



February 2024

**HAP CareSource
Formulary Drug List**

Your Drug Coverage

Your HAP CareSource plan covers drugs. There are no copays for covered drugs. You must use a pharmacy in the network to fill your prescriptions. You can find a pharmacy near you by searching our website.

We cover drugs on a list called the preferred drug list or Common Formulary. A formulary is a list of covered drugs. If you want to look at the drugs on the formulary, or search for a certain drug, you can search the list. It includes drugs from a pharmacy, not drugs from your doctor's office or the hospital. The list includes prescription drugs and covered over-the-counter drugs. We also cover all drugs to help you stop smoking. You can search the list by brand name or generic name.

HAP CareSource works with the state and other health plans to develop and update the list. We update it at least four times a year. We add new drugs and sometimes change the status of drugs. We make changes to the list to meet the state's rules.

When we make a change, we update the website so it's available for you, providers and our Member Services team. If we make a change to the drug list that affects you, we'll send a letter to you and your doctor. This gives you time to talk to your doctor about the change.

Go here to find the drug list: [CareSource.com/MIMedicaidFormulary](https://www.caresource.com/MIMedicaidFormulary)

Drug Coverage Information

Formulary list and restrictions

We cover up to a one-month supply for most medications, or less, if your doctor prescribes less. We cover up to a 12-month supply of birth control drugs. We also cover a three-month supply for many drugs that are taken every day. This includes drugs to treat diabetes, asthma, high blood pressure, cholesterol and other conditions.

For safety reasons, you must use a certain amount of your medication before you can fill it again.

We cover both brand and generics. Sometimes, we only cover the brand. Other times, we cover the generic. Your pharmacy will give you the drug that is covered. Some drugs need approval before we'll cover them. Prior authorization may be required when:

- A drug has step therapy, which means you must try certain drugs before another drug is covered.
- We need certain medical information from your doctor to make sure the drug is appropriate for treatment. For example, we might need diagnosis information, lab test results and history of medications.
- A drug is on the list but there are other drugs that are preferred.
- When the generic drug is covered, but the brand name drug is needed instead for a medical reason. For example, you're allergic to a certain dye/color in the medication. These situations are rare.

Some drugs have age restrictions or quantity limits. These are usually based on safety.

All drugs on the list are covered. If you need a drug that is not on the list, or there isn't another drug on the list that you can take, you or your doctor can ask for an exception to the formulary. You can also ask us to not apply restrictions or limits on a drug. You can request an exception at the website, or by telephone through Member Services. Your doctor can send us a Request form via fax or call us at 1-833-230-2102, option "Provider," then option "Pharmacy".

We work with your doctor for the information we need for prior authorization or exception requests. Your doctor will tell us why the drug is necessary.

If we deny a drug request, we'll send a letter to you and your doctor. The letter will tell you the reason why we denied the request. You have the right to appeal. If you want to appeal, you have 60 days from the date on the letter to appeal.

Benefit limitations

Some drugs are covered by the state of Michigan, not HAP CareSource Medicaid. When you go to the pharmacy, you should always take your HAP CareSource card and your mihealth Medicaid card. Your pharmacy knows about these drugs and will bill the state for these drugs.

There are some drugs not covered by HAP CareSource or mihealth Medicaid, including:

- Drugs not approved by the Food and Drug Administration
- Drugs for cosmetic use
- Experimental or investigational drugs
- Cough/cold medications
- Fertility drugs
- Lifestyle drugs
- Sexual or erectile dysfunction drugs
- Replacement of lost or stolen medication
- Any drug excluded for coverage by the state of Michigan

HAP CareSource Preferred Drug List

Table of Contents

Antihistamine Drugs.....	5
Anti-Infective Agents.....	7
Antineoplastic Agents.....	15
Antitoxins,Immune Glob,Toxoids,Vaccines.....	17
Autonomic Drugs.....	19
Blood Formation, Coagulation, Thrombosis.....	24
Cardiovascular Drugs.....	33
Central Nervous System Agents.....	53
Devices.....	70
Diagnostic Agents.....	73
Electrolytic, Caloric, And Water Balance.....	73
Enzymes.....	79
Eye, Ear, Nose And Throat (Eent) Preps.....	80
Gastrointestinal Drugs.....	85
Heavy Metal Antagonists.....	95
Hormones And Synthetic Substitutes.....	96
Miscellaneous Therapeutic Agents.....	112
Nonhormonal Contraceptives.....	120
Oxytocics.....	121
Respiratory Tract Agents.....	121
Skin And Mucous Membrane Agents.....	130
Smooth Muscle Relaxants.....	140
Vitamins.....	140

CURRENT AS OF 2/1/2024

Drug	Status	Notes
Antihistamine Drugs		
Ethanolamine Derivatives		
ALLER-G-TIME	Tier 1	AGE (Max 64 Years)
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET	Tier 1	AGE (Max 64 Years)
BANOPHEN ORAL TABLET	Tier 1	AGE (Max 64 Years)
DAYHIST ALLERGY	Tier 1	
<i>dimenhydrinate oral</i>	Tier 1	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl injection syringe</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral liquid</i>	Tier 1	
<i>diphenhydramine hcl oral tablet</i>	Tier 1	AGE (Max 64 Years)
First Gen. Antihist. Derivatives, Misc.		
<i>cyproheptadine</i>	Tier 1	AGE (Max 64 Years)
First Generation Antihistamines		
ALLER-CHLOR	Tier 1	
ALLER-G-TIME	Tier 1	AGE (Max 64 Years)

Drug	Status	Notes
ALLERGY (CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET	Tier 1	AGE (Max 64 Years)
ALLERGY-TIME	Tier 1	
BANOPHEN ORAL TABLET	Tier 1	AGE (Max 64 Years)
<i>carbinoxamine maleate oral liquid</i>	Tier 1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet extended release</i>	Tier 1	
CHLORTABS	Tier 1	
<i>cyproheptadine</i>	Tier 1	AGE (Max 64 Years)
DAYHIST ALLERGY	Tier 1	
<i>dimenhydrinate oral</i>	Tier 1	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl injection syringe</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule</i>	Tier 1	AGE (Max 64 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>diphenhydramine hcl oral liquid</i>	Tier 1	
<i>diphenhydramine hcl oral tablet</i>	Tier 1	AGE (Max 64 Years)
PHARBECHLOR	Tier 1	
WAL-FINATE	Tier 1	
Phenothiazine Derivatives		
<i>promethazine oral</i>	Tier 1	AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	Tier 1	QL (4 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 50 mg</i>	Tier 1	QL (2 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
Piperazine Derivatives		
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	Tier 1	AGE (Max 12 Years)
<i>hydroxyzine hcl oral tablet</i>	Tier 2	
<i>hydroxyzine pamoate</i>	Tier 2	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	Tier 1	

Drug	Status	Notes
<i>meclizine oral tablet, chewable</i>	Tier 1	
VISTARIL ORAL CAPSULE 25 MG	Tier 3	PA
Propylamine Derivatives		
ALLER-CHLOR	Tier 1	
ALLERGY (CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(CHLORPHENIRAMINE)	Tier 1	
ALLERGY-TIME	Tier 1	
<i>chlorpheniramine maleate oral tablet</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet extended release</i>	Tier 1	
CHLORTABS	Tier 1	
PHARBECHLOR	Tier 1	
WAL-FINATE	Tier 1	
Second Generation Antihistamines		
24HR ALLERGY RELIEF	Tier 2	
ALL DAY ALLERGY (CETIRIZINE) ORAL SOLUTION	Tier 2	
ALL DAY ALLERGY (CETIRIZINE) ORAL TABLET	Tier 2	
ALLER-EASE ORAL TABLET 180 MG	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ALLERGY RELIEF (CETIRIZINE) ORAL CAPSULE	Tier 3	PA
ALLERGY RELIEF (CETIRIZINE) ORAL TABLET 10 MG	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL SOLUTION	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET, DISINTEGRATING 10 MG	Tier 2	
<i>cetirizine oral solution 1 mg/ml</i>	Tier 2	
<i>cetirizine oral solution 5 mg/5 ml</i>	Tier 3	PA
<i>cetirizine oral tablet</i>	Tier 2	
<i>cetirizine oral tablet, chewable</i>	Tier 3	PA
CHILD ALLERGY RELIEF (CETIRIZINE)	Tier 2	
CHILDREN'S ALLERGY RELIEF (FEX)	Tier 2	
CHILDREN'S ALLERGY RELIEF (LOR) ORAL SOLUTION	Tier 2	
CHILDREN'S ALLERGY (CETIRIZINE)	Tier 2	

Drug	Status	Notes
CHILDREN'S CETIRIZINE ORAL SOLUTION	Tier 2	
CHILDREN'S CETIRIZINE ORAL TABLET, CHEWABLE	Tier 3	PA
CHILDREN'S LORATADINE	Tier 2	
CHILD'S ALL DAY ALLERGY (CETIR)	Tier 2	
CLARINEX ORAL TABLET	Tier 3	PA
<i>desloratadine oral tablet</i>	Tier 3	PA
<i>desloratadine oral tablet, disintegrating 2.5 mg</i>	Tier 3	PA; AGE (Max 11 Years)
<i>desloratadine oral tablet, disintegrating 5 mg</i>	Tier 3	PA
<i>fexofenadine</i>	Tier 2	
<i>levocetirizine oral solution</i>	Tier 3	PA
<i>levocetirizine oral tablet</i>	Tier 2	
<i>loratadine oral solution</i>	Tier 2	
<i>loratadine oral tablet</i>	Tier 2	
Anti-Infective Agents		
1st Generation Cephalosporin Antibiotics		
<i>cefadroxil oral capsule</i>	Tier 2	QL (28 capsules per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	Tier 2	
<i>cefadroxil oral tablet</i>	Tier 3	PA; QL (28 tablets per 1 fill)
<i>cephalexin</i>	Tier 2	
2Nd Generation Cephalosporin Antibiotics		
<i>cefaclor oral capsule</i>	Tier 3	PA; QL (42 capsules per 1 fill)
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	Tier 3	PA
<i>cefaclor oral tablet extended release 12 hr</i>	Tier 3	PA; QL (42 tablets per 1 fill)
<i>cefprozil oral suspension for reconstitution</i>	Tier 2	
<i>cefprozil oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
<i>cefuroxime axetil oral tablet</i>	Tier 2	QL (42 tablets per 1 fill)
3Rd Generation Cephalosporin Antibiotics		
<i>cefdinir oral capsule</i>	Tier 2	QL (28 capsules per 1 fill)

Drug	Status	Notes
<i>cefdinir oral suspension for reconstitution</i>	Tier 2	
<i>cefixime oral capsule</i>	Tier 2	
<i>cefixime oral suspension for reconstitution</i>	Tier 3	PA
<i>cefpodoxime oral suspension for reconstitution</i>	Tier 3	PA
<i>cefpodoxime oral tablet</i>	Tier 3	PA; QL (28 tablets per 1 fill)
Adamantane Antivirals		
<i>amantadine hcl oral capsule</i>	Tier 2	
<i>amantadine hcl oral solution</i>	Tier 2	
<i>amantadine hcl oral tablet</i>	Tier 3	PA
FLUMADINE ORAL TABLET	Tier 3	PA
GOCOVRI	Tier 3	PA
OSMOLEX ER	Tier 3	PA
<i>rimantadine</i>	Tier 2	
Allylamine Antifungals		
<i>terbinafine hcl oral</i>	Tier 2	QL (84 tablets per 1 fill)
Amebicides		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
FLAGYL ORAL CAPSULE	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>metronidazole oral capsule</i>	Tier 3	PA
<i>metronidazole oral tablet</i>	Tier 2	
<i>paromomycin</i>	Tier 1	
PYLERA	Tier 2	
Aminoglycoside Antibiotics		
BETHKIS	Tier 2	
KITABIS PAK	Tier 2	
<i>neomycin</i>	Tier 2	
<i>paromomycin</i>	Tier 1	
TOBI	Tier 3	PA
TOBI PODHALER	Tier 2	
<i>tobramycin in 0.225 % nacl</i>	Tier 2	
<i>tobramycin inhalation</i>	Tier 3	PA
<i>tobramycin with nebulizer</i>	Tier 3	PA
Aminopenicillin Antibiotics		
<i>amoxicil-clarithromy-lansopraz</i>	Tier 3	PA; QL (224 capsules per 1 fill)
<i>amoxicillin oral capsule</i>	Tier 1	
<i>amoxicillin oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin oral tablet</i>	Tier 1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	Tier 1	

Drug	Status	Notes
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	Tier 1	
<i>ampicillin oral capsule 500 mg</i>	Tier 1	
OMECLAMOX-PAK	Tier 3	PA
TALICIA	Tier 3	PA
Anthelmintics		
<i>ivermectin oral</i>	Tier 1	QL (10 tablet per 30 days)
REESE'S PINWORM MEDICINE	Tier 1	
Antifungals, Miscellaneous		
BREXAFEMME	Tier 3	PA; QL (4 tablets per 1 fill)
<i>griseofulvin microsize oral suspension</i>	Tier 2	
<i>griseofulvin microsize oral tablet</i>	Tier 3	PA
<i>griseofulvin ultramicrosize</i>	Tier 3	PA
Antimalarials		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
<i>chloroquine phosphate</i>	Tier 1	QL (1 tablet per 1 day)
<i>hydroxychloroquine</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
KRINTAFEL	Tier 1	PA; QL (2 tablets per 1 year); AGE (Min 16 Years)
<i>mefloquine</i>	Tier 1	PA; QL (5 tablets per 30 dayss)
<i>primaquine</i>	Tier 1	
PYLERA	Tier 2	
<i>pyrimethamine</i>	Tier 1	PA; QL (3 tablets per 1 day)
<i>quinidine sulfate oral tablet</i>	Tier 1	
Antimycobacterials, Miscellaneous		
<i>dapsone oral</i>	Tier 1	
Antiprotozoals, Miscellaneous		
<i>atovaquone</i>	Tier 1	
<i>benznidazole</i>	Tier 1	PA
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
<i>dapsone oral</i>	Tier 1	
FLAGYL ORAL CAPSULE	Tier 3	PA
<i>metronidazole oral capsule</i>	Tier 3	PA
<i>metronidazole oral tablet</i>	Tier 2	
<i>nitazoxanide</i>	Tier 3	PA; QL (6 tablets per 30 days)
PYLERA	Tier 2	

Drug	Status	Notes
<i>tinidazole</i>	Tier 2	
Antituberculosis Agents		
CIPRO ORAL SUSPENSION, MICR OCAPSULE RECON	Tier 2	
CIPRO ORAL TABLET 250 MG, 500 MG	Tier 3	PA; QL (42 tablets per 1 fill)
<i>ciprofloxacin</i>	Tier 2	
<i>ciprofloxacin hcl oral</i>	Tier 2	QL (42 tablets per 1 fill)
<i>clarithromycin oral suspension for reconstitution</i>	Tier 2	
<i>clarithromycin oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
<i>clarithromycin oral tablet extended release 24 hr</i>	Tier 3	PA
<i>cycloserine</i>	Tier 1	QL (4 capsules per 1 day)
<i>ethambutol</i>	Tier 1	
<i>isoniazid oral solution</i>	Tier 1	AGE (Max 12 Years)
<i>isoniazid oral tablet</i>	Tier 1	
<i>levofloxacin oral solution</i>	Tier 2	
<i>levofloxacin oral tablet 250 mg, 500 mg</i>	Tier 2	QL (14 tablets per 1 fill)
<i>levofloxacin oral tablet 750 mg</i>	Tier 2	QL (28 tablets per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>moxifloxacin oral</i>	Tier 3	PA; QL (14 tablets per 1 fill)
<i>pretomanid</i>	Tier 1	PA
PRIFTIN	Tier 1	QL (24 tablets per 28 dayss)
<i>pyrazinamide</i>	Tier 1	
<i>rifabutin</i>	Tier 1	
<i>rifampin oral</i>	Tier 1	
SIRTURO	Tier 1	PA
TRECTOR	Tier 1	
Antivirals, Miscellaneous		
LIVTENCITY	Tier 1	PA
PAXLOVID	Tier 1	
XOFLUZA ORAL TABLET 20 MG, 40 MG	Tier 2	
XOFLUZA ORAL TABLET 80 MG	Tier 1	
Azole Antifungals		
CRESEMBA ORAL CAPSULE 186 MG	Tier 3	PA
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA
DIFLUCAN ORAL TABLET 100 MG, 200 MG	Tier 3	PA
<i>fluconazole oral suspension for reconstitution</i>	Tier 2	
<i>fluconazole oral tablet 100 mg, 200 mg, 50 mg</i>	Tier 2	

Drug	Status	Notes
<i>fluconazole oral tablet 150 mg</i>	Tier 2	QL (2 tablets per 1 fill)
<i>itraconazole oral capsule</i>	Tier 3	PA; QL (100 EA per 30 days)
<i>itraconazole oral solution</i>	Tier 3	PA; QL (840 ML per 1 fill)
<i>ketoconazole oral</i>	Tier 2	
NOXAFIL ORAL	Tier 3	PA
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
SPORANOX ORAL CAPSULE	Tier 3	PA; QL (4 capsules per 1 day)
SPORANOX ORAL SOLUTION	Tier 3	PA; QL (840 ML per 1 fill)
TOLSURA	Tier 3	PA
VFEND	Tier 3	PA
<i>voriconazole oral</i>	Tier 3	PA
Erythromycin Antibiotics		
E.E.S. 400 ORAL TABLET	Tier 3	PA
E.E.S. GRANULES	Tier 3	PA
ERYPED 200	Tier 3	PA
ERYPED 400	Tier 3	PA
ERY-TAB	Tier 3	PA
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	Tier 3	PA
<i>erythromycin ethylsuccinate oral tablet</i>	Tier 2	
<i>erythromycin oral</i>	Tier 3	PA
Glycopeptide Antibiotics		
FIRVANQ	Tier 2	
VANCOGIN	Tier 3	PA
<i>vancomycin intravenous recon soln 10 gram, 5 gram, 750 mg</i>	Tier 1	
<i>vancomycin oral capsule</i>	Tier 2	
<i>vancomycin oral recon soln</i>	Tier 3	PA
Hiv Nucleoside, Nucleotide Rt Inhibitors		
<i>lamivudine oral tablet 100 mg</i>	Tier 1	QL (1 tablet per 1 day)
Hiv Protease Inhibitor Antiretrovirals		
PAXLOVID	Tier 1	

Drug	Status	Notes
Lincomycin Antibiotics		
<i>clindamycin hcl</i>	Tier 1	
CLINDAMYCIN PEDIATRIC	Tier 1	AGE (Max 12 Years)
Monobactam Antibiotics		
CAYSTON	Tier 2	
Monoclonal Antibody Antivirals		
BEYFORTUS	Tier 1	PA
SYNAGIS	Tier 1	PA; QL (5 doses per 365 days)
Natural Penicillin Antibiotics		
<i>penicillin v potassium</i>	Tier 1	
Neuraminidase Inhibitor Antivirals		
<i>oseltamivir oral capsule</i>	Tier 2	QL (14 capsules per 1 Fill)
<i>oseltamivir oral suspension for reconstitution</i>	Tier 2	QL (120 ML per 1 fill)
RELENZA DISKHALER	Tier 2	QL (20 blisters per 1 fill)
TAMIFLU ORAL CAPSULE	Tier 3	PA; QL (14 capsules per 1 fill)
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA; QL (120 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Nucleoside And Nucleotide Antivirals		
<i>acyclovir oral</i>	Tier 2	
<i>adefovir</i>	Tier 1	QL (1 tablet per 1 day)
<i>entecavir</i>	Tier 1	QL (1 tablet per 1 day)
<i>famciclovir</i>	Tier 2	
LAGEVRIO (EUA)	Tier 1	
<i>valacyclovir</i>	Tier 2	
<i>valganciclovir oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
VALTREX	Tier 3	PA
VEMLIDY	Tier 1	PA; QL (30 tablets per 30 days); AGE (Min 12 Years)
ZOVIRAX ORAL SUSPENSION	Tier 3	PA
Other Macrolide Antibiotics		
<i>amoxicil-clarithromy-lansopraz</i>	Tier 3	PA; QL (224 capsules per 1 fill)
<i>azithromycin oral packet</i>	Tier 2	QL (2 packets per 1 fill)
<i>azithromycin oral suspension for reconstitution</i>	Tier 2	
<i>azithromycin oral tablet 250 mg</i>	Tier 2	
<i>azithromycin oral tablet 500 mg</i>	Tier 2	QL (3 tablets per 1 fill)

Drug	Status	Notes
<i>azithromycin oral tablet 600 mg</i>	Tier 2	QL (12 tablets per 1 fill)
<i>clarithromycin oral suspension for reconstitution</i>	Tier 2	
<i>clarithromycin oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
<i>clarithromycin oral tablet extended release 24 hr</i>	Tier 3	PA
DIFICID	Tier 2	
OMECLAMOX-PAK	Tier 3	PA
ZITHROMAX ORAL PACKET	Tier 3	PA; QL (2 packets per 1 fill)
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA
ZITHROMAX ORAL TABLET 250 MG	Tier 3	PA
ZITHROMAX ORAL TABLET 500 MG	Tier 3	PA; QL (3 tablets per 1 fill)
ZITHROMAX TRI-PAK	Tier 3	PA; QL (3 tablets per 1 fill)
ZITHROMAX Z-PAK	Tier 3	PA
Other Misc. Antibacterial Agents		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
PYLERA	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Oxazolidinone Antibiotics		
<i>linezolid oral suspension for reconstitution</i>	Tier 3	PA
<i>linezolid oral tablet</i>	Tier 2	QL (28 tablets per 1 fill)
SIVEXTRO ORAL	Tier 3	PA; QL (14 tablets per 1 fill)
ZYVOX ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA
ZYVOX ORAL TABLET	Tier 3	PA; QL (28 tablets per 1 fill)
Penicillinase-Resistant Penicillins		
<i>dicloxacillin</i>	Tier 1	
Polyene Antifungals		
<i>nystatin oral</i>	Tier 2	
Pyrimidine Antifungals		
ANCOBON	Tier 3	PA
<i>flucytosine</i>	Tier 3	PA
Quinolone Antibiotics		
BAXDELA ORAL	Tier 3	PA
CIPRO ORAL SUSPENSION, MICR OCAPSULE RECON	Tier 2	
CIPRO ORAL TABLET 250 MG, 500 MG	Tier 3	PA; QL (42 tablets per 1 fill)
<i>ciprofloxacin</i>	Tier 2	

Drug	Status	Notes
<i>ciprofloxacin hcl oral</i>	Tier 2	QL (42 tablets per 1 fill)
<i>levofloxacin oral solution</i>	Tier 2	
<i>levofloxacin oral tablet 250 mg, 500 mg</i>	Tier 2	QL (14 tablets per 1 fill)
<i>levofloxacin oral tablet 750 mg</i>	Tier 2	QL (28 tablets per 1 fill)
<i>moxifloxacin oral</i>	Tier 3	PA; QL (14 tablets per 1 fill)
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	Tier 3	PA
Rifamycin Antibiotics		
AEMCOLO	Tier 3	PA; QL (12 tablets per 3 days); AGE (Min 18 Years)
PRIFTIN	Tier 1	QL (24 tablets per 28 days)
<i>rifabutin</i>	Tier 1	
<i>rifampin oral</i>	Tier 1	
TALICIA	Tier 3	PA
XIFAXAN ORAL TABLET 200 MG	Tier 3	PA; QL (9 tablets per 1 fill); AGE (Min 12 Years)
XIFAXAN ORAL TABLET 550 MG	Tier 3	PA; AGE (Min 18 Years)
Sulfonamide Antibiotics (Systemic)		
AZULFIDINE	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
AZULFIDINE EN-TABS	Tier 3	PA
<i>sulfamethoxazole-trimethoprim oral</i>	Tier 1	
<i>sulfasalazine</i>	Tier 2	
SULFATRIM	Tier 1	
Tetracycline Antibiotics		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
<i>doxycycline hyclate oral capsule</i>	Tier 1	
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier 1	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	Tier 1	
<i>minocycline oral capsule</i>	Tier 1	
PYLERA	Tier 2	
Urinary Anti-Infectives		
<i>methenamine hippurate</i>	Tier 1	
<i>methenamine mandelate</i>	Tier 1	

Drug	Status	Notes
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	Tier 1	QL (2 capsules per 1 day); AGE (Max 64 Years)
<i>nitrofurantoin monohyd/m-cryst</i>	Tier 1	QL (2 capsules per 1 day); AGE (Max 64 Years)
<i>trimethoprim</i>	Tier 1	
Antineoplastic Agents		
Antineoplastic Agents		
<i>abiraterone</i>	Tier 1	
AFINITOR DISPERZ	Tier 1	
AKEEGA	Tier 1	
ALIMTA	Tier 1	
ALKERAN	Tier 1	
<i>anastrozole</i>	Tier 1	
BESREMI	Tier 1	
<i>bexarotene</i>	Tier 1	
<i>bicalutamide</i>	Tier 1	
BLINCYTO INTRAVENOUS KIT	Tier 1	
BRAFTOVI	Tier 1	
CAMCEVI (6 MONTH)	Tier 1	
<i>capecitabine</i>	Tier 1	
<i>cyclophosphamide oral capsule</i>	Tier 1	
DAURISMO	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>diclofenac sodium topical gel 3 %</i>	Tier 1	
DROXIA	Tier 1	
EMCYT	Tier 1	
ERIVEDGE	Tier 1	
ERLEADA ORAL TABLET 60 MG	Tier 1	
<i>etoposide oral</i>	Tier 1	
<i>everolimus (antineoplastic) oral tablet</i>	Tier 1	
<i>exemestane</i>	Tier 1	
<i>fluorouracil topical cream</i>	Tier 1	
HYCAMTIN ORAL	Tier 1	
<i>hydroxyurea</i>	Tier 1	
IDHIFA	Tier 1	
INQOVI	Tier 1	
JAKAFI	Tier 1	
JYLAMVO	Tier 1	
KISQALI FEMARA CO-PACK	Tier 1	
KRAZATI	Tier 1	
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	Tier 1	
<i>letrozole</i>	Tier 1	
LEUKERAN	Tier 1	
<i>leuprolide (3 month)</i>	Tier 1	
<i>leuprolide subcutaneous kit</i>	Tier 1	
LONSURF	Tier 1	
LOQTORZI	Tier 1	

Drug	Status	Notes
LUMAKRAS ORAL TABLET 120 MG	Tier 1	
LYSODREN	Tier 1	
MATULANE	Tier 1	
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)</i>	Tier 2	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	Tier 3	PA
<i>megestrol oral tablet</i>	Tier 1	
<i>melfalan</i>	Tier 1	
<i>mercaptopurine</i>	Tier 1	
<i>methotrexate sodium</i>	Tier 1	
<i>methotrexate sodium (pf) injection solution</i>	Tier 1	
MYLERAN	Tier 1	
<i>nelarabine</i>	Tier 1	
<i>nilutamide</i>	Tier 1	
NUBEQA	Tier 1	
ODOMZO	Tier 1	
ONUREG	Tier 1	
ORGOVYX	Tier 1	
ORSERDU	Tier 1	
<i>pemetrexed disodium intravenous recon soln 100 mg, 500 mg</i>	Tier 1	
POMALYST	Tier 1	
REZLIDHIA	Tier 1	
RIABNI	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
SIKLOS	Tier 1	PA; AGE (Min 2 Years)
TABLOID	Tier 1	
<i>tamoxifen</i>	Tier 1	
TARGRETIN TOPICAL	Tier 1	
TAZVERIK	Tier 1	
<i>temozolomide</i>	Tier 1	
TIBSOVO	Tier 1	
<i>toremifene</i>	Tier 1	
<i>tretinoin (antineoplastic)</i>	Tier 1	
VENCLEXTA	Tier 1	
VENCLEXTA STARTING PACK	Tier 1	
XATMEP	Tier 1	
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)	Tier 1	
XTANDI	Tier 1	
ZOLINZA	Tier 1	
ZYTIGA ORAL TABLET 500 MG	Tier 1	

Drug	Status	Notes
Antitoxins, Immune Glob, Toxoids, Vaccines		
Allergenic Extracts (Therapeutic)		
PALFORZIA (LEVEL 1)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 2)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 3)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 4)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 5)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 6)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 7)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 8)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PALFORZIA (LEVEL 9)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 10)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA (LEVEL 11 UP-DOSE)	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA INITIAL DOSE	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
PALFORZIA LEVEL 11 MAINTENANCE	Tier 1	PA; AGE (Min 4 Years and Max 17 Years)
Toxoids		
ADACEL(TDAP ADOLESN/ADULT)(P F) INTRAMUSCULAR SYRINGE	Tier 1	QL (1 fill per 5 years); AGE (Min 10 Years and Max 64 Years)
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	Tier 1	QL (1 fill per 5 years); AGE (Min 10 Years)
TDVAX	Tier 1	
TENIVAC (PF)	Tier 1	
Vaccines		
AFLURIA QD 2023-24(3YR UP)(PF)	Tier 1	
AFLURIA QUAD 2023-2024(6MO UP)	Tier 1	

Drug	Status	Notes
BEXSERO	Tier 1	
ENGERIX-B (PF)	Tier 1	
ENGERIX-B PEDIATRIC (PF)	Tier 1	
FLUAD QUAD 2023-24(65Y UP)(PF)	Tier 1	
FLUARIX QUAD 2023-2024 (PF)	Tier 1	
FLUBLOK QUAD 2023-2024 (PF)	Tier 1	
FLUCELVAX QUAD 2023-2024	Tier 1	
FLUCELVAX QUAD 2023-2024 (PF)	Tier 1	
FLULAVAL QUAD 2023-2024 (PF)	Tier 1	
FLUMIST QUAD 2023-2024	Tier 1	
FLUZONE HIGHDOSE QUAD 23-24 PF	Tier 1	
FLUZONE QUAD 2023-2024	Tier 1	
FLUZONE QUAD 2023-2024 (PF)	Tier 1	
GARDASIL 9 (PF)	Tier 1	
HAVRIX (PF)	Tier 1	QL (2 syringes per 1 lifetime); AGE (Min 19 Years)
MENVEO A-C-Y-W-135-DIP (PF)	Tier 1	
M-M-R II (PF)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
MODERNA COVID 23-24(6M-11Y)PF	Tier 1	
PNEUMOVAX-23	Tier 1	
PREHEVBRIO (PF)	Tier 1	
PREVNAR 13 (PF)	Tier 1	
PREVNAR 20 (PF)	Tier 1	
RECOMBIVAX HB (PF)	Tier 1	
SHINGRIX (PF)	Tier 1	AGE (Min 50 Years)
SPIKEVAX 2023-2024(12Y UP)(PF)	Tier 1	
TRUMENBA	Tier 1	
TWINRIX (PF)	Tier 1	
VAQTA (PF) INTRAMUSCULAR SUSPENSION	Tier 1	QL (2 ML per 1 lifetime); AGE (Min 19 Years)
VAQTA (PF) INTRAMUSCULAR SYRINGE	Tier 1	QL (2 syringes per 1 lifetime); AGE (Min 19 Years)
VARIVAX (PF)	Tier 1	
VAXNEUVANCE (PF)	Tier 1	
Autonomic Drugs		
Alpha- And Beta-Adrenergic Agonists		
AUVI-Q	Tier 3	PA; QL (4 injectors per 1 Fill)
<i>epinephrine injection auto-injector 0.15 mg/0.15 ml</i>	Tier 3	PA; QL (4 injectors per 1 fill)

Drug	Status	Notes
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	Tier 2	QL (4 injectors per 1 fill)
EPIPEN	Tier 2	QL (4 injectors per 1 fill)
EPIPEN 2-PAK	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR 2-PAK	Tier 2	QL (4 injectors per 1 fill)
SYMJEPI	Tier 3	PA
Alpha-Adrenergic Agonists		
<i>clonidine</i>	Tier 2	QL (4 patches per 28 days)
<i>clonidine hcl oral tablet</i>	Tier 2	
<i>clonidine hcl oral tablet extended release 24 hr</i>	Tier 2	
LUCEMYRA	Tier 1	QL (224 EA per 14 days)
<i>methyldopa</i>	Tier 2	
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA
<i>midodrine</i>	Tier 1	QL (3 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Antimuscarinics/Antispasmodics		
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
ATROVENT HFA	Tier 2	QL (2 inhalers per 30 days)
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)
<i>dicyclomine oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>dicyclomine oral solution</i>	Tier 1	AGE (Max 64 Years)
<i>dicyclomine oral tablet</i>	Tier 1	AGE (Max 64 Years)
<i>diphenoxylate-atropine</i>	Tier 2	
DUAKLIR PRESSAIR	Tier 3	PA
<i>glycopyrrolate oral solution</i>	Tier 1	AGE (Max 12 Years)
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral</i>	Tier 1	AGE (Max 64 Years)
<i>hyoscyamine sulfate sublingual</i>	Tier 1	AGE (Max 64 Years)
INCRUSE ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>ipratropium bromide inhalation</i>	Tier 2	
<i>ipratropium-albuterol</i>	Tier 2	
SPIRIVA RESPIMAT	Tier 2	QL (1 inhaler per 30 days)

Drug	Status	Notes
SPIRIVA WITH HANDIHALER	Tier 2	QL (1 capsule per 1 day)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
<i>tiotropium bromide</i>	Tier 3	QL (1 capsule per 1 day)
TUDORZA PRESSAIR	Tier 3	PA
YUPELRI	Tier 3	PA
Autonomic Drugs, Miscellaneous		
TYRVAYA	Tier 3	QL (8.4 ML per 30 days)
Centrally Acting Skeletal Muscle Relaxant		
AMRIX	Tier 3	PA
<i>chlorzoxazone</i>	Tier 3	PA
<i>cyclobenzaprine oral capsule, extended release 24hr</i>	Tier 3	PA
<i>cyclobenzaprine oral tablet</i>	Tier 2	
FEXMID	Tier 3	PA
LORZONE	Tier 3	PA
<i>metaxalone</i>	Tier 3	PA
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	Tier 2	
<i>tizanidine oral capsule</i>	Tier 3	PA
<i>tizanidine oral tablet</i>	Tier 2	
ZANAFLEX	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Direct-Acting Skeletal Muscle Relaxants		
DANTRIUM ORAL CAPSULE 25 MG	Tier 3	PA
<i>dantrolene oral</i>	Tier 3	PA
Gaba-Derivative Skeletal Muscle Relaxant		
<i>baclofen oral solution 5 mg/5 ml</i>	Tier 3	
<i>baclofen oral suspension</i>	Tier 3	PA
<i>baclofen oral tablet</i>	Tier 2	
FLEQSUVY	Tier 3	PA
Indirect-Acting Skeletal Muscle Relaxant		
<i>orphenadrine citrate oral</i>	Tier 2	
Non-Sel. Beta-Adrenergic Blocking Agents		
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
BYSTOLIC	Tier 2	
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 3	PA
COREG	Tier 3	PA
COREG CR	Tier 2	
CORGARD	Tier 3	PA
HEMANGEOL	Tier 3	PA

Drug	Status	Notes
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
<i>nadolol</i>	Tier 3	PA
<i>nebivolol</i>	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
<i>timolol maleate oral</i>	Tier 3	PA
Non-Sel. Alpha-1-Adrenergic Blocking Agts		
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA
<i>doxazosin</i>	Tier 2	
MINIPRESS	Tier 3	PA
<i>prazosin</i>	Tier 2	
<i>terazosin</i>	Tier 2	
Parasympathomimetic (Cholinergic Agents)		
ARICEPT	Tier 3	PA
<i>bethanechol chloride</i>	Tier 1	QL (4 tablets per 1 day)
<i>donepezil oral tablet 10 mg, 5 mg</i>	Tier 2	
<i>donepezil oral tablet 23 mg</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>donepezil oral tablet, disintegrating</i>	Tier 2	
EXELON PATCH	Tier 2	
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	Tier 3	PA
<i>galantamine oral solution</i>	Tier 3	PA
<i>galantamine oral tablet</i>	Tier 2	
NAMZARIC	Tier 3	PA
<i>pilocarpine hcl oral</i>	Tier 1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	Tier 1	
<i>rivastigmine</i>	Tier 3	PA
<i>rivastigmine tartrate</i>	Tier 2	
Selective Alpha-1-Adrenergic Block.Agent		
<i>alfuzosin</i>	Tier 2	
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 3	PA
COREG	Tier 3	PA
COREG CR	Tier 2	
<i>dutasteride-tamsulosin</i>	Tier 3	PA
FLOMAX	Tier 3	PA
JALYN	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
RAPAFLO	Tier 3	PA
<i>silodosin</i>	Tier 3	PA
<i>tamsulosin</i>	Tier 2	

Drug	Status	Notes
Selective Beta-2-Adrenergic Agonists		
ADVAIR DISKUS	Tier 2	QL (3 Inhalers per 90 days)
ADVAIR HFA	Tier 2	QL (1 inhaler per 30 days)
AIRDUO DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler</i>	Tier 3	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation solution for nebulization</i>	Tier 2	
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>arformoterol</i>	Tier 3	PA
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	Tier 3	PA; QL (60 blisters per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 50-25 MCG/DOSE	Tier 3	PA; QL (60 EA per 30 days)
BROVANA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>budesonide-formoterol</i>	Tier 3	PA; QL (2 inhalers per 30 days)
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)
DUAKLIR PRESSAIR	Tier 3	PA
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	Tier 2	QL (3 inhalers per 90 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION	Tier 2	QL (3 Inhalers per 90 days)
<i>fluticasone furoate-vilanterol</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	Tier 3	PA; QL (1 inhaler per 30 dayss)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	Tier 3	PA; QL (60 blisters per 30 dayss)
<i>fluticasone propion-salmeterol inhalation hfa aerosol inhaler</i>	Tier 3	PA; QL (1 inhaler per 30 days)
<i>formoterol fumarate</i>	Tier 3	PA
<i>ipratropium-albuterol</i>	Tier 2	
<i>levalbuterol hcl</i>	Tier 3	PA
<i>levalbuterol tartrate</i>	Tier 3	PA; QL (2 inhalers per 30 days)

Drug	Status	Notes
PERFOROMIST	Tier 3	PA
PROAIR DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
PROAIR RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
PROVENTIL HFA	Tier 2	QL (2 inhalers per 30 days)
SEREVENT DISKUS	Tier 2	QL (1 inhaler per 30 days)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
STRIVERDI RESPIMAT	Tier 3	PA
SYMBICORT	Tier 2	QL (2 inhalers per 30 days)
<i>terbutaline oral</i>	Tier 1	
VENTOLIN HFA	Tier 2	QL (2 inhalers per 30 days)
WIXELA INHUB	Tier 3	PA; QL (60 blisters per 30 days)
XOPENEX HFA	Tier 2	QL (6 inhalers per 90 days)
Selective Beta-Adrenergic Blocking Agent		
<i>acebutolol</i>	Tier 3	PA
<i>atenolol</i>	Tier 2	
<i>atenolol-chlorthalidone</i>	Tier 2	
<i>betaxolol oral</i>	Tier 3	PA
<i>bisoprolol fumarate</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
KAPSPARGO SPRINKLE	Tier 3	PA
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
<i>metoprolol tartrate oral</i>	Tier 2	
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
TENORMIN	Tier 3	PA
TOPROL XL	Tier 3	PA
Skeletal Muscle Relaxants, Miscellaneous		
NORGESIC	Tier 3	PA
NORGESIC FORTE	Tier 3	PA
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	Tier 3	PA
Smoking Cessation Agents		
CHANTIX CONTINUING MONTH BOX	Tier 1	QL (2 tablets per 1 day)
<i>nicotine (polacrilex) buccal gum</i>	Tier 1	QL (306 pieces per 34 days)
<i>nicotine (polacrilex) buccal lozenge</i>	Tier 1	QL (306 lozenges per 34 days)

Drug	Status	Notes
<i>nicotine (polacrilex) buccal mini lozenge</i>	Tier 1	QL (306 lozenges per 34 days)
<i>nicotine transdermal patch 24 hour</i>	Tier 1	QL (1 patch per 1 day)
<i>nicotine transdermal patch, td daily, sequential</i>	Tier 1	QL (56 patches per 56 days)
NICOTROL	Tier 1	QL (168 cartridges per 30 days)
NICOTROL NS	Tier 1	QL (40 ML per 30 days)
<i>varenicline</i>	Tier 1	QL (2 tablets per 1 day)
Blood Formation, Coagulation, Thrombosis		
Anticoagulants, Miscellaneous		
ARIXTRA	Tier 3	PA
<i>fondaparinux</i>	Tier 3	PA
Blood Form.,Coag,Thrombosis Agents Misc.		
OXBRYTA ORAL TABLET 300 MG	Tier 1	PA; QL (90 tablets per 30 days); AGE (Min 4 Years)
OXBRYTA ORAL TABLET 500 MG	Tier 1	PA; QL (90 tablets per 30 days); AGE (Min 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
OXBRYTA ORAL TABLET FOR SUSPENSION	Tier 1	PA; QL (90 tablets per 30 days); AGE (Min 4 Years)
Coumarin Derivatives		
JANTOVEN	Tier 2	
<i>warfarin</i>	Tier 2	
Direct Factor Xa Inhibitors		
ELIQUIS DVT-PE TREAT 30D START	Tier 2	QL (74 tablets per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	Tier 2	QL (2 tablets per 1 day)
ELIQUIS ORAL TABLET 5 MG	Tier 2	QL (218 tablets per 102 days)
SAVAYSA	Tier 3	PA
XARELTO DVT-PE TREAT 30D START	Tier 2	QL (51 tablets per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	Tier 2	QL (20 ML per 1 day)
XARELTO ORAL TABLET 10 MG, 20 MG	Tier 2	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG	Tier 2	QL (102 tablets per 102 days)
XARELTO ORAL TABLET 2.5 MG	Tier 2	QL (2 tablets per 1 day)
Direct Thrombin Inhibitors		
<i>dabigatran etexilate oral capsule 150 mg, 75 mg</i>	Tier 3	PA; QL (2 capsules per 1 day)

Drug	Status	Notes
PRADAXA ORAL CAPSULE 110 MG	Tier 2	QL (4 capsules per 1 day)
PRADAXA ORAL CAPSULE 150 MG, 75 MG	Tier 2	QL (2 capsules per 1 day)
PRADAXA ORAL PELLETS IN PACKET	Tier 3	PA; AGE (Max 11 Years)
Hematopoietic Agents		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	Tier 2	PA
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	Tier 2	PA
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	Tier 2	PA
FULPHILA	Tier 3	PA; QL (1 syringe per 14 days)
FYLNETRA	Tier 3	PA; QL (0.6 ML per 14 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
GRANIX	Tier 3	PA
LEUKINE INJECTION RECON SOLN	Tier 3	PA
NEULASTA	Tier 3	PA; QL (1 syringe per 14 days)
NEULASTA ONPRO	Tier 3	PA; QL (1 syringe per 14 days)
NEUPOGEN	Tier 2	
NIVESTYM	Tier 3	PA
NYVEPRIA	Tier 2	QL (0.6 ML per 14 days)
PROCRIT	Tier 3	PA
RELEUKO SUBCUTANEOUS	Tier 3	PA
RETACRIT	Tier 2	PA
STIMUFEND	Tier 3	PA; QL (0.6 ML per 14 days)
UDENYCA	Tier 3	PA; QL (1 syringe per 14 days)
UDENYCA AUTOINJECTOR	Tier 3	PA
ZARXIO	Tier 3	PA; QL (45 ML per 30 days)
ZIEXTENZO	Tier 3	PA; QL (1 syringe per 14 days)
Hemorrhologic Agents		
<i>pentoxifylline</i>	Tier 1	

Drug	Status	Notes
Hemostatics		
<i>desmopressin nasal spray, non-aerosol 10 mcg/spray (0.1 ml)</i>	Tier 1	PA
<i>desmopressin oral</i>	Tier 1	QL (6 tablets per 1 day)
Heparins		
<i>enoxaparin</i>	Tier 2	
FRAGMIN SUBCUTANEOUS SOLUTION 2,500 ANTI-XA UNIT/ML	Tier 3	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	Tier 3	PA
FRAGMIN SUBCUTANEOUS SYRINGE	Tier 3	PA
<i>heparin (porcine) injection solution 10,000 unit/ml, 5,000 unit/ml</i>	Tier 1	
LOVENOX	Tier 3	PA
Iron Preparations		
A THRU Z ADVANCED FORMULA	Tier 1	
A THRU Z MEN'S ULTIMATE	Tier 1	
A THRU Z SELECT WOMEN'S	Tier 1	
BACMIN	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
CENTRAL-VITE WOMEN'S MATURE	Tier 1	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM COMPLETE	Tier 1	
CENTRUM MEN	Tier 1	
CENTRUM SILVER WOMEN	Tier 1	
CENTRUM ULTRA MEN'S	Tier 1	
CENTURY	Tier 1	
CERTA PLUS	Tier 1	
CERTAVITE-ANTIOXIDANT	Tier 1	
CLASSIC PRENATAL	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
COMPLETE MULTIVITAMIN-MINERAL ORAL TABLET	Tier 1	
COMPLETENATE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
DAILY MULTIPLE FOR WOMEN	Tier 1	

Drug	Status	Notes
DAILY MULTIVITAMIN WITH IRON	Tier 1	
DAILY VITAMIN FORMULA-IRON	Tier 1	
DAILY VITAMIN WITH IRON	Tier 1	
DAILY VITES/IRON	Tier 1	
ESSENTIA	Tier 1	
FE C PLUS	Tier 1	AGE (Max 12 Years)
FEOSOL ORAL TABLET 325 MG (65 MG IRON)	Tier 1	
FERATE	Tier 1	
FERGON ORAL TABLET 240 MG (27 MG IRON)	Tier 1	
FEROSUL	Tier 1	
FERRO-TIME	Tier 1	
<i>ferrous gluconate oral tablet 236 mg (27 mg iron), 240 mg (27 mg iron), 324 mg (37.5 mg iron), 324 mg (38 mg iron)</i>	Tier 1	
<i>ferrous sulfate oral drops</i>	Tier 1	AGE (Max 12 Years)
<i>ferrous sulfate oral liquid</i>	Tier 1	AGE (Max 12 Years)
<i>ferrous sulfate oral solution</i>	Tier 1	AGE (Max 12 Years)
<i>ferrous sulfate oral tablet</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>ferrous sulfate oral tablet, delayed release (dr/ec)</i>	Tier 1	
FORTAVIT	Tier 1	
FREEDAVITE	Tier 1	
HAIR, SKIN AND NAILS-ARGAN OIL	Tier 1	
HAIR, SKIN AND NAILS ORAL TABLET 1 MG IRON-66.7 MCG-1,000 MCG	Tier 1	
IRON (FERROUS SULFATE)	Tier 1	
IRON 100 PLUS	Tier 1	AGE (Max 12 Years)
IRON ORAL TABLET 325 MG (65 MG IRON)	Tier 1	
IRON ORAL TABLET EXTENDED RELEASE	Tier 1	
K-PAX IMMUNE SUPPORT	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MONOCAPS	Tier 1	
MULTI COMPLETE WITH IRON	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MULTI-DAY WITH IRON	Tier 1	

Drug	Status	Notes
MULTI-VIT WITH FLUORIDE-IRON	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
<i>multivitamin with iron</i>	Tier 1	
<i>multivit-min-iron fumaric ac</i>	Tier 1	
NANO VM 1-3	Tier 1	
NANO VM 4-8	Tier 1	
NANOVM 9-18	Tier 1	
NANOVM T-F	Tier 1	
NEPHRON FA	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
ONE DAILY CALCIUM/IRON	Tier 1	
ONE DAILY COMPLETE ORAL TABLET 18-0.4 MG	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ONE DAILY FOR WOMEN	Tier 1	
ONE DAILY HEALTHY WEIGHT	Tier 1	
ONE DAILY MAXIMUM	Tier 1	
ONE DAILY MULTI-VIT W-MINERAL ORAL TABLET	Tier 1	
ONE DAILY MULTIVIT-IRON(FOLIC)	Tier 1	
ONE DAILY PLUS IRON	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	
ONE-A-DAY ENERGY	Tier 1	
ONE-A-DAY TEEN ADVANTAGE	Tier 1	
ONE-A-DAY WEIGHTSMART	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	
OPURITY MULTIVITAMIN	Tier 1	
PARVLEX	Tier 1	

Drug	Status	Notes
<i>pnv cmb#95-ferrous fumarate-fa</i>	Tier 1	QL (1 tablet per 1 day)
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL FORMULA ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTI-DHA(WITH VIT K)	Tier 1	AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTIVITAMINS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PROCERV HP	Tier 1	
PRORENAL	Tier 1	
PRORENAL QD	Tier 1	
QUINTABS-M	Tier 1	
SE-NATAL-19	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
SENTRY	Tier 1	
SIDEROL	Tier 1	

Drug	Status	Notes
SLOW RELEASE IRON ORAL TABLET EXTENDED RELEASE 142 MG (45 MG IRON), 160 MG (50 MG IRON), 250 MG (50 MG IRON)	Tier 1	
SPECTRAVITE ADVANCED FORMULA	Tier 1	
SPECTRAVITE MEN'S	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
SUNVITE	Tier 1	
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 15 MG IRON- 400 MCG	Tier 1	
THERA-M ORAL TABLET 27-0.4 MG	Tier 1	
THERANATAL ORAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
THERAPEUTIC-M	Tier 1	
THERATRUM COMPLETE WITH LUTEIN	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
TRICARE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
ULTRA FREEDA ORAL TABLET 6 MG IRON-267 MCG	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S DAILY FORMULA ORAL TABLET 27-0.4 MG	Tier 1	
WOMEN'S ONE DAILY	Tier 1	
YELETS	Tier 1	
Platelet-Aggregation Inhibitors		
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet,chewable</i>	Tier 1	QL (1 tablet per 1 day)

Drug	Status	Notes
<i>aspirin oral tablet,delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet,delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin,buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>aspirin-dipyridamole</i>	Tier 3	PA
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BRILINTA	Tier 2	
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
<i>cilostazol</i>	Tier 1	QL (2 tablets per 1 day)
<i>clopidogrel oral tablet 300 mg</i>	Tier 2	QL (2 tablets per 30 days)
<i>clopidogrel oral tablet 75 mg</i>	Tier 2	QL (1 tablet per 1 day)
<i>dipyridamole oral</i>	Tier 3	PA
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
EFFIENT	Tier 3	PA; AGE (Max 75 Years)
PLAVIX ORAL TABLET 75 MG	Tier 3	PA; QL (1 tablet per 1 day)
<i>prasugrel</i>	Tier 2	AGE (Max 75 Years)
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
YOSPRALA	Tier 3	PA
Platelet-Reducing Agents		
<i>anagrelide</i>	Tier 1	
Thrombolytic Agents		
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)

Drug	Status	Notes
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, chewable</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet, delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin, buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
YOSPRALA	Tier 3	PA
Cardiovascular Drugs		
Alpha-Adrenergic Blocking Agents		
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 3	PA
COREG	Tier 3	PA
COREG CR	Tier 2	
<i>doxazosin</i>	Tier 2	
<i>labetalol oral</i>	Tier 2	
MINIPRESS	Tier 3	PA
<i>prazosin</i>	Tier 2	
<i>terazosin</i>	Tier 2	
Alpha-Adrenergic Blocking Agt.(Hypoten)		
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA

Drug	Status	Notes
<i>doxazosin</i>	Tier 2	
<i>labetalol oral</i>	Tier 2	
MINIPRESS	Tier 3	PA
<i>prazosin</i>	Tier 2	
<i>terazosin</i>	Tier 2	
Angiotensin II Receptor Antagon.(Hypotn)		
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazid</i>	Tier 2	
ATACAND	Tier 3	PA
ATACAND HCT	Tier 3	PA
AVALIDE	Tier 3	PA
AVAPRO	Tier 3	PA
AZOR	Tier 3	PA
BENICAR	Tier 3	PA
BENICAR HCT	Tier 3	PA
<i>candesartan</i>	Tier 3	PA
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA
COZAAR	Tier 3	PA
DIOVAN	Tier 3	PA
DIOVAN HCT	Tier 3	PA
EDARBI	Tier 3	PA
EDARBYCLOR	Tier 3	PA
<i>eprosartan</i>	Tier 3	PA
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
HYZAAR	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>irbesartan</i>	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>losartan</i>	Tier 2	
<i>losartan-hydrochlorothiazide</i>	Tier 2	
MICARDIS	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan</i>	Tier 2	
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	
<i>telmisartan</i>	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<i>valsartan oral solution</i>	Tier 3	PA
<i>valsartan oral tablet</i>	Tier 2	
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
Angiotensin II Receptor Antagonists		
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazid</i>	Tier 2	
ATACAND	Tier 3	PA
ATACAND HCT	Tier 3	PA

Drug	Status	Notes
AVALIDE	Tier 3	PA
AVAPRO	Tier 3	PA
AZOR	Tier 3	PA
BENICAR	Tier 3	PA
BENICAR HCT	Tier 3	PA
<i>candesartan</i>	Tier 3	PA
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA
COZAAR	Tier 3	PA
DIOVAN	Tier 3	PA
DIOVAN HCT	Tier 3	PA
EDARBI	Tier 3	PA
EDARBYCLOR	Tier 3	PA
ENTRESTO	Tier 2	QL (60 tablets per 30 days)
<i>eprosartan</i>	Tier 3	PA
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
HYZAAR	Tier 3	PA
<i>irbesartan</i>	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>losartan</i>	Tier 2	
<i>losartan-hydrochlorothiazide</i>	Tier 2	
MICARDIS	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan</i>	Tier 2	
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>telmisartan</i>	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<i>valsartan oral solution</i>	Tier 3	PA
<i>valsartan oral tablet</i>	Tier 2	
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
Angiotensin-Convert.Enzyme Inhib(Hypotn)		
ACCUPRIL	Tier 3	PA
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
ALTACE	Tier 3	PA
<i>amlodipine-benazepril</i>	Tier 2	
<i>benazepril</i>	Tier 2	
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
<i>captopril</i>	Tier 3	PA
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
<i>enalapril maleate oral solution</i>	Tier 3	PA
<i>enalapril maleate oral tablet</i>	Tier 2	
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EPANED	Tier 3	PA
<i>fosinopril</i>	Tier 3	PA
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA

Drug	Status	Notes
<i>lisinopril</i>	Tier 2	
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	
LOTENSIN HCT	Tier 3	PA
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	PA
LOTREL	Tier 3	PA
<i>moexipril</i>	Tier 3	PA
<i>perindopril erbumine</i>	Tier 3	PA
QBRELIS	Tier 3	PA
<i>quinapril</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>ramipril</i>	Tier 2	
<i>trandolapril</i>	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
VASERETIC	Tier 3	PA
VASOTEC	Tier 3	PA
ZESTORETIC	Tier 3	PA
ZESTRIL	Tier 3	PA
Angiotensin-Converting Enzyme Inhibitors		
ACCUPRIL	Tier 3	PA
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
ALTACE	Tier 3	PA
<i>amlodipine-benazepril</i>	Tier 2	
<i>benazepril</i>	Tier 2	
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
<i>captopril</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
<i>enalapril maleate oral solution</i>	Tier 3	PA
<i>enalapril maleate oral tablet</i>	Tier 2	
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EPANED	Tier 3	PA
<i>fosinopril</i>	Tier 3	PA
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA
<i>lisinopril</i>	Tier 2	
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	
LOTENSIN HCT	Tier 3	PA
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	PA
LOTREL	Tier 3	PA
<i>moexipril</i>	Tier 3	PA
<i>perindopril erbumine</i>	Tier 3	PA
QBRELIS	Tier 3	PA
<i>quinapril</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>ramipril</i>	Tier 2	
<i>trandolapril</i>	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
VASERETIC	Tier 3	PA
VASOTEC	Tier 3	PA
ZESTORETIC	Tier 3	PA
ZESTRIL	Tier 3	PA

Drug	Status	Notes
Antiarrhythmics, Miscellaneous		
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	Tier 1	
<i>magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml</i>	Tier 1	
<i>magnesium sulfate in water</i>	Tier 1	
<i>magnesium sulfate injection</i>	Tier 1	
Antilipemic Agents, Miscellaneous		
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 250 MG	Tier 1	
FISH OIL ORAL CAPSULE 100-160-1,000 MG, 300-1,000 MG, 300-500 MG, 360-1,200 MG, 60-90-500 MG	Tier 1	
FISH OIL ORAL CAPSULE, DELAYED RELEASE (DR/EC) 300-1,000 MG, 360-1,200 MG	Tier 1	
<i>icosapent ethyl oral capsule 1 gram</i>	Tier 3	PA
LOVAZA	Tier 3	PA
NEXLETOL	Tier 3	PA; AGE (Min 18 Years)
NEXLIZET	Tier 3	PA; AGE (Min 18 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>niacin (inositol niacinate) oral capsule 400 mg niacin (500 mg), 500 mg</i>	Tier 1	
<i>niacin (inositol niacinate) oral tablet</i>	Tier 1	
NIACIN FLUSH FREE	Tier 1	
NIACIN NO FLUSH	Tier 1	
<i>niacin oral capsule, extended release 500 mg</i>	Tier 2	
<i>niacin oral tablet 100 mg, 500 mg</i>	Tier 2	
<i>niacin oral tablet 250 mg, 50 mg</i>	Tier 1	
<i>niacin oral tablet extended release 1,000 mg, 250 mg</i>	Tier 1	
<i>niacin oral tablet extended release 24 hr</i>	Tier 3	PA
<i>niacin oral tablet extended release 500 mg</i>	Tier 2	
<i>omega 3-dha-epa-fish oil oral capsule 1,000 mg (120 mg-180 mg), 1,200 (144-216) mg, 300-1,000 mg</i>	Tier 1	
<i>omega 3-dha-epa-fish oil oral capsule, delayed release(dr/ec) 300 mg (120 mg- 180mg)- 1,000 mg, 300-1,000 mg</i>	Tier 1	

Drug	Status	Notes
<i>omega-3 acid ethyl esters</i>	Tier 3	PA
<i>omega-3 fatty acids</i>	Tier 1	
<i>omega-3 fatty acids-fish oil oral capsule 300-1,000 mg, 360-1,200 mg</i>	Tier 1	
SLO-NIACIN ORAL TABLET EXTENDED RELEASE 250 MG, 750 MG	Tier 1	
SMART HEART OMEGA-3	Tier 1	
SUPER OMEGA-3	Tier 1	
VASCEPA	Tier 3	PA
Beta-Adrenergic Blocking Agents		
<i>acebutolol</i>	Tier 3	PA
<i>atenolol</i>	Tier 2	
<i>atenolol-chlorthalidone</i>	Tier 2	
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
<i>betaxolol oral</i>	Tier 3	PA
<i>bisoprolol fumarate</i>	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
BYSTOLIC	Tier 2	
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 3	PA
COREG	Tier 3	PA
COREG CR	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
CORGARD	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
KAPSPARGO SPRINKLE	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
<i>metoprolol tartrate oral</i>	Tier 2	
<i>nadolol</i>	Tier 3	PA
<i>nebivolol</i>	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
TENORMIN	Tier 3	PA
<i>timolol maleate oral</i>	Tier 3	PA
TOPROL XL	Tier 3	PA
Beta-Adrenergic Blocking Agt.(Hypoten)		
<i>acebutolol</i>	Tier 3	PA

Drug	Status	Notes
<i>atenolol</i>	Tier 2	
<i>atenolol-chlorthalidone</i>	Tier 2	
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
<i>betaxolol oral</i>	Tier 3	PA
<i>bisoprolol fumarate</i>	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
CORGARD	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
KAPSPARGO SPRINKLE	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
<i>metoprolol tartrate oral</i>	Tier 2	
<i>nadolol</i>	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
TENORMIN	Tier 3	PA
<i>timolol maleate oral</i>	Tier 3	PA
TOPROL XL	Tier 3	PA
Bile Acid Sequestrants		
<i>cholestyramine (with sugar)</i>	Tier 2	
CHOLESTYRAMINE LIGHT	Tier 2	
<i>cholestyramine-aspartame</i>	Tier 2	
<i>colesevelam</i>	Tier 3	PA
COLESTID	Tier 3	PA
COLESTID FLAVORED	Tier 3	PA
<i>colestipol oral granules</i>	Tier 3	PA
<i>colestipol oral packet</i>	Tier 3	PA
<i>colestipol oral tablet</i>	Tier 2	
PREVALITE	Tier 2	
QUESTRAN	Tier 3	PA
QUESTRAN LIGHT	Tier 3	PA
WELCHOL	Tier 3	PA
Calcium-Channel Block.Agt,Misc(Hypoten)		
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA

Drug	Status	Notes
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule,extended release 24 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule,extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 3	PA
DILT-XR	Tier 2	
MATZIM LA	Tier 3	PA
TAZTIA XT	Tier 2	
TIADYLT ER	Tier 3	PA
TIAZAC	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	
VERELAN PM	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Calcium-Channel Blocking Agents		
<i>amlodipine</i>	Tier 2	
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazyd</i>	Tier 2	
AZOR	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	

Drug	Status	Notes
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 3	PA
DILT-XR	Tier 2	
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
MATZIM LA	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazyd</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
TAZTIA XT	Tier 2	
<i>telmisartan-amlodipine</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
TIADYLT ER	Tier 3	PA
TIAZAC	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	
VERELAN PM	Tier 3	PA
Calcium-Channel Blocking Agents(Hypoten)		
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule,extended release 24 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule,extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	

Drug	Status	Notes
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 3	PA
DILT-XR	Tier 2	
MATZIM LA	Tier 3	PA
TAZTIA XT	Tier 2	
TIADYLT ER	Tier 3	PA
TIAZAC	Tier 3	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	
VERELAN PM	Tier 3	PA
Calcium-Channel Blocking Agents, Misc.		
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule,extended release 24 hr</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
<i>diltiazem hcl oral capsule, extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 3	PA
DILT-XR	Tier 2	
MATZIM LA	Tier 3	PA
TAZTIA XT	Tier 2	
TIADYL T ER	Tier 3	PA
TIAZAC	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule, ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	
VERELAN PM	Tier 3	PA
Carbonic Anhydrase Inhibitors(Hypoten)		
<i>acetazolamide oral capsule, extended release</i>	Tier 1	QL (2 capsules per 1 day)
<i>acetazolamide oral tablet</i>	Tier 1	QL (4 tablets per 1 day)

Drug	Status	Notes
Cardiac Drugs, Miscellaneous		
CORLANOR	Tier 1	PA
<i>ranolazine</i>	Tier 1	PA; QL (2 tablets per 1 day)
VYNDAMAX	Tier 1	PA; QL (1 capsule per 1 day); AGE (Min 18 Years)
VYNDAQEL	Tier 1	PA; QL (4 capsules per 1 day); AGE (Min 18 Years)
Cardiotonic Agents		
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	Tier 1	
Central Alpha-Agonists		
<i>clonidine</i>	Tier 2	QL (4 patches per 28 days)
<i>clonidine hcl oral tablet</i>	Tier 2	
<i>clonidine hcl oral tablet extended release 24 hr</i>	Tier 2	
<i>guanfacine oral tablet</i>	Tier 2	
<i>methyldopa</i>	Tier 2	
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Cholesterol Absorption Inhibitors		
<i>ezetimibe</i>	Tier 2	
<i>ezetimibe-simvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
NEXLIZET	Tier 3	PA; AGE (Min 18 Years)
VYTORIN 10-10	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-20	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-40	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-80	Tier 3	PA; QL (1 tablet per 1 day)
ZETIA	Tier 3	PA
Class Ia Antiarrhythmics		
<i>disopyramide phosphate oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>quinidine sulfate oral tablet</i>	Tier 1	
Class Ib Antiarrhythmics		
<i>mexiletine</i>	Tier 1	
Class Ic Antiarrhythmics		
<i>flecainide</i>	Tier 1	

Drug	Status	Notes
<i>propafenone oral tablet</i>	Tier 1	
Class II Antiarrhythmics		
<i>acebutolol</i>	Tier 3	PA
<i>atenolol</i>	Tier 2	
<i>atenolol-chlorthalidone</i>	Tier 2	
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
<i>betaxolol oral</i>	Tier 3	PA
<i>bisoprolol fumarate</i>	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 3	PA
COREG	Tier 3	PA
COREG CR	Tier 2	
CORGARD	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
KAPSPARGO SPRINKLE	Tier 3	PA
<i>labetalol oral</i>	Tier 2	
LOPRESSOR ORAL	Tier 3	PA
<i>metoprolol succinate</i>	Tier 2	
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>metoprolol tartrate oral</i>	Tier 2	
<i>nadolol</i>	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
TENORMIN	Tier 3	PA
<i>timolol maleate oral</i>	Tier 3	PA
TOPROL XL	Tier 3	PA
Class Iii Antiarrhythmics		
<i>amiodarone oral tablet 100 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>amiodarone oral tablet 200 mg, 400 mg</i>	Tier 1	
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
Class Iv Antiarrhythmics		
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA

Drug	Status	Notes
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 3	PA
DILT-XR	Tier 2	
MATZIM LA	Tier 3	PA
TAZTIA XT	Tier 2	
TIADYLT ER	Tier 3	PA
TIAZAC	Tier 3	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule, ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	
VERELAN PM	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Dihydropyridines		
<i>amlodipine</i>	Tier 2	
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazyd</i>	Tier 2	
AZOR	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA

Drug	Status	Notes
<i>olmesartan-amlodipin-hcthiazyd</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
Dihydropyridines (Antihypertensive)		
<i>amlodipine</i>	Tier 2	
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>amlodipine-valsartan-hcthiazyd</i>	Tier 2	
AZOR	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
EXFORGE	Tier 3	PA
EXFORGE HCT	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazyd</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
<i>telmisartan-amlodipine</i>	Tier 3	PA
TRIBENZOR	Tier 3	PA
Direct Vasodilators		
<i>hydralazine injection</i>	Tier 1	
<i>hydralazine oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	QL (4 tablets per 1 day)
<i>hydralazine oral tablet 100 mg</i>	Tier 1	QL (3 tablets per 1 day)
<i>minoxidil oral</i>	Tier 1	
Diuretics, Miscellaneous (Hypotensive)		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	

Drug	Status	Notes
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	
Fibric Acid Derivatives		
<i>fenofibrate micronized oral capsule 130 mg, 43 mg, 90 mg</i>	Tier 3	PA
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	Tier 2	
<i>fenofibrate nanocrystallized</i>	Tier 2	
<i>fenofibrate oral capsule</i>	Tier 3	PA
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	Tier 3	PA
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	Tier 2	
<i>fenofibric acid (choline)</i>	Tier 3	PA
<i>fenofibric acid oral tablet 105 mg</i>	Tier 3	PA
<i>fenofibric acid oral tablet 35 mg</i>	Tier 1	
FENOGLIDE	Tier 3	PA
<i>gemfibrozil</i>	Tier 2	
LIPOFEN	Tier 3	PA
LOPID	Tier 3	PA
TRICOR	Tier 3	PA
TRILIPIX	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Hmg-Coa Reductase Inhibitors		
ALTOPREV	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
ATORVALIQ	Tier 3	PA; QL (20 ML per 1 day)
<i>atorvastatin</i>	Tier 2	QL (1 tablet per 1 day)
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
CRESTOR	Tier 3	PA; QL (1 tablet per 1 day)
EZALLOR SPRINKLE	Tier 3	PA; QL (1 capsule per 1 day)
<i>ezetimibe-simvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>fluvastatin oral capsule 20 mg</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>fluvastatin oral capsule 40 mg</i>	Tier 3	PA; QL (1 capsule per 1 day)
<i>fluvastatin oral tablet extended release 24 hr</i>	Tier 3	PA; QL (1 tablet per 1 day)
LESCOL XL	Tier 3	PA; QL (1 tablet per 1 day)

Drug	Status	Notes
LIPITOR	Tier 3	PA; QL (1 tablet per 1 day)
LIVALO	Tier 3	PA; QL (1 tablet per 1 day)
<i>lovastatin</i>	Tier 2	QL (1 tablet per 1 day)
<i>pitavastatin calcium</i>	Tier 3	PA
<i>pravastatin</i>	Tier 2	QL (1 tablet per 1 day)
<i>rosuvastatin</i>	Tier 2	QL (1 tablet per 1 day)
<i>simvastatin</i>	Tier 2	QL (1 tablet per 1 day)
VYTORIN 10-10	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-20	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-40	Tier 3	PA; QL (1 tablet per 1 day)
VYTORIN 10-80	Tier 3	PA; QL (1 tablet per 1 day)
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	PA; QL (1 tablet per 1 day)
ZYPITAMAG	Tier 3	PA; QL (1 tablet per 1 day)
Hypotensive Agents, Miscellaneous		
<i>acebutolol</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>amlodipine</i>	Tier 2	
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
AZOR	Tier 3	PA
BETAPACE AF	Tier 3	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	PA
<i>betaxolol oral</i>	Tier 3	PA
CARDURA	Tier 3	PA
CARDURA XL	Tier 3	PA
<i>carvedilol</i>	Tier 2	
<i>carvedilol phosphate</i>	Tier 3	PA
COREG	Tier 3	PA
COREG CR	Tier 2	
<i>doxazosin</i>	Tier 2	
EXFORGE	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	

Drug	Status	Notes
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
<i>pindolol</i>	Tier 3	PA
PROCARDIA XL	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
SOTALOL AF	Tier 2	
<i>sotalol oral</i>	Tier 2	
SOTYLIZE	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
<i>terazosin</i>	Tier 2	
<i>timolol maleate oral</i>	Tier 3	PA
Loop Diuretics (Hypotensive Agents)		
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	Tier 1	AGE (Max 12 Years)
<i>furosemide oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>toremide oral tablet 10 mg, 20 mg</i>	Tier 1	QL (4 tablets per 1 day)
<i>toremide oral tablet 100 mg, 5 mg</i>	Tier 1	QL (2 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Mineralocorticoid (Aldosterone) Antagnts		
KERENDIA	Tier 1	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
Mineralocorticoid(Aldoster.)Antag(Hypot)		
KERENDIA	Tier 1	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
Nitrates And Nitrites		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>isosorbide dinitrate oral tablet 40 mg</i>	Tier 2	
<i>isosorbide mononitrate oral tablet</i>	Tier 1	

Drug	Status	Notes
<i>isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 60 mg</i>	Tier 1	QL (2 tablets per 1 day)
<i>isosorbide mononitrate oral tablet extended release 24 hr 30 mg</i>	Tier 1	QL (1 tablet per 1 day)
NITRO-BID	Tier 1	
<i>nitroglycerin oral</i>	Tier 1	
<i>nitroglycerin sublingual</i>	Tier 1	
<i>nitroglycerin transdermal patch 24 hour</i>	Tier 1	QL (1 patch per 1 day)
<i>nitroglycerin translingual</i>	Tier 1	ST
Pcsk9 Inhibitors		
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML	Tier 3	PA; QL (2 pens per 28 dayss)
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 75 MG/ML	Tier 3	PA; QL (2 injectors per 28 dayss)
REPATHA PUSHTRONEX	Tier 2	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	Tier 2	PA; QL (2 injectors per 28 dayss)
REPATHA SYRINGE	Tier 2	PA; QL (2 syringes per 28 dayss)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
Phosphodiesterase Type 5 Inhibitors		
ADCIRCA	Tier 3	PA
ALYQ	Tier 2	PA
<i>cilostazol</i>	Tier 1	QL (2 tablets per 1 day)
ENTADFI	Tier 1	PA
LIQREV	Tier 3	PA
REVATIO ORAL	Tier 3	PA
<i>sildenafil (pulm.hypertension) oral</i>	Tier 2	PA
<i>tadalafil (pulm.hypertension)</i>	Tier 2	PA
TADLIQ	Tier 3	PA; AGE (Min 18 Years)
Potassium-Sparing Diuretics (Hypoten)		
<i>amiloride</i>	Tier 1	QL (1 tablet per 1 day)
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
Renin Inhibitors		
<i>aliskiren</i>	Tier 3	PA
TEKTURNA	Tier 3	PA

Drug	Status	Notes
Renin-Angioten.-Aldost. Sys. Inhib, Misc		
ENTRESTO	Tier 2	QL (60 tablets per 30 dayss)
Thiazide Diuretics(Hypotensive Agents)		
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>amlodipine-valsartan-hcthiiazid</i>	Tier 2	
ATACAND HCT	Tier 3	PA
AVALIDE	Tier 3	PA
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
BENICAR HCT	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
DIOVAN HCT	Tier 3	PA
DIURIL	Tier 1	AGE (Max 12 Years)
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EXFORGE HCT	Tier 3	PA
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA
<i>hydrochlorothiazide</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
HYZAAR	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	
<i>losartan-hydrochlorothiazide</i>	Tier 2	
LOTENSIN HCT	Tier 3	PA
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
TRIBENZOR	Tier 3	PA
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
VASERETIC	Tier 3	PA
ZESTORETIC	Tier 3	PA

Drug	Status	Notes
Thiazide-Like Diuretics(Hypotensive Agt)		
<i>atenolol-chlorthalidone</i>	Tier 2	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier 1	QL (4 tablets per 1 day)
EDARBYCLOR	Tier 3	PA
<i>indapamide</i>	Tier 1	QL (1 tablet per 1 day)
<i>metolazone</i>	Tier 1	QL (1 tablet per 1 day)
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
Vasodilating Agents, Miscellaneous		
ADEMPAS	Tier 3	PA
<i>ambrisentan</i>	Tier 2	PA
<i>amlodipine</i>	Tier 2	
<i>amlodipine-atorvastatin</i>	Tier 3	PA; QL (1 tablet per 1 day)
<i>amlodipine-benazepril</i>	Tier 2	
<i>amlodipine-olmesartan</i>	Tier 2	
<i>amlodipine-valsartan</i>	Tier 2	
<i>aspirin-dipyridamole</i>	Tier 3	PA
AZOR	Tier 3	PA
<i>bosentan</i>	Tier 3	PA
CADUET	Tier 3	PA; QL (1 tablet per 1 day)
CARDIZEM CD	Tier 3	PA
CARDIZEM LA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	PA
CARTIA XT	Tier 2	
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24 hr</i>	Tier 2	
<i>diltiazem hcl oral capsule, extended release 24hr</i>	Tier 2	
<i>diltiazem hcl oral tablet</i>	Tier 2	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 3	PA
DILT-XR	Tier 2	
<i>dipyridamole oral</i>	Tier 3	PA
EXFORGE	Tier 3	PA
<i>felodipine</i>	Tier 3	PA
<i>isradipine</i>	Tier 3	PA
KATERZIA	Tier 3	PA; AGE (Min 6 Years)
LETAIRIS	Tier 3	PA
<i>levamlodipine</i>	Tier 3	PA
LOTREL	Tier 3	PA
MATZIM LA	Tier 3	PA
<i>nicardipine oral</i>	Tier 3	PA
<i>nifedipine</i>	Tier 2	

Drug	Status	Notes
<i>nimodipine</i>	Tier 1	QL (252 capsules per 1 year)
<i>nisoldipine</i>	Tier 3	PA
NORLIQVA	Tier 3	PA; AGE (Min 6 Years)
NORVASC	Tier 3	PA
OPSUMIT	Tier 2	PA
ORENITRAM	Tier 3	PA
ORENITRAM MONTH 1 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 2 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 3 TITRATION KT	Tier 3	PA
PROCARDIA XL	Tier 3	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	PA
TAZTIA XT	Tier 2	
<i>telmisartan-amlodipine</i>	Tier 3	PA
TIADYL ER	Tier 3	PA
TIAZAC	Tier 3	PA
TRACLEER ORAL TABLET	Tier 2	PA
TRACLEER ORAL TABLET FOR SUSPENSION	Tier 3	PA
<i>trandolapril-verapamil</i>	Tier 3	PA
TYVASO	Tier 2	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16 MCG (112)- 32 MCG (84), 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG	Tier 2	PA
TYVASO INSTITUTIONAL START KIT	Tier 2	PA
TYVASO REFILL KIT	Tier 2	PA
TYVASO STARTER KIT	Tier 2	PA
UPTRAVI ORAL	Tier 2	PA
VENTAVIS	Tier 2	PA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	Tier 3	PA
<i>verapamil oral capsule, ext rel. pellets 24 hr</i>	Tier 3	PA
<i>verapamil oral tablet</i>	Tier 2	
<i>verapamil oral tablet extended release</i>	Tier 2	
VERELAN PM	Tier 3	PA
VERQUVO	Tier 1	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)

Drug	Status	Notes
Central Nervous System Agents		
Adamantanes (Cns)		
<i>amantadine hcl oral capsule</i>	Tier 2	
<i>amantadine hcl oral solution</i>	Tier 2	
<i>amantadine hcl oral tablet</i>	Tier 3	PA
GOCOVRI	Tier 3	PA
OSMOLEX ER	Tier 3	PA
Amphetamine Derivatives		
ADIPEX-P ORAL TABLET	Tier 2	PA; AGE (Min 18 Years)
<i>diethylpropion</i>	Tier 2	PA; AGE (Min 18 Years)
LOMAIRA	Tier 2	PA; AGE (Min 18 Years)
<i>phendimetrazine tartrate</i>	Tier 2	PA; AGE (Min 18 Years)
<i>phentermine</i>	Tier 2	PA; AGE (Min 18 Years)
Amphetamines		
<i>benzphetamine</i>	Tier 2	PA; AGE (Min 18 Years)
Analgesics And Antipyretics, Misc.		
ACETAMINOPHEN EXTRA STRENGTH	Tier 1	
<i>acetaminophen oral elixir</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen oral liquid 160 mg/5 ml</i>	Tier 1	QL (3 GM per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>acetaminophen oral solution 160 mg/5 ml (5 ml)</i>	Tier 1	QL (3 MG per 1 day)
<i>acetaminophen oral suspension 160 mg/5 ml</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen oral tablet</i>	Tier 1	
<i>acetaminophen oral tablet extended release</i>	Tier 1	
<i>acetaminophen oral tablet, disintegrating 160 mg</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen oral tablet, disintegrating 80 mg</i>	Tier 1	
ACETAMINOPHEN PAIN RELIEF	Tier 1	
<i>acetaminophen rectal suppository 120 mg</i>	Tier 1	QL (3 GM per 1 day)
<i>acetaminophen rectal suppository 650 mg</i>	Tier 1	
<i>acetaminophen-caff-dihydrocod</i>	Tier 3	PA
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	Tier 2	AGE (Min 12 Years)
<i>acetaminophen-codeine oral tablet</i>	Tier 2	AGE (Min 12 Years)
ATHENOL	Tier 1	
BETATEMP	Tier 1	
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)

Drug	Status	Notes
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
CHILD FEVER REDUCER-PAIN RELVR	Tier 1	
CHILD PAIN REL-FEVER REDUCER	Tier 1	
CHILDREN'S ACETAMINOPHEN ORAL SUSPENSION	Tier 1	
CHILDREN'S ACETAMINOPHEN ORAL TABLET,CHEWABLE 80 MG	Tier 1	
CHILDREN'S FEVER REDUCING	Tier 1	
CHILDREN'S MAPAP ORAL TABLET,CHEWABLE 80 MG	Tier 1	
CHILDREN'S NON-ASPIRIN	Tier 1	
CHILDREN'S PAIN RELIEF ORAL SUSPENSION	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
CHILDREN'S PAIN-FEVER RELIEF ORAL SUSPENSION	Tier 1	
CHILDREN'S TYLENOL ORAL SUSPENSION	Tier 1	
DUAL ACTION PAIN RELIEVER	Tier 3	PA
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	Tier 2	
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FEVER REDUCER	Tier 1	
FEVERALL RECTAL SUPPOSITORY 120 MG, 325 MG, 650 MG	Tier 1	
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	Tier 3	PA; QL (3 EA per 1 day)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG, 600 MG, 750 MG, 900 MG	Tier 3	PA; QL (1800 MG per 1 day)
HORIZANT	Tier 3	PA; QL (2 tablets per 1 day)

Drug	Status	Notes
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier 2	
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	Tier 2	
INFANT FEVER REDUCER-PAIN RELF	Tier 1	
INFANT PAIN RELIEVER	Tier 1	
INFANTS' PAIN AND FEVER	Tier 1	
INFANTS' PAIN RELIEF	Tier 1	
LITTLE REMEDIES FEVER AND PAIN	Tier 1	
MAPAP (ACETAMINOPHEN) ORAL CAPSULE	Tier 1	
M-PAP	Tier 1	
NON-ASPIRIN	Tier 1	
NON-ASPIRIN EXTRA STRENGTH	Tier 1	
NON-ASPIRIN PAIN RELIEF	Tier 1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PAIN RELIEF (ACETAMINOPHEN) ORAL LIQUID	Tier 1	
PAIN RELIEF (ACETAMINOPHEN) ORAL TABLET	Tier 1	
PAIN RELIEF ES (ACETAMINOPHEN)	Tier 1	
PAIN RELIEVER (ACETAMINOPHEN) ORAL TABLET 325 MG	Tier 1	
PAIN RELIEVER ES(ACETAMINOPHN)	Tier 1	
PERCOCET	Tier 3	PA
PHARBETOL	Tier 1	
TACTINAL	Tier 1	
TENCON	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>tramadol-acetaminophen</i>	Tier 2	AGE (Min 12 Years)
TYLENOL EXTRA STRENGTH ORAL TABLET	Tier 1	
TYLENOL ORAL TABLET	Tier 1	
Anticonvulsants, Miscellaneous		
HORIZANT	Tier 3	PA; QL (2 tablets per 1 day)

Drug	Status	Notes
<i>magnesium chloride injection</i>	Tier 1	
<i>magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml</i>	Tier 1	
<i>magnesium sulfate in water</i>	Tier 1	
<i>magnesium sulfate injection</i>	Tier 1	
Antidepressants, Miscellaneous		
<i>bupropion hcl (smoking deter)</i>	Tier 1	QL (2 tablets per 1 day)
Antimigraine Agents, Miscellaneous		
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, chewable</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet, delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>aspirin oral tablet, delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin, buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
BUTALBITAL COMPOUND W/CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)

Drug	Status	Notes
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
<i>codeine-butalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
HEMANGEOL	Tier 3	PA
INDERAL LA	Tier 3	PA
INDERAL XL	Tier 3	PA
INNOPRAN XL	Tier 3	PA
<i>propranolol oral</i>	Tier 2	
<i>timolol maleate oral</i>	Tier 3	PA
<i>tramadol-acetaminophen</i>	Tier 2	AGE (Min 12 Years)
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
Anxiolytics, Sedatives, And Hypnotics, Misc		
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	Tier 1	AGE (Max 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>hydroxyzine hcl oral tablet</i>	Tier 2	
<i>hydroxyzine pamoate</i>	Tier 2	
<i>promethazine oral</i>	Tier 1	AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	Tier 1	QL (4 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine rectal suppository 50 mg</i>	Tier 1	QL (2 suppositories per 1 day); AGE (Min 2 Years and Max 64 Years)
VISTARIL ORAL CAPSULE 25 MG	Tier 3	PA
Barbiturates (Anxiolytic, Sedative/Hyp)		
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
BUTALBITAL COMPOUND W/CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminop-caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)

Drug	Status	Notes
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
<i>codeine-butalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
TENCON	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Benzodiazepines (Anxiolytic, Sedativ/ Hyp)		
<i>midazolam (pf) injection solution 5 mg/ml</i>	Tier 1	
<i>midazolam injection solution 5 mg/ml</i>	Tier 1	
Calcitonin Gene- Related Peptide Antag.		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	Tier 2	PA; QL (1 injector per 30 days); AGE (Min 18 Years)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	Tier 2	PA; QL (2 injectors per 30 days); AGE (Min 18 Years)
AJOVY AUTOINJECTOR	Tier 2	PA; QL (1.5 ML per 30 days); AGE (Min 18 Years)
AJOVY SYRINGE	Tier 2	PA; QL (1.5 ML per 30 days); AGE (Min 18 Years)
EMGALITY PEN	Tier 2	PA; QL (1 ML per 30 days); AGE (Min 18 Years)

Drug	Status	Notes
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	Tier 2	PA; QL (1 ML per 30 days); AGE (Min 18 Years)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	Tier 2	PA; QL (3 syringes per 30 days); AGE (Min 18 Years)
NURTEC ODT	Tier 2	PA; QL (16 tablets per 32 days); AGE (Min 18 Years)
QULIPTA	Tier 3	PA; QL (90 tablets per 90 days); AGE (Min 18 Years)
UBRELVY	Tier 3	PA; QL (16 tablets per 30 days); AGE (Min 18 Years)
ZAVZPRET	Tier 3	PA
Catechol-O- Methyltransferase(C omt)Inhib.		
<i>carbidopa-levodopa- entacapone</i>	Tier 3	PA
COMTAN	Tier 3	PA
<i>entacapone</i>	Tier 3	PA
ONGENTYS	Tier 3	PA
STALEVO 100	Tier 3	PA
STALEVO 125	Tier 3	PA
STALEVO 150	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
STALEVO 200	Tier 3	PA
STALEVO 50	Tier 3	PA
STALEVO 75	Tier 3	PA
TASMAR ORAL TABLET 100 MG	Tier 3	PA
<i>tolcapone</i>	Tier 3	PA
Central Nervous System Agents, Misc.		
<i>carbidopa</i>	Tier 3	PA
EXSERVAN	Tier 1	PA; AGE (Min 18 Years)
<i>guanfacine oral tablet</i>	Tier 2	
LODOSYN	Tier 3	PA
<i>memantine oral capsule, sprinkle, er 24hr</i>	Tier 3	PA
<i>memantine oral solution</i>	Tier 2	
<i>memantine oral tablet</i>	Tier 2	
<i>memantine oral tablets, dose pack</i>	Tier 2	
NAMENDA ORAL TABLET 5 MG	Tier 3	PA
NAMENDA TITRATION PAK	Tier 3	PA
NAMENDA XR	Tier 3	PA
NAMZARIC	Tier 3	PA
NOURIANZ	Tier 3	PA
RELYVRIO	Tier 1	PA; QL (4 packets per 1 day); AGE (Min 18 Years)

Drug	Status	Notes
<i>riluzole</i>	Tier 1	
<i>sodium oxybate</i>	Tier 1	PA; QL (540 ML per 30 days); AGE (Min 7 Years)
TIGLUTIK	Tier 1	PA; AGE (Min 18 Years)
XYWAV	Tier 1	PA; QL (540 ML per 30 days); AGE (Min 7 Years)
Cyclooxygenase-2 (Cox-2) Inhibitors		
CELEBREX ORAL CAPSULE 100 MG, 200 MG, 50 MG	Tier 3	QL (2 capsules per 1 day)
CELEBREX ORAL CAPSULE 400 MG	Tier 3	QL (1 capsule per 1 day)
<i>celecoxib</i>	Tier 2	QL (2 capsules per 1 day)
ELYXYB	Tier 3	PA; AGE (Min 18 Years)
SEGLENTIS	Tier 3	PA; QL (4 tablets per 1 day); AGE (Min 12 Years)
Dopamine Precursors		
<i>carbidopa-levodopa oral tablet</i>	Tier 2	
<i>carbidopa-levodopa oral tablet extended release</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>carbidopa-levodopa oral tablet, disintegrating</i>	Tier 3	PA
<i>carbidopa-levodopa-entacapone</i>	Tier 3	PA
DHIVY	Tier 3	PA
DUOPA	Tier 3	PA
INBRIJA	Tier 3	PA
RYTARY	Tier 3	PA
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	Tier 3	PA
STALEVO 100	Tier 3	PA
STALEVO 125	Tier 3	PA
STALEVO 150	Tier 3	PA
STALEVO 200	Tier 3	PA
STALEVO 50	Tier 3	PA
STALEVO 75	Tier 3	PA
Ergot-Deriv. Dopamine Receptor Agonists		
<i>bromocriptine</i>	Tier 3	PA
<i>cabergoline</i>	Tier 1	
PARLODEL	Tier 3	PA
Fibromyalgia Agents		
SAVELLA	Tier 2	QL (60 tablets per 30 days)
Monoamine Oxidase B Inhibitors		
AZILECT	Tier 3	PA; AGE (Min 18 Years)
<i>rasagiline</i>	Tier 3	PA; AGE (Min 18 Years)

Drug	Status	Notes
<i>selegiline hcl</i>	Tier 3	PA
XADAGO	Tier 3	PA
ZELAPAR	Tier 3	PA
Monoamine Oxidase Inhibitors		
AZILECT	Tier 3	PA; AGE (Min 18 Years)
<i>rasagiline</i>	Tier 3	PA; AGE (Min 18 Years)
<i>selegiline hcl</i>	Tier 3	PA
ZELAPAR	Tier 3	PA
Nonergot-Deriv. Dopamine Receptor Agonist		
MIRAPEX ER	Tier 3	PA
NEUPRO	Tier 3	PA; QL (30 patches per 30 days)
<i>pramipexole oral tablet</i>	Tier 2	
<i>pramipexole oral tablet extended release 24 hr</i>	Tier 3	PA
<i>ropinirole oral tablet</i>	Tier 2	
<i>ropinirole oral tablet extended release 24 hr</i>	Tier 3	PA
Opiate Agonists		
<i>acetaminophen-caff-dihydrocod</i>	Tier 3	PA
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	Tier 2	AGE (Min 12 Years)
<i>acetaminophen-codeine oral tablet</i>	Tier 2	AGE (Min 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
BUTALBITAL COMPOUND W/CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>bitalbital-acetaminop- caf-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>codeine sulfate</i>	Tier 2	QL (180 tablets per 30 days); AGE (Min 12 Years)
<i>codeine-butalbital- asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
CONZIP	Tier 3	PA; AGE (Min 12 Years)
DILAUDID ORAL LIQUID	Tier 3	PA; QL (120 ML per 30 days)
DILAUDID ORAL TABLET 2 MG	Tier 3	PA; QL (180 tablets per 30 days)
DILAUDID ORAL TABLET 4 MG	Tier 3	PA; QL (165 tablets per 30 days)
DILAUDID ORAL TABLET 8 MG	Tier 3	PA; QL (84 tablets per 30 days)
DISKETS	Tier 3	PA
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	Tier 2	
<i>fentanyl citrate buccal lozenge on a handle</i>	Tier 3	PA; QL (120 lozenges per 30 days)

Drug	Status	Notes
<i>fentanyl citrate buccal tablet, effervescent</i>	Tier 3	PA; QL (120 tablets per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	Tier 2	QL (10 patches per 1 fill)
<i>fentanyl transdermal patch 72 hour 37.5 mcg/hour, 62.5 mcg/hour, 87.5 mcg/hour</i>	Tier 3	PA
FENTORA	Tier 3	PA; QL (120 tablets per 30 days)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
<i>hydrocodone bitartrate</i>	Tier 3	PA
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier 2	
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	Tier 2	
<i>hydrocodone-ibuprofen</i>	Tier 3	PA
<i>hydromorphone oral liquid</i>	Tier 2	QL (120 ML per 30 days)
<i>hydromorphone oral tablet 2 mg</i>	Tier 2	QL (180 tablets per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>hydromorphone oral tablet 4 mg</i>	Tier 2	QL (135 tablets per 30 days)
<i>hydromorphone oral tablet 8 mg</i>	Tier 2	QL (67 tablets per 30 days)
<i>hydromorphone oral tablet extended release 24 hr</i>	Tier 3	PA
<i>hydromorphone rectal</i>	Tier 3	PA
HYSINGLA ER	Tier 3	PA
<i>levorphanol tartrate</i>	Tier 3	PA
<i>meperidine oral solution</i>	Tier 3	PA; QL (240 ML per 30 days)
<i>meperidine oral tablet 50 mg</i>	Tier 3	PA; QL (120 tablets per 30 days)
METHADONE INTENSOL	Tier 3	PA
<i>methadone oral concentrate</i>	Tier 3	PA
<i>methadone oral solution</i>	Tier 3	PA
<i>methadone oral tablet</i>	Tier 3	PA
<i>methadone oral tablet, soluble</i>	Tier 3	PA
METHADOSE ORAL CONCENTRATE	Tier 3	PA
METHADOSE ORAL TABLET, SOLUBLE	Tier 3	PA
<i>morphine concentrate oral solution</i>	Tier 2	QL (120 ML per 30 days)
<i>morphine concentrate oral syringe</i>	Tier 2	

Drug	Status	Notes
<i>morphine oral capsule, er multiphase 24 hr</i>	Tier 3	PA
<i>morphine oral capsule, extend. release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	Tier 3	PA
<i>morphine oral solution</i>	Tier 2	QL (240 ML per 30 days)
<i>morphine oral tablet 15 mg</i>	Tier 2	QL (180 tablets per 30 days)
<i>morphine oral tablet 30 mg</i>	Tier 2	QL (90 tablets per 30 days)
<i>morphine oral tablet extended release</i>	Tier 2	
<i>morphine rectal</i>	Tier 2	
MS CONTIN	Tier 3	PA
NUCYNTA	Tier 3	PA
NUCYNTA ER	Tier 3	PA
<i>oxycodone oral capsule</i>	Tier 3	PA; QL (90 capsules per 30 days)
<i>oxycodone oral concentrate</i>	Tier 3	PA; QL (90 ML per 30 days)
<i>oxycodone oral solution</i>	Tier 2	QL (240 ML per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 5 mg</i>	Tier 2	QL (90 tablets per 30 days)
<i>oxycodone oral tablet 20 mg</i>	Tier 3	PA; QL (90 tablets per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>oxycodone oral tablet 30 mg</i>	Tier 3	PA; QL (60 tablets per 30 days)
<i>oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg</i>	Tier 3	PA; QL (180 tablets per 30 days)
<i>oxycodone oral tablet,oral only,ext.rel.12 hr 20 mg</i>	Tier 3	PA; QL (90 tablets per 30 days)
<i>oxycodone oral tablet,oral only,ext.rel.12 hr 40 mg</i>	Tier 3	PA; QL (45 tablets per 30 days)
<i>oxycodone oral tablet,oral only,ext.rel.12 hr 80 mg</i>	Tier 3	PA; QL (22 tablets per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 2	
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG	Tier 3	PA; QL (180 tablets per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 15 MG	Tier 3	PA; QL (120 tablets per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 20 MG	Tier 3	PA; QL (90 tablets per 30 days)

Drug	Status	Notes
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 30 MG	Tier 3	PA; QL (60 tablets per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 40 MG	Tier 3	PA; QL (45 tablets per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	Tier 3	PA; QL (30 tablets per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	Tier 3	PA; QL (22 tablets per 30 days)
<i>oxymorphone oral tablet 10 mg</i>	Tier 3	PA; QL (90 tablets per 30 days)
<i>oxymorphone oral tablet 5 mg</i>	Tier 3	PA; QL (120 tablets per 30 days)
<i>oxymorphone oral tablet extended release 12 hr</i>	Tier 3	PA
PERCOCET	Tier 3	PA
ROXICODONE ORAL TABLET 15 MG	Tier 3	PA; QL (90 tablets per 30 days)
ROXICODONE ORAL TABLET 30 MG	Tier 3	PA; QL (60 tablets per 30 days)
ROXYBOND ORAL TABLET, ORAL ONLY 15 MG, 5 MG	Tier 3	QL (3 tablets per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ROXYBOND ORAL TABLET, ORAL ONLY 30 MG	Tier 3	QL (2 tablets per 1 day)
SEGLENTIS	Tier 3	PA; QL (4 tablets per 1 day); AGE (Min 12 Years)
<i>tramadol oral capsule, er biphasic 24 hr 17-83</i>	Tier 3	PA; AGE (Min 12 Years)
<i>tramadol oral capsule, er biphasic 24 hr 25-75 100 mg, 200 mg</i>	Tier 3	PA; AGE (Min 12 Years)
<i>tramadol oral solution</i>	Tier 3	PA; QL (80 ML per 1 day); AGE (Min 12 Years)
<i>tramadol oral tablet 100 mg, 50 mg</i>	Tier 2	AGE (Min 12 Years)
<i>tramadol oral tablet extended release 24 hr</i>	Tier 2	AGE (Min 12 Years)
<i>tramadol oral tablet, er multiphasic 24 hr</i>	Tier 2	AGE (Min 12 Years)
<i>tramadol-acetaminophen</i>	Tier 2	AGE (Min 12 Years)
XTAMPZA ER	Tier 3	PA; QL (60 capsules per 30 days)
Opiate Antagonists		
<i>naloxone injection solution</i>	Tier 1	QL (2 doses per 30 days)

Drug	Status	Notes
<i>naloxone injection syringe</i>	Tier 1	QL (2 doses per 30 days)
<i>naloxone nasal</i>	Tier 2	QL (6 doses per 90 days)
NARCAN	Tier 2	QL (6 doses per 90 days)
OPVEE	Tier 1	QL (6 devices per 90 days)
ZIMHI	Tier 1	QL (3 syringes per 90 days)
Opiate Partial Agonists		
BELBUCA	Tier 3	PA; QL (60 films per 30 days)
<i>buprenorphine</i>	Tier 3	PA; QL (6 patches per 28 days)
<i>butorphanol nasal</i>	Tier 3	PA; QL (15 ML per 30 days)
BUTRANS	Tier 2	QL (6 patches per 28 days)
<i>pentazocine-naloxone</i>	Tier 3	PA
Other Nonsteroidal Anti-Inflam. Agents		
ALL DAY PAIN RELIEF	Tier 2	
ALL DAY RELIEF	Tier 2	
ARTHROTEC 50	Tier 3	PA
ARTHROTEC 75	Tier 3	PA
CHILDREN'S IBUPROFEN	Tier 2	
DAYPRO	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>diclofenac epolamine</i>	Tier 3	PA; QL (2 patches per 1 day)
<i>diclofenac potassium oral capsule</i>	Tier 3	PA
<i>diclofenac potassium oral tablet</i>	Tier 3	PA
<i>diclofenac sodium oral tablet extended release 24 hr</i>	Tier 3	PA
<i>diclofenac sodium oral tablet, delayed release (dr/ec)</i>	Tier 2	
<i>diclofenac sodium topical drops</i>	Tier 2	
<i>diclofenac sodium topical gel 1 %</i>	Tier 2	
<i>diclofenac sodium topical solution in metered-dose pump</i>	Tier 3	PA
<i>diclofenac-misoprostol</i>	Tier 3	PA
<i>diflunisal</i>	Tier 3	PA
DUAL ACTION PAIN RELIEVER	Tier 3	PA
DUEXIS	Tier 3	PA
EC-NAPROXEN	Tier 3	PA
<i>etodolac</i>	Tier 3	PA
FELDENE	Tier 3	PA
<i>fenoprofen oral capsule 400 mg</i>	Tier 3	PA
<i>fenoprofen oral tablet</i>	Tier 3	PA
FLECTOR	Tier 3	PA; QL (2 patches per 1 day)

Drug	Status	Notes
<i>flurbiprofen oral tablet 100 mg</i>	Tier 3	PA
<i>hydrocodone-ibuprofen</i>	Tier 3	PA
IBU	Tier 2	
IBU-200	Tier 2	
IBUPROFEN IB ORAL TABLET,CHEWABLE	Tier 2	
IBUPROFEN JR STRENGTH	Tier 2	
<i>ibuprofen oral capsule</i>	Tier 2	
<i>ibuprofen oral drops,suspension</i>	Tier 2	
<i>ibuprofen oral suspension</i>	Tier 2	
<i>ibuprofen oral tablet</i>	Tier 2	
<i>ibuprofen-famotidine</i>	Tier 3	PA
INDOCIN	Tier 3	PA
<i>indomethacin oral capsule</i>	Tier 2	
<i>indomethacin oral capsule, extended release</i>	Tier 3	PA
<i>indomethacin oral suspension</i>	Tier 3	PA
INFANT'S IBUPROFEN	Tier 2	
<i>ketoprofen oral capsule 50 mg, 75 mg</i>	Tier 2	
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>ketorolac nasal</i>	Tier 3	PA; QL (5 doses per 1 fill)
<i>ketorolac oral</i>	Tier 2	QL (21 tablets per 1 fill)
LICART	Tier 3	PA; QL (15 patches per 30 days)
LOFENA	Tier 3	PA
<i>meclofenamate</i>	Tier 3	PA
<i>mefenamic acid</i>	Tier 3	PA
<i>meloxicam oral tablet</i>	Tier 2	
<i>meloxicam submicronized</i>	Tier 3	PA
<i>nabumetone</i>	Tier 2	
NALFON ORAL CAPSULE 400 MG	Tier 3	PA
NALFON ORAL TABLET	Tier 3	PA
NAPRELAN CR	Tier 3	PA
<i>naproxen oral suspension</i>	Tier 3	PA
<i>naproxen oral tablet</i>	Tier 2	
<i>naproxen oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
<i>naproxen sodium oral capsule</i>	Tier 2	
<i>naproxen sodium oral tablet 220 mg</i>	Tier 2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	Tier 3	PA

Drug	Status	Notes
<i>naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 500 mg</i>	Tier 3	PA
<i>naproxen-esomeprazole</i>	Tier 3	PA
<i>oxaprozin oral tablet</i>	Tier 3	PA
PENNSAID	Tier 3	PA
<i>piroxicam</i>	Tier 3	PA
RELAFEN DS	Tier 3	PA
SPRIX	Tier 3	PA; QL (5 doses per 1 fill)
<i>sulindac</i>	Tier 2	
<i>sumatriptan-naproxen</i>	Tier 3	PA
TREXIMET	Tier 3	PA
VIMOVO	Tier 3	PA
ZIPSOR	Tier 3	PA
ZORVOLEX	Tier 3	PA
Phenothiazines		
<i>prochlorperazine</i>	Tier 1	QL (2 suppositories per 1 day)
<i>prochlorperazine maleate</i>	Tier 1	QL (4 tablets per 1 day)
Respiratory And Cns Stimulants		
<i>acetaminophen-caff-dihydrocod</i>	Tier 3	PA
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
BUTALBITAL COMPOUND W/CODEINE	Tier 3	PA; AGE (Min 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>butalbital-acetaminop-caff-cod</i>	Tier 3	PA; AGE (Min 12 Years)
<i>butalbital-acetaminophen-caff oral tablet</i>	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
<i>caffeine citrate oral</i>	Tier 1	AGE (Max 1 Years)
<i>codeine-butalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
ESGIC ORAL TABLET	Tier 1	QL (4 tablets per 1 day); AGE (Min 10 Years and Max 64 Years)
FIORICET WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
Salicylates		
ASCOMP WITH CODEINE	Tier 3	PA; AGE (Min 12 Years)
ASPIRIN CHILDRENS	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)

Drug	Status	Notes
<i>aspirin oral tablet, chewable</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin oral tablet, delayed release (dr/ec) 325 mg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
<i>aspirin oral tablet, delayed release (dr/ec) 81 mg</i>	Tier 1	QL (1 tablet per 1 day)
<i>aspirin rectal suppository 300 mg</i>	Tier 1	
<i>aspirin, buffd-calcium carb-mag</i>	Tier 1	AGE (Min 40 Years and Max 79 Years)
<i>aspirin-dipyridamole</i>	Tier 3	PA
BAYER ASPIRIN	Tier 1	QL (1 tablet per 1 day); AGE (Min 40 Years and Max 79 Years)
BAYER CHEWABLE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BAYER LOW DOSE ASPIRIN	Tier 1	QL (1 tablet per 1 day)
BUFFERIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
BUTALBITAL COMPOUND W/CODEINE	Tier 3	PA; AGE (Min 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>butalbital-aspirin-caffeine oral capsule</i>	Tier 1	QL (4 capsules per 1 day); AGE (Max 64 Years)
CHILDREN'S ASPIRIN	Tier 1	QL (1 tablet per 1 day)
<i>codeine-butalbital-asa-caff</i>	Tier 3	PA; AGE (Min 12 Years)
ECOTRIN LOW STRENGTH	Tier 1	QL (1 tablet per 1 day)
NORGESIC	Tier 3	PA
NORGESIC FORTE	Tier 3	PA
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	Tier 3	PA
TRI-BUFFERED ASPIRIN	Tier 1	AGE (Min 40 Years and Max 79 Years)
YOSPRALA	Tier 3	PA
Sel.Serotonin,Norepi Reuptake Inhibitor		
SAVELLA	Tier 2	QL (60 tablets per 30 days)
Selective Serotonin Agonists		
<i>almotriptan malate</i>	Tier 3	PA; QL (9 tablets per 1 fill)
<i>eletriptan</i>	Tier 3	PA; QL (12 tablets per 1 fill)
FROVA	Tier 3	PA; QL (18 tablets per 1 fill)

Drug	Status	Notes
<i>frovatriptan</i>	Tier 3	PA; QL (18 tablets per 1 fill)
IMITREX ORAL	Tier 3	PA; QL (18 tablets per 1 fill)
IMITREX STATDOSE PEN	Tier 3	PA; QL (4 injectors per 1 fill)
IMITREX STATDOSE REFILL	Tier 3	PA; QL (4 cartridges per 1 fill)
IMITREX SUBCUTANEOUS	Tier 3	PA; QL (2 ML per 1 fill)
MAXALT ORAL TABLET 10 MG	Tier 3	PA; QL (18 tablets per 1 fill)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG	Tier 3	PA; QL (18 tablets per 1 fill)
<i>naratriptan</i>	Tier 3	PA; QL (9 tablets per 1 fill)
ONZETRA XSAIL	Tier 3	PA
RELPAK	Tier 3	PA; QL (12 tablets per 1 fill)
REYVOW	Tier 3	PA; QL (8 tablets per 30 days); AGE (Min 18 Years)
<i>rizatriptan</i>	Tier 2	QL (18 tablets per 1 fill)
<i>sumatriptan</i>	Tier 3	PA; QL (6 doses per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>sumatriptan succinate oral</i>	Tier 2	QL (18 tablets per 1 fill)
<i>sumatriptan succinate subcutaneous cartridge</i>	Tier 2	QL (4 cartridges per 1 fill)
<i>sumatriptan succinate subcutaneous pen injector</i>	Tier 2	QL (4 injectors per 1 fill)
<i>sumatriptan succinate subcutaneous solution</i>	Tier 2	QL (2 ML per 1 fill)
<i>sumatriptan-naproxen</i>	Tier 3	PA
TOSYMRA	Tier 3	PA; QL (6 units per 1 fill)
TREXIMET	Tier 3	PA
ZEMBRACE SYMTOUCH	Tier 3	PA
<i>zolmitriptan nasal spray, non-aerosol 5 mg</i>	Tier 3	PA
<i>zolmitriptan oral</i>	Tier 3	PA; QL (12 tablets per 1 fill)
ZOMIG NASAL	Tier 3	PA
ZOMIG ORAL	Tier 3	PA; QL (12 tablets per 1 fill)
Vesicular Monoamine Transport2 Inhibitor		
AUSTEDO	Tier 1	PA; AGE (Min 18 Years)
AUSTEDO XR	Tier 1	PA; AGE (Min 18 Years)
INGREZZA	Tier 1	PA; AGE (Min 18 Years)

Drug	Status	Notes
INGREZZA INITIATION PACK	Tier 1	PA; AGE (Min 18 Years)
Devices		
Devices		
ACE AEROSOL CLOUD ENHANCER	Tier 1	QL (4 units per 1 year)
AEROCHAMBER MINI	Tier 1	QL (4 units per 1 year)
AEROCHAMBER MV	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU,L MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU,M MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS FLOW-VU,S MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT LG MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT MD MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER PLUS Z STAT SM MSK	Tier 1	QL (4 units per 1 year)
AEROCHAMBER Z-STAT PLUS-FLW SG	Tier 1	QL (4 units per 1 year)
AEROTRACH PLUS	Tier 1	QL (4 units per 1 year)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
AIRZONE PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
ASTHMA CHECK METER	Tier 1	QL (4 units per 1 year)
BD AUTOSHIELD DUO PEN NEEDLE	Tier 1	
BD INSULIN SYRINGE (HALF UNIT)	Tier 1	
BD INSULIN SYRINGE U-500	Tier 1	
BD INSULIN SYRINGE ULTRA-FINE	Tier 1	
BD NANO 2ND GEN PEN NEEDLE	Tier 1	
BD ULTRA-FINE MICRO PEN NEEDLE	Tier 1	
BD ULTRA-FINE MINI PEN NEEDLE	Tier 1	
BD ULTRA-FINE NANO PEN NEEDLE	Tier 1	
BD ULTRA-FINE ORIG PEN NEEDLE	Tier 1	
BD ULTRA-FINE SHORT PEN NEEDLE	Tier 1	
BD VEO INSULIN SYR (HALF UNIT)	Tier 1	
BD VEO INSULIN SYRINGE UF	Tier 1	
BREATHERITE MDI SPACER	Tier 1	QL (4 units per 1 year)

Drug	Status	Notes
BREATHERITE VALVED MDI CHAMBER	Tier 1	QL (4 units per 1 year)
BREATHERITE VALVED MDI SPACER	Tier 1	QL (4 units per 1 year)
EASIVENT HOLDING CHAMBER	Tier 1	QL (4 units per 1 year)
EASIVENT MASK LARGE	Tier 1	QL (4 units per 1 year)
EASIVENT MASK MEDIUM	Tier 1	QL (4 units per 1 year)
EASIVENT MASK SMALL	Tier 1	QL (4 units per 1 year)
FEMCAP	Tier 1	
FREESTYLE CONTROL	Tier 1	QL (1 bottle per 90 days)
FREESTYLE FREEDOM	Tier 1	
FREESTYLE FREEDOM LITE	Tier 1	QL (1 meter per 1 year)
FREESTYLE INSULINX	Tier 1	QL (1 meter per 2 years)
FREESTYLE LANCETS	Tier 1	
FREESTYLE LITE METER	Tier 1	QL (1 meter per 1 year)
FREESTYLE PRECISION NEO METER	Tier 1	QL (1 meter per 1 year)
GLUCOSE KETONE CONTROL SOLN	Tier 1	QL (1 bottle per 90 days)
IN-CHECK NASAL WITH MASK	Tier 1	QL (4 units per 1 year)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
IN-CHECK ORAL FLOW METER	Tier 1	QL (4 units per 1 year)
<i>lancets</i>	Tier 1	
LITE TOUCH-MEDIUM MASK	Tier 1	QL (4 units per 1 year)
LITEAIRE MDI CHAMBER	Tier 1	QL (4 units per 1 year)
LITETOUCH-LARGE MASK	Tier 1	QL (4 units per 1 year)
LITETOUCH-SMALL MASK	Tier 1	QL (4 units per 1 year)
MICROCHAMBER	Tier 1	QL (4 units per 1 year)
MICROLIFE PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
MICROSPACER	Tier 1	QL (4 units per 1 year)
MINI WRIGHT PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
MOUTHPIECE	Tier 1	QL (4 units per 1 year)
ONE WAY VALVED MOUTHPIECE	Tier 1	QL (4 units per 1 year)
OPTICHAMBER ADULT MASK-LARGE	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND LG MASK	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND VHC	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND-MED MSK	Tier 1	QL (4 units per 1 year)
OPTICHAMBER DIAMOND-SML MASK	Tier 1	QL (4 units per 1 year)

Drug	Status	Notes
PANDA MASK	Tier 1	QL (4 units per 1 year)
PEAK AIR PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
PEDIATRIC MEDIUM MASK	Tier 1	QL (4 units per 1 year)
PEDIATRIC PANDA MASK	Tier 1	QL (4 units per 1 year)
PEDIATRIC SMALL MASK	Tier 1	QL (4 units per 1 year)
PERSONAL BEST FULL RANGE	Tier 1	QL (4 units per 1 year)
PIKO 1	Tier 1	QL (4 units per 1 year)
POCKET CHAMBER	Tier 1	QL (4 units per 1 year)
POCKET PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
PRECISION XTRA B-KETONE	Tier 1	
PRECISION XTRA MONITOR	Tier 1	QL (1 meter per 1 year)
PRIMEAIRE	Tier 1	QL (4 units per 1 year)
PRO COMFORT SPACER-ADULT MASK	Tier 1	QL (4 units per 1 year)
PRO COMFORT SPACER-CHILD MASK	Tier 1	QL (4 units per 1 year)
PROCARE SPACER WITH ADULT MASK	Tier 1	QL (4 units per 1 year)
PROCARE SPACER WITH CHILD MASK	Tier 1	QL (4 units per 1 year)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PROCHAMBER	Tier 1	QL (4 units per 1 year)
RITEFLO AEROCHAMBER	Tier 1	QL (4 units per 1 year)
SIDESTREAM PEDIATRIC FACE MASK	Tier 1	QL (4 units per 1 year)
SILICONE MASK - INFANT	Tier 1	QL (4 units per 1 year)
SILICONE MASK - PEDIATRIC	Tier 1	QL (4 units per 1 year)
<i>sodium chloride inhalation solution for nebulization 0.9 %</i>	Tier 1	
SPEEDYSWAB COVID-19 HOME TEST	Tier 1	
TRUZONE PEAK FLOW METER	Tier 1	QL (4 units per 1 year)
VORTEX ADULT MASK	Tier 1	QL (4 units per 1 year)
VORTEX HOLDING CHAMBER	Tier 1	QL (4 units per 1 year)
VORTEX VHC FROG MASK-CHILD	Tier 1	QL (4 units per 1 year)
VORTEX VHC LADYBUG MASK-TODDLR	Tier 1	QL (4 units per 1 year)
Diagnostic Agents		
Diabetes Mellitus		
FREESTYLE INSULINX TEST STRIPS	Tier 1	
FREESTYLE LITE STRIPS	Tier 1	

Drug	Status	Notes
FREESTYLE PRECISION NEO STRIPS	Tier 1	
FREESTYLE TEST	Tier 1	
PRECISION XTRA TEST	Tier 1	
Electrolytic, Caloric, And Water Balance		
Acidifying Agents		
K-PHOS NO 2	Tier 1	
K-PHOS ORIGINAL	Tier 1	
Alkalinizing Agents		
<i>potassium citrate oral tablet extended release</i>	Tier 1	
<i>potassium citrate-citric acid</i>	Tier 1	
<i>sodium citrate-citric acid oral solution 500-334 mg/5 ml</i>	Tier 1	
Ammonia Detoxicants		
<i>lactulose oral solution 10 gram/15 ml (15 ml)</i>	Tier 1	QL (180 ML per 1 day)
RELYVRIO	Tier 1	PA; QL (4 packets per 1 day); AGE (Min 18 Years)
Carbonic Anhydrase Inhibitors		
<i>acetazolamide oral capsule, extended release</i>	Tier 1	QL (2 capsules per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>acetazolamide oral tablet</i>	Tier 1	QL (4 tablets per 1 day)
Diuretics, Miscellaneous		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	
Loop Diuretics		
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	Tier 1	AGE (Max 12 Years)
<i>furosemide oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>torseamide oral tablet 10 mg, 20 mg</i>	Tier 1	QL (4 tablets per 1 day)
<i>torseamide oral tablet 100 mg, 5 mg</i>	Tier 1	QL (2 tablets per 1 day)
Phosphate-Removing Agents		
AURYXIA	Tier 3	PA
<i>calcium acetate(phosphat bind)</i>	Tier 2	PA
FOSRENOL	Tier 3	PA
<i>lanthanum</i>	Tier 3	PA
REVELA	Tier 3	PA
<i>sevelamer carbonate oral powder in packet</i>	Tier 3	PA

Drug	Status	Notes
<i>sevelamer carbonate oral tablet</i>	Tier 2	PA
<i>sevelamer hcl</i>	Tier 3	PA
VELPHORO	Tier 3	PA
Potassium-Removing Agents		
<i>sodium polystyrene sulfonate oral powder</i>	Tier 1	
Potassium-Sparing Diuretics		
<i>amiloride</i>	Tier 1	QL (1 tablet per 1 day)
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolactone oral tablet</i>	Tier 1	QL (2 tablets per 1 day)
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
Replacement Preparations		
ACTICAL	Tier 1	
ANTACID (CALCIUM CARBONATE) ORAL TABLET,CHEWABLE 200 MG CALCIUM (500 MG)	Tier 1	
ANTACID CALCIUM	Tier 1	
ANTACID EXT STR (CALCIUM CARB)	Tier 1	
ANTACID EXTRA-STRENGTH ORAL TABLET,CHEWABLE 300 MG (750 MG)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ANTACID ULTRA STRENGTH ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
BEELITH	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	
BIOCAL	Tier 1	
CALCIUM 500 + D ORAL TABLET	Tier 1	
CALCIUM 500 WITH D	Tier 1	
CALCIUM 600	Tier 1	
CALCIUM 600 + D(3) ORAL TABLET	Tier 1	
CALCIUM ANTACID	Tier 1	
<i>calcium carbonate oral suspension</i>	Tier 1	
<i>calcium carbonate oral tablet 500 mg calcium (1,250 mg), 600 mg calcium (1,500 mg)</i>	Tier 1	
<i>calcium carbonate oral tablet,chewable 200 mg calcium (500 mg), 260 mg calcium (650 mg), 400 mg calcium (1,000 mg)</i>	Tier 1	

Drug	Status	Notes
<i>calcium carbonate-vitamin d3 oral tablet 250 mg-3.125 mcg (125 unit), 500 mg-10 mcg (400 unit), 500 mg-15 mcg (600 unit), 500 mg-3.125 mcg (125 unit), 500 mg-5 mcg (200 unit), 600 mg-10 mcg (400 unit), 600 mg-20 mcg (800 unit), 600 mg-5 mcg (200 unit)</i>	Tier 1	
<i>calcium carbonate-vitamin d3 oral tablet,chewable 500 mg-2.5 mcg (100 unit)</i>	Tier 1	
CALCIUM CITRATE + D	Tier 1	
<i>calcium citrate oral tablet</i>	Tier 1	
<i>calcium citrate-vitamin d3 oral tablet 315 mg-5 mcg (200 unit), 315 mg-6.25 mcg (250 unit)</i>	Tier 1	
<i>calcium gluconate intravenous</i>	Tier 1	
CALCIUM WITH VITAMIN D	Tier 1	
CAL-GEST ANTACID	Tier 1	
CALTRATE WITH VITAMIN D3	Tier 1	
CERALYTE-70 ORAL SOLUTION	Tier 1	
CITRACAL + D MAXIMUM	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
CITRACAL-D3 MAXIMUM PLUS	Tier 1	
DAILY MULTIPLE FOR WOMEN	Tier 1	
<i>electrolytes-dextrose oral solution</i>	Tier 1	
ENFAMIL ENFALYTE	Tier 1	
FLAVOR CHEWS ANTACID	Tier 1	
GLYCOPHOS	Tier 1	
HAIR,SKIN AND NAILS ORAL TABLET 1 MG IRON- 66.7 MCG-1,000 MCG	Tier 1	
KLOR-CON/EF	Tier 1	
MAG GLYCINATE	Tier 1	
MAG-G	Tier 1	
MAGINEX	Tier 1	
MAGNESIUM (OXIDE/AA CHELATE)	Tier 1	
<i>magnesium amino acid chelate</i>	Tier 1	
<i>magnesium chloride oral tablet, delayed release (dr/ec)</i>	Tier 1	
<i>magnesium citrate oral tablet</i>	Tier 1	
<i>magnesium gluconate oral tablet 27 mg magnesium (500 mg), 27.5 mg magne- sium (500 mg), 30 mg (550 mg)</i>	Tier 1	

Drug	Status	Notes
<i>magnesium oral tablet 200 mg</i>	Tier 1	
MAGTAB	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NU-MAG	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	
ONE-A-DAY ENERGY	Tier 1	
ONE-A-DAY MENOPAUSE FORMULA	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ONE-A-DAY TEEN ADVANTAGE ORAL TABLET 9 MG IRON-400 MCG	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	
ORALYTE	Tier 1	
ORAZINC	Tier 1	
OS-CAL 500 + D3	Tier 1	
OYSCO 500/D	Tier 1	
OYSTER SHELL + D3	Tier 1	
OYSTER SHELL CALCIUM	Tier 1	
OYSTER SHELL CALCIUM 500	Tier 1	
OYSTER SHELL CALCIUM-VIT D3	Tier 1	
OYSTERCAL-D	Tier 1	
PEDIALYTE ADVANCED CARE	Tier 1	
PEDIALYTE FREEZER POPS	Tier 1	
PEDIALYTE ORAL SOLUTION	Tier 1	
PEDIALYTE SINGLES	Tier 1	

Drug	Status	Notes
PEDIATRIC ELECTROLYTE ORAL SOLUTION	Tier 1	
PEDIATRIC FREEZER POPS	Tier 1	
PEDIAVANCE	Tier 1	
<i>potassium chloride oral capsule, extended release</i>	Tier 1	
<i>potassium chloride oral tablet extended release</i>	Tier 1	
<i>potassium chloride oral tablet, er particles/crystals 10 meq, 20 meq</i>	Tier 1	
<i>potassium phosphate m-/d-basic intravenous solution 3 mmol/ml</i>	Tier 1	
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRO-CAL	Tier 1	
QUINTABS-M	Tier 1	
SLOW-MAG	Tier 1	
SLOWMAG MUSCLE RECOVERY	Tier 1	
<i>sodium chloride inhalation solution for nebulization 0.9 %</i>	Tier 1	
THERAPEUTIC-M ORAL TABLET 9 MG IRON-400 MCG	Tier 1	
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TUMS	Tier 1	
TUMS E-X	Tier 1	

Drug	Status	Notes
TUMS EXTRA STRENGTH SMOOTHIES	Tier 1	
TUMS FRESHERS	Tier 1	
TUMS ULTRA ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
ULTRA FREEDA	Tier 1	
ULTRA STRENGTH ANTACID	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S ONE DAILY	Tier 1	
<i>zinc gluconate oral tablet 100 mg</i>	Tier 1	
<i>zinc sulfate oral</i>	Tier 1	
ZINC-220	Tier 1	
Thiazide Diuretics		
ACCURETIC ORAL TABLET 20-25 MG	Tier 3	PA
<i>amiloride-hydrochlorothiazide</i>	Tier 1	QL (2 tablets per 1 day)
<i>amlodipine-valsartan-hcthiiazid</i>	Tier 2	
ATACAND HCT	Tier 3	PA
AVALIDE	Tier 3	PA
<i>benazepril-hydrochlorothiazide</i>	Tier 2	
BENICAR HCT	Tier 3	PA
<i>bisoprolol-hydrochlorothiazide</i>	Tier 2	
<i>candesartan-hydrochlorothiazid</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>captopril-hydrochlorothiazide</i>	Tier 3	PA
DIOVAN HCT	Tier 3	PA
DIURIL	Tier 1	AGE (Max 12 Years)
<i>enalapril-hydrochlorothiazide</i>	Tier 2	
EXFORGE HCT	Tier 3	PA
<i>fosinopril-hydrochlorothiazide</i>	Tier 3	PA
<i>hydrochlorothiazide</i>	Tier 1	
HYZAAR	Tier 3	PA
<i>irbesartan-hydrochlorothiazide</i>	Tier 3	PA
<i>lisinopril-hydrochlorothiazide</i>	Tier 2	
<i>losartan-hydrochlorothiazide</i>	Tier 2	
LOTENSIN HCT	Tier 3	PA
<i>methyldopa-hydrochlorothiazide</i>	Tier 3	PA
<i>metoprolol ta-hydrochlorothiaz</i>	Tier 3	PA
MICARDIS HCT	Tier 3	PA
<i>olmesartan-amlodipin-hcthiazid</i>	Tier 3	PA
<i>olmesartan-hydrochlorothiazide</i>	Tier 2	
<i>propranolol-hydrochlorothiazid</i>	Tier 3	PA
<i>quinapril-hydrochlorothiazide</i>	Tier 3	PA
<i>spironolacton-hydrochlorothiaz</i>	Tier 1	QL (3 tablets per 1 day)

Drug	Status	Notes
<i>telmisartan-hydrochlorothiazid</i>	Tier 3	PA
<i>triamterene-hydrochlorothiazid</i>	Tier 1	
TRIBENZOR	Tier 3	PA
<i>valsartan-hydrochlorothiazide</i>	Tier 2	
VASERETIC	Tier 3	PA
ZESTORETIC	Tier 3	PA
Thiazide-Like Diuretics		
<i>atenolol-chlorthalidone</i>	Tier 2	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier 1	QL (4 tablets per 1 day)
EDARBYCLOR	Tier 3	PA
<i>indapamide</i>	Tier 1	QL (1 tablet per 1 day)
<i>metolazone</i>	Tier 1	QL (1 tablet per 1 day)
TENORETIC 100	Tier 3	PA
TENORETIC 50	Tier 3	PA
Uricosuric Agents		
<i>probenecid</i>	Tier 2	
<i>probenecid-colchicine</i>	Tier 2	
Enzymes		
Enzymes		
PULMOZYME	Tier 1	PA; QL (75 EA per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Eye, Ear, Nose And Throat (Eent) Preps.		
Alpha-Adrenergic Agonists (Eent)		
ALPHAGAN P	Tier 3	PA
<i>brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %</i>	Tier 3	PA
<i>brimonidine ophthalmic (eye) drops 0.2 %</i>	Tier 2	
<i>brimonidine-timolol</i>	Tier 3	PA
COMBIGAN	Tier 2	
SIMBRINZA	Tier 2	
Antiallergic Agents		
ALAWAY	Tier 2	
ALOCRIAL	Tier 3	PA
ALOMIDE	Tier 3	PA
<i>azelastine</i>	Tier 2	
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>bepotastine besilate</i>	Tier 3	PA
BEPREVE	Tier 3	PA
CHILDREN'S ALAWAY	Tier 2	
<i>cromolyn nasal</i>	Tier 1	
<i>cromolyn ophthalmic (eye)</i>	Tier 2	
DYMISTA	Tier 3	PA
<i>epinastine</i>	Tier 3	PA
EYE ITCH RELIEF	Tier 2	
<i>ketotifen fumarate</i>	Tier 2	
NASALCROM	Tier 1	
<i>olopatadine nasal</i>	Tier 3	PA

Drug	Status	Notes
<i>olopatadine ophthalmic (eye)</i>	Tier 2	
PATADAY ONCE DAILY RELIEF	Tier 3	PA
PATADAY TWICE DAILY RELIEF	Tier 3	PA
PATANASE	Tier 3	PA
RYALTRIS	Tier 3	PA
ZADITOR	Tier 2	
ZERVIATE	Tier 3	PA
Antibacterials (Eent)		
AZASITE	Tier 3	PA
<i>bacitracin ophthalmic (eye)</i>	Tier 1	
<i>bacitracin-polymyxin b</i>	Tier 1	
BESIVANCE	Tier 3	PA
CILOXAN OPHTHALMIC (EYE) OINTMENT	Tier 3	PA
CIPRO HC	Tier 3	PA
<i>ciprofloxacin hcl ophthalmic (eye)</i>	Tier 2	
<i>ciprofloxacin hcl otic (ear)</i>	Tier 3	PA
<i>ciprofloxacin-dexamethasone</i>	Tier 3	PA
<i>ciprofloxacin-fluocinolone</i>	Tier 3	PA
E.E.S. 400 ORAL TABLET	Tier 3	PA
E.E.S. GRANULES	Tier 3	PA
ERYPED 200	Tier 3	PA
ERYPED 400	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ERY-TAB	Tier 3	PA
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	Tier 3	PA
<i>erythromycin ethylsuccinate oral tablet</i>	Tier 2	
<i>erythromycin ophthalmic (eye)</i>	Tier 2	
<i>erythromycin oral</i>	Tier 3	PA
<i>gatifloxacin</i>	Tier 3	PA
<i>gentamicin ophthalmic (eye) drops</i>	Tier 1	
<i>moxifloxacin ophthalmic (eye)</i>	Tier 3	PA
<i>neomycin</i>	Tier 2	
<i>neomycin-bacitracin-poly-hc</i>	Tier 1	
<i>neomycin-bacitracin-polymyxin</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth</i>	Tier 1	
<i>neomycin-polymyxin-gramicidin</i>	Tier 1	

Drug	Status	Notes
<i>neomycin-polymyxin-hc otic (ear)</i>	Tier 1	
OCUFLOX	Tier 3	PA
<i>ofloxacin ophthalmic (eye)</i>	Tier 2	
<i>ofloxacin otic (ear)</i>	Tier 2	
<i>polymyxin b sulf-trimethoprim</i>	Tier 1	
<i>sulfacetamide sodium ophthalmic (eye)</i>	Tier 1	
<i>sulfacetamide-prednisolone</i>	Tier 1	
<i>tobramycin ophthalmic (eye)</i>	Tier 1	
<i>tobramycin-dexamethasone</i>	Tier 1	
VIGAMOX	Tier 2	
Antiglaucoma Agents, Miscellaneous		
RHOPRESSA	Tier 2	
ROCKLATAN	Tier 2	
Beta-Adrenergic Blocking Agents (Eent)		
<i>betaxolol ophthalmic (eye)</i>	Tier 3	PA
BETIMOL	Tier 3	PA
BETOPTIC S	Tier 2	
<i>brimonidine-timolol</i>	Tier 3	PA
<i>carteolol</i>	Tier 2	
COMBIGAN	Tier 2	
COSOPT	Tier 3	PA
COSOPT (PF)	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>dorzolamide-timolol</i>	Tier 2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	Tier 3	PA
ISTALOL	Tier 3	PA
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	Tier 3	PA
<i>timolol maleate (pf) ophthalmic (eye) dropperette 0.5 %</i>	Tier 3	PA
<i>timolol maleate ophthalmic (eye) drops</i>	Tier 2	
<i>timolol maleate ophthalmic (eye) drops, once daily</i>	Tier 3	PA
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	Tier 2	
TIMOPTIC OCUDOSE (PF)	Tier 3	PA
Carbonic Anhydrase Inhibitors (Eent)		
<i>acetazolamide oral capsule, extended release</i>	Tier 1	QL (2 capsules per 1 day)
<i>acetazolamide oral tablet</i>	Tier 1	QL (4 tablets per 1 day)
AZOPT	Tier 2	
<i>brinzolamide</i>	Tier 3	PA
COSOPT	Tier 3	PA
COSOPT (PF)	Tier 3	PA
<i>dorzolamide</i>	Tier 2	
<i>dorzolamide-timolol</i>	Tier 2	

Drug	Status	Notes
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	Tier 3	PA
SIMBRINZA	Tier 2	
Corticosteroids (Eent)		
24 HOUR NASAL ALLERGY	Tier 3	PA
ALLERGY RELIEF (FLUTICASONE)	Tier 3	PA
ALREX	Tier 3	PA
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>budesonide nasal</i>	Tier 3	PA
CHILDREN'S FLONASE ALLERGY RLF	Tier 3	PA
CIPRO HC	Tier 3	PA
<i>ciprofloxacin-dexamethasone</i>	Tier 3	PA
<i>ciprofloxacin-fluocinolone</i>	Tier 3	PA
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	Tier 1	
DYMISTA	Tier 3	PA
EYSUVIS	Tier 3	PA; QL (8.3 ML per 30 days)
<i>flunisolide</i>	Tier 3	PA
<i>fluorometholone</i>	Tier 1	QL (15 ML per 30 dayss)
<i>fluticasone propionate nasal</i>	Tier 2	
<i>hydrocortisone-acetic acid</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>Ioteprednol etabonate ophthalmic (eye) drops, suspension 0.2 %</i>	Tier 3	PA
<i>mometasone nasal</i>	Tier 3	PA
NASAL ALLERGY	Tier 3	PA
NASONEX 24HR ALLERGY	Tier 3	PA
<i>neomycin-bacitracin-poly-hc</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth</i>	Tier 1	
OMNARIS	Tier 3	PA
<i>prednisolone acetate</i>	Tier 1	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	Tier 1	
QNASL	Tier 3	PA
RYALTRIS	Tier 3	PA
<i>tobramycin-dexamethasone</i>	Tier 1	
<i>triamcinolone acetate nasal</i>	Tier 3	PA
XHANCE	Tier 3	PA
ZETONNA	Tier 3	PA
Eent Anti-Infectives, Miscellaneous		
<i>acetic acid otic (ear)</i>	Tier 1	
<i>chlorhexidine gluconate mucous membrane</i>	Tier 1	
<i>hydrocortisone-acetic acid</i>	Tier 1	

Drug	Status	Notes
PAROEX ORAL RINSE	Tier 1	
Eent Anti-Inflammatory Agents, Misc.		
CEQUA	Tier 3	PA; QL (60 ampules per 30 days)
<i>cyclosporine ophthalmic (eye)</i>	Tier 3	PA; QL (60 ampules per 30 days)
RESTASIS	Tier 2	QL (60 ampules per 30 days)
RESTASIS MULTIDOSE	Tier 2	QL (5.5 ML per 30 days)
XIIDRA	Tier 2	QL (60 units per 30 days)
Eent Drugs, Miscellaneous		
<i>apraclonidine</i>	Tier 2	
ARTIFICIAL TEARS (PF)	Tier 1	
ARTIFICIAL TEARS (POLYVIN ALC)	Tier 1	
ARTIFICIAL TEARS(DEX70-HYPRO)	Tier 1	
ARTIFICIAL TEARS(GLYCERIN-PEG)	Tier 1	
ARTIFICIAL TEARS(PVALCH-POVID)	Tier 1	
BABY AYR SALINE	Tier 1	
BION TEARS (PF)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>carboxymethylcellulose sodium ophthalmic (eye) dropperette, gel</i>	Tier 1	
<i>carboxymethylcellulose sodium ophthalmic (eye) drops</i>	Tier 1	
IOPIDINE OPTHALMIC (EYE) DROPPERETTE	Tier 3	PA
<i>ipratropium bromide nasal</i>	Tier 2	
LUBRICANT (P-GLYCOL-GLYCERIN)	Tier 1	
LUBRICANT EYE (PG-PEG 400)	Tier 1	
LUBRICATING PLUS	Tier 1	
MIEBO	Tier 3	PA
NATURAL TEARS (PF)	Tier 1	
OXERVATE	Tier 1	PA; QL (28 vials per 28 dayss); AGE (Min 2 Years)
<i>polyvinyl alcohol</i>	Tier 1	
REFRESH LACRI-LUBE	Tier 1	
REFRESH LIQUIGEL	Tier 1	
REFRESH P.M.	Tier 1	
<i>sodium chloride ophthalmic (eye)</i>	Tier 1	
SYSTANE (PROPYLENE GLYCOL)	Tier 1	

Drug	Status	Notes
SYSTANE GEL OPTHALMIC (EYE) DROPS, GEL	Tier 1	
SYSTANE ULTRA	Tier 1	
Eent Nonsteroidal Anti-Inflam. Agents		
ACULAR	Tier 3	PA
ACULAR LS	Tier 3	PA
ACUVAIL (PF)	Tier 3	PA
<i>bromfenac</i>	Tier 3	PA
BROMSITE	Tier 3	PA
<i>diclofenac sodium ophthalmic (eye)</i>	Tier 2	
<i>flurbiprofen sodium</i>	Tier 2	
ILEVRO	Tier 3	PA
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	Tier 3	PA
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	Tier 2	
NEVANAC	Tier 3	PA
PROLENSA	Tier 3	PA
Local Anesthetics (Eent)		
<i>lidocaine hcl mucous membrane jelly in applicator</i>	Tier 1	
LIDOCAINE VISCOUS	Tier 1	
<i>proparacaine</i>	Tier 1	
Miotics		
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Mydriatics		
<i>atropine ophthalmic (eye) drops 1 %</i>	Tier 1	
<i>atropine ophthalmic (eye) ointment</i>	Tier 1	
<i>cyclopentolate ophthalmic (eye) drops 1 %</i>	Tier 1	
<i>tropicamide</i>	Tier 1	
Prostaglandin Analogs		
<i>bimatoprost ophthalmic (eye)</i>	Tier 3	PA
<i>latanoprost</i>	Tier 2	
LUMIGAN OPTHALMIC (EYE) DROPS 0.01 %	Tier 3	PA
ROCKLATAN	Tier 2	
<i>tafluprost (pf)</i>	Tier 3	PA
TRAVATAN Z	Tier 3	PA
<i>travoprost</i>	Tier 3	PA
VYZULTA	Tier 3	PA
XALATAN	Tier 3	PA
XELPROS	Tier 3	PA
ZIOPTAN (PF)	Tier 3	PA
Rho Kinase Inhibitors		
RHOPRESSA	Tier 2	
ROCKLATAN	Tier 2	
Vasoconstrictors		
ALLERGY EYE (NAPHAZOLINE-PHEN)	Tier 1	

Drug	Status	Notes
EYE ALLERGY RELIEF	Tier 1	
NAPHCON-A	Tier 1	
OPCON-A	Tier 1	
<i>phenylephrine hcl ophthalmic (eye) drops 2.5 %</i>	Tier 1	
Gastrointestinal Drugs		
5-Ht3 Receptor Antagonists		
AKYNZEO (NETUPITANT)	Tier 3	PA; QL (1 Box per 1 Claim)
<i>granisetron hcl oral</i>	Tier 2	QL (60 tablets per 30 days)
<i>ondansetron hcl oral solution</i>	Tier 2	QL (75 ML per 1 fill)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	Tier 2	QL (60 tablets per 30 days)
<i>ondansetron oral tablet, disintegrating 4 mg</i>	Tier 2	QL (60 tablets per 30 days)
<i>ondansetron oral tablet, disintegrating 8 mg</i>	Tier 2	QL (60 tablets per 30 fills)
SANCUSO	Tier 3	PA; QL (1 patch per 5 days)
Antacids And Adsorbents		
ACID GONE ANTACID	Tier 1	
ADVANCED ANTACID-ANTIGAS	Tier 1	
ALMACONE-2	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>aluminum hydroxide gel</i>	Tier 1	
ANTACID	Tier 1	
ANTACID (CALCIUM CARBONATE) ORAL TABLET,CHEWABLE 200 MG CALCIUM (500 MG)	Tier 1	
ANTACID ANTI-GAS	Tier 1	
ANTACID CALCIUM	Tier 1	
ANTACID EXT STR (CALCIUM CARB)	Tier 1	
ANTACID EXTRA-STRENGTH ORAL TABLET,CHEWABLE 300 MG (750 MG)	Tier 1	
ANTACID LIQUID	Tier 1	
ANTACID M	Tier 1	
ANTACID MAXIMUM STRENGTH	Tier 1	
ANTACID PLUS ANTI-GAS	Tier 1	
ANTACID REGULAR STRENGTH	Tier 1	
ANTACID ULTRA STRENGTH ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
ANTACID-ANTIGAS	Tier 1	
ANTI-DIARRHEAL	Tier 1	
BISMUTH	Tier 1	
<i>bismuth subsalicylate oral tablet,chewable</i>	Tier 1	
CALCIUM ANTACID	Tier 1	

Drug	Status	Notes
<i>calcium carbonate oral tablet,chewable 200 mg calcium (500 mg), 400 mg calcium (1,000 mg)</i>	Tier 1	
CAL-GEST ANTACID	Tier 1	
COMFORT GEL	Tier 1	
COMFORT GEL EXTRA STRENGTH	Tier 1	
DIARRHEA RELIEF (BISMUTH SUBS)	Tier 1	
DIOTAME	Tier 1	
FLAVOR CHEWS ANTACID	Tier 1	
FOAMING ANTACID	Tier 1	
GAVISCON ORAL SUSPENSION	Tier 1	
GERI-LANTA ORAL SUSPENSION 200-200-20 MG/5 ML	Tier 1	
GERI-MOX ANTACID-ANTIGAS	Tier 1	
KAOPECTATE (BISMUTH SUBSALICY) ORAL SUSPENSION	Tier 1	
KAOPECTATE EX STR (BISMUTH SS)	Tier 1	
K-PEC ANTIDIARRHEAL (BISM SUB)	Tier 1	
MAG-AL PLUS	Tier 1	
MAG-AL PLUS EXTRA STRENGTH	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>magnesium oxide oral capsule</i>	Tier 1	
<i>magnesium oxide oral tablet 250 mg magnesium, 400 mg (241.3 mg magnesium), 400 mg magnesium, 420 mg, 500 mg magnesium</i>	Tier 1	
MAGOX	Tier 1	
MINTOX MAXIMUM STRENGTH	Tier 1	
PEPTO-BISMOL	Tier 1	
PEPTO-BISMOL MAX ST	Tier 1	
PEPTO-BISMOL TO-GO	Tier 1	
PHILLIPS	Tier 1	
PINK BISMUTH MAXIMUM STRENGTH	Tier 1	
PINK BISMUTH ORAL SUSPENSION 262 MG/15 ML	Tier 1	
PINK BISMUTH ORAL TABLET	Tier 1	
PINK BISMUTH ORAL TABLET,CHEWABLE	Tier 1	
<i>sodium bicarbonate oral</i>	Tier 1	
SOOTHE (BISMUTH SUBSALICYLATE)	Tier 1	
SOOTHE REGULAR STRENGTH	Tier 1	
STOMACH RELIEF	Tier 1	

Drug	Status	Notes
STOMACH RELIEF MAX STRENGTH	Tier 1	
STOMACH RELIEF ORIGINAL	Tier 1	
TUMS	Tier 1	
TUMS E-X	Tier 1	
TUMS EXTRA STRENGTH SMOOTHIES	Tier 1	
TUMS FRESHERS	Tier 1	
TUMS ULTRA ORAL TABLET,CHEWABLE 400 MG CALCIUM (1,000 MG)	Tier 1	
ULTRA STRENGTH ANTACID	Tier 1	
URO-MAG	Tier 1	
Antidiarrhea Agents		
ANTI-DIARRHEAL	Tier 1	
ANTI-DIARRHEAL (LOPERAMIDE) ORAL CAPSULE	Tier 1	
ANTI-DIARRHEAL (LOPERAMIDE) ORAL LIQUID	Tier 2	
ANTI-DIARRHEAL (LOPERAMIDE) ORAL TABLET	Tier 2	
BISMUTH	Tier 1	
<i>bismuth subsalicylate oral tablet,chewable</i>	Tier 1	
DIARRHEA RELIEF (BISMUTH SUBS)	Tier 1	
DIOTAME	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>diphenoxylate-atropine</i>	Tier 2	
KAOPECTATE (BISMUTH SUBSALICY) ORAL SUSPENSION	Tier 1	
KAOPECTATE EX STR (BISMUTH SS)	Tier 1	
K-PEC ANTIDIARRHEAL (BISM SUB)	Tier 1	
<i>loperamide oral capsule</i>	Tier 2	
<i>loperamide oral liquid</i>	Tier 1	
PEPTO-BISMOL	Tier 1	
PEPTO-BISMOL MAX ST	Tier 1	
PEPTO-BISMOL TO-GO	Tier 1	
PINK BISMUTH MAXIMUM STRENGTH	Tier 1	
PINK BISMUTH ORAL SUSPENSION 262 MG/15 ML	Tier 1	
PINK BISMUTH ORAL TABLET	Tier 1	
PINK BISMUTH ORAL TABLET,CHEWABLE	Tier 1	
SOOTHE (BISMUTH SUBSALICYLATE)	Tier 1	
SOOTHE REGULAR STRENGTH	Tier 1	
STOMACH RELIEF	Tier 1	

Drug	Status	Notes
STOMACH RELIEF MAX STRENGTH	Tier 1	
STOMACH RELIEF ORIGINAL	Tier 1	
Antiemetics, Miscellaneous		
<i>dronabinol</i>	Tier 1	PA
Antiflatulents		
ADVANCED ANTACID-ANTIGAS	Tier 1	
ALMACONE-2	Tier 1	
ANTACID	Tier 1	
ANTACID ANTI-GAS	Tier 1	
ANTACID LIQUID	Tier 1	
ANTACID M	Tier 1	
ANTACID MAXIMUM STRENGTH	Tier 1	
ANTACID PLUS ANTI-GAS	Tier 1	
ANTACID REGULAR STRENGTH	Tier 1	
ANTACID-ANTIGAS	Tier 1	
COMFORT GEL	Tier 1	
COMFORT GEL EXTRA STRENGTH	Tier 1	
GAS RELIEF (SIMETHICONE) ORAL TABLET,CHEWABLE	Tier 1	
GAS RELIEF 80 (SIMETHICONE)	Tier 1	
GAS RELIEF EXTRA STRENGTH ORAL TABLET,CHEWABLE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
GAS-X EXTRA STRENGTH ORAL TABLET,CHEWABLE	Tier 1	
GERI-LANTA ORAL SUSPENSION 200-200-20 MG/5 ML	Tier 1	
GERI-MOX ANTACID-ANTIGAS	Tier 1	
INFANTS GAS RELIEF ORAL DROPS,SUSPENSION	Tier 1	
MAG-AL PLUS	Tier 1	
MAG-AL PLUS EXTRA STRENGTH	Tier 1	
MINTOX MAXIMUM STRENGTH	Tier 1	
<i>simethicone oral tablet,chewable</i>	Tier 1	
Antihistamines (Gi Drugs)		
<i>dimenhydrinate oral</i>	Tier 1	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	Tier 1	
<i>meclizine oral tablet,chewable</i>	Tier 1	
<i>prochlorperazine</i>	Tier 1	QL (2 suppositories per 1 day)
<i>prochlorperazine maleate</i>	Tier 1	QL (4 tablets per 1 day)
Anti-Inflammatory Agents (Gi Drugs)		
<i>alosetron</i>	Tier 3	PA
APRISO	Tier 2	

Drug	Status	Notes
<i>balsalazide</i>	Tier 3	PA
COLAZAL	Tier 3	PA
DELZICOL	Tier 3	PA
DIPENTUM	Tier 3	PA
LIALDA	Tier 2	
LOTRONEX	Tier 3	PA
<i>mesalamine oral</i>	Tier 3	PA
<i>mesalamine rectal enema</i>	Tier 1	
PENTASA	Tier 3	PA
Antiulcer Agents And Acid Suppress.,Misc		
<i>bismuth subcit k-metronidz-tcn</i>	Tier 3	PA
PYLERA	Tier 2	
TALICIA	Tier 3	PA
Cathartics And Laxatives		
ALOPHEN (BISACODYL)	Tier 1	
AMITIZA	Tier 2	
<i>bisacodyl</i>	Tier 1	
CITRATE OF MAGNESIA	Tier 1	
CITROMA	Tier 1	
COLACE CLEAR	Tier 1	
CORRECTOL	Tier 1	
DAILY FIBER (PSYLLIUM-SUCROSE) ORAL POWDER 3.4 GRAM/7 GRAM	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
DOCUPRENE	Tier 1	
<i>docusate calcium</i>	Tier 1	
<i>docusate sodium oral capsule</i>	Tier 1	
<i>docusate sodium oral liquid</i>	Tier 1	
<i>docusate sodium oral tablet</i>	Tier 1	
<i>docusate sodium rectal</i>	Tier 1	
DOK ORAL TABLET	Tier 1	
DULCOLAX (BISACODYL) ORAL	Tier 1	
ENEMA	Tier 1	
ENEMA DISPOSABLE	Tier 1	
ENEMEEZ PLUS	Tier 1	
EX-LAX (SENNOSIDES) ORAL TABLET	Tier 1	
EX-LAX MAXIMUM STRENGTH	Tier 1	
FIBER (PSYLLIUM HUSK-SUGAR) ORAL POWDER 3.4 GRAM/7 GRAM	Tier 1	
FIBER (WITH ASPARTAME) ORAL POWDER 3.4 GRAM/5.8 GRAM	Tier 1	
FLEET ENEMA	Tier 1	
FLEET MINERAL OIL	Tier 1	
GENTLE LAXATIVE (BISACODYL) ORAL	Tier 1	
GERI-KOT	Tier 1	

Drug	Status	Notes
GERI-MUCIL (ASPARTAME)	Tier 1	
LAXATIVE (BISACODYL) ORAL	Tier 1	
LAXATIVE (SENNOSIDES)	Tier 1	
LAXATIVE PEG 3350	Tier 1	
LAXATIVE PILLS	Tier 1	
LAXATIVE PILLS REGULAR	Tier 1	
<i>lubiprostone</i>	Tier 3	PA
<i>magnesium citrate oral solution</i>	Tier 1	
<i>magnesium hydroxide oral suspension 400 mg/5 ml</i>	Tier 1	
METAMUCIL (SUGAR)	Tier 1	
METAMUCIL (WITH SUGAR) ORAL POWDER 3.4 GRAM/7 GRAM	Tier 1	
METAMUCIL MULTIHEALTH FIBER	Tier 1	
METAMUCIL SUGAR-FREE (ASPART)	Tier 1	
MILK OF MAGNESIA	Tier 1	
<i>mineral oil rectal</i>	Tier 1	
NATURAL DAILY FIBER	Tier 1	
NATURAL FIBER LAXATIVE (SUGAR)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
NATURAL FIBER LAXATIVE(ASPART)	Tier 1	
NATURAL SENNA LAXATIVE	Tier 1	
NATURAL VEG LAXATIVE(SENNOSID)	Tier 1	
P-COL RITE	Tier 1	
PEDIATRIC ENEMA	Tier 1	
<i>peg 3350-electrolytes</i>	Tier 1	
<i>peg-electrolyte soln</i>	Tier 1	
PERDIEM OVERNIGHT RELIEF	Tier 1	
PHILLIPS MILK OF MAGNESIA ORAL SUSPENSION	Tier 1	
<i>polyethylene glycol 3350 oral powder</i>	Tier 1	
PROMOLAXIN	Tier 1	
READY-TO-USE ENEMA	Tier 1	
READY-TO-USE ENEMA (MIN OIL)	Tier 1	
SENEXON-S	Tier 1	
SENNALAX	Tier 1	
SENNALAXATIVE	Tier 1	
SENNALAX ORAL CAPSULE	Tier 1	
SENNALAX ORAL SYRUP 8.8 MG/5 ML	Tier 1	
SENNALAX ORAL TABLET	Tier 1	
SENNALAX PLUS ORAL TABLET	Tier 1	

Drug	Status	Notes
SENNALAX WITH DOCUSATE SODIUM	Tier 1	
SENNALAX-S	Tier 1	
SENNALAX-TIME S	Tier 1	
<i>sennosides oral syrup</i>	Tier 1	
<i>sennosides-docusate sodium</i>	Tier 1	
SENNALAX EXTRA STRENGTH	Tier 1	
SENNALAX ORAL TABLET	Tier 1	
SENNALAX-S	Tier 1	
SENNALAX-O-TAB	Tier 1	
<i>sodium,potassium,mag sulfates</i>	Tier 1	
STIMULANT LAXATIVE PLUS	Tier 1	
STOOL SOFTENER ORAL CAPSULE 50 MG	Tier 1	
STOOL SOFTENER ORAL TABLET	Tier 1	
STOOL SOFTENER-LAXATIVE	Tier 1	
STOOL SOFTENER-STIMULANT LAXATIVE ORAL TABLET	Tier 1	
VEGETABLE LAXATIVE	Tier 1	
WAL-MUCIL FIBER (ASPARTAME)	Tier 1	
WAL-MUCIL FIBER (SUGAR)	Tier 1	
WOMAN'S LAXATIVE (BISACODYL)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
WOMEN'S GENTLE LAXATIVE(BISAC)	Tier 1	
WOMEN'S LAXATIVE (BISACODYL) ORAL TABLET	Tier 1	
Cholelitholytic Agents		
RELTONE	Tier 3	PA
URSO 250	Tier 3	PA
URSO FORTE	Tier 3	PA
<i>ursodiol oral capsule 300 mg</i>	Tier 2	
<i>ursodiol oral tablet</i>	Tier 2	
Digestants		
CREON	Tier 2	PA
PERTZYE	Tier 3	PA
VIOKACE	Tier 3	PA
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000-84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000-24,000 UNIT	Tier 2	PA
Gi Drugs, Miscellaneous		
<i>adalimumab-adaz</i>	Tier 3	PA
<i>adalimumab-fkjp</i>	Tier 3	PA

Drug	Status	Notes
AMJEVITA(CF)	Tier 3	PA
AMJEVITA(CF) AUTOINJECTOR	Tier 3	PA
CIMZIA	Tier 3	PA
CIMZIA POWDER FOR RECONST	Tier 3	PA
CIMZIA STARTER KIT	Tier 3	PA
CULTURELLE ORAL CAPSULE, SPRINKLE	Tier 1	
CYLTEZO(CF)	Tier 3	PA
CYLTEZO(CF) PEN	Tier 3	PA
CYLTEZO(CF) PEN CROHN'S-UC-HS	Tier 3	PA
CYLTEZO(CF) PEN PSORIASIS-UV	Tier 3	PA
ENDARI	Tier 1	PA; QL (180 packets per 30 dayss); AGE (Min 5 Years)
HADLIMA	Tier 3	PA
HADLIMA PUSHTOUCH	Tier 3	PA
HADLIMA(CF)	Tier 3	PA
HADLIMA(CF) PUSHTOUCH	Tier 3	PA
HULIO(CF)	Tier 3	PA
HULIO(CF) PEN	Tier 3	PA
HUMIRA PEN	Tier 2	
HUMIRA PEN CROHNS-UC-HS START	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	Tier 2	
HUMIRA(CF)	Tier 2	
HUMIRA(CF) PEDI CROHNS STARTER	Tier 2	
HUMIRA(CF) PEN	Tier 2	
HUMIRA(CF) PEN CROHNS-UC-HS	Tier 2	
HUMIRA(CF) PEN PSOR-UV-ADOL HS	Tier 2	
HYRIMOZ PEN CROHN'S-UC STARTER	Tier 3	PA
HYRIMOZ PEN PSORIASIS STARTER	Tier 3	PA
HYRIMOZ(CF)	Tier 3	PA
HYRIMOZ(CF) PEDI CROHN STARTER	Tier 3	PA
HYRIMOZ(CF) PEN	Tier 3	PA
IBSRELA	Tier 3	PA; QL (2 tablets per 1 day); AGE (Min 18 Years)
IDACIO(CF)	Tier 3	PA
IDACIO(CF) PEN	Tier 3	PA
IDACIO(CF) PEN CROHN-UC STARTER	Tier 3	PA
IDACIO(CF) PEN PSORIASIS START	Tier 3	PA
LINZESS	Tier 2	
MOVANTIK	Tier 3	PA

Drug	Status	Notes
<i>orlistat</i>	Tier 2	PA; AGE (Min 12 Years)
RELISTOR ORAL	Tier 3	PA
RELISTOR SUBCUTANEOUS SOLUTION	Tier 3	PA
RELISTOR SUBCUTANEOUS SYRINGE	Tier 3	PA
SIMPONI	Tier 3	PA
SIMPONI ARIA	Tier 3	PA
SYMPROIC	Tier 3	PA
TRULANCE	Tier 3	PA
VIBERZI	Tier 3	PA; QL (60 tablets per 30 days)
XENICAL	Tier 2	PA; AGE (Min 12 Years)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	Tier 3	PA
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	Tier 3	PA
YUSIMRY(CF) PEN	Tier 3	PA
Histamine H2-Antagonists		
<i>cimetidine</i>	Tier 1	
DUEXIS	Tier 3	PA
<i>famotidine oral suspension for reconstitution</i>	Tier 1	QL (5 ML per 1 day); AGE (Max 6 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>famotidine oral tablet</i>	Tier 1	
<i>ibuprofen-famotidine</i>	Tier 3	PA
Immunomodulatory Agent		
ENTYVIO	Tier 3	PA
ENTYVIO PEN	Tier 3	PA
Lipotropic Agents		
ALGAL OMEGA-3 DHA	Tier 1	
PRENATAL DHA	Tier 1	
Neurokinin-1 Receptor Antagonists		
AKYNZEO (NETUPITANT)	Tier 3	PA; QL (1 Box per 1 Claim)
<i>aprepitant oral capsule 125 mg, 40 mg</i>	Tier 3	PA; QL (1 capsule per 1 fill); AGE (Min 12 Years)
<i>aprepitant oral capsule 80 mg</i>	Tier 3	PA; QL (2 capsules per 1 fill); AGE (Min 12 Years)
<i>aprepitant oral capsule, dose pack</i>	Tier 3	PA; QL (3 capsules per 1 fill); AGE (Min 12 Years)
EMEND ORAL CAPSULE 80 MG	Tier 2	QL (2 capsules per 1 fill); AGE (Min 12 Years)

Drug	Status	Notes
EMEND ORAL CAPSULE, DOSE PACK	Tier 3	PA; QL (3 capsules per 1 fill); AGE (Min 12 Years)
EMEND ORAL SUSPENSION FOR RECONSTITUTION	Tier 3	PA; QL (1 ML per 30 days); AGE (Min 12 Years)
Prokinetic Agents		
<i>metoclopramide hcl oral solution</i>	Tier 1	
<i>metoclopramide hcl oral tablet</i>	Tier 1	
MOTEGRITY	Tier 3	PA
Prostaglandins		
ARTHROTEC 50	Tier 3	PA
ARTHROTEC 75	Tier 3	PA
<i>diclofenac-misoprostol</i>	Tier 3	PA
<i>misoprostol</i>	Tier 1	QL (4 tablets per 1 day)
Protectants		
<i>sucralfate oral tablet</i>	Tier 1	QL (4 tablets per 1 day)
Proton-Pump Inhibitors		
ACID REDUCER (OMEPRAZOLE)	Tier 3	PA
ACIPHEX	Tier 3	PA
ACIPHEX SPRINKLE	Tier 3	PA
<i>amoxicil-clarithromy-lansopraz</i>	Tier 3	PA; QL (224 capsules per 1 fill)
DEXILANT	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>dexlansoprazole</i>	Tier 3	PA
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	Tier 3	PA
<i>esomeprazole magnesium oral granules dr for susp in packet</i>	Tier 3	PA; QL (2 packets per 1 day)
<i>esomeprazole magnesium oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
KONVOMEF	Tier 3	PA
<i>lansoprazole</i>	Tier 3	PA
<i>naproxen-esomeprazole</i>	Tier 3	PA
NEXIUM	Tier 3	PA
NEXIUM PACKET	Tier 2	QL (2 packets per 1 day)
OMECLAMOX-PAK	Tier 3	PA
<i>omeprazole magnesium</i>	Tier 3	PA
<i>omeprazole oral capsule, delayed release(dr/ec)</i>	Tier 2	QL (2 capsules per 1 day)
<i>omeprazole oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
<i>omeprazole oral tablet, disintegrat, delay rel</i>	Tier 3	PA
<i>omeprazole-sodium bicarbonate</i>	Tier 3	PA

Drug	Status	Notes
<i>pantoprazole oral granules dr for susp in packet</i>	Tier 3	PA; QL (2 packets per 1 day)
<i>pantoprazole oral tablet, delayed release (dr/ec)</i>	Tier 2	QL (2 tablets per 1 day)
PREVACID 24HR	Tier 3	PA
PREVACID ORAL CAPSULE, DELAYED RELEASE(DR/EC) 30 MG	Tier 3	PA
PREVACID SOLUTAB	Tier 3	PA
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON	Tier 3	PA
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET	Tier 2	QL (2 paclets per 1 day)
PROTONIX ORAL TABLET, DELAYED RELEASE (DR/EC)	Tier 2	QL (2 tablets per 1 day)
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
TALICIA	Tier 3	PA
VIMOVO	Tier 3	PA
YOSPRALA	Tier 3	PA
ZEGERID	Tier 3	PA
Heavy Metal Antagonists		
Heavy Metal Antagonists		
CHEMET	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Hormones And Synthetic Substitutes		
Adrenals		
ADVAIR DISKUS	Tier 2	QL (3 Inhalers per 90 days)
ADVAIR HFA	Tier 2	QL (1 inhaler per 30 days)
AIRDUO DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
ALKINDI SPRINKLE	Tier 1	
ALVESCO	Tier 3	
ARMONAIR DIGIHALER	Tier 3	PA
ARNUITY ELLIPTA	Tier 3	PA
ASMANEX HFA	Tier 3	PA; QL (3 inhalers per 90 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30)	Tier 2	QL (1 inhaler per 30 days); AGE (Max 11 Years)

Drug	Status	Notes
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	Tier 2	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	Tier 3	PA; QL (60 blisters per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 50-25 MCG/DOSE	Tier 3	PA; QL (60 EA per 30 days)
<i>budesonide inhalation</i>	Tier 2	QL (2 respules per 1 day)
<i>budesonide oral capsule, delayed, extended release</i>	Tier 1	PA; QL (16 weeks per 4 months)
<i>budesonide oral tablet, delayed and extended release</i>	Tier 3	PA
<i>budesonide-formoterol</i>	Tier 3	PA; QL (2 inhalers per 30 days)
<i>dexamethasone oral elixir</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>dexamethasone oral solution</i>	Tier 1	
<i>dexamethasone oral tablet</i>	Tier 1	
<i>dexamethasone sodium phos (pf) injection syringe</i>	Tier 1	
<i>dexamethasone sodium phosphate injection syringe</i>	Tier 1	
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	Tier 2	QL (3 inhalers per 90 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION	Tier 2	QL (3 Inhalers per 90 days)
EMFLAZA	Tier 1	
<i>fludrocortisone</i>	Tier 1	
<i>fluticasone furoate-vilanterol</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propionate inhalation blister with device</i>	Tier 3	PA
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation, 44 mcg/actuation</i>	Tier 3	PA; QL (3 inhalers per 90 days)

Drug	Status	Notes
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	Tier 3	PA; QL (6 inhalers per 90 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	Tier 3	PA; QL (1 inhaler per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propion-salmeterol inhalation hfa aerosol inhaler</i>	Tier 3	PA; QL (1 inhaler per 30 days)
HEMADY	Tier 1	
<i>hydrocortisone oral</i>	Tier 1	
<i>methylprednisolone</i>	Tier 1	
<i>prednisolone oral solution</i>	Tier 1	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	Tier 1	
<i>prednisone</i>	Tier 1	
PULMICORT	Tier 3	PA; QL (2 respules per 1 day)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	Tier 3	PA; QL (6 inhalers per 90 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	Tier 3	PA; QL (3 inhalers per 90 days)
QVAR REDIHALER	Tier 3	PA
SYMBICORT	Tier 2	QL (2 inhalers per 30 days)
TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (27 TABS), 1.5 MG (49 TABS)	Tier 1	
UCERIS ORAL	Tier 3	PA
WIXELA INHUB	Tier 3	PA; QL (60 blisters per 30 days)
Alpha-Glucosidase Inhibitors		
<i>acarbose</i>	Tier 2	
<i>miglitol</i>	Tier 2	
PRECOSE	Tier 3	PA
Amylinomimetics		
SYMLINPEN 120	Tier 2	
SYMLINPEN 60	Tier 2	
Androgens		
ANDRODERM	Tier 3	PA
ANDROGEL	Tier 3	PA
<i>danazol</i>	Tier 1	
FORTESTA	Tier 3	PA
NATESTO	Tier 3	PA
TESTIM	Tier 3	PA

Drug	Status	Notes
<i>testosterone cypionate</i>	Tier 1	
<i>testosterone transdermal gel</i>	Tier 3	PA
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %)</i>	Tier 3	PA
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	Tier 2	PA
<i>testosterone transdermal gel in packet</i>	Tier 3	PA
<i>testosterone transdermal solution in metered pump w/app</i>	Tier 3	PA
VOGELXO	Tier 3	PA
Antidiabetic Agents, Miscellaneous		
<i>colesevelam</i>	Tier 3	PA
WELCHOL	Tier 3	PA
Antiestrogens		
<i>anastrozole</i>	Tier 1	
<i>exemestane</i>	Tier 1	
KISQALI FEMARA CO-PACK	Tier 1	
<i>letrozole</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Antigonadotropins		
MYFEMBREE	Tier 2	PA; QL (28 EA per 28 days); AGE (Min 18 Years)
ORGOVYX	Tier 1	
ORIAHNN	Tier 2	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
ORLISSA ORAL TABLET 150 MG	Tier 1	PA; QL (28 EA per 28 days); AGE (Min 18 Years)
ORLISSA ORAL TABLET 200 MG	Tier 1	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
Antihypoglycemic Agents, Miscellaneous		
<i>diazoxide</i>	Tier 3	PA
PROGLYCEM	Tier 2	
Antiparathyroid Agents		
<i>calcitonin (salmon) nasal</i>	Tier 2	
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	Tier 1	PA; QL (2 tablets per 1 day)
<i>cinacalcet oral tablet 90 mg</i>	Tier 1	PA; QL (4 tablets per 1 day)

Drug	Status	Notes
Antithyroid Agents		
<i>methimazole oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>propylthiouracil</i>	Tier 1	
Biguanides		
ACTOPLUS MET ORAL TABLET 15-850 MG	Tier 3	PA
<i>alogliptin-metformin</i>	Tier 3	PA
<i>dapaglifloz propaned-metformin</i>	Tier 3	PA
<i>glipizide-metformin</i>	Tier 3	PA
GLUMETZA	Tier 3	PA
<i>glyburide-metformin</i>	Tier 2	
INVOKAMET	Tier 2	
INVOKAMET XR	Tier 3	PA
JANUMET	Tier 2	QL (2 tablets per 1 day)
JANUMET XR	Tier 2	
JENTADUETO	Tier 2	
JENTADUETO XR	Tier 3	PA
KAZANO	Tier 3	PA
KOMBIGLYZE XR	Tier 3	PA
<i>metformin oral solution</i>	Tier 3	PA
<i>metformin oral tablet</i>	Tier 2	
<i>metformin oral tablet extended release 24 hr</i>	Tier 2	
<i>metformin oral tablet extended release 24hr</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>metformin oral tablet,er gast.retention 24 hr</i>	Tier 3	PA
<i>pioglitazone-metformin</i>	Tier 3	PA
RIOMET	Tier 3	PA
RIOMET ER	Tier 3	PA
<i>saxagliptin-metformin</i>	Tier 3	PA
SEGLUROMET	Tier 3	PA
SYNJARDY	Tier 2	
SYNJARDY XR	Tier 3	PA
TRIJARDY XR	Tier 3	PA
XIGDUO XR	Tier 2	
Contraceptives		
AFTERA	Tier 1	
ALYACEN 1/35 (28)	Tier 1	
ALYACEN 7/7/7 (28)	Tier 1	
APRI	Tier 1	
ARANELLE (28)	Tier 1	
AVIANE	Tier 1	
AZURETTE (28)	Tier 1	
BLISOVI 24 FE	Tier 1	
BLISOVI FE 1.5/30 (28)	Tier 1	
BLISOVI FE 1/20 (28)	Tier 1	
BRIELLYN	Tier 1	
CAMILA	Tier 1	
CAZIAN (28)	Tier 1	
CRYSSELLE (28)	Tier 1	
DASETTA 1/35 (28)	Tier 1	
DASETTA 7/7/7 (28)	Tier 1	
DEBLITANE	Tier 1	

Drug	Status	Notes
<i>desog-e.estradiol/e.estradiol</i>	Tier 1	
<i>desogestrel-ethinyl estradiol</i>	Tier 1	
<i>drospirenone-ethinyl estradiol</i>	Tier 1	
ECONTRA EZ	Tier 1	
ELINEST	Tier 1	
ELLA	Tier 1	
ELURYNG	Tier 1	QL (3 rings per 84 days)
ENPRESSE	Tier 1	
ENSKYCE	Tier 1	
ERRIN	Tier 1	
ESTARYLLA	Tier 1	
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	Tier 1	
<i>etonogestrel-ethinyl estradiol</i>	Tier 1	QL (3 rings per 84 days)
FALMINA (28)	Tier 1	
HEATHER	Tier 1	
ISIBLOOM	Tier 1	
JENCYCLA	Tier 1	
JULEBER	Tier 1	
JUNEL 1/20 (21)	Tier 1	
JUNEL FE 1.5/30 (28)	Tier 1	
KELNOR 1/35 (28)	Tier 1	
KURVELO (28)	Tier 1	
LARIN 1.5/30 (21)	Tier 1	
LARIN 1/20 (21)	Tier 1	
LARIN FE 1.5/30 (28)	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
LARIN FE 1/20 (28)	Tier 1	
LEENA 28	Tier 1	
LEVONEST (28)	Tier 1	
<i>levonorgestrel-ethinyl estrad</i>	Tier 1	
LOW-OGESTREL (28)	Tier 1	
LUTERA (28)	Tier 1	
MARLISSA (28)	Tier 1	
MIBELAS 24 FE	Tier 1	
MICROGESTIN 1.5/30 (21)	Tier 1	
MICROGESTIN FE 1.5/30 (28)	Tier 1	
MICROGESTIN FE 1/20 (28)	Tier 1	
MONO-LINYAH	Tier 1	
MY WAY	Tier 1	
NIKKI (28)	Tier 1	
NORA-BE	Tier 1	
<i>noreth-ethinyl estradiol-iron</i>	Tier 1	
<i>norethindrone (contraceptive)</i>	Tier 1	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	Tier 1	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	Tier 1	
<i>norgestimate-ethinyl estradiol</i>	Tier 1	
NORTREL 0.5/35 (28)	Tier 1	

Drug	Status	Notes
NORTREL 1/35 (28)	Tier 1	
OPCICON ONE-STEP	Tier 1	
PHILITH	Tier 1	
PIMTREA (28)	Tier 1	
PORTIA 28	Tier 1	
RECLIPSEN (28)	Tier 1	
SETLAKIN	Tier 1	
SHAROBEL	Tier 1	
SPRINTEC (28)	Tier 1	
SRONYX	Tier 1	
TAKE ACTION	Tier 1	
TARINA FE 1/20 (28)	Tier 1	
TRI-ESTARYLLA	Tier 1	
TRI-LEGEST FE	Tier 1	
TRI-LINYAH	Tier 1	
TRI-LO-MARZIA	Tier 1	
TRI-LO-SPRINTEC	Tier 1	
TRI-SPRINTEC (28)	Tier 1	
TRIVORA (28)	Tier 1	
TRI-VYLIBRA LO	Tier 1	
VELIVET TRIPHASIC REGIMEN (28)	Tier 1	
VESTURA (28)	Tier 1	
VYFEMLA (28)	Tier 1	
WERA (28)	Tier 1	
XULANE	Tier 1	QL (9 patches per 84 dayss)
ZAFEMY	Tier 1	QL (9 patches per 84 days)
ZARAH	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
Dipeptidyl Peptidase-4(Dpp-4) Inhibitors		
<i>alogliptin</i>	Tier 3	PA
<i>alogliptin-metformin</i>	Tier 3	PA
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	Tier 3	PA
GLYXAMBI	Tier 2	PA
JANUMET	Tier 2	QL (2 tablets per 1 day)
JANUMET XR	Tier 2	
JANUVIA	Tier 2	QL (2 tablets per 1 day)
JENTADUETO	Tier 2	
JENTADUETO XR	Tier 3	PA
KAZANO	Tier 3	PA
KOMBIGLYZE XR	Tier 3	PA
NESINA	Tier 3	PA
ONGLYZA	Tier 3	PA
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	Tier 3	PA
QTERN	Tier 3	PA
<i>saxagliptin</i>	Tier 3	PA
<i>saxagliptin-metformin</i>	Tier 3	PA
STEGLUJAN	Tier 3	PA
TRADJENTA	Tier 2	
TRIJARDY XR	Tier 3	PA

Drug	Status	Notes
Estrogen Agonist-Antagonists		
EVISTA	Tier 3	PA
<i>raloxifene</i>	Tier 2	
<i>tamoxifen</i>	Tier 1	
<i>toremifene</i>	Tier 1	
Estrogens		
DELESTROGEN	Tier 1	
<i>estradiol oral</i>	Tier 1	AGE (Max 64 Years)
<i>estradiol transdermal patch semiweekly</i>	Tier 1	QL (8 patches per 28 days); AGE (Max 64 Years)
<i>estradiol transdermal patch weekly</i>	Tier 1	QL (4 patches per 28 days); AGE (Max 64 Years)
<i>estradiol vaginal cream</i>	Tier 1	QL (42.5 GM per 30 days)
<i>estradiol vaginal tablet</i>	Tier 1	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	Tier 1	
<i>estradiol-norethindrone acet</i>	Tier 1	AGE (Max 64 Years)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	Tier 1	AGE (Max 64 Years)
MYFEMBREE	Tier 2	PA; QL (28 EA per 28 days); AGE (Min 18 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
<i>norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg</i>	Tier 1	AGE (Max 64 Years)
ORIAHNN	Tier 2	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
PREMARIN ORAL	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
PREMPHASE	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
PREMPRO	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
VAGIFEM	Tier 1	
YUVAFEM	Tier 1	
Glycogenolytic Agents		
BAQSIMI	Tier 2	QL (2 Devices per 30 days)
GLUCAGEN HYPOKIT	Tier 2	
GLUCAGON (HCL) EMERGENCY KIT	Tier 3	PA; QL (6 EA per 1 Fill)
GLUCAGON EMERGENCY KIT (HUMAN)	Tier 2	QL (6 EA per 1 Fill)

Drug	Status	Notes
GVOKE	Tier 3	PA; QL (0.4 ML per 30 days)
GVOKE HYPOPEN 1-PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE HYPOPEN 2-PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)
ZEGALOGUE AUTOINJECTOR	Tier 2	
ZEGALOGUE SYRINGE	Tier 2	
Gonadotropins		
CAMCEVI (6 MONTH)	Tier 1	
<i>leuprolide (3 month)</i>	Tier 1	
<i>leuprolide subcutaneous kit</i>	Tier 1	
Incretin Mimetics		
BYDUREON BCISE	Tier 3	PA; QL (3.4 ML per 28 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	Tier 2	QL (2.4 ML per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	Tier 2	QL (1.2 ML per 30 days)
MOUNJARO	Tier 3	PA; QL (2 ML per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	Tier 3	PA; QL (3 ML per 28 days)
RYBELSUS	Tier 3	PA; QL (1 EA per 1 day)
SAXENDA	Tier 1	PA; AGE (Min 18 Years)
SOLIQUA 100/33	Tier 3	PA; QL (15 ML per 28 days)
TRULICITY	Tier 2	PA; QL (4 Pens per 28 days)
VICTOZA 2-PAK	Tier 2	PA; QL (6 ML per 30 days)
VICTOZA 3-PAK	Tier 2	PA; QL (9 ML per 30 days)
WEGOVY	Tier 2	PA; AGE (Min 12 Years)

Drug	Status	Notes
XULTOPHY 100/3.6	Tier 3	PA; QL (15 ML per 30 days)
Insulins		
ADMELOG SOLOSTAR U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
ADMELOG U-100 INSULIN LISPRO	Tier 3	PA; QL (90 ML per 1 fill)
AFREZZA	Tier 3	PA; QL (180 cartridges per 1 fill)
APIDRA SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
APIDRA U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
BASAGLAR KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
BASAGLAR TEMPO PEN(U-100)INSLN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP FLEXTOUCH U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PENFILL U- 100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PUMPCART	Tier 3	PA; QL (90 ML per 1 Fill)
FIASP U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
HUMALOG JUNIOR KWIKPEN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Tier 2	QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Tier 3	PA; QL (90 ML per 1 fill)
HUMALOG MIX 50-50 INSULN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 50-50 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG TEMPO PEN(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMULIN N NPH INSULIN KWIKPEN	Tier 3	PA; QL (90 ML per 1 fill)
HUMULIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R REGULAR U-100 INSULN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) KWIKPEN	Tier 2	QL (90 ML per 1 fill)
<i>insulin asp prt-insulin aspart</i>	Tier 2	QL (90 ML per 1 fill)

Drug	Status	Notes
<i>insulin aspart u-100 subcutaneous cartridge</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin degludec</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin glargine u-300 conc</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin glargine-yfqn</i>	Tier 3	PA; QL (90 ML per 1 claim)
<i>insulin lispro protamin-lispro</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous insulin pen, half-unit</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
LANTUS SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LANTUS U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR FLEXPEN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
LYUMJEV KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV KWIKPEN U-200 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV TEMPO PEN(U-100)INSULN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70/30 U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70-30 FLEXPEN U-100	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN N FLEXPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN R FLEXPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN R REGULAR U100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG FLEXPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30 U-100 INSULN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30FLEXPEN U-100	Tier 2	QL (90 ML per 1 fill)
NOVOLOG PENFILL U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG U-100 INSULIN ASPART	Tier 3	PA; QL (90 ML per 1 fill)
REZVOGLAR KWIKPEN	Tier 3	PA; QL (90 ML per 1 Fill)

Drug	Status	Notes
SEMGLEE(INSULIN GLARGINE-YFGN)	Tier 3	PA; QL (90 ML per 1 claim)
SEMGLEE(INSULIN GLARG-YFGN)PEN	Tier 3	PA; QL (90 ML per 1 claim)
SOLIQUA 100/33	Tier 3	PA; QL (15 ML per 28 days)
TOUJEO MAX U-300 SOLOSTAR	Tier 3	PA; QL (90 ML per 1 fill)
TOUJEO SOLOSTAR U-300 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-100	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-200	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
XULTOPHY 100/3.6	Tier 3	PA; QL (15 ML per 30 days)
Intermediate-Acting Insulins		
HUMALOG MIX 50-50 INSULN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 50-50 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 KWIKPEN	Tier 2	QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
HUMULIN N NPH INSULIN KWIKPEN	Tier 3	PA; QL (90 ML per 1 fill)
HUMULIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
<i>insulin asp prt-insulin aspart</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro protamin-lispro</i>	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70/30 U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70-30 FLEXPEN U-100	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN N FLEXPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN N NPH U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG MIX 70-30 U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30 FLEXPEN U-100	Tier 2	QL (90 ML per 1 fill)
Long-Acting Insulins		
BASAGLAR KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
BASAGLAR TEMPO PEN(U-100)INSLN	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin degludec</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin glargine u-300 conc</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin glargine-yfgn</i>	Tier 3	PA; QL (90 ML per 1 claim)

Drug	Status	Notes
LANTUS SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LANTUS U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR FLEXPEN	Tier 2	QL (90 ML per 1 fill)
LEVEMIR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
REZVOGLAR KWIKPEN	Tier 3	PA; QL (90 ML per 1 Fill)
SEMGLEE(INSULIN GLARGINE-YFGN)	Tier 3	PA; QL (90 ML per 1 claim)
SEMGLEE(INSULIN GLARG-YFGN)PEN	Tier 3	PA; QL (90 ML per 1 claim)
SOLIQUA 100/33	Tier 3	PA; QL (15 ML per 28 days)
TOUJEO MAX U-300 SOLOSTAR	Tier 3	PA; QL (90 ML per 1 fill)
TOUJEO SOLOSTAR U-300 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-100	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA FLEXTOUCH U-200	Tier 3	PA; QL (90 ML per 1 fill)
TRESIBA U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
XULTOPHY 100/3.6	Tier 3	PA; QL (15 ML per 30 days)
Meglitinides		
<i>nateglinide</i>	Tier 2	
<i>repaglinide</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Parathyroid Agents		
FORTEO	Tier 3	PA
<i>teriparatide</i>	Tier 3	PA
TYMLOS	Tier 3	PA
Pituitary		
<i>desmopressin nasal spray with pump</i>	Tier 1	PA
<i>desmopressin nasal spray, non-aerosol 10 mcg/spray (0.1 ml)</i>	Tier 1	PA
<i>desmopressin oral</i>	Tier 1	QL (6 tablets per 1 day)
GENOTROPIN	Tier 2	PA
GENOTROPIN MINIQUICK	Tier 2	PA
HUMATROPE INJECTION CARTRIDGE	Tier 3	PA
NORDITROPIN FLEXPRO	Tier 2	PA
NUTROPIN AQ NUSPIN	Tier 3	PA
OMNITROPE	Tier 3	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	Tier 3	PA
SKYTROFA	Tier 3	PA
SOGROYA	Tier 3	PA
ZOMACTON	Tier 3	PA
Progestins		
CRINONE	Tier 3	PA
<i>estradiol-norethindrone acet</i>	Tier 1	AGE (Max 64 Years)

Drug	Status	Notes
<i>hydroxyprogesterone caproate</i>	Tier 2	
<i>medroxyprogesterone intramuscular suspension</i>	Tier 1	QL (1 ML per 75 days)
<i>medroxyprogesterone oral</i>	Tier 2	
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)</i>	Tier 2	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	Tier 3	PA
<i>megestrol oral tablet</i>	Tier 1	
MYFEMBREE	Tier 2	PA; QL (28 EA per 28 days); AGE (Min 18 Years)
<i>norethindrone acetate</i>	Tier 2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	Tier 1	QL (1 tablet per 1 day); AGE (Max 64 Years)
<i>norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg</i>	Tier 1	AGE (Max 64 Years)
ORIAHNN	Tier 2	PA; QL (56 EA per 28 days); AGE (Min 18 Years)
<i>progesterone</i>	Tier 3	PA
<i>progesterone micronized</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PROMETRIUM	Tier 3	PA
PROVERA	Tier 3	PA
Rapid-Acting Insulins		
ADMELOG SOLOSTAR U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
ADMELOG U-100 INSULIN LISPRO	Tier 3	PA; QL (90 ML per 1 fill)
AFREZZA	Tier 3	PA; QL (180 cartridges per 1 fill)
APIDRA SOLOSTAR U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
APIDRA U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
FIASP FLEXTOUCH U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PENFILL U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
FIASP PUMPCART	Tier 3	PA; QL (90 ML per 1 Fill)
FIASP U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
HUMALOG JUNIOR KWIKPEN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Tier 2	QL (90 ML per 1 fill)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Tier 3	PA; QL (90 ML per 1 fill)

Drug	Status	Notes
HUMALOG MIX 50-50 INSULN U-100	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 50-50 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMALOG MIX 75-25(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG TEMPO PEN(U-100)INSULN	Tier 2	QL (90 ML per 1 fill)
HUMALOG U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
<i>insulin asp prt-insulin aspart</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous cartridge</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin aspart u-100 subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro protamin-lispro</i>	Tier 3	PA; QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous insulin pen</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous insulin pen, half-unit</i>	Tier 2	QL (90 ML per 1 fill)
<i>insulin lispro subcutaneous solution</i>	Tier 2	QL (90 ML per 1 fill)
LYUMJEV KWIKPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
LYUMJEV KWIKPEN U-200 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV TEMPO PEN(U-100)INSULN	Tier 3	PA; QL (90 ML per 1 fill)
LYUMJEV U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG FLEXPEN U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30 U-100 INSULN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLOG MIX 70-30FLEXPEN U-100	Tier 2	QL (90 ML per 1 fill)
NOVOLOG PENFILL U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
NOVOLOG U-100 INSULIN ASPART	Tier 3	PA; QL (90 ML per 1 fill)
Short-Acting Insulins		
HUMULIN 70/30 U-100 INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN 70/30 U-100 KWIKPEN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R REGULAR U-100 INSULN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) INSULIN	Tier 2	QL (90 ML per 1 fill)
HUMULIN R U-500 (CONC) KWIKPEN	Tier 2	QL (90 ML per 1 fill)
NOVOLIN 70/30 U-100 INSULIN	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN 70-30 FLEXPEN U-100	Tier 3	PA; QL (90 ML per 1 fill)
NOVOLIN R FLEXPEN	Tier 2	QL (90 ML per 1 fill)

Drug	Status	Notes
NOVOLIN R REGULAR U100 INSULIN	Tier 2	QL (90 ML per 1 fill)
Sodium-Gluc Cotransport 2 (Sglt2) Inhib		
<i>dapaglifloz propaned-metformin</i>	Tier 3	PA
<i>dapagliflozin propanediol</i>	Tier 3	PA
FARXIGA	Tier 2	
GLYXAMBI	Tier 2	PA
INPEFA ORAL TABLET 200 MG	Tier 3	PA
INVOKAMET	Tier 2	
INVOKAMET XR	Tier 3	PA
INVOKANA	Tier 2	
JARDIANCE	Tier 2	
QTERN	Tier 3	PA
SEGLUROMET	Tier 3	PA
STEGLATRO	Tier 3	PA
STEGLUJAN	Tier 3	PA
SYNJARDY	Tier 2	
SYNJARDY XR	Tier 3	PA
TRIJARDY XR	Tier 3	PA
XIGDUO XR	Tier 2	
Somatostatin Agonists		
<i>octreotide acetate injection solution 1,000 mcg/ml, 200 mcg/ml</i>	Tier 1	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Somatotropin Agonists		
INCRELEX	Tier 1	PA
Sulfonylureas		
DUETACT	Tier 3	PA
<i>glimepiride</i>	Tier 2	
<i>glipizide oral tablet 10 mg, 5 mg</i>	Tier 2	
<i>glipizide oral tablet extended release 24hr</i>	Tier 2	
<i>glipizide-metformin</i>	Tier 3	PA
GLUCOTROL XL	Tier 3	PA
<i>glyburide</i>	Tier 2	
<i>glyburide micronized</i>	Tier 2	
<i>glyburide-metformin</i>	Tier 2	
GLYNASE	Tier 3	PA
<i>pioglitazone-glimepiride</i>	Tier 3	PA
Thiazolidinediones		
ACTOPLUS MET ORAL TABLET 15-850 MG	Tier 3	PA
ACTOS	Tier 3	PA
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	Tier 3	PA
DUETACT	Tier 3	PA
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	Tier 3	PA
<i>pioglitazone</i>	Tier 2	

Drug	Status	Notes
<i>pioglitazone-glimepiride</i>	Tier 3	PA
<i>pioglitazone-metformin</i>	Tier 3	PA
Thyroid Agents		
ADTHYZA ORAL TABLET 130 MG, 16.25 MG, 32.5 MG, 65 MG, 97.5 MG	Tier 1	
ARMOUR THYROID	Tier 1	
CYTOMEL	Tier 1	
ERMEZA	Tier 1	
<i>levothyroxine intravenous recon soln</i>	Tier 1	
<i>levothyroxine oral tablet</i>	Tier 1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 1	
<i>liothyronine</i>	Tier 1	
NP THYROID	Tier 1	
SYNTHROID	Tier 1	
THYQUIDITY	Tier 1	
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 50 MCG/ML, 75 MCG/ML, 88 MCG/ML	Tier 1	
UNITHROID	Tier 1	
Miscellaneous Therapeutic Agents		
5-Alpha-Reductase Inhibitors		
AVODART	Tier 3	PA
<i>dutasteride</i>	Tier 2	
<i>dutasteride- tamsulosin</i>	Tier 3	PA
ENTADFI	Tier 1	PA
<i>finasteride oral tablet 5 mg</i>	Tier 2	
JALYN	Tier 3	PA
PROSCAR	Tier 3	PA
Antidotes		
BAQSIMI	Tier 2	QL (2 Devices per 30 days)
CHEMET	Tier 1	
FOSRENOL	Tier 3	PA
GLUCAGEN HYPOKIT	Tier 2	

Drug	Status	Notes
GLUCAGON (HCL) EMERGENCY KIT	Tier 3	PA; QL (6 EA per 1 Fill)
GLUCAGON EMERGENCY KIT (HUMAN)	Tier 2	QL (6 EA per 1 Fill)
GVOKE	Tier 3	PA; QL (0.4 ML per 30 days)
GVOKE HYPOPEN 1- PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE HYPOPEN 2- PACK	Tier 2	QL (2 syringes per 30 days)
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Tier 3	PA; QL (2 syringes per 30 days)
KLOXXADO	Tier 1	QL (2 devices per 90 days)
<i>lanthanum</i>	Tier 3	PA
<i>leucovorin calcium oral</i>	Tier 1	
<i>magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml</i>	Tier 1	
<i>magnesium sulfate in water</i>	Tier 1	
<i>magnesium sulfate injection</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>naloxone injection solution</i>	Tier 1	QL (2 doses per 30 days)
<i>naloxone injection syringe</i>	Tier 1	QL (2 doses per 30 days)
<i>naloxone nasal</i>	Tier 2	QL (6 doses per 90 days)
NARCAN	Tier 2	QL (6 doses per 90 days)
<i>phytonadione (vitamin k1) oral tablet 5 mg</i>	Tier 1	QL (3 tablets per 30 dayss)
RENVELA	Tier 3	PA
<i>sevelamer carbonate oral powder in packet</i>	Tier 3	PA
<i>sevelamer carbonate oral tablet</i>	Tier 2	PA
<i>sevelamer hcl</i>	Tier 3	PA
<i>sodium polystyrene sulfonate oral powder</i>	Tier 1	
ZIMHI	Tier 1	QL (3 syringes per 90 days)
Antigout Agents		
ALL DAY PAIN RELIEF	Tier 2	
ALL DAY RELIEF	Tier 2	
<i>allopurinol</i>	Tier 2	
<i>colchicine oral capsule</i>	Tier 3	PA
<i>colchicine oral tablet</i>	Tier 2	
COLCRYS	Tier 3	PA
EC-NAPROXEN	Tier 3	PA
<i>febuxostat</i>	Tier 3	PA
GLOPERBA	Tier 3	PA
INDOCIN	Tier 3	PA

Drug	Status	Notes
<i>indomethacin oral capsule</i>	Tier 2	
<i>indomethacin oral capsule, extended release</i>	Tier 3	PA
<i>indomethacin oral suspension</i>	Tier 3	PA
MITIGARE	Tier 3	PA
NAPRELAN CR	Tier 3	PA
<i>naproxen oral suspension</i>	Tier 3	PA
<i>naproxen oral tablet</i>	Tier 2	
<i>naproxen oral tablet, delayed release (dr/ec)</i>	Tier 3	PA
<i>naproxen sodium oral capsule</i>	Tier 2	
<i>naproxen sodium oral tablet 220 mg</i>	Tier 2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	Tier 3	PA
<i>naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 500 mg</i>	Tier 3	PA
<i>probenecid</i>	Tier 2	
<i>probenecid-colchicine</i>	Tier 2	
ULORIC	Tier 3	PA
ZYLOPRIM ORAL TABLET 100 MG	Tier 3	PA
Bone Anabolic Agents		
FORTEO	Tier 3	PA
<i>teriparatide</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
TYMLOS	Tier 3	PA
Bone Resorption Inhibitors		
ACTONEL ORAL TABLET 150 MG	Tier 3	PA; QL (4 EA per 28 days)
ACTONEL ORAL TABLET 35 MG	Tier 3	PA; QL (4 tablets per 28 days)
<i>alendronate oral solution</i>	Tier 3	PA
<i>alendronate oral tablet 10 mg, 5 mg</i>	Tier 2	
<i>alendronate oral tablet 35 mg</i>	Tier 2	QL (4 tablets per 28 days)
<i>alendronate oral tablet 70 mg</i>	Tier 2	QL (4 tablets per 30 days)
ATELVIA	Tier 3	PA; QL (4 tablets per 30 days)
<i>calcitonin (salmon) nasal</i>	Tier 2	
EVISTA	Tier 3	PA
FOSAMAX ORAL TABLET 70 MG	Tier 3	PA; QL (4 tablets per 28 days)
FOSAMAX PLUS D	Tier 3	PA; QL (4 tablets per 28 days)
<i>ibandronate oral</i>	Tier 3	PA; QL (1 tablet per 28 days)
<i>raloxifene</i>	Tier 2	
<i>risedronate oral tablet 150 mg, 30 mg, 5 mg</i>	Tier 3	PA

Drug	Status	Notes
<i>risedronate oral tablet 35 mg</i>	Tier 3	PA; QL (4 tablets per 28 days)
<i>risedronate oral tablet, delayed release (dr/ec)</i>	Tier 3	PA; QL (4 tablets per 30 days)
Cariostatic Agents		
DENTA 5000 PLUS	Tier 1	
<i>fluoride (sodium) oral drops</i>	Tier 1	QL (4 ML per 1 day); AGE (Max 16 Years)
<i>fluoride (sodium) oral tablet, chewable</i>	Tier 1	QL (1 tablet per 1 day); AGE (Max 16 Years)
LUIDENT FLUORIDE	Tier 1	QL (1 tablet per 1 day); AGE (Max 16 Years)
MULTI-VIT WITH FLUORIDE-IRON	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
MULTI-VITAMIN WITH FLUORIDE ORAL DROPS	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET, CHEWABLE 0.25 MG	Tier 1	QL (1 tablet per 1 day)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.5 MG, 1 MG	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
MVC-FLUORIDE	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
SF	Tier 1	
SF 5000 PLUS	Tier 1	
SODIUM FLUORIDE 5000 PLUS	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
Disease-Modifying Antirheumatic Agents		
ACTEMRA ACTPEN	Tier 3	PA
ACTEMRA SUBCUTANEOUS	Tier 3	PA
<i>adalimumab-adaz</i>	Tier 3	PA
<i>adalimumab-fkjp</i>	Tier 3	PA
AMJEVITA(CF)	Tier 3	PA
AMJEVITA(CF) AUTOINJECTOR	Tier 3	PA
<i>azathioprine</i>	Tier 1	
AZULFIDINE	Tier 3	PA

Drug	Status	Notes
AZULFIDINE EN-TABS	Tier 3	PA
CIBINQO	Tier 3	PA; AGE (Min 12 Years)
CIMZIA	Tier 3	PA
CIMZIA POWDER FOR RECONST	Tier 3	PA
CIMZIA STARTER KIT	Tier 3	PA
COSENTYX (2 SYRINGES)	Tier 2	
COSENTYX PEN	Tier 2	
COSENTYX PEN (2 PENS)	Tier 2	
COSENTYX SUBCUTANEOUS	Tier 2	
COSENTYX UNOREADY PEN	Tier 2	
<i>cyclosporine modified</i>	Tier 1	
<i>cyclosporine oral capsule</i>	Tier 1	
CYLTEZO(CF)	Tier 3	PA
CYLTEZO(CF) PEN	Tier 3	PA
CYLTEZO(CF) PEN CROHN'S-UC-HS	Tier 3	PA
CYLTEZO(CF) PEN PSORIASIS-UV	Tier 3	PA
ENBREL MINI	Tier 2	
ENBREL SUBCUTANEOUS SOLUTION	Tier 2	
ENBREL SUBCUTANEOUS SYRINGE	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ENBREL SURECLICK	Tier 2	
HADLIMA	Tier 3	PA
HADLIMA PUSHTOUCH	Tier 3	PA
HADLIMA(CF)	Tier 3	PA
HADLIMA(CF) PUSHTOUCH	Tier 3	PA
HULIO(CF)	Tier 3	PA
HULIO(CF) PEN	Tier 3	PA
HUMIRA PEN	Tier 2	
HUMIRA PEN CROHNS-UC-HS START	Tier 2	
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	Tier 2	
HUMIRA(CF)	Tier 2	
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	Tier 2	
HUMIRA(CF) PEN	Tier 2	
HUMIRA(CF) PEN CROHNS-UC-HS	Tier 2	
HUMIRA(CF) PEN PSOR-UV-ADOL HS	Tier 2	
<i>hydroxychloroquine</i>	Tier 1	
HYRIMOZ PEN CROHN'S-UC STARTER	Tier 3	PA

Drug	Status	Notes
HYRIMOZ PEN PSORIASIS STARTER	Tier 3	PA
HYRIMOZ(CF)	Tier 3	PA
HYRIMOZ(CF) PEDI CROHN STARTER	Tier 3	PA
HYRIMOZ(CF) PEN	Tier 3	PA
IDACIO(CF)	Tier 3	PA
IDACIO(CF) PEN	Tier 3	PA
IDACIO(CF) PEN CROHN-UC STARTR	Tier 3	PA
IDACIO(CF) PEN PSORIASIS START	Tier 3	PA
JYLAMVO	Tier 1	
KEVZARA	Tier 3	PA
<i>leflunomide</i>	Tier 1	QL (1 tablet per 1 day)
<i>methotrexate sodium</i>	Tier 1	
<i>methotrexate sodium (pf) injection solution</i>	Tier 1	
OLUMIANT	Tier 3	PA
ORENCIA	Tier 3	PA
ORENCIA CLICKJECT	Tier 3	PA
OTEZLA	Tier 3	PA
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 3	PA
RINVOQ	Tier 3	PA
SIMPONI	Tier 3	PA
SIMPONI ARIA	Tier 3	PA
STELARA	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>sulfasalazine</i>	Tier 2	
XATMEP	Tier 1	
XELJANZ	Tier 3	PA
XELJANZ XR	Tier 3	PA
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	Tier 3	PA
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	Tier 3	PA
YUSIMRY(CF) PEN	Tier 3	PA
Immunomodulatory Agents		
ACTEMRA ACTPEN	Tier 3	PA
ACTEMRA SUBCUTANEOUS	Tier 3	PA
<i>adalimumab-adaz</i>	Tier 3	PA
<i>adalimumab-fkjp</i>	Tier 3	PA
AMJEVITA(CF)	Tier 3	PA
AMJEVITA(CF) AUTOINJECTOR	Tier 3	PA
AUBAGIO	Tier 3	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	Tier 2	QL (4 EA per 1 Fill)
AVONEX INTRAMUSCULAR SYRINGE KIT	Tier 2	QL (4 syringes per 1 fill)
<i>azathioprine</i>	Tier 1	
BAFIERTAM	Tier 3	PA; QL (120 capsules per 30 days)

Drug	Status	Notes
BETASERON	Tier 2	
CIBINQO	Tier 3	PA; AGE (Min 12 Years)
CIMZIA	Tier 3	PA
CIMZIA POWDER FOR RECONST	Tier 3	PA
CIMZIA STARTER KIT	Tier 3	PA
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	Tier 2	
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	Tier 3	PA
<i>cyclosporine modified</i>	Tier 1	
<i>cyclosporine oral capsule</i>	Tier 1	
CYLTEZO(CF)	Tier 3	PA
CYLTEZO(CF) PEN	Tier 3	PA
CYLTEZO(CF) PEN CROHN'S-UC-HS	Tier 3	PA
CYLTEZO(CF) PEN PSORIASIS-UV	Tier 3	PA
<i>dimethyl fumarate</i>	Tier 2	
ENBREL MINI	Tier 2	
ENBREL SUBCUTANEOUS SOLUTION	Tier 2	
ENBREL SUBCUTANEOUS SYRINGE	Tier 2	
ENBREL SURECLICK	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ENSPRYNG	Tier 1	PA; QL (1 ML per 4 weeks); AGE (Min 18 Years)
EXTAVIA	Tier 3	PA
<i>fingolimod</i>	Tier 3	PA
GILENYA	Tier 2	
<i>glatiramer</i>	Tier 3	PA
GLATOPA	Tier 3	PA
HADLIMA	Tier 3	PA
HADLIMA PUSH TOUCH	Tier 3	PA
HADLIMA(CF)	Tier 3	PA
HADLIMA(CF) PUSH TOUCH	Tier 3	PA
HULIO(CF)	Tier 3	PA
HULIO(CF) PEN	Tier 3	PA
HUMIRA PEN	Tier 2	
HUMIRA PEN CROHNS-UC-HS START	Tier 2	
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	Tier 2	
HUMIRA(CF)	Tier 2	
HUMIRA(CF) PEDI CROHNS STARTER	Tier 2	
HUMIRA(CF) PEN	Tier 2	
HUMIRA(CF) PEN CROHNS-UC-HS	Tier 2	
HUMIRA(CF) PEN PSOR-UV-ADOL HS	Tier 2	
<i>hydroxychloroquine</i>	Tier 1	

Drug	Status	Notes
HYRIMOZ PEN CROHN'S-UC STARTER	Tier 3	PA
HYRIMOZ PEN PSORIASIS STARTER	Tier 3	PA
HYRIMOZ(CF)	Tier 3	PA
HYRIMOZ(CF) PEDI CROHN STARTER	Tier 3	PA
HYRIMOZ(CF) PEN	Tier 3	PA
IDACIO(CF)	Tier 3	PA
IDACIO(CF) PEN	Tier 3	PA
IDACIO(CF) PEN CROHN-UC STARTR	Tier 3	PA
IDACIO(CF) PEN PSORIASIS START	Tier 3	PA
JYLAMVO	Tier 1	
KESIMPTA PEN	Tier 3	PA
KEVZARA	Tier 3	PA
<i>leflunomide</i>	Tier 1	QL (1 tablet per 1 day)
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	Tier 1	
MAYZENT	Tier 3	PA
MAYZENT STARTER(FOR 1MG MAINT)	Tier 3	PA
MAYZENT STARTER(FOR 2MG MAINT)	Tier 3	PA
<i>methotrexate sodium</i>	Tier 1	
<i>methotrexate sodium (pf) injection solution</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
OLUMIANT	Tier 3	PA
ORENCIA	Tier 3	PA
ORENCIA CLICKJECT	Tier 3	PA
OTEZLA	Tier 3	PA
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 3	PA
PLEGRIDY	Tier 3	PA
POMALYST	Tier 1	
PONVORY	Tier 3	PA; AGE (Min 18 Years and Max 55 Years)
PONVORY 14-DAY STARTER PACK	Tier 3	PA; AGE (Min 18 Years and Max 55 Years)
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 22 MCG/0.5 ML	Tier 3	PA
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 44 MCG/0.5 ML	Tier 3	PA; QL (0.25 ML per 1 day)
REBIF REBIDOSE	Tier 3	PA
REBIF TITRATION PACK	Tier 3	PA
RINVOQ	Tier 3	PA
SIMPONI	Tier 3	PA
SIMPONI ARIA	Tier 3	PA

Drug	Status	Notes
STELARA	Tier 3	PA
TASCENSO ODT	Tier 3	PA; AGE (Min 10 Years and Max 17 Years)
TECFIDERA	Tier 3	PA
<i>teriflunomide</i>	Tier 3	PA
THALOMID	Tier 1	PA
VUMERITY	Tier 3	PA
XATMEP	Tier 1	
XELJANZ	Tier 3	PA
XELJANZ XR	Tier 3	PA
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	Tier 3	PA
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	Tier 3	PA
YUSIMRY(CF) PEN	Tier 3	PA
ZEPOSIA	Tier 3	PA
ZEPOSIA STARTER KIT (28-DAY)	Tier 3	PA
ZEPOSIA STARTER PACK (7-DAY)	Tier 3	PA
Immunosuppressive Agents		
<i>azathioprine</i>	Tier 1	
<i>cyclophosphamide oral capsule</i>	Tier 1	
<i>cyclosporine modified</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>cyclosporine oral capsule</i>	Tier 1	
<i>everolimus (immunosuppressive) oral tablet 1 mg</i>	Tier 1	
JYLAMVO	Tier 1	
MAVENCLAD (10 TABLET PACK)	Tier 3	PA
MAVENCLAD (4 TABLET PACK)	Tier 3	PA
MAVENCLAD (5 TABLET PACK)	Tier 3	PA
MAVENCLAD (6 TABLET PACK)	Tier 3	PA
MAVENCLAD (7 TABLET PACK)	Tier 3	PA
MAVENCLAD (8 TABLET PACK)	Tier 3	PA
MAVENCLAD (9 TABLET PACK)	Tier 3	PA
<i>mercaptopurine</i>	Tier 1	
<i>methotrexate sodium</i>	Tier 1	
<i>methotrexate sodium (pf) injection solution</i>	Tier 1	
<i>mycophenolate mofetil</i>	Tier 1	
<i>mycophenolate mofetil (hcl)</i>	Tier 1	
<i>mycophenolate sodium</i>	Tier 1	
<i>sirolimus oral tablet</i>	Tier 1	
<i>tacrolimus oral</i>	Tier 1	
XATMEP	Tier 1	

Drug	Status	Notes
Other Miscellaneous Therapeutic Agents		
<i>acetylcysteine</i>	Tier 1	
<i>dalfampridine</i>	Tier 1	PA; QL (2 tablets per 1 day); AGE (Min 18 Years and Max 70 Years)
ENDARI	Tier 1	PA; QL (180 packets per 30 dayss); AGE (Min 5 Years)
LITFULO	Tier 1	PA; QL (1 EA per 1 day); AGE (Min 12 Years and Max 150 Years)
REZUROCK	Tier 1	
RIABNI	Tier 1	
Protective Agents		
ELMIRON	Tier 1	PA; QL (3 capsules per 1 day)
MESNEX ORAL	Tier 1	
Nonhormonal Contraceptives		
Nonhormonal Contraceptives		
AIMSCO LATEX CONDOM	Tier 1	QL (36 condoms per 30 days)
CAYA CONTOURED	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
FANTASY CONDOM	Tier 1	QL (36 condoms per 30 days)
FC2 FEMALE CONDOM	Tier 1	QL (36 condoms per 30 days)
FEMCAP	Tier 1	
KIMONO CONDOMS(NON-LUBRICATED)	Tier 1	QL (36 condoms per 30 days)
KIMONO MICROTHIN AQUA LUBE CON	Tier 1	QL (36 condoms per 30 days)
KIMONO MICROTHIN CONDOMS	Tier 1	QL (36 condoms per 30 days)
KIMONO MICROTHIN LARGE CONDOMS	Tier 1	QL (36 condoms per 30 days)
KIMONO TEXTURED CONDOMS	Tier 1	QL (36 condoms per 30 days)
PHEXXI	Tier 1	QL (180 GM per 30 days)
TRUSTEX LATEX CONDOM	Tier 1	QL (36 condoms per 30 days)
TRUSTEX LUBRICATED CONDOMS	Tier 1	QL (36 condoms per 30 days)
TRUSTEX NON-LUB CONDOMS	Tier 1	QL (36 condoms per 30 days)
TRUSTEX-RIA LUB/SPERMICIDE	Tier 1	QL (36 condoms per 30 days)

Drug	Status	Notes
TRUSTEX-RIA NON-LUB CONDOMS	Tier 1	QL (36 condoms per 30 days)
WIDE-SEAL DIAPHRAGM 60	Tier 1	
WIDE-SEAL DIAPHRAGM 65	Tier 1	
WIDE-SEAL DIAPHRAGM 70	Tier 1	
WIDE-SEAL DIAPHRAGM 75	Tier 1	
WIDE-SEAL DIAPHRAGM 80	Tier 1	
WIDE-SEAL DIAPHRAGM 85	Tier 1	
WIDE-SEAL DIAPHRAGM 90	Tier 1	
WIDE-SEAL DIAPHRAGM 95	Tier 1	
Oxytocics		
Oxytocics		
<i>methylergonovine oral</i>	Tier 1	QL (28 tablets per 180 days); AGE (Min 12 Years)
Respiratory Tract Agents		
Alpha And Beta Adrenergic Agonist(Respr)		
AUVI-Q	Tier 3	PA; QL (4 injectors per 1 Fill)
<i>epinephrine injection auto-injector 0.15 mg/0.15 ml</i>	Tier 3	PA; QL (4 injectors per 1 fill)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	Tier 2	QL (4 injectors per 1 fill)
EPIPEN	Tier 2	QL (4 injectors per 1 fill)
EPIPEN 2-PAK	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR	Tier 2	QL (4 injectors per 1 fill)
EPIPEN JR 2-PAK	Tier 2	QL (4 injectors per 1 fill)
SYMJEPI	Tier 3	PA
Anticholinergic Agents (Respir. Tract)		
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
ATROVENT HFA	Tier 2	QL (2 inhalers per 30 days)
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
BREZTRI AEROSPHERE	Tier 3	PA; QL (3 inhalers per 90 days)
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)
DUAKLIR PRESSAIR	Tier 3	PA
INCRUSE ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>ipratropium bromide inhalation</i>	Tier 2	

Drug	Status	Notes
<i>ipratropium-albuterol</i>	Tier 2	
SPIRIVA RESPIMAT	Tier 2	QL (1 inhaler per 30 days)
SPIRIVA WITH HANDIHALER	Tier 2	QL (1 capsule per 1 day)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
<i>tiotropium bromide</i>	Tier 3	QL (1 capsule per 1 day)
TRELEGY ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
TUDORZA PRESSAIR	Tier 3	PA
Antitussives		
<i>codeine sulfate</i>	Tier 2	QL (180 tablets per 30 days); AGE (Min 12 Years)
First Generation Antihist.(Respir Tract)		
ALLER-CHLOR	Tier 1	
ALLER-G-TIME	Tier 1	AGE (Max 64 Years)
ALLERGY (CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(CHLORPHENIRAMINE)	Tier 1	
ALLERGY RELIEF(DIPHENHYDRAMINE) ORAL TABLET	Tier 1	AGE (Max 64 Years)
ALLERGY-TIME	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
BANOPHEN ORAL TABLET	Tier 1	AGE (Max 64 Years)
<i>carbinoxamine maleate oral liquid</i>	Tier 1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet</i>	Tier 1	
<i>chlorpheniramine maleate oral tablet extended release</i>	Tier 1	
CHLORTABS	Tier 1	
<i>cyproheptadine</i>	Tier 1	AGE (Max 64 Years)
DAYHIST ALLERGY	Tier 1	
<i>dimenhydrinate oral</i>	Tier 1	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl injection syringe</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule</i>	Tier 1	AGE (Max 64 Years)
<i>diphenhydramine hcl oral liquid</i>	Tier 1	
<i>diphenhydramine hcl oral tablet</i>	Tier 1	AGE (Max 64 Years)
PHARBECHLOR	Tier 1	
<i>promethazine oral</i>	Tier 1	AGE (Min 2 Years and Max 64 Years)
WAL-FINATE	Tier 1	

Drug	Status	Notes
Interleukin Antagonists		
FASENRA PEN	Tier 3	PA; AGE (Min 12 Years)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	Tier 3	PA; AGE (Min 6 Years)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	Tier 3	PA; AGE (Min 6 Years)
Leukotriene Modifiers		
ACCOLATE	Tier 3	PA
<i>montelukast oral granules in packet</i>	Tier 3	PA; AGE (Max 5 Years)
<i>montelukast oral tablet</i>	Tier 2	
<i>montelukast oral tablet, chewable 4 mg</i>	Tier 2	AGE (Max 5 Years)
<i>montelukast oral tablet, chewable 5 mg</i>	Tier 2	AGE (Max 14 Years)
SINGULAIR ORAL GRANULES IN PACKET	Tier 3	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET	Tier 3	PA
SINGULAIR ORAL TABLET, CHEWABLE 4 MG	Tier 3	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET, CHEWABLE 5 MG	Tier 3	PA; AGE (Max 14 Years)
<i>zafirlukast</i>	Tier 3	PA
<i>zileuton</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ZYFLO	Tier 3	PA
Mast-Cell Stabilizers		
ALOCRIAL	Tier 3	PA
<i>cromolyn nasal</i>	Tier 1	
<i>cromolyn ophthalmic (eye)</i>	Tier 2	
NASALCROM	Tier 1	
Mucolytic Agents		
<i>acetylcysteine</i>	Tier 1	
PULMOZYME	Tier 1	PA; QL (75 EA per 30 days)
Nasal Preparations (Steroids)		
24 HOUR NASAL ALLERGY	Tier 3	PA
ALLERGY RELIEF (FLUTICASONE)	Tier 3	PA
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>budesonide nasal</i>	Tier 3	PA
CHILDREN'S FLONASE ALLERGY RLF	Tier 3	PA
DYMISTA	Tier 3	PA
<i>flunisolide</i>	Tier 3	PA
<i>fluticasone propionate nasal</i>	Tier 2	
<i>mometasone nasal</i>	Tier 3	PA
NASAL ALLERGY	Tier 3	PA
NASONEX 24HR ALLERGY	Tier 3	PA
OMNARIS	Tier 3	PA
QNASL	Tier 3	PA

Drug	Status	Notes
RYALTRIS	Tier 3	PA
<i>triamcinolone acetonide nasal</i>	Tier 3	PA
XHANCE	Tier 3	PA
ZETONNA	Tier 3	PA
Orally Inhaled Preparations (Steroids)		
ADVAIR DISKUS	Tier 2	QL (3 Inhalers per 90 days)
ADVAIR HFA	Tier 2	QL (1 inhaler per 30 days)
AIRDUO DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
ALVESCO	Tier 3	
ARMONAIR DIGIHALER	Tier 3	PA
ARNUIITY ELLIPTA	Tier 3	PA
ASMANEX HFA	Tier 3	PA; QL (3 inhalers per 90 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30)	Tier 2	QL (1 inhaler per 30 days); AGE (Max 11 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	Tier 2	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	Tier 3	PA; QL (60 blisters per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 50-25 MCG/DOSE	Tier 3	PA; QL (60 EA per 30 days)
BREZTRI AEROSPHERE	Tier 3	PA; QL (3 inhalers per 90 days)
<i>budesonide inhalation</i>	Tier 2	QL (2 respules per 1 day)
<i>budesonide- formoterol</i>	Tier 3	PA; QL (2 inhalers per 30 days)

Drug	Status	Notes
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	Tier 2	QL (3 inhalers per 90 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION	Tier 2	QL (3 Inhalers per 90 days)
<i>fluticasone furoate- vilanterol</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propionate inhalation blister with device</i>	Tier 3	PA
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation, 44 mcg/actuation</i>	Tier 3	PA; QL (3 inhalers per 90 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	Tier 3	PA; QL (6 inhalers per 90 days)
<i>fluticasone propion- salmeterol inhalation aerosol powdr breath activated</i>	Tier 3	PA; QL (1 inhaler per 30 days)
<i>fluticasone propion- salmeterol inhalation blister with device</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propion- salmeterol inhalation hfa aerosol inhaler</i>	Tier 3	PA; QL (1 inhaler per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PULMICORT	Tier 3	PA; QL (2 respules per 1 day)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	Tier 3	PA; QL (6 inhalers per 90 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	Tier 3	PA; QL (3 inhalers per 90 days)
QVAR REDIHALER	Tier 3	PA
SYMBICORT	Tier 2	QL (2 inhalers per 30 days)
TRELEGY ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
WIXELA INHUB	Tier 3	PA; QL (60 blisters per 30 days)
Phosphodiesterase Type 4 Inhibitors		
DALIRESP	Tier 3	PA
<i>roflumilast</i>	Tier 1	PA
ZORYVE TOPICAL FOAM	Tier 1	PA
Phosphodiesterase-5 Inhibitors (Respir)		
LIQREV	Tier 3	PA
REVATIO ORAL	Tier 3	PA

Drug	Status	Notes
<i>sildenafil (pulm.hypertension) oral</i>	Tier 2	PA
Respiratory Tract Agents, Miscellaneous		
BRONCHITOL	Tier 1	PA; QL (560 capsules per 28 days); AGE (Min 18 Years)
TEZSPIRE SUBCUTANEOUS PEN INJECTOR	Tier 3	PA; AGE (Min 12 Years)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	Tier 2	AGE (Min 6 Years)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML	Tier 2	PA; AGE (Min 6 Years)
Second Generation Antihist(Respir Tract)		
24HR ALLERGY RELIEF	Tier 2	
ALL DAY ALLERGY (CETIRIZINE) ORAL SOLUTION	Tier 2	
ALL DAY ALLERGY (CETIRIZINE) ORAL TABLET	Tier 2	
ALLER-EASE ORAL TABLET 180 MG	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ALLERGY RELIEF (CETIRIZINE) ORAL CAPSULE	Tier 3	PA
ALLERGY RELIEF (CETIRIZINE) ORAL TABLET 10 MG	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL SOLUTION	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET	Tier 2	
ALLERGY RELIEF (LORATADINE) ORAL TABLET, DISINTEGRATING 10 MG	Tier 2	
<i>azelastine-fluticasone</i>	Tier 3	PA
<i>cetirizine oral solution 1 mg/ml</i>	Tier 2	
<i>cetirizine oral solution 5 mg/5 ml</i>	Tier 3	PA
<i>cetirizine oral tablet</i>	Tier 2	
<i>cetirizine oral tablet, chewable</i>	Tier 3	PA
CHILD ALLERGY RELIEF (CETIRIZINE)	Tier 2	
CHILDREN'S ALLERGY RELIEF (FEX)	Tier 2	
CHILDREN'S ALLERGY RELIEF (LOR) ORAL SOLUTION	Tier 2	

Drug	Status	Notes
CHILDREN'S ALLERGY (CETIRIZINE)	Tier 2	
CHILDREN'S CETIRIZINE ORAL SOLUTION	Tier 2	
CHILDREN'S CETIRIZINE ORAL TABLET, CHEWABLE	Tier 3	PA
CHILDREN'S LORATADINE	Tier 2	
CHILD'S ALL DAY ALLERGY (CETIR)	Tier 2	
CLARINEX ORAL TABLET	Tier 3	PA
<i>desloratadine oral tablet</i>	Tier 3	PA
<i>desloratadine oral tablet, disintegrating 2.5 mg</i>	Tier 3	PA; AGE (Max 11 Years)
<i>desloratadine oral tablet, disintegrating 5 mg</i>	Tier 3	PA
DYMISTA	Tier 3	PA
<i>fexofenadine</i>	Tier 2	
<i>levocetirizine oral solution</i>	Tier 3	PA
<i>levocetirizine oral tablet</i>	Tier 2	
<i>loratadine oral solution</i>	Tier 2	
<i>loratadine oral tablet</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
Select.Beta-2-Adrenergic Agonist(Respir)		
ADVAIR DISKUS	Tier 2	QL (3 Inhalers per 90 days)
ADVAIR HFA	Tier 2	QL (1 inhaler per 30 days)
AIRDUO DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler</i>	Tier 3	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation solution for nebulization</i>	Tier 2	
ANORO ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
<i>arformoterol</i>	Tier 3	PA
BEVESPI AEROSPHERE	Tier 2	QL (3 inhalers per 90 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	Tier 3	PA; QL (60 blisters per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 50-25 MCG/DOSE	Tier 3	PA; QL (60 EA per 30 days)

Drug	Status	Notes
BREZTRI AEROSPHERE	Tier 3	PA; QL (3 inhalers per 90 days)
BROVANA	Tier 3	PA
<i>budesonide-formoterol</i>	Tier 3	PA; QL (2 inhalers per 30 days)
COMBIVENT RESPIMAT	Tier 2	QL (5 inhalers per 90 days)
DUAKLIR PRESSAIR	Tier 3	PA
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	Tier 2	QL (3 inhalers per 90 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION	Tier 2	QL (3 Inhalers per 90 days)
<i>fluticasone furoate-vilanterol</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	Tier 3	PA; QL (1 inhaler per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	Tier 3	PA; QL (60 blisters per 30 days)
<i>fluticasone propion-salmeterol inhalation hfa aerosol inhaler</i>	Tier 3	PA; QL (1 inhaler per 30 days)
<i>formoterol fumarate</i>	Tier 3	PA
<i>ipratropium-albuterol</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>levalbuterol hcl</i>	Tier 3	PA
<i>levalbuterol tartrate</i>	Tier 3	PA; QL (2 inhalers per 30 days)
PERFOROMIST	Tier 3	PA
PROAIR DIGIHALER	Tier 3	PA; QL (1 inhaler per 30 days)
PROAIR RESPICLICK	Tier 3	PA; QL (1 inhaler per 30 days)
PROVENTIL HFA	Tier 2	QL (2 inhalers per 30 days)
SEREVENT DISKUS	Tier 2	QL (1 inhaler per 30 days)
STIOLTO RESPIMAT	Tier 2	QL (3 inhalers per 90 days)
STRIVERDI RESPIMAT	Tier 3	PA
SYMBICORT	Tier 2	QL (2 inhalers per 30 days)
<i>terbutaline oral</i>	Tier 1	
TRELEGY ELLIPTA	Tier 2	QL (3 inhalers per 90 days)
VENTOLIN HFA	Tier 2	QL (2 inhalers per 30 days)
WIXELA INHUB	Tier 3	PA; QL (60 blisters per 30 days)
XOPENEX HFA	Tier 2	QL (6 inhalers per 90 days)
Vasodilating Agents (Respiratory Tract)		
ADCIRCA	Tier 3	PA
ADEMPAS	Tier 3	PA

Drug	Status	Notes
ALYQ	Tier 2	PA
<i>ambroxol</i>	Tier 2	PA
<i>bosentan</i>	Tier 3	PA
LETAIRIS	Tier 3	PA
LIQREV	Tier 3	PA
OPSUMIT	Tier 2	PA
ORENITRAM	Tier 3	PA
ORENITRAM MONTH 1 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 2 TITRATION KT	Tier 3	PA
ORENITRAM MONTH 3 TITRATION KT	Tier 3	PA
REVATIO ORAL	Tier 3	PA
<i>sildenafil (pulm.hypertension) oral</i>	Tier 2	PA
<i>tadalafil (pulm.hypertension)</i>	Tier 2	PA
TADLIQ	Tier 3	PA; AGE (Min 18 Years)
TRACLEER ORAL TABLET	Tier 2	PA
TRACLEER ORAL TABLET FOR SUSPENSION	Tier 3	PA
TYVASO	Tier 2	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16 MCG (112)- 32 MCG (84), 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG	Tier 2	PA
TYVASO INSTITUTIONAL START KIT	Tier 2	PA
TYVASO REFILL KIT	Tier 2	PA
TYVASO STARTER KIT	Tier 2	PA
UPTRAVI ORAL	Tier 2	PA
VENTAVIS	Tier 2	PA
Xanthine Derivatives		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	
Skin And Mucous Membrane Agents		
Allylamines (Skin And Mucous Membrane)		
<i>naftifine topical cream</i>	Tier 3	PA
NAFTIN TOPICAL GEL	Tier 3	PA

Drug	Status	Notes
<i>terbinafine hcl topical</i>	Tier 1	
Antibacterials (Skin, Mucous Membrane)		
ACANYA TOPICAL GEL WITH PUMP	Tier 3	PA
<i>bacitracin topical</i>	Tier 1	
<i>bacitracin zinc</i>	Tier 1	
CENTANY	Tier 3	PA
CENTANY AT	Tier 3	PA
CLEOCIN VAGINAL CREAM	Tier 3	PA
CLEOCIN VAGINAL SUPPOSITORY	Tier 2	
<i>clindamycin phosphate topical solution</i>	Tier 1	QL (180 ML per 30 dayss)
<i>clindamycin phosphate topical swab</i>	Tier 1	
<i>clindamycin phosphate vaginal</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %</i>	Tier 1	PA
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %, 1.2-2.5 %</i>	Tier 2	
CLINDESSE	Tier 2	
E.E.S. 400 ORAL TABLET	Tier 3	PA
E.E.S. GRANULES	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
ERYPED 200	Tier 3	PA
ERYPED 400	Tier 3	PA
ERY-TAB	Tier 3	PA
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	Tier 2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	Tier 3	PA
<i>erythromycin ethylsuccinate oral tablet</i>	Tier 2	
<i>erythromycin oral</i>	Tier 3	PA
<i>erythromycin with ethanol topical solution</i>	Tier 1	
<i>erythromycin-benzoyl peroxide</i>	Tier 1	
<i>gentamicin topical</i>	Tier 1	
<i>metronidazole topical cream</i>	Tier 1	
<i>metronidazole topical gel 0.75 %</i>	Tier 1	
<i>metronidazole vaginal</i>	Tier 2	
<i>mupirocin</i>	Tier 2	
<i>mupirocin calcium</i>	Tier 3	PA
<i>neomycin</i>	Tier 2	
NEUAC	Tier 3	PA

Drug	Status	Notes
NEUAC KIT	Tier 3	PA
NUVESSA	Tier 2	
ONEXTON	Tier 3	PA
TRIPLE ANTIBIOTIC	Tier 1	
VANDAZOLE	Tier 3	PA
XACIATO	Tier 3	PA; AGE (Min 12 Years)
XEPI	Tier 3	PA; QL (60 GM per 30 days)
Anti-Inflammatory Agents, Misc (Skin)		
EUCRISA	Tier 2	PA; QL (100 GM per 30 days); AGE (Min 3 Months)
Antipruritics And Local Anesthetics		
ASPERCREME (LIDOCAINE HCL) TOPICAL CREAM	Tier 1	QL (153 GM per 30 dayss)
ASPERCREME (LIDOCAINE) TOPICAL ADHESIVE PATCH,MEDICATED	Tier 1	QL (30 patches per 30 days)
<i>lidocaine hcl topical cream 3 %</i>	Tier 1	QL (85 GM per 30 days)
LIDOCAINE PAIN RELIEF TOPICAL ADHESIVE PATCH,MEDICATED	Tier 1	QL (30 patches per 30 days)
<i>lidocaine topical adhesive patch,medicated 4 %</i>	Tier 1	QL (30 patches per 30 days)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
<i>lidocaine topical adhesive patch, medicated 5 %</i>	Tier 1	PA; QL (3 patches per 1 day)
<i>lidocaine topical ointment</i>	Tier 1	QL (100 GM per 30 days)
<i>lidocaine-prilocaine topical cream</i>	Tier 1	QL (1 GM per 1 day)
<i>phenazopyridine oral tablet 100 mg, 200 mg</i>	Tier 1	
Antivirals (Skin And Mucous Membrane)		
<i>acyclovir topical cream</i>	Tier 3	PA
<i>acyclovir topical ointment</i>	Tier 2	
DENAVIR	Tier 2	
<i>docosanol</i>	Tier 1	
<i>penciclovir</i>	Tier 3	PA
XERESE	Tier 3	PA
ZOVIRAX TOPICAL CREAM	Tier 2	
ZOVIRAX TOPICAL OINTMENT	Tier 3	PA
Azoles (Skin And Mucous Membrane)		
3-DAY VAGINAL	Tier 1	
ANTIFUNGAL (CLOTRIMAZOLE)	Tier 2	
ANTIFUNGAL (MICONAZOLE) TOPICAL CREAM	Tier 2	
CLOTRIMAZOLE 3 DAY	Tier 1	

Drug	Status	Notes
<i>clotrimazole mucous membrane</i>	Tier 2	
<i>clotrimazole topical</i>	Tier 2	
<i>clotrimazole vaginal</i>	Tier 1	
CLOTRIMAZOLE-3	Tier 1	
CLOTRIMAZOLE-7	Tier 1	
<i>clotrimazole-betamethasone topical cream</i>	Tier 2	
<i>clotrimazole-betamethasone topical lotion</i>	Tier 3	PA
<i>econazole</i>	Tier 3	PA
ERTACZO	Tier 3	PA
EXTINA	Tier 3	PA
JUBLIA	Tier 3	PA; AGE (Min 6 Years)
<i>ketoconazole topical cream</i>	Tier 2	
<i>ketoconazole topical foam</i>	Tier 3	PA
<i>ketoconazole topical shampoo</i>	Tier 2	
KETODAN	Tier 3	PA
KETODAN KIT	Tier 3	PA
LOTRIMIN AF (CLOTRIMAZOLE) TOPICAL CREAM	Tier 3	PA
<i>luliconazole</i>	Tier 3	PA
LUZU	Tier 3	PA
<i>miconazole nitrate topical cream</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>miconazole nitrate vaginal comb pack, prefill appl, cream</i>	Tier 1	
<i>miconazole nitrate vaginal cream</i>	Tier 1	
<i>miconazole nitrate vaginal suppository</i>	Tier 1	
<i>miconazole nitrate-zinc ox-pet</i>	Tier 3	PA
MICONAZOLE-3 PREFIL, CREAM, WIP E	Tier 1	
MICONAZOLE-3 VAGINAL COMB PACK, PREFILL APPL, CREAM	Tier 1	
MICONAZOLE-3 VAGINAL KIT	Tier 1	
MICONAZOLE-7	Tier 1	
MONISTAT 3 VAGINAL COMB PACK, PREFILL APPL, CREAM	Tier 1	
MONISTAT 3 VAGINAL KIT	Tier 1	
MONISTAT 7 VAGINAL CREAM	Tier 1	
MYCOZYL AC	Tier 3	PA
ORAVIG	Tier 3	PA
<i>oxiconazole</i>	Tier 3	PA
OXISTAT	Tier 3	PA
<i>terconazole vaginal cream</i>	Tier 1	
VUSION	Tier 3	PA

Drug	Status	Notes
Basic Lotions And Liniments		
<i>ammonium lactate topical lotion</i>	Tier 1	QL (225 GM per 30 days)
Basic Ointments And Protectants		
<i>ammonium lactate topical cream</i>	Tier 1	QL (140 GM per 30 days)
Benzylamines (Skin And Mucous Membrane)		
<i>butenafine</i>	Tier 3	PA
MENTAX	Tier 3	PA
Cell Stimulants And Proliferants		
<i>tretinoin topical cream 0.025 %, 0.05 %</i>	Tier 1	QL (0.7 GM per 1 day); AGE (Max 30 Years)
Corticosteroids (Skin, Mucous Membrane)		
<i>alclometasone</i>	Tier 3	PA
ANTI-ITCH (HC) TOPICAL CREAM	Tier 2	
APEXICON E	Tier 3	PA
BESER	Tier 3	PA
BESER KIT	Tier 3	PA
<i>betamethasone dipropionate</i>	Tier 2	
<i>betamethasone valerate topical cream</i>	Tier 2	
<i>betamethasone valerate topical foam</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>betamethasone valerate topical lotion</i>	Tier 2	
<i>betamethasone valerate topical ointment</i>	Tier 2	
<i>betamethasone, augmented</i>	Tier 3	PA
BRYHALI	Tier 3	PA
<i>clobetasol scalp</i>	Tier 2	
<i>clobetasol topical cream</i>	Tier 2	
<i>clobetasol topical foam</i>	Tier 3	PA
<i>clobetasol topical gel</i>	Tier 2	
<i>clobetasol topical lotion</i>	Tier 3	PA
<i>clobetasol topical ointment</i>	Tier 2	
<i>clobetasol topical shampoo</i>	Tier 3	PA
<i>clobetasol topical spray, non-aerosol</i>	Tier 3	PA
<i>clobetasol-emollient</i>	Tier 3	PA
CLOBEX	Tier 3	PA
<i>clocortolone pivalate</i>	Tier 3	PA
CLODAN	Tier 3	PA
CLODAN KIT	Tier 3	PA
<i>clotrimazole-betamethasone topical cream</i>	Tier 2	
<i>clotrimazole-betamethasone topical lotion</i>	Tier 3	PA

Drug	Status	Notes
DERMA-SMOOTH/FS BODY OIL	Tier 3	PA
DERMA-SMOOTH/FS SCALP OIL	Tier 3	PA
<i>desonide topical cream</i>	Tier 3	PA
<i>desonide topical lotion</i>	Tier 3	PA
<i>desonide topical ointment</i>	Tier 3	PA
DESOWEN TOPICAL CREAM	Tier 3	PA
<i>desoximetasone</i>	Tier 3	PA
<i>diflorasone</i>	Tier 3	PA
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	Tier 3	PA
<i>fluocinolone</i>	Tier 3	PA
<i>fluocinolone and shower cap</i>	Tier 3	PA
<i>fluocinonide</i>	Tier 3	PA
FLUOCINONIDE-E	Tier 3	PA
<i>fluocinonide-emollient</i>	Tier 3	PA
<i>flurandrenolide</i>	Tier 3	PA
<i>fluticasone propionate topical cream</i>	Tier 2	
<i>fluticasone propionate topical lotion</i>	Tier 3	PA
<i>fluticasone propionate topical ointment</i>	Tier 2	
<i>halcinonide</i>	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>halobetasol propionate topical cream</i>	Tier 2	
<i>halobetasol propionate topical foam</i>	Tier 3	PA
<i>halobetasol propionate topical ointment</i>	Tier 2	
HALOG	Tier 3	PA
<i>hydrocortisone acetate topical cream</i>	Tier 2	
<i>hydrocortisone acetate topical ointment</i>	Tier 2	
<i>hydrocortisone butyrate</i>	Tier 3	PA
<i>hydrocortisone butyr-emollient</i>	Tier 3	PA
<i>hydrocortisone topical cream</i>	Tier 2	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	Tier 1	
<i>hydrocortisone topical lotion 2.5 %</i>	Tier 2	
<i>hydrocortisone topical ointment</i>	Tier 2	
<i>hydrocortisone valerate</i>	Tier 3	PA
<i>hydrocortisone-aloe vera topical cream 1 %</i>	Tier 3	PA
KENALOG TOPICAL	Tier 3	PA
LEXETTE	Tier 3	PA

Drug	Status	Notes
LOCOID LIPOCREAM	Tier 3	PA
LOCOID TOPICAL LOTION	Tier 3	PA
<i>mometasone topical</i>	Tier 2	
OLUX	Tier 3	PA
PANDEL	Tier 3	PA
<i>prednicarbate</i>	Tier 3	PA
PROCTOCORT TOPICAL	Tier 3	PA
PROCTOSOL HC TOPICAL	Tier 1	
SERNIVO	Tier 3	PA
SYNALAR	Tier 3	PA
SYNALAR CREAM KIT	Tier 3	PA
SYNALAR OINTMENT KIT	Tier 3	PA
SYNALAR TS	Tier 3	PA
TEMOVATE TOPICAL OINTMENT	Tier 3	PA
TEXACORT	Tier 3	PA
TOPICORT	Tier 3	PA
TOVET EMOLLIENT	Tier 3	PA
TOVET KIT	Tier 3	PA
<i>triamcinolone acetonide dental</i>	Tier 1	QL (5 GM per 30 dayss)
<i>triamcinolone acetonide topical aerosol</i>	Tier 3	PA
<i>triamcinolone acetonide topical cream</i>	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
<i>triamcinolone acetonide topical lotion</i>	Tier 2	
<i>triamcinolone acetonide topical ointment</i>	Tier 2	
TRIANEX	Tier 3	PA
TRIDERM TOPICAL CREAM 0.1 %	Tier 2	
ULTRAVATE TOPICAL LOTION	Tier 3	PA
VANOS	Tier 3	PA
XERESE	Tier 3	PA
Hydroxypyridones (Skin, Mucous Membrane)		
CICLODAN	Tier 3	PA
CICLODAN KIT	Tier 3	PA
<i>ciclopirox topical cream</i>	Tier 2	
<i>ciclopirox topical gel</i>	Tier 3	PA
<i>ciclopirox topical shampoo</i>	Tier 3	PA
<i>ciclopirox topical solution</i>	Tier 2	
<i>ciclopirox topical suspension</i>	Tier 3	PA
<i>ciclopirox-ure-camph-menth-euc</i>	Tier 3	PA
LOPROX (AS OLAMINE)	Tier 3	PA
LOPROX KIT	Tier 3	PA

Drug	Status	Notes
Immunomodulatory Agent(S)		
ADBRY	Tier 3	PA; QL (4 syringes per 28 days)
ELIDEL	Tier 2	PA; QL (30 GM per 30 days); AGE (Min 2 Years)
ILUMYA	Tier 3	PA
<i>pimecrolimus</i>	Tier 3	PA; QL (30 GM per 30 dayss); AGE (Min 2 Years)
SILIQ	Tier 3	PA
SKYRIZI SUBCUTANEOUS PEN INJECTOR	Tier 3	PA
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	Tier 3	PA
<i>tacrolimus topical ointment 0.03 %</i>	Tier 3	PA; QL (30 GM per 30 dayss); AGE (Min 2 Years)
<i>tacrolimus topical ointment 0.1 %</i>	Tier 3	PA; QL (30 GM per 30 days); AGE (Min 16 Years)
TREMFYA	Tier 3	PA
Keratolytic Agents		
ACANYA TOPICAL GEL WITH PUMP	Tier 3	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
<i>benzoyl peroxide topical cleanser 10 %, 5 %</i>	Tier 1	
<i>benzoyl peroxide topical gel 10 %</i>	Tier 1	QL (3.78 GM per 1 day)
<i>benzoyl peroxide topical gel 5 %</i>	Tier 1	
CICLODAN KIT TOPICAL SOLUTION	Tier 3	PA
<i>ciclopirox-ure-camph-menth-euc</i>	Tier 3	PA
<i>clindamycin-benzoyl peroxide topical gel</i>	Tier 2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2 %(1 % base) -3.75 %</i>	Tier 1	PA
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %, 1.2-2.5 %</i>	Tier 2	
CREAMY ACNE FACE	Tier 1	
NEUAC	Tier 3	PA
NEUAC KIT	Tier 3	PA
ONEXTON	Tier 3	PA
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	Tier 1	
Local Anti-Infectives, Miscellaneous		
<i>alcohol swabs</i>	Tier 1	
BD ALCOHOL SWABS	Tier 1	

Drug	Status	Notes
EASY TOUCH ALCOHOL PREP PADS	Tier 1	
<i>selenium sulfide topical lotion</i>	Tier 1	
<i>silver sulfadiazine</i>	Tier 1	
SSD	Tier 1	
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	Tier 1	
Nonsteroidal Anti-Inflammat.Agents(Skin)		
<i>diclofenac epolamine</i>	Tier 3	PA; QL (2 patches per 1 day)
<i>diclofenac sodium topical drops</i>	Tier 2	
<i>diclofenac sodium topical gel 1 %</i>	Tier 2	
<i>diclofenac sodium topical gel 3 %</i>	Tier 1	
<i>diclofenac sodium topical solution in metered-dose pump</i>	Tier 3	PA
FLECTOR	Tier 3	PA; QL (2 patches per 1 day)
LICART	Tier 3	PA; QL (15 patches per 30 days)
PENNSAID	Tier 3	PA
Oxaboroles		
KERYDIN	Tier 3	PA; AGE (Min 6 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>tavaborole</i>	Tier 3	PA; AGE (Min 6 Years)
Polyenes (Skin And Mucous Membrane)		
KLAYESTA	Tier 2	
NYAMYC	Tier 2	
<i>nystatin topical</i>	Tier 2	
<i>nystatin-triamcinolone</i>	Tier 2	
NYSTOP	Tier 2	
Scabicides And Pediculicides		
LICE KILLING	Tier 1	QL (59 ML per 30 dayss)
LICE PYRINYL SHAMPOO	Tier 1	QL (59 ML per 30 dayss)
LICE TREATMENT	Tier 1	QL (59 ML per 30 dayss)
LICE TREATMENT (PERMETHRIN)	Tier 1	QL (59 ML per 30 dayss)
<i>malathion</i>	Tier 1	QL (1.97 ML per 1 day); ST
NIX CREME RINSE	Tier 1	QL (59 ML per 30 dayss)
<i>permethrin</i>	Tier 1	QL (2 GM per 1 day)
RID LICE KILLING	Tier 1	QL (59 ML per 30 dayss)
<i>spinosad</i>	Tier 1	QL (240 ML per 180 dayss); ST

Drug	Status	Notes
Skin And Mucous Membrane Agents, Misc.		
<i>acitretin</i>	Tier 1	PA; QL (2 capsules per 1 day)
<i>adapalene topical gel 0.1 %</i>	Tier 1	QL (45 GM per 30 days)
<i>adapalene topical gel 0.3 %</i>	Tier 1	QL (1.5 GM per 1 day); AGE (Max 30 Years)
<i>adapalene-benzoyl peroxide topical gel with pump 0.1-2.5 %</i>	Tier 1	QL (1.5 GM per 1 day); AGE (Max 30 Years)
AMNESTEEM	Tier 1	PA; QL (2 capsules per 1 day)
<i>bexarotene topical</i>	Tier 1	
<i>calcipotriene scalp</i>	Tier 1	PA; AGE (Min 2 Years)
<i>calcipotriene topical cream</i>	Tier 1	PA; AGE (Min 2 Years)
<i>calcipotriene topical ointment</i>	Tier 1	PA; AGE (Min 2 Years)
<i>calcitriol topical</i>	Tier 1	PA; AGE (Min 2 Years)
CICLODAN KIT TOPICAL COMBO PACK	Tier 3	PA
CLARAVIS	Tier 1	PA; QL (2 capsules per 1 day)
COSENTYX (2 SYRINGES)	Tier 2	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Drug	Status	Notes
COSENTYX PEN	Tier 2	
COSENTYX PEN (2 PENS)	Tier 2	
COSENTYX SUBCUTANEOUS	Tier 2	
COSENTYX UNOREADY PEN	Tier 2	
DIFFERIN TOPICAL GEL 0.1 %	Tier 1	QL (45 GM per 30 days)
DUPIXENT PEN	Tier 2	PA; AGE (Min 2 Years)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML	Tier 2	PA
ENBREL MINI	Tier 2	
ENBREL SUBCUTANEOUS SOLUTION	Tier 2	
ENBREL SUBCUTANEOUS SYRINGE	Tier 2	
ENBREL SURECLICK	Tier 2	
<i>fluorouracil topical cream</i>	Tier 1	
<i>imiquimod topical cream in packet 5 %</i>	Tier 1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	PA; QL (2 capsules per 1 day)
LOPROX KIT	Tier 3	PA

Drug	Status	Notes
OPZELURA	Tier 3	PA; QL (240 GM per 30 days); AGE (Min 12 Years)
OTEZLA	Tier 3	PA
OTEZLA STARTER ORAL TABLETS, DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 3	PA
<i>podofilox topical solution</i>	Tier 1	
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR	Tier 3	PA
SOTYKTU	Tier 3	PA; QL (1 tablet per 1 day); AGE (Min 18 Years)
STELARA	Tier 3	PA
TALTZ AUTOINJECTOR	Tier 3	PA
TALTZ AUTOINJECTOR (2 PACK)	Tier 3	PA
TALTZ AUTOINJECTOR (3 PACK)	Tier 3	PA
TALTZ SYRINGE	Tier 3	PA
TARGRETIN TOPICAL	Tier 1	
<i>tazarotene topical cream</i>	Tier 1	PA

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>tazarotene topical gel</i>	Tier 1	PA
VTAMA	Tier 1	PA; QL (60 GM per 1 Fill); AGE (Min 18 Years)
ZENATANE	Tier 1	PA; QL (2 capsules per 1 day)
ZORYVE TOPICAL CREAM	Tier 1	PA; AGE (Min 6 Years)
Thiocarbamates(Skin And Mucous Membrane)		
ANTIFUNGAL (TOLNAFTATE) TOPICAL CREAM	Tier 2	
<i>tolnaftate topical cream</i>	Tier 2	
<i>tolnaftate topical powder</i>	Tier 2	
Smooth Muscle Relaxants		
Antimuscarinics		
<i>darifenacin</i>	Tier 3	PA
DETROL	Tier 3	PA
DETROL LA	Tier 3	PA
<i>fesoterodine</i>	Tier 3	PA
<i>flavoxate</i>	Tier 3	PA
GELNIQUE TRANSDERMAL GEL IN PACKET	Tier 3	PA
<i>oxybutynin chloride</i>	Tier 2	
OXYTROL	Tier 3	PA
OXYTROL FOR WOMEN	Tier 1	

Drug	Status	Notes
<i>solifenacin</i>	Tier 2	
<i>tolterodine</i>	Tier 3	PA
TOVIAZ	Tier 2	
<i>tropium</i>	Tier 3	PA
VESICARE	Tier 3	PA
VESICARE LS	Tier 3	PA
Respiratory Smooth Muscle Relaxants		
<i>theophylline oral elixir</i>	Tier 1	
<i>theophylline oral solution</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr</i>	Tier 1	
Selective Beta-3-Adrenergic Agonists		
GEMTESA	Tier 3	PA
MYRBETRIQ	Tier 3	PA
Vitamins		
Multivitamin Preparations		
A THRU Z	Tier 1	
A THRU Z ADVANCED FORMULA	Tier 1	
A THRU Z MEN'S ULTIMATE	Tier 1	
A THRU Z SELECT 50PLUS FORMULA	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
A THRU Z SELECT ORAL TABLET 300-60-600-300 MCG, 500-300-250 MCG	Tier 1	
A THRU Z SELECT WOMEN'S	Tier 1	
ABC PLUS	Tier 1	
ADULT MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
ADULT ONE DAILY GUMMIES	Tier 1	
BACMIN	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	
BIOCEL (WITH LUTEIN)	Tier 1	
BODY, HAIR, SKIN AND NAILS	Tier 1	
CENTRAL-VITE WOMEN'S MATURE	Tier 1	
CENTRAVITES	Tier 1	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM COMPLETE	Tier 1	
CENTRUM MEN	Tier 1	
CENTRUM SILVER ORAL TABLET	Tier 1	
CENTRUM SILVER ULTRA MEN'S	Tier 1	

Drug	Status	Notes
CENTRUM SILVER WOMEN	Tier 1	
CENTRUM SPECIALIST HEART	Tier 1	
CENTRUM ULTRA MEN'S	Tier 1	
CENTURY	Tier 1	
CENTURY MATURE	Tier 1	
CERTA PLUS	Tier 1	
CERTAVITE SENIOR	Tier 1	
CERTAVITE-ANTIOXIDANT	Tier 1	
CLASSIC PRENATAL	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
COMPLETE MULTIVITAMIN-MINERAL ORAL TABLET	Tier 1	
COMPLETE MV ADULT 50 PLUS	Tier 1	
COMPLETENATE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
CORVITE FREE	Tier 1	
DAILY GUMMIES	Tier 1	
DAILY MULTIPLE FOR WOMEN	Tier 1	
DAILY MULTIVITAMIN	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
DAILY MULTIVITAMIN WITH IRON	Tier 1	
DAILY VALUE	Tier 1	
DAILY VITAMIN FORMULA	Tier 1	
DAILY VITAMIN FORMULA-IRON	Tier 1	
DAILY VITAMIN FORMULA-MINERALS	Tier 1	
DAILY VITAMIN WITH IRON	Tier 1	
DAILY VITES/IRON	Tier 1	
DAILY-VITE	Tier 1	
DAILY-VITE (WITH FOLIC ACID)	Tier 1	
DECUBI VITE	Tier 1	
DEKAS ESSENTIAL	Tier 1	
DEKAS PLUS (FOLIC ACID)	Tier 1	
DEKAS PLUS LIQUID	Tier 1	
DIABETES HEALTH FORMULA	Tier 1	
ESSENTIA	Tier 1	
ESSENTIAL MAN	Tier 1	
ESSENTIAL MAN 50 PLUS	Tier 1	
ESSENTIAL WOMAN 50 PLUS	Tier 1	
EYE HEALTH PLUS LUTEIN	Tier 1	
FORTAVIT	Tier 1	
FREEDAVITE	Tier 1	

Drug	Status	Notes
HAIR, SKIN AND NAILS-ARGAN OIL	Tier 1	
HAIR,SKIN AND NAILS	Tier 1	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL TABLET 66.7-1,000 MCG	Tier 1	
ICAPS MV	Tier 1	
K-PAX IMMUNE SUPPORT	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MEGA MULTIVITAMIN FOR MEN	Tier 1	
MEN'S DAILY	Tier 1	
MEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
MEN'S ONE DAILY ORAL TABLET 400-20-300 MCG	Tier 1	
MONOCAPS	Tier 1	
MULTI COMPLETE WITH IRON	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MULTI-DAY WITH IRON	Tier 1	
MULTIPLE VITAMIN-MINERALS	Tier 1	
MULTIPLE VITAMINS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
MULTI-VIT WITH FLUORIDE-IRON	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
<i>multivitamin</i>	Tier 1	
MULTI-VITAMIN WITH FLUORIDE ORAL DROPS	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.25 MG	Tier 1	QL (1 tablet per 1 day)
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.5 MG, 1 MG	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
<i>multivitamin with iron</i>	Tier 1	
<i>multivit-min-iron fum-folic ac</i>	Tier 1	
MVC-FLUORIDE	Tier 1	QL (1 tablet per 1 day); AGE (Max 12 Years)
<i>mv-min-folic acid-lutein</i>	Tier 1	
MVW COMPLETE FORMUL MULTIVIT ORAL CAPSULE 750-500 UNIT-MCG	Tier 1	
MVW COMPLETE FORMULATION D3000 ORAL TABLET,CHEWABLE	Tier 1	
MY-VITALIFE	Tier 1	

Drug	Status	Notes
NANO VM 1-3	Tier 1	
NANO VM 4-8	Tier 1	
NANOVM 9-18	Tier 1	
NANOVM T-F	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
OCUTABS	Tier 1	
OMNICAP	Tier 1	
ONCOVITE	Tier 1	
ONE DAILY	Tier 1	
ONE DAILY CALCIUM/IRON	Tier 1	
ONE DAILY COMPLETE	Tier 1	
ONE DAILY ENERGY ORAL TABLET	Tier 1	
ONE DAILY ESSENTIAL ORAL TABLET , 0.4 MG, 400 MCG	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
ONE DAILY FOR MEN	Tier 1	
ONE DAILY FOR MEN 50 PLUS ADV	Tier 1	
ONE DAILY FOR WOMEN	Tier 1	
ONE DAILY HEALTHY WEIGHT	Tier 1	
ONE DAILY MAXIMUM	Tier 1	
ONE DAILY MEN'S 50 PLUS MEMORY	Tier 1	
ONE DAILY MULTI-VIT W-MINERAL ORAL TABLET	Tier 1	
ONE DAILY MULTIVITAMIN ORAL TABLET	Tier 1	
ONE DAILY MULTIVIT-IRON(FOLIC)	Tier 1	
ONE DAILY PLUS IRON	Tier 1	
ONE DAILY PLUS MINERALS	Tier 1	
ONE DAILY WOMEN 50 PLUS	Tier 1	
ONE DAILY WOMENS 50 PLUS	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	
ONE-A-DAY ENERGY	Tier 1	

Drug	Status	Notes
ONE-A-DAY ESSENTIAL	Tier 1	
ONE-A-DAY MAXIMUM FORMULA	Tier 1	
ONE-A-DAY MEN VITACRAVES	Tier 1	
ONE-A-DAY MENOPAUSE FORMULA	Tier 1	
ONE-A-DAY MEN'S 50PLUS(GINKGO)	Tier 1	
ONE-A-DAY MEN'S MULTIVITAMIN	Tier 1	
ONE-A-DAY TEEN ADVANTAGE	Tier 1	
ONE-A-DAY VITACRAVES	Tier 1	
ONE-A-DAY VITACRAVES IMMUNITY	Tier 1	
ONE-A-DAY VITACRAVES OMEGA-3	Tier 1	
ONE-A-DAY WEIGHTSMART	Tier 1	
ONE-A-DAY WOMEN VITACRAVES	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
OPURITY MULTIVITAMIN	Tier 1	
<i>pnv cmb#95-ferrous fumarate-fa</i>	Tier 1	QL (1 tablet per 1 day)
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL FORMULA ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTI- DHA(WITH VIT K)	Tier 1	AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTIVITAMINS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Drug	Status	Notes
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PROCERV HP	Tier 1	
PRORENAL QD	Tier 1	
PROTECT CARDIO AF	Tier 1	
PROTECT PLUS SO	Tier 1	
QUINTABS	Tier 1	
QUINTABS-M	Tier 1	
QUINTABS-M IRON FREE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
SE-NATAL-19	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
SENTRY	Tier 1	
SENTRY SENIOR	Tier 1	
SOLO	Tier 1	
SPECTRAVITE ADVANCED FORMULA	Tier 1	
SPECTRAVITE MEN'S	Tier 1	
STRESS FORMULA	Tier 1	
SUNVITE	Tier 1	
SUPER GINSENG MULTIVITAMIN	Tier 1	
SUPER MULTIPLE - LOW IRON	Tier 1	
SUPER THERA VITE M	Tier 1	
TAB-A-VITE MULTIVITAMIN W- IRON ORAL TABLET 15 MG IRON- 400 MCG	Tier 1	
THERA	Tier 1	
THERAGRAN-M PREMIER 50 PLUS	Tier 1	
THERALOGIX COMPANION	Tier 1	
THERA-M ORAL TABLET 27-0.4 MG	Tier 1	

Drug	Status	Notes
THERANATAL ORAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
THERAPEUTIC-M	Tier 1	
THERA-TABS	Tier 1	
THERATRUM COMPLETE WITH LUTEIN	Tier 1	
TRICARE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRI-VI-SOL	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
ULTRA FREEDA	Tier 1	
V-C FORTE	Tier 1	
VIC-FORTE	Tier 1	
VITACEL (WITH LUTEIN)	Tier 1	
VITALEE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
VITAMINS A-D-E SELENIUM	Tier 1	
VITATRUM	Tier 1	
VITRUM SENIOR ORAL TABLET 500-300-250 MCG	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S DAILY FORMULA ORAL TABLET 27-0.4 MG	Tier 1	
WOMEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
WOMEN'S ONE DAILY	Tier 1	
YELETS	Tier 1	
Vitamin A		
<i>beta carotene</i>	Tier 1	
DEKAS ESSENTIAL	Tier 1	
TRI-VI-SOL	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
<i>vitamin a palmitate oral capsule</i>	Tier 1	

Drug	Status	Notes
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
VITAMINS A-D-E SELENIUM	Tier 1	
Vitamin B Complex		
A THRU Z ADVANCED FORMULA	Tier 1	
A THRU Z MEN'S ULTIMATE	Tier 1	
A THRU Z SELECT 50PLUS FORMULA	Tier 1	
A THRU Z SELECT ORAL TABLET 300-60-600-300 MCG, 500-300-250 MCG	Tier 1	
ABC PLUS	Tier 1	
ADULT MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
ADULT ONE DAILY GUMMIES	Tier 1	
ALBA-LYBE	Tier 1	
APETEX	Tier 1	
APETIGEN	Tier 1	
ARKALIOX	Tier 1	
B COMPLEX	Tier 1	
B COMPLEX 1 (WITH FOLIC ACID)	Tier 1	
B COMPLEX 100	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
B COMPLEX PLUS VITAMIN C	Tier 1	
B COMPLEX W-VIT C	Tier 1	
<i>b complex-vitamin c-folic acid</i>	Tier 1	
B-100 COMPLEX	Tier 1	
BACMIN	Tier 1	
BALANCE B-100 (FOLIC ACID)	Tier 1	
BALANCE B-50 (WITH FOLIC ACID)	Tier 1	
BALANCED B-100 COMPLEX	Tier 1	
BALANCED B-100 ORAL TABLET	Tier 1	
BALANCED B-50	Tier 1	
B-COMPLEX WITH B-12	Tier 1	
B-COMPLEX WITH VITAMIN C ORAL TABLET 400-500 MCG-MG	Tier 1	
BEELITH	Tier 1	
BIO-35, GLUTEN FREE	Tier 1	
BIOCAL	Tier 1	
BIOCEL (WITH LUTEIN)	Tier 1	
BIOPETIT	Tier 1	
<i>biotin oral capsule 1 mg, 2,500 mcg, 5 mg</i>	Tier 1	
<i>biotin oral tablet</i>	Tier 1	

Drug	Status	Notes
CENTRAL-VITE WOMEN'S MATURE	Tier 1	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM COMPLETE	Tier 1	
CENTRUM MEN	Tier 1	
CENTRUM SILVER ORAL TABLET	Tier 1	
CENTRUM SILVER ULTRA MEN'S	Tier 1	
CENTRUM SILVER WOMEN	Tier 1	
CENTRUM ULTRA MEN'S	Tier 1	
CENTURY	Tier 1	
CENTURY MATURE	Tier 1	
CERTA PLUS	Tier 1	
CERTAVITE SENIOR	Tier 1	
CERTAVITE-ANTIOXIDANT	Tier 1	
CLASSIC PRENATAL	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
COMPLETE MULTIVITAMIN-MINERAL ORAL TABLET	Tier 1	
COMPLETE MV ADULT 50 PLUS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
COMPLETENATE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
COMPLEX B-100	Tier 1	
COMPLEX B-50	Tier 1	
CORVITE FREE	Tier 1	
<i>cyanocobalamin (vitamin b-12) injection</i>	Tier 1	
DAILY GUMMIES	Tier 1	
DAILY MULTIPLE FOR WOMEN	Tier 1	
DAILY MULTIVITAMIN	Tier 1	
DAILY MULTIVITAMIN WITH IRON	Tier 1	
DAILY VITAMIN FORMULA-IRON	Tier 1	
DAILY-VITE (WITH FOLIC ACID)	Tier 1	
DECUBI VITE	Tier 1	
DEKAS PLUS (FOLIC ACID)	Tier 1	
DIABETES HEALTH FORMULA	Tier 1	
DIALYVITE	Tier 1	
DIALYVITE 3000	Tier 1	
DIALYVITE 5000	Tier 1	
DIALYVITE 800 ORAL TABLET	Tier 1	

Drug	Status	Notes
DIALYVITE 800 PLUS D	Tier 1	
DIALYVITE 800 WITH ZINC 15	Tier 1	
DIALYVITE 800 WITH ZINC 50	Tier 1	
DIALYVITE 800-ULTRA D	Tier 1	
DIALYVITE SUPREME D	Tier 1	
ESSENTIA	Tier 1	
ESSENTIAL MAN	Tier 1	
ESSENTIAL MAN 50 PLUS	Tier 1	
ESSENTIAL WOMAN 50 PLUS	Tier 1	
FE C PLUS	Tier 1	AGE (Max 12 Years)
FOLBEE	Tier 1	
FOLBEE PLUS	Tier 1	
FOLBIC	Tier 1	
<i>folic acid oral tablet 1 mg, 800 mcg</i>	Tier 1	
<i>folic acid oral tablet 400 mcg</i>	Tier 1	QL (1 tablet per 1 day)
FOLINIC-PLUS	Tier 1	
FOLPLEX 2.2	Tier 1	
FOLTABS 800	Tier 1	
FREEDAVITE	Tier 1	
FULL SPECTRUM B-VITAMIN C	Tier 1	
HAIR, SKIN AND NAILS-ARGAN OIL	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
HAIR,SKIN AND NAILS ORAL TABLET 1 MG IRON-66.7 MCG-1,000 MCG	Tier 1	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL TABLET 66.7-1,000 MCG	Tier 1	
HARD NAILS	Tier 1	
HOMOCYSTEINE FORMULA	Tier 1	
ICAPS MV	Tier 1	
IRON 100 PLUS	Tier 1	AGE (Max 12 Years)
KOBEE	Tier 1	
K-PAX IMMUNE SUPPORT	Tier 1	
MEDTYCHOLL-B COMPLEX-LIVER	Tier 1	
MEGA BIOTIN	Tier 1	
MEGA MULTI FOR WOMEN	Tier 1	
MEGA MULTIVITAMIN FOR MEN	Tier 1	
MEN'S DAILY	Tier 1	
MEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
MEN'S ONE DAILY ORAL TABLET 400-20-300 MCG	Tier 1	
MERIBIN	Tier 1	

Drug	Status	Notes
MONOCAPS	Tier 1	
MULTI COMPLETE WITH IRON	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MULTI-DAY WITH IRON	Tier 1	
<i>multivit-min-iron fum-folic ac</i>	Tier 1	
<i>mv-min-folic acid-lutein</i>	Tier 1	
MYNEPHROCAPS	Tier 1	
NANO VM 1-3	Tier 1	
NANO VM 4-8	Tier 1	
NEPHPLEX RX	Tier 1	
NEPHRON FA	Tier 1	
NEPHRONEX-SL	Tier 1	
NEPHRO-VITE	Tier 1	
NESTABS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
NESTABS DHA	Tier 1	QL (2 capsules per 1 day); AGE (Min 12 Years and Max 55 Years)
NEWGEN	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>niacinamide</i>	Tier 1	
OMNICAP	Tier 1	
ONE DAILY	Tier 1	
ONE DAILY COMPLETE ORAL TABLET 18-0.4 MG	Tier 1	
ONE DAILY ESSENTIAL ORAL TABLET 0.4 MG, 400 MCG	Tier 1	
ONE DAILY FOR MEN	Tier 1	
ONE DAILY FOR MEN 50 PLUS ADV	Tier 1	
ONE DAILY FOR WOMEN	Tier 1	
ONE DAILY HEALTHY WEIGHT	Tier 1	
ONE DAILY MAXIMUM	Tier 1	
ONE DAILY MEN'S 50 PLUS MEMORY	Tier 1	
ONE DAILY MULTIVIT-IRON(FOLIC)	Tier 1	
ONE DAILY PLUS IRON	Tier 1	
ONE DAILY WOMEN 50 PLUS	Tier 1	
ONE DAILY WOMENS 50 PLUS	Tier 1	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-450 MG CA	Tier 1	

Drug	Status	Notes
ONE-A-DAY ENERGY	Tier 1	
ONE-A-DAY MEN VITACRAVES	Tier 1	
ONE-A-DAY MENOPAUSE FORMULA	Tier 1	
ONE-A-DAY MEN'S 50PLUS(GINKGO)	Tier 1	
ONE-A-DAY MEN'S MULTIVITAMIN	Tier 1	
ONE-A-DAY TEEN ADVANTAGE	Tier 1	
ONE-A-DAY VITACRAVES	Tier 1	
ONE-A-DAY VITACRAVES IMMUNITY	Tier 1	
ONE-A-DAY VITACRAVES OMEGA-3	Tier 1	
ONE-A-DAY WEIGHTSMART	Tier 1	
ONE-A-DAY WOMEN VITACRAVES	Tier 1	
ONE-A-DAY WOMEN'S ACTIVE	Tier 1	
ONE-A-DAY WOMEN'S HEALTHY SKIN	Tier 1	
ONE-A-DAY WOMEN'S PETITES	Tier 1	
OPTISOURCE	Tier 1	
OPURITY MULTIVITAMIN	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
PARVLEX	Tier 1	
<i>pnv cmb#95-ferrous fumarate-fa</i>	Tier 1	QL (1 tablet per 1 day)
PRENATABS RX	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL COMPLETE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL FORMULA ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTI-DHA(WITH VIT K)	Tier 1	AGE (Min 12 Years and Max 55 Years)
PRENATAL MULTIVITAMINS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)

Drug	Status	Notes
PRENATAL PLUS (CALCIUM CARB)	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN PLUS LOW IRON	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PRENATAL VITAMIN WITH MINERALS	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
PROCERV HP	Tier 1	
PRORENAL	Tier 1	
PRORENAL QD	Tier 1	
PROTECT CARDIO AF	Tier 1	
PROTECT PLUS SO	Tier 1	
QUIN B STRONG	Tier 1	
QUINTABS	Tier 1	
QUINTABS-M	Tier 1	
QUINTABS-M IRON FREE	Tier 1	
RENAL CAPS	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
RENA-VITE	Tier 1	
RENA-VITE RX	Tier 1	
SE-NATAL-19	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
SENTRY	Tier 1	
SENTRY SENIOR	Tier 1	
SIDEROL	Tier 1	
SOLO	Tier 1	
SPECTRAVITE ADVANCED FORMULA	Tier 1	
SPECTRAVITE MEN'S	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
SUNVITE	Tier 1	
SUPER MULTIPLE - LOW IRON	Tier 1	
SUPER QUINTS	Tier 1	
SUPER QUINTS B-50	Tier 1	
TAB-A-VITE MULTIVITAMIN W- IRON ORAL TABLET 15 MG IRON- 400 MCG	Tier 1	
THERA	Tier 1	
THERAGRAN-M PREMIER 50 PLUS	Tier 1	

Drug	Status	Notes
THERALOGIX COMPANION	Tier 1	
THERA-M ORAL TABLET 27-0.4 MG	Tier 1	
THERANATAL ORAL TABLET	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
THERAPEUTIC-M	Tier 1	
TRICARE	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRINATAL RX 1	Tier 1	QL (1 tablet per 1 day); AGE (Min 12 Years and Max 55 Years)
TRIPHROCAPS	Tier 1	
ULTRA B-100 COMPLEX	Tier 1	
ULTRA FREEDA	Tier 1	
V-C FORTE	Tier 1	
VIC-FORTE	Tier 1	
VIRT-CAPS	Tier 1	
VITACEL (WITH LUTEIN)	Tier 1	
VITAL-D RX	Tier 1	
VITALEE	Tier 1	
<i>vitamin b complex oral capsule</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>vitamin b complex oral tablet</i>	Tier 1	
<i>vitamin b complex-folic acid</i>	Tier 1	
VITAMINS B COMPLEX	Tier 1	
VITA-RESPA	Tier 1	
VITRUM SENIOR ORAL TABLET 500-300-250 MCG	Tier 1	
WESCAPS	Tier 1	
WESTAB MAX	Tier 1	
WESTAB PLUS	Tier 1	
WOMEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG	Tier 1	
WOMEN'S ONE DAILY	Tier 1	
YELETS	Tier 1	
Vitamin C		
B COMPLEX W-VIT C	Tier 1	
<i>b complex-vitamin c-folic acid</i>	Tier 1	
DECUBI VITE	Tier 1	
DIALYVITE	Tier 1	
DIALYVITE 800 ORAL TABLET	Tier 1	
DIALYVITE 800 PLUS D	Tier 1	
DIALYVITE 800 WITH ZINC 15	Tier 1	

Drug	Status	Notes
DIALYVITE 800 WITH ZINC 50	Tier 1	
DIALYVITE 800-ULTRA D	Tier 1	
FE C PLUS	Tier 1	AGE (Max 12 Years)
FOLBEE PLUS ORAL TABLET 5 MG	Tier 1	
FULL SPECTRUM B-VITAMIN C	Tier 1	
IRON 100 PLUS	Tier 1	AGE (Max 12 Years)
MYNEPHROCAPS	Tier 1	
NEPHPLEX RX	Tier 1	
NEPHRON FA	Tier 1	
NEPHRONEX-SL	Tier 1	
NEPHRO-VITE	Tier 1	
PARVLEX	Tier 1	
PRORENAL	Tier 1	
QUIN B STRONG	Tier 1	
RENAL CAPS	Tier 1	
RENA-VITE	Tier 1	
RENA-VITE RX	Tier 1	
SIDEROL	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
TRIPHROCAPS	Tier 1	
TRI-VI-SOL	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
VIRT-CAPS	Tier 1	
VITAL-D RX	Tier 1	
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)
WESCAPS	Tier 1	
Vitamin D		
ACTICAL	Tier 1	
BIOCAL	Tier 1	
<i>calcitriol oral capsule</i>	Tier 1	QL (4 capsules per 1 day)
<i>calcitriol oral solution</i>	Tier 1	AGE (Max 12 Years)
CALCIUM 500 + D ORAL TABLET	Tier 1	
CALCIUM 500 WITH D	Tier 1	
CALCIUM 600 + D(3) ORAL TABLET	Tier 1	

Drug	Status	Notes
<i>calcium carbonate-vitamin d3 oral tablet 250 mg-3.125 mcg (125 unit), 500 mg-10 mcg (400 unit), 500 mg-15 mcg (600 unit), 500 mg-3.125 mcg (125 unit), 500 mg-5 mcg (200 unit), 600 mg-10 mcg (400 unit), 600 mg-20 mcg (800 unit), 600 mg-5 mcg (200 unit)</i>	Tier 1	
<i>calcium carbonate-vitamin d3 oral tablet, chewable 500 mg-2.5 mcg (100 unit)</i>	Tier 1	
CALCIUM CITRATE + D	Tier 1	
<i>calcium citrate-vitamin d3 oral tablet 315 mg-5 mcg (200 unit), 315 mg-6.25 mcg (250 unit)</i>	Tier 1	
CALCIUM WITH VITAMIN D	Tier 1	
CALTRATE WITH VITAMIN D3	Tier 1	
<i>cholecalciferol (vitamin d3) oral capsule 1,250 mcg (50,000 unit), 10 mcg (400 unit), 125 mcg (5,000 unit), 25 mcg (1,000 unit), 50 mcg (2,000 unit)</i>	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
<i>cholecalciferol (vitamin d3) oral drops 10 mcg/ml (400 unit/ml)</i>	Tier 1	
<i>cholecalciferol (vitamin d3) oral tablet 125 mcg (5,000 unit), 25 mcg (1,000 unit), 250 mcg (10,000 unit), 50 mcg (2,000 unit)</i>	Tier 1	
<i>cholecalciferol (vitamin d3) oral tablet, chewable 10 mcg (400 unit)</i>	Tier 1	
CITRACAL + D MAXIMUM	Tier 1	
CITRACAL-D3 MAXIMUM PLUS	Tier 1	
DEKAS ESSENTIAL	Tier 1	
DIALYVITE 800 PLUS D	Tier 1	
DIALYVITE 800-ULTRA D	Tier 1	
DIALYVITE SUPREME D	Tier 1	
DIALYVITE VITAMIN D3 MAX	Tier 1	
DRISDOL	Tier 1	
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	Tier 1	
FOSAMAX PLUS D	Tier 3	PA; QL (4 tablets per 28 dayss)

Drug	Status	Notes
MVW COMPLETE FORMUL MULTIVIT ORAL CAPSULE 750-500 UNIT-MCG	Tier 1	
MVW COMPLETE FORMULATION D3000 ORAL TABLET,CHEWABLE	Tier 1	
NEPHRONEX-SL	Tier 1	
OS-CAL 500 + D3	Tier 1	
OYSCO 500/D	Tier 1	
OYSTER SHELL + D3	Tier 1	
OYSTER SHELL CALCIUM-VIT D3	Tier 1	
OYSTERCAL-D	Tier 1	
PRORENAL	Tier 1	
PRORENAL QD	Tier 1	
TRI-VI-SOL	Tier 1	
TRI-VITAMIN WITH FLUORIDE	Tier 1	QL (2 drops per 1 day); AGE (Max 12 Years)
VITAL-D RX	Tier 1	
VITAMIN D2	Tier 1	
VITAMIN D3 ORAL CAPSULE	Tier 1	
VITAMIN D3 ORAL TABLET	Tier 1	
VITAMINS A,C,D AND FLUORIDE ORAL DROPS 0.25 MG FLUOR. (0.55 MG)/ML	Tier 1	QL (2 ML per 1 day); AGE (Max 12 Years)

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Drug	Status	Notes
VITAMINS A-D-E SELENIUM	Tier 1	
Vitamin E		
DEKAS ESSENTIAL	Tier 1	
STRESS FORMULA WITH IRON	Tier 1	
STRESS FORMULA WITH IRON(SULF)	Tier 1	
<i>vitamin e (dl, acetate) oral capsule 450 mg (1,000 unit), 90 mg (200 unit)</i>	Tier 1	
<i>vitamin e (dl, acetate) oral drops</i>	Tier 1	
<i>vitamin e acetate</i>	Tier 1	
<i>vitamin e mixed oral capsule 400 unit</i>	Tier 1	
<i>vitamin e mixed oral tablet</i>	Tier 1	
<i>vitamin e oral capsule 268 mg (400 unit)</i>	Tier 1	
<i>vitamin e oral drops</i>	Tier 1	
<i>vitamin e oral liquid</i>	Tier 1	
<i>vitamin e succinate</i>	Tier 1	
VITAMINS A-D-E SELENIUM	Tier 1	
<i>wheat germ oil</i>	Tier 1	
Vitamin K Activity		
A THRU Z SELECT ORAL TABLET 300-60-600-300 MCG	Tier 1	
BIOCAL	Tier 1	
CENTRAL-VITE WOMEN'S MATURE	Tier 1	

Drug	Status	Notes
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 10 MCG	Tier 1	
CENTRUM SILVER ULTRA MEN'S	Tier 1	
CENTRUM SILVER WOMEN	Tier 1	
DAILY MULTIVITAMIN	Tier 1	
DEKAS ESSENTIAL	Tier 1	
DEKAS PLUS (FOLIC ACID)	Tier 1	
MEN'S ONE DAILY ORAL TABLET 400-20-300 MCG	Tier 1	
MULTI FOR HER ORAL TABLET	Tier 1	
MVW COMPLETE FORMUL MULTIVIT ORAL CAPSULE 750-500 UNIT-MCG	Tier 1	
MVW COMPLETE FORMULATION D3000 ORAL TABLET,CHEWABLE	Tier 1	
ONE-A-DAY MEN'S MULTIVITAMIN	Tier 1	
OPTISOURCE	Tier 1	
<i>phytonadione (vitamin k1) oral tablet 5 mg</i>	Tier 1	QL (3 tablets per 30 dayss)
PROCERV HP	Tier 1	
SOLO	Tier 1	
SUNVITE	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we willcover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that iscovered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs firstbefore other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain agerequirement.

Medical Benefit

Drug	Status	Notes
GUARDIAN 4 GLUCOSE SENSOR	Tier 1	
GUARDIAN 4 TRANSMITTER	Tier 1	
GUARDIAN CONNECT TRANSMITTER	Tier 1	
GUARDIAN LINK 3 TRANSMITTER	Tier 1	
GUARDIAN SENSOR 3	Tier 1	

Tier 1= MCO Covered (This Drug Is Covered)

Tier 2= Preferred PDL Product (This Drug Is Covered But May Have Restrictions)

Tier 3= Non-Preferred PDL Product (This Drug Requires Approval Before It Is Covered)

PA =Prior Authorization - You (or your physician) must get approval before we will cover this drug.

QL =Quantity Limits Apply - There is a limit on the amount of this drug that is covered per prescription, or within a certain time period.

ST =Step Therapy Required - In some cases, you may have to try certain drugs first before other drugs are covered.

AGE =Age Restriction - This drug may only be covered if you meet a certain age requirement.

Index

24 HOUR NASAL ALLERGY	82, 124	<i>acyclovir</i>	13, 132	AFLURIA QUAD 2023- 2024(6MO UP).....	18
24HR ALLERGY RELIEF 6,	126	ADACEL(TDAP		AFREZZA.....	104, 109
3-DAY VAGINAL.....	132	ADOLESN/ADULT)(PF).....	18	AFTERA.....	100
A THRU Z.....	140	<i>adalimumab-adaz</i> ..	92, 115, 117	AIMOVIG AUTOINJECTOR..	59
A THRU Z ADVANCED		<i>adalimumab-fkjp</i>	92, 115, 117	AIMSCO LATEX CONDOM.	120
FORMULA.....	26, 140, 147	<i>adapalene</i>	138	AIRDUO DIGIHALER	
A THRU Z MEN'S		<i>adapalene-benzoyl peroxide</i>	138	.....	22, 96, 124, 128
ULTIMATE.....	26, 140, 147	ADBRY.....	136	AIRDUO RESPICLICK	
A THRU Z SELECT		ADCIRCA.....	50, 129	.....	22, 96, 124, 128
.....	141, 147, 157	<i>adefovir</i>	13	AIRZONE PEAK FLOW	
A THRU Z SELECT 50PLUS		ADEMPAS.....	51, 129	METER.....	71
FORMULA.....	140, 147	ADIPEX-P.....	53	AJOVY AUTOINJECTOR.....	59
A THRU Z SELECT		ADMELOG SOLOSTAR U-		AJOVY SYRINGE.....	59
WOMEN'S.....	26, 141	100 INSULIN.....	104, 109	AKEEGA.....	15
ABC PLUS.....	141, 147	ADMELOG U-100 INSULIN		AKYNZEO (NETUPITANT)	
<i>abiraterone</i>	15	LISPRO.....	104, 109	.....	85, 94
ACANYA.....	130, 136	ADTHYZA.....	111	ALAWAY.....	80
<i>acarbose</i>	98	ADULT MULTIVITAMIN		ALBA-LYBE.....	147
ACCOLATE.....	123	GUMMIES.....	141, 147	<i>albuterol sulfate</i>	22, 128
ACCUPRIL.....	35	ADULT ONE DAILY		<i>alclometasone</i>	133
ACCURETIC.....	35, 50, 78	GUMMIES.....	141, 147	<i>alcohol swabs</i>	137
ACE AEROSOL CLOUD		ADVAIR DISKUS		<i>alendronate</i>	114
ENHANCER.....	70	.....	22, 96, 124, 128	<i>alfuzosin</i>	22
<i>acebutolol</i>	23, 37, 38, 43, 47	ADVAIR HFA... 22, 96, 124, 128		ALGAL OMEGA-3 DHA.....	94
<i>acetaminophen</i>	53, 54	ADVANCED ANTACID-		ALIMTA.....	15
ACETAMINOPHEN EXTRA		ANTIGAS.....	85, 88	<i>aliskiren</i>	50
STRENGTH.....	53	AEMCOLO.....	14	ALKERAN.....	15
ACETAMINOPHEN PAIN		AEROCHAMBER MINI.....	70	ALKINDI SPRINKLE.....	96
RELIEF.....	54	AEROCHAMBER MV.....	70	ALL DAY ALLERGY	
<i>acetaminophen-caff-</i>		AEROCHAMBER PLUS		(CETIRIZINE).....	6, 126
<i>dihydrocod</i>	54, 61, 67	FLOW-VU.....	70	ALL DAY PAIN RELIEF.	65, 113
<i>acetaminophen-codeine</i> ..	54, 61	AEROCHAMBER PLUS		ALL DAY RELIEF.....	65, 113
<i>acetazolamide</i>	42, 73, 74, 82	FLOW-VU,L MSK.....	70	ALLER-CHLOR.....	5, 6, 122
<i>acetic acid</i>	83	AEROCHAMBER PLUS		ALLER-EASE.....	6, 126
<i>acetylcysteine</i>	120, 124	FLOW-VU,M MSK.....	70	ALLER-G-TIME.....	5, 122
ACID GONE ANTACID.....	85	AEROCHAMBER PLUS		ALLERGY	
ACID REDUCER		FLOW-VU,S MSK.....	70	(CHLORPHENIRAMINE)	
(OMEPRAZOLE).....	94	AEROCHAMBER PLUS Z		.....	5, 6, 122
ACIPHEX.....	94	STAT.....	70	ALLERGY EYE	
ACIPHEX SPRINKLE.....	94	AEROCHAMBER PLUS Z		(NAPHAZOLINE-PHEN).....	85
<i>acitretin</i>	138	STAT LG MSK.....	70	ALLERGY RELIEF	
ACTEMRA.....	115, 117	AEROCHAMBER PLUS Z		(CETIRIZINE).....	7, 127
ACTEMRA ACTPEN... 115, 117		STAT MD MSK.....	70	ALLERGY RELIEF	
ACTICAL.....	74, 155	AEROCHAMBER PLUS Z		(FLUTICASONE).....	82, 124
ACTONEL.....	114	STAT SM MSK.....	70	ALLERGY RELIEF	
ACTOPLUS MET.....	99, 111	AEROCHAMBER Z-STAT		(LORATADINE).....	7, 127
ACTOS.....	111	PLUS-FLW SG.....	70	ALLERGY	
ACULAR.....	84	AEROTRACH PLUS.....	70	RELIEF(CHLORPHENIRAM	
ACULAR LS.....	84	AFINITOR DISPERZ.....	15	N).....	5, 6, 122
ACUVAIL (PF).....	84	AFLURIA QD 2023-24(3YR			
		UP)(PF).....	18		

ALLERGY	<i>anagrelide</i>	32	ARICEPT.....	21
RELIEF(DIPHENHYDRAMIN)	<i>anastrozole</i>	15, 98	ARIXTRA.....	24
N).....	ANCOBON.....	14	ARKALIOX.....	147
ALLERGY-TIME.....	ANDRODERM.....	98	ARMONAIR DIGIHALER	
<i>allopurinol</i>	ANDROGEL.....	98	.....	96, 124
ALMACONE-2.....	ANORO ELLIPTA		ARMOUR THYROID.....	111
<i>almotriptan malate</i>.....	.....	20, 22, 122, 128	ARNUITY ELLIPTA.....	96, 124
ALOCRIL.....	ANTACID.....	86, 88	ARTHROTEC 50.....	65, 94
<i>alogliptin</i>	ANTACID (CALCIUM		ARTHROTEC 75.....	65, 94
<i>alogliptin-metformin</i>	CARBONATE).....	74, 86	ARTIFICIAL TEARS (PF).....	83
<i>alogliptin-pioglitazone</i> ..	ANTACID ANTI-GAS.....	86, 88	ARTIFICIAL TEARS	
ALOMIDE.....	ANTACID CALCIUM.....	74, 86	(POLYVIN ALC).....	83
ALOPHEN (BISACODYL).....	ANTACID EXT STR		ARTIFICIAL	
<i>alosetron</i>	(CALCIUM CARB).....	74, 86	TEARS(DEXT70-HYPRO).....	83
ALPHAGAN P.....	ANTACID EXTRA-		ARTIFICIAL	
ALREX.....	STRENGTH.....	74, 86	TEARS(GLYCERIN-PEG).....	83
ALTACE.....	ANTACID LIQUID.....	86, 88	ARTIFICIAL	
ALTOPREV.....	ANTACID M.....	86, 88	TEARS(PVALCH-POVID).....	83
<i>aluminum hydroxide gel</i>	ANTACID MAXIMUM		ASCOMP WITH CODEINE	
ALVESCO.....	STRENGTH.....	86, 88	.....	56, 58, 62, 67, 68
ALYACEN 1/35 (28).....	ANTACID PLUS ANTI-GAS		ASMANEX HFA.....	96, 124
ALYACEN 7/7/7 (28).....	.....	86, 88	ASMANEX TWISTHALER	
ALYQ.....	ANTACID REGULAR		.....	96, 124, 125
<i>amantadine hcl</i>	STRENGTH.....	86, 88	ASPERCREME	
<i>ambrisentan</i>	ANTACID ULTRA		(LIDOCAINE HCL).....	131
<i>amiloride</i>	STRENGTH.....	75, 86	ASPERCREME	
<i>amiloride-</i>	ANTACID-ANTIGAS.....	86, 88	(LIDOCAINE).....	131
<i>hydrochlorothiazide</i> ...	ANTI-DIARRHEAL.....	86, 87	<i>aspirin</i>	31, 32, 56, 57, 68
50, 74, 78	ANTI-DIARRHEAL		ASPIRIN CHILDRENS	
<i>amiodarone</i>	(LOPERAMIDE).....	87	.....	31, 32, 56, 68
AMITIZA.....	ANTIFUNGAL		<i>aspirin,buffd-calcium carb-</i>	
AMJEVITA(CF).....	(CLOTRIMAZOLE).....	132	<i>mag</i>	31, 32, 57, 68
AMJEVITA(CF)	ANTIFUNGAL		<i>aspirin-dipyridamole</i> ..	31, 51, 68
AUTOINJECTOR...92, 115, 117	(MICONAZOLE).....	132	ASTHMA CHECK METER....	71
<i>amlodipine</i>	ANTIFUNGAL		ATACAND.....	33, 34
40, 45, 48, 51	(TOLNAFTATE).....	140	ATACAND HCT... 33, 34, 50, 78	
<i>amlodipine-atorvastatin</i>	ANTI-ITCH (HC).....	133	ATELVIA.....	114
.....	APETEX.....	147	<i>atenolol</i>	23, 37, 38, 43
40, 45, 47, 51	APETIGEN.....	147	<i>atenolol-chlorthalidone</i>	
<i>amlodipine-benazepril</i>	APEXICON E.....	133	.....	23, 37, 38, 43, 51, 79
.....	APIDRA SOLOSTAR U-100		ATHENOL.....	54
35, 40, 45, 48, 51	INSULIN.....	104, 109	ATORVALIQ.....	47
<i>amlodipine-olmesartan</i>	APIDRA U-100 INSULIN		<i>atorvastatin</i>	47
.....	.....	104, 109	<i>atovaquone</i>	10
33, 34, 40, 45, 48, 51	<i>apraclonidine</i>	83	<i>atropine</i>	85
<i>amlodipine-valsartan</i>	<i>aprepitant</i>	94	ATROVENT HFA.....	20, 122
.....	APRI.....	100	AUBAGIO.....	117
33, 34, 40, 45, 50, 78	APRISO.....	89	AURYXIA.....	74
<i>ammonium lactate</i>	ARANELLE (28).....	100	AUSTEDO.....	70
133	ARANESP (IN		AUSTEDO XR.....	70
AMNESTEEM.....	POLYSORBATE).....	25	AUVI-Q.....	19, 121
138	<i>arformoterol</i>	22, 128	AVALIDE.....	33, 34, 50, 78
<i>amoxicil-clarithromy-</i>				
<i>lansopraz</i>				
9, 13, 94				
<i>amoxicillin</i>				
9				
<i>amoxicillin-pot clavulanate</i>				
9				
<i>ampicillin</i>				
9				
AMRIX.....				
20				

AVAPRO.....	33, 34	BAYER LOW DOSE	BETAPACE
AVIANE.....	100	ASPIRIN.....	21, 37, 38, 43, 44, 48
AVODART.....	112	B-COMPLEX WITH B-12.....	148
AVONEX.....	117	B-COMPLEX WITH	BETAPACE AF
AZASITE.....	80	VITAMIN C.....	21, 37, 38, 43, 44, 48
<i>azathioprine</i>	115, 117, 119	BD ALCOHOL SWABS.....	137
<i>azelastine</i>	80	BD AUTOSHIELD DUO	BETASERON.....
<i>azelastine-fluticasone</i>		PEN NEEDLE.....	117
.....	80, 82, 124, 127	BD INSULIN SYRINGE	BETATEMP.....
AZILECT.....	61	(HALF UNIT).....	54
<i>azithromycin</i>	13	BD INSULIN SYRINGE U-	<i>betaxolol</i> ..
AZOPT.....	82	500.....	23, 37, 38, 43, 48, 81
AZOR.....	33, 34, 40, 45, 48, 51	BD INSULIN SYRINGE	<i>bethanechol chloride</i>
AZULFIDINE.....	14, 115	ULTRA-FINE.....	21
AZULFIDINE EN-TABS.	15, 115	BD NANO 2ND GEN PEN	BETHKIS.....
AZURETTE (28).....	100	NEEDLE.....	9
B COMPLEX.....	147	BD ULTRA-FINE MICRO	BETIMOL.....
B COMPLEX 1 (WITH		PEN NEEDLE.....	81
FOLIC ACID).....	147	BD ULTRA-FINE MINI PEN	BETOPTIC S.....
B COMPLEX 100.....	147	NEEDLE.....	81
B COMPLEX PLUS		BD ULTRA-FINE NANO	BEVESPI AEROSPHERE
VITAMIN C.....	148	PEN NEEDLE.....	.....
B COMPLEX W-VIT C.	148, 154	BD ULTRA-FINE ORIG PEN	.....
<i>b complex-vitamin c-folic</i>		NEEDLE.....	20, 22, 122, 128
<i>acid</i>	148, 154	BD ULTRA-FINE SHORT	<i>bexarotene</i>
B-100 COMPLEX.....	148	PEN NEEDLE.....	15, 138
BABY AYR SALINE.....	83	BD VEO INSULIN SYR	BEXSERO.....
<i>bacitracin</i>	80, 130	(HALF UNIT).....	18
<i>bacitracin zinc</i>	130	BD VEO INSULIN SYRINGE	BEYFORTUS.....
<i>bacitracin-polymyxin b</i>	80	UF.....	12
<i>baclofen</i>	21	BEELITH.....	<i>bicalutamide</i>
BACMIN.....	26, 141, 148	BELBUCA.....	15
BAFIERTAM.....	117	<i>benazepril</i>	<i>bimatoprost</i>
BALANCE B-100 (FOLIC		<i>benazepril-</i>	85
ACID).....	148	<i>hydrochlorothiazide</i> ...	BIO-35, GLUTEN FREE
BALANCE B-50 (WITH		BENICAR.....	.....
FOLIC ACID).....	148	.....	26, 75, 141, 148
BALANCED B-100.....	148	BENICAR HCT....	BIOCAL.....
BALANCED B-100		<i>benznidazole</i>	75, 148, 155, 157
COMPLEX.....	148	<i>benzoyl peroxide</i>	BIOCEL (WITH LUTEIN)
BALANCED B-50.....	148	<i>benzphetamine</i>.....	.....
<i>balsalazide</i>	89	<i>bepotastine besilate</i>	141, 148
BANOPHEN.....	5, 123	BEPREVE.....	BION TEARS (PF).....
BAQSIMI.....	103, 112	BESER.....	83
BASAGLAR KWIKPEN U-		BESER KIT.....	BIOPETIT.....
100 INSULIN.....	104, 107	BESIVANCE.....	148
BASAGLAR TEMPO		BESREMI.....	<i>biotin</i>
PEN(U-100)INSLN.....	104, 107	<i>beta carotene</i>	148
BAXDELA.....	14	<i>betamethasone dipropionate</i>	<i>bisacodyl</i>
BAYER ASPIRIN.	31, 32, 57, 68	.....	89
BAYER CHEWABLE		<i>betamethasone valerate</i>	BISMUTH.....
ASPIRIN.....	31, 32, 57, 68	.....	86, 87
		<i>betamethasone, augmented</i>	<i>bismuth subcit k-metronidz-</i>
		.....	<i>tcn</i>
			8, 9, 10, 13, 15, 89
			<i>bismuth subsalicylate</i>
			86, 87
			<i>bisoprolol fumarate</i>
		
			23, 37, 38, 43
			<i>bisoprolol-</i>
			<i>hydrochlorothiazide</i>
		
			24, 37, 38, 43, 50, 78
			BLINCYTO.....
			15
			BLISOVI 24 FE.....
			100
			BLISOVI FE 1.5/30 (28).....
			100
			BLISOVI FE 1/20 (28).....
			100
			BODY, HAIR, SKIN AND
			NAILS.....
			141
			BOOSTRIX TDAP.....
			18
			<i>bosentan</i>
			51, 129
			BRAFTOVI.....
			15
			BREATHERITE MDI
			SPACER.....
			71
			BREATHERITE VALVED
			MDI CHAMBER.....
			71
			BREATHERITE VALVED
			MDI SPACER.....
			71

BREO ELLIPTA.....22, 96, 125, 128	<i>calcium carbonate-vitamin d3</i>.....75, 155	CENTANY..... 130
BREXAFEMME..... 9	<i>calcium citrate</i>.....75	CENTANY AT..... 130
BREZTRI AEROSPHERE.....122, 125, 128	CALCIUM CITRATE + D75, 155	CENTRAL-VITE WOMEN'S MATURE..... 27, 141, 148, 157
BRIELLYN..... 100	<i>calcium citrate-vitamin d3</i>.....75, 155	CENTRAVITES..... 141
BRILINTA..... 31	<i>calcium gluconate</i>.....75	CENTRUM CHEWABLES.....27, 141, 148, 157
<i>brimonidine</i> 80	CALCIUM WITH VITAMIN D.....75, 155	CENTRUM COMPLETE.....27, 141, 148
<i>brimonidine-timolol</i> 80, 81	CAL-GEST ANTACID..... 75, 86	CENTRUM MEN....27, 141, 148
<i>brinzolamide</i> 82	CALTRATE WITH VITAMIN D3..... 75, 155	CENTRUM SILVER....141, 148
<i>bromfenac</i>.....84	CAMCEVI (6 MONTH)...15, 103	CENTRUM SILVER ULTRA MEN'S..... 141, 148, 157
<i>bromocriptine</i>.....61	CAMILA..... 100	CENTRUM SILVER WOMEN..... 27, 141, 148, 157
BROMSITE.....84	<i>candesartan</i> 33, 34	CENTRUM SPECIALIST HEART..... 141
BRONCHITOL..... 126	<i>candesartan- hydrochlorothiazid</i> 33, 34, 50, 78	CENTRUM ULTRA MEN'S.....27, 141, 148
BROVANA..... 22, 128	<i>capecitabine</i> 15	CENTURY..... 27, 141, 148
BRYHALI..... 134	<i>captopril</i>.....35	CENTURY MATURE... 141, 148
<i>budesonide</i> 82, 96, 124, 125	<i>captopril-hydrochlorothiazide</i> 35, 36, 50, 79	<i>cephalexin</i> 8
<i>budesonide-formoterol</i>.....23, 96, 125, 128	<i>carbidopa</i>.....60	CEQUA.....83
BUFFERIN.....31, 32, 57, 68	<i>carbidopa-levodopa</i> 60, 61	CERALYTE-70..... 75
<i>buprenorphine</i> 65	<i>carbidopa-levodopa- entacapone</i>.....59, 61	CERTA PLUS.....27, 141, 148
<i>bupropion hcl (smoking deter)</i> 56	<i>carbinoxamine maleate</i> ... 5, 123	CERTAVITE SENIOR..141, 148
BUTALBITAL COMPOUND W/CODEINE..57, 58, 62, 67, 68	<i>carboxymethylcellulose sodium</i>.....84	CERTAVITE-ANTIOXIDANT.....27, 141, 148
<i>butalbital-acetaminop-caf- cod</i>.....54, 57, 58, 62, 68	CARDIZEM....39, 40, 41, 44, 52	<i>cetirizine</i> 7, 127
<i>butalbital-acetaminophen</i> 54, 58	CARDIZEM CD.....39, 40, 41, 44, 51	CHANTIX CONTINUING MONTH BOX.....24
<i>butalbital-acetaminophen- caff</i>.....54, 57, 58, 68	CARDIZEM LA.....39, 40, 41, 44, 51	CHEMET..... 95, 112
<i>butalbital-aspirin-caffeine</i>.....31, 33, 57, 58, 68, 69	CARDURA.....21, 33, 48	CHILD ALLERGY RELF(CETIRIZINE)..... 7, 127
<i>butenafine</i> 133	CARDURA XL..... 21, 33, 48	CHILD FEVER REDUCER- PAIN RELVR..... 54
<i>butorphanol</i>.....65	<i>carteolol</i>.....81	CHILD PAIN REL-FEVER REDUCER.....54
BUTRANS..... 65	CARTIA XT....39, 40, 41, 44, 52	CHILDREN'S ACETAMINOPHEN..... 54
BYDUREON BCISE..... 103	<i>carvedilol</i> . 21, 22, 33, 37, 43, 48	CHILDREN'S ALAWAY..... 80
BYETTA.....104	<i>carvedilol phosphate</i> 21, 22, 33, 37, 43, 48	CHILDREN'S ALLERGY RELIEF(FEX).....7, 127
BYSTOLIC.....21, 37	CAYA CONTOURED.....120	CHILDREN'S ALLERGY RELIEF(LOR)..... 7, 127
<i>cabergoline</i>.....61	CAYSTON..... 12	CHILDREN'S ALLERGY(CETIRIZINE)..7, 127
CADUET..... 40, 45, 47, 51	CAZIAN (28)..... 100	CHILDREN'S ASPIRIN.....32, 33, 57, 69
<i>caffeine citrate</i> 68	<i>cefaclor</i>.....8	CHILDREN'S CETIRIZINE.....7, 127
<i>calcipotriene</i> 138	<i>cefadroxil</i> 7, 8	
<i>calcitonin (salmon)</i>.....99, 114	<i>cefdinir</i> 8	
<i>calcitriol</i>.....138, 155	<i>cefixime</i> 8	
CALCIUM 500 + D.....75, 155	<i>cefpodoxime</i> 8	
CALCIUM 500 WITH D..75, 155	<i>cefprozil</i> 8	
CALCIUM 600..... 75	<i>cefuroxime axetil</i>.....8	
CALCIUM 600 + D(3).... 75, 155	CELEBREX..... 60	
<i>calcium acetate(phosphat bind)</i>.....74	<i>celecoxib</i>.....60	
CALCIUM ANTACID.....75, 86		
<i>calcium carbonate</i> 75, 86		

CHILDREN'S FEVER REDUCING..... 54	CITRACAL-D3 MAXIMUM PLUS..... 76, 156	COMPLETE MULTIVITAMIN-MINERAL.....27, 141, 148
CHILDREN'S FLONASE ALLERGY RLF..... 82, 124	CITRATE OF MAGNESIA..... 89	COMPLETE MV ADULT 50 PLUS..... 141, 148
CHILDREN'S IBUPROFEN... 65	CITROMA..... 89	COMPLETENATE. 27, 141, 149
CHILDREN'S LORATADINE.....7, 127	CLARAVIS.....138	COMPLEX B-100..... 149
CHILDREN'S MAPAP..... 54	CLARINEX.....7, 127	COMPLEX B-50..... 149
CHILDREN'S NON-ASPIRIN.54	<i>clarithromycin</i> 10, 13	COMTAN.....59
CHILDREN'S PAIN RELIEF.. 54	CLASSIC PRENATAL.....27, 141, 148	CONZIP.....62
CHILDREN'S PAIN-FEVER RELIEF.....55	CLEOCIN.....130	COPAXONE..... 117
CHILDREN'S TYLENOL.....55	<i>clindamycin hcl</i> 12	COREG... 21, 22, 33, 37, 43, 48
CHILD'S ALL DAY ALLERGY(CETIR).....7, 127	CLINDAMYCIN PEDIATRIC..12	COREG CR.....21, 22, 33, 37, 43, 48
<i>chlorhexidine gluconate</i>.....83	<i>clindamycin phosphate</i> 130	CORGARD..... 21, 38, 43
<i>chloroquine phosphate</i> 9	<i>clindamycin-benzoyl peroxide</i> 130, 137	CORLANOR..... 42
<i>chlorpheniramine maleate</i>.....5, 6, 123	CLINDESSE..... 130	CORRECTOL.....89
CHLORTABS.....5, 6, 123	<i>clobetasol</i> 134	CORVITE FREE..... 141, 149
<i>chlorthalidone</i> 51, 79	<i>clobetasol-emollient</i>.....134	COSENTYX.....115, 139
<i>chlorzoxazone</i> 20	<i>clocortolone pivalate</i>.....134	COSENTYX (2 SYRINGES) .....115, 138
<i>cholecalciferol (vitamin d3)</i> 155, 156	CLODAN.....134	COSENTYX PEN..... 115, 139
<i>cholestyramine (with sugar)</i> ...39	CLODAN KIT..... 134	COSENTYX PEN (2 PENS) .....115, 139
CHOLESTYRAMINE LIGHT..39	<i>clonidine</i> 19, 42	COSENTYX UNOREADY PEN..... 115, 139
<i>cholestyramine-aspartame</i> 39	<i>clonidine hcl</i>.....19, 42	COSOPT..... 81, 82
CIBINQO..... 115, 117	<i>clopidogrel</i> 32	COSOPT (PF)..... 81, 82
CICLODAN..... 136	<i>clotrimazole</i> 132	COZAAR.....33, 34
CICLODAN KIT... 136, 137, 138	CLOTTRIMAZOLE 3 DAY..... 132	CREAMY ACNE FACE.....137
<i>ciclopirox</i>.....136	CLOTTRIMAZOLE-3..... 132	CREON.....92
<i>ciclopirox-ure-camph-menth- euc</i> 136, 137	CLOTTRIMAZOLE-7..... 132	CRESEMBA..... 11
<i>cilostazol</i>.....32, 50	<i>clotrimazole-betamethasone</i> 132, 134	CRESTOR.....47
CILOXAN.....80	<i>codeine sulfate</i> 62, 122	CRINONE..... 108
<i>cimetidine</i> 93	<i>codeine-butalbital-asa-caff</i>.....57, 58, 62, 68, 69	<i>cromolyn</i> 80, 124
CIMZIA..... 92, 115, 117	COLACE CLEAR.....89	CRYSSELLE (28)..... 100
CIMZIA POWDER FOR RECONST..... 92, 115, 117	COLAZAL..... 89	CULTURELLE..... 92
CIMZIA STARTER KIT.....92, 115, 117	<i>colchicine</i>.....113	<i>cyanocobalamin (vitamin b- 12)</i> 149
<i>cinacalcet</i>.....99	COLCRYS..... 113	<i>cyclobenzaprine</i>.....20
CIPRO..... 10, 14	<i>colesevelam</i>.....39, 98	<i>cyclopentolate</i>.....85
CIPRO HC.....80, 82	COLESTID.....39	<i>cyclophosphamide</i>.....15, 119
<i>ciprofloxacin</i>.....10, 14	COLESTID FLAVORED..... 39	<i>cycloserine</i>.....10
<i>ciprofloxacin hcl</i> 10, 14, 80	<i>colestipol</i>.....39	<i>cyclosporine</i> ...83, 115, 117, 120
<i>ciprofloxacin- dexamethasone</i> 80, 82	COMBIGAN..... 80, 81	<i>cyclosporine modified</i> 115, 117, 119
<i>ciprofloxacin-fluocinolone</i> 80, 82	COMBIVENT RESPIMAT.....20, 23, 122, 128	CYLTEZO(CF).....92, 115, 117
CITRACAL + D MAXIMUM.....75, 156	COMFORT GEL..... 86, 88	CYLTEZO(CF) PEN.....92, 115, 117
	COMFORT GEL EXTRA STRENGTH..... 86, 88	CYLTEZO(CF) PEN.....92, 115, 117
		CROHN'S-UC-HS..92, 115, 117

CYLTEZO(CF) PEN	DERMA-SMOOTH/FS	<i>diflorasone</i> 134
PSORIASIS-UV 92, 115, 117	BODY OIL.....134	DIFLUCAN.....11
<i>cyproheptadine</i> 5, 123	DERMA-SMOOTH/FS	<i>diflunisal</i>.....66
CYTOMEL..... 111	SCALP OIL..... 134	<i>digoxin</i> 36, 42
<i>dabigatran etexilate</i> 25	<i>desloratadine</i> 7, 127	DILAUDID.....62
DAILY FIBER (PSYLLIUM-SUCROSE).....89	<i>desmopressin</i> 26, 108	<i>diltiazem hcl</i>
DAILY GUMMIES..... 141, 149	<i>desog-e.estradiol/e.estradiol</i> 100	..... 39, 40, 41, 42, 44, 52
DAILY MULTIPLE FOR	<i>desogestrel-ethinyl estradiol</i> 100	DILT-XR...39, 40, 41, 42, 44, 52
WOMEN..... 27, 76, 141, 149	<i>desonide</i> 134	<i>dimenhydrinate</i> 5, 89, 123
DAILY MULTIVITAMIN	DESOWEN..... 134	<i>dimethyl fumarate</i> 117
..... 141, 149, 157	<i>desoximetasone</i> 134	DIOTAME..... 86, 87
DAILY MULTIVITAMIN	DETROL..... 140	DIOVAN..... 33, 34
WITH IRON..... 27, 142, 149	DETROL LA.....140	DIOVAN HCT..... 33, 34, 50, 79
DAILY VALUE..... 142	<i>dexamethasone</i> 96, 97	DIPENTUM.....89
DAILY VITAMIN FORMULA 142	<i>dexamethasone sodium</i>	<i>diphenhydramine hcl</i> ... 5, 6, 123
DAILY VITAMIN FORMULA-	<i>phos (pf)</i> 97	<i>diphenoxylate-atropine</i> ... 20, 88
IRON.....27, 142, 149	<i>dexamethasone sodium</i>	DIPROLENE
DAILY VITAMIN FORMULA-	<i>phosphate</i> 82, 97	(AUGMENTED)..... 134
MINERALS..... 142	DEXILANT..... 94	<i>dipyridamole</i> 32, 52
DAILY VITAMIN WITH IRON	<i>dexlansoprazole</i> 95	DISKETS..... 62
..... 27, 142	DHIVY.....61	<i>disopyramide phosphate</i> 43
DAILY VITES/IRON.....27, 142	DIABETES HEALTH	DIURIL..... 50, 79
DAILY-VITE..... 142	FORMULA..... 142, 149	<i>docosanol</i> 132
DAILY-VITE (WITH FOLIC	DIALYVITE..... 149, 154	DOCUPRENE.....90
ACID)..... 142, 149	DIALYVITE 3000..... 149	<i>docusate calcium</i>.....90
<i>dalfampridine</i> 120	DIALYVITE 5000..... 149	<i>docusate sodium</i> 90
DALIRESP..... 126	DIALYVITE 800..... 149, 154	DOK.....90
<i>danazol</i>.....98	DIALYVITE 800 PLUS D	<i>donepezil</i> 21, 22
DANTRIUM.....21	..... 149, 154, 156	<i>dorzolamide</i> 82
<i>dantrolene</i>.....21	DIALYVITE 800 WITH ZINC	<i>dorzolamide-timolol</i> 82
<i>dapaglifloz propaned-</i>	15.....149, 154	<i>dorzolamide-timolol (pf)</i> 82
<i>metformin</i>.....99, 110	DIALYVITE 800 WITH ZINC	<i>doxazosin</i> 21, 33, 48
<i>dapagliflozin propanediol</i> 110	50.....149, 154	<i>doxycycline hyclate</i> 15
<i>dapsone</i> 10	DIALYVITE 800-ULTRA D	<i>doxycycline monohydrate</i> 15
<i>darifenacin</i> 140	..... 149, 154, 156	DRISDOL..... 156
DASETTA 1/35 (28).....100	DIALYVITE SUPREME D	<i>dronabinol</i>.....88
DASETTA 7/7/7 (28).....100	..... 149, 156	<i>drosiprone-ethinyl</i>
DAURISMO..... 15	DIALYVITE VITAMIN D3	<i>estradiol</i> 100
DAYHIST ALLERGY..... 5, 123	MAX..... 156	DROXIA..... 16
DAYPRO..... 65	DIARRHEA RELIEF	DUAKLIR PRESSAIR
DEBLITANE.....100	(BISMUTH SUBS)..... 86, 87	..... 20, 23, 122, 128
DECUBI VITE..... 142, 149, 154	<i>diazoxide</i> 99	DUAL ACTION PAIN
DEKAS ESSENTIAL	<i>diclofenac epolamine</i> 66, 137	RELIEVER..... 55, 66
..... 142, 147, 156, 157	<i>diclofenac potassium</i> 66	DUETACT.....111
DEKAS PLUS (FOLIC ACID)	<i>diclofenac sodium</i>	DUEXIS..... 66, 93
..... 142, 149, 157	..... 16, 66, 84, 137	DULCOLAX (BISACODYL)... 90
DEKAS PLUS LIQUID..... 142	<i>diclofenac-misoprostol</i> 66, 94	DULERA..... 23, 97, 125, 128
DELESTROGEN..... 102	<i>dicloxacillin</i> 14	DUOPA.....61
DELZICOL..... 89	<i>dicyclomine</i>.....20	DUPIXENT PEN..... 139
DENAVIR.....132	<i>diethylpropion</i> 53	DUPIXENT SYRINGE..... 139
DENTA 5000 PLUS..... 114	DIFFERIN..... 139	<i>dutasteride</i> 112
	DIFICID..... 13	<i>dutasteride-tamsulosin</i> .. 22, 112

DYMISTA.....	80, 82, 124, 127	ENPRESSE.....	100	<i>etonogestrel-ethinyl estradiol</i>	.....	100
E.E.S. 400.....	11, 80, 130	ENSKYCE.....	100	.....	.....	16
E.E.S. GRANULES..	11, 80, 130	ENSPRYNG.....	118	<i>etoposide</i>.....	.....	131
EASIVENT HOLDING		<i>entacapone</i>	59	EUCRISA.....	.....	131
CHAMBER.....	71	ENTADFI.....	50, 112	<i>everolimus (antineoplastic)</i>....	.....	16
EASIVENT MASK LARGE....	71	<i>entecavir</i>	13	<i>everolimus</i>	.....	120
EASIVENT MASK MEDIUM..	71	ENTRESTO.....	34, 50	<i>(immunosuppressive)</i>.....	.....	120
EASIVENT MASK SMALL....	71	ENTYVIO.....	94	EVISTA.....	.....	102, 114
EASY TOUCH ALCOHOL		ENTYVIO PEN.....	94	EXELON PATCH.....	.....	22
PREP PADS.....	137	EPANED.....	35, 36	<i>exemestane</i>.....	.....	16, 98
EC-NAPROXEN.....	66, 113	<i>epinastine</i>	80	EXFORGE	.....	33, 34, 40, 45, 48, 52
<i>econazole</i>	132	<i>epinephrine</i>	19, 121, 122	.....	.....	33, 34, 40, 45, 50, 79
ECONTRA EZ.....	100	EPIPEN.....	19, 122	EXFORGE HCT	.....	90
ECOTRIN LOW STRENGTH		EPIPEN 2-PAK.....	19, 122	.....	.....	33, 34, 40, 45, 50, 79
.....	32, 33, 57, 69	EPIPEN JR.....	19, 122	EX-LAX (SENNOSIDES).....	.....	90
EDARBI.....	33, 34	EPIPEN JR 2-PAK.....	19, 122	EX-LAX MAXIMUM	.....	90
EDARBYCLOR....	33, 34, 51, 79	EPOGEN.....	25	STRENGTH.....	.....	90
EFFIENT.....	32	<i>eprosartan</i>	33, 34	EXSERVAN.....	.....	60
<i>electrolytes-dextrose</i>	76	<i>ergocalciferol (vitamin d2)</i> ...	156	EXTAVIA.....	.....	118
<i>eletriptan</i>	69	ERIVEDGE.....	16	EXTINA.....	.....	132
ELIDEL.....	136	ERLEADA.....	16	EYE ALLERGY RELIEF.....	.....	85
ELINEST.....	100	ERMEZA.....	111	EYE HEALTH PLUS	.....	142
ELIQUIS.....	25	ERRIN.....	100	LUTEIN.....	.....	142
ELIQUIS DVT-PE TREAT		ERTACZO.....	132	EYE ITCH RELIEF.....	.....	80
30D START.....	25	ERYPED 200.....	11, 80, 131	EYSUVIS.....	.....	82
ELLA.....	100	ERYPED 400.....	11, 80, 131	EZALLOR SPRINKLE.....	.....	47
ELMIRON.....	120	ERY-TAB.....	11, 81, 131	<i>ezetimibe</i>.....	.....	43
ELURYNG.....	100	ERYTHROCIN (AS		<i>ezetimibe-simvastatin</i>.....	.....	43, 47
ELYXYB.....	60	STEARATE).....	11, 81, 131	FALMINA (28).....	.....	100
EMCYT.....	16	<i>erythromycin</i>	12, 81, 131	<i>famciclovir</i>.....	.....	13
EMEND.....	94	<i>erythromycin ethylsuccinate</i>		<i>famotidine</i>.....	.....	93, 94
EMFLAZA.....	97	.....	12, 81, 131	FANTASY CONDOM.....	.....	121
EMGALITY PEN.....	59	<i>erythromycin with ethanol</i>	131	FARXIGA.....	.....	110
EMGALITY SYRINGE.....	59	<i>erythromycin-benzoyl</i>		FASENRA PEN.....	.....	123
<i>enalapril maleate</i>	35, 36	<i>peroxide</i>	131	FC2 FEMALE CONDOM.....	.....	121
<i>enalapril-hydrochlorothiazide</i>		ESGIC.....	55, 57, 58, 68	FE C PLUS.....	.....	27, 149, 154
.....	35, 36, 50, 79	<i>esomeprazole magnesium</i>	95	<i>febuxostat</i>.....	.....	113
ENBREL.....	115, 117, 139	ESSENTIA.....	27, 142, 149	FELDENE.....	.....	66
ENBREL MINI.....	115, 117, 139	ESSENTIAL MAN.....	142, 149	<i>felodipine</i>.....	.....	40, 45, 48, 52
ENBREL SURECLICK		ESSENTIAL MAN 50 PLUS		FEMCAP.....	.....	71, 121
.....	116, 117, 139	.....	142, 149	<i>fenofibrate</i>.....	.....	46
ENDARI.....	92, 120	ESSENTIAL WOMAN 50		<i>fenofibrate micronized</i>.....	.....	46
ENDOCET.....	55, 62	PLUS.....	142, 149	<i>fenofibrate nanocrystallized</i>...	.....	46
ENDUR-ACIN.....	36	ESTARYLLA.....	100	<i>fenofibric acid</i>.....	.....	46
ENEMA.....	90	<i>estradiol</i>	102	<i>fenofibric acid (choline)</i>.....	.....	46
ENEMA DISPOSABLE.....	90	<i>estradiol valerate</i>	102	FENOGLIDE.....	.....	46
ENEMEEZ PLUS.....	90	<i>estradiol-norethindrone acet</i>		<i>fenoprofen</i>.....	.....	66
ENFAMIL ENFALYTE.....	76	.....	102, 108	<i>fentanyl</i>.....	.....	62
ENGERIX-B (PF).....	18	<i>ethambutol</i>	10	<i>fentanyl citrate</i>.....	.....	62
ENGERIX-B PEDIATRIC		<i>ethynodiol diac-eth estradiol</i>	100	FENTORA.....	.....	62
(PF).....	18	<i>etodolac</i>	66	FEOSOL.....	.....	27
<i>enoxaparin</i>	26			FERATE.....	.....	27

FERGON.....	27	FLUMIST QUAD 2023-2024..	18	FREESTYLE FREEDOM	
FEROSUL.....	27	<i>flunisolide</i>	82, 124	LITE.....	71
FERRO-TIME.....	27	<i>fluocinolone</i>	134	FREESTYLE INSULINX.....	71
<i>ferrous gluconate</i>	27	<i>fluocinolone and shower cap</i>		FREESTYLE INSULINX	
<i>ferrous sulfate</i>	27, 28	.....	134	TEST STRIPS.....	73
<i>fesoterodine</i>	140	<i>fluocinonide</i>	134	FREESTYLE LANCETS.....	71
FEVER REDUCER.....	55	FLUOCINONIDE-E.....	134	FREESTYLE LITE METER... 71	
FEVERALL.....	55	<i>fluocinonide-emollient</i>	134	FREESTYLE LITE STRIPS... 73	
FEXMID.....	20	<i>fluoride (sodium)</i>	114	FREESTYLE PRECISION	
<i>fexofenadine</i>	7, 127	<i>fluorometholone</i>	82	NEO METER.....	71
FIASP FLEXTOUCH U-100		<i>fluorouracil</i>	16, 139	FREESTYLE PRECISION	
INSULIN.....	104, 109	<i>flurandrenolide</i>	134	NEO STRIPS.....	73
FIASP PENFILL U-100		<i>flurbiprofen</i>	66	FREESTYLE TEST.....	73
INSULIN.....	104, 109	<i>flurbiprofen sodium</i>	84	FROVA.....	69
FIASP PUMPCART.....	104, 109	<i>fluticasone furoate-vilanterol</i>		<i>frovatriptan</i>	69
FIASP U-100 INSULIN	104, 109	.....	23, 97, 125, 128	FULL SPECTRUM B-	
FIBER (PSYLLIUM HUSK-		<i>fluticasone propionate</i>		VITAMIN C.....	149, 154
SUGAR).....	90	.....	82, 97, 124, 125, 134	FULPHILA.....	25
FIBER (WITH		<i>fluticasone propion-</i>		<i>furosemide</i>	48, 74
ASPARTAME).....	90	<i>salmeterol</i>	23, 97, 125, 128	FYLNETRA.....	25
<i>finasteride</i>	112	<i>fluvastatin</i>	47	<i>galantamine</i>	22
<i>finngolimod</i>	118	FLUZONE HIGHDOSE		GARDASIL 9 (PF).....	18
FIORICET WITH CODEINE		QUAD 23-24 PF.....	18	GAS RELIEF	
.....	55, 57, 58, 62, 68	FLUZONE QUAD 2023-		(SIMETHICONE).....	88
FIRVANQ.....	12	2024.....	18	GAS RELIEF 80	
FISH OIL.....	36	FLUZONE QUAD 2023-		(SIMETHICONE).....	88
FLAGYL.....	8, 10	2024 (PF).....	18	GAS RELIEF EXTRA	
FLAVOR CHEWS ANTACID		FOAMING ANTACID.....	86	STRENGTH.....	88
.....	76, 86	FOLBEE.....	149	GAS-X EXTRA STRENGTH..	89
<i>flavoxate</i>	140	FOLBEE PLUS.....	149, 154	<i>gatifloxacin</i>	81
<i>flecainide</i>	43	FOLBIC.....	149	GAVISCON.....	86
FLECTOR.....	66, 137	<i>folic acid</i>	149	GELNIQUE.....	140
FLEET ENEMA.....	90	FOLINIC-PLUS.....	149	<i>gemfibrozil</i>	46
FLEET MINERAL OIL.....	90	FOLPLEX 2.2.....	149	GEMTESA.....	140
FLEQSUVY.....	21	FOLTABS 800.....	149	GENOTROPIN.....	108
FLOMAX.....	22	<i>fondaparinux</i>	24	GENOTROPIN MINIQUICK	108
FLUAD QUAD 2023-24(65Y		<i>formoterol fumarate</i>	23, 128	<i>gentamicin</i>	81, 131
UP)(PF).....	18	FORTAVIT.....	28, 142	GENTLE LAXATIVE	
FLUARIX QUAD 2023-2024		FORTEO.....	108, 113	(BISACODYL).....	90
(PF).....	18	FORTESTA.....	98	GERI-KOT.....	90
FLUBLOK QUAD 2023-2024		FOSAMAX.....	114	GERI-LANTA.....	86, 89
(PF).....	18	FOSAMAX PLUS D.....	114, 156	GERI-MOX ANTACID-	
FLUCELVAX QUAD 2023-		<i>fosinopril</i>	35, 36	ANTIGAS.....	86, 89
2024.....	18	<i>fosinopril-</i>		GERI-MUCIL	
FLUCELVAX QUAD 2023-		<i>hydrochlorothiazide</i>		(ASPARTAME).....	90
2024 (PF).....	18	.....	35, 36, 50, 79	GILENYA.....	118
<i>fluconazole</i>	11	FOSRENOL.....	74, 112	<i>glatiramer</i>	118
<i>flucytosine</i>	14	FRAGMIN.....	26	GLATOPA.....	118
<i>fludrocortisone</i>	97	FREEDAVITE.....	28, 142, 149	<i>glimepiride</i>	111
FLULAVAL QUAD 2023-		FREESTYLE CONTROL.....	71	<i>glipizide</i>	111
2024 (PF).....	18	FREESTYLE FREEDOM.....	71	<i>glipizide-metformin</i>	99, 111
FLUMADINE.....	8			GLOPERBA.....	113

GLUCAGEN HYPOKIT 103, 112	HAIR,SKIN AND NAILS(FA-	HUMULIN N NPH U-100
GLUCAGON (HCL)	BIOTIN)..... 142, 150	INSULIN..... 105, 107
EMERGENCY KIT 103, 112	<i>halcinonide</i> 134	HUMULIN R REGULAR U-
GLUCAGON EMERGENCY	<i>halobetasol propionate</i> 135	100 INSULN..... 105, 110
KIT (HUMAN)..... 103, 112	HALOG..... 135	HUMULIN R U-500 (CONC)
GLUCOSE KETONE	HARD NAILS..... 150	INSULIN..... 105, 110
CONTROL SOLN..... 71	HAVRIX (PF)..... 18	HUMULIN R U-500 (CONC)
GLUCOTROL XL..... 111	HEATHER..... 100	KWIKPEN..... 105, 110
GLUMETZA..... 99	HEMADY..... 97	HYCANTIN..... 16
<i>glyburide</i> 111	HEMANGEOL21, 38, 43, 48, 57	<i>hydralazine</i> 46
<i>glyburide micronized</i> 111	<i>heparin (porcine)</i> 26	<i>hydrochlorothiazide</i> 50, 79
<i>glyburide-metformin</i> 99, 111	HOMOCYSTEINE	<i>hydrocodone bitartrate</i> 62
GLYCOPHOS..... 76	FORMULA..... 150	<i>hydrocodone-</i>
<i>glycopyrrolate</i> 20	HORIZANT..... 55, 56	<i>acetaminophen</i> 55, 62
GLYNASE..... 111	HULIO(CF)..... 92, 116, 118	<i>hydrocodone-ibuprofen</i> 62, 66
GLYXAMBI..... 102, 110	HULIO(CF) PEN... 92, 116, 118	<i>hydrocortisone</i> 97, 135
GOCOVRI..... 8, 53	HUMALOG JUNIOR	<i>hydrocortisone acetate</i> 135
GRALISE..... 55	KWIKPEN U-100..... 104, 109	<i>hydrocortisone butyrate</i> 135
<i>granisetron hcl</i> 85	HUMALOG KWIKPEN	<i>hydrocortisone butyr-</i>
GRANIX..... 26	INSULIN..... 104, 105, 109	<i>emollient</i> 135
<i>griseofulvin microsize</i> 9	HUMALOG MIX 50-50	<i>hydrocortisone valerate</i> 135
<i>griseofulvin ultramicrosize</i> 9	INSULN U-100..... 105, 106, 109	<i>hydrocortisone-acetic acid</i>
<i>guanfacine</i> 42, 60	HUMALOG MIX 50-50	..... 82, 83
GUARDIAN 4 GLUCOSE	KWIKPEN..... 105, 106, 109	<i>hydrocortisone-aloe vera</i> 135
SENSOR..... 158	HUMALOG MIX 75-25	<i>hydromorphone</i> 62, 63
GUARDIAN 4	KWIKPEN..... 105, 106, 109	<i>hydroxychloroquine</i> . 9, 116, 118
TRANSMITTER..... 158	HUMALOG MIX 75-25(U-	<i>hydroxyprogesterone</i>
GUARDIAN CONNECT	100)INSULN..... 105, 106, 109	<i>caproate</i> 108
TRANSMITTER..... 158	HUMALOG TEMPO PEN(U-	<i>hydroxyurea</i> 16
GUARDIAN LINK 3	100)INSULN..... 105, 109	<i>hydroxyzine hcl</i> 6, 57, 58
TRANSMITTER..... 158	HUMALOG U-100 INSULIN	<i>hydroxyzine pamoate</i> 6, 58
GUARDIAN SENSOR 3..... 158	..... 105, 109	<i>hyoscyamine sulfate</i> 20
GVOKE..... 103, 112	HUMATROPE..... 108	HYRIMOZ PEN CROHN'S-
GVOKE HYPOPEN 1-PACK	HUMIRA..... 93, 116, 118	UC STARTER..... 93, 116, 118
..... 103, 112	HUMIRA PEN..... 92, 116, 118	HYRIMOZ PEN PSORIASIS
GVOKE HYPOPEN 2-PACK	HUMIRA PEN CROHNS-	STARTER..... 93, 116, 118
..... 103, 112	UC-HS START..... 92, 116, 118	HYRIMOZ(CF)..... 93, 116, 118
GVOKE PFS 1-PACK	HUMIRA(CF)..... 93, 116, 118	HYRIMOZ(CF) PEDI
SYRINGE..... 103, 112	HUMIRA(CF) PEDI	CROHN STARTER 93, 116, 118
GVOKE PFS 2-PACK	CROHNS STARTER	HYRIMOZ(CF) PEN
SYRINGE..... 103, 112	..... 93, 116, 118	..... 93, 116, 118
HADLIMA..... 92, 116, 118	HUMIRA(CF) PEN. 93, 116, 118	HYSINGLA ER..... 63
HADLIMA PUSHTOUCH	HUMIRA(CF) PEN	HYZAAR..... 33, 34, 51, 79
..... 92, 116, 118	CROHNS-UC-HS.. 93, 116, 118	<i>ibandronate</i> 114
HADLIMA(CF)..... 92, 116, 118	HUMIRA(CF) PEN PSOR-	IBSRELA..... 93
HADLIMA(CF)	UV-ADOL HS..... 93, 116, 118	IBU..... 66
PUSHTOUCH..... 92, 116, 118	HUMULIN 70/30 U-100	IBU-200..... 66
HAIR, SKIN AND NAILS-	INSULIN..... 105, 106, 110	<i>ibuprofen</i> 66
ARGAN OIL..... 28, 142, 149	HUMULIN 70/30 U-100	IBUPROFEN IB..... 66
HAIR,SKIN AND NAILS	KWIKPEN..... 105, 106, 110	IBUPROFEN JR
..... 28, 76, 142, 150	HUMULIN N NPH INSULIN	STRENGTH..... 66
	KWIKPEN..... 105, 107	<i>ibuprofen-famotidine</i> 66, 94

ICAPS MV.....	142, 150	<i>insulin lispro protamin-lispro</i>	KESIMPTA PEN.....	118
<i>icosapent ethyl</i>	36	.....	<i>ketoconazole</i>	11, 132
IDACIO(CF).....	93, 116, 118	INVOKAMET.....	KETODAN.....	132
IDACIO(CF) PEN...93, 116, 118		INVOKAMET XR.....	KETODAN KIT.....	132
IDACIO(CF) PEN CROHN-		INVOKANA.....	<i>ketoprofen</i>	66
UC STARTR.....	93, 116, 118	IOPIDINE.....	<i>ketorolac</i>	67, 84
IDACIO(CF) PEN		<i>ipratropium bromide</i>	<i>ketotifen fumarate</i>	80
PSORIASIS START		.....	KEVZARA.....	116, 118
.....	93, 116, 118	<i>ipratropium-albuterol</i>	KIMONO CONDOMS(NON-	
IDHIFA.....	16	.....	LUBRICATED).....	121
ILEVRO.....	84	<i>irbesartan</i>	KIMONO MICROTHIN	
ILUMYA.....	136	.....	AQUA LUBE CON.....	121
<i>imiquimod</i>	139	<i>irbesartan-</i>	KIMONO MICROTHIN	
IMITREX.....	69	<i>hydrochlorothiazide</i> ... 34, 51, 79	CONDOMS.....	121
IMITREX STATDOSE PEN... 69		IRON.....	KIMONO MICROTHIN	
IMITREX STATDOSE		IRON (FERROUS	LARGE CONDOMS.....	121
REFILL.....	69	SULFATE).....	KIMONO TEXTURED	
INBRIJA.....	61	IRON 100 PLUS.... 28, 150, 154	CONDOMS.....	121
IN-CHECK NASAL WITH		ISIBLOOM.....	KISQALI FEMARA CO-	
MASK.....	71	<i>isoniazid</i>	PACK.....	16, 98
IN-CHECK ORAL FLOW		<i>isosorbide dinitrate</i>	KITABIS PAK.....	9
METER.....	72	<i>isosorbide mononitrate</i>	KLAYESTA.....	138
INCRELEX.....	111	<i>isotretinoin</i>	KLOR-CON/EF.....	76
INCRUSE ELLIPTA.....	20, 122	<i>isradipine</i>	KLOXXADO.....	65, 112
<i>indapamide</i>	51, 79	ISTALOL.....	KOBEE.....	150
INDERAL LA..21, 38, 43, 48, 57		<i>itraconazole</i>	KOMBIGLYZE XR.....	99, 102
INDERAL XL..21, 38, 43, 48, 57		<i>ivermectin</i>	KONVOMEPE.....	95
INDOCIN.....	66, 113	JAKAFI.....	K-PAX IMMUNE SUPPORT	
<i>indomethacin</i>	66, 113	JALYN.....	.....	28, 142, 150
INFANT FEVER REDUCER-		JANTOVEN.....	K-PEC ANTIDIARRHEAL	
PAIN RELF.....	55	JANUMET.....	(BISM SUB).....	86, 88
INFANT PAIN RELIEVER....	55	JANUMET XR.....	K-PHOS NO 2.....	73
INFANTS GAS RELIEF.....	89	JANUVIA.....	K-PHOS ORIGINAL.....	73
INFANT'S IBUPROFEN.....	66	JARDIANCE.....	KRAZATI.....	16
INFANTS' PAIN AND		JENCYCLA.....	KRINTAFEL.....	10
FEVER.....	55	JENTADUETO.....	KURVELO (28).....	100
INFANTS' PAIN RELIEF.....	55	JENTADUETO XR.....	<i>labetalol</i>	21, 22, 33, 38, 43
INGREZZA.....	70	JUBLIA.....	<i>lactulose</i>	73
INGREZZA INITIATION		JULEBER.....	LAGEVRIO (EUA).....	13
PACK.....	70	JUNEL 1/20 (21).....	<i>lamivudine</i>	12
INNOPRAN XL		JUNEL FE 1.5/30 (28).....	<i>lancets</i>	72
.....	21, 38, 43, 48, 57	JYLAMVO.....	<i>lansoprazole</i>	95
INPEFA.....	110	16, 116, 118, 120	<i>lanthanum</i>	74, 112
INQOVI.....	16	KAOPECTATE (BISMUTH	LANTUS SOLOSTAR U-100	
<i>insulin asp prt-insulin aspart</i>		SUBSALICY).....	INSULIN.....	105, 107
.....	105, 107, 109	.....	LANTUS U-100 INSULIN	
<i>insulin aspart u-100</i>	105, 109	KAOPECTATE EX STR	.....	105, 107
<i>insulin degludec</i>	105, 107	(BISMUTH SS).....	LARIN 1.5/30 (21).....	100
<i>insulin glargine u-300 conc</i>		86, 88	LARIN 1/20 (21).....	100
.....	105, 107	KAPSPARGO SPRINKLE	LARIN FE 1.5/30 (28).....	100
<i>insulin glargine-yfgn</i>	105, 107	.....	LARIN FE 1/20 (28).....	101
<i>insulin lispro</i>	105, 109	.....	<i>latanoprost</i>	85
		KATERZIA.....		
		40, 45, 48, 52		
		KAZANO.....		
		99, 102		
		KELNOR 1/35 (28).....		
		100		
		KENALOG.....		
		135		
		KERENDIA.....		
		49		
		KERYDIN.....		
		137		

LAXATIVE (BISACODYL).....	90	<i>lisinopril-hydrochlorothiazide</i>	LUZU.....	132
LAXATIVE (SENNOSIDES)..	90	.....	LYSODREN.....	16
LAXATIVE PEG 3350.....	90	LITE TOUCH-MEDIUM	LYUMJEV KWIKPEN U-100	
LAXATIVE PILLS.....	90	MASK.....	INSULIN.....	106, 109
LAXATIVE PILLS		LITEAIRE MDI CHAMBER....	LYUMJEV KWIKPEN U-200	
REGULAR.....	90	LITETOUCH-LARGE MASK..	INSULIN.....	106, 110
LEENA 28.....	101	LITETOUCH-SMALL MASK..	LYUMJEV TEMPO PEN(U-	
<i>leflunomide</i>	116, 118	LITFULO.....	100)INSULN.....	106, 110
<i>lenalidomide</i>	16, 118	LITTLE REMEDIES FEVER	LYUMJEV U-100 INSULIN	
LESCOL XL.....	47	AND PAIN.....	.....	106, 110
LETAIRIS.....	52, 129	LIVALO.....	MAG GLYCINATE.....	76
<i>letrozole</i>	16, 98	LIVTENCITY.....	MAG-AL PLUS.....	86, 89
<i>leucovorin calcium</i>	112	LOCOID.....	MAG-AL PLUS EXTRA	
LEUKERAN.....	16	LOCOID LIPOCREAM.....	STRENGTH.....	86, 89
LEUKINE.....	26	LODOSYN.....	MAG-G.....	76
<i>leuprolide</i>	16, 103	LOFENA.....	MAGINEX.....	76
<i>leuprolide (3 month)</i>	16, 103	LOMAIRA.....	<i>magnesium</i>	76
<i>levabuterol hcl</i>	23, 129	LONSURF.....	MAGNESIUM (OXIDE/AA	
<i>levabuterol tartrate</i>	23, 129	<i>loperamide</i>	CHELATE).....	76
<i>levamlodipine</i>	40, 45, 48, 52	LOPID.....	<i>magnesium amino acid</i>	
LEVEMIR FLEXPEN... 105, 107		LOPRESSOR.....	<i>chelate</i>	76
LEVEMIR U-100 INSULIN		LOPROX (AS OLAMINE)....	<i>magnesium chloride</i>	56, 76
.....	105, 107	LOPROX KIT.....	<i>magnesium citrate</i>	76, 90
<i>levobunolol</i>	82	LOQTORZI.....	<i>magnesium gluconate</i>	76
<i>levocetirizine</i>	7, 127	<i>loratadine</i>	<i>magnesium hydroxide</i>	90
<i>levofloxacin</i>	10, 14	LORZONE.....	<i>magnesium oxide</i>	87
LEVONEST (28).....	101	<i>losartan</i>	<i>magnesium sulfate</i> ..	36, 56, 112
<i>levonorgestrel-ethinyl estrad</i>	101	<i>losartan-hydrochlorothiazide</i>	<i>magnesium sulfate in d5w</i>	
<i>levorphanol tartrate</i>	63	.....	.....	36, 56, 112
<i>levothyroxine</i>	111	LOTENSIN.....	<i>magnesium sulfate in water</i>	
LEVOXYL.....	111	LOTENSIN HCT..	.....	36, 56, 112
LEXETTE.....	135	<i>loteprednol etabonate</i>	MAGOX.....	87
LIALDA.....	89	LOTREL...35, 36, 40, 45, 48, 52	MAGTAB.....	76
LICART.....	67, 137	LOTRIMIN AF	<i>malathion</i>	138
LICE KILLING.....	138	(CLOTRIMAZOLE).....	MAPAP	
LICE PYRINYL SHAMPOO..	138	LOTRONEX.....	(ACETAMINOPHEN).....	55
LICE TREATMENT.....	138	<i>lovastatin</i>	MARLISSA (28).....	101
LICE TREATMENT		LOVAZA.....	MATULANE.....	16
(PERMETHRIN).....	138	LOVENOX.....	MATZIM LA	
<i>lidocaine</i>	131, 132	LOW-OGESTREL (28).....	.....	39, 40, 41, 42, 44, 52
<i>lidocaine hcl</i>	84, 131	<i>lubiprostone</i>	MAVENCLAD (10 TABLET	
LIDOCAINE PAIN RELIEF..	131	LUBRICANT (P-GLYCOL-	PACK).....	120
LIDOCAINE VISCOUS.....	84	GLYCERIN).....	MAVENCLAD (4 TABLET	
<i>lidocaine-prilocaine</i>	132	LUBRICANT EYE (PG-PEG	PACK).....	120
<i>linezolid</i>	14	400).....	MAVENCLAD (5 TABLET	
LINZESS.....	93	LUBRICATING PLUS.....	PACK).....	120
<i>liothyronine</i>	111	LUCEMYRA.....	MAVENCLAD (6 TABLET	
LIPITOR.....	47	LUDENT FLUORIDE.....	PACK).....	120
LIPOFEN.....	46	<i>luliconazole</i>	MAVENCLAD (7 TABLET	
LIQREV.....	50, 126, 129	LUMAKRAS.....	PACK).....	120
<i>lisinopril</i>	35, 36	LUMIGAN.....	MAVENCLAD (8 TABLET	
		LUTERA (28).....	PACK).....	120

MAVENCLAD (9 TABLET PACK).....	120	<i>methenamine hippurate</i>	15	<i>minocycline</i>	15
MAXALT.....	69	<i>methenamine mandelate</i>	15	<i>minoxidil</i>	46
MAXALT-MLT.....	69	<i>methimazole</i>	99	MINTOX MAXIMUM STRENGTH.....	87, 89
MAYZENT.....	118	<i>methocarbamol</i>	20	MIRAPEX ER.....	61
MAYZENT STARTER(FOR 1MG MAINT).....	118	<i>methotrexate sodium</i>	16, 116, 118, 120	<i>misoprostol</i>	94
MAYZENT STARTER(FOR 2MG MAINT).....	118	<i>methotrexate sodium (pf)</i>	16, 116, 118, 120	MITIGARE.....	113
<i>meclizine</i>	6, 89	<i>methyldopa</i>	19, 42	M-M-R II (PF).....	18
<i>meclofenamate</i>	67	<i>methyldopa-</i> <i>hydrochlorothiazide</i>	19, 42, 51, 79	MODERNA COVID 23- 24(6M-11Y)PF.....	19
<i>medroxyprogesterone</i>	108	<i>methylergonovine</i>	121	<i>moexipril</i>	35, 36
MEDTYCHOLL-B COMPLEX-LIVER.....	150	<i>methylprednisolone</i>	97	<i>mometasone</i>	83, 124, 135
<i>mefenamic acid</i>	67	<i>metoclopramide hcl</i>	94	MONISTAT 3.....	133
<i>mefloquine</i>	10	<i>metolazone</i>	51, 79	MONISTAT 7.....	133
MEGA BIOTIN.....	150	<i>metoprolol succinate</i> ..	24, 38, 43	MONOCAPS.....	28, 142, 150
MEGA MULTI FOR WOMEN	28, 76, 142, 150	<i>metoprolol ta-</i> <i>hydrochlorothiaz</i>	24, 38, 43, 51, 79	MONO-LINYAH.....	101
MEGA MULTIVITAMIN FOR MEN.....	142, 150	<i>metoprolol tartrate</i>	24, 38, 44	<i>montelukast</i>	123
<i>megestrol</i>	16, 108	<i>metronidazole</i>	9, 10, 131	<i>morphine</i>	63
<i>meloxicam</i>	67	<i>mexiletine</i>	43	<i>morphine concentrate</i>	63
<i>meloxicam submicronized</i>	67	MIBELAS 24 FE.....	101	MOTEGRITY.....	94
<i>melphalan</i>	16	MICARDIS.....	34	MOUNJARO.....	104
<i>memantine</i>	60	MICARDIS HCT.....	34, 51, 79	MOUTHPIECE.....	72
MENEST.....	102	<i>miconazole nitrate</i>	132, 133	MOVANTIK.....	93
MEN'S DAILY.....	142, 150	<i>miconazole nitrate-zinc ox-</i> <i>pet</i>	133	<i>moxifloxacin</i>	11, 14, 81
MEN'S MULTIVITAMIN GUMMIES.....	142, 150	MICONAZOLE-3.....	133	M-PAP.....	55
MEN'S ONE DAILY	142, 150, 157	MICONAZOLE-3 PREFIL, CREAM, WIPE.....	133	MS CONTIN.....	63
MENTAX.....	133	MICONAZOLE-7.....	133	MULTI COMPLETE WITH IRON.....	28, 142, 150
MENVEO A-C-Y-W-135-DIP (PF).....	18	MICROCHAMBER.....	72	MULTI FOR HER	28, 76, 142, 150, 157
<i>mepерidine</i>	63	MICROGESTIN.....	72	MULTI-DAY WITH IRON	28, 142, 150
<i>mercaptopurine</i>	16, 120	MICROGESTIN 1.5/30 (21). MICROGESTIN FE 1.5/30 (28).....	101	MULTIPLE VITAMIN- MINERALS.....	142
MERIBIN.....	150	MICROGESTIN FE 1/20 (28).....	101	MULTIPLE VITAMINS.....	142
<i>mesalamine</i>	89	MICROLIFE PEAK FLOW METER.....	72	MULTI-VIT WITH FLUORIDE-IRON..	28, 114, 143
MESNEX.....	120	MICROSPACER.....	72	<i>multivitamin</i>	143
METAMUCIL (SUGAR).....	90	<i>midazolam</i>	59	MULTI-VITAMIN WITH FLUORIDE.....	114, 115, 143
METAMUCIL (WITH SUGAR).....	90	<i>midazolam (pf)</i>	59	<i>multivitamin with iron</i>	28, 143
METAMUCIL MULTIHEALTH FIBER.....	90	<i>midodrine</i>	19	<i>multivit-min-iron fum-folic ac</i>	28, 143, 150
METAMUCIL SUGAR-FREE (ASPART).....	90	MIEBO.....	84	<i>mupirocin</i>	131
<i>metaxalone</i>	20	<i>miglitol</i>	98	<i>mupirocin calcium</i>	131
<i>metformin</i>	99, 100	MILK OF MAGNESIA.....	90	MVC-FLUORIDE.....	115, 143
<i>methadone</i>	63	<i>mineral oil</i>	90	<i>mv-min-folic acid-lutein</i>	143, 150
METHADONE INTENSOL.....	63	MINI WRIGHT PEAK FLOW METER.....	72	MVW COMPLETE FORMUL MULTIVIT.....	143, 156, 157
METHADOSE.....	63	MINIPRESS.....	21, 33		

MVW COMPLETE FORMULATION D3000	<i>neomycin</i> 9, 81, 131	NIX CREME RINSE.....138
..... 143, 156, 157	<i>neomycin-bacitracin-poly-hc</i>	NON-ASPIRIN..... 55
MY WAY..... 101	..... 81, 83	NON-ASPIRIN EXTRA
<i>mycophenolate mofetil</i>.....120	<i>neomycin-bacitracin-</i>	STRENGTH.....55
<i>mycophenolate mofetil (hcl)</i> .120	<i>polymyxin</i>.....81	NON-ASPIRIN PAIN
<i>mycophenolate sodium</i>.....120	<i>neomycin-polymyxin b-</i>	RELIEF..... 55
MYCOZYL AC..... 133	<i>dexameth</i>.....81, 83	NORA-BE..... 101
MYFEMBREE.....99, 102, 108	<i>neomycin-polymyxin-</i>	NORDITROPIN FLEXPRO..108
MYLERAN..... 16	<i>gramicidin</i> 81	<i>noreth-ethinyl estradiol-iron</i> . 101
MYNEPHROCAPS..... 150, 154	<i>neomycin-polymyxin-hc</i> 81	<i>norethindrone</i>
MYRBETRIQ..... 140	NEPHPLEX RX..... 150, 154	(<i>contraceptive</i>)..... 101
MY-VITALIFE..... 143	NEPHRON FA..... 28, 150, 154	<i>norethindrone acetate</i>.....108
<i>nabumetone</i>.....67	NEPHRONEX-SL 150, 154, 156	<i>norethindrone ac-eth</i>
<i>nadolol</i> 21, 38, 44	NEPHRO-VITE..... 150, 154	<i>estradiol</i> 101, 103, 108
<i>naftifine</i> 130	NESINA..... 102	<i>norethindrone-e.estradiol-</i>
NAFTIN.....130	NESTABS.....28, 76, 143, 150	<i>iron</i>.....101
NALFON..... 67	..... 28, 76, 143, 150	NORGESIC..... 24, 69
<i>naloxone</i> 65, 113	NEUAC..... 131, 137	NORGESIC FORTE..... 24, 69
NAMENDA.....60	NEUAC KIT..... 131, 137	<i>norgestimate-ethinyl</i>
NAMENDA TITRATION PAK 60	NEULASTA.....26	<i>estradiol</i> 101
NAMENDA XR.....60	NEULASTA ONPRO..... 26	NORLIQVA... 40, 45, 46, 48, 52
NAMZARIC..... 22, 60	NEUPOGEN.....26	NORTREL 0.5/35 (28)..... 101
NANO VM 1-3.....28, 143, 150	NEUPRO..... 61	NORTREL 1/35 (28)..... 101
NANO VM 4-8.....28, 143, 150	NEVANAC..... 84	NORVASC.....40, 45, 46, 48, 52
NANOVM 9-18.....28, 143	NEWGEN..... 28, 76, 143, 150	NOURIANZ.....60
NANOVM T-F..... 28, 143	NEXIUM.....95	NOVOLIN 70/30 U-100
NAPHCON-A..... 85	NEXIUM PACKET..... 95	INSULIN..... 106, 107, 110
NAPRELAN CR..... 67, 113	NEXLETOL.....36	NOVOLIN 70-30 FLEXPEN
<i>naproxen</i>.....67, 113	NEXLIZET..... 36, 43	U-100..... 106, 107, 110
<i>naproxen sodium</i>.....67, 113	<i>niacin</i>.....37	NOVOLIN N FLEXPEN106, 107
<i>naproxen-esomeprazole</i> ..67, 95	<i>niacin (inositol niacinate)</i> 37	NOVOLIN N NPH U-100
<i>naratriptan</i> 69	NIACIN FLUSH FREE..... 37	INSULIN..... 106, 107
NARCAN..... 65, 113	NIACIN NO FLUSH..... 37	NOVOLIN R FLEXPEN106, 110
NASAL ALLERGY..... 83, 124	<i>niacinamide</i> 151	NOVOLIN R REGULAR
NASALCROM.....80, 124	<i>nicardipine</i> 40, 45, 46, 48, 52	U100 INSULIN..... 106, 110
NASONEX 24HR ALLERGY	<i>nicotine</i>.....24	NOVOLOG FLEXPEN U-
.....83, 124	<i>nicotine (polacrilex)</i>.....24	100 INSULIN..... 106, 110
<i>nateglinide</i> 107	NICOTROL.....24	NOVOLOG MIX 70-30 U-
NATESTO.....98	NICOTROL NS.....24	100 INSULN..... 106, 107, 110
NATURAL DAILY FIBER.....90	<i>nifedipine</i> 40, 45, 46, 48, 52	NOVOLOG MIX 70-
NATURAL FIBER	NIKKI (28)..... 101	30FLEXPEN U-100
LAXATIVE (SUGAR)..... 90	<i>nilutamide</i> 16	..... 106, 107, 110
NATURAL FIBER	<i>nimodipine</i> 40, 45, 46, 48, 52	NOVOLOG PENFILL U-100
LAXATIVE(ASPART).....91	<i>nisoldipine</i>....40, 45, 46, 48, 52	INSULIN..... 106, 110
NATURAL SENNA	<i>nitazoxanide</i> 10	NOVOLOG U-100 INSULIN
LAXATIVE..... 91	NITRO-BID.....49	ASPART..... 106, 110
NATURAL TEARS (PF).....84	<i>nitrofurantoin macrocrystal</i> ... 15	NOXAFIL..... 11
NATURAL VEG	<i>nitrofurantoin monohyd/m-</i>	NP THYROID..... 111
LAXATIVE(SENNOSID)..... 91	<i>cryst</i> 15	NUBEQA..... 16
<i>nebivolol</i> 21, 38	<i>nitroglycerin</i>.....49	NUCALA..... 123
<i>nelarabine</i> 16	NIVESTYM..... 26	NUCYNTA..... 63
		NUCYNTA ER..... 63

NU-MAG.....	76	ONE DAILY MAXIMUM	29, 144, 151	ONE-A-DAY WOMEN'S	HEALTHY SKIN	29, 77, 144, 151
NURTEC ODT.....	59	ONE DAILY MEN'S 50	PLUS MEMORY.....	144, 151	ONE-A-DAY WOMEN'S	PETITES.....
NUTROPIN AQ NUSPIN.....	108	ONE DAILY MULTI-VIT W-	MINERAL.....	29, 144	ONEXTON.....	131, 137
NUVESSA.....	131	ONE DAILY MULTIVITAMIN	.....	144	ONGENTYS.....	59
NYAMYC.....	138	ONE DAILY MULTIVIT-	IRON(FOLIC).....	29, 144, 151	ONGLYZA.....	102
<i>nystatin</i>	14, 138	ONE DAILY PLUS IRON	.....	29, 144, 151	ONUREG.....	16
<i>nystatin-triamcinolone</i>	138	ONE DAILY PLUS	MINERALS.....	144	ONZETRA XSAIL.....	69
NYSTOP.....	138	ONE DAILY WOMEN 50	PLUS.....	144, 151	OPCICON ONE-STEP.....	101
NYVEPRIA.....	26	ONE DAILY WOMEN'S	.....	29, 76, 144, 151	OPCON-A.....	85
<i>octreotide acetate</i>	110	ONE DAILY WOMENS 50	PLUS.....	144, 151	OPSUMIT.....	52, 129
OCUFLOX.....	81	ONE WAY VALVED	MOUTHPIECE.....	72	OPTICHAMBER ADULT	MASK-LARGE.....
OCUTABS.....	143	ONE-A-DAY ENERGY	.....	29, 76, 144, 151	OPTICHAMBER DIAMOND	LG MASK.....
ODOMZO.....	16	ONE-A-DAY ESSENTIAL....	144	ONE-A-DAY MAXIMUM	FORMULA.....	144
<i>ofloxacin</i>	14, 81	ONE-A-DAY MEN	VITACRAVES.....	144, 151	ONE-A-DAY MEN	OPVEE.....
<i>olmesartan</i>	34	ONE-A-DAY MENOPAUSE	FORMULA.....	76, 144, 151	ONE-A-DAY MEN'S	OPZELURA.....
<i>olmesartan-amlodipin-</i>		ONE-A-DAY MEN'S	50PLUS(GINKGO).....	144, 151	ONE-A-DAY MEN'S	ORALYTE.....
<i>hcthiamid..</i>	34, 40, 45, 46, 51, 79	MULTIVITAMIN... ..	144, 151, 157	ONE-A-DAY TEEN	ADVANTAGE..	29, 77, 144, 151
<i>olmesartan-</i>		ONE-A-DAY VITACRAVES	.....	144, 151	ONE-A-DAY VITACRAVES	IMMUNITY.....
<i>hydrochlorothiazide</i> ...	34, 51, 79	ONE-A-DAY VITACRAVES	OMEGA-3.....	144, 151	ONE-A-DAY	WEIGHTSMART....
<i>olopatadine</i>	80	ONE-A-DAY VITACRAVES	ONE-A-DAY	WOMEN	VITACRAVES.....	144, 151
OLUMIANT.....	116, 119	ONE-A-DAY VITACRAVES	ONE-A-DAY WOMEN'S	ACTIVE.....	29, 77, 144, 151	
OLUX.....	135	ONE-A-DAY VITACRAVES	ORSERDU.....	16	OS-CAL 500 + D3.....	77, 156
OMECLAMOX-PAK.....	9, 13, 95	ONE-A-DAY VITACRAVES	ORGOPYX.....	16, 99	<i>oseltamivir</i>	12
<i>omega 3-dha-epa-fish oil</i>	37	ONE-A-DAY VITACRAVES	ORIAHNN.....	99, 103, 108	OSENI.....	102, 111
<i>omega-3 acid ethyl esters</i>	37	ONE-A-DAY VITACRAVES	ORLISSA.....	99		
<i>omega-3 fatty acids</i>	37	ONE-A-DAY VITACRAVES	<i>orlistat</i>	93		
<i>omega-3 fatty acids-fish oil</i> ...	37	ONE-A-DAY VITACRAVES	<i>orphenadrine citrate</i>	21		
<i>omeprazole</i>	95	ONE-A-DAY VITACRAVES	<i>orphenadrine-asa-caffeine</i>	24, 69		
<i>omeprazole magnesium</i>	95	ONE-A-DAY VITACRAVES	.....		
<i>omeprazole-sodium</i>		ONE-A-DAY VITACRAVES				
<i>bicarbonate</i>	95	ONE-A-DAY VITACRAVES				
OMNARIS.....	83, 124	ONE-A-DAY VITACRAVES				
OMNICAP.....	143, 151	ONE-A-DAY VITACRAVES				
OMNITROPE.....	108	ONE-A-DAY VITACRAVES				
ONCOVITE.....	143	ONE-A-DAY VITACRAVES				
<i>ondansetron</i>	85	ONE-A-DAY VITACRAVES				
<i>ondansetron hcl</i>	85	ONE-A-DAY VITACRAVES				
ONE DAILY.....	143, 151	ONE-A-DAY VITACRAVES				
ONE DAILY		ONE-A-DAY VITACRAVES				
CALCIUM/IRON.....	28, 143	ONE-A-DAY VITACRAVES				
ONE DAILY COMPLETE		ONE-A-DAY VITACRAVES				
.....	28, 143, 151	ONE-A-DAY VITACRAVES				
ONE DAILY ENERGY.....	143	ONE-A-DAY VITACRAVES				
ONE DAILY ESSENTIAL		ONE-A-DAY VITACRAVES				
.....	143, 151	ONE-A-DAY VITACRAVES				
ONE DAILY FOR MEN	144, 151	ONE-A-DAY VITACRAVES				
ONE DAILY FOR MEN 50		ONE-A-DAY VITACRAVES				
PLUS ADV.....	144, 151	ONE-A-DAY VITACRAVES				
ONE DAILY FOR WOMEN		ONE-A-DAY VITACRAVES				
.....	29, 144, 151	ONE-A-DAY VITACRAVES				
ONE DAILY HEALTHY		ONE-A-DAY VITACRAVES				
WEIGHT.....	29, 144, 151	ONE-A-DAY VITACRAVES				

OSMOLEX ER.....	8, 53	PARLODEL.....	61	<i>phendimetrazine tartrate</i>	53
OTEZLA.....	116, 119, 139	PAROEX ORAL RINSE.....	83	<i>phentermine</i>	53
OTEZLA STARTER		<i>paromomycin</i>	9	<i>phenylephrine hcl</i>	85
.....	116, 119, 139	PARVLEX.....	29, 152, 154	PHEXXI.....	121
<i>oxaprozin</i>	67	PATADAY ONCE DAILY		PHILITH.....	101
OXBRYTA.....	24, 25	RELIEF.....	80	PHILLIPS.....	87
OXERVATE.....	84	PATADAY TWICE DAILY		PHILLIPS MILK OF	
<i>oxiconazole</i>	133	RELIEF.....	80	MAGNESIA.....	91
OXISTAT.....	133	PATANASE.....	80	<i>phytonadione (vitamin k1)</i>	
<i>oxybutynin chloride</i>	140	PAXLOVID.....	11, 12	.....	113, 157
<i>oxycodone</i>	63, 64	P-COL RITE.....	91	PIKO 1.....	72
<i>oxycodone-acetaminophen</i>		PEAK AIR PEAK FLOW		<i>pilocarpine hcl</i>	22, 84
.....	55, 64	METER.....	72	<i>pimecrolimus</i>	136
OXYCONTIN.....	64	PEDIALYTE.....	77	PIMTREA (28).....	101
<i>oxymorphone</i>	64	PEDIALYTE ADVANCED		<i>pindolol</i>	21, 38, 44, 48
OXYTROL.....	140	CARE.....	77	PINK BISMUTH.....	87, 88
OXYTROL FOR WOMEN...	140	PEDIALYTE FREEZER		PINK BISMUTH MAXIMUM	
OYSCO 500/D.....	77, 156	POPS.....	77	STRENGTH.....	87, 88
OYSTER SHELL + D3...	77, 156	PEDIALYTE SINGLES.....	77	<i>pioglitazone</i>	111
OYSTER SHELL CALCIUM..	77	PEDIATRIC ELECTROLYTE	77	<i>pioglitazone-glimepiride</i>	111
OYSTER SHELL CALCIUM		PEDIATRIC ENEMA.....	91	<i>pioglitazone-metformin</i> 100,	111
500.....	77	PEDIATRIC FREEZER		<i>piroxicam</i>	67
OYSTER SHELL CALCIUM-		POPS.....	77	<i>pitavastatin calcium</i>	47
VIT D3.....	77, 156	PEDIATRIC MEDIUM MASK.	72	PLAVIX.....	32
OYSTERCAL-D.....	77, 156	PEDIATRIC PANDA MASK...	72	PLEGRIDY.....	119
OZEMPIC.....	104	PEDIATRIC SMALL MASK...	72	PNEUMOVAX-23.....	19
PAIN RELIEF		PEDIAVANCE.....	77	<i>pnv cmb#95-ferrous</i>	
(ACETAMINOPHEN).....	56	<i>peg 3350-electrolytes</i>	91	<i>fumarate-fa</i>	29, 145, 152
PAIN RELIEF ES		<i>peg-electrolyte soln</i>	91	POCKET CHAMBER.....	72
(ACETAMINOPHEN).....	56	<i>pemetrexed disodium</i>	16	POCKET PEAK FLOW	
PAIN RELIEVER		<i>penciclovir</i>	132	METER.....	72
(ACETAMINOPHEN).....	56	<i>penicillin v potassium</i>	12	<i>podofilox</i>	139
PAIN RELIEVER		PENNSAID.....	67, 137	<i>polyethylene glycol 3350</i>	91
ES(ACETAMINOPHN).....	56	PENTASA.....	89	<i>polymyxin b sulf-</i>	
PALFORZIA (LEVEL 1).....	17	<i>pentazocine-naloxone</i>	65	<i>trimethoprim</i>	81
PALFORZIA (LEVEL 2).....	17	<i>pentoxifylline</i>	26	<i>polyvinyl alcohol</i>	84
PALFORZIA (LEVEL 3).....	17	PEPTO-BISMOL.....	87, 88	POMALYST.....	16, 119
PALFORZIA (LEVEL 4).....	17	PEPTO-BISMOL MAX ST		PONVORY.....	119
PALFORZIA (LEVEL 5).....	17	.....	87, 88	PONVORY 14-DAY	
PALFORZIA (LEVEL 6).....	17	PEPTO-BISMOL TO-GO.	87, 88	STARTER PACK.....	119
PALFORZIA (LEVEL 7).....	17	PERCOCET.....	56, 64	PORTIA 28.....	101
PALFORZIA (LEVEL 8).....	17	PERDIEM OVERNIGHT		<i>posaconazole</i>	11
PALFORZIA (LEVEL 9).....	18	RELIEF.....	91	<i>potassium chloride</i>	77
PALFORZIA (LEVEL 10).....	18	PERFOROMIST.....	23, 129	<i>potassium citrate</i>	73
PALFORZIA (LEVEL 11 UP-		<i>perindopril erbumine</i>	35, 36	<i>potassium citrate-citric acid</i> ..	73
DOSE).....	18	<i>permethrin</i>	138	<i>potassium phosphate m-/d-</i>	
PALFORZIA INITIAL DOSE..	18	PERSONAL BEST FULL		<i>basic</i>	77
PALFORZIA LEVEL 11		RANGE.....	72	PRADAXA.....	25
MAINTENANCE.....	18	PERTZYE.....	92	PRALUENT PEN.....	49
PANDA MASK.....	72	PHARBECHLOR.....	6, 123	<i>pramipexole</i>	61
PANDEL.....	135	PHARBETOL.....	56	<i>prasugrel</i>	32
<i>pantoprazole</i>	95	<i>phenazopyridine</i>	132	<i>pravastatin</i>	47

<i>prazosin</i>	21, 33	PRO COMFORT SPACER- CHILD MASK.....	72	<i>pyrimethamine</i>	10
PRECISION XTRA B- KETONE.....	72	PROAIR DIGIHALER....	23, 129	QBRELIS.....	35, 36
PRECISION XTRA MONITOR.....	72	PROAIR RESPICLICK..	23, 129	QNASL.....	83, 124
PRECISION XTRA TEST.....	73	<i>probenecid</i>	79, 113	QTERN.....	102, 110
PRECOSE.....	98	<i>probenecid-colchicine</i>	79, 113	QUESTRAN.....	39
<i>prednicarbate</i>	135	PRO-CAL.....	78	QUESTRAN LIGHT.....	39
<i>prednisolone</i>	97	PROCARDIA XL	40, 45, 46, 48, 52	QUIN B STRONG.....	152, 154
<i>prednisolone acetate</i>	83	PROCARE SPACER WITH ADULT MASK.....	72	<i>quinapril</i>	35, 36
<i>prednisolone sodium phosphate</i>	83, 97	PROCARE SPACER WITH CHILD MASK.....	72	<i>quinapril-hydrochlorothiazide</i>	35, 36, 51, 79
<i>prednisone</i>	97	PROCERV HP	30, 145, 152, 157	<i>quinidine sulfate</i>	10, 43
PREHEVBRIO (PF).....	19	PROCHAMBER.....	73	QUINTABS.....	145, 152
PREMARIN.....	103	<i>prochlorperazine</i>	67, 89	QUINTABS-M..	30, 78, 145, 152
PREMPHASE.....	103	<i>prochlorperazine maleate</i>	67, 89	QUINTABS-M IRON FREE	145, 152
PREMPRO.....	103	PROCRIT.....	26	QULIPTA.....	59
PRENATABS RX	29, 77, 145, 152	PROCTOCORT.....	135	QVAR REDIHALER.....	98, 126
PRENATAL.....	29, 145, 152	PROCTOSOL HC.....	135	<i>rabeprazole</i>	95
PRENATAL COMPLETE	29, 77, 145, 152	<i>progesterone</i>	108	<i>raloxifene</i>	102, 114
PRENATAL DHA.....	94	<i>progesterone micronized</i>	108	<i>ramipril</i>	35, 36
PRENATAL FORMULA	29, 145, 152	PROGLYCEM.....	99	<i>ranolazine</i>	42
PRENATAL MULTI- DHA(WITH VIT K)..	29, 145, 152	PROLENSA.....	84	RAPAFLO.....	22
PRENATAL MULTIVITAMINS...29,	145, 152	<i>promethazine</i>	6, 58, 123	<i>rasagiline</i>	61
PRENATAL PLUS (CALCIUM CARB)	30, 77, 145, 152	PROMETRIUM.....	109	READY-TO-USE ENEMA.....	91
PRENATAL TABLET	30, 78, 145, 152	PROMOLAXIN.....	91	READY-TO-USE ENEMA (MIN OIL).....	91
PRENATAL VITAMIN PLUS LOW IRON.....	30, 78, 145, 152	<i>propafenone</i>	43	REBIF (WITH ALBUMIN)....	119
PRENATAL VITAMIN WITH MINERALS.....	30, 78, 145, 152	<i>proparacaine</i>	84	REBIF REBIDOSE.....	119
<i>pretomanid</i>	11	<i>propranolol</i>....21, 38, 44,	48, 57	REBIF TITRATION PACK... 119	
PREVACID.....	95	<i>propranolol- hydrochlorothiazid</i>	21, 38, 44, 51, 79	RECLIPSEN (28).....	101
PREVACID 24HR.....	95	<i>propylthiouracil</i>	99	RECOMBIVAX HB (PF).....	19
PREVACID SOLUTAB.....	95	PRORENAL...30, 152, 154,	156	REESE'S PINWORM MEDICINE.....	9
PREVALITE.....	39	PRORENAL QD	30, 145, 152, 156	REFRESH LACRI-LUBE.....	84
PREVNAR 13 (PF).....	19	PROSCAR.....	112	REFRESH LIQUIGEL.....	84
PREVNAR 20 (PF).....	19	PROTECT CARDIO AF	145, 152	REFRESH P.M.....	84
PRIFTIN.....	11, 14	PROTECT PLUS SO... 145,	152	RELAFEN DS.....	67
PRILOSEC.....	95	PROTONIX.....	95	RELENZA DISKHALER.....	12
<i>primaquine</i>	10	PROVENTIL HFA.....	23, 129	RELEUKO.....	26
PRIMEAIRE.....	72	PROVERA.....	109	RELISTOR.....	93
PRO COMFORT SPACER- ADULT MASK.....	72	PULMICORT.....	97, 126	RELPAK.....	69
		PULMICORT FLEXHALER	97, 98, 126	RELTONE.....	92
		PULMOZYME.....	79, 124	RELYVRIO.....	60, 73
		PYLERA.....	9, 10, 13, 15, 89	RENAL CAPS.....	152, 154
		<i>pyrazinamide</i>	11	RENA-VITE.....	153, 154
		<i>pyridostigmine bromide</i>	22	RENA-VITE RX.....	153, 154
				REVELA.....	74, 113
				<i>repaglinide</i>	107
				REPATHA PUSHTRONEX...49	
				REPATHA SURECLICK.....	49
				REPATHA SYRINGE.....	49
				RESTASIS.....	83

RESTASIS MULTIDOSE.....	83	SENNA WITH DOCUSATE		SLOWMAG MUSCLE	
RETACRIT.....	26	SODIUM.....	91	RECOVERY.....	78
REVATIO.....	50, 126, 129	SENNA-S.....	91	SMART HEART OMEGA-3... 37	
REYVOW.....	69	SENNA-TIME S.....	91	<i>sodium bicarbonate</i>	87
REZLIDHIA.....	16	<i>sennosides</i>	91	<i>sodium chloride</i>	73, 78, 84
REZUROCK.....	120	<i>sennosides-docusate</i>		<i>sodium citrate-citric acid</i>	73
REZVOGLAR KWIKPEN		<i>sodium</i>	91	SODIUM FLUORIDE 5000	
.....	106, 107	SENOKOT.....	91	PLUS.....	115
RHOPRESSA.....	81, 85	SENOKOT EXTRA		<i>sodium oxybate</i>	60
RIABNI.....	16, 120	STRENGTH.....	91	<i>sodium polystyrene</i>	
RID LICE KILLING.....	138	SENOKOT-S.....	91	<i>sulfonate</i>	74, 113
<i>rifabutin</i>	11, 14	SEN-O-TAB.....	91	<i>sodium,potassium,mag</i>	
<i>rifampin</i>	11, 14	SENTRY.....	30, 146, 153	<i>sulfates</i>	91
<i>riluzole</i>	60	SENTRY SENIOR.....	146, 153	SOGROYA.....	108
<i>rimantadine</i>	8	SEREVENT DISKUS....	23, 129	<i>solifenacin</i>	140
RINVOQ.....	116, 119	SERNIVO.....	135	SOLIQUA 100/33.104, 106, 107	
RIOMET.....	100	SEROSTIM.....	108	SOLO.....	146, 153, 157
RIOMET ER.....	100	SETLAKIN.....	101	SOOTHE (BISMUTH	
<i>risedronate</i>	114	<i>sevelamer carbonate</i>	74, 113	SUBSALICYLATE).....	87, 88
RITEFLO AEROCHAMBER..	73	<i>sevelamer hcl</i>	74, 113	SOOTHE REGULAR	
<i>rivastigmine</i>	22	SF.....	115	STRENGTH.....	87, 88
<i>rivastigmine tartrate</i>	22	SF 5000 PLUS.....	115	<i>sotalol</i>	21, 38, 44, 48
<i>rizatriptan</i>	69	SHAROBEL.....	101	SOTALOL AF.....	21, 38, 44, 48
ROCKLATAN.....	81, 85	SHINGRIX (PF).....	19	SOTYKTU.....	139
<i>roflumilast</i>	126	SIDEROL.....	30, 153, 154	SOTYLIZE.....	21, 38, 44, 48
<i>ropinirole</i>	61	SIDESTREAM PEDIATRIC		SPECTRAVITE ADVANCED	
<i>rosuvastatin</i>	47	FACE MASK.....	73	FORMULA.....	30, 146, 153
ROXICODONE.....	64	SIKLOS.....	17	SPECTRAVITE MEN'S	
ROXYBOND.....	64, 65	<i>sildenafil</i>		.....	30, 146, 153
RYALTRIS.....	80, 83, 124	(<i>pulm.hypertension</i>)		SPEEDYSWAB COVID-19	
RYBELSUS.....	104	.....	50, 126, 129	HOME TEST.....	73
RYTARY.....	61	SILICONE MASK - INFANT..	73	SPIKEVAX 2023-2024(12Y	
SANCUSO.....	85	SILICONE MASK -		UP)(PF).....	19
SAVAYSA.....	25	PEDIATRIC.....	73	<i>spinosad</i>	138
SAVELLA.....	61, 69	SILIQ.....	136	SPIRIVA RESPIMAT....	20, 122
<i>saxagliptin</i>	102	<i>silodosin</i>	22	SPIRIVA WITH	
<i>saxagliptin-metformin</i> ..	100, 102	<i>silver sulfadiazine</i>	137	HANDIHALER.....	20, 122
SAXENDA.....	104	SIMBRINZA.....	80, 82	<i>spironolactone</i>	49, 50, 74
SEGLENTIS.....	60, 65	<i>simethicone</i>	89	<i>spironolacton-</i>	
SEGLUROMET.....	100, 110	SIMPONI.....	93, 116, 119	<i>hydrochlorothiaz</i>	
<i>selegiline hcl</i>	61	SIMPONI ARIA.....	93, 116, 119	.....	49, 50, 51, 74, 79
<i>selenium sulfide</i>	137	<i>simvastatin</i>	47	SPORANOX.....	11
SEMGLEE(INSULIN		SINEMET.....	61	SPRINTEC (28).....	101
GLARGINE-YFGN).....	106, 107	SINGULAIR.....	123	SPRIX.....	67
SEMGLEE(INSULIN		<i>sirolimus</i>	120	SRONYX.....	101
GLARG-YFGN)PEN....	106, 107	SIRTURO.....	11	SSD.....	137
SE-NATAL-19.....	30, 146, 153	SIVEXTRO.....	14	STALEVO 100.....	59, 61
SENEXON-S.....	91	SKYRIZI.....	136, 139	STALEVO 125.....	59, 61
SENNA.....	91	SKYTROFA.....	108	STALEVO 150.....	59, 61
SENNA LAX.....	91	SLO-NIACIN.....	37	STALEVO 200.....	60, 61
SENNA LAXATIVE.....	91	SLOW RELEASE IRON.....	30	STALEVO 50.....	60, 61
SENNA PLUS.....	91	SLOW-MAG.....	78	STALEVO 75.....	60, 61

STEGLATRO.....	110	SYNALAR.....	135	TENIVAC (PF).....	18
STEGLUJAN.....	102, 110	SYNALAR CREAM KIT.....	135	TENORETIC 100	
STELARA.....	116, 119, 139	SYNALAR OINTMENT KIT.....	135	.....	24, 38, 39, 44, 51, 79
STIMUFEND.....	26	SYNALAR TS.....	135	TENORETIC 50	
STIMULANT LAXATIVE		SYNJARDY.....	100, 110	.....	24, 38, 39, 44, 51, 79
PLUS.....	91	SYNJARDY XR.....	100, 110	TENORMIN.....	24, 38, 39, 44
STIOLTO RESPIMAT		SYNTHROID.....	111	<i>terazosin</i>	21, 33, 48
.....	20, 23, 122, 129	SYSTANE (PROPYLENE		<i>terbinafine hcl</i>	8, 130
STOMACH RELIEF.....	87, 88	GLYCOL).....	84	<i>terbutaline</i>	23, 129
STOMACH RELIEF MAX		SYSTANE GEL.....	84	<i>terconazole</i>	133
STRENGTH.....	87, 88	SYSTANE ULTRA.....	84	<i>teriflunomide</i>	119
STOMACH RELIEF		TAB-A-VITE MULTIVITAMIN		<i>teriparatide</i>	108, 113
ORIGINAL.....	87, 88	W-IRON.....	30, 146, 153	TESTIM.....	98
STOOL SOFTENER.....	91	TABLOID.....	17	<i>testosterone</i>	98
STOOL SOFTENER-		<i>tacrolimus</i>	120, 136	<i>testosterone cypionate</i>	98
LAXATIVE.....	91	TACTINAL.....	56	TEXACORT.....	135
STOOL SOFTENER-		<i>tadalafil (pulm. hypertension)</i>		TEZSPIRE.....	126
STIMULANT LAXAT.....	91	.....	50, 129	THALOMID.....	119
STRESS FORMULA.....	146	TADLIQ.....	50, 129	<i>theophylline</i>	46, 74, 130, 140
STRESS FORMULA WITH		<i>tafluprost (pf)</i>	85	THERA.....	146, 153
IRON.....	30, 153, 154, 157	TAKE ACTION.....	101	THERAGRAN-M PREMIER	
STRESS FORMULA WITH		TALICIA.....	9, 14, 89, 95	50 PLUS.....	146, 153
IRON(SULF)..	30, 153, 154, 157	TALTZ AUTOINJECTOR.....	139	THERALOGIX	
STRIVERDI RESPIMAT	23, 129	TALTZ AUTOINJECTOR (2		COMPANION.....	146, 153
<i>sucralfate</i>	94	PACK).....	139	THERA-M.....	30, 146, 153
SULAR.....	40, 45, 46, 48, 52	TALTZ AUTOINJECTOR (3		THERANATAL.....	30, 146, 153
<i>sulfacetamide sodium</i>	81	PACK).....	139	THERAPEUTIC-M	
<i>sulfacetamide sodium-sulfur</i>	137	TALTZ SYRINGE.....	139	.....	30, 78, 146, 153
<i>sulfacetamide-prednisolone</i> ..	81	TAMIFLU.....	12	THERA-TABS.....	146
<i>sulfamethoxazole-</i>		<i>tamoxifen</i>	17, 102	THERATRUM COMPLETE	
<i>trimethoprim</i>	15	<i>tamsulosin</i>	22	WITH LUTEIN.....	30, 146
<i>sulfasalazine</i>	15, 117	TAPERDEX.....	98	THYQUIDITY.....	111
SULFATRIM.....	15	TARGRETIN.....	17, 139	TIADYLT ER..	39, 41, 42, 44, 52
<i>sulindac</i>	67	TARINA FE 1/20 (28).....	101	TIAZAC.....	39, 41, 42, 44, 52
<i>sumatriptan</i>	69	TASCENSO ODT.....	119	TIBSOVO.....	17
<i>sumatriptan succinate</i>	70	TASMAR.....	60	TIGLUTIK.....	60
<i>sumatriptan-naproxen</i>	67, 70	<i>tavaborole</i>	138	<i>timolol maleate</i>	
SUNVITE.....	30, 146, 153, 157	<i>tazarotene</i>	139, 140	.....	21, 38, 39, 44, 48, 57, 82
SUPER GINSENG		TAZTIA XT		<i>timolol maleate (pf)</i>	82
MULTIVITAMIN.....	146	.....	39, 40, 41, 42, 44, 52	TIMOPTIC OCUDOSE (PF)..	82
SUPER MULTIPLE - LOW		TAZVERIK.....	17	<i>tinidazole</i>	10
IRON.....	146, 153	TDVAX.....	18	<i>tiotropium bromide</i>	20, 122
SUPER OMEGA-3.....	37	TECFIDERA.....	119	TIROSINT.....	111
SUPER QUINTS.....	153	TEKTRUNA.....	50	TIROSINT-SOL.....	112
SUPER QUINTS B-50.....	153	<i>telmisartan</i>	34, 35	<i>tizanidine</i>	20
SUPER THERA VITE M.....	146	<i>telmisartan-amlodipine</i>		TOBI.....	9
SYMBICORT...	23, 98, 126, 129	.....	34, 35, 40, 45, 46, 52	TOBI PODHALER.....	9
SYMJEPI.....	19, 122	<i>telmisartan-</i>		<i>tobramycin</i>	9, 81
SYMLINPEN 120.....	98	<i>hydrochlorothiazid</i>	34, 35, 51, 79	<i>tobramycin in 0.225 % nacl</i>	9
SYMLINPEN 60.....	98	TEMOVATE.....	135	<i>tobramycin with nebulizer</i>	9
SYMPROIC.....	93	<i>temozolomide</i>	17		
SYNAGIS.....	12	TENCON.....	56, 58		

<i>tobramycin-dexamethasone</i>	TRIDERM.....	136	TYVASO INSTITUTIONAL
..... 81, 83	TRI-ESTARYLLA.....	101	START KIT.....
<i>tolcapone</i>	TRIJARDY XR.....	100, 102, 110	53, 130
<i>tolnaftate</i>	TRI-LEGEST FE.....	101	TYVASO REFILL KIT ...
TOLSURA.....	TRI-LINYAH.....	101	53, 130
<i>tolterodine</i>	TRILIPIX.....	46	TYVASO STARTER KIT
TOPICORT.....	TRI-LO-MARZIA.....	101	53, 130
TOPROL XL.....	TRI-LO-SPRINTEC.....	101	UBRELVY.....
<i>toremifene</i>	<i>trimethoprim</i>	15	UCERIS.....
<i>torseamide</i>	TRINATAL RX 1		UDENYCA.....
TOSYMRA.....	.....	31, 78, 146, 153	UDENYCA
TOUJEO MAX U-300	TRIPHROCAPS.....	153, 154	AUTOINJECTOR.....
SOLOSTAR.....	TRIPLE ANTIBIOTIC.....	131	ULORIC.....
TOUJEO SOLOSTAR U-300	TRI-SPRINTEC (28).....	101	ULTRA B-100 COMPLEX... 153
INSULIN.....	TRI-VI-SOL..	146, 147, 154, 156	ULTRA FREEDA
TOVET EMOLLIENT.....	TRI-VITAMIN WITH		.....
TOVET KIT.....	FLUORIDE		31, 78, 146, 153
TOVIAZ.....	.....	115, 146, 147, 155, 156	ULTRA STRENGTH
TRACLEER.....	TRIVORA (28).....	101	ANTACID.....
TRADJENTA.....	TRI-VYLIBRA LO.....	101	78, 87
<i>tramadol</i>	<i>tropicamide</i>	85	ULTRAVATE.....
<i>tramadol-acetaminophen</i>	<i>trospium</i>	140	136
.....	TRULANCE.....	93	UNITHROID.....
56, 57, 65	TRULICITY.....	104	112
<i>trandolapril</i>	TRUMENBA.....	19	UPTRAVI.....
35, 36	TRUSTEX LATEX		53, 130
<i>trandolapril-verapamil</i>	CONDOM.....	121	URO-MAG.....
.....	TRUSTEX LUBRICATED		87
35, 36, 39, 41, 42, 52	CONDOMS.....	121	URSO 250.....
TRAVATAN Z.....	TRUSTEX NON-LUB		92
85	CONDOMS.....	121	URSO FORTE.....
<i>travoprost</i>	TRUSTEX-RIA		92
85	LUB/SPERMICIDE.....	121	<i>ursodiol</i>
TRECTOR.....	TRUSTEX-RIA NON-LUB		92
11	CONDOMS.....	121	VAGIFEM.....
TRELEGY ELLIPTA	TRUZONE PEAK FLOW		103
.....	METER.....	73	<i>valacyclovir</i>
122, 126, 129	TUDORZA PRESSAIR..	20, 122	13
TREMFYA.....	TUMS.....	78, 87	<i>valganciclovir</i>
136	TUMS E-X.....	78, 87	13
TRESIBA FLEXTOUCH U-	TUMS EXTRA STRENGTH		<i>valsartan</i>
100.....	SMOOTHIES.....	78, 87	34, 35
106, 107	TUMS FRESHERS.....	78, 87	<i>valsartan-</i>
TRESIBA FLEXTOUCH U-	TUMS ULTRA.....	78, 87	<i>hydrochlorothiazide</i>
200.....	TWINRIX (PF).....	19	.....
106, 107	TYLENOL.....	56	34, 35, 51, 79
TRESIBA U-100 INSULIN	TYLENOL EXTRA		VALTREX.....
.....	STRENGTH.....	56	13
106, 107	TYMLOS.....	108, 114	VANCOGIN.....
<i>tretinoin</i>	TYRVAYA.....	20	12
133	TYVASO.....	52, 129	<i>vancomycin</i>
<i>tretinoin (antineoplastic)</i>	TYVASO DPI.....	53, 130	12
17			VANDAZOLE.....
TREXIMET.....			131
67, 70			VANOS.....
<i>triamcinolone acetonide</i>			136
.....			VAQTA (PF).....
83, 124, 135, 136			19
<i>triamterene-</i>			<i>varenicline</i>
<i>hydrochlorothiazid</i>			24
50, 51, 74, 79			VARIVAX (PF).....
TRIANEX.....			19
136			VASCEPA.....
TRIBENZOR			37
.....			VASERETIC.....
34, 35, 41, 45, 46, 51, 79			35, 36, 51, 79
TRI-BUFFERED ASPIRIN			VASOTEC.....
.....			35, 36
32, 33, 57, 69			VAXNEUVANCE (PF).....
TRICARE.....			19
31, 146, 153			V-C FORTE.....
TRICOR.....			146, 153
46			VEGETABLE LAXATIVE.....
			91
			VELIVET TRIPHASIC
			REGIMEN (28).....
			101
			VELPHORO.....
			74
			VEMLIDY.....
			13
			VENCLEXTA.....
			17
			VENCLEXTA STARTING
			PACK.....
			17
			VENTAVIS.....
			53, 130
			VENTOLIN HFA.....
			23, 129

<i>verapamil</i>	39, 41, 42, 44, 53	VYNDAQEL.....	42	XALATAN.....	85
VERELAN PM39,	41, 42, 44, 53	VYTORIN 10-10.....	43, 47	XARELTO.....	25
VERQUVO.....	53	VYTORIN 10-20.....	43, 47	XARELTO DVT-PE TREAT	
VESICARE.....	140	VYTORIN 10-40.....	43, 47	30D START.....	25
VESICARE LS.....	140	VYTORIN 10-80.....	43, 47	XATMEP.....	17, 117, 119, 120
VESTURA (28).....	101	VYZULTA.....	85	XELJANZ.....	117, 119
VFEND.....	11	WAL-FINATE.....	6, 123	XELJANZ XR.....	117, 119
VIBERZI.....	93	WAL-MUCIL FIBER		XELPROS.....	85
VIC-FORTE.....	146, 153	(ASPARTAME).....	91	XENICAL.....	93
VICTOZA 2-PAK.....	104	WAL-MUCIL FIBER		XEPI.....	131
VICTOZA 3-PAK.....	104	(SUGAR).....	91	XERESE.....	132, 136
VIGAMOX.....	81	<i>warfarin</i>	25	XHANCE.....	83, 124
VIMOVO.....	67, 95	WEGOVY.....	104	XIFAXAN.....	14
VIOKACE.....	92	WELCHOL.....	39, 98	XIGDUO XR.....	100, 110
VIRT-CAPS.....	153, 155	WERA (28).....	101	XIIDRA.....	83
VISTARIL.....	6, 58	WESCAPS.....	154, 155	XOFLUZA.....	11
VITACEL (WITH LUTEIN)		WESTAB MAX.....	154	XOLAIR.....	126
.....	146, 153	WESTAB PLUS		XOPENEX HFA.....	23, 129
VITAL-D RX.....	153, 155, 156	.....	31, 78, 147, 154	XPOVIO.....	17
VITALEE.....	146, 153	<i>wheat germ oil</i>	157	XTAMPZA ER.....	65
<i>vitamin a palmitate</i>	147	WIDE-SEAL DIAPHRAGM		XTANDI.....	17
<i>vitamin b complex</i>	153, 154	60.....	121	XULANE.....	101
<i>vitamin b complex-folic acid</i>	154	WIDE-SEAL DIAPHRAGM		XULTOPHY 100/3.6	
VITAMIN D2.....	156	65.....	121	.....	104, 106, 107
VITAMIN D3.....	156	WIDE-SEAL DIAPHRAGM		XYWAV.....	60
<i>vitamin e</i>	157	70.....	121	YELETS.....	31, 147, 154
<i>vitamin e (dl, acetate)</i>	157	WIDE-SEAL DIAPHRAGM		YOSPRALA.....	32, 33, 69, 95
<i>vitamin e acetate</i>	157	75.....	121	YUFLYMA(CF).....	93, 117, 119
<i>vitamin e mixed</i>	157	WIDE-SEAL DIAPHRAGM		YUFLYMA(CF)	
<i>vitamin e succinate</i>	157	80.....	121	AUTOINJECTOR...93,	117, 119
VITAMINS A,C,D AND		WIDE-SEAL DIAPHRAGM		YUPELRI.....	20
FLUORIDE..	115, 147, 155, 156	85.....	121	YUSIMRY(CF) PEN	
VITAMINS A-D-E		WIDE-SEAL DIAPHRAGM		.....	93, 117, 119
SELENIUM.....	147, 157	90.....	121	YUVAFEM.....	103
VITAMINS B COMPLEX.....	154	WIDE-SEAL DIAPHRAGM		ZADITOR.....	80
VITA-RESPA.....	154	95.....	121	ZAFEMY.....	101
VITATRUM.....	147	WIXELA INHUB		<i>zafirlukast</i>	123
VITRUM SENIOR.....	147, 154	.....	23, 98, 126, 129	ZANAFLEX.....	20
VOGELXO.....	98	WOMAN'S LAXATIVE		ZARAH.....	101
<i>voriconazole</i>	11	(BISACODYL).....	91	ZARXIO.....	26
VORTEX ADULT MASK.....	73	WOMEN'S DAILY		ZAVZPRET.....	59
VORTEX HOLDING		FORMULA.....	31, 147	ZEGALOGUE	
CHAMBER.....	73	WOMEN'S GENTLE		AUTOINJECTOR.....	103
VORTEX VHC FROG		LAXATIVE(BISAC).....	92	ZEGALOGUE SYRINGE.....	103
MASK-CHILD.....	73	WOMEN'S LAXATIVE		ZEGERID.....	95
VORTEX VHC LADYBUG		(BISACODYL).....	92	ZELAPAR.....	61
MASK-TODDLR.....	73	WOMEN'S MULTIVITAMIN		ZEMBRACE SYMTOUCH.....	70
VTAMA.....	140	GUMMIES.....	147, 154	ZENATANE.....	140
VUMERITY.....	119	WOMEN'S ONE DAILY		ZENPEP.....	92
VUSION.....	133	.....	31, 78, 147, 154	ZEPOSIA.....	119
VYFEMLA (28).....	101	XACIATO.....	131	ZEPOSIA STARTER KIT	
VYNDAMAX.....	42	XADAGO.....	61	(28-DAY).....	119

ZEPOSIA STARTER PACK	
(7-DAY).....	119
ZERVIAE.....	80
ZESTORETIC.....	35, 36, 51, 79
ZESTRIL.....	35, 36
ZETIA.....	43
ZETONNA.....	83, 124
ZIEXTENZO.....	26
<i>zileuton</i>	123
ZIMHI.....	65, 113
<i>zinc gluconate</i>	78
<i>zinc sulfate</i>	78
ZINC-220.....	78
ZIOPTAN (PF).....	85
ZIPSOR.....	67
ZITHROMAX.....	13
ZITHROMAX TRI-PAK.....	13
ZITHROMAX Z-PAK.....	13
ZOCOR.....	47
ZOLINZA.....	17
<i>zolmitriptan</i>	70
ZOMACTON.....	108
ZOMIG.....	70
ZORVOLEX.....	67
ZORYVE.....	126, 140
ZOVIRAX.....	13, 132
ZYFLO.....	124
ZYLOPRIM.....	113
ZYPITAMAG.....	47
ZYTIGA.....	17
ZYVOX.....	14