Plan for your best health

2026 Aetna Pharmacy Drug Guide

Standard Opt Out Plan - Aetna West Virginia

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 annually in July. The formulary is subject to change. Previous versions are no longer in effect.

Aetna.com

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2026 Pharmacy Drug Guide

Standard Opt Out Plan - Aetna WV

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Definitions

Allowed amount is the maximum amount on which the health insurance issuer bases its payment for a covered health care service. This may be called “eligible expense”, “payment allowance”, or “negotiated rate”. If your health care provider charges more than the allowed amount and is not part of the provider network, you may have to pay the difference.

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 service, which you are responsible to pay. The cost of the covered health care service is generally deemed to be the allowed amount, which may differ from the retail price that you would pay for the same service without using insurance. Typically, a coinsurance does not apply until after you have met the deductible, unless the health insurance issuer has waived or lowered the deductible for the health care service in question.

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, unless the health insurance issuer has waived or lowered the deductible for the health care service in question.

Covered individual is an individual enrolled in, subscribed to, or insured under a health product, whether directly or as a dependent or beneficiary.

Deductible means the amount you pay for covered health care benefits before your health insurer begins to pay for all or part of the cost of the health care benefits under the terms of coverage. If your health product has a deductible, it may have either one deductible or separate deductibles for medical benefits and drug benefits. For some health care services, such as preventive services, your health insurance company might waive or lower the deductible to pay for costs of the health care service from the first dollar of coverage, but this tends not to happen for most other covered services.

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 i) a nonformulary drug, ii) a drug being removed from the formulary, iii) a quantity of a drug above a quantity limit, or iv) a drug that is subject to a step therapy requirement. If you, your designee, or your attending or prescribing provider submits an exception request for coverage of a drug, the health insurance issuer must cover the drug when the drug is determined to be medically necessary to treat your condition.

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 complete list of drugs preferred for use and eligible for coverage under a health product, and includes all drugs covered under the outpatient or pharmacy drug benefit of the health product. Formulary is also known as a drug list or prescription drug list.

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, but may become eligible for coverage under an “exception request.

Oral Anti-Cancer drugs are prescribed, orally administered medications used to kill or slow the growth of cancerous cells. They are no more restrictive than those applied to intravenously injected or administered cancer medications covered by the health product. There are no separate cost-sharing requirements or treatment limitations for prescribed, orally-administered cancer medications.

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 authorized to write a prescription to treat your health condition.

Prescription means an oral, written, or electronic order from a prescribing provider for you that contains the name of the drug, the quantity of the drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by you, the health condition or purpose for which the drug is being prescribed.

Prescription drug means a drug that is prescribed by your prescribing provider and requires a prescription under applicable law.

Prior Authorization means a health product's requirement that you or your prescribing provider obtain the health insurance issuer's authorization for a drug before the health product will cover the drug. The health insurance issuer must grant a prior authorization when it is medically necessary for you to obtain 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.

Your plan includes

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

What you can expect to pay

With your pharmacy plan, the amount you pay depends on the drug your doctor prescribes. It's either a flat fee or a percentage of the drug's/medicine's price. If a pharmacy's retail price for a prescription drug is less than your total cost share amount, you will not be required to pay more than the retail drug 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 may require special handling, storage, or administration. Specialty prescription drugs may also require monitoring from healthcare providers.

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

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

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

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

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

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

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

Have more questions about your pharmacy benefits?

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

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

Specialty Pharmacy Network

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

How to get started with a specialty pharmacy

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

- **To transfer your prescription**, just call us toll-free at **1-866-353-1892 (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 by CVS Caremark Mail Service Pharmacy. These are drugs that are taken regularly for chronic conditions like diabetes or asthma. Depending on your plan, you can get up to a 90-day supply of medicine for less cost. It's fast and convenient, and standard shipping is always free.

Get started right away

You can submit your order using one of these options:

1. **Online** — Visit your secure member website and sign in to your account. There you can add or remove your prescriptions.
2. **Phone** — Call us toll-free, 24/7 at **1-888-792-3862 (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 pharmacy may save you money. For more information, visit the website on your member ID card and log in to your account.

What are generic drugs?

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

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

What is precertification/prior authorization (PA)?

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.

The length of approval for a prior authorization may be different depending on the type of drug, the way your provider prescribed your drug, or the time of year you get your coverage.

- Most prior authorization approvals will be valid for 6 months, the length of treatment as determined by your prescribing provider, or the renewal of your plan, whichever of these is the shortest amount of time
- For maintenance medications to treat a chronic condition or long-term condition, your prior authorization will be valid for either 12 months or the length of time determined by your prescribing provider
- Different prior authorization requirements might apply to benzodiazepines and Schedule II narcotic drugs. Please refer to the formulary or contact us with questions about these drugs.

What is step therapy (ST)?

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

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

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

What are quantity limits (QL)?

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

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

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

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

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

How can your provider request a medical exception?

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

Pharmacy and Therapeutics (P&T) committee

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

Can the formulary change during the year?

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

- New drugs are approved.
- Existing drugs are removed from the market.
- Prescription drugs may become available over the counter (without a prescription). Over-the-counter drugs are not generally covered in a formulary.
- Brand-name drugs lose patent protection and generic versions become available. When this happens, the generic drug will be covered in place of the brandname 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.
- Change in drug or dosage form.
- Changes in tier placement of a drug that results in an increase in cost sharing.
- Any changes of utilization review restrictions, including any additions of these restrictions.

Does Aetna provide notice of these changes?

Yes, Aetna provides member and provider notifications 60 days in advance.

What is a medical benefit drug versus a drug covered under the Outpatient Prescription Drug Benefit?

A medical benefit drug is a drug that is generally not self-administered and requires administration by health care provider. The Outpatient Prescription Drug Benefit includes FDA-approved drugs that are self-administered, commonly oral or self-injectable drugs, not otherwise excluded from coverage.

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

For a more detailed summary of your coverage or benefits plan you can log in to your secure member site on **www.aetna.com** or call the toll-free number on your member ID card.

Discrimination is Against the Law

Aetna complies with applicable California and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnic group, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, medical condition, genetic information, or sex (consistent with 45 CFR § 92.101(a)(2) and California 2 CCR § 14025). Aetna does not exclude people or treat them less favorably because of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability.

Aetna:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified sign language interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-800-872-3862 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability, by action or inaction, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332, (HMO customers: P.O. Box 14032 Lexington, KY 40512-4032)
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.
Please visit https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html#california for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.
This notice is available at Aetna's website: https://www.aetna.com/.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of companies offering and administering health and dental plans and other products such as life, disability, and long-term care insurance. In California, this includes Aetna's wholly-owned subsidiaries Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Better Health of California Inc., Aetna Dental of California Inc., and Health and Human Resource Center Inc., and its other affiliates licensed in California. Aetna's ultimate parent is CVS Health Corporation ("CVS Health").

Language accessibility statement

Interpreter services are available for free.
TTY: 711

To access language services at no cost to you, call **1-800-385-4104**.

Para acceder a los servicios de idiomas sin costo, llame al **1-800-385-4104**. (Spanish)

如欲使用免費語言服務，請致電 **1-800-385-4104**. (Chinese)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số **1-800-385-4104**. (Vietnamese)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa **1-800-385-4104**. (Tagalog)

무료 언어 서비스를 이용하려면 1-800-385-4104 번으로 전화해 주십시오. (Korean)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք **1-800-385-4104** հեռախոսահամարով: (Armenian)

برای دسترسی به خدمات زبان به طور رایگان، با شماره **1-800-385-4104** تماس بگیرید. (Persian-Farsi)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону **1-800-385-4104**. (Russian)

言語サービスを無料でご利用いただくには、 **1-800-385-4104** までお電話ください。 (Japanese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم **1-800-385-4104**. (Arabic)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, **1-800-385-4104** 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

ដើម្បីទទួលនសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទលេខ 1-800-385-4104 ។ (Mon-Khmer, Cambodian)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu **1-800-385-4104**. (Hmong)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, **1-800-385-4104** पर कॉल करें। (Hindi)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-385-4104. (Thai)

Notice of Language Assistance

HMO and DMO-based plans:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117. Planes basados en DMO y HMO –

IMPORTANTE: ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Traditional Plans:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

Non-discrimination notice

Aetna® complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity. We:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call us at 1-888-982-3862 (TTY: 711).

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity you can file a grievance with:

Civil Rights Coordinator
[P.O. Box 14462, Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779)]
[1-800-648-7817, TTY: 711]
Fax: [859-425-3379 (CA HMO customers: 860-262-7705)]
Email: [CRCoordinator@aetna.com]

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf], or by mail or phone at:
  U.S. Department of Health and Human Services
  [200 Independence Avenue, SW Room 509F, HHH Building
  Washington, D.C. 20201]
  [1-800-368-1019, 800-537-7697 (TDD)]
  Complaint forms are available at [http://www.hhs.gov/ocr/office/file/index.html]
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at [https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status], or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at [https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx]

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY:711

To access language services at no cost to you, call 1-888-982-3862 .
Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862 . (Spanish)
如欲使用免費語言服務，請致電 1-888-982-3862 . (Chinese)
Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)
T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-888-982-3862 . (Navajo)
Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)
Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862 . (Albanian)
የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862. (Arabic)
Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով: (Armenian)
Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862 . (Bantu)
আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-982-3862 । (Bengali)
Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862 . (Bisayan-Visayan)
သင့်အတွက် အခကြေးငွေ မရှိဘဲ ဘာသာစကားဝန်ဆောင်မှုများကို ဝင်ရောက်အသုံးပြုရန် 1-888-982-3862 ကိုခေါ်ဆိုပါ။ (Burmese)
ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-982-3862 (Carolinian (Kapasal Falawasch)
Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862 . (Catalan)
Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862 . (Chamorro)
ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏩᏫᏓᏁᏗ Ꮳ ᎪᎢᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᎣᎩ, ᎾᏥᎯᏏᎳᎵᏏ 1-888-982-3862 . (Cherokee)
Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862 . (Choctaw)
Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862 . (Cushite-Oromo)
Voor gratis toegang tot taaldiensten, bell 1-888-982-3862 . (Dutch)
Pou jwenn sèvis lang gratis, rele 1-888-982-3862 . (French Creole-Haitian)
Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862 . (Greek)
તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862 . (Gujarati)
No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862 . Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)
आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें। (Hindi)
Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862 . (Hmong)
Iji nwetaòhèrè na rụ gasị asụsụ n'efu, kpọọ 1-888-982-3862 . (Ibo)
Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862 . (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862 . (Indonesian)
Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 . (Italian)
言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。 (Japanese)
လာကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိဉ်လာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိး 1-888-982-3862 . (Karen)
무료 언어 서비스를 이용하려면 1-888-982-3862 **번으로 전화해 주십시오.** (Korean)
M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-888-982-3862 . (Kru-Bassa)
بۆ دەسپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-888-982-3862 (Kurdish)
ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862 . (Laotian)
कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा. (Marathi)
Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862 . (Marshallese)
Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862 . (Micronesian-Pohnpeian)
ដើម្បីទទួលនសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទលេខ 1-888-982-3862 ។ (Mon-Khmer, Cambodian)
निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862 मा टेलिफोन गर्नुहोस् । (Nepali)
Të kɔɔr yïn wëëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-982-3862 . (Nilotic-Dinka)
For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862 . (Norwegian)
Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862 . (Pennsylvania Dutch)
برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید. (Persian-Farsi)
Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)
ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)
Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862. (Romanian)
Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. (Russian)
Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862. (Samoan)
Za besplatne prevodilačke usluge pozovite 1-888-982-3862. (Serbo-Croatian)
Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862. (Sudanic-Fulfulde)
Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862. (Swahili)
ܐܸܢ ܣܢܝܼܩܵܐ ܝܘܸܬ ܥܲܠ ܚܠܵܡܬܵܐ ܕܬܲܪܓܡܵܢܘܼܬܵܐ ܒܠܸܫܵܢܵܐ ܡܲܓܵܢܵܝܬܵܐ، ܘܩܪܝܼ ܠܸܢ: 1-888-982-3862 (Syriac Assyrian)
మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-982-3862 కాల్ చేయండి. (Telugu)
หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862. (Thai)
Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862. (Tongan)
Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862. (Trukese)
Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın. (Turkish)
Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862. (Ukrainian)
بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔(Urdu)
Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)
צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-888-982-3862 . (Yiddish)
Lati wọnú awọn isẹ̀ èdè l'ọ́fẹ fun ọ, pe 1-888-982-3862. (Yoruba)

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.

Coverage Requirements such as Prior Authorization or Step Therapy may vary by state.

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Your plan may not cover certain drugs to treat conditions such as infertility, erectile dysfunction and weight loss. 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 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.

In accordance with state law or insurer policies, changes to drug coverage are not effective for commercial fully insured plans (including HMOs) in Arizona, Iowa, Louisiana, New York, Texas, and in most circumstances Connecticut and Ver-mont, and in some circumstances Washington and Tennessee, 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.

For fully insured plans (including HMOs) in Maryland, changes in prior authorization requirements for previously authorized immune globulin (human) and drugs used in the treatment of a mental disorder may not apply on reauthorization under certain conditions.

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.

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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.

In certain states, including Maine, step therapy programs do not apply to fully insured members utilizing prescription drugs for the treatment of metastatic cancer and conditions associated with metastatic cancer.

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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.
G = Generic
NF = Non-formulary, not covered unless exception request granted
NPB = Non-Preferred Brands
NPSP = Non-Preferred Specialty Drugs
PB = Preferred Brand
PSP = Preferred Specialty Drugs

Coverage Requirements and Limits
AL = Age Limit
IBC = Indication Based Coverage
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	G	
GOUT		
allopurinol oral tablet 100 mg, 300 mg	G	
colchicine oral capsule 0.6 mg	G	
colchicine oral tablet 0.6 mg	G	
colchicine-probenecid oral tablet 0.5-500 mg	G	
febuxostat oral tablet 40 mg, 80 mg	G	
KRYSTEXXA INTRAVENOUS SOLUTION 8 MG/50ML, 8 MG/ML (*pegloticase*)	NPSP	PA
probenecid oral tablet 500 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MISCELLANEOUS		
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 500 MCG/20ML, 500 MCG/5ML (*ziconotide acetate*)	NPSP	
NON-OPIOID ANALGESICS		
ALLZITAL ORAL TABLET 25-325 MG (*butalbital-acetaminophen*)	NPB	STX; QL (96 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	G	STX; QL (48 TABLETS per 25 DAYs)
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	G	STX; QL (48 CAPSULES per 25 DAYs)
butalbital-apap-caffeine oral tablet 50-325-40 mg	G	STX; QL (48 TABLETS per 25 days)
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	G	STX; QL (48 CAPSULES per 25 days)
FIORICET ORAL CAPSULE 50-300-40 MG (*butalbital-apap-caffeine*)	NPB	STX; QL (48 CAPSULES per 25 DAYs)
NSAIDS		
diclofenac epolamine external patch 1.3 %	G	STX; QL (30 PATCHES per 25 days)
diclofenac potassium oral capsule 25 mg	NF	
diclofenac potassium oral tablet 25 mg	NF	
diclofenac potassium oral tablet 50 mg	G	
diclofenac potassium(migraine) oral packet 50 mg	NF	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	G	
diclofenac sodium external solution 1.5 %	G	
diclofenac sodium external solution 2 %	NF	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	G	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	G	
etodolac oral capsule 200 mg, 300 mg	G	
etodolac oral tablet 400 mg, 500 mg	G	
fenoprofen calcium oral capsule 400 mg	NF	
FENOPRON ORAL CAPSULE 300 MG (*fenoprofen calcium*)	NPB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLECTOR EXTERNAL PATCH 1.3 % (*diclofenac epolamine*)	NPB	STX; QL (30 PATCHES per 25 days)
flurbiprofen oral tablet 100 mg, 50 mg	G	
ibuprofen oral tablet 300 mg, 400 mg, 600 mg, 800 mg	G	
INDOCIN ORAL SUSPENSION 25 MG/5ML (*indomethacin*)	NF	STX
indomethacin oral capsule 25 mg, 50 mg	G	STX
indomethacin rectal suppository 50 mg	NF	STX
ketoprofen er oral capsule extended release 24 hour 200 mg	NF	
ketoprofen oral capsule 25 mg	NF	
ketoprofen oral capsule 50 mg, 75 mg	G	
ketorolac tromethamine oral tablet 10 mg	G	QL (20 TABLETS per 25 DAYs)
LICART EXTERNAL PATCH 24 HOUR 1.3 % (*diclofenac epolamine*)	NPB	STX; QL (15 PATCHES per 25 days)
diclofenac potassium (Lofena Oral Tablet 25 Mg)	NF	
meclofenamate sodium oral capsule 100 mg, 50 mg	G	
mefenamic acid oral capsule 250 mg	G	N8 (Listing does not include certain NDCs)
meloxicam oral capsule 10 mg, 5 mg	NF	
meloxicam oral tablet 15 mg, 7.5 mg	G	
nabumetone oral tablet 500 mg, 750 mg	G	
NAPRELAN ORAL TABLET EXTENDED RELEASE 24 HOUR 375 MG, 500 MG (*naproxen sodium*)	NF	
naproxen oral suspension 125 mg/5ml	NF	
naproxen oral tablet 250 mg, 375 mg, 500 mg	G	
naproxen oral tablet delayed release 375 mg, 500 mg	G	
naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg	NF	
naproxen sodium oral tablet 275 mg, 550 mg	G	
oxaprozin oral tablet 600 mg	G	
piroxicam oral capsule 10 mg, 20 mg	G	
SPRIX NASAL SOLUTION 15.75 MG/SPRAY (*ketorolac tromethamine*)	NF	
sulindac oral tablet 150 mg, 200 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, COMBINATIONS		
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	G	
naproxen-esomeprazole mg oral tablet delayed release 375-20 mg, 500-20 mg	NF	
OPIOID ANALGESICS		
acetaminophen-codeine oral solution 300-30 mg/12.5ml	G	N8 (Subject to initial limit); QL (2700 ML per 25 days)
acetaminophen-codeine oral tablet 300-15 mg	G	N8 (Subject to initial limit); QL (400 TABLETS per 25 DAYs)
acetaminophen-codeine oral tablet 300-30 mg	G	N8 (Subject to initial limit); QL (360 TABLETS per 25 Days)
acetaminophen-codeine oral tablet 300-60 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	G	N8 (Subject to initial limit); QL (300 CAPSULES per 25 days)
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	G	STX; QL (48 CAPSULES per 25 DAYs)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	G	STX; QL (48 CAPSULES per 25 days)
butorphanol tartrate nasal solution 10 mg/ml	G	QL (2 BOTTLES per 25 DAYs)
codeine sulfate oral tablet 30 mg	G	N8 (Subject to initial limit); QL (42 TABLETS per 25 days)
codeine sulfate oral tablet 60 mg	NPB	N8 (Subject to initial limit); QL (42 TABLETS per 25 days)
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (*tramadol hcl*)	NPB	ST; QL (30 CAPSULES per 25 DAYs)
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG, 300 MG (*tramadol hcl*)	NPB	ST; N8 (High Strength Requires Prior Auth)
DILAUDID ORAL LIQUID 1 MG/ML (*hydromorphone hcl*)	NPB	N8 (Subject to initial limit); QL (480 ML per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DILAUDID ORAL TABLET 2 MG (*hydromorphone hcl*)	NPB	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
DILAUDID ORAL TABLET 4 MG (*hydromorphone hcl*)	NPB	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
DILAUDID ORAL TABLET 8 MG (*hydromorphone hcl*)	NPB	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
DISKETS ORAL TABLET SOLUBLE 40 MG (*methadone hcl*)	NPB	QL (9 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	G	ST; N8 (High Strength Requires Prior Auth)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr	G	ST; QL (10 PATCHES per 25 DAYs)
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg	G	ST; QL (60 CAPSULES per 25 days)
hydrocodone bitartrate er oral capsule extended release 12 hour 50 mg	G	ST; N8 (High Strength Requires Prior Auth)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg	G	ST; N8 (High Strength Requires Prior Auth)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	G	ST; QL (30 TABLETS per 25 DAYs)
hydrocodone-acetaminophen oral solution 10-300 mg/15ml	G	N8 (Subject to initial limit); QL (2025 ML per 25 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	G	N8 (Subject to initial limit); QL (2700 ML per 25 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 7.5-300 mg, 7.5-325 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 DAYs)
hydrocodone-acetaminophen oral tablet 10-325 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
hydrocodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	G	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
hydrocodone-acetaminophen oral tablet 5-300 mg	G	N8 (Subject to initial limit); QL (240 TABLETS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	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	G	ST; QL (30 TABLETS per 25 DAYs)
hydromorphone hcl er oral tablet extended release 24 hour 32 mg	G	ST; N8 (High Strength Requires Prior Auth)
hydromorphone hcl oral liquid 1 mg/ml	G	N8 (Subject to initial limit); QL (480 ML per 25 days)
hydromorphone hcl oral tablet 2 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
hydromorphone hcl oral tablet 4 mg	G	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
hydromorphone hcl oral tablet 8 mg	G	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG (*hydrocodone bitartrate*)	NPB	ST; N8 (High Strength Requires Prior Auth)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 20 MG, 30 MG, 40 MG, 60 MG, 80 MG (*hydrocodone bitartrate*)	NPB	ST; QL (30 TABLETS per 25 days)
levorphanol tartrate oral tablet 2 mg, 3 mg	NF	
meperidine hcl oral solution 50 mg/5ml	G	N8 (Subject to initial limit); QL (90 ML per 25 days)
meperidine hcl oral tablet 50 mg	G	N8 (Subject to initial limit); QL (18 TABLETS per 25 days)
methadone hcl (Methadone Hcl Intensol Oral Concentrate 10 Mg/Ml)	G	ST; QL (45 ML per 25 days)
methadone hcl oral concentrate 10 mg/ml	G	QL (30 ML per 25 DAYs)
methadone hcl oral solution 10 mg/5ml	G	ST; QL (225 ML per 25 days)
methadone hcl oral solution 5 mg/5ml	G	ST; QL (450 ML per 25 DAYs)
methadone hcl oral tablet 10 mg	G	ST; QL (30 TABLETS per 25 days)
methadone hcl oral tablet 5 mg	G	ST; QL (90 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methadone hcl oral tablet soluble 40 mg	G	QL (9 TABLETS per 25 DAYs)
METHADOSE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*)	NPB	QL (30 ML per 25 DAYs)
methadone hcl (Methadose Oral Tablet Soluble 40 Mg)	G	QL (9 TABLETS per 25 DAYs)
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*)	NPB	QL (30 ML per 25 DAYs)
morphine sulfate (concentrate) oral solution 10 mg/0.5ml	G	N8 (Subject to initial limit); QL (135 ML per 25 Days)
morphine sulfate er beads oral capsule extended release 24 hour 120 mg	G	ST; N8 (High Strength Requires Prior Auth)
morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	G	ST; QL (30 CAPSULES per 25 DAYs)
morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg	G	ST; N8 (High Strength Requires Prior Auth)
morphine sulfate er oral tablet extended release 15 mg	G	ST; QL (90 TABLETS per 25 days)
morphine sulfate er oral tablet extended release 30 mg	G	ST; QL (90 TABLETS per 25 DAYs)
morphine sulfate oral solution 10 mg/5ml	G	N8 (Subject to initial limit); QL (900 ML per 25 days)
morphine sulfate oral solution 20 mg/5ml	G	N8 (Subject to initial limit); QL (675 ML per 25 DAYs)
morphine sulfate oral tablet 15 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
morphine sulfate oral tablet 30 mg	G	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG (*morphine sulfate*)	NPB	ST; QL (90 TABLETS per 25 DAYs)
MS CONTIN ORAL TABLET EXTENDED RELEASE 60 MG (*morphine sulfate*)	NPB	ST; N8 (High Strength Requires Prior Auth)
nalocet oral tablet 2.5-300 mg	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*)	NPB	ST; QL (60 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (*tapentadol hcl*)	NPB	ST; N8 (High Strength Requires Prior Auth)
NUCYNTA ORAL TABLET 100 MG (*tapentadol hcl*)	NPB	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
NUCYNTA ORAL TABLET 50 MG (*tapentadol hcl*)	NPB	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
NUCYNTA ORAL TABLET 75 MG (*tapentadol hcl*)	NPB	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)
oxycodone hcl oral capsule 5 mg	G	N8 (Subject to initial limit); QL (180 CAPSULES per 25 days)
oxycodone hcl oral concentrate 100 mg/5ml	G	N8 (Subject to initial limit); QL (90 ML per 25 days)
oxycodone hcl oral solution 5 mg/5ml	G	N8 (Subject to initial limit); QL (900 ML per 25 days)
oxycodone hcl oral tablet 10 mg, 5 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
oxycodone hcl oral tablet 15 mg	G	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
oxycodone hcl oral tablet 20 mg	G	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)
oxycodone hcl oral tablet 30 mg	G	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
oxycodone hcl oral tablet abuse-deterrent 10 mg	NPB	N8 (Subject to initial limit); QL (180 TABLETS per 25 DAYs)
oxycodone hcl oral tablet abuse-deterrent 15 mg	NPB	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
oxycodone hcl oral tablet abuse-deterrent 30 mg	NPB	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxycodone hcl oral tablet abuse-deterrent 5 mg	NPB	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
oxycodone-acetaminophen oral solution 10-300 mg/5ml	NPB	N8 (Subject to initial limit); QL (900 ML per 25 days)
oxycodone-acetaminophen oral solution 5-325 mg/5ml	G	N8 (Subject to initial limit); QL (1800 ML per 25 days)
oxycodone-acetaminophen oral tablet 10-300 mg	NPB	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 10-325 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 2.5-300 mg, 5-300 mg	NPB	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	G	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 7.5-300 mg	NPB	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
oxycodone-acetaminophen oral tablet 7.5-325 mg	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*)	NPB	ST; QL (60 TABLETS per 25 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 40 MG, 60 MG, 80 MG (*oxycodone hcl*)	NPB	ST; N8 (High Strength Requires Prior Auth)
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg	G	ST; QL (60 TABLETS per 25 days)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg	G	ST; N8 (High Strength Requires Prior Auth)
oxymorphone hcl oral tablet 10 mg	G	N8 (Subject to initial limit); QL (90 TABLETS per 25 days)
oxymorphone hcl oral tablet 5 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PERCOCET ORAL TABLET 10-325 MG (*oxycodone-acetaminophen*)	NPB	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
PERCOCET ORAL TABLET 5-325 MG (*oxycodone-acetaminophen*)	NPB	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
PERCOCET ORAL TABLET 7.5-325 MG (*oxycodone-acetaminophen*)	NPB	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
PROLATE ORAL SOLUTION 10-300 MG/5ML (*oxycodone-acetaminophen*)	NPB	N8 (Subject to initial limit); QL (900 ML per 25 DAYs)
PROLATE ORAL TABLET 10-300 MG (*oxycodone-acetaminophen*)	NPB	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
PROLATE ORAL TABLET 5-300 MG (*oxycodone-acetaminophen*)	NPB	N8 (Subject to initial limit); QL (360 TABLETS per 25 days)
PROLATE ORAL TABLET 7.5-300 MG (*oxycodone-acetaminophen*)	NPB	N8 (Subject to initial limit); QL (240 TABLETS per 25 days)
ROXICODONE ORAL TABLET 15 MG (*oxycodone hcl*)	NPB	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
ROXICODONE ORAL TABLET 30 MG (*oxycodone hcl*)	NPB	N8 (Subject to initial limit); QL (60 TABLETS per 25 days)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 10 MG, 5 MG (*oxycodone hcl*)	NPB	N8 (Subject to initial limit); QL (180 TABLETS per 25 DAYs)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 15 MG (*oxycodone hcl*)	NPB	N8 (Subject to initial limit); QL (120 TABLETS per 25 DAYs)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 30 MG (*oxycodone hcl*)	NPB	N8 (Subject to initial limit); QL (60 TABLETS per 25 DAYs)
tapentadol hcl er oral tablet extended release 12 hour 100 mg, 50 mg	NPB	ST; QL (60 TABLETS per 25 DAYs)
tapentadol hcl er oral tablet extended release 12 hour 150 mg, 200 mg, 250 mg	NPB	ST; N8 (High Strength Requires Prior Auth)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tapentadol hcl oral tablet 100 mg	G	N8 (Subject to initial limit); QL (60 TABLETS per 25 DAYs)
tapentadol hcl oral tablet 50 mg	G	N8 (Subject to initial limit); QL (120 TABLETS per 25 DAYs)
tapentadol hcl oral tablet 75 mg	G	N8 (Subject to initial limit); QL (90 TABLETS per 25 DAYs)
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 200 mg, 300 mg	G	ST; N8 (High Strength Requires Prior Auth)
tramadol hcl er oral tablet extended release 24 hour 100 mg	G	ST; QL (30 TABLETS per 25 days)
tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg	G	ST; N8 (High Strength Requires Prior Auth)
tramadol hcl oral tablet 100 mg	NF	
tramadol hcl oral tablet 25 mg	G	QL (120 TABLETS per 25 days)
tramadol hcl oral tablet 50 mg	G	N8 (Subject to initial limit); QL (180 TABLETS per 25 days)
tramadol hcl oral tablet 75 mg	G	N8 (Subject to initial limit); QL (120 TABLETS per 25 days)
tramadol hcl solution 5 mg/ml oral	G	N8 (Subject to initial limit); QL (1800 ML per 25 Days)
tramadol hcl solution 5 mg/ml oral	NPB	N8 (Subject to initial limit); QL (1800 ML per 25 Days)
tramadol-acetaminophen oral tablet 37.5-325 mg	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*)	PB	ST; QL (60 CAPSULES per 25 days)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (*oxycodone*)	PB	ST; N8 (High Strength Requires Prior Auth)
OPIOID PARTIAL AGONISTS		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 75 MCG (*buprenorphine hcl*)	PB	ST; QL (60 FILMS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELBUCA BUCCAL FILM 600 MCG, 750 MCG, 900 MCG (*buprenorphine hcl*)	PB	ST; N8 (High Strength Requires Prior Auth)
buprenorphine transdermal patch weekly 10 mcg/hr, 5 mcg/hr, 7.5 mcg/hr	G	ST; QL (4 PATCHES per 25 DAYs)
buprenorphine transdermal patch weekly 15 mcg/hr, 20 mcg/hr	G	ST; N8 (High Strength Requires Prior Auth)
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HR, 5 MCG/HR, 7.5 MCG/HR (*buprenorphine*)	NPB	ST; QL (4 PATCHES per 25 days)
BUTRANS TRANSDERMAL PATCH WEEKLY 15 MCG/HR, 20 MCG/HR (*buprenorphine*)	NPB	ST; N8 (High Strength Requires Prior Auth)
pentazocine-naloxone hcl oral tablet 50-0.5 mg	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*)	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	G	
VISCOSUPPLEMENTS		
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE 60 MG/3ML (*sodium hyaluronate (viscosup)*)	PSP	PA
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	PSP	PA
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE 30 MG/3ML (*cross-link hyal acid (visc)*)	NF	
GELSYN-3 INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 16.8 MG/2ML (*sodium hyaluronate (viscosup)*)	PSP	PA
GENVISC 850 INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 25 MG/2.5ML (*sodium hyaluronate (viscosup)*)	NF	
HYALGAN INTRA-ARTICULAR SOLUTION 20 MG/2ML (*sodium hyaluronate (viscosup)*)	NF	
HYALGAN INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYMOVIS INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 24 MG/3ML (*hyaluronan*)	NF	
HYMOVIS ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 32 MG/4ML (*hyaluronan*)	NF	
MONOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 88 MG/4ML (*hyaluronan*)	NF	
ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 30 MG/2ML (*hyaluronan*)	PSP	PA
SUPARTZ FX INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 25 MG/2.5ML (*sodium hyaluronate (viscosup)*)	NF	
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	G	QL (336 TABLETS per 365 days)
BILTRICIDE ORAL TABLET 600 MG (*praziquantel*)	NPB	QL (24 TABLETS per 365 DAYs)
EMVERM ORAL TABLET CHEWABLE 100 MG (*mebendazole*)	PB	QL (12 TABLETS per 365 DAYs)
ivermectin oral tablet 3 mg, 6 mg	G	
praziquantel oral tablet 600 mg	G	QL (24 TABLETS per 365 DAYs)
ANTI-BACTERIALS - MISCELLANEOUS		
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (*amikacin sulfate liposome*)	NPSP	PA
neomycin sulfate oral tablet 500 mg	G	
tinidazole oral tablet 250 mg, 500 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	G	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	G	
flucytosine oral capsule 500 mg	NF	
griseofulvin microsize oral suspension 125 mg/5ml	G	
griseofulvin microsize oral tablet 500 mg	G	
griseofulvin ultramicrosize oral tablet 125 mg, 165 mg, 250 mg	G	
itraconazole oral capsule 100 mg	G	
itraconazole oral solution 10 mg/ml	G	
ketoconazole oral tablet 200 mg	G	STX
nystatin oral tablet 500000 unit	G	
posaconazole oral tablet delayed release 100 mg	NF	
terbinafine hcl oral tablet 250 mg	G	
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*voriconazole*)	PB	
voriconazole oral suspension reconstituted 40 mg/ml	G	
voriconazole oral tablet 200 mg, 50 mg	G	
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	G	
chloroquine phosphate oral tablet 250 mg, 500 mg	G	
MALARONE ORAL TABLET 250-100 MG, 62.5-25 MG (*atovaquone-proguanil hcl*)	PB	
mefloquine hcl oral tablet 250 mg	G	
primaquine phosphate oral tablet 26.3 (15 base) mg	G	
quinine sulfate oral capsule 324 mg	G	
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate oral solution 20 mg/ml	G	QL (900 ML per 30 DAYs)
abacavir sulfate oral tablet 300 mg	G	QL (60 TABLETS per 30 DAYs)
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML (*cabotegravir*)	PB	N8 (Exception process available for $0 copay when medically necessary for pre-exposure prophylaxis); QL (2 VIALS per 90 DAYs)
APTIVUS ORAL CAPSULE 250 MG (*tipranavir*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
atazanavir sulfate oral capsule 150 mg, 300 mg	G	QL (30 CAPSULES per 30 DAYs)
atazanavir sulfate oral capsule 200 mg	G	QL (60 CAPSULES per 30 DAYs)
darunavir oral tablet 600 mg	G	QL (60 TABLETS per 30 days)
darunavir oral tablet 800 mg	G	QL (30 TABLETS per 30 DAYs)
EDURANT ORAL TABLET 25 MG (*rilpivirine hcl*)	NF	
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (*rilpivirine hcl*)	NF	
efavirenz oral tablet 600 mg	G	QL (30 TABLETS per 30 days)
emtricitabine oral capsule 200 mg	G	QL (30 TABLETS per 30 DAYs)
EMTRIVA ORAL CAPSULE 200 MG (*emtricitabine*)	NPB	QL (30 CAPSULES per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML (*emtricitabine*)	NPB	QL (680 ML per 28 days)
EPIVIR ORAL SOLUTION 10 MG/ML (*lamivudine*)	NPB	QL (900 ML per 30 days)
EPIVIR ORAL TABLET 150 MG (*lamivudine*)	NPB	QL (60 tablets per 30 days)
EPIVIR ORAL TABLET 300 MG (*lamivudine*)	NPB	QL (30 tablets per 30 days)
etravirine oral tablet 100 mg	G	QL (120 TABLETS per 30 DAYs)
etravirine oral tablet 200 mg	G	QL (60 TABLETS per 30 DAYs)
fosamprenavir calcium oral tablet 700 mg	G	QL (120 TABLETS per 30 DAYs)
INTELENCE ORAL TABLET 100 MG, 200 MG, 25 MG (*etravirine*)	NF	
ISENTRESS HD ORAL TABLET 600 MG (*raltegravir potassium*)	PB	QL (60 TABLETS per 30 DAYs)
ISENTRESS ORAL PACKET 100 MG (*raltegravir potassium*)	PB	QL (60 PACKETS per 30 days)
ISENTRESS ORAL TABLET 400 MG (*raltegravir potassium*)	PB	QL (120 TABLETS per 30 DAYs)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (*raltegravir potassium*)	PB	QL (180 TABLETS per 30 DAYs)
lamivudine oral solution 10 mg/ml	G	QL (900 ML per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lamivudine oral tablet 150 mg	G	QL (60 TABLETS per 30 DAYs)
lamivudine oral tablet 300 mg	G	QL (30 TABLETS per 30 DAYs)
maraviroc oral tablet 150 mg	G	QL (60 TABLETS per 30 DAYs)
maraviroc oral tablet 300 mg	G	QL (120 TABLETS per 30 DAYs)
nevirapine er oral tablet extended release 24 hour 400 mg	G	QL (30 TABLETS per 30 DAYs)
nevirapine oral suspension 50 mg/5ml	G	QL (1200 ML per 30 days)
nevirapine oral tablet 200 mg	G	QL (60 TABLETS per 30 DAYs)
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*)	NPB	QL (180 CAPSULES per 30 DAYs)
RETROVIR ORAL SYRUP 50 MG/5ML (*zidovudine*)	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	
rilpivirine hcl oral tablet 25 mg	G	QL (60 TABLETS per 30 DAYs)
ritonavir oral tablet 100 mg	G	QL (360 TABLETS per 30 days)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (*fostemsavir tromethamine*)	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 300 MG (*lenacapavir sodium*)	NF	
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG (*lenacapavir sodium*)	NF	
tenofovir disoproxil fumarate oral tablet 300 mg	G	QL (30 TABLETS per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TIVICAY ORAL TABLET 50 MG (*dolutegravir sodium*)	PB	QL (60 TABLETS per 30 DAYs)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (*dolutegravir sodium*)	PB	QL (360 TABLETS per 30 days)
VIRACEPT ORAL TABLET 250 MG, 625 MG (*nelfinavir mesylate*)	NF	
VIREAD ORAL POWDER 40 MG/GM (*tenofovir disoproxil fumarate*)	NPB	QL (240 GRAMS per 30 days)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG, 300 MG (*tenofovir disoproxil fumarate*)	NPB	QL (30 TABLETS per 30 days)
YEZTUGO ORAL TABLET 300 MG (*lenacapavir sodium*)	PB	N8 (Exception process available for $0 copay when medically necessary for pre-exposure prophylaxis); QL (8 TABLETS per 4 days)
YEZTUGO SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML (*lenacapavir sodium*)	PB	N8 (Exception process available for $0 copay when medically necessary for pre-exposure prophylaxis); QL (4 VIALS per 168 days)
ZIAGEN ORAL SOLUTION 20 MG/ML (*abacavir sulfate*)	NPB	QL (900 ML per 30 days)
zidovudine oral capsule 100 mg	G	QL (180 CAPSULES per 30 days)
zidovudine oral syrup 50 mg/5ml	G	QL (1800 ML per 30 DAYs)
zidovudine oral tablet 300 mg	G	QL (60 TABLETS per 30 days)
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine oral tablet 600-300 mg	G	QL (30 TABLETS per 30 days)
BIKTARVY ORAL TABLET 30-120-15 MG (*bictegravir-emtricitab-tenofov*)	PB	QL (30 TABLETS per 30 days)
BIKTARVY ORAL TABLET 50-200-25 MG (*bictegravir-emtricitab-tenofov*)	PB	QL (30 TABLETS per 30 DAYs)
CIMDUO ORAL TABLET 300-300 MG (*lamivudine-tenofovir*)	PB	QL (30 TABLETS per 30 DAYs)
COMPLERA ORAL TABLET 200-25-300 MG (*emtricitab-rilpivir-tenofovir*)	NF	
DELSTRIGO ORAL TABLET 100-300-300 MG (*doravirin-lamivudin-tenofov df*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DESCOVY ORAL TABLET 120-15 MG (*emtricitabine-tenofovir af*)	PB	QL (30 TABLETS per 30 DAYs)
DESCOVY ORAL TABLET 200-25 MG (*emtricitabine-tenofovir af*)	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*)	PB	QL (30 TABLETS per 30 days)
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	G	QL (30 TABLETS per 30 Days)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	G	QL (30 TABLETS per 30 DAYs)
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	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)
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	G	QL (30 TABLETS per 30 DAYs)
EVOTAZ ORAL TABLET 300-150 MG (*atazanavir-cobicistat*)	NPB	QL (30 TABLETS per 30 days)
GENVOYA ORAL TABLET 150-150-200-10 MG (*elviteg-cobic-emtricit-tenofaf*)	PB	QL (30 TABLETS per 30 DAYs)
IDVYNSO ORAL TABLET 100-0.25 MG (*doravirine-islatravir*)	NF	
JULUCA ORAL TABLET 50-25 MG (*dolutegravir-rilpivirine*)	NPB	QL (30 TABLETS per 30 DAYs)
KALETRA ORAL SOLUTION 400-100 MG/5ML (*lopinavir-ritonavir*)	NPB	QL (480 ML per 30 DAYs)
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (*lopinavir-ritonavir*)	NF	
lamivudine-zidovudine oral tablet 150-300 mg	G	QL (60 TABLETS per 30 DAYs)
lopinavir-ritonavir oral tablet 100-25 mg	G	QL (300 TABLETS per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	G	QL (120 TABLETS per 30 DAYs)
ODEFSEY ORAL TABLET 200-25-25 MG (*emtricitab-rilpivir-tenofov af*)	PB	QL (30 TABLETS per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREZCOBIX ORAL TABLET 675-150 MG (*darunavir-cobicistat*)	NPB	QL (30 TABLETS per 30 DAYs)
PREZCOBIX ORAL TABLET 800-150 MG (*darunavir-cobicistat*)	NPB	QL (30 TABLETS per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG (*elviteg-cobic-emtricit-tenofdf*)	NF	
SYMFI ORAL TABLET 600-300-300 MG (*efavirenz-lamivudine-tenofovir*)	NPB	QL (30 TABLETS per 30 days)
SYMTUZA ORAL TABLET 800-150-200-10 MG (*darun-cobic-emtricit-tenofaf*)	PB	QL (30 TABLETS per 30 days)
TRIUMEQ ORAL TABLET 600-50-300 MG (*abacavir-dolutegravir-lamivud*)	PB	QL (30 TABLETS per 30 DAYs)
triumeq pd oral tablet soluble 60-5-30 mg	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	G	
ethambutol hcl oral tablet 100 mg, 400 mg	G	
isoniazid oral syrup 50 mg/5ml	G	
isoniazid oral tablet 100 mg, 300 mg	G	
pyrazinamide oral tablet 500 mg	G	
rifabutin oral capsule 150 mg	G	
rifampin oral capsule 150 mg, 300 mg	G	
SIRTURO ORAL TABLET 100 MG, 20 MG (*bedaquiline fumarate*)	NPSP	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
acyclovir oral capsule 200 mg	G	
acyclovir oral suspension 200 mg/5ml	G	
acyclovir oral tablet 400 mg, 800 mg	G	
cidofovir intravenous solution 75 mg/ml	G	
famciclovir oral tablet 125 mg, 250 mg, 500 mg	G	
LIVTENCITY ORAL TABLET 200 MG (*maribavir*)	NPB	PA; QL (120 TABLETS per 30 days)
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	G	
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	PB	
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (*nirmatrelvir-ritonavir*)	PB	
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	PB	
PREVYMIS ORAL PACKET 120 MG, 20 MG (*letermovir*)	NPB	QL (4 PACKETS per 1 DAY)
PREVYMIS ORAL TABLET 240 MG (*letermovir*)	NPB	QL (2 TABLETS per 1 day)
PREVYMIS ORAL TABLET 480 MG (*letermovir*)	NPB	QL (1 TABLET per 1 DAY)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (*zanamivir*)	PB	
rimantadine hcl oral tablet 100 mg	G	
valacyclovir hcl oral tablet 1 gm, 500 mg	G	
VALCYTE ORAL SOLUTION RECONSTITUTED 50 MG/ML (*valganciclovir hcl*)	NPB	PA; QL (1144 ML per 30 days)
valganciclovir hcl oral solution reconstituted 50 mg/ml	G	PA; QL (1144 ML per 30 days)
valganciclovir hcl oral tablet 450 mg	G	PA; QL (120 TABLETS per 30 days)
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
cefaclor oral capsule 250 mg, 500 mg	G	
cefaclor oral suspension reconstituted 250 mg/5ml	G	
cefadroxil oral capsule 500 mg	G	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	G	
cefadroxil oral tablet 1 gm	G	
cefdinir oral capsule 300 mg	G	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	G	
cefixime oral capsule 400 mg	G	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	G	
cefixime oral tablet 400 mg	G	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	G	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	G	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	G	
cefprozil oral tablet 250 mg, 500 mg	G	
cefuroxime axetil oral tablet 250 mg, 500 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cephalexin oral capsule 250 mg, 500 mg, 750 mg	G	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	G	
cephalexin oral tablet 250 mg, 500 mg	G	
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	G	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	G	
clarithromycin er oral tablet extended release 24 hour 500 mg	G	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	G	
clarithromycin oral tablet 250 mg, 500 mg	G	
E.E.S. 400 ORAL TABLET 400 MG (*erythromycin ethylsuccinate*)	G	
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*)	NF	
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (*erythromycin ethylsuccinate*)	NF	
erythromycin base oral capsule delayed release particles 250 mg	G	
erythromycin base oral tablet 250 mg, 500 mg	G	
erythromycin base oral tablet delayed release 333 mg	G	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml	G	
erythromycin oral tablet delayed release 250 mg, 500 mg	G	
fidaxomicin oral tablet 200 mg	G	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	G	
levofloxacin oral solution 25 mg/ml	G	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	G	
moxifloxacin hcl oral tablet 400 mg	G	
HEPATITIS B		
adefovir dipivoxil oral tablet 10 mg	G	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (*entecavir*)	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	G	QL (30 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lamivudine oral tablet 100 mg	G	
VEMLIDY ORAL TABLET 25 MG (*tenofovir alafenamide fumarate*)	NF	
HEPATITIS C		
EPCLUSA ORAL PACKET 150-37.5 MG (*sofosbuvir-velpatasvir*)	PSP	PA; IBC (Preferred for all genotypes); QL (28 PELLETS per 28 DAYs)
EPCLUSA ORAL PACKET 200-50 MG (*sofosbuvir-velpatasvir*)	PSP	PA; IBC (Preferred for all genotypes); QL (56 PELLETS per 28 days)
EPCLUSA ORAL TABLET 200-50 MG (*sofosbuvir-velpatasvir*)	PSP	PA; IBC (Preferred for all genotypes); QL (56 TABLETS per 28 days)
EPCLUSA ORAL TABLET 400-100 MG (*sofosbuvir-velpatasvir*)	PSP	PA; IBC (Preferred for all genotypes); QL (28 TABLETS per 28 days)
HARVONI ORAL PACKET 33.75-150 MG (*ledipasvir-sofosbuvir*)	PSP	PA; QL (28 PACKET per 28 DAYs)
HARVONI ORAL PACKET 45-200 MG (*ledipasvir-sofosbuvir*)	PSP	PA; QL (56 PELLETS per 28 days)
HARVONI ORAL TABLET 45-200 MG (*ledipasvir-sofosbuvir*)	PSP	PA; IBC (Preferred for genotypes 1,4,5,6); QL (56 TABLETS per 28 days)
HARVONI ORAL TABLET 90-400 MG (*ledipasvir-sofosbuvir*)	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	G	
ribavirin oral tablet 200 mg	G	
sofosbuvir-velpatasvir oral tablet 400-100 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOVALDI ORAL PACKET 150 MG (*sofosbuvir*)	NPSP	PA; QL (28 PELLETS per 28 days)
SOVALDI ORAL PACKET 200 MG (*sofosbuvir*)	NPSP	PA; QL (56 PELLETS per 28 days)
SOVALDI ORAL TABLET 200 MG (*sofosbuvir*)	NPSP	PA; QL (56 TABLETS per 28 days)
SOVALDI ORAL TABLET 400 MG (*sofosbuvir*)	NPSP	PA; QL (28 TABLETS per 28 days)
VOSEVI ORAL TABLET 400-100-100 MG (*sofosbuv-velpatasv-voxilaprev*)	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	G	
CLEOCIN ORAL CAPSULE 150 MG, 300 MG, 75 MG (*clindamycin hcl*)	PB	
CLEOCIN ORAL SOLUTION RECONSTITUTED 75 MG/5ML (*clindamycin palmitate hcl*)	PB	
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	G	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	G	
colistimethate sodium (cba) injection solution reconstituted 150 mg	G	
dapsone oral tablet 100 mg, 25 mg	G	
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (*vancomycin hcl*)	NPB	QL (450 ML per 10 DAYs)
linezolid oral suspension reconstituted 100 mg/5ml	G	
linezolid oral tablet 600 mg	G	
MACROBID ORAL CAPSULE 100 MG (*nitrofurantoin monohyd macro*)	PB	
MACRODANTIN ORAL CAPSULE 100 MG, 25 MG, 50 MG (*nitrofurantoin macrocrystal*)	NF	
methenamine hippurate oral tablet 1 gm	G	
methenamine mandelate oral tablet 0.5 gm, 1 gm	G	
metronidazole oral capsule 375 mg	G	
metronidazole oral tablet 125 mg, 250 mg, 500 mg	G	
nitazoxanide oral tablet 500 mg	G	QL (20 TABLETS per 25 DAYs); AL (Min 12 Years)
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
nitrofurantoin monohyd macro oral capsule 100 mg	G	
nitrofurantoin oral suspension 25 mg/5ml	G	N8 (Listing does not include certain NDCs)
pentamidine isethionate inhalation solution reconstituted 300 mg	G	
pyrimethamine oral tablet 25 mg	G	
sulfamethoxazole-trimethoprim oral suspension 800-160 mg/20ml	G	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	G	
VANCOCIN ORAL CAPSULE 125 MG (*vancomycin hcl*)	PB	QL (80 CAPSULES per 10 Days)
VANCOCIN ORAL CAPSULE 250 MG (*vancomycin hcl*)	PB	QL (80 capsules per 10 days)
vancomycin hcl oral capsule 125 mg, 250 mg	G	QL (80 CAPSULES per 10 days)
vancomycin hcl oral solution reconstituted 50 mg/ml	G	QL (450 ML per 10 DAYs)
XIFAXAN ORAL TABLET 550 MG (*rifaximin*)	PB	
PENICILLINS - DRUGS TO TREAT INFECTIONS		
amoxicillin oral capsule 250 mg, 500 mg	G	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	G	
amoxicillin oral tablet 500 mg, 875 mg	G	
amoxicillin oral tablet chewable 125 mg, 250 mg	G	
amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg	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	G	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	G	
ampicillin oral capsule 500 mg	G	
dicloxacillin sodium oral capsule 250 mg, 500 mg	G	
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	G	
penicillin v potassium oral tablet 250 mg, 500 mg	G	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
demeclocycline hcl oral tablet 150 mg, 300 mg	G	
doxycycline hyclate oral capsule 100 mg, 50 mg	G	
doxycycline hyclate oral tablet 100 mg, 20 mg	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	NF	
doxycycline monohydrate oral capsule 100 mg, 50 mg	G	
doxycycline monohydrate oral capsule 150 mg, 75 mg	NF	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	G	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	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	G	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	G	
NUZYRA ORAL TABLET 150 MG (*omadacycline tosylate*)	NPB	
doxycycline hyclate (Targadox Oral Tablet 50 Mg)	NF	
tetracycline hcl oral capsule 250 mg, 500 mg	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)
lomustine oral capsule 10 mg, 100 mg, 40 mg	CE	N7 (PSP)
MATULANE ORAL CAPSULE 50 MG (*procarbazine hcl*)	CE	N7 (NPSP)
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)
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 suspension 2000 mg/100ml	CE	PA; N7 (PSP)
mercaptopurine oral tablet 50 mg	CE	N7 (G)
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	G	
methotrexate sodium injection solution reconstituted 1 gm	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)
XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*)	CE	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 per 28 days)
BIOLOGIC RESPONSE MODIFIERS		
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML (*ropeginterferon alfa-2b-njft*)	PSP	PA; QL (2 SYRINGES per 28 days)
DAURISMO ORAL TABLET 100 MG, 25 MG (*glasdegib maleate*)	CE	N7 (NF)
ERIVEDGE ORAL CAPSULE 150 MG (*vismodegib*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg	CE	PA; N7 (PSP); QL (28 CAPSULES per 28 DAYs)
lenalidomide oral capsule 20 mg, 25 mg	CE	PA; N7 (PSP); QL (21 CAPSULES per 28 DAYs)
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	CE	PA; N7 (PSP); QL (21 CAPSULES per 28 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, 20 MG, 25 MG, 5 MG (*lenalidomide*)	CE	N7 (NF)
THALOMID ORAL CAPSULE 100 MG (*thalidomide*)	PSP	PA; QL (112 CAPSULES per 28 days)
THALOMID ORAL CAPSULE 50 MG (*thalidomide*)	PSP	PA; QL (28 CAPSULES per 28 days)
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate micronized oral tablet 125 mg	CE	PA; N7 (PSP); QL (120 TABLETS per 30 Days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
abiraterone acetate oral tablet 250 mg	CE	PA; N7 (G); QL (120 TABLETS per 30 days)
abiraterone acetate oral tablet 500 mg	CE	PA; N7 (G); 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)*)	PSP	PA
ELIGARD SUBCUTANEOUS KIT 30 MG (*leuprolide acetate (4 month)*)	PSP	PA
ELIGARD SUBCUTANEOUS KIT 45 MG (*leuprolide acetate (6 month)*)	PSP	PA
ELIGARD SUBCUTANEOUS KIT 7.5 MG (*leuprolide acetate*)	PSP	PA
ERLEADA ORAL TABLET 240 MG (*apalutamide*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
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*)	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	PSP	PA
INLURIYO ORAL TABLET 200 MG (*imlunestrant tosylate*)	CE	N7 (NF)
letrozole oral tablet 2.5 mg	CE	N7 (G)
leuprolide acetate injection kit 1 mg/0.2ml	PSP	PA
LIFYORLI (125 MG DOSE) ORAL CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG (*relacorilant*)	NF	
LIFYORLI (150 MG DOSE) ORAL CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG (*relacorilant*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG (*leuprolide acetate*)	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)*)	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	
LUTRATE DEPOT INTRAMUSCULAR INJECTABLE 22.5 MG (*leuprolide acetate (3 month)*)	NF	
LYSODREN ORAL TABLET 500 MG (*mitotane*)	CE	N7 (NPSP)
megestrol acetate oral tablet 20 mg, 40 mg	CE	N7 (G)
nilutamide oral tablet 150 mg	CE	N7 (G)
NUBEQA ORAL TABLET 300 MG (*darolutamide*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
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	
VABRINTY SUBCUTANEOUS KIT 22.5 MG (*leuprolide acetate (3 month)*)	NF	
VABRINTY SUBCUTANEOUS KIT 30 MG (*leuprolide acetate (4 month)*)	NF	
VABRINTY SUBCUTANEOUS KIT 45 MG (*leuprolide acetate (6 month)*)	NF	
VABRINTY SUBCUTANEOUS KIT 7.5 MG (*leuprolide acetate*)	NF	
XTANDI ORAL CAPSULE 40 MG (*enzalutamide*)	CE	PA; N7 (PB); QL (120 CAPSULES per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XTANDI ORAL TABLET 40 MG (*enzalutamide*)	CE	PA; N7 (PB); QL (120 TABLETS per 30 days)
XTANDI ORAL TABLET 80 MG (*enzalutamide*)	CE	PA; N7 (PB); QL (60 TABLETS per 30 days)
YONSA ORAL TABLET 125 MG (*abiraterone acetate micronized*)	CE	PA; N7 (PB); 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 (NF)
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)
AUGTYRO ORAL CAPSULE 160 MG (*repotrectinib*)	CE	PA; N7 (PSP); QL (60 CAPSULES per 30 days)
AUGTYRO ORAL CAPSULE 40 MG (*repotrectinib*)	CE	PA; N7 (PSP); QL (240 CAPSULES per 30 days)
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG (*avutometinib-defactinib*)	CE	N7 (NF)
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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
BRUKINSA ORAL TABLET 160 MG (*zanubrutinib*)	CE	PA; N7 (PSP); QL (60 TABLETS 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)
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	N7 (NF)
COTELLIC ORAL TABLET 20 MG (*cobimetinib fumarate*)	CE	N7 (NF)
DANZITEN ORAL TABLET 71 MG, 95 MG (*nilotinib tartrate*)	CE	N7 (NF)
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)
ENSACOVE ORAL CAPSULE 100 MG, 25 MG (*ensartinib hcl*)	CE	N7 (NF)
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, 5 mg, 7.5 mg	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
everolimus oral tablet 2.5 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 (*fruquintinib*)	CE	PA; N7 (NPSP); QL (84 CAPSULES per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG (*fruquintinib*)	CE	PA; N7 (NPSP); QL (21 CAPSULES per 28 days)
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)
GOMEKLI ORAL CAPSULE 1 MG (*mirdametinib*)	CE	PA; N7 (PSP); QL (42 CAPSULES per 28 DAYs)
GOMEKLI ORAL CAPSULE 2 MG (*mirdametinib*)	CE	PA; N7 (PSP); QL (84 CAPSULES per 28 DAYs)
GOMEKLI ORAL TABLET SOLUBLE 1 MG (*mirdametinib*)	CE	PA; N7 (PSP); QL (168 TABLETS per 28 DAYs)
HERNEXEOS ORAL TABLET 60 MG (*zongertinib*)	CE	N7 (NF)
HYRNUO ORAL TABLET 10 MG (*sevabertinib*)	CE	N7 (NF)
IBRANCE ORAL CAPSULE 100 MG, 125 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)
IBTROZI ORAL CAPSULE 200 MG (*taletrectinib adipate*)	CE	PA; N7 (PSP); QL (90 CAPSULES per 30 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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
imkeldi oral solution 80 mg/ml	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)
ITOVEBI ORAL TABLET 3 MG (*inavolisib*)	CE	PA; N7 (NPSP); QL (60 TABLETS per 30 days)
ITOVEBI ORAL TABLET 9 MG (*inavolisib*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 days)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (*ruxolitinib phosphate*)	CE	PA; IBC (Preferred for Polycythemia Vera, Graft-versus-host disease (GVDH) and Oncology); N7 (PSP); QL (60 TABLETS per 30 days)
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG (*ruxolitinib phosphate*)	CE	PA; N7 (PSP)
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)
KOSELUGO ORAL CAPSULE 25 MG (*selumetinib sulfate*)	CE	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG, 7.5 MG (*selumetinib sulfate*)	CE	PA; N7 (NPSP)
lapatinib ditosylate oral tablet 250 mg	CE	PA; N7 (PSP); QL (180 TABLETS per 30 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 (*lorlatinib*)	CE	PA; N7 (NPSP); QL (30 TABLETS per 30 days)
LORBRENA ORAL TABLET 25 MG (*lorlatinib*)	CE	PA; N7 (NPSP); QL (90 TABLETS per 30 days)
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 (PSP); QL (1080 ML per 28 days)
MEKINIST ORAL TABLET 0.5 MG (*trametinib dimethyl sulfoxide*)	CE	PA; N7 (PSP); QL (90 TABLETS per 30 days)
MEKINIST ORAL TABLET 2 MG (*trametinib dimethyl sulfoxide*)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 days)
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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
nilotinib d-tartrate oral capsule 150 mg, 200 mg, 50 mg	CE	N7 (NF)
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	CE	PA; N7 (PSP); N8 (Generic of Tasigna); QL (120 CAPSULES per 30 DAYs)
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*)	NPSP	PA; QL (30 TABLETS per 30 DAYs)
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)
PHYRAGO ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG (*dasatinib*)	CE	N7 (NF)
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG (*alpelisib*)	CE	PA; N7 (PSP); QL (28 TABLETS per 28 days)
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG (*alpelisib*)	CE	PA; N7 (PSP); QL (56 TABLETS per 28 days)
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG (*alpelisib*)	CE	PA; N7 (PSP); QL (56 TABLETS per 28 days)
QINLOCK ORAL TABLET 50 MG (*ripretinib*)	CE	N7 (NF)
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)
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (*vimseltinib*)	CE	N7 (NF)
ROZLYTREK ORAL CAPSULE 100 MG (*entrectinib*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)
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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SCEMBLIX ORAL TABLET 100 MG (*asciminib hcl*)	CE	PA; N7 (PSP); QL (120 TABLETS per 30 days)
SCEMBLIX ORAL TABLET 20 MG (*asciminib hcl*)	CE	PA; N7 (PSP); QL (60 TABLETS per 30 days)
SCEMBLIX ORAL TABLET 40 MG (*asciminib hcl*)	CE	PA; N7 (PSP); QL (240 TABLETS per 30 days)
sorafenib tosylate oral tablet 200 mg	CE	PA; N7 (PSP); QL (120 TABLETS per 30 DAYs)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG (*dasatinib*)	CE	N7 (NF)
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	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
TAFINLAR ORAL TABLET SOLUBLE 10 MG (*dabrafenib mesylate*)	CE	PA; N7 (PSP); 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)
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG (*nilotinib hcl*)	CE	N7 (NF)
TEPMETKO ORAL TABLET 225 MG (*tepotinib hcl*)	CE	N7 (NF)
everolimus (Torpenz Oral Tablet 10 Mg, 2.5 Mg, 5 Mg, 7.5 Mg)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
TRUQAP ORAL TABLET 200 MG (*capivasertib*)	CE	PA; N7 (PSP); QL (64 TABLETS per 28 days)
TRUQAP ORAL TABLET THERAPY PACK 160 MG, 200 MG (*capivasertib*)	CE	PA; N7 (PSP); QL (64 TABLETS per 28 days)
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	PA; N7 (PSP); QL (120 CAPSULES per 30 days)
TYKERB ORAL TABLET 250 MG (*lapatinib ditosylate*)	CE	PA; N7 (NPSP); QL (180 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VANFLYTA ORAL TABLET 17.7 MG, 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)
everolimus (Yulithira Oral Tablet 10 Mg, 2.5 Mg, 5 Mg, 7.5 Mg)	CE	PA; N7 (PSP); QL (30 TABLETS per 30 DAYs)
ZELBORAF ORAL TABLET 240 MG (*vemurafenib*)	CE	N7 (NF)
ZYDELIG ORAL TABLET 100 MG, 150 MG (*idelalisib*)	CE	N7 (NF)
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 (G)
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)
KOMZIFTI ORAL CAPSULE 200 MG (*ziftomenib*)	CE	N7 (NF)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 240 MG (*sotorasib*)	CE	PA; N7 (PSP); QL (120 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)
MODEYSO ORAL CAPSULE 125 MG (*dordaviprone hcl*)	CE	N7 (NF)
ODOMZO ORAL CAPSULE 200 MG (*sonidegib phosphate*)	CE	PA; N7 (PSP); QL (30 CAPSULES per 30 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG (*nirogacestat hydrobromide*)	CE	N7 (NF)
REVUFORJ ORAL TABLET 110 MG (*revumenib citrate*)	CE	PA; N7 (NPSP); QL (120 TABLETS per 30 days)
REVUFORJ ORAL TABLET 160 MG (*revumenib citrate*)	CE	PA; N7 (NPSP); QL (60 TABLETS per 30 days)
REVUFORJ ORAL TABLET 25 MG (*revumenib citrate*)	CE	PA; N7 (NPSP); QL (240 TABLETS per 30 days)
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)
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*)	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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (16 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 ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG (*selinexor*)	CE	PA; N7 (NPSP); QL (4 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 (NPSP); 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)
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 (NPB)
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	G	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	G	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	G	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	G	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG (*amlodipine besy-benazepril hcl*)	PB	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	G	
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg	G	
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	G	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	G	
enalapril maleate oral solution 1 mg/ml	G	
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	G	
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	G	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	G	
moexipril hcl oral tablet 15 mg, 7.5 mg	G	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	G	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	G	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	G	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	G	
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (*spironolactone*)	PB	
eplerenone oral tablet 25 mg, 50 mg	G	
KERENDIA ORAL TABLET 10 MG, 20 MG, 40 MG (*finerenone*)	PB	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	G	
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	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	G	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	G	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	G	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	G	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	G	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	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	G	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	G	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	G	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	G	
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
azilsartan medoxomil oral tablet 40 mg, 80 mg	G	
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	G	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	G	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	G	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	G	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	G	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	G	
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg	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	G	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	G	
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	G	
MULTAQ ORAL TABLET 400 MG (*dronedarone hcl*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg	G	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	G	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	G	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	G	
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (*dofetilide*)	NPB	ST
ANTILIPEMICS, ACL INHIBITORS/COMBINATIONS - DRUGS TO TREAT HIGH CHOLESTEROL		
NEXLETOL ORAL TABLET 180 MG (*bempedoic acid*)	PB	
NEXLIZET ORAL TABLET 180-10 MG (*bempedoic acid-ezetimibe*)	PB	
ANTILIPEMICS, BILE ACID RESINS - DRUGS TO TREAT HIGH CHOLESTEROL		
cholestyramine light oral packet 4 gm	G	
cholestyramine light oral powder 4 gm/dose	G	
cholestyramine oral packet 4 gm	G	
cholestyramine oral powder 4 gm/dose	G	
colesevelam hcl oral packet 3.75 gm	G	
colesevelam hcl oral tablet 625 mg	G	
colestipol hcl oral granules 5 gm	G	
colestipol hcl oral packet 5 gm	G	
colestipol hcl oral tablet 1 gm	G	
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR - DRUGS TO TREAT HIGH CHOLESTEROL		
ezetimibe oral tablet 10 mg	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	G	
fenofibrate oral capsule 150 mg, 200 mg	G	
fenofibrate oral capsule 50 mg	NF	
fenofibrate oral tablet 120 mg, 40 mg	NF	
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	G	
fenofibric acid oral capsule delayed release 135 mg, 45 mg	G	
fenofibric acid oral tablet 105 mg, 35 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
gemfibrozil oral tablet 600 mg	G	
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
atorvastatin calcium oral tablet 10 mg, 20 mg	CE	N7 (G); AL (Min 40 Years and Max 75 Years)
atorvastatin calcium oral tablet 40 mg, 80 mg	G	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	G	
fluvastatin sodium oral capsule 20 mg, 40 mg	G	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	G	
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	G	
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	G	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	CE	N7 (G); AL (Min 40 Years and Max 75 Years)
simvastatin oral tablet 80 mg	G	N8 (Exception process available for $0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease)
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	G	
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
JUXTAPID ORAL CAPSULE 10 MG, 2 MG, 20 MG, 30 MG, 5 MG (*lomitapide mesylate*)	NF	
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	G	
NIACOR ORAL TABLET 500 MG (*niacin (antihyperlipidemic)*)	NF	
ANTILIPEMICS, OMEGA-3 FATTY ACIDS - DRUGS TO TREAT HIGH CHOLESTEROL		
omega-3-acid ethyl esters oral capsule 1 gm	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM (*icosapent ethyl*)	PB	
ANTILIPEMICS, PCSK9 INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
LEROCHOL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/1.2ML (*lerodalcibep-liga*)	NF	
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML (*alirocumab*)	NF	
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (*evolocumab*)	PB	QL (3 SYRINGES per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (*evolocumab*)	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	G	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	G	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	G	
BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
acebutolol hcl oral capsule 200 mg, 400 mg	G	
atenolol oral tablet 100 mg, 25 mg, 50 mg	G	
betaxolol hcl oral tablet 10 mg, 20 mg	G	
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg	G	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	G	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	G	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg	G	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	G	
metoprolol tartrate oral tablet 100 mg, 12.5 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	G	
nadolol oral tablet 20 mg, 40 mg, 80 mg	G	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	G	
pindolol oral tablet 10 mg, 5 mg	G	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	G	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	G	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	G	
DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS		
digoxin oral solution 0.05 mg/ml	G	
digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg	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	G	
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
acetazolamide er oral capsule extended release 12 hour 500 mg	G	
acetazolamide oral tablet 125 mg, 250 mg	G	
amiloride hcl oral tablet 5 mg	G	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	G	
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	G	
chlorthalidone oral tablet 25 mg, 50 mg	G	
dichlorphenamide oral tablet 50 mg	G	PA; QL (120 TABLETS per 30 days)
DYRENIUM ORAL CAPSULE 100 MG, 50 MG (*triamterene*)	NF	
ethacrynic acid oral tablet 25 mg	G	
furosemide oral tablet 20 mg, 40 mg, 80 mg	G	
hydrochlorothiazide oral capsule 12.5 mg	G	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	G	
indapamide oral tablet 1.25 mg, 2.5 mg	G	
KEVEYIS ORAL TABLET 50 MG (*dichlorphenamide*)	NPB	PA; QL (120 TABLETS per 30 days)
methazolamide oral tablet 25 mg, 50 mg	G	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	G	
spironolactone-hctz oral tablet 25-25 mg	G	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	G	
triamterene oral capsule 100 mg, 50 mg	G	
triamterene-hctz oral capsule 37.5-25 mg	G	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEART FAILURE		
INPEFA ORAL TABLET 200 MG, 400 MG (*sotagliflozin*)	PB	
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	G	
ivabradine hcl oral tablet 5 mg, 7.5 mg	G	
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	G	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (*vericiguat*)	PB	
MISCELLANEOUS		
ATTRUBY ORAL TABLET THERAPY PACK 356 MG (*acoramidis hcl*)	NF	
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (*mavacamten*)	NPSP	PA; QL (30 CAPSULES per 30 days)
CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY 0.1 MG/24HR (*clonidine*)	PB	
CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY 0.2 MG/24HR (*clonidine*)	PB	
CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY 0.3 MG/24HR (*clonidine*)	PB	
clonidine er oral tablet extended release 24 hour 0.17 mg	G	
clonidine hcl oral tablet 0.05 mg, 0.1 mg, 0.2 mg, 0.3 mg	G	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	G	
droxidopa oral capsule 100 mg, 200 mg, 300 mg	G	PA; QL (180 CAPSULES per 30 days)
guanfacine hcl oral tablet 1 mg, 2 mg	G	
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	G	
metyrosine oral capsule 250 mg	PSP	PA; QL (480 CAPSULES per 30 days)
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	G	
minoxidil oral tablet 10 mg, 2.5 mg	G	
MYQORZO ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (*aficamten*)	NF	
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG (*droxidopa*)	NF	
phenoxybenzamine hcl oral capsule 10 mg	G	
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REDEMPLO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (*plozasiran sodium*)	NF	
TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*olezarsen sodium*)	NF	
VECAMYL ORAL TABLET 2.5 MG (*mecamylamine hcl*)	NPB	
VYNDAMAX ORAL CAPSULE 61 MG (*tafamidis*)	PB	PA; QL (30 CAPSULES per 30 days)
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	G	
isosorbide dinitrate oral tablet 40 mg	NF	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	G	
isosorbide mononitrate oral tablet 10 mg, 20 mg	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*)	PB	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	G	
nitroglycerin transdermal ointment 2 %	G	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	G	
nitroglycerin translingual solution 0.4 mg/spray	G	
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADCIRCA ORAL TABLET 20 MG (*tadalafil (pah)*)	NF	
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (*riociguat*)	PSP	PA; QL (90 TABLETS per 30 days)
tadalafil (pah) (Alyq Oral Tablet 20 Mg)	G	PA; QL (60 TABLETS per 30 days)
ambrisentan oral tablet 10 mg, 5 mg	PSP	PA; QL (30 TABLETS per 30 DAYs)
bosentan oral tablet 125 mg, 62.5 mg	PSP	PA; QL (60 TABLETS per 30 days)
bosentan oral tablet soluble 32 mg	PSP	PA; QL (112 TABLETS per 28 DAYs)
epoprostenol sodium intravenous solution reconstituted 0.5 mg, 1.5 mg	PSP	PA
FLOLAN INTRAVENOUS SOLUTION RECONSTITUTED 1.5 MG (*epoprostenol sodium*)	NPSP	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LETAIRIS ORAL TABLET 10 MG, 5 MG (*ambrisentan*)	NF	
OPSUMIT ORAL TABLET 10 MG (*macitentan*)	PSP	PA; QL (30 TABLETS per 30 days)
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG (*macitentan-tadalafil*)	PSP	PA; QL (30 TABLETS per 30 DAYs)
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	PSP	PA
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	PSP	PA
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (*treprostinil diolamine*)	PSP	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (*treprostinil diolamine*)	PSP	PA
REMODULIN INJECTION SOLUTION 100 MG/20ML, 20 MG/20ML, 200 MG/20ML, 50 MG/20ML, 8 MG/20ML (*treprostinil*)	NF	
REVATIO ORAL TABLET 20 MG (*sildenafil citrate*)	NF	
sildenafil citrate oral suspension reconstituted 10 mg/ml	PSP	PA; QL (784 ML per 30 days)
sildenafil citrate oral tablet 20 mg	G	PA; QL (360 TABLETS per 30 days)
tadalafil (pah) oral tablet 20 mg	G	PA; QL (60 TABLETS per 30 days)
TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*)	PB	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	PSP	PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG (*treprostinil*)	PSP	PA; QL (224 CARTRIDGES per 28 days)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (*treprostinil*)	PSP	PA; QL (112 CARTRIDGES per 28 DAYs)
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 80 MCG (*treprostinil*)	PSP	PA; QL (112 CARTRIDGES per 28 days)
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG (*treprostinil*)	PSP	PA; QL (252 CARTRIDGES per 28 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYVASO INHALATION SOLUTION 0.6 MG/ML (*treprostinil*)	PSP	PA; QL (28 AMPULES per 28 DAYs)
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*)	PSP	PA; QL (28 AMPULES per 28 DAYs)
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*)	PSP	PA; QL (28 AMPULES per 28 DAYs)
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG (*selexipag*)	PSP	PA; QL (60 TABLETS per 30 days)
UPTRAVI ORAL TABLET 200 MCG (*selexipag*)	PSP	PA; QL (140 TABLETS per 28 days)
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (*selexipag*)	PSP	PA; QL (1 TABLET per 28 days)
VELETRI INTRAVENOUS SOLUTION RECONSTITUTED 0.5 MG, 1.5 MG (*epoprostenol sodium*)	NPSP	PA
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG (*sotatercept-csrk*)	NPSP	PA; QL (2 VIALS per 21 days)
WINREVAIR SUBCUTANEOUS KIT 45 MG, 60 MG (*sotatercept-csrk*)	NPSP	PA; QL (1 VIAL per 21 days)
YUTREPIA INHALATION CAPSULE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (*treprostinil sodium*)	PSP	PA; QL (140 CAPSULES per 28 days)
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ALCOHOL DETERRENTS		
acamprosate calcium oral tablet delayed release 333 mg	G	
disulfiram oral tablet 250 mg	G	
AMYOTROPHIC LATERAL SCLEROSIS (ALS) - DRUGS TO TREAT ALS		
RADICAVA ORS ORAL SUSPENSION 105 MG/5ML (*edaravone*)	PSP	PA; QL (50 ML per 28 days)
RADICAVA ORS STARTER KIT ORAL SUSPENSION 105 MG/5ML (*edaravone*)	PSP	PA; QL (70 ML per 28 days)
riluzole oral tablet 50 mg	G	
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg	G	QL (150 TABLETS per 25 days)
alprazolam er oral tablet extended release 24 hour 3 mg	G	QL (90 TABLETS per 25 days)
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (*alprazolam*)	NPB	QL (300 ML per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	G	QL (150 TABLETS per 25 days)
alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg	G	QL (150 TABLETS per 25 days)
ANAFRANIL ORAL CAPSULE 25 MG, 50 MG, 75 MG (*clomipramine hcl*)	PB	
ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG (*lorazepam*)	NPB	QL (150 TABLETS per 25 days)
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	G	
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	G	QL (360 CAPSULES per 25 DAYs)
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	G	
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	G	
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	G	
lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/Ml)	G	QL (150 ML per 25 DAYs)
lorazepam oral tablet 0.5 mg, 1 mg	G	QL (150 TABLETS per 25 days)
lorazepam oral tablet 2 mg	G	QL (150 TABLETS per 25 DAYs)
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 1 MG, 1.5 MG, 2 MG (*lorazepam*)	NPB	QL (150 CAPSULES per 25 DAYs)
LOREEV XR ORAL CAPSULE ER 24 HOUR SPRINKLE 3 MG (*lorazepam*)	NPB	QL (90 CAPSULES per 25 DAYs)
oxazepam oral capsule 10 mg, 15 mg, 30 mg	G	QL (120 CAPSULES per 25 DAYs)
XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG (*alprazolam*)	NPB	QL (150 TABLETS per 25 days)
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2 MG (*alprazolam*)	NPB	QL (150 TABLETS per 25 days)
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hcl oral tablet 10 mg, 23 mg, 5 mg	G	
donepezil hcl oral tablet dispersible 10 mg, 5 mg	G	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	G	
galantamine hydrobromide oral solution 4 mg/ml	G	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEQEMBI IQLIK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 360 MG/1.8ML (*lecanemab-irmb*)	NF	
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	G	
memantine hcl oral solution 2 mg/ml	G	
memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg	G	
memantine hcl-donepezil hcl er oral capsule extended release 24 hour 14-10 mg, 21-10 mg, 28-10 mg	G	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (*memantine hcl-donepezil hcl*)	PB	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	G	
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	G	
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	G	
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	G	
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (*dextromethorphan-bupropion*)	PB	
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	G	
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	G	
bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg	NF	
bupropion hcl oral tablet 100 mg, 75 mg	G	
citalopram hydrobromide oral capsule 30 mg	G	
citalopram hydrobromide oral solution 20 mg/10ml	G	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	G	
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	G	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	G	
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	G	
doxepin hcl oral concentrate 10 mg/ml	G	
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
escitalopram oxalate oral solution 5 mg/5ml	G	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	G	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (*levomilnacipran hcl*)	PB	
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (*levomilnacipran hcl*)	PB	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	G	
fluoxetine hcl oral capsule delayed release 90 mg	G	
fluoxetine hcl oral solution 20 mg/5ml	G	
fluoxetine hcl oral tablet 10 mg, 20 mg	G	
fluoxetine hcl oral tablet 60 mg	NF	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	G	
imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg	G	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	G	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	G	
NARDIL ORAL TABLET 15 MG (*phenelzine sulfate*)	PB	
NORPRAMIN ORAL TABLET 10 MG, 25 MG (*desipramine hcl*)	PB	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	G	
nortriptyline hcl oral solution 10 mg/5ml	G	
PAMELOR ORAL CAPSULE 10 MG, 25 MG, 50 MG, 75 MG (*nortriptyline hcl*)	PB	
PARNATE ORAL TABLET 10 MG (*tranylcypromine sulfate*)	PB	
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	G	
paroxetine hcl oral suspension 10 mg/5ml	G	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	G	
phenelzine sulfate oral tablet 15 mg	G	
protriptyline hcl oral tablet 10 mg, 5 mg	G	
sertraline hcl oral capsule 150 mg, 200 mg	G	
sertraline hcl oral concentrate 20 mg/ml	G	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	G	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*)	PSP	PA
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (*esketamine hcl*)	PSP	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tranylcypromine sulfate oral tablet 10 mg	G	
trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg	G	
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	G	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (*vortioxetine hbr*)	PB	
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	G	
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg, 37.5 mg, 75 mg	G	
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	G	
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (*vilazodone hcl*)	PB	
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	G	
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (*zuranolone*)	PSP	PA; QL (28 CAPSULES per 14 DAYs)
ZURZUVAE ORAL CAPSULE 30 MG (*zuranolone*)	PSP	PA; QL (14 CAPSULES per 14 DAYs)
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
amantadine hcl oral capsule 100 mg	G	
amantadine hcl oral solution 50 mg/5ml	G	
amantadine hcl oral tablet 100 mg	G	
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (*apomorphine hcl*)	NF	
apomorphine hcl subcutaneous solution cartridge 30 mg/3ml	PSP	PA; QL (20 CARTRIDGES per 30 days)
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	G	
bromocriptine mesylate oral capsule 5 mg	G	
bromocriptine mesylate oral tablet 2.5 mg	G	
carbidopa oral tablet 25 mg	G	
carbidopa-levodopa er oral capsule extended release 23.75-95 mg, 36.25-145 mg, 48.75-195 mg, 61.25-245 mg	G	
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	G	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	G	
carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	G	
CREXONT ORAL CAPSULE EXTENDED RELEASE 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG (*carbidopa-levodopa*)	PB	
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML (*carbidopa-levodopa*)	NPSP	PA; QL (28 CASSETTES per 28 days)
entacapone oral tablet 200 mg	G	
INBRIJA INHALATION CAPSULE 42 MG (*levodopa*)	PB	PA; QL (300 CAPSULES per 30 days)
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (*rotigotine*)	PB	
NOURIANZ ORAL TABLET 20 MG, 40 MG (*istradefylline*)	NPSP	
ONAPGO SUBCUTANEOUS SOLUTION CARTRIDGE 98 MG/20ML (*apomorphine hcl*)	NF	
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	G	
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	G	
rasagiline mesylate oral tablet 0.5 mg, 1 mg	G	
ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	G	
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	G	
RYTARY ORAL CAPSULE EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG (*carbidopa-levodopa*)	PB	
selegiline hcl oral capsule 5 mg	G	
selegiline hcl oral tablet 5 mg	G	
trihexyphenidyl hcl oral solution 0.4 mg/ml	G	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	G	
VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML (*foscarbidopa-foslevodopa*)	NF	
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML, 960 MG/3.2ML (*aripiprazole*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG (*aripiprazole*)	PB	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG (*aripiprazole*)	PB	
aripiprazole oral solution 1 mg/ml	G	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	G	
aripiprazole oral tablet dispersible 10 mg, 15 mg	G	
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML (*aripiprazole lauroxil*)	PB	
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML (*aripiprazole lauroxil*)	PB	
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	G	
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	G	
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	G	
clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg	G	
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*iloperidone*)	NF	
FANAPT TITRATION PACK A ORAL TABLET 1 & 2 & 4 & 6 MG (*iloperidone*)	NF	
fluphenazine hcl oral concentrate 5 mg/ml	G	
fluphenazine hcl oral elixir 2.5 mg/5ml	G	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	G	
haloperidol lactate oral concentrate 2 mg/ml	G	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	G	
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML (*paliperidone palmitate*)	PB	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML (*paliperidone palmitate*)	PB	
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML (*paliperidone palmitate*)	PB	
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg	G	
NUPLAZID ORAL CAPSULE 34 MG (*pimavanserin tartrate*)	NPB	PA; QL (30 CAPSULES per 30 days)
NUPLAZID ORAL TABLET 10 MG (*pimavanserin tartrate*)	NPB	PA; QL (30 TABLETS per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	G	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	G	
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg	G	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	G	
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	G	
quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	G	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG, 50 MG (*risperidone microspheres*)	PB	
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg	G	
risperidone oral solution 1 mg/ml	G	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	G	
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	G	
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	G	
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	G	
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	G	
VRAYLAR ORAL CAPSULE 0.5 MG, 0.75 MG, 1.5 MG, 3 MG, 4.5 MG, 6 MG (*cariprazine hcl*)	PB	
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	G	
ziprasidone mesylate intramuscular solution reconstituted 20 mg	G	
ANTISEIZURE AGENTS - DRUGS TO TREAT SEIZURES		
brivaracetam oral solution 10 mg/ml	G	
brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	G	
BRIVIACT ORAL SOLUTION 10 MG/ML (*brivaracetam*)	PB	
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (*brivaracetam*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	G	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	G	
carbamazepine oral suspension 100 mg/5ml	G	
carbamazepine oral tablet 200 mg	G	
carbamazepine oral tablet chewable 100 mg, 200 mg	G	
clobazam oral suspension 2.5 mg/ml	G	
clobazam oral tablet 10 mg, 20 mg	G	
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	G	QL (300 TABLETS per 25 days)
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	G	QL (300 TABLETS per 25 days)
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	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)	G	QL (240 ML per 25 days)
diazepam oral solution 5 mg/5ml	G	QL (1200 ML per 25 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	G	QL (120 TABLETS per 25 days)
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	G	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	G	
divalproex sodium oral capsule delayed release sprinkle 125 mg	G	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	G	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (*cannabidiol*)	NPSP	PA; QL (800 ML per 30 days)
eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg	G	
ethosuximide oral capsule 250 mg	G	
ethosuximide oral solution 250 mg/5ml	G	
felbamate oral suspension 600 mg/5ml	G	
felbamate oral tablet 400 mg, 600 mg	G	
FINTEPLA ORAL SOLUTION 2.2 MG/ML (*fenfluramine hcl*)	NF	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	G	
gabapentin oral solution 250 mg/5ml, 300 mg/6ml	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
gabapentin oral tablet 600 mg, 800 mg	G	
GABARONE ORAL TABLET 100 MG, 400 MG (*gabapentin*)	NPB	
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG (*clonazepam*)	NPB	QL (300 TABLETS per 25 days)
lacosamide oral solution 10 mg/ml	G	
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	G	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	G	
lamotrigine oral kit 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	G	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	G	
lamotrigine oral tablet chewable 25 mg, 5 mg	G	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	G	
lamotrigine starter kit-blue oral kit 35 x 25 mg	G	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	G	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	G	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	G	
levetiracetam oral solution 500 mg/5ml	G	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	G	
levetiracetam oral tablet disintegrating soluble 250 mg, 500 mg	G	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (*pregabalin*)	NPB	
LYRICA ORAL SOLUTION 20 MG/ML (*pregabalin*)	NPB	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (*midazolam (anticonvulsant)*)	NPB	QL (10 SOLUTION per 25 days)
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (*gabapentin*)	NPB	
NEURONTIN ORAL SOLUTION 250 MG/5ML (*gabapentin*)	NPB	
NEURONTIN ORAL TABLET 600 MG, 800 MG (*gabapentin*)	NPB	
oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg, 600 mg	G	
oxcarbazepine oral suspension 300 mg/5ml	G	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	G	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG, 600 MG (*oxcarbazepine*)	PB	
perampanel oral suspension 0.5 mg/ml	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	G	
phenobarbital oral elixir 30 mg/7.5ml, 60 mg/15ml	G	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	G	
phenytoin oral suspension 100 mg/4ml	G	
phenytoin oral tablet chewable 50 mg	G	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	G	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	G	
pregabalin oral solution 20 mg/ml	G	
primidone oral tablet 125 mg, 250 mg, 50 mg	G	
rufinamide oral suspension 40 mg/ml	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	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	G	
topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg	G	
topiramate oral solution 25 mg/ml	G	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	G	
VALIUM ORAL TABLET 10 MG, 2 MG, 5 MG (*diazepam*)	NPB	QL (120 TABLETS per 25 days)
valproic acid oral capsule 250 mg	G	
valproic acid oral solution 250 mg/5ml	G	
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (*diazepam*)	NPB	QL (10 BLISTER per 25 days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML (*diazepam*)	NPB	QL (10 BLISTER per 25 days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML (*diazepam*)	NPB	QL (10 BLISTER per 25 days)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (*diazepam*)	NPB	QL (10 BLISTER per 25 days)
vigabatrin oral packet 500 mg	PSP	PA; QL (180 PACKETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
vigabatrin oral tablet 500 mg	PSP	PA; QL (180 TABLETS per 30 days)
vigabatrin (Vigadrone Oral Packet 500 Mg)	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*)	PB	
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG (*cenobamate*)	PB	
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*cenobamate*)	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*)	PB	
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (*zonisamide*)	NF	
zonisamide oral capsule 100 mg, 25 mg, 50 mg	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*)	NPB	QL (90 TABLETS per 25 DAYs)
ADDERALL ORAL TABLET 15 MG, 20 MG (*amphetamine-dextroamphetamine*)	NPB	QL (60 TABLETS per 25 DAYs)
ADDERALL ORAL TABLET 30 MG (*amphetamine-dextroamphetamine*)	NPB	QL (30 TABLETS per 25 DAYs)
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 5 MG (*amphetamine-dextroamphetamine*)	NPB	QL (90 CAPSULES per 25 DAYs)
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 15 MG, 20 MG, 25 MG, 30 MG (*amphetamine-dextroamphetamine*)	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*)	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*)	NPB	QL (60 TABLETS per 25 DAYs)
amphetamine er oral tablet extended release dispersible 12.5 mg, 15.7 mg, 18.8 mg	G	QL (30 TABLETS per 25 DAYs)
amphetamine er oral tablet extended release dispersible 3.1 mg, 6.3 mg, 9.4 mg	G	QL (60 TABLETS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
amphetamine sulfate oral tablet 10 mg, 5 mg	G	STX; QL (120 TABLETS per 25 days)
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 5 mg	G	QL (90 CAPSULES per 25 days)
amphetamine-dextroamphet er oral capsule extended release 24 hour 15 mg, 20 mg, 25 mg, 30 mg	G	QL (30 CAPSULES per 25 days)
amphetamine-dextroamphetamine oral tablet 10 mg	G	QL (90 TABLETS per 25 DAYs)
amphetamine-dextroamphetamine oral tablet 12.5 mg, 5 mg, 7.5 mg	G	QL (90 TABLETS per 25 days)
amphetamine-dextroamphetamine oral tablet 15 mg	G	QL (60 TABLETS per 25 days)
amphetamine-dextroamphetamine oral tablet 20 mg	G	QL (60 TABLETS per 25 DAYs)
amphetamine-dextroamphetamine oral tablet 30 mg	G	QL (30 TABLETS per 25 days)
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg	G	QL (60 CAPSULES per 25 DAYs)
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 37.5 mg, 50 mg	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*)	NPB	QL (60 CAPSULES per 25 DAYs)
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 40 MG, 50 MG, 60 MG (*methylphenidate hcl*)	NPB	QL (30 CAPSULES per 25 DAYs)
ARYNTA ORAL SOLUTION 10 MG/ML (*lisdexamfetamine dimesylate*)	NPB	QL (210 ML per 25 DAYs)
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	G	
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (*serdexmethylphen-dexmethylphen*)	PB	QL (30 CAPSULES per 25 days)
CONCERTA ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 36 MG (*methylphenidate hcl*)	NPB	QL (60 TABLETS per 25 DAYs)
CONCERTA ORAL TABLET EXTENDED RELEASE 54 MG (*methylphenidate hcl*)	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*)	NPB	QL (60 TABLETS per 25 DAYs)
DAYTRANA TRANSDERMAL PATCH 10 MG/9HR, 15 MG/9HR, 20 MG/9HR, 30 MG/9HR (*methylphenidate*)	NPB	QL (30 PATCHES per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG (*dextroamphetamine sulfate*)	NPB	QL (120 CAPSULES per 25 DAYs)
DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 15 MG (*dextroamphetamine sulfate*)	NPB	QL (60 CAPSULES per 25 DAYs)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 5 mg	G	QL (60 CAPSULES per 25 DAYs)
dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg, 30 mg, 35 mg, 40 mg	G	QL (30 CAPSULES per 25 DAYs)
dexmethylphenidate hcl oral tablet 10 mg	G	QL (60 TABLETS per 25 days)
dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg	G	QL (120 TABLETS per 25 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg	G	QL (120 CAPSULES per 25 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	G	QL (60 CAPSULES per 25 days)
dextroamphetamine sulfate oral solution 5 mg/5ml	G	QL (1200 ML per 25 DAYs)
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	G	QL (120 TABLETS per 25 DAYs)
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (*amphetamine*)	NPB	QL (240 ML per 25 days)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 10 MG, 5 MG (*amphetamine*)	NPB	QL (60 TABLETS per 25 days)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE 15 MG, 20 MG (*amphetamine*)	NPB	QL (30 TABLETS per 25 days)
EVEKEO ORAL TABLET 10 MG, 5 MG (*amphetamine sulfate*)	NPB	STX; QL (120 TABLETS per 25 days)
FOCALIN ORAL TABLET 10 MG (*dexmethylphenidate hcl*)	NPB	QL (60 TABLETS per 25 days)
FOCALIN ORAL TABLET 2.5 MG, 5 MG (*dexmethylphenidate hcl*)	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*)	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*)	NPB	QL (30 CAPSULES per 25 days)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	G	
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 60 MG, 80 MG (*methylphenidate hcl*)	NPB	QL (30 CAPSULES per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 20 MG, 40 MG (*methylphenidate hcl*)	NPB	QL (60 CAPSULES per 25 DAYs)
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg	G	QL (60 CAPSULES per 25 DAYs)
lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg	G	QL (30 CAPSULES per 25 DAYs)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg	G	QL (60 TABLETS per 25 DAYs)
lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg	G	QL (30 TABLETS per 25 DAYs)
METADATE CD ORAL CAPSULE EXTENDED RELEASE 10 MG, 20 MG, 30 MG (*methylphenidate hcl*)	NPB	QL (60 CAPSULES per 25 DAYs)
METADATE CD ORAL CAPSULE EXTENDED RELEASE 40 MG, 50 MG, 60 MG (*methylphenidate hcl*)	NPB	QL (30 CAPSULES per 25 DAYs)
methamphetamine hcl oral tablet 5 mg	G	STX; QL (150 TABLETS per 25 days)
METHYLIN ORAL SOLUTION 10 MG/5ML (*methylphenidate hcl*)	NPB	QL (900 ML per 25 DAYs)
METHYLIN ORAL SOLUTION 5 MG/5ML (*methylphenidate hcl*)	NPB	QL (1800 ML per 25 DAYs)
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg	G	QL (60 CAPSULES per 25 days)
methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg	G	QL (30 CAPSULES per 25 days)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg	G	QL (60 CAPSULES per 25 days)
methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg	G	QL (30 CAPSULES per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 18 mg	G	QL (60 TABLETS per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 27 mg, 36 mg	G	QL (60 tablets per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 45 mg, 63 mg, 72 mg	G	QL (30 TABLETS per 25 days)
methylphenidate hcl er (osm) oral tablet extended release 54 mg	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	G	QL (60 CAPSULES per 25 DAYs)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 40 mg, 50 mg, 60 mg	G	QL (30 CAPSULES per 25 DAYs)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELEXXII ORAL TABLET EXTENDED RELEASE 54 MG, 72 MG (*methylphenidate hcl*)	NPB	QL (30 TABLETS per 25 DAYs)
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 30 MG (*methylphenidate hcl*)	NPB	QL (60 CAPSULES per 25 DAYs)
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 40 MG (*methylphenidate hcl*)	NPB	QL (30 CAPSULES per 25 DAYs)
RITALIN ORAL TABLET 10 MG, 5 MG (*methylphenidate hcl*)	NPB	QL (180 TABLETS per 25 days)
RITALIN ORAL TABLET 20 MG (*methylphenidate hcl*)	NPB	QL (90 TABLETS per 25 days)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG (*lisdexamfetamine dimesylate*)	NPB	QL (60 CAPSULES per 25 days)
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG (*lisdexamfetamine dimesylate*)	NPB	QL (30 CAPSULES per 25 days)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG (*lisdexamfetamine dimesylate*)	NPB	QL (60 TABLETS per 25 days)
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG (*lisdexamfetamine dimesylate*)	NPB	QL (30 TABLETS per 25 days)
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (*dextroamphetamine*)	NPB	QL (30 PATCHES per 25 DAYs)
dextroamphetamine sulfate (Zenzedi Oral Tablet 15 Mg, 20 Mg)	G	QL (60 TABLETS per 25 days)
dextroamphetamine sulfate (Zenzedi Oral Tablet 2.5 Mg, 7.5 Mg)	G	QL (120 TABLETS per 25 days)
dextroamphetamine sulfate (Zenzedi Oral Tablet 30 Mg)	G	QL (30 TABLETS per 25 days)
BOTULINUM TOXINS		
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT (*onabotulinumtoxina*)	NF	
DAXXIFY INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT (*daxibotulinumtoxina-lanm*)	PSP	PA; N8 (Not covered for cosmetic use)
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT (*abobotulinumtoxina*)	PSP	PA; N8 (Not covered for cosmetic use)
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT (*incobotulinumtoxina*)	PSP	PA; N8 (Not covered for cosmetic use)
FIBROMYALGIA		
milnacipran hcl oral 12.5 & 25 & 50 mg	G	
milnacipran hcl oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	G	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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*)	PB	
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (*atogepant*)	PB	
UBRELVY ORAL TABLET 100 MG, 50 MG (*ubrogepant*)	PB	
MIGRAINE - MONOCLONAL ANTIBODIES - DRUGS TO TREAT SEVERE HEADACHES		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (*erenumab-aooe*)	PB	
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML (*fremanezumab-vfrm*)	PB	
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (*fremanezumab-vfrm*)	PB	
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*galcanezumab-gnlm*)	PB	
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (*galcanezumab-gnlm*)	PB	
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*galcanezumab-gnlm*)	PB	
MIGRAINE - TRIPTANS AND COMBINATIONS - DRUGS TO TREAT SEVERE HEADACHES		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	G	
eletriptan hydrobromide oral tablet 20 mg, 40 mg	G	
frovatriptan succinate oral tablet 2.5 mg	G	
naratriptan hcl oral tablet 1 mg, 2.5 mg	G	
ONZETRA XSAIL NASAL EXHALER POWDER 11 MG/NOSEPC (*sumatriptan succinate*)	PB	
rizatriptan benzoate oral tablet 10 mg, 5 mg	G	
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	G	
sumatriptan nasal solution 20 mg/act, 5 mg/act	G	
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	G	
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	G	
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	G	
sumatriptan-naproxen sodium oral tablet 85-500 mg	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOSYMRA NASAL SOLUTION 10 MG/ACT (*sumatriptan*)	PB	
TREXIMET ORAL TABLET 85-500 MG (*sumatriptan-naproxen sodium*)	NF	
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (*sumatriptan succinate*)	PB	
zolmitriptan nasal solution 2.5 mg, 5 mg	G	
zolmitriptan oral tablet 2.5 mg, 5 mg	G	
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	G	
MISCELLANEOUS		
DAYBUE ORAL SOLUTION 200 MG/ML (*trofinetide*)	NPSP	PA; QL (3600 ML per 30 days)
DAYBUE STIX ORAL PACKET 5000 MG, 6000 MG (*trofinetide*)	NPSP	PA; QL (120 PACKETS per 30 days)
DAYBUE STIX ORAL PACKET 8000 MG (*trofinetide*)	NPSP	PA; QL (60 PACKETS per 30 days)
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*satralizumab-mwge*)	PSP	PA; QL (1 SYRINGE per 28 days)
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (*risdiplam*)	NPSP	PA; QL (2 BOTTLES per 24 days)
EVRYSDI ORAL TABLET 5 MG (*risdiplam*)	NPSP	PA; QL (30 TABLETS per 30 DAYs)
FIRDAPSE ORAL TABLET 10 MG (*amifampridine phosphate*)	NPSP	PA; QL (300 TABLETS per 30 days)
SKYCLARYS ORAL CAPSULE 50 MG (*omaveloxolone*)	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 - DRUGS TO TREAT MOOD DISORDERS		
lithium carbonate er oral tablet extended release 300 mg, 450 mg	G	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	G	
lithium carbonate oral tablet 300 mg	G	
lithium oral solution 8 meq/5ml	G	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (*lithium carbonate*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MOVEMENT DISORDERS		
AUSTEDO ORAL TABLET 12 MG, 9 MG (*deutetrabenazine*)	PSP	PA; QL (120 TABLETS per 30 days)
AUSTEDO ORAL TABLET 6 MG (*deutetrabenazine*)	PSP	PA; QL (60 TABLETS per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (*deutetrabenazine*)	NF	
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (*deutetrabenazine*)	NF	
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (*valbenazine tosylate*)	PB	PA; QL (30 CAPSULES per 30 days)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (*valbenazine tosylate*)	PB	PA; QL (30 CAPSULES per 30 days)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (*valbenazine tosylate*)	PB	PA; QL (1 PACK per 28 days)
tetrabenazine oral tablet 12.5 mg	G	PA; QL (240 TABLETS per 30 days)
tetrabenazine oral tablet 25 mg	G	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*)	NPB	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*)	PSP	PA; QL (4 SYRINGES per 28 days)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (*interferon beta-1a*)	PSP	PA; QL (4 SYRINGES per 28 days)
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (*monomethyl fumarate*)	PSP	PA; QL (120 CAPSULES per 30 days)
BETASERON SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*)	PSP	PA; QL (14 INJECTIONS per 28 days)
BRIUMVI INTRAVENOUS SOLUTION 150 MG/6ML (*ublituximab-xiiy*)	PSP	PA; QL (3 VIALS per 168 DAYs)
cladribine (10 tabs) oral tablet therapy pack 10 mg	PSP	PA; QL (20 TABLETS per 270 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cladribine (4 tabs) oral tablet therapy pack 10 mg	PSP	PA; QL (20 TABLETS per 270 days)
cladribine (5 tabs) oral tablet therapy pack 10 mg	PSP	PA; QL (20 TABLETS per 270 days)
cladribine (6 tabs) oral tablet therapy pack 10 mg	PSP	PA; QL (20 TABLETS per 270 days)
cladribine (7 tabs) oral tablet therapy pack 10 mg	PSP	PA; QL (20 TABLETS per 270 days)
cladribine (8 tabs) oral tablet therapy pack 10 mg	PSP	PA; QL (20 TABLETS per 270 days)
cladribine (9 tabs) oral tablet therapy pack 10 mg	PSP	PA; QL (20 TABLETS per 270 days)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (*glatiramer acetate*)	NF	
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (*glatiramer acetate*)	NPSP	PA; QL (12 SYRINGES per 28 days)
dalfampridine er oral tablet extended release 12 hour 10 mg	G	PA; QL (60 TABLETS per 30 days)
dimethyl fumarate oral capsule delayed release 120 mg	G	PA; N8 (Listing does not include certain NDCs); QL (14 CAPSULES per 28 days)
dimethyl fumarate oral capsule delayed release 240 mg	G	PA; QL (60 CAPSULES per 30 days)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	G	PA; QL (1 KIT per 30 days)
fingolimod hcl oral capsule 0.5 mg	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	PSP	PA; QL (30 ML per 30 days)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	PSP	PA; QL (12 ML per 28 days)
glatiramer acetate (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/Ml)	PSP	PA; QL (30 ML per 30 days)
glatiramer acetate (Glatopa Subcutaneous Solution Prefilled Syringe 40 Mg/Ml)	PSP	PA; QL (12 ML per 28 days)
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (*ofatumumab*)	PSP	PA; QL (1 PEN per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NPSP	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NPSP	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NPSP	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NPSP	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NPSP	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NPSP	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	NPSP	PA; QL (20 TABLETS per 270 days)
MAYZENT ORAL TABLET 0.25 MG (*siponimod fumarate*)	PSP	PA; QL (12 TABLETS per 5 days)
MAYZENT ORAL TABLET 1 MG (*siponimod fumarate*)	PSP	PA; QL (30 TABLETS per 30 days)
MAYZENT ORAL TABLET 2 MG (*siponimod fumarate*)	PSP	PA; QL (30 TABLETS per 30 DAYs)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (*siponimod fumarate*)	PSP	PA; QL (12 TABLETS per 5 Days)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (*siponimod fumarate*)	PSP	PA; QL (7 TABLETS per 4 days)
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML (*ocrelizumab*)	PSP	PA; QL (2 VIALS per 168 DAYs)
OCREVUS ZUNOVO SUBCUTANEOUS SOLUTION 920-23000 MG-UT/23ML (*ocrelizumab-hyaluronidase-ocsq*)	PSP	PA; QL (1 VIAL per 168 DAYs)
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	NPSP	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	NPSP	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	NPSP	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (*peginterferon beta-1a*)	NPSP	PA; QL (2 INJECTIONS per 28 days)
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	NPSP	PA; QL (2 INJECTIONS per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PONVORY ORAL TABLET 20 MG (*ponesimod*)	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*)	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*)	PSP	PA; QL (12 PENS per 28 days)
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG (*interferon beta-1a*)	PSP	PA; QL (1 ML per 28 days)
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (*interferon beta-1a*)	PSP	PA; QL (12 SYRINGES per 28 DAYs)
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (*interferon beta-1a*)	PSP	PA; QL (1 ML per 28 days)
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG, 0.5 MG (*fingolimod lauryl sulfate*)	NF	
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	G	PA; QL (30 TABLETS per 30 days)
TYRUKO INTRAVENOUS CONCENTRATE 300 MG/15ML (*natalizumab-sztn*)	PSP	PA; QL (1 VIAL per 28 days)
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML (*natalizumab*)	PSP	PA; QL (1 ML per 28 days)
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG (*diroximel fumarate*)	PB	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*)	PSP	PA; ST; IBC (Preferred agent for Ulcerative Colitis); QL (1 PACK per 7 days)
ZEPOSIA ORAL CAPSULE 0.92 MG (*ozanimod hcl*)	PSP	PA; ST; 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*)	PSP	PA; ST; IBC (Preferred agent for Ulcerative Colitis); QL (1 KIT per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MUSCULOSKELETAL THERAPY AGENTS		
AMRIX ORAL CAPSULE EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (*cyclobenzaprine hcl*)	NF	
baclofen oral tablet 10 mg, 20 mg, 5 mg	G	
carisoprodol oral tablet 250 mg	NF	
carisoprodol oral tablet 350 mg	G	QL (84 TABLETS per 28 days)
chlorzoxazone oral tablet 250 mg, 375 mg, 750 mg	NF	
chlorzoxazone oral tablet 500 mg	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	G	
cyclobenzaprine hcl oral tablet 7.5 mg	NF	
DANTRIUM ORAL CAPSULE 25 MG (*dantrolene sodium*)	PB	
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	G	
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (*givinostat hcl*)	NF	
cyclobenzaprine hcl (Fexmid Oral Tablet 7.5 Mg)	NF	
metaxalone oral tablet 400 mg	NF	
metaxalone oral tablet 800 mg	G	
methocarbamol oral tablet 500 mg, 750 mg	G	N8 (Listing does not include certain NDCs)
norgesic forte oral tablet 50-770-60 mg	NF	
NORGESIC ORAL TABLET 25-385-30 MG (*orphenadrine-aspirin-caffeine*)	NF	
orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg	NF	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (*orphenadrine-aspirin-caffeine*)	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*)	NPB	QL (84 TABLETS per 28 DAYs)
tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg, 8 mg	G	
tizanidine hcl oral tablet 2 mg, 4 mg	G	
MYASTHENIA GRAVIS - DRUGS TO TREAT MYASTHENIA GRAVIS		
pyridostigmine bromide er oral tablet extended release 180 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
pyridostigmine bromide oral solution 60 mg/5ml	G	
pyridostigmine bromide oral tablet 30 mg, 60 mg	G	
VYVGART HYTRULO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1000-10000 MG-UNT/5ML (*efgartigimod alfa-hyalur-qvfc*)	PSP	PA; QL (4 SYRINGES per 28 days)
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	G	
LUMRYZ ORAL PACKET 4.5 GM, 6 GM, 7.5 GM, 9 GM (*sodium oxybate*)	PSP	PA; QL (30 PACKETS per 30 days)
LUMRYZ STARTER PACK ORAL THERAPY PACK 4.5 & 6 & 7.5 GM (*sodium oxybate*)	PSP	PA; QL (28 PACKETS per 28 days)
modafinil oral tablet 100 mg, 200 mg	G	
sodium oxybate oral solution 500 mg/ml	PSP	PA; N8 (Listing does not include certain NDCs); QL (540 ML per 30 days)
SUNOSI ORAL TABLET 150 MG, 75 MG (*solriamfetol hcl*)	PB	
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (*pitolisant hcl*)	PB	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*)	PSP	PA; QL (540 ML per 30 days)
OPIOID AGONIST/ANTAGONIST		
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg	G	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	CE	
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG (*buprenorphine hcl-naloxone hcl*)	NPB	
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (*buprenorphine hcl-naloxone hcl*)	PB	
OPIOID ANTAGONIST		
KLOXXADO NASAL LIQUID 8 MG/0.1ML (*naloxone hcl*)	PB	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	G	
naloxone hcl injection solution cartridge 0.4 mg/ml	G	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
naloxone hcl nasal liquid 4 mg/0.1ml	G	
naltrexone hcl oral tablet 50 mg	CE	
NARCAN NASAL LIQUID 4 MG/0.1ML (*naloxone hcl*)	G	
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (*nalmefene hcl*)	NPB	
REXTOVY NASAL LIQUID 4 MG/0.25ML (*naloxone hcl*)	NPB	
REZENOPY NASAL LIQUID 10 MG/0.11ML (*naloxone hcl*)	NPB	
RIVIVE NASAL LIQUID 3 MG/0.1ML (*naloxone hcl*)	NPB	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (*naltrexone*)	NPSP	QL (380 MG per 28 days)
ZURNAI INJECTION SOLUTION AUTO-INJECTOR 1.5 MG/0.5ML (*nalmefene hcl*)	NPB	
OPIOID PARTIAL AGONISTS		
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	CE	
POSTHERPETIC NEURALGIA (PHN)		
gabapentin (once-daily) oral tablet 300 mg, 450 mg, 600 mg, 750 mg, 900 mg	G	
GRALISE ORAL TABLET 300 MG, 450 MG, 600 MG, 750 MG, 900 MG (*gabapentin (once-daily)*)	PB	
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	G	
PSYCHOTHERAPEUTIC-MISC		
ADDYI ORAL TABLET 100 MG (*flibanserin*)	NPB	SPC
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	G	
fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg	NF	
lofexidine hcl oral tablet 0.18 mg	G	
LUCEMYRA ORAL TABLET 0.18 MG (*lofexidine hcl*)	NPB	
NUEDEXTA ORAL CAPSULE 20-10 MG (*dextromethorphan-quinidine*)	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	G	
pimozide oral tablet 1 mg, 2 mg	G	
VYLEESI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.75 MG/0.3ML (*bremelanotide acetate*)	NPB	SPC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
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 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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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		
BYNFEZIA PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 2500 MCG/ML (*octreotide acetate*)	NF	
MYCAPSSA ORAL CAPSULE DELAYED RELEASE 20 MG (*octreotide acetate*)	NF	
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	G	PA; QL (90 ML per 30 days)
octreotide acetate injection solution 1000 mcg/ml	G	PA; QL (45 ML per 30 days)
octreotide acetate injection solution 200 mcg/ml	G	PA; QL (225 ML per 30 days)
octreotide acetate intramuscular kit 10 mg	PSP	PA; QL (1 INJECTION per 28 DAYs)
octreotide acetate intramuscular kit 20 mg	PSP	PA; QL (2 INJECTIONS per 28 days)
octreotide acetate intramuscular kit 30 mg	PSP	PA; QL (1 INJECTION per 28 days)
octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	G	PA; QL (90 ML per 30 days)
PALSONIFY ORAL TABLET 20 MG, 30 MG (*paltusotine hcl*)	NF	
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML (*octreotide acetate*)	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*)	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*)	NPB	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVEED INTRAMUSCULAR SOLUTION 750 MG/3ML (*testosterone undecanoate*)	NPSP	PA
AZMIRO INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 200 MG/ML (*testosterone cypionate*)	NPB	PA
JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG (*testosterone undecanoate*)	NPB	PA
KYZATREX ORAL CAPSULE 150 MG, 200 MG (*testosterone undecanoate*)	NPB	PA
methitest oral tablet 10 mg	G	PA; STX
methyltestosterone oral capsule 10 mg	G	PA; STX
NATESTO NASAL GEL 5.5 MG/ACT (*testosterone*)	PB	PA
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	NPB	PA
testosterone cypionate injection solution 200 mg/ml	NPB	PA
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	G	PA
testosterone enanthate intramuscular solution 200 mg/ml	G	PA
testosterone transdermal gel 1.62 %, 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%)	G	PA
testosterone transdermal solution 30 mg/act	G	PA
TLANDO ORAL CAPSULE 112.5 MG (*testosterone undecanoate*)	NPB	PA
VOGELXO PUMP TRANSDERMAL GEL 12.5 MG/ACT (1%) (*testosterone*)	NPB	PA
VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	NPB	PA
XYOSTED SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/0.5ML, 50 MG/0.5ML, 75 MG/0.5ML (*testosterone enanthate*)	NPB	PA
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose oral tablet 100 mg, 25 mg, 50 mg	G	
miglitol oral tablet 100 mg, 25 mg, 50 mg	G	
ANTIDIABETICS, BIGUANIDE		
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	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	G	
metformin hcl oral tablet 1000 mg, 500 mg, 750 mg	G	
metformin hcl oral tablet 850 mg	CE	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	G	
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR COMBINATIONS		
alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg	G	
alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg	G	
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (*sitagliptin phos-metformin hcl*)	PB	
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (*sitagliptin phos-metformin hcl*)	PB	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (*linagliptin-metformin hcl*)	PB	
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG (*linagliptin-metformin hcl*)	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*)	PB	
ZITUVIMET ORAL TABLET 50-1000 MG, 50-500 MG (*sitagliptin base-metformin hcl*)	PB	
ZITUVIMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (*sitagliptin base-metformin hcl*)	PB	
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg	G	
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (*sitagliptin phosphate*)	PB	
TRADJENTA ORAL TABLET 5 MG (*linagliptin*)	PB	
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG (*sitagliptin*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIABETICS, INCRETIN MIMETIC AGENTS		
liraglutide subcutaneous solution pen-injector 18 mg/3ml	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*)	PB	ST
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (*semaglutide*)	PB	ST
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (*semaglutide*)	PB	ST
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (*semaglutide*)	PB	ST
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (*semaglutide*)	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*)	PB	ST
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide*)	NPB	ST
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (*insulin glargine-lixisenatide*)	PB	
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML (*insulin degludec-liraglutide*)	PB	
ANTIDIABETICS, INSULIN		
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	PB	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	PB	
FIASP INJECTION SOLUTION 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	PB	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	PB	
HUMALOG INJECTION SOLUTION 100 UNIT/ML (*insulin lispro*)	PB	
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	NPB	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin lispro*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (*insulin lispro prot & lispro*)	PB	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	PB	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	PB	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin lispro*)	PB	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	PB	
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	PB	
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	PB	
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	PB	
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	PB	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (*insulin regular human*)	PB	
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	PB	
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	PB	
insulin aspart injection solution 100 unit/ml	PB	
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	PB	
insulin lispro injection solution 100 unit/ml	PB	
insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml	PB	
insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml	PB	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	PB	
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin glargine*)	PB	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIABETICS, INSULIN SENSITIZER		
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	G	
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	G	
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	G	
ANTIDIABETICS, MEGLITINIDE		
nateglinide oral tablet 120 mg, 60 mg	G	
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	G	
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS		
dapagliflozin base-metformin er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-1000 mg, 5-500 mg	G	
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (*empagliflozin-metformin hcl*)	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*)	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 base-metformin*)	PB	
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS		
dapagliflozin-saxagliptin oral tablet 10-5 mg	G	
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (*empagliflozin-linagliptin*)	PB	
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS		
dapagliflozin oral tablet 10 mg, 5 mg	G	
FARXIGA ORAL TABLET 10 MG, 5 MG (*dapagliflozin*)	PB	
JARDIANCE ORAL TABLET 10 MG, 25 MG (*empagliflozin*)	PB	
ANTIDIABETICS, SULFONYLUREA		
glimepiride oral tablet 1 mg, 2 mg, 4 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	G	
glipizide oral tablet 10 mg, 2.5 mg, 5 mg	G	
ANTIOBESITY		
benzphetamine hcl oral tablet 50 mg	G	PA; SPC; QL (90 TABLETS per 25 days)
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (*naltrexone-bupropion hcl*)	NPB	PA; SPC; QL (120 TABLETS per 25 days)
diethylpropion hcl er oral tablet extended release 24 hour 75 mg	G	PA; SPC; QL (30 TABLETS per 25 days)
diethylpropion hcl oral tablet 25 mg	G	PA; SPC; QL (90 TABLETS per 25 days)
FOUNDAYO ORAL TABLET 0.8 MG, 14.5 MG, 17.2 MG, 2.5 MG, 5.5 MG, 9 MG (*orforglipron-weight management*)	PB	PA; SPC; QL (30 TABLETS per 25 days)
liraglutide -weight management subcutaneous solution pen-injector 18 mg/3ml	G	PA; SPC; QL (5 PENS per 25 DAYs)
phentermine hcl (Lomaira Oral Tablet 8 Mg)	G	PA; SPC; QL (90 TABLETS per 25 days)
orlistat oral capsule 120 mg	G	PA; SPC; QL (90 CAPSULES per 25 days)
phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg	NPB	PA; SPC; QL (30 CAPSULES per 25 DAYs)
phendimetrazine tartrate oral tablet 35 mg	G	PA; SPC; QL (180 TABLETS per 25 days)
phentermine hcl oral capsule 15 mg	G	PA; SPC; QL (60 CAPSULES per 25 days)
phentermine hcl oral capsule 30 mg, 37.5 mg	G	PA; SPC; QL (30 CAPSULES per 25 days)
phentermine hcl oral tablet 37.5 mg	G	PA; SPC; QL (30 TABLETS per 25 days)
phentermine-topiramate er oral capsule extended release 24 hour 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg	G	PA; SPC; QL (30 CAPSULES 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*)	PB	PA; SPC; QL (30 CAPSULES per 25 days)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide -weight management*)	NPB	PA; SPC; QL (5 PENS per 25 days)
WEGOVY HD SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.2 MG/0.75ML (*semaglutide-weight management*)	PB	PA; SPC; QL (4 PENS per 21 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WEGOVY ORAL TABLET 1.5 MG, 25 MG, 4 MG, 9 MG (*semaglutide-weight management*)	PB	PA; SPC; QL (30 TABLETS 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*)	PB	PA; SPC; QL (4 PENS per 21 days)
XENICAL ORAL CAPSULE 120 MG (*orlistat*)	NPB	PA; SPC; QL (90 CAPSULES per 25 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*)	PB	PA; SPC; QL (4 PENS per 21 days)
CALCIUM RECEPTOR AGONISTS		
cinacalcet hcl oral tablet 30 mg, 60 mg	G	PA; QL (60 TABLETS per 30 days)
cinacalcet hcl oral tablet 90 mg	G	PA; QL (120 TABLETS per 30 days)
SENSIPAR ORAL TABLET 30 MG, 60 MG (*cinacalcet hcl*)	NPB	PA; QL (60 TABLETS per 30 days)
SENSIPAR ORAL TABLET 90 MG (*cinacalcet hcl*)	NPB	PA; QL (120 TABLETS per 30 days)
CALCIUM REGULATORS, BISPHOSPHONATES - DRUGS TO TREAT BONE LOSS		
alendronate sodium oral solution 70 mg/75ml	G	
alendronate sodium oral tablet 10 mg, 35 mg, 70 mg	G	
ibandronate sodium intravenous solution 3 mg/3ml	G	
ibandronate sodium oral tablet 150 mg	G	
pamidronate disodium intravenous solution 30 mg/10ml, 90 mg/10ml	G	
pamidronate disodium intravenous solution 6 mg/ml	NPSP	
RECLAST INTRAVENOUS SOLUTION 5 MG/100ML (*zoledronic acid*)	NPSP	PA
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	G	
risedronate sodium oral tablet delayed release 35 mg	G	
zoledronic acid intravenous concentrate 4 mg/5ml	G	PA
zoledronic acid intravenous solution 4 mg/100ml	NPSP	PA
zoledronic acid intravenous solution 5 mg/100ml	G	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM REGULATORS, MISCELLANEOUS		
AUKELSO SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab-kyqq*)	NF	
BILDYOS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab-nxxp*)	NF	
BILPREVDA SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab-nxxp*)	NF	
BOMYNTRA SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab-bnht*)	NF	
BOMYNTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/1.7ML (*denosumab-bnht*)	NF	
BOSAYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab-kyqq*)	NF	
calcitonin (salmon) nasal solution 200 unit/act	G	
CONEXXENCE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab-bnht*)	NF	
ENOBY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab-qbde*)	NF	
JUBBONTI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab-bbdz*)	NF	
OSENVELT SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab-bmwo*)	PSP	PA; QL (1 VIAL per 28 days)
OSPOMYV SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab-dssb*)	PSP	PA; QL (1 SYRINGE per 180 days)
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab*)	NF	
STOBOCLO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (*denosumab-bmwo*)	PSP	PA; QL (1 SYRINGE per 180 days)
WYOST SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab-bbdz*)	NF	
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab*)	NF	
XTRENBO SUBCUTANEOUS SOLUTION 120 MG/1.7ML (*denosumab-qbde*)	NF	
CALCIUM REGULATORS, PARATHYROID HORMONES		
BONSITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (*teriparatide*)	PSP	PA; QL (1 PEN per 28 days)
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML (*teriparatide*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml	PSP	PA; QL (1 PEN per 28 days)
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (*abaloparatide*)	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*)	NPSP	PA; QL (2 PENS per 28 days)
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	G	
levocarnitine oral tablet 330 mg	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*)	PSP	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG (*leuprolide acetate (3 month)*)	PSP	PA
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT 45 MG (*leuprolide acetate (6 month)*)	PSP	PA
TRIPTODUR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 22.5 MG (*triptorelin pamoate*)	PSP	PA
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	PSP	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	PSP	PA
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	PSP	PA
deferiprone oral tablet 1000 mg, 500 mg	PSP	PA
deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg	NPSP	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	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FERRIPROX ORAL TABLET 1000 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	G	
penicillamine oral tablet 250 mg	G	
SYPRINE ORAL CAPSULE 250 MG (*trientine hcl*)	NF	
trientine hcl oral capsule 250 mg, 500 mg	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)
desogestrel-ethinyl estradiol (Apri Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG (*norethin-eth estrad triphasic*)	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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
AVERI ORAL TABLET 0.15-0.03 MG (*desogestrel-eth estrad-fe*)	CE	N7 (NPB)
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)
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); QL (12 CONDOMS per 25 DAYs)
desogestrel-ethinyl estradiol (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
norethindrone-eth estradiol (Dasetta 1/35 (28) 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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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*)	PB	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (*medroxyprogesterone acetate*)	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)
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)
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)
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)
norethin ace-eth estrad-fe (Feirza 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Feirza 1/20 Oral Tablet 1-20 Mg-Mcg)	CE	N7 (G)
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (*cervical caps*)	CE	N7 (NPB); QL (1 DEVICE per 300 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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-eth estradiol-fe (Galbriela Oral Tablet Chewable 0.8-25 Mg-Mcg)	CE	N7 (G)
norethin ace-eth estrad-fe (Gemmily Oral Capsule 1-20 Mg-Mcg(24))	CE	N7 (G)
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)
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)
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)
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 estrad 91-day oral tablet 0.1-0.02 & 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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
drospirenone-ethinyl estradiol (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	CE	N7 (G)
norethindrone acet-ethinyl est (Luizza 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	CE	N7 (G)
norethindrone acet-ethinyl est (Luizza 1/20 Oral Tablet 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)
norethindrone (Meleya Oral Tablet 0.35 Mg)	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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
levonorgest-eth estradiol-iron (Minzoya Oral Tablet 0.1-20 Mg-Mcg(21))	CE	N7 (G)
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/DAY (*levonorgestrel*)	CE	N7 (PB); QL (1 INTRAUTERINE DEVICE per 300 days)
MIUDELLA INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (*copper*)	CE	N7 (NPB); 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)
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 chewable 1-20 mg-mcg(24)	CE	N7 (G)
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	CE	N7 (G)
norethindrone oral tablet 0.35 mg	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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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*)	NPB	QL (13 RING per 300 days)
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)
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)
norethindrone (Orquidea Oral Tablet 0.35 Mg)	CE	N7 (G)
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)
PLAN B ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
levonorgestrel-ethinyl estrad (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	CE	N7 (G)
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 (Rosyrah 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)
SHEWISE ORAL TABLET 1.5 MG (*levonorgestrel*)	CE	N7 (Not Covered)
desogestrel-ethinyl estradiol (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	CE	N7 (G)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levonorgest-eth estrad 91-day (Simpesse Oral Tablet 0.15-0.03 &0.01 Mg)	CE	N7 (G)
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)
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)
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)
norgestim-eth estrad triphasic (Tri-Vylibra Lo 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-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)
ethynodiol diac-eth estradiol (Valtya 1/35 Oral Tablet 1-35 Mg-Mcg)	CE	N7 (G)
VALTYA 1/50 ORAL TABLET 1-50 MG-MCG (*ethynodiol diac-eth estradiol*)	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)
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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
norethindron-ethinyl estrad-fe (Xarah Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	CE	N7 (G)
norethin-eth estradiol-fe (Xelria 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*)	PB	QL (150 TEST STRIPS per 25 days)
ACCU-CHEK FASTCLIX LANCET KIT (*lancets misc.*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)
ACCU-CHEK FASTCLIX LANCETS (*lancets*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)
ACCU-CHEK GUIDE TEST IN VITRO STRIP (*glucose blood*)	PB	QL (150 TEST STRIPS per 25 days)
ACCU-CHEK SAFE-T PRO LANCETS (*lancets*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)
ACCU-CHEK SMARTVIEW IN VITRO STRIP (*glucose blood*)	PB	QL (150 TEST STRIPS per 25 days)
ACCU-CHEK SOFTCLIX LANCET DEV KIT (*lancets misc.*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCU-CHEK SOFTCLIX LANCETS (*lancets*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)
ACCUTREND GLUCOSE IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
ADVANCE MICRO-DRAW TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
alcohol swabs pad	NPB	
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (*insulin syringe/needle u-500*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML, 31G X 15/64" 1 ML (*insulin syringe-needle u-100*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
CARETOUCH TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
CONTOUR NEXT TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
CONTOUR TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
CVS ADVANCED GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	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*)	NPB	QL (150 TEST STRIPS per 25 days)
DEXCOM G6 RECEIVER DEVICE (*continuous glucose receiver*)	PB	
DEXCOM G6 SENSOR (*continuous glucose sensor*)	PB	QL (3 SENSORS per 25 days)
DEXCOM G6 TRANSMITTER (*continuous glucose transmitter*)	PB	
DEXCOM G7 15 DAY SENSOR (*continuous glucose sensor*)	PB	QL (2 SENSORS per 25 DAYs)
DEXCOM G7 RECEIVER DEVICE (*continuous glucose receiver*)	PB	
DEXCOM G7 SENSOR (*continuous glucose sensor*)	PB	QL (3 SENSORS per 25 days)
EASY TOUCH TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
EASYMAX 15 TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
EASYMAX TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
EMBECTA AUTOSHIELD DUO 30G X 5 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (*insulin syringe-needle u-100*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (*insulin syringe/needle u-500*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
EMBECTA PEN NEEDLE NANO 32G X 4 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (*insulin pen needle*)	PB	N8 (BD and select Embecta Ultrafine Syringe or Pen Needles are preferred)
EMBRACE BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
EMBRACE WAVE BLOOD GLUCOSE IN VITRO STRIP (*glucose blood*)	NPB	QL (150 test strips per 25 days)
ENLITE GLUCOSE SENSOR (*continuous glucose sensor*)	NPB	QL (5 SENSORS per 25 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
eq blood glucose test in vitro strip	NPB	QL (150 TEST STRIPS per 25 days)
EVERSENSE 365 SENSOR/HOLDER (*continuous glucose sensor*)	NPB	QL (1 SENSOR per 305 days)
EVERSENSE 365 SMART TRANSMIT (*continuous glucose transmitter*)	NPB	
EVERSENSE SENSOR/HOLDER (*continuous glucose sensor*)	NPB	QL (1 SENSOR per 75 DAYs)
fondcircle blood glucose test in vitro strip	NPB	QL (150 TEST STRIPS per 25 days)
FORA 6 CONNECT/GTEL TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 DAYs)
FREESTYLE LIBRE 14 DAY SENSOR (*continuous glucose sensor*)	PB	QL (2 SENSORS per 21 days)
FREESTYLE LIBRE 2 PLUS SENSOR (*continuous glucose sensor*)	PB	QL (2 SENSORS per 25 DAYs)
FREESTYLE LIBRE 2 SENSOR (*continuous glucose sensor*)	PB	QL (2 SENSORS per 21 DAYs)
FREESTYLE LIBRE 3 PLUS SENSOR (*continuous glucose sensor*)	PB	QL (2 SENSORS per 25 days)
FREESTYLE LIBRE 3 READER DEVICE (*continuous glucose receiver*)	PB	
FREESTYLE LIBRE 3 SENSOR (*continuous glucose sensor*)	PB	QL (2 SENSORS per 21 days)
FREESTYLE PRECISION NEO TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
GNP TRUETRACK TEST STRIPS IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
GOJJI BLOOD TEST STRIP/LANCETS IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
GUARDIAN 4 GLUCOSE SENSOR (*continuous glucose sensor*)	NPB	QL (5 SENSORS per 21 DAYs)
GUARDIAN 4 TRANSMITTER (*continuous glucose transmitter*)	NPB	
GUARDIAN SENSOR (3) (*continuous glucose sensor*)	NPB	QL (5 SENSORS per 21 DAYs)
guardian sensor 3	NPB	QL (5 SENSORS per 21 DAYs)
MICRODOT TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED INSTINCT GLUC SENSOR (*continuous glucose sensor*)	NPB	QL (2 SENSORS per 25 DAYs)
NEUTEK 2TEK TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (*insulin disposable pump*)	PB	
OMNIPOD 5 DEXG7G6 PODS GEN 5 (*insulin disposable pump*)	PB	
OMNIPOD DASH INTRO (GEN 4) KIT (*insulin disposable pump*)	PB	
OMNIPOD DASH PDM (GEN 4) KIT (*insulin disposable pump*)	PB	
OMNIPOD DASH PODS (GEN 4) (*insulin disposable pump*)	PB	
ONETOUCH DELICA PLUS LANCET30G (*lancets*)	NPB	
ONETOUCH DELICA PLUS LANCET33G (*lancets*)	NPB	
ONETOUCH DELICA PLUS LANCING (*lancet devices*)	NPB	
ONETOUCH ULTRA TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 Days)
ONETOUCH ULTRASOFT 2 LANCETS (*lancets*)	NPB	
ONETOUCH VERIO IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
OPTIUMEZ TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
PRECISION XTRA BLOOD GLUCOSE IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 DAYs)
QUINTET AC BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
QUINTET BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
RELION TRUE METRIX TEST STRIPS IN VITRO STRIP (*glucose blood*)	PB	QL (150 TEST STRIPS per 25 DAYs)
SIMPLERA SENSOR (*continuous glucose sensor*)	NPB	QL (5 SENSORS per 25 DAYs)
SIMPLERA SYNC SENSOR (*continuous glucose sensor*)	NPB	QL (5 SENSORS per 25 DAYs)
SIMPLERA SYSTEM (*continuous glucose sensor*)	NPB	QL (5 SENSORS per 25 DAYs)
SUPREME TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
true focus blood glucose strip in vitro strip	NPB	QL (150 TEST STRIPS per 25 days)
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	PB	QL (150 TEST STRIPS per 25 days)
TRUEPLUS LANCETS 28G (*lancets*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)
TRUEPLUS LANCETS 30G (*lancets*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)
TRUEPLUS LANCETS 33G (*lancets*)	PB	N8 (Accu-Chek or Trueplus (only certain NDCs) are the only preferred options)
TRUETEST TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
TRUETRACK TEST IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
TWIIST REFILL KIT KIT (*insulin disposable pump*)	PB	
TWIIST REFILL KIT/INFUSION SET KIT (*insulin disposable pump*)	PB	
TWIIST STARTER KIT KIT (*insulin disposable pump*)	PB	
UNISTRIP CONTROL IN VITRO SOLUTION LOW (*blood glucose calibration*)	NPB	
UNISTRIP1 GENERIC IN VITRO STRIP (*glucose blood*)	NPB	QL (150 TEST STRIPS per 25 days)
V-GO 20 KIT 20 UNIT/24HR (*insulin disposable pump*)	NPB	
V-GO 30 KIT 30 UNIT/24HR (*insulin disposable pump*)	NPB	
V-GO 40 KIT 40 UNIT/24HR (*insulin disposable pump*)	NPB	
ENDOMETRIOSIS		
danazol oral capsule 100 mg, 200 mg, 50 mg	G	
ORILISSA ORAL TABLET 150 MG, 200 MG (*elagolix sodium*)	PB	
SYNAREL NASAL SOLUTION 2 MG/ML (*nafarelin acetate*)	NPB	PA
FERTILITY REGULATORS		
cetrorelix acetate subcutaneous kit 0.25 mg	PSP	PA; SPC
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (*cetrorelix acetate*)	NF	
chorionic gonadotropin intramuscular solution reconstituted 10000 unit	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clomiphene citrate (Clomid Oral Tablet 50 Mg)	G	SPC
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML, 600 UNT/0.72ML, 900 UNT/1.08ML (*follitropin beta*)	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	PSP	PA; SPC
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (*follitropin alfa*)	NF	
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (*follitropin alfa*)	NF	
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (*menotropins*)	PSP	PA; SPC
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (*chorionic gonadotropin*)	NF	
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (*choriogonadotropin alfa*)	NF	
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT (*chorionic gonadotropin*)	PSP	PA; SPC
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*)	NPB	
deflazacort oral suspension 22.75 mg/ml	PSP	PA; QL (52 ML per 30 days)
deflazacort oral tablet 18 mg, 30 mg, 36 mg	PSP	PA; QL (30 TABLETS per 30 days)
deflazacort oral tablet 6 mg	PSP	PA; QL (60 TABLETS per 30 days)
dexamethasone oral elixir 0.5 mg/5ml	G	
dexamethasone oral solution 0.5 mg/5ml	G	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	G	
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	G	
dexamethasone (Hidex 6-Day Oral Tablet Therapy Pack 1.5 Mg (21))	G	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	G	
jaythari oral suspension 22.75 mg/ml	PSP	PA; QL (52 ML per 30 DAYs)
jaythari oral tablet 18 mg, 30 mg, 36 mg	PSP	PA; QL (30 TABLETS per 30 DAYs)
jaythari oral tablet 6 mg	PSP	PA; QL (60 TABLETS per 30 DAYs)
deflazacort (Kymbee Oral Tablet 18 Mg, 30 Mg, 36 Mg)	PSP	PA; QL (30 TABLETS per 30 days)
deflazacort (Kymbee Oral Tablet 6 Mg)	PSP	PA; QL (60 TABLETS per 30 days)
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	G	
methylprednisolone oral tablet therapy pack 4 mg	G	
prednisolone oral solution 15 mg/5ml	G	
prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml	NF	
prednisolone sodium phosphate oral solution 15 mg/5ml, 25 mg/5ml, 5 mg/5ml	G	
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	G	
prednisone oral solution 5 mg/5ml	G	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	G	
prednisone oral tablet delayed release 1 mg, 2 mg	G	
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	G	
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (*dexamethasone*)	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*)	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (*glucagon*)	PB	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (*glucagon*)	PB	
BD GLUCOSE ORAL TABLET CHEWABLE 5 GM (*dextrose (diabetic use)*)	NPB	
diazoxide oral suspension 50 mg/ml	G	
glucagon emergency injection solution reconstituted 1 mg	G	
glucose oral tablet chewable 4 gm	G	
gnp glucose gummies oral tablet chewable 2 gm	G	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (*glucagon*)	PB	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (*glucagon*)	PB	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (*glucagon*)	PB	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (*glucagon*)	PB	
lanreotide acetate solution 120 mg/0.5ml subcutaneous	NF	
lanreotide acetate solution 120 mg/0.5ml subcutaneous	PSP	PA; QL (1 INJECTION per 28 days)
GROWTH IMPROVEMENT AGENTS - DRUGS TO PROMOTE GROWTH		
VOXZOGO SUBCUTANEOUS SOLUTION RECONSTITUTED 0.4 MG, 0.56 MG, 1.2 MG (*vosoritide*)	NPSP	PA; QL (30 VIALS per 30 days)
YUVIWEL SUBCUTANEOUS SOLUTION RECONSTITUTED 1.3 MG, 2.8 MG, 5.5 MG (*navepegritide*)	NF	
HEREDITARY TYROSINEMIA TYPE 1 AGENTS - DRUGS FOR REPLACEMENT, MODIFICATION, TREATMENT		
nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg	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*)	PSP	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (*nitisinone*)	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*)	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, 5 MG/1.5ML (*somatropin*)	PSP	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 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)*)	NPSP	PA
SKYTROFA SUBCUTANEOUS CARTRIDGE 0.7 MG, 1.4 MG, 1.8 MG, 11 MG, 13.3 MG, 2.1 MG, 2.5 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*)	PSP	PA; QL (4 PENS per 28 days)
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG (*somatropin*)	NF	
LYSOSOMAL STORAGE DISORDERS - DRUGS TO TREAT LYSOSOMAL STORAGE DISORDERS		
ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5ML (*laronidase*)	NPSP	PA
AQNEURSA ORAL PACKET 1 GM (*levacetylleucine*)	NF	
ELAPRASE INTRAVENOUS SOLUTION 6 MG/3ML (*idursulfase*)	NPSP	PA
KANUMA INTRAVENOUS SOLUTION 20 MG/10ML (*sebelipase alfa*)	NPSP	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (*arimoclomol citrate*)	NF	
NAGLAZYME INTRAVENOUS SOLUTION 1 MG/ML (*galsulfase*)	NPSP	PA
OPFOLDA ORAL CAPSULE 65 MG (*miglustat (gaa deficiency)*)	NF	
VIMIZIM INTRAVENOUS SOLUTION 5 MG/5ML (*elosulfase alfa*)	NPSP	PA
LYSOSOMAL STORAGE DISORDERS - FABRY DISEASE - DRUGS TO TREAT FABRY DISEASE		
ELFABRIO INTRAVENOUS SOLUTION 20 MG/10ML, 5 MG/2.5ML (*pegunigalsidase alfa-iwxj*)	PSP	PA
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 35 MG, 5 MG (*agalsidase beta*)	PSP	PA
GALAFOLD ORAL CAPSULE 123 MG (*migalastat hcl*)	PSP	PA
LYSOSOMAL STORAGE DISORDERS - GAUCHER DISEASE - DRUGS TO TREAT GAUCHER DISEASE		
CERDELGA ORAL CAPSULE 84 MG (*eliglustat tartrate*)	PSP	PA; QL (56 CAPSULES per 28 days)
CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT (*imiglucerase*)	PSP	PA; QL (15 VIALS per 14 days)
ELELYSO INTRAVENOUS SOLUTION RECONSTITUTED 200 UNIT (*taliglucerase alfa*)	NF	
miglustat oral capsule 100 mg	PSP	PA; QL (90 CAPSULES per 30 days)
VPRIV INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT (*velaglucerase alfa*)	NF	
ZAVESCA ORAL CAPSULE 100 MG (*miglustat*)	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*)	PB	
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (*estradiol-norethindrone acet*)	PB	
DUAVEE ORAL TABLET 0.45-20 MG (*conj estrogens-bazedoxifene*)	PB	N10 (PA applies)
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	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	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	G	
estradiol vaginal cream 0.01 %	G	
estradiol vaginal tablet 10 mcg	G	
estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml	G	
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	G	
ESTRING VAGINAL RING 7.5 MCG/24HR (*estradiol*)	PB	
estrogens conjugated oral tablet 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	G	
norethindrone-eth estradiol (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg, 1-5 Mg-Mcg)	G	
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG (*estradiol*)	PB	
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (*estradiol*)	PB	
norethindrone-eth estradiol (Jinteli Oral Tablet 1-5 Mg-Mcg)	G	
estradiol-norethindrone acet (Mimvey Oral Tablet 1-0.5 Mg)	G	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (*estrogens conjugated*)	PB	
PREMARIN VAGINAL CREAM 0.625 MG/GM (*estrogens, conjugated*)	PB	
PREMPHASE ORAL TABLET 0.625-5 MG (*conj estrog-medroxyprogest ace*)	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*)	PB	
MISCELLANEOUS		
ACTHAR GEL SUBCUTANEOUS PEN-INJECTOR 40 UNIT/0.5ML, 80 UNIT/ML (*corticotropin*)	NPSP	PA; QL (28 PENS per 28 days)
ACTHAR INJECTION GEL 80 UNIT/ML (*corticotropin*)	NPSP	PA; QL (35 ML per 21 days)
betaine oral powder	PSP	PA
cabergoline oral tablet 0.5 mg	G	
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (*corticotropin*)	NPSP	PA; QL (28 SYRINGES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTROPHIN INJECTION GEL 80 UNIT/ML (*corticotropin*)	NPSP	PA; QL (35 ML per 21 days)
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (*crinecerfont*)	NPSP	PA; QL (60 CAPSULES per 30 days)
CRENESSITY ORAL SOLUTION 50 MG/ML (*crinecerfont*)	NPSP	PA; QL (120 ML per 30 days)
CYSTADANE ORAL POWDER (*betaine*)	NF	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (*cysteamine bitartrate*)	PSP	PA
EVENITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 105 MG/1.17ML (*romosozumab-aqqg*)	NF	
FORZINITY SUBCUTANEOUS SOLUTION 280 MG/3.5ML (*elamipretide hcl*)	NF	
HARLIKU ORAL TABLET 2 MG (*nitisinone (aku)*)	NF	
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (*setmelanotide acetate*)	NF	
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (*mecasermin*)	NPSP	PA
JYNARQUE ORAL TABLET 15 MG, 30 MG (*tolvaptan*)	NF	
JYNARQUE ORAL TABLET THERAPY PACK 15 MG, 30 & 15 MG, 45 & 15 MG, 60 & 30 MG, 90 & 30 MG (*tolvaptan*)	NF	
KORLYM ORAL TABLET 300 MG (*mifepristone*)	NF	
KUVAN ORAL PACKET 100 MG, 500 MG (*sapropterin dihydrochloride*)	NF	
KUVAN ORAL TABLET 100 MG (*sapropterin dihydrochloride*)	NF	
KYGEVVI ORAL PACKET 2-2 GM (*doxecitine-doxribtimine*)	NF	
methylergonovine maleate (Methergine Oral Tablet 0.2 Mg)	G	
methylergonovine maleate oral tablet 0.2 mg	G	
mifepristone oral tablet 300 mg	PSP	PA; QL (120 TABLETS per 30 days)
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (*metreleptin*)	NPSP	PA; QL (30 VIALS per 30 days)
OSPHENA ORAL TABLET 60 MG (*ospemifene*)	PB	N10 (PA applies)
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 (hyponatremia)*)	NPSP	PA
sapropterin dihydrochloride oral packet 100 mg, 500 mg	PSP	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sapropterin dihydrochloride oral tablet 100 mg	PSP	PA
SEPHIENCE ORAL PACKET 1000 MG, 250 MG (*sepiapterin*)	NF	
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*)	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*)	NPSP	PA
tolvaptan (hyponatremia) oral tablet 15 mg, 30 mg	PSP	PA; N8 (Generic of Samsca)
tolvaptan oral tablet 15 mg	PSP	PA; N8 (Generic of Jynarque); QL (60 TABLETS per 30 Days)
tolvaptan oral tablet 30 mg	PSP	PA; N8 (Generic of Jynarque); QL (30 TABLETS per 30 Days)
tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	PSP	PA; N8 (Generic of Jynarque); QL (56 TABLETS per 28 DAYs)
VIJOICE ORAL PACKET 50 MG (*alpelisib*)	NF	
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 200 & 50 MG, 50 MG (*alpelisib*)	NF	
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 25 MG, 75 MG (*diazoxide choline*)	NF	
XURIDEN ORAL PACKET 2 GM (*uridine triacetate*)	NPSP	QL (4 PACKETS per 1 day)
ZOKINVY ORAL CAPSULE 50 MG, 75 MG (*lonafarnib*)	NPSP	PA; QL (120 CAPSULES per 30 days)
ZYCUBO SUBCUTANEOUS SOLUTION RECONSTITUTED 2.9 MG (*copper histidinate*)	NF	
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
AURYXIA ORAL TABLET 1 GM 210 MG(FE) (*ferric citrate*)	PB	
calcium acetate (phos binder) oral capsule 667 mg	G	
ferric citrate oral tablet 1 gm 210 mg(fe)	G	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg	NF	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	G	
sevelamer carbonate oral tablet 800 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sevelamer hcl oral tablet 400 mg, 800 mg	G	
POLYNEUROPATHY		
WAINUA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.8ML (*eplontersen sodium*)	NF	
WAINUA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.8ML (*eplontersen sodium*)	NF	
POTASSIUM-REMOVING AGENTS - DRUGS TO REGULATE POTASSIUM LEVELS		
LOKELMA ORAL PACKET 10 GM, 5 GM (*sodium zirconium cyclosilicate*)	PB	
sodium polystyrene sulfonate oral powder	G	
sodium polystyrene sulfonate (Sps (Sodium Polystyrene Sulf) Combination Suspension 15 Gm/60Ml)	G	
VELTASSA ORAL PACKET 1 GM, 16.8 GM, 25.2 GM, 8.4 GM (*patiromer sorbitex calcium*)	PB	
PROGESTINS - DRUGS TO REGULATE PROGESTIN		
CRINONE VAGINAL GEL 4 %, 8 % (*progesterone*)	PB	
ENDOMETRIN VAGINAL INSERT 100 MG (*progesterone*)	PB	
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	G	
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml	CE	N7 (G)
norethindrone acetate oral tablet 5 mg	G	
progesterone oral capsule 100 mg, 200 mg	G	
progesterone vaginal insert 100 mg	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	G	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	G	
methimazole oral tablet 10 mg, 5 mg	G	
propylthiouracil oral tablet 50 mg	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*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	PSP	PA
glycerol phenylbutyrate oral liquid 1.1 gm/ml	PSP	PA
LOARGYS INJECTION SOLUTION 2 MG/0.4ML (*pegzilarginase-nbln*)	NF	
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	
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*)	PSP	PA; QL (672 GRAMS per 30 days)
RAVICTI ORAL LIQUID 1.1 GM/ML (*glycerol phenylbutyrate*)	NF	
sodium phenylbutyrate oral powder 3 gm/tsp	PSP	PA; QL (798 GRAMS per 30 days)
sodium phenylbutyrate oral tablet 500 mg	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*)	PB	
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG (*elagolix-estradiol-norethind*)	PB	
VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES		
desmopressin ace spray refrig nasal solution 0.01 %	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desmopressin acetate nasal solution 1.5 mg/ml	NPSP	PA
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	G	
desmopressin acetate spray nasal solution 0.01 %	G	
VITAMIN D ANALOGS		
calcitriol oral capsule 0.25 mcg, 0.5 mcg	G	
calcitriol oral solution 1 mcg/ml	G	
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	G	
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	G	
ROCALTROL ORAL CAPSULE 0.25 MCG, 0.5 MCG (*calcitriol*)	PB	
ROCALTROL ORAL SOLUTION 1 MCG/ML (*calcitriol*)	PB	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (*paricalcitol*)	PB	
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTICHOLINERGICS		
dicyclomine hcl oral capsule 10 mg	G	
dicyclomine hcl oral tablet 20 mg, 40 mg	G	
GLYCATE ORAL TABLET 1.5 MG (*glycopyrrolate*)	NF	
glycopyrrolate oral solution 1 mg/5ml	G	
glycopyrrolate oral tablet 1 mg, 2 mg	G	
glycopyrrolate oral tablet 1.5 mg	NF	
methscopolamine bromide oral tablet 2.5 mg, 5 mg	G	
ANTIDIARRHEALS		
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	G	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	G	
LOMOTIL ORAL TABLET 2.5-0.025 MG (*diphenoxylate-atropine*)	PB	
MYTESI ORAL TABLET DELAYED RELEASE 125 MG (*crofelemer*)	NF	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
aprepitant oral capsule 125 mg, 40 mg, 80 mg	G	
aprepitant oral capsule therapy pack 80 & 125 mg	G	
prochlorperazine (Compro Rectal Suppository 25 Mg)	G	
doxylamine-pyridoxine oral tablet delayed release 10-10 mg	G	
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
granisetron hcl oral tablet 1 mg	G	
metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml	G	
metoclopramide hcl oral tablet 10 mg, 5 mg	G	
ondansetron hcl oral solution 4 mg/5ml	G	
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	G	
ondansetron oral tablet dispersible 4 mg, 8 mg	G	
prochlorperazine maleate oral tablet 10 mg, 5 mg	G	
promethazine hcl oral solution 6.25 mg/5ml	G	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	G	
promethazine hcl rectal suppository 12.5 mg, 25 mg	G	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (*promethazine hcl*)	G	
SANCUSO TRANSDERMAL PATCH 3.1 MG/24HR (*granisetron*)	PB	
scopolamine transdermal patch 72 hour 1 mg/3days	G	
trimethobenzamide hcl oral capsule 300 mg	G	
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK 2 X 90 MG (*rolapitant hcl*)	PB	
ANTISPASMODICS - DRUGS FOR MUSCLE SPASM		
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	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	G	
famotidine oral tablet 40 mg	G	
nizatidine oral capsule 150 mg, 300 mg	G	
ranitidine hcl oral tablet 150 mg, 300 mg	G	
INFLAMMATORY BOWEL DISEASE - BOWEL, INTESTINE, AND STOMACH CONDITION DRUGS		
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (*mesalamine*)	NPB	
balsalazide disodium oral capsule 750 mg	G	
budesonide er oral tablet extended release 24 hour 9 mg	G	
budesonide oral capsule delayed release particles 3 mg	G	
budesonide rectal foam 2 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTIFOAM EXTERNAL FOAM 10 % (*hydrocortisone acetate*)	PB	
mesalamine er oral capsule extended release 24 hour 0.375 gm	G	
mesalamine oral capsule delayed release 400 mg	G	
mesalamine oral tablet delayed release 1.2 gm, 800 mg	G	
mesalamine rectal enema 4 gm	G	
mesalamine rectal suppository 1000 mg	G	
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG, 500 MG (*mesalamine*)	PB	
sulfasalazine oral tablet 500 mg	G	
sulfasalazine oral tablet delayed release 500 mg	G	
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (*linaclotide*)	PB	
lubiprostone oral capsule 24 mcg, 8 mcg	G	
IRRITABLE BOWEL SYNDROME WITH DIARRHEA		
alosetron hcl oral tablet 0.5 mg, 1 mg	G	
VIBERZI ORAL TABLET 100 MG, 75 MG (*eluxadoline*)	PB	
LAXATIVES		
lactulose oral solution 20 gm/30ml	G	
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	G	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (*peg 3350-kcl-nabcb-nacl-nasulf*)	G	
peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)	G	
lactulose (Kristalose Oral Packet 10 Gm, 20 Gm)	G	
lactulose oral packet 10 gm, 20 gm	G	N8 (Listing does not include certain NDCs)
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM (*peg-kcl-nacl-nasulf-na asc-c*)	NPB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	G	
peg-3350/electrolytes oral solution reconstituted 236 gm	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	
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (*cholic acid*)	NPSP	PA
CTEXLI ORAL TABLET 250 MG (*chenodiol (basds)*)	NF	
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (*misoprostol*)	PB	
GATTEX SUBCUTANEOUS KIT 5 MG (*teduglutide (rdna)*)	NPSP	PA; QL (1 KIT per 30 days)
IQIRVO ORAL TABLET 80 MG (*elafibranor*)	PSP	PA; QL (30 TABLETS per 30 days)
LIVDELZI ORAL CAPSULE 10 MG (*seladelpar lysine*)	NF	
LIVMARLI ORAL SOLUTION 19 MG/ML (*maralixibat chloride*)	NPSP	PA; QL (60 ML per 30 DAYs)
LIVMARLI ORAL SOLUTION 9.5 MG/ML (*maralixibat chloride*)	NPSP	PA; QL (90 ML per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG, 30 MG (*maralixibat chloride*)	NF	
misoprostol oral tablet 100 mcg, 200 mcg	G	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (*naloxegol oxalate*)	PB	
SUCRAID ORAL SOLUTION 8500 UNIT/ML (*sacrosidase*)	NPSP	
sucralfate oral suspension 1 gm/10ml	NF	
sucralfate oral tablet 1 gm	G	
SYMPROIC ORAL TABLET 0.2 MG (*naldemedine tosylate*)	PB	
URSO FORTE ORAL TABLET 500 MG (*ursodiol*)	PB	
ursodiol oral capsule 300 mg	G	
ursodiol oral tablet 250 mg, 500 mg	G	
VOWST ORAL CAPSULE (*fecal microb spores, live-brpk*)	NPSP	PA; QL (12 CAPSULES per 30 DAYs)
XERMELO ORAL TABLET 250 MG (*telotristat etiprate*)	NPB	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)*)	PB	
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (*pancrelipase (lip-prot-amyl)*)	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)*)	PB	
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
dexlansoprazole oral capsule delayed release 30 mg, 60 mg	G	
esomeprazole magnesium oral capsule delayed release 20 mg	G	Select OTC
esomeprazole magnesium oral capsule delayed release 40 mg	G	
esomeprazole magnesium oral packet 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg	G	
esomeprazole magnesium oral tablet delayed release 20 mg	G	Select OTC
lansoprazole oral capsule delayed release 15 mg	G	Select OTC
lansoprazole oral capsule delayed release 30 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lansoprazole oral tablet delayed release dispersible 30 mg	NF	
NEXIUM 24HR ORAL TABLET DELAYED RELEASE 20 MG (*esomeprazole magnesium*)	G	Select OTC
omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg	G	Select OTC
omeprazole magnesium oral tablet delayed release 20 mg	G	Select OTC
omeprazole oral capsule delayed release 10 mg, 40 mg	G	
omeprazole oral capsule delayed release 20 mg	G	Select OTC
omeprazole oral tablet delayed release 20 mg	G	Select OTC
omeprazole-sodium bicarbonate oral capsule 20-1100 mg	G	Select OTC
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	G	
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (*omeprazole magnesium*)	NF	
PRILOSEC OTC ORAL TABLET DELAYED RELEASE 20 MG (*omeprazole magnesium*)	G	Select OTC
rabeprazole sodium oral capsule sprinkle 10 mg	NPB	
rabeprazole sodium oral tablet delayed release 20 mg	G	
ZEGERID OTC ORAL CAPSULE 20-1100 MG (*omeprazole-sodium bicarbonate*)	G	Select OTC
RECTAL, CORTICOSTEROIDS		
ANUSOL-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*)	PB	
hydrocortisone (perianal) external cream 2.5 %	G	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (*hydrocortisone ace-pramoxine*)	PB	
hydrocortisone (Proctozone-Hc External Cream 2.5 %)	G	
ULCER THERAPY COMBINATIONS		
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	G	
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	G	
TALICIA ORAL CAPSULE DELAYED RELEASE 250-12.5-10 MG (*amoxicill-rifabutin-omeprazole*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	G	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	G	
dutasteride oral capsule 0.5 mg	G	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	G	
finasteride oral tablet 5 mg	G	
silodosin oral capsule 4 mg, 8 mg	G	
tamsulosin hcl oral capsule 0.4 mg	G	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	G	
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)
PHEXX 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		
avanafil oral tablet 100 mg, 200 mg, 50 mg	G	SPC
bi-mix intracavernosal solution reconstituted 150-5 mg	NPB	SPC
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (*alprostadil (vasodilator)*)	NPB	SPC
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 40 MCG (*alprostadil (vasodilator)*)	NPB	SPC
CIALIS ORAL TABLET 10 MG, 20 MG, 5 MG (*tadalafil*)	NPB	SPC
quad-mix intracavernosal solution reconstituted 150-10-0.1-1 mg	NPB	SPC
sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg	G	SPC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG (*avanafil*)	NF	
super bi-mix intracavernosal solution reconstituted 150-10 mg	NPB	SPC
super quad-mix intracavernosal solution reconstituted 150-20-0.2-2 mg	NPB	SPC
super tri-mix intracavernosal solution reconstituted 150-10-100 mg-mg-mcg	NPB	SPC
tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	G	SPC
vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	G	SPC
vardenafil hcl oral tablet dispersible 10 mg	G	SPC
VIAGRA ORAL TABLET 100 MG, 25 MG, 50 MG (*sildenafil citrate*)	NPB	SPC
VYBRIQUE ORAL FILM 100 MG, 25 MG, 50 MG, 75 MG (*sildenafil citrate*)	NPB	SPC
MISCELLANEOUS		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	G	
ELMIRON ORAL CAPSULE 100 MG (*pentosan polysulfate sodium*)	NPB	QL (90 CAPSULES per 25 days)
FILSPARI ORAL TABLET 200 MG (*sparsentan*)	PSP	PA; QL (60 TABLETS per 30 days)
FILSPARI ORAL TABLET 400 MG (*sparsentan*)	PSP	PA; QL (30 TABLETS per 30 days)
pot & sod cit-cit ac oral solution 550-500-334 mg/5ml	G	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	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	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tiopronin oral tablet 100 mg	PSP	PA
tiopronin oral tablet delayed release 100 mg, 300 mg	PSP	PA
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1080 MG) (*potassium citrate*)	PB	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG) (*potassium citrate*)	PB	
VANRAFIA ORAL TABLET 0.75 MG (*atrasentan hcl*)	PSP	PA; QL (30 TABLETS per 30 days)
VOYXACT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 400 MG/2ML (*sibeprenlimab-szsi*)	NF	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	G	
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	G	
flavoxate hcl oral tablet 100 mg	G	
GEMTESA ORAL TABLET 75 MG (*vibegron*)	PB	
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	G	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	G	
oxybutynin chloride oral solution 5 mg/5ml	G	
oxybutynin chloride oral tablet 5 mg	G	
solifenacin succinate oral tablet 10 mg, 5 mg	G	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	G	
tolterodine tartrate oral tablet 1 mg, 2 mg	G	
trospium chloride er oral capsule extended release 24 hour 60 mg	G	
trospium chloride oral tablet 20 mg	G	
VAGINAL ANTI-INFECTIVES - DRUGS TO TREAT VAGINAL INFECTIONS		
CLEOCIN VAGINAL CREAM 2 % (*clindamycin phosphate*)	PB	
clindamycin phosphate vaginal cream 2 %	G	
metronidazole vaginal gel 0.75 %	G	
miconazole 3 vaginal suppository 200 mg	G	
terconazole vaginal cream 0.4 %, 0.8 %	G	
terconazole vaginal suppository 80 mg	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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*)	PB	
dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg	G	
ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG (*apixaban*)	PB	
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG (*apixaban*)	PB	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (*apixaban*)	PB	
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG (*apixaban*)	PB	
ELIQUIS ORAL TABLET 2.5 MG, 5 MG (*apixaban*)	PB	
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG (*apixaban*)	PB	
enoxaparin sodium injection solution 300 mg/3ml	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	G	
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	G	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (*dalteparin sodium*)	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*)	PB	
rivaroxaban oral suspension reconstituted 1 mg/ml	G	
rivaroxaban oral tablet 2.5 mg	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	G	
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (*rivaroxaban*)	PB	
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG (*rivaroxaban*)	PB	
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (*rivaroxaban*)	PB	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML (*darbepoetin alfa*)	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*)	PSP	PA; QL (2 SYRINGES per 28 days)
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-pbbk*)	NF	
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML (*tbo-filgrastim*)	NF	
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*tbo-filgrastim*)	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 SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim*)	NF	
NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML (*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	
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*)	PSP	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-aafi*)	PSP	PA
NYPOZI INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-txid*)	NF	
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-apgf*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (*epoetin alfa*)	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*)	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 ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-cbqv*)	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	
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	
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)*)	PSP	PA
adynovate intravenous solution reconstituted 1000 unit, 1500 unit, 2000 unit, 250 unit, 3000 unit, 500 unit, 750 unit	PSP	PA
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact single chain*)	PSP	PA
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact fc-vwf-xten-ehtl*)	PSP	PA
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)*)	PSP	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESPEROCT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihemoph fact rcmb gpeg-exei*)	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*)	NPSP	PA
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*)	NPSP	PA
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*ahf (bdd-rfviii peg-aucl)*)	PSP	PA
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*)	NPSP	PA
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (*antihemophilic factor*)	NPSP	PA
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*)	PSP	PA
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact bd truncated*)	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)*)	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)*)	PSP	PA
obizur intravenous solution reconstituted 500 unit	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)*)	NPSP	PA
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*)	PSP	PA
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*)	PSP	PA
HEMOPHILIA A AND B AGENTS		
ALHEMO SUBCUTANEOUS SOLUTION PEN-INJECTOR 150 MG/1.5ML, 300 MG/3ML, 60 MG/1.5ML (*concizumab-mtci*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYMPAVZI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*marstacimab-hncq*)	NF	
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2ML (*fitusiran sodium*)	NF	
QFITLIA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/0.5ML (*fitusiran sodium*)	NF	
HEMOPHILIA B AGENTS		
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*coagulation factor ix*)	NPSP	PA
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*coagulation factor ix (rfixfc)*)	NF	
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*)	PSP	PA
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (*coagulation factor ix (rix-fp)*)	NPSP	PA
IXINITY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*)	NF	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*factor ix complex*)	NPSP	PA
REBINYN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix glycopeg*)	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*)	PB	
aminocaproic acid oral solution 0.25 gm/ml	G	
aminocaproic acid oral tablet 1000 mg, 500 mg	G	
anagrelide hcl oral capsule 0.5 mg, 1 mg	G	
AQVESME ORAL TABLET 100 MG (*mitapivat sulfate*)	NF	
cilostazol oral tablet 100 mg, 50 mg	G	
pentoxifylline er oral tablet extended release 400 mg	G	
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (*mitapivat sulfate*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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*)	NPB	PA; QL (180 CAPSULES per 30 days)
tranexamic acid oral tablet 650 mg	G	
PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) AGENTS		
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML (*pegcetacoplan*)	PSP	PA; QL (10 VIALS per 30 days)
EPYSQLI INTRAVENOUS SOLUTION 300 MG/30ML (*eculizumab-aagh*)	PSP	PA; IBC (Preferred for Myasthenia Gravis and Paroxysmal Nocturnal Hemoglobinuria (PNH) and Atypical hemolytic uremic syndrome (aHUS) indications); QL (12 VIALS per 28 DAYs)
FABHALTA ORAL CAPSULE 200 MG (*iptacopan hcl*)	NPSP	PA; QL (60 CAPSULES per 30 days)
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30ML (*eculizumab*)	NF	
ULTOMIRIS INTRAVENOUS SOLUTION 1100 MG/11ML, 300 MG/3ML (*ravulizumab-cwvz*)	NPSP	PA
VOYDEYA ORAL TABLET 100 MG (*danicopan*)	NF	
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	G	
clopidogrel bisulfate oral tablet 300 mg, 75 mg	G	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	G	
prasugrel hcl oral tablet 10 mg, 5 mg	G	
ticagrelor oral tablet 60 mg, 90 mg	G	
SICKLE CELL DISEASE		
ENDARI ORAL PACKET 5 GM (*glutamine (sickle cell)*)	PSP	PA; QL (180 PACKETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
l-glutamine oral packet 5 gm	PSP	PA; QL (180 PACKETS per 30 DAYs)
SIKLOS ORAL TABLET 100 MG, 1000 MG (*hydroxyurea*)	PB	
THROMBOCYTOPENIA AGENTS - DRUGS TO TREAT PLATELET DISORDERS		
ALVAIZ ORAL TABLET 18 MG, 36 MG (*eltrombopag choline*)	PSP	PA; QL (90 TABLETS per 30 DAYs)
ALVAIZ ORAL TABLET 54 MG, 9 MG (*eltrombopag choline*)	PSP	PA; QL (60 TABLETS per 30 DAYs)
DOPTELET ORAL TABLET 20 MG (*avatrombopag maleate*)	PSP	PA; QL (60 TABLETS per 30 days)
DOPTELET SPRINKLE ORAL CAPSULE SPRINKLE 10 MG (*avatrombopag maleate*)	PSP	PA; QL (60 CAPSULES per 30 DAYs)
eltrombopag olamine oral packet 12.5 mg	PSP	PA; QL (120 PACKETS per 30 DAYs)
eltrombopag olamine oral packet 25 mg	PSP	PA; QL (180 PACKETS per 30 DAYs)
eltrombopag olamine oral tablet 12.5 mg, 75 mg	PSP	PA; QL (60 TABLETS per 30 DAYs)
eltrombopag olamine oral tablet 25 mg, 50 mg	PSP	PA; QL (90 TABLETS per 30 DAYs)
MULPLETA ORAL TABLET 3 MG (*lusutrombopag*)	NF	
NPLATE SUBCUTANEOUS SOLUTION RECONSTITUTED 125 MCG, 250 MCG, 500 MCG (*romiplostim*)	NF	
PROMACTA ORAL PACKET 12.5 MG, 25 MG (*eltrombopag olamine*)	NF	
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG (*eltrombopag olamine*)	NF	
TAVALISSE ORAL TABLET 100 MG, 150 MG (*fostamatinib disodium*)	NF	
WAYRILZ ORAL TABLET 400 MG (*rilzabrutinib*)	NF	
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
ALLERGENIC EXTRACTS		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (*timothy grass pollen allergen*)	PB	
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (*dust mite mixed allergen ext*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (*grass mix pollens allergen ext*)	PSP	PA
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (*short ragweed pollen ext*)	PB	
AUTOIMMUNE AGENTS (PHYSICIAN-ADMINISTERED)		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-axxq*)	PSP	PA; ST; QL (5 VIALS per 42 days)
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (*vedolizumab*)	NPSP	PA; QL (1 VIAL per 56 days)
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*tildrakizumab-asmn*)	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*)	PSP	PA; QL (5 VIALS per 42 days)
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-abda*)	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	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	PSP	PA; ST; QL (4 PENS per 28 days)
adalimumab-adaz subcutaneous solution auto-injector 80 mg/0.8ml	PSP	PA; ST; QL (2 PENS per 28 days)
adalimumab-adaz subcutaneous solution prefilled syringe 10 mg/0.1ml	PSP	PA; ST; QL (2 SYRINGES per 28 days)
adalimumab-adaz subcutaneous solution prefilled syringe 20 mg/0.2ml, 40 mg/0.4ml	PSP	PA; ST; QL (4 SYRINGES per 28 days)
adalimumab-adbm (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 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-bwwd subcutaneous solution auto-injector 40 mg/0.4ml	NF	
adalimumab-bwwd subcutaneous solution prefilled syringe 40 mg/0.4ml	NF	
adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	PSP	PA; ST; QL (4 PENS per 28 days)
adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml	PSP	PA; ST; QL (4 SYRINGES per 28 days)
adalimumab-ryvk (1 pen) subcutaneous auto-injector kit 80 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 (*adalimumab-atto*)	NF	
AVTOZMA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab-anoh*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVTOZMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab-anoh*)	NF	
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (*bimekizumab-bkzx*)	PSP	PA; IBC (Preferred agent for Psoriasis. Not covered for Non-radiographical Axial Spondyloarthritis, Hidradenitis Suppurativa); QL (2 INJECTIONS per 28 days)
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML (*bimekizumab-bkzx*)	PSP	PA; IBC (Preferred agent for Psoriasis. Not covered for Non-radiographical Axial Spondyloarthritis, Hidradenitis Suppurativa); QL (1 INJECTION per 28 DAYs)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (*bimekizumab-bkzx*)	PSP	PA; IBC (Preferred agent for Psoriasis. Not covered for Non-radiographical Axial Spondyloarthritis, Hidradenitis Suppurativa); QL (2 INJECTIONS per 28 days)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML (*bimekizumab-bkzx*)	PSP	PA; IBC (Preferred agent for Psoriasis. Not covered for Non-radiographical Axial Spondyloarthritis, Hidradenitis Suppurativa); QL (1 INJECTION per 28 DAYs)
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*)	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 (4 SYRINGES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*)	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*)	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 1 TIME USE ONLY)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*)	PSP	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, Hidradenitis Suppurativa. Not covered for Psoriasis); QL (2 SYRINGES per 28 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	PSP	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, Hidradenitis Suppurativa. Not covered for Psoriasis); QL (2 PENS per 28 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	PSP	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, Non-radiographical Axial Spondyloarthritis, Hidradenitis Suppurativa. Not covered for Psoriasis); QL (1 PEN per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML (*secukinumab*)	PSP	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, Non-radiographical Axial Spondyloarthritis, Hidradenitis Suppurativa. Not covered for Psoriasis); QL (1 SYRINGE per 28 days)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*secukinumab*)	PSP	PA; ST; IBC (Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, Hidradenitis Suppurativa. 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	
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML (*dupilumab*)	PSP	PA; IBC (Preferred agent for Asthma, Atopic Dermatitis, Chronic Spontaneous Urticaria and Eosinophilic Esophagitis); QL (2 PENS per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*dupilumab*)	PSP	PA; IBC (Preferred agent for Asthma, Atopic Dermatitis, Chronic Rhinosinusitis with Nasal Polyps, COPD, Chronic Spontaneous Urticaria, Eosinophilic Esophagitis, and Prurigo Nodularis); QL (4 PENS per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (*dupilumab*)	PSP	PA; IBC (Preferred agent for Asthma, Atopic Dermatitis, Chronic Spontaneous Urticaria and Eosinophilic Esophagitis); QL (2 SYRINGES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*dupilumab*)	PSP	PA; IBC (Preferred agent for Asthma, Atopic Dermatitis, Chronic Rhinosinusitis with Nasal Polyps, COPD, Chronic Spontaneous Urticaria, Eosinophilic Esophagitis, and Prurigo Nodularis); QL (4 SYRINGES per 28 days)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (*etanercept*)	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*)	PSP	PA; ST; IBC (Preferred agent for all conditions except Psoriasis); QL (8 VIALS per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (*etanercept*)	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*)	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*)	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*)	PSP	PA; QL (2 PENS per 28 days)
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 (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (*adalimumab*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 (*adalimumab-adaz*)	PSP	PA; ST; N8 (Sandoz manufactured NDCs (61314-XXXX-XX) are excluded. Cordavis manufactured NDCs are preferred.); QL (4 PENS per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*adalimumab-adaz*)	PSP	PA; ST; N8 (Sandoz manufactured NDCs (61314-XXXX-XX) are excluded. Cordavis manufactured NDCs are preferred.); QL (2 PENS per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 40 MG/0.4ML (*adalimumab-adaz*)	PSP	PA; ST; N8 (Sandoz manufactured NDCs (61314-XXXX-XX) are excluded. Cordavis manufactured NDCs are preferred.); QL (4 SYRINGES per 28 days)
HYRIMOZ-PLAQUE PSORIASIS START SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML (*adalimumab-adaz*)	PSP	PA; ST; N8 (Sandoz manufactured NDCs (61314-XXXX-XX) are excluded. Cordavis manufactured NDCs are preferred.); QL (1 KIT per 28 days)
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-srlf*)	NF	
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*)	PSP	PA; IBC (Preferred agent for Rheumatoid Arthritis); QL (2 PENS per 28 days)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (*sarilumab*)	PSP	PA; IBC (Preferred agent for Rheumatoid Arthritis); QL (2 SYRINGES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*anakinra*)	NF	
LEQSELVI ORAL TABLET 8 MG (*deuruxolitinib phosphate*)	NF	
LITFULO ORAL CAPSULE 50 MG (*ritlecitinib tosylate*)	PSP	PA; QL (28 CAPSULES per 28 days)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*mepolizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and COPD); QL (3 INJECTIONS per 28 days)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*mepolizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and COPD); QL (3 INJECTIONS per 28 days)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (*mepolizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and COPD); QL (1 SYRINGE per 28 days)
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG (*mepolizumab*)	NF	
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (*baricitinib*)	PSP	PA; IBC (Preferred agent for Alopecia Areata. Not covered for Rheumatoid Arthritis); QL (30 TABLETS per 30 days)
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML & 200 MG/2ML (*mirikizumab-mrkz*)	NF	
OMVOH (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML & 200 MG/2ML (*mirikizumab-mrkz*)	NF	
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*mirikizumab-mrkz*)	NF	
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (*mirikizumab-mrkz*)	NF	
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (*abatacept*)	PSP	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis. Not covered for other conditions); QL (4 SYRINGES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (*abatacept*)	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 50 MG/0.4ML, 87.5 MG/0.7ML (*abatacept*)	NPSP	PA; ST; QL (4 SYRINGES per 28 days)
OTEZLA ORAL TABLET 20 MG, 30 MG (*apremilast*)	PB	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (60 TABLETS per 30 days)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG (*apremilast*)	PB	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (55 TABLETS per 28 days)
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (*apremilast*)	PB	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (30 TABLETS per 30 DAYs)
OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG (*apremilast*)	PB	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (41 TABLETS per 28 DAYs)
OTULFI SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-aauz*)	NF	
OTULFI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-aauz*)	NF	
PYZCHIVA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-ttwe*)	NF	
PYZCHIVA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 45 MG/0.5ML (*ustekinumab-ttwe*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 PEN per 84 DAYs)
PYZCHIVA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 90 MG/ML (*ustekinumab-ttwe*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 PEN per 56 DAYs)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PYZCHIVA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (*ustekinumab-ttwe*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Sandoz manufactured NDCs (61314-XXXX-XX) are excluded. Cordavis manufactured NDCs are preferred.); QL (1 SYRINGE per 84 days)
PYZCHIVA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (*ustekinumab-ttwe*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis, Sandoz manufactured NDCs (61314-XXXX-XX) are excluded. Cordavis manufactured NDCs are preferred.); QL (1 SYRINGE per 56 days)
RINVOQ LQ ORAL SOLUTION 1 MG/ML (*upadacitinib*)	PB	PA; IBC (Preferred agent for Psoriatic Arthritis); QL (2 BOTTLES per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG (*upadacitinib*)	PB	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*)	PB	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*)	PB	PA; IBC (Preferred agent for Ulcerative Colitis and Crohn's Disease); QL (1 FILL per 1 day)
SAPHNELO PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/0.8ML (*anifrolumab-fnia*)	NF	
SELARSDI SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-aekn*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-aekn*)	NF	
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML (*brodalumab*)	NF	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (*adalimumab-ryvk*)	NF	
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-ryvk*)	NF	
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 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*)	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*)	PSP	PA; IBC (Preferred agent for Crohn's Disease and Ulcerative Colitis); QL (1 CARTRIDGE per 56 DAYs)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML (*risankizumab-rzaa*)	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*)	PSP	PA; IBC (Preferred agent for Psoriasis and Psoriatic Arthritis); QL (1 SYRINGE per 84 days)
SOTYKTU ORAL TABLET 6 MG (*deucravacitinib*)	PSP	PA; IBC (Preferred agent for Psoriasis); QL (30 TABLETS per 30 DAYs)
STARJEMZA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-hmny*)	NF	
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-hmny*)	NF	
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab*)	NF	
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-stba*)	NF	
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-stba*)	NF	
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML (*ixekizumab*)	NF	
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML, 80 MG/ML (*ixekizumab*)	NF	
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (*guselkumab*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 PEN per 56 days)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*guselkumab*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 PEN per 56 DAYs)
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (*guselkumab*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 PEN per 28 days)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*guselkumab*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 syringe per 56 days)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (*guselkumab*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 SYRINGE per 28 days)
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab-aazg*)	NF	
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab-aazg*)	NF	
ustekinumab subcutaneous solution 45 mg/0.5ml	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ustekinumab subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml	NF	
ustekinumab-aauz subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml	NF	
ustekinumab-aekn subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml	NF	
ustekinumab-ttwe subcutaneous solution 45 mg/0.5ml	NF	
ustekinumab-ttwe subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml	NF	
VELSIPITY ORAL TABLET 2 MG (*etrasimod arginine*)	PSP	PA; IBC (Preferred agent for Ulcerative Colitis); QL (30 TABLETS per 30 DAYs)
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-auub*)	NF	
WEZLANA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab-auub*)	NF	
XELJANZ ORAL SOLUTION 1 MG/ML (*tofacitinib citrate*)	NPB	PA; ST; QL (240 ML per 24 days)
XELJANZ ORAL TABLET 10 MG (*tofacitinib citrate*)	PB	PA; ST; IBC (Preferred agent for Ulcerative Colitis after the failure of two preferred agents. Not covered for Psoriatic Arthritis, Ankylosing Spondylitis); QL (60 TABLETS per 30 days)
XELJANZ ORAL TABLET 5 MG (*tofacitinib citrate*)	PB	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis and preferred agent for Ulcerative Colitis after the failure of two preferred agents. Not covered for Psoriatic Arthritis, Ankylosing Spondylitis); QL (60 TABLETS per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG (*tofacitinib citrate*)	PB	PA; ST; IBC (Preferred agent for Rheumatoid Arthritis and preferred agent for Ulcerative Colitis after the failure of two preferred agents. Not covered for Psoriatic Arthritis, Ankylosing Spondylitis); QL (30 TABLETS per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG (*tofacitinib citrate*)	PB	PA; ST; IBC (Preferred agent for Ulcerative Colitis after the failure of two preferred agents. Not covered for Psoriatic Arthritis, Ankylosing Spondylitis); QL (30 TABLETS per 30 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*omalizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and Chronic Spontaneous Urticaria); QL (8 INJECTIONS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*omalizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and Chronic Spontaneous Urticaria); QL (4 INJECTIONS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (*omalizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and Chronic Spontaneous Urticaria); QL (2 INJECTIONS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*omalizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and Chronic Spontaneous Urticaria); QL (8 SYRINGES per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*omalizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and Chronic Spontaneous Urticaria); QL (4 SYRINGES per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (*omalizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and Chronic Spontaneous Urticaria); QL (2 SYRINGES per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (*omalizumab*)	PSP	PA; IBC (Preferred agent for Asthma, Chronic Rhinosinusitis with Nasal Polyps and Chronic Spontaneous Urticaria); QL (8 VIALS per 28 days)
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab-kfce*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 VIAL per 84 days)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (*ustekinumab-kfce*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 SYRINGE per 84 days)
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (*ustekinumab-kfce*)	PSP	PA; IBC (Preferred agent for Crohn's Disease, Psoriasis, Psoriatic Arthritis, Ulcerative Colitis); QL (1 SYRINGE per 56 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*)	PB	
hydroxychloroquine sulfate oral tablet 200 mg	G	
leflunomide oral tablet 10 mg, 20 mg	G	
methotrexate sodium oral tablet 2.5 mg	CE	N7 (G)
PLAQUENIL ORAL TABLET 200 MG (*hydroxychloroquine sulfate*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)*)	PSP	PA; QL (4 INJECTIONS per 28 DAYs)
HEREDITARY ANGIOEDEMA		
ANDEMBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.2ML (*garadacimab-gxii*)	NPSP	PA; QL (1 INJECTION per 30 days)
BERINERT INTRAVENOUS KIT 500 UNIT (*c1 esterase inhibitor (human)*)	NF	
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT (*c1 esterase inhibitor (human)*)	NF	
DAWNZERA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*donidalorsen sodium*)	NF	
EKTERLY ORAL TABLET 300 MG (*sebetralstat*)	NF	
FIRAZYR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML (*icatibant acetate*)	NF	
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (*c1 esterase inhibitor (human)*)	NPSP	PA; QL (20 VIALS per 30 days)
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	PSP	PA; QL (45 SYRINGES per 90 days)
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML (*ecallantide*)	NPSP	PA; QL (30 ML per 90 days)
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (*berotralstat hcl*)	PSP	PA; QL (28 CAPSULES per 28 days)
ORLADEYO ORAL PACKET 108 MG, 132 MG, 72 MG, 96 MG (*berotralstat hcl*)	PSP	PA; QL (28 PACKETS per 28 DAYs)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (*c1 esterase inhibitor (recomb)*)	PSP	PA; QL (60 VIALS per 90 days)
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML (*lanadelumab-flyo*)	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	
BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML, 5 GM/50ML (*immune globulin (human)*)	NPSP	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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*)	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)*)	NPSP	PA
GAMMAGARD ERC INJECTION SOLUTION 10 GM/100ML, 5 GM/50ML (*immune globulin (human)*)	NF	
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)*)	NPSP	PA
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM (*immune globulin (human)*)	NPSP	PA
GAMMAKED INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML (*immune globulin (human)*)	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)*)	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)*)	NPSP	PA
HIZENTRA SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML (*immune globulin (human)*)	NPSP	PA
HIZENTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML (*immune globulin (human)*)	NPSP	PA
HYPERRHO INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT (*rho d immune globulin*)	NPSP	
HYPERRHO MINI-DOSE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 250 UNIT (*rho d immune globulin*)	NPSP	
HYQVIA SUBCUTANEOUS KIT 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML (*immune globulin-hyaluronidase*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)*)	NPSP	PA
qivigy intravenous solution 10 gm/100ml, 5 gm/50ml	NF	
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT (*rho d immune globulin*)	NPSP	
RHOPHYLAC INJECTION SOLUTION PREFILLED SYRINGE 1500 UNIT/2ML (*rho d immune globulin*)	NPSP	
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML (*varicella-zoster immune glob*)	NPSP	
WINRHO SDF INJECTION SOLUTION 1500 UNIT/1.3ML, 2500 UNIT/2.2ML (*rho d immune globulin*)	NPSP	
XEMBIFY SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML (*immune globulin (human)-klhw*)	PSP	PA
YIMMUGO INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 5 GM/50ML (*immune globulin (human)-dira*)	NF	
IMMUNOMODULATORS		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (*interferon gamma-1b*)	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	G	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (*belimumab*)	NPSP	PA; QL (4 INJECTIONS per 28 days)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (*belimumab*)	NPSP	PA; QL (4 INJECTIONS per 28 days)
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	G	
cyclosporine modified oral solution 100 mg/ml	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cyclosporine oral capsule 100 mg, 25 mg	G	
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	G	
cyclosporine modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	G	
IMURAN ORAL TABLET 50 MG (*azathioprine*)	PB	
LUPKYNIS ORAL CAPSULE 7.9 MG (*voclosporin*)	NF	
mycophenolate mofetil oral capsule 250 mg	G	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	G	
mycophenolate mofetil oral tablet 500 mg	G	
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	G	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (*mycophenolate mofetil*)	NF	
NEORAL ORAL CAPSULE 100 MG, 25 MG (*cyclosporine modified*)	NPB	
NEORAL ORAL SOLUTION 100 MG/ML (*cyclosporine modified*)	NPB	
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML (*tacrolimus*)	NPSP	
REZUROCK ORAL TABLET 200 MG (*belumosudil mesylate*)	NF	
SANDIMMUNE INTRAVENOUS SOLUTION 50 MG/ML (*cyclosporine*)	NPSP	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (*cyclosporine*)	NPB	
sirolimus oral solution 1 mg/ml	G	
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	G	
tacrolimus er oral capsule extended release 24 hour 0.5 mg, 1 mg, 5 mg	G	
tacrolimus intravenous solution 5 mg/ml	PSP	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	G	
MISCELLANEOUS		
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML (*canakinumab*)	NPSP	PA; QL (2 VIALS per 28 days)
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS		
ELECTROLYTES		
potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)	G	
potassium chloride crys er (Klor-Con M15 Oral Tablet Extended Release 15 Meq)	G	
potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)	G	
potassium chloride (Klor-Con Oral Packet 20 Meq)	G	
potassium chloride crys er oral tablet extended release 10 meq, 20 meq	G	
potassium chloride er oral capsule extended release 10 meq, 8 meq	G	
potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq	G	
potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)	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	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	G	
PRENATAL VITAMINS		
azesco oral tablet 13-1 mg	NF	
pnv-dha oral capsule 27-0.6-0.4-300 mg	G	
zalvit oral tablet 13-1 mg	NF	
ziphex oral tablet 13-1 mg	NF	
VITAMINS - VITAMINS AND SUPPLEMENTS		
cyanocobalamin injection solution 1000 mcg/ml	G	
FA-8 ORAL CAPSULE 0.8 MG (*folic acid*)	CE	N7 (Not Covered); QL (100 CAPSULES per 30 DAYs); AL (Max 55 Years)
folic acid oral tablet 400 mcg	CE	N7 (Not Covered); QL (100 tablets per 30 days); AL (Max 55 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	G	
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	G	
phytonadione oral tablet 5 mg	G	
reno caps oral capsule 1 mg	G	Select OTC
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	G	
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
azelastine hcl ophthalmic solution 0.05 %	G	
bepotastine besilate ophthalmic solution 1.5 %	G	
cromolyn sodium ophthalmic solution 4 %	G	
epinastine hcl ophthalmic solution 0.05 %	G	
ketotifen fumarate ophthalmic solution 0.035 %	G	Select OTC
ZADITOR OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	G	Select OTC
ZERVIATE OPHTHALMIC SOLUTION 0.24 % (*cetirizine hcl*)	PB	
ANTIGLAUCOMA BETA-BLOCKERS - DRUGS TO TREAT GLAUCOMA		
betaxolol hcl ophthalmic solution 0.5 %	G	
BETIMOL OPHTHALMIC SOLUTION 0.5 % (*timolol hemihydrate*)	PB	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (*betaxolol hcl*)	PB	
carteolol hcl ophthalmic solution 1 %	G	
levobunolol hcl ophthalmic solution 0.5 %	G	
timolol hemihydrate ophthalmic solution 0.5 %	G	
timolol maleate (once-daily) ophthalmic solution 0.5 %	G	
timolol maleate (Timolol Maleate Ocudose Ophthalmic Solution 0.5 %)	G	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	G	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	G	
timolol maleate pf ophthalmic solution 0.25 %	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIGLAUCOMA COMBINATION AGENTS - DRUGS TO TREAT GLAUCOMA		
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	G	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	G	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	G	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (*netarsudil-latanoprost*)	PB	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (*brinzolamide-brimonidine*)	PB	
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
loteprednol-tobramycin ophthalmic suspension 0.5-0.3 %	G	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	G	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	G	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	G	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (*tobramycin-dexamethasone*)	PB	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (*tobramycin-dexamethasone*)	PB	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	G	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (*loteprednol-tobramycin*)	NPB	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	G	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (*besifloxacin hcl*)	PB	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (*ciprofloxacin hcl*)	PB	
ciprofloxacin hcl ophthalmic solution 0.3 %	G	
erythromycin ophthalmic ointment 5 mg/gm	G	
gatifloxacin ophthalmic solution 0.5 %	G	
gentamicin sulfate ophthalmic solution 0.3 %	G	
levofloxacin ophthalmic solution 0.5 %	G	
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	G	
moxifloxacin hcl ophthalmic solution 0.5 %	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ofloxacin ophthalmic solution 0.3 %	G	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	G	
sulfacetamide sodium ophthalmic solution 10 %	G	
tobramycin ophthalmic solution 0.3 %	G	
trifluridine ophthalmic solution 1 %	G	
XDEMVY OPHTHALMIC SOLUTION 0.25 % (*lotilaner*)	PB	
ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION		
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (*ketorolac tromethamine*)	PB	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	G	
bromfenac sodium ophthalmic solution 0.07 %, 0.075 %	G	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	G	
diclofenac sodium ophthalmic solution 0.1 %	G	
difluprednate ophthalmic emulsion 0.05 %	G	
FLAREX OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone acetate*)	NPB	
fluorometholone ophthalmic suspension 0.1 %	G	
flurbiprofen sodium ophthalmic solution 0.03 %	G	
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (*fluorometholone*)	PB	
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone*)	NF	
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (*nepafenac*)	PB	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	G	
loteprednol etabonate ophthalmic gel 0.5 %	G	
loteprednol etabonate ophthalmic suspension 0.2 %, 0.5 %	G	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (*dexamethasone*)	PB	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (*nepafenac*)	PB	
PRED FORTE OPHTHALMIC SUSPENSION 1 % (*prednisolone acetate*)	NF	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (*prednisolone acetate*)	PB	
prednisolone acetate ophthalmic suspension 1 %	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARBONIC ANHYDRASE INHIBITORS - DRUGS TO TREAT GLAUCOMA		
brinzolamide ophthalmic suspension 1 %	G	
dorzolamide hcl ophthalmic solution 2 %	G	
DRY EYE DISEASE		
cyclosporine (pf) ophthalmic emulsion 0.05 %	G	
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (*perfluorohexyloctane*)	PB	
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	PB	
RESTASIS OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	PB	
VEVYE OPHTHALMIC SOLUTION 0.1 % (*cyclosporine*)	PB	
XIIDRA OPHTHALMIC SOLUTION 5 % (*lifitegrast*)	PB	
MISCELLANEOUS		
atropine sulfate ophthalmic solution 1 %	G	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 % (*cysteamine hcl*)	NF	
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (*cysteamine hcl*)	NPSP	PA; QL (4 BOTTLES per 28 days)
OXERVATE OPHTHALMIC SOLUTION 0.002 % (*cenegermin-bkbj*)	NPSP	PA; QL (2 ML per 7 DAYs)
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	G	
tropicamide ophthalmic solution 0.5 %, 1 %	G	
VISUDYNE INTRAVENOUS SOLUTION RECONSTITUTED 15 MG (*verteporfin*)	NPSP	PA
PROSTAGLANDINS - DRUGS TO TREAT GLAUCOMA		
bimatoprost ophthalmic solution 0.01 %, 0.03 %	G	
latanoprost ophthalmic solution 0.005 %	G	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (*bimatoprost*)	PB	
tafluprost (pf) ophthalmic solution 0.0015 %	G	
travoprost (bak free) ophthalmic solution 0.004 %	G	
RETINAL DISORDERS		
BYOOVIZ INTRAVITREAL SOLUTION 0.5 MG/0.05ML (*ranibizumab-nuna*)	PSP	PA
EYLEA INTRAVITREAL SOLUTION 2 MG/0.05ML (*aflibercept*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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*)	PB	
SYMPATHOMIMETICS - DRUGS TO TREAT GLAUCOMA		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %, 0.15 % (*brimonidine tartrate*)	PB	
brimonidine tartrate ophthalmic solution 0.1 %, 0.15 %, 0.2 %	G	
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*)	PSP	PA
GLASSIA INTRAVENOUS SOLUTION 1000 MG/50ML, 4 GM/200ML, 5 GM/250ML (*alpha1-proteinase inhibitor*)	PSP	PA
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML (*alpha1-proteinase inhibitor*)	NF	
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 4000 MG, 5000 MG (*alpha1-proteinase inhibitor*)	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*)	PB	QL (4 INJECTIONS per 25 days)
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml	G	QL (4 INJECTIONS per 25 DAYs)
epinephrine injection solution auto-injector 0.3 mg/0.3ml	G	QL (4 INJECTIONS per 25 days)
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (*epinephrine*)	NPB	QL (4 INJECTIONS per 25 days)
EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML (*epinephrine*)	NPB	QL (4 INJECTIONS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEFFY NASAL SOLUTION 1 MG/0.1ML (*epinephrine*)	NPB	QL (4 SPRAYS per 25 DAYs)
NEFFY NASAL SOLUTION 2 MG/0.1ML (*epinephrine*)	NPB	QL (4 SPRAYS per 25 days)
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (*umeclidinium-vilanterol*)	PB	
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (*glycopyrrolate-formoterol*)	PB	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (*ipratropium-albuterol*)	NPB	
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	G	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (*tiotropium bromide-olodaterol*)	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*)	PB	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*)	PB	
ANTICHOLINERGICS		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (*ipratropium bromide hfa*)	PB	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (*umeclidinium bromide*)	PB	
ipratropium bromide hfa inhalation aerosol solution 17 mcg/act	G	
ipratropium bromide inhalation solution 0.02 %	G	
ipratropium bromide nasal solution 0.03 %, 0.06 %	G	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (*tiotropium bromide*)	PB	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (*tiotropium bromide*)	PB	
YUPELRI INHALATION NEBULIZATION SOLUTION 175 MCG/3ML (*revefenacin*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINE COMBINATIONS		
azelastine-fluticasone nasal suspension 137-50 mcg/act	G	
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
ALLEGRA ALLERGY CHILDRENS ORAL SUSPENSION 30 MG/5ML (*fexofenadine hcl*)	G	Select OTC
ALLEGRA ALLERGY CHILDRENS ORAL TABLET DISPERSIBLE 30 MG (*fexofenadine hcl*)	G	Select OTC
ALLEGRA ALLERGY ORAL TABLET 180 MG, 60 MG (*fexofenadine hcl*)	G	Select OTC
allergy rel child (cetirizine) oral tablet dispersible 10 mg	G	Select OTC
azelastine hcl nasal solution 0.1 %	G	
carbinoxamine maleate oral tablet 4 mg	G	
carbinoxamine maleate oral tablet 6 mg	G	N8 (Listing does not include certain NDCs)
cetirizine hcl allergy child oral solution 5 mg/5ml	G	Select OTC
cetirizine hcl oral tablet 10 mg, 5 mg	G	Select OTC
cetirizine hcl oral tablet chewable 10 mg, 5 mg	G	Select OTC
CLARITIN ALLERGY CHILDRENS ORAL SOLUTION 5 MG/5ML (*loratadine*)	G	Select OTC
CLARITIN ORAL CAPSULE 10 MG (*loratadine*)	G	Select OTC
CLARITIN ORAL TABLET 10 MG (*loratadine*)	G	Select OTC
CLARITIN ORAL TABLET CHEWABLE 10 MG, 5 MG (*loratadine*)	G	Select OTC
CLARITIN REDITABS JUNIORS ORAL TABLET DISPERSIBLE 10 MG (*loratadine*)	G	Select OTC
CLARITIN REDITABS ORAL TABLET DISPERSIBLE 5 MG (*loratadine*)	G	Select OTC
clemastine fumarate oral tablet 2.68 mg	G	
cvs allergy relief childrens oral suspension 30 mg/5ml	G	Select OTC
cyproheptadine hcl oral syrup 2 mg/5ml	G	
cyproheptadine hcl oral tablet 4 mg	G	
desloratadine oral tablet 5 mg	G	
desloratadine oral tablet dispersible 2.5 mg, 5 mg	G	
eq loratadine childrens oral tablet chewable 5 mg	G	Select OTC
fexofenadine hcl oral tablet 180 mg	G	Select OTC
gnp loratadine oral tablet dispersible 10 mg	G	Select OTC

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydroxyzine hcl oral syrup 10 mg/5ml	G	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	G	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	G	
kp fexofenadine hcl oral tablet 60 mg	G	Select OTC
levocetirizine dihydrochloride oral tablet 5 mg	G	Select OTC
loratadine childrens oral solution 5 mg/5ml	G	Select OTC
loratadine oral capsule 10 mg	G	Select OTC
loratadine oral tablet 10 mg	G	Select OTC
olopatadine hcl nasal solution 0.6 %	G	
qc all day allergy relief oral capsule 10 mg	G	Select OTC
RYCLORA ORAL SOLUTION 2 MG/5ML (*dexchlorpheniramine maleate*)	NF	
carbinoxamine maleate (Ryvent Oral Tablet 6 Mg)	G	
XYZAL ALLERGY 24HR ORAL TABLET 5 MG (*levocetirizine dihydrochloride*)	G	Select OTC
ZYRTEC ALLERGY CHILDRENS ORAL TABLET DISPERSIBLE 10 MG (*cetirizine hcl*)	G	Select OTC
ZYRTEC ALLERGY ORAL CAPSULE 10 MG (*cetirizine hcl*)	G	Select OTC
ZYRTEC ALLERGY ORAL TABLET 10 MG (*cetirizine hcl*)	G	Select OTC
ZYRTEC CHILDRENS ALLERGY ORAL SOLUTION 1 MG/ML (*cetirizine hcl*)	G	Select OTC
ZYRTEC CHILDRENS ALLERGY ORAL TABLET CHEWABLE 10 MG, 2.5 MG (*cetirizine hcl*)	G	Select OTC
ZYRTEC ORAL TABLET CHEWABLE 10 MG (*cetirizine hcl*)	G	Select OTC
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	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	G	
albuterol sulfate oral syrup 2 mg/5ml	G	
albuterol sulfate oral tablet 2 mg, 4 mg	G	
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	G	
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	G	
levalbuterol tartrate inhalation aerosol 45 mcg/act	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (*albuterol sulfate*)	NPB	
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*salmeterol xinafoate*)	PB	
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (*olodaterol hcl*)	PB	
terbutaline sulfate oral tablet 2.5 mg, 5 mg	G	
COLD/COUGH		
ALLEGRA-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 12 HOUR 60-120 MG (*fexofenadine-pseudoephedrine*)	G	Select OTC
ALLEGRA-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 24 HOUR 180-240 MG (*fexofenadine-pseudoephedrine*)	G	Select OTC
benzonatate oral capsule 100 mg, 200 mg	G	
cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg	G	Select OTC
CLARITIN-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG (*loratadine-pseudoephedrine*)	G	Select OTC
CLARITIN-D 24 HOUR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-240 MG (*loratadine-pseudoephedrine*)	G	Select OTC
coditussin ac oral liquid 200-10 mg/5ml	G	Select OTC; QL (60 ML per 1 day)
fexofenadine-pseudoephed er oral tablet extended release 12 hour 60-120 mg	G	Select OTC
fexofenadine-pseudoephed er oral tablet extended release 24 hour 180-240 mg	G	Select OTC
ft allergy d-12 hour oral tablet extended release 12 hour 5-120 mg	G	Select OTC
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	G	QL (30 ML per 1 day)
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	G	QL (6 TABLETS per 1 day)
loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg	G	Select OTC
promethazine-codeine oral syrup 6.25-10 mg/5ml	G	QL (30 ML per 1 DAY)
promethazine-dm oral syrup 6.25-15 mg/5ml	G	
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	G	
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (*chlorpheniramine-codeine*)	NPB	QL (2 TABLETS per 1 DAY)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYRTEC-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG (*cetirizine-pseudoephedrine*)	G	Select OTC
CYSTIC FIBROSIS		
ALYFTREK ORAL TABLET 10-50-125 MG (*vanzacaft-tezacaft-deutivacaft*)	NPSP	PA; QL (56 TABLETS per 28 days)
ALYFTREK ORAL TABLET 4-20-50 MG (*vanzacaft-tezacaft-deutivacaft*)	NPSP	PA; QL (84 TABLETS per 28 days)
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*)	NF	
KALYDECO ORAL PACKET 13.4 MG, 5.8 MG (*ivacaftor*)	NPSP	PA; QL (56 PACKETS per 28 DAYs)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (*ivacaftor*)	NPSP	PA; QL (56 PACKET per 28 days)
KALYDECO ORAL TABLET 150 MG (*ivacaftor*)	NPSP	PA; QL (1 CARTONS per 28 days)
KITABIS PAK (W/ NEBULIZER) INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*)	NF	
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG (*lumacaftor-ivacaftor*)	NPSP	PA; QL (56 PACKET per 28 days)
ORKAMBI ORAL PACKET 75-94 MG (*lumacaftor-ivacaftor*)	NPSP	PA; QL (56 PACKETS per 28 DAYs)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (*lumacaftor-ivacaftor*)	NPSP	PA; QL (112 TABLETS per 28 days)
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (*dornase alfa*)	NPSP	PA; QL (150 ML per 30 Days)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (*tezacaftor-ivacaftor*)	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	PSP	PA; QL (224 ML per 28 days)
tobramycin inhalation nebulization solution 300 mg/5ml	PSP	PA; QL (280 ML per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG (*elexacaftor-tezacaftor-ivacaft*)	NPSP	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*)	NPSP	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	G	
montelukast sodium oral tablet 10 mg	G	
montelukast sodium oral tablet chewable 4 mg, 5 mg	G	
zafirlukast oral tablet 10 mg, 20 mg	G	
MAST CELL STABILIZERS - DRUGS TO TREAT ALLERGIES		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	G	
MISCELLANEOUS		
acetylcysteine inhalation solution 10 %, 20 %	G	
roflumilast oral tablet 250 mcg, 500 mcg	G	
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
budesonide nasal suspension 32 mcg/act	G	Select OTC
FLONASE ALLERGY REL CHILDRENS NASAL SUSPENSION 50 MCG/ACT (*fluticasone propionate*)	G	Select OTC
flunisolide nasal solution 25 mcg/act (0.025%)	G	
fluticasone propionate nasal suspension 50 mcg/act	G	Select OTC
NASACORT ALLERGY 24HR NASAL AEROSOL 55 MCG/ACT (*triamcinolone acetonide*)	G	Select OTC
triamcinolone acetonide nasal aerosol 55 mcg/act	G	Select OTC
XHANCE NASAL EXHALER SUSPENSION 93 MCG/ACT (*fluticasone propionate*)	PB	
PULMONARY FIBROSIS AGENTS		
ESBRIET ORAL TABLET 267 MG, 801 MG (*pirfenidone*)	NF	
JASCAYD ORAL TABLET 18 MG, 9 MG (*nerandomilast*)	NF	
nintedanib esylate oral capsule 100 mg, 150 mg	G	PA; QL (60 CAPSULES per 30 DAYs)
OFEV ORAL CAPSULE 100 MG, 150 MG (*nintedanib esylate*)	PB	PA; QL (60 CAPSULES per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
pirfenidone oral capsule 267 mg	PSP	PA; QL (270 CAPSULES per 30 DAYs)
pirfenidone oral tablet 267 mg	PSP	PA; QL (270 TABLETS per 30 Days)
pirfenidone oral tablet 534 mg	PSP	PA; QL (90 TABLETS per 30 days)
pirfenidone oral tablet 801 mg	PSP	PA; QL (90 TABLETS per 30 Days)
SEVERE ASTHMA AGENTS		
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (*benralizumab*)	PSP	PA; QL (1 PEN per 28 days)
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (*benralizumab*)	PSP	PA; QL (1 SYRINGE per 56 days)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (*tezepelumab-ekko*)	PSP	PA; QL (1 PEN per 28 days)
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.91ML (*tezepelumab-ekko*)	PSP	PA; QL (1 SYRINGE per 28 DAYs)
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT (*fluticasone furoate*)	PB	
beclomethasone diprop hfa inhalation aerosol solution 40 mcg/act, 80 mcg/act	G	
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml	G	
fluticasone furoate ellipta inhalation aerosol powder breath activated 100 mcg/act, 200 mcg/act, 50 mcg/act	G	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (*budesonide*)	PB	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (*beclomethasone diprop hfa*)	PB	
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*)	PB	
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH (*fluticasone furoate-vilanterol*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	G	
fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act	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	G	
fluticasone-salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	G	
XANTHINES - DRUGS TO TREAT COPD		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (*theophylline*)	NF	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg	G	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	G	
theophylline oral elixir 80 mg/15ml	G	
theophylline oral solution 80 mg/15ml	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*)	NPB	PA
ABSORICA ORAL CAPSULE 10 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG (*isotretinoin*)	PB	PA
ACANYA EXTERNAL GEL 1.2-2.5 % (*clindamycin phos-benzoyl perox*)	NPB	
isotretinoin (Accutane Oral Capsule 20 Mg, 30 Mg, 40 Mg)	G	PA
adapalene external cream 0.1 %	G	PA; AL (Max 35 Years)
adapalene external gel 0.1 %	G	PA; N8 (PA applies to members 35 and older); Select OTC; AL (Max 35 Years)
adapalene external gel 0.3 %	G	PA; AL (Max 35 Years)
adapalene external pad 0.1 %	NF	
adapalene-benzoyl peroxide external gel 0.1-2.5 %	G	PA; N8 (PA applies to members 35 and older); AL (Max 35 Years)
adapalene-benzoyl peroxide external gel 0.3-2.5 %	G	PA; AL (Max 35 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AKLIEF EXTERNAL CREAM 0.005 % (*trifarotene*)	PB	
isotretinoin (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	G	PA
ARAZLO EXTERNAL LOTION 0.045 % (*tazarotene*)	PB	PA; AL (Max 35 Years)
benzoyl peroxide-erythromycin external gel 5-3 %	G	
isotretinoin (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	G	PA
clindamycin phosphate (Clindacin-P External Swab 1 %)	G	
clindamycin phos (once-daily) external gel 1 %	G	N8 (Listing does not include certain NDCs)
clindamycin phos (twice-daily) external gel 1 %	G	N8 (Listing does not include certain NDCs)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %, 1.2-5 %	G	
clindamycin phosphate external foam 1 %	G	
clindamycin phosphate external lotion 1 %	G	
clindamycin phosphate external solution 1 %	G	
clindamycin-tretinoin external gel 1.2-0.025 %	G	PA; N8 (PA applies to members 35 and older); AL (Max 35 Years)
dapsone external gel 5 %, 7.5 %	G	
DIFFERIN EXTERNAL GEL 0.1 % (*adapalene*)	G	PA; Select OTC; AL (Max 35 Years)
EPIDUO EXTERNAL GEL 0.1-2.5 % (*adapalene-benzoyl peroxide*)	PB	PA; AL (Max 35 Years)
EPIDUO FORTE EXTERNAL GEL 0.3-2.5 % (*adapalene-benzoyl peroxide*)	PB	PA; AL (Max 35 Years)
ery external pad 2 %	G	
erythromycin external solution 2 %	G	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	G	PA
isotretinoin oral capsule 25 mg, 35 mg	NF	
RETIN-A MICRO PUMP EXTERNAL GEL 0.06 %, 0.08 % (*tretinoin microsphere*)	NPB	PA; AL (Max 35 Years)
sulfacetamide sodium (acne) external lotion 10 %	G	
tretinoin external cream 0.025 %	G	PA; N8 (PA applies to members 35 and older); AL (Max 35 Years)
tretinoin external cream 0.05 %, 0.1 %	G	PA; AL (Max 35 Years)
tretinoin external gel 0.01 %, 0.025 %, 0.05 %	G	PA; AL (Max 35 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tretinoin microsphere external gel 0.04 %, 0.1 %	G	PA; N8 (PA applies to members 35 and older); AL (Max 35 Years)
tretinoin microsphere pump external gel 0.08 %	G	PA; AL (Max 35 Years)
WINLEVI EXTERNAL CREAM 1 % (*clascoterone*)	PB	
isotretinoin (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	G	PA
ZIANA EXTERNAL GEL 1.2-0.025 % (*clindamycin-tretinoin*)	NPB	PA; AL (Max 35 Years)
DERMATOLOGY, ACTINIC KERATOSIS		
diclofenac sodium external gel 3 %	G	PA; QL (100 GRAMS per 25 days)
fluorouracil external cream 5 %	G	
fluorouracil external solution 2 %, 5 %	G	
imiquimod external cream 5 %	G	
imiquimod pump external cream 3.75 %	G	
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate external cream 0.1 %	G	
gentamicin sulfate external ointment 0.1 %	G	
mupirocin calcium external cream 2 %	NF	
mupirocin external ointment 2 %	G	
NEO-SYNALAR EXTERNAL CREAM 0.5-0.025 % (*neomycin-fluocinolone*)	NF	
SILVADENE EXTERNAL CREAM 1 % (*silver sulfadiazine*)	PB	
silver sulfadiazine external cream 1 %	G	
silver sulfadiazine (Ssd External Cream 1 %)	G	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox external gel 0.77 %	G	
ciclopirox external shampoo 1 %	G	
ciclopirox external solution 8 %	G	STX
ciclopirox olamine external cream 0.77 %	G	
ciclopirox olamine external suspension 0.77 %	G	
clotrimazole-betamethasone external cream 1-0.05 %	G	STX; QL (60 GRAMS per 25 days)
clotrimazole-betamethasone external lotion 1-0.05 %	G	STX; QL (60 ML per 25 days)
econazole nitrate external cream 1 %	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JUBLIA EXTERNAL SOLUTION 10 % (*efinaconazole*)	NPB	QL (4 ML per 21 days)
ketoconazole external cream 2 %	G	
ketoconazole external foam 2 %	NF	
luliconazole external cream 1 %	NF	
miconazole-zinc oxide-petrolat external ointment 0.25-15-81.35 %	G	
naftifine hcl external cream 1 %, 2 %	G	
naftifine hcl external gel 2 %	G	
nystatin external cream 100000 unit/gm	G	
nystatin external ointment 100000 unit/gm	G	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	G	STX; QL (60 GRAMS per 25 days)
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	G	STX; QL (60 GRAMS per 25 days)
oxiconazole nitrate external cream 1 %	G	N8 (Listing does not include certain NDCs); QL (60 GRAMS per 25 days)
OXISTAT EXTERNAL LOTION 1 % (*oxiconazole nitrate*)	NPB	QL (60 ML per 25 days)
sulconazole nitrate external cream 1 %	G	
sulconazole nitrate external solution 1 %	G	
tavaborole external solution 5 %	NF	
DERMATOLOGY, ANTIPRURITIC		
doxepin hcl external cream 5 %	NF	
PRUDOXIN EXTERNAL CREAM 5 % (*doxepin hcl (antipruritic)*)	NPB	QL (45 GRAMS per 25 days)
ZONALON EXTERNAL CREAM 5 % (*doxepin hcl (antipruritic)*)	NPB	QL (45 GRAMS per 25 days)
DERMATOLOGY, ANTIPSORIATICS		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	G	
calcipotriene external cream 0.005 %	NF	
calcipotriene external ointment 0.005 %	G	
calcipotriene external solution 0.005 %	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*)	PB	
ICOTYDE ORAL TABLET 200 MG (*icotrokinra hcl*)	NF	
methoxsalen rapid oral capsule 10 mg	G	
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*spesolimab-sbzo*)	NPSP	PA; QL (2 SYRINGES per 28 days)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (*spesolimab-sbzo*)	NPSP	PA; QL (1 SYRINGE per 28 days)
tazarotene external cream 0.05 %	G	
tazarotene external cream 0.1 %	G	PA; AL (Max 35 Years)
tazarotene external gel 0.05 %, 0.1 %	G	
VECTICAL EXTERNAL OINTMENT 3 MCG/GM (*calcitriol*)	NF	
VTAMA EXTERNAL CREAM 1 % (*tapinarof*)	PB	
ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*)	PB	
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole external shampoo 2 %	G	
ZORYVE EXTERNAL FOAM 0.3 % (*roflumilast*)	PB	IBC (Preferred for Seborrheic Dermatitis and Plaque Psoriasis)
DERMATOLOGY, ATOPIC DERMATITIS		
ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*tralokinumab-ldrm*)	NPSP	PA; QL (2 PENS per 28 days)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*tralokinumab-ldrm*)	NPSP	PA; QL (4 SYRINGES per 28 days)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*)	PB	PA; QL (30 TABLETS per 30 days)
EBGLYSS SUBCUTANEOUS SOLUTION AUTO-INJECTOR 250 MG/2ML (*lebrikizumab-lbkz*)	PSP	PA; QL (2 PENS per 28 DAYs)
EBGLYSS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MG/2ML (*lebrikizumab-lbkz*)	PSP	PA; QL (2 SYRINGES per 28 DAYs)
EUCRISA EXTERNAL OINTMENT 2 % (*crisaborole*)	PB	
OPZELURA EXTERNAL CREAM 1.5 % (*ruxolitinib phosphate*)	PB	
pimecrolimus external cream 1 %	G	
tacrolimus external ointment 0.03 %, 0.1 %	G	
ZORYVE EXTERNAL CREAM 0.05 %, 0.15 % (*roflumilast*)	PB	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DERMATOLOGY, CHRONIC SPONTANEOUS URTICARIA		
RHAPSIDO ORAL TABLET 25 MG (*remibrutinib*)	NPB	PA; QL (60 TABLETS per 25 DAYs)
DERMATOLOGY, CORTICOSTEROIDS		
alclometasone dipropionate external cream 0.05 %	G	QL (120 GRAMS per 25 days)
alclometasone dipropionate external ointment 0.05 %	G	QL (120 GRAMS per 25 days)
amcinonide external cream 0.1 %	G	QL (120 GRAMS per 25 days)
amcinonide external ointment 0.1 %	G	QL (120 GRAMS per 25 days)
betamethasone dipropionate aug external cream 0.05 %	G	QL (120 GRAMS per 25 days)
betamethasone dipropionate aug external gel 0.05 %	G	QL (120 GRAMS per 25 days)
betamethasone dipropionate aug external lotion 0.05 %	G	QL (120 ML per 25 DAYs)
betamethasone dipropionate aug external ointment 0.05 %	G	QL (120 GRAMS per 25 days)
betamethasone dipropionate external cream 0.05 %	G	QL (120 GRAMS per 25 days)
betamethasone dipropionate external lotion 0.05 %	G	QL (120 ML per 25 DAYs)
betamethasone dipropionate external ointment 0.05 %	NF	
betamethasone valerate external cream 0.1 %	G	QL (120 GRAMS per 25 days)
betamethasone valerate external foam 0.12 %	G	QL (120 GRAMS per 25 days)
betamethasone valerate external lotion 0.1 %	G	QL (120 ML per 25 DAYs)
betamethasone valerate external ointment 0.1 %	G	QL (120 GRAMS per 25 days)
BRYHALI EXTERNAL LOTION 0.01 % (*halobetasol propionate*)	PB	QL (120 GRAMS per 25 days)
clobetasol prop emollient base external cream 0.05 %	G	QL (120 GRAMS per 30 Days)
clobetasol propionate e external cream 0.05 %	G	QL (120 GRAMS per 25 days)
clobetasol propionate emulsion external foam 0.05 %	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clobetasol propionate external cream 0.025 %	G	QL (120 GRAMS per 25 days)
clobetasol propionate external foam 0.05 %	G	QL (120 GRAMS per 25 days)
clobetasol propionate external gel 0.05 %	G	QL (120 GRAMS per 25 days)
clobetasol propionate external liquid 0.05 %	G	QL (120 ML per 25 days)
clobetasol propionate external lotion 0.05 %	G	QL (120 ML per 25 DAYs)
clobetasol propionate external ointment 0.05 %	G	QL (120 GRAMS per 25 days)
clobetasol propionate external shampoo 0.05 %	G	QL (120 ML per 25 days)
clobetasol propionate external solution 0.05 %	G	QL (120 ML per 25 days)
CLOBEX EXTERNAL LOTION 0.05 % (*clobetasol propionate*)	PB	QL (120 ML per 25 DAYs)
CLOBEX EXTERNAL SHAMPOO 0.05 % (*clobetasol propionate*)	PB	QL (120 ML per 25 days)
CLOBEX SPRAY EXTERNAL LIQUID 0.05 % (*clobetasol propionate*)	NPB	QL (120 ML per 25 DAYs)
clocortolone pivalate external cream 0.1 %	NF	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (*flurandrenolide*)	NPB	QL (1 TAPE per 25 DAYs)
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	NPB	QL (120 ML per 25 days)
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	NPB	QL (120 ML per 25 days)
desonide external cream 0.05 %	G	QL (120 GRAMS per 25 days)
desonide external gel 0.05 %	NF	
desonide external lotion 0.05 %	G	QL (120 ML per 25 days)
desonide external ointment 0.05 %	G	QL (120 GRAMS per 25 days)
desoximetasone external cream 0.05 %, 0.25 %	G	QL (120 GRAMS per 25 days)
desoximetasone external gel 0.05 %	G	QL (120 GRAMS per 25 days)
desoximetasone external liquid 0.25 %	G	QL (120 ML per 25 days)
desoximetasone external ointment 0.05 %	NF	
desoximetasone external ointment 0.25 %	G	QL (120 GRAMS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diflorasone diacetate external cream 0.05 %	NF	
diflorasone diacetate external ointment 0.05 %	NF	
DIPROLENE EXTERNAL OINTMENT 0.05 % (*betamethasone dipropionate aug*)	NPB	QL (120 GRAMS per 25 days)
fluocinolone acetonide body external oil 0.01 %	G	QL (120 ML per 25 days)
fluocinolone acetonide external cream 0.01 %, 0.025 %	G	QL (120 GRAMS per 25 days)
fluocinolone acetonide external ointment 0.025 %	G	QL (120 GRAMS per 25 days)
fluocinolone acetonide external solution 0.01 %	G	QL (120 ML per 25 days)
fluocinolone acetonide scalp external oil 0.01 %	G	QL (120 ML per 25 days)
fluocinonide emulsified base external cream 0.05 %	G	QL (120 GRAMS per 25 days)
fluocinonide external cream 0.05 %	G	QL (120 GRAMS per 25 days)
fluocinonide external cream 0.1 %	NF	
fluocinonide external gel 0.05 %	G	QL (120 GRAMS per 25 days)
fluocinonide external ointment 0.05 %	G	QL (120 GRAMS per 25 days)
fluocinonide external solution 0.05 %	G	QL (120 ML per 25 days)
flurandrenolide external lotion 0.05 %	NF	
fluticasone propionate external cream 0.05 %	G	QL (120 GRAMS per 25 days)
fluticasone propionate external lotion 0.05 %	G	QL (120 ML per 25 days)
fluticasone propionate external ointment 0.005 %	G	QL (120 GRAMS per 25 days)
halcinonide external cream 0.1 %	NF	
halcinonide external solution 0.1 %	G	QL (120 ML per 25 DAYs)
halobetasol propionate external cream 0.05 %	G	QL (120 GRAMS per 25 days)
halobetasol propionate external foam 0.05 %	G	QL (120 GRAMS per 25 days)
halobetasol propionate external lotion 0.05 %	NPB	QL (120 ML per 25 DAYs)
halobetasol propionate external ointment 0.05 %	G	QL (120 GRAMS per 25 days)
HALOG EXTERNAL CREAM 0.1 % (*halcinonide*)	NPB	QL (120 GRAMS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HALOG EXTERNAL SOLUTION 0.1 % (*halcinonide*)	NPB	QL (120 ML per 25 days)
hydrocortisone butyrate external cream 0.1 %	G	QL (120 GRAMS per 25 days)
hydrocortisone butyrate external lotion 0.1 %	NF	
hydrocortisone butyrate external ointment 0.1 %	G	QL (120 GRAMS per 25 days)
hydrocortisone butyrate external solution 0.1 %	G	QL (120 ML per 25 days)
hydrocortisone external cream 2.5 %	G	QL (120 GRAMS per 25 days)
hydrocortisone external lotion 2 %	G	QL (120 ML per 25 DAYs)
hydrocortisone external lotion 2.5 %	G	QL (120 ML per 25 days)
hydrocortisone external ointment 2.5 %	G	QL (120 GRAMS per 25 days)
hydrocortisone external solution 2.5 %	G	QL (120 ML per 25 days)
hydrocortisone valerate external cream 0.2 %	G	QL (120 GRAMS per 25 days)
hydrocortisone valerate external ointment 0.2 %	G	QL (120 GRAMS per 25 days)
IMPOYZ EXTERNAL CREAM 0.025 % (*clobetasol propionate*)	NPB	QL (120 GRAMS per 25 days)
LEXETTE EXTERNAL FOAM 0.05 % (*halobetasol propionate*)	NPB	QL (120 GRAMS per 25 days)
MICORT HC EXTERNAL CREAM 2.5 % (*hydrocortisone acetate*)	G	QL (120 GRAMS per 25 days)
mometasone furoate external cream 0.1 %	G	QL (120 GRAMS per 25 days)
mometasone furoate external ointment 0.1 %	G	QL (120 GRAMS per 25 days)
mometasone furoate external solution 0.1 %	G	QL (120 ML per 25 days)
SERNIVO EXTERNAL EMULSION 0.05 % (*betamethasone dipropionate*)	NPB	QL (120 ML per 25 DAYs)
SYNALAR EXTERNAL CREAM 0.025 % (*fluocinolone acetonide*)	NPB	QL (120 GRAMS per 25 days)
SYNALAR EXTERNAL OINTMENT 0.025 % (*fluocinolone acetonide*)	NPB	QL (120 GRAMS per 25 days)
TEXACORT EXTERNAL SOLUTION 2.5 % (*hydrocortisone*)	G	QL (120 ML per 25 days)
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (*desoximetasone*)	NPB	QL (120 GRAMS per 25 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICORT SPRAY EXTERNAL LIQUID 0.25 % (*desoximetasone*)	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 %	G	QL (120 GRAMS per 25 days)
triamcinolone acetonide external lotion 0.025 %, 0.1 %	G	QL (120 ML per 25 days)
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	G	QL (120 GRAMS per 25 days)
ULTRAVATE EXTERNAL LOTION 0.05 % (*halobetasol propionate*)	NPB	QL (120 ML per 25 DAYs)
VANOS EXTERNAL CREAM 0.1 % (*fluocinonide*)	NPB	QL (120 GRAMS per 25 days)
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine external ointment 5 %	G	QL (50 GRAMS per 25 days)
lidocaine external patch 5 %	G	QL (90 PATCH per 25 days)
lidocaine hcl external solution 4 %	G	QL (50 ML per 25 DAYs)
lidocaine-prilocaine external cream 2.5-2.5 %	G	QL (30 GRAMS per 25 days)
LIDODERM EXTERNAL PATCH 5 % (*lidocaine*)	PB	QL (90 PATCHES per 25 days)
PLIAGLIS EXTERNAL CREAM 7-7 % (*lidocaine-tetracaine*)	NF	
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
ABREVA EXTERNAL CREAM 10 % (*docosanol*)	G	Select OTC
acyclovir external cream 5 %	NF	
acyclovir external ointment 5 %	G	
bexarotene external gel 1 %	G	PA
docosanol external cream 10 %	G	Select OTC
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 % (*aminolevulinic acid hcl*)	NPSP	QL (1 STICK per 25 DAYs)
NEMLUVIO SUBCUTANEOUS AUTO-INJECTOR 30 MG (*nemolizumab-ilto*)	PSP	PA; IBC (Preferred agent for Atopic Dermatitis and Prurigo Nodularis); QL (2 PENS per 28 DAYs)
podofilox external gel 0.5 %	G	
podofilox external solution 0.5 %	G	
TARGRETIN EXTERNAL GEL 1 % (*bexarotene*)	NF	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VALCHLOR EXTERNAL GEL 0.016 % (*mechlorethamine hcl (topical)*)	NPSP	PA; QL (2 GRAMS per 30 days)
DERMATOLOGY, ROSACEA		
azelaic acid external gel 15 %	G	
doxycycline oral capsule delayed release 40 mg	G	
FINACEA EXTERNAL FOAM 15 % (*azelaic acid*)	PB	
ivermectin external cream 1 %	G	
metronidazole external cream 0.75 %	G	
metronidazole external gel 0.75 %, 1 %	G	
metronidazole external lotion 0.75 %	G	
DERMATOLOGY, SCABICIDES AND PEDICULICIDES		
CROTAN EXTERNAL LOTION 10 % (*crotamiton*)	G	
malathion external lotion 0.5 %	G	
OVIDE EXTERNAL LOTION 0.5 % (*malathion*)	PB	
permethrin external cream 5 %	G	
spinosad external suspension 0.9 %	G	
DERMATOLOGY, WOUND CARE AGENTS		
acetic acid irrigation solution 0.25 %	G	
sodium chloride irrigation solution 0.9 %	G	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl oral capsule 30 mg	G	
chlorhexidine gluconate mouth/throat solution 0.12 %	G	
clotrimazole mouth/throat troche 10 mg	G	
EVOXAC ORAL CAPSULE 30 MG (*cevimeline hcl*)	PB	
lidocaine viscous hcl mouth/throat solution 2 %	G	
nystatin mouth/throat suspension 100000 unit/ml	G	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	G	
SALAGEN ORAL TABLET 5 MG, 7.5 MG (*pilocarpine hcl*)	PB	
triamcinolone acetonide mouth/throat paste 0.1 %	G	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
acetic acid otic solution 2 %	G	
ciprofloxacin hcl otic solution 0.2 %	G	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	G	
ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %	NF	
ciprofloxacin-hydrocortisone otic suspension 0.2-1 %	G	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluocinolone acetonide otic oil 0.01 %	G	
hydrocortisone-acetic acid otic solution 1-2 %	G	
neomycin-polymyxin-hc otic solution 1 %	G	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	G	
ofloxacin otic solution 0.3 %	G	

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