lbkz*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EUCRISA EXTERNAL OINTMENT 2 % (*crisaborole*)	Tier 2 (PB)	
OPZELURA EXTERNAL CREAM 1.5 % (*ruxolitinib phosphate*)	Tier 2 (PB)	
pimecrolimus external cream 1 %	Tier 1 (G)	
tacrolimus external ointment 0.03 %, 0.1 %	Tier 1 (G)	
ZORYVE EXTERNAL CREAM 0.15 % (*roflumilast (dermatologic)*)	Tier 2 (PB)	
DERMATOLOGY, CORTICOSTEROIDS		
alclometasone dipropionate external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
alclometasone dipropionate external ointment 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
amcinonide external cream 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
amcinonide external ointment 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
APEXICON E EXTERNAL CREAM 0.05 % (*diflorasone diacet emoll base*)	Tier 3 (NPB)	QL (120 G per 25 days)
betamethasone dipropionate aug external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
betamethasone dipropionate aug external gel 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
betamethasone dipropionate aug external lotion 0.05 %	Tier 1 (G)	QL (120 ML per 25 DAYs)
betamethasone dipropionate aug external ointment 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
betamethasone dipropionate external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
betamethasone dipropionate external lotion 0.05 %	Tier 1 (G)	QL (120 ML per 25 DAYs)
betamethasone dipropionate external ointment 0.05 %	NF	
betamethasone valerate external cream 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
betamethasone valerate external foam 0.12 %	Tier 1 (G)	QL (120 G per 25 days)
betamethasone valerate external lotion 0.1 %	Tier 1 (G)	QL (120 ML per 25 DAYs)
betamethasone valerate external ointment 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
BRYHALI EXTERNAL LOTION 0.01 % (*halobetasol propionate*)	Tier 2 (PB)	QL (120 G per 25 days)
clobetasol propionate e external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
clobetasol propionate emulsion external foam 0.05 %	NF	
clobetasol propionate external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
clobetasol propionate external foam 0.05 %	Tier 1 (G)	QL (120 G per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clobetasol propionate external gel 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
clobetasol propionate external liquid 0.05 %	Tier 1 (G)	QL (120 ML per 25 days)
clobetasol propionate external lotion 0.05 %	Tier 1 (G)	QL (120 ML per 25 DAYs)
clobetasol propionate external ointment 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
clobetasol propionate external shampoo 0.05 %	Tier 1 (G)	QL (120 ML per 25 days)
clobetasol propionate external solution 0.05 %	Tier 1 (G)	QL (120 ML per 25 days)
CLOBEX EXTERNAL LOTION 0.05 % (*clobetasol propionate*)	Tier 2 (PB)	QL (120 ML per 25 DAYs)
CLOBEX EXTERNAL SHAMPOO 0.05 % (*clobetasol propionate*)	Tier 2 (PB)	QL (120 ML per 25 days)
CLOBEX SPRAY EXTERNAL LIQUID 0.05 % (*clobetasol propionate*)	Tier 3 (NPB)	QL (120 ML per 25 DAYs)
clocortolone pivalate external cream 0.1 %	NF	
CLODERM EXTERNAL CREAM 0.1 % (*clocortolone pivalate*)	Tier 3 (NPB)	QL (120 G per 25 days)
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (*flurandrenolide*)	Tier 3 (NPB)	QL (1 TAPE per 25 DAYs)
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	Tier 3 (NPB)	QL (120 ML per 25 days)
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	Tier 3 (NPB)	QL (120 ML per 25 days)
desonide external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
desonide external gel 0.05 %	NF	
desonide external lotion 0.05 %	Tier 1 (G)	QL (120 ML per 25 days)
desonide external ointment 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
DESOWEN EXTERNAL CREAM 0.05 % (*desonide*)	Tier 3 (NPB)	QL (120 G per 25 days)
desoximetasone external cream 0.05 %, 0.25 %	Tier 1 (G)	QL (120 G per 25 days)
desoximetasone external gel 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
desoximetasone external liquid 0.25 %	Tier 1 (G)	QL (120 ML per 25 days)
desoximetasone external ointment 0.05 %	NF	
desoximetasone external ointment 0.25 %	Tier 1 (G)	QL (120 G per 25 days)
diflorasone diacetate external cream 0.05 %	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diflorasone diacetate external ointment 0.05 %	NF	
DIPROLENE EXTERNAL OINTMENT 0.05 % (*betamethasone dipropionate aug*)	Tier 3 (NPB)	QL (120 G per 25 days)
DUOBRII EXTERNAL LOTION 0.01-0.045 % (*halobetasol prop-tazarotene*)	Tier 2 (PB)	
fluocinolone acetonide body external oil 0.01 %	Tier 1 (G)	QL (120 ML per 25 days)
fluocinolone acetonide external cream 0.01 %, 0.025 %	Tier 1 (G)	QL (120 G per 25 days)
fluocinolone acetonide external ointment 0.025 %	Tier 1 (G)	QL (120 G per 25 days)
fluocinolone acetonide external solution 0.01 %	Tier 1 (G)	QL (120 ML per 25 days)
fluocinolone acetonide scalp external oil 0.01 %	Tier 1 (G)	QL (120 ML per 25 days)
fluocinonide emulsified base external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
fluocinonide external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
fluocinonide external cream 0.1 %	NF	
fluocinonide external gel 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
fluocinonide external ointment 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
fluocinonide external solution 0.05 %	Tier 1 (G)	QL (120 ML per 25 days)
flurandrenolide external cream 0.05 %	NF	
flurandrenolide external lotion 0.05 %	NF	
fluticasone propionate external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
fluticasone propionate external lotion 0.05 %	Tier 1 (G)	QL (120 ML per 25 days)
fluticasone propionate external ointment 0.005 %	Tier 1 (G)	QL (120 G per 25 days)
halcinonide external cream 0.1 %	NF	
halobetasol propionate external cream 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
halobetasol propionate external foam 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
halobetasol propionate external ointment 0.05 %	Tier 1 (G)	QL (120 G per 25 days)
HALOG EXTERNAL CREAM 0.1 % (*halcinonide*)	Tier 3 (NPB)	QL (120 G per 25 days)
HALOG EXTERNAL OINTMENT 0.1 % (*halcinonide*)	Tier 3 (NPB)	QL (120 G per 25 days)
HALOG EXTERNAL SOLUTION 0.1 % (*halcinonide*)	Tier 3 (NPB)	QL (120 ML per 25 days)
hydrocortisone butyrate external cream 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
hydrocortisone butyrate external lotion 0.1 %	NF	

The formulary is updated the first week of each month.

CE=Copay Exception | Tier 1(G)=Generic | Tier 2(PB)=Preferred Brand | Tier 3(NPB)=Non-Preferred Brand | Tier 4(PSP)=Preferred Specialty | Tier 5(NPSP)=Non-Preferred Specialty | NF=Non-Formulary | PA=Prior Authorization | ST=Step Therapy | QL=Quantity Limits | AL=Age Limits | SPC=Only available for select plans. Refer to member plan documents for coverage. | LGC=Lowest Generic Copay | IBC=Indication Based Coverage | STX=Safer and/or more effective treatments are available | N7=Drug tier when CE does not apply | N8=Drug Specific Coverage

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrocortisone butyrate external ointment 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
hydrocortisone butyrate external solution 0.1 %	Tier 1 (G)	QL (120 ML per 25 days)
hydrocortisone external cream 2.5 %	Tier 1 (G)	QL (120 G per 25 days)
hydrocortisone external lotion 2 %	Tier 1 (G)	QL (120 ML per 25 DAYs)
hydrocortisone external lotion 2.5 %	Tier 1 (G)	QL (120 ML per 25 days)
hydrocortisone external ointment 2.5 %	Tier 1 (G)	QL (120 G per 25 days)
hydrocortisone valerate external cream 0.2 %	Tier 1 (G)	QL (120 G per 25 days)
hydrocortisone valerate external ointment 0.2 %	Tier 1 (G)	QL (120 G per 25 days)
IMPOYZ EXTERNAL CREAM 0.025 % (*clobetasol propionate*)	Tier 3 (NPB)	QL (120 G per 25 days)
KENALOG EXTERNAL AEROSOL SOLUTION 0.147 MG/GM (*triamcinolone acetonide*)	Tier 3 (NPB)	QL (120 G per 25 days)
LEXETTE EXTERNAL FOAM 0.05 % (*halobetasol propionate*)	Tier 3 (NPB)	QL (120 G per 25 days)
LOCOID EXTERNAL LOTION 0.1 % (*hydrocortisone butyrate*)	Tier 3 (NPB)	QL (120 ML per 25 DAYs)
mometasone furoate external cream 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
mometasone furoate external ointment 0.1 %	Tier 1 (G)	QL (120 G per 25 days)
mometasone furoate external solution 0.1 %	Tier 1 (G)	QL (120 ML per 25 days)
PANDEL EXTERNAL CREAM 0.1 % (*hydrocortisone probutate*)	Tier 3 (NPB)	QL (120 G per 25 days)
SERNIVO EXTERNAL EMULSION 0.05 % (*betamethasone dipropionate*)	Tier 3 (NPB)	QL (120 ML per 25 DAYs)
SYNALAR EXTERNAL CREAM 0.025 % (*fluocinolone acetonide*)	Tier 3 (NPB)	QL (120 G per 25 days)
SYNALAR EXTERNAL OINTMENT 0.025 % (*fluocinolone acetonide*)	Tier 3 (NPB)	QL (120 G per 25 days)
TEXACORT EXTERNAL SOLUTION 2.5 % (*hydrocortisone*)	Tier 3 (NPB)	QL (120 ML per 25 days)
TOPICORT EXTERNAL CREAM 0.05 %, 0.25 % (*desoximetasone*)	Tier 3 (NPB)	QL (120 G per 25 days)
TOPICORT EXTERNAL GEL 0.05 % (*desoximetasone*)	Tier 3 (NPB)	QL (120 G per 25 days)
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (*desoximetasone*)	Tier 3 (NPB)	QL (120 G per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICORT SPRAY EXTERNAL LIQUID 0.25 % (*desoximetasone*)	Tier 3 (NPB)	QL (120 ML per 25 DAYs)
clobetasol propionate emulsion (Tovet External Foam 0.05 %)	NF	
triamcinolone acetonide external aerosol solution 0.147 mg/gm	NF	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	Tier 1 (G)	QL (120 G per 25 days)
triamcinolone acetonide external lotion 0.025 %, 0.1 %	Tier 1 (G)	QL (120 ML per 25 days)
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	Tier 1 (G)	QL (120 G per 25 days)
ULTRAVATE EXTERNAL LOTION 0.05 % (*halobetasol propionate*)	Tier 3 (NPB)	QL (120 ML per 25 DAYs)
VANOS EXTERNAL CREAM 0.1 % (*fluocinonide*)	Tier 3 (NPB)	QL (120 G per 25 days)
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine external ointment 5 %	Tier 1 (G)	QL (50 G per 25 days)
lidocaine external patch 5 %	Tier 1 (G)	QL (90 PATCH per 25 days)
lidocaine hcl external solution 4 %	Tier 1 (G)	QL (50 ML per 25 DAYs)
lidocaine-prilocaine external cream 2.5-2.5 %	Tier 1 (G)	QL (30 G per 25 days)
LIDODERM EXTERNAL PATCH 5 % (*lidocaine*)	Tier 2 (PB)	QL (90 PATCH per 25 days)
PLIAGLIS EXTERNAL CREAM 7-7 % (*lidocaine-tetracaine*)	NF	
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
ABREVA EXTERNAL CREAM 10 % (*docosanol*)	Tier 1 (G)	Select OTC
acyclovir external cream 5 %	NF	
acyclovir external ointment 5 %	Tier 1 (G)	
bexarotene external gel 1 %	Tier 4 (PSP)	PA
docosanol external cream 10 %	Tier 1 (G)	Select OTC
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (*aminolevulinic acid hcl*)	Tier 5 (NPSP)	QL (1 STICK per 25 DAYs)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (*nemolizumab-ilto*)	NF	
podofilox external gel 0.5 %	Tier 1 (G)	
podofilox external solution 0.5 %	Tier 1 (G)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TARGRETIN EXTERNAL GEL 1 % (*bexarotene*)	NF	
VALCHLOR EXTERNAL GEL 0.016 % (*mechlorethamine hcl (topical)*)	Tier 5 (NPSP)	PA; QL (2 G per 30 days)
DERMATOLOGY, ROSACEA		
azelaic acid external gel 15 %	Tier 1 (G)	
doxycycline oral capsule delayed release 40 mg	Tier 1 (G)	
FINACEA EXTERNAL FOAM 15 % (*azelaic acid*)	Tier 2 (PB)	
ivermectin external cream 1 %	Tier 1 (G)	
metronidazole external cream 0.75 %	Tier 1 (G)	
metronidazole external gel 0.75 %, 1 %	Tier 1 (G)	
metronidazole external lotion 0.75 %	Tier 1 (G)	
SOOLANTRA EXTERNAL CREAM 1 % (*ivermectin*)	Tier 2 (PB)	
DERMATOLOGY, SCABICIDES AND PEDICULICIDES		
CROTAN EXTERNAL LOTION 10 % (*crotamiton*)	Tier 1 (G)	
malathion external lotion 0.5 %	Tier 1 (G)	
OVIDE EXTERNAL LOTION 0.5 % (*malathion*)	Tier 2 (PB)	
permethrin external cream 5 %	Tier 1 (G)	
spinosad external suspension 0.9 %	Tier 1 (G)	
DERMATOLOGY, WOUND CARE AGENTS		
acetic acid irrigation solution 0.25 %	Tier 1 (G)	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl oral capsule 30 mg	Tier 1 (G)	
chlorhexidine gluconate mouth/throat solution 0.12 %	Tier 1 (G)	
clotrimazole mouth/throat troche 10 mg	Tier 1 (G)	
EVOXAC ORAL CAPSULE 30 MG (*cevimeline hcl*)	Tier 2 (PB)	
lidocaine viscous hcl mouth/throat solution 2 %	Tier 1 (G)	
nystatin mouth/throat suspension 100000 unit/ml	Tier 1 (G)	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	Tier 1 (G)	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (*pilocarpine hcl*)	Tier 2 (PB)	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
triamcinolone acetonide mouth/throat paste 0.1 %	Tier 1 (G)	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
acetic acid otic solution 2 %	Tier 1 (G)	
ciprofloxacin hcl otic solution 0.2 %	Tier 1 (G)	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	Tier 1 (G)	
ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %	NF	
fluocinolone acetonide otic oil 0.01 %	Tier 1 (G)	
hydrocortisone-acetic acid otic solution 1-2 %	Tier 1 (G)	
neomycin-polymyxin-hc otic solution 1 %	Tier 1 (G)	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	Tier 1 (G)	
ofloxacin otic solution 0.3 %	Tier 1 (G)	

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