

2025 Formulary (List of Covered Drugs or “Drug List”)



wellcare™

Wellcare Complete - Giveback (HMO-POS),
Wellcare Giveback (HMO),
Wellcare Giveback (HMO-POS),
Wellcare Giveback Dividend (HMO-POS),
Wellcare Giveback Open (PPO),
Wellcare Mutual of Omaha Premium Enhanced Open (PPO),
Wellcare Mutual of Omaha Simple Open (PPO),
Wellcare Mutual of Omaha Simple Secure Open (PPO),
Wellcare ‘Ohana Simple (HMO), Wellcare Premium Ultra (HMO),
Wellcare Simple (HMO), Wellcare Simple (HMO-POS),
Wellcare Simple Exclusive (HMO), Wellcare Simple Focus (HMO),
Wellcare Simple Open (PPO), Wellcare Simple Ruby (HMO), Wellcare Simple Value (HMO)

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**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION
ABOUT THE DRUGS WE COVER IN THIS PLAN**

HPMS Approved Formulary File Submission ID 25076

This formulary was updated on 09/01/2024. For more recent information or other questions, please contact us, Wellcare Member Services at the telephone number or website for your plan listed on the inside front and back covers of this formulary, between October 1 and March 31, representatives are available seven days a week, 8 a.m. to 8 p.m., between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

Arkansas

Wellcare Giveback Dividend (HMO-POS)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Giveback (HMO-POS)

1-800-977-7522 (TTY: 711)

wellcare.com/allwellAR

Arizona

Wellcare Simple Open (PPO)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Giveback (HMO),

Wellcare Simple (HMO),

Wellcare Simple Value (HMO)

1-800-977-7522 (TTY: 711)

wellcare.com/allwellAZ

California

Wellcare Giveback (HMO),

Wellcare Simple (HMO)

1-866-999-3945 (TTY: 711)

wellcare.com/medicare

Wellcare Premium Ultra (HMO),

Wellcare Simple Focus (HMO),

Wellcare Simple Ruby (HMO),

Wellcare Simple Focus (HMO)

1-800-275-4737 (TTY: 711)

wellcare.com/healthnetCA

Connecticut

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Florida

HMO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Georgia

HMO-POS, PPO

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Hawaii

HMO

1-877-457-7621 (TTY: 711)

wellcare.com/ohana

Illinois

Wellcare Giveback Open (PPO),

Wellcare Simple (HMO-POS)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Simple Exclusive (HMO)

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Kansas

Wellcare Giveback (HMO-POS)

1-800-977-7522 (TTY: 711)

wellcare.com/allwellKS

Wellcare Complete - Giveback (HMO-POS)

1-800-977-7522 (TTY: 711)

wellcarecomplete.com

Kentucky

HMO-POS

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Louisiana

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Maine

HMO-POS, PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Michigan

HMO-POS, PPO

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Mississippi

HMO-POS

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Missouri

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

HMO-POS

1-800-977-7522 (TTY: 711)

wellcare.com/allwellMO

Nevada

HMO-POS

1-800-977-7522 (TTY: 711)

wellcare.com/allwellNV

New York

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

North Carolina

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Ohio

HMO-POS

1-800-977-7522 (TTY: 711)

wellcare.com/allwellOH

Oregon

PPO

1-844-582-5177 (TTY: 711)

wellcare.com/healthnetOR

South Carolina

HMO-POS, PPO

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Tennessee

HMO-POS

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Texas

Wellcare Giveback (HMO) H0174017000,
Wellcare Giveback (HMO) H0174018000,
Wellcare Giveback (HMO) H0174019000,
Wellcare Giveback (HMO) H0174020000,
Wellcare Giveback (HMO) H0174021000,
Wellcare Mutual of Omaha Simple Secure Open
(PPO) H7323011000,
Wellcare Mutual of Omaha Simple Secure Open
(PPO) H7323012000,
Wellcare Simple (HMO) H0174002000,
Wellcare Simple (HMO) H0174010000,
Wellcare Simple (HMO) H0174014000

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Giveback (HMO) H5294019000

1-800-977-7522 (TTY: 711)

wellcare.com/allwellTX

Washington

Wellcare Mutual of Omaha Premium Enhanced Open
(PPO),

Wellcare Mutual of Omaha Simple Open (PPO)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Giveback Open (PPO)

1-844-582-5177 (TTY: 711)

wellcare.com/healthnetOR

Note to existing members: This Formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (Formulary) refers to “we,” “us” or “our,” it means Wellcare. When it refers to “plan” or “our plan,” it means Wellcare Complete - Giveback (HMO-POS), Wellcare Giveback (HMO), Wellcare Giveback (HMO-POS), Wellcare Giveback Dividend (HMO-POS), Wellcare Giveback Open (PPO), Wellcare Mutual of Omaha Premium Enhanced Open (PPO), Wellcare Mutual of Omaha Simple Open (PPO), Wellcare Mutual of Omaha Simple Secure Open (PPO), Wellcare ‘Ohana Simple (HMO), Wellcare Premium Ultra (HMO), Wellcare Simple (HMO), Wellcare Simple (HMO-POS), Wellcare Simple Exclusive (HMO), Wellcare Simple Focus (HMO), Wellcare Simple Open (PPO), Wellcare Simple Ruby (HMO), Wellcare Simple Value (HMO).

This document includes a Drug List (formulary) for our plan which is current as of 09/01/2024. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the inside front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025, and from time to time during the year.

What is the Wellcare Complete - Giveback (HMO-POS), Wellcare Giveback (HMO), Wellcare Giveback (HMO-POS), Wellcare Giveback Dividend (HMO-POS), Wellcare Giveback Open (PPO), Wellcare Mutual of Omaha Premium Enhanced Open (PPO), Wellcare Mutual of Omaha Simple Open (PPO), Wellcare Mutual of Omaha Simple Secure Open (PPO), Wellcare ‘Ohana Simple (HMO), Wellcare Premium Ultra (HMO), Wellcare Simple (HMO), Wellcare Simple (HMO-POS), Wellcare Simple Exclusive (HMO), Wellcare Simple Focus (HMO), Wellcare Simple Open (PPO), Wellcare Simple Ruby (HMO), Wellcare Simple Value (HMO) formulary?

In this document, we use the terms Drug list and formulary to mean the same thing. A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website which appears on the inside front and back cover pages.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Wellcare Complete - Giveback (HMO-POS), Wellcare Giveback (HMO), Wellcare Giveback (HMO-POS), Wellcare Giveback Dividend (HMO-POS), Wellcare Giveback Open (PPO), Wellcare Mutual of Omaha Premium Enhanced Open (PPO), Wellcare Mutual of Omaha Simple Open (PPO), Wellcare Mutual of Omaha Simple Secure Open (PPO), Wellcare ‘Ohana Simple (HMO), Wellcare Premium Ultra (HMO), Wellcare Simple (HMO), Wellcare Simple (HMO-POS), Wellcare Simple Exclusive (HMO), Wellcare Simple Focus (HMO), Wellcare Simple Open (PPO), Wellcare Simple Ruby (HMO), Wellcare Simple Value (HMO)’s Formulary?”

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Wellcare Complete - Giveback (HMO-POS), Wellcare Giveback (HMO), Wellcare Giveback (HMO-POS), Wellcare Giveback Dividend (HMO-POS), Wellcare Giveback Open (PPO), Wellcare Mutual of Omaha Premium Enhanced Open (PPO), Wellcare Mutual of Omaha Simple Open (PPO), Wellcare Mutual of Omaha Simple Secure Open (PPO), Wellcare ‘Ohana Simple (HMO), Wellcare Premium Ultra (HMO), Wellcare Simple (HMO), Wellcare Simple (HMO-POS), Wellcare Simple Exclusive (HMO), Wellcare Simple Focus (HMO), Wellcare Simple Open (PPO), Wellcare Simple Ruby (HMO), Wellcare Simple Value (HMO)’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 09/01/2024. To get updated information about the drugs covered by our plan please contact us. Our contact information appears on the inside front and back cover pages.

The formulary will be updated monthly and posted on our website. To get an updated printed formulary or to get information about the drugs covered by our plan, please visit our website or call Member Services at our contact information on the inside front and back cover pages.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular, Hypertension / Lipids.” If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page INDEX-1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Our plan requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, our plan provides 18 tablets per prescription for rizatriptan 5mg. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the inside front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Wellcare Complete - Giveback (HMO-POS), Wellcare Giveback (HMO), Wellcare Giveback (HMO-POS), Wellcare Giveback Dividend (HMO-POS), Wellcare Giveback Open (PPO), Wellcare Mutual of Omaha Premium Enhanced Open (PPO), Wellcare Mutual of Omaha Simple Open (PPO), Wellcare Mutual of Omaha Simple Secure Open (PPO), Wellcare ‘Ohana Simple (HMO), Wellcare Premium Ultra (HMO), Wellcare Simple (HMO), Wellcare Simple (HMO-POS), Wellcare Simple Exclusive (HMO), Wellcare Simple Focus (HMO), Wellcare Simple Open (PPO), Wellcare Simple Ruby (HMO), Wellcare Simple Value (HMO)’s formulary?” on page VIII for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that our plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by our plan.
- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Wellcare Complete - Giveback (HMO-POS), Wellcare Giveback (HMO), Wellcare Giveback (HMO-POS), Wellcare Giveback Dividend (HMO-POS), Wellcare Giveback Open (PPO), Wellcare Mutual of Omaha Premium Enhanced Open (PPO), Wellcare Mutual of Omaha Simple Open (PPO), Wellcare Mutual of Omaha Simple Secure Open (PPO), Wellcare ‘Ohana Simple (HMO), Wellcare Premium Ultra (HMO), Wellcare Simple (HMO), Wellcare Simple (HMO-POS), Wellcare Simple Exclusive (HMO), Wellcare Simple Focus (HMO), Wellcare Simple Open (PPO), Wellcare Simple Ruby (HMO), Wellcare Simple Value (HMO)’s Formulary?

You can ask our plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or, formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30 day supply of medication. If coverage is not approved, after your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you experience a level of care change (such as being discharged or admitted to a long-term care facility), your physician or pharmacy can call our Provider Service Center and request a one-time override. This one-time override will be up to a 30-day supply (unless you have a prescription written for fewer days).

For more information

For more detailed information about your plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about our plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the inside front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (**1-800-633-4227**) 24 hours a day/7 days a week. TTY users should call **1-877-486-2048**. Or, visit <http://www.medicare.gov>.

Our plan's Formulary

The formulary below provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page INDEX-1.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ELIQUIS) and generic drugs are listed in lower-case italics (e.g., *simvastatin*).

The information in the Requirements/Limits column tells you if our plan has any special requirements for coverage of your drug.

- **NT** stands for Not Part D: This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count toward your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving Extra Help to pay for your prescriptions, you will not get any extra help to pay for this drug.
- **NM** means the drug is not available via your monthly mail service benefit. This is noted in the Requirements/ Limits column of your formulary. You may be able to receive more than one month's supply of most of the drugs on your formulary via mail service at a reduced cost share. Please see Chapter 5 of your Evidence of Coverage for more information.
- **PA** stands for Prior Authorization: Please see page VI for details.
- **PA-NS** stands for Prior Authorization for New Starts: This means that if this drug is new to you, you will need to get approval from us before you fill your prescription. If you are taking this drug at the time of enrollment, you will not be required to meet criteria for approval.
- **B/D** stands for Covered under Medicare B or D: This drug may be eligible for payment under Medicare Part B or Part D. You (or your physician) are required to get prior authorization from us to determine that this drug is covered under Medicare Part D before you fill your prescription for this drug. Without prior approval, we may not cover this drug.
- **QL** stands for Quantity Limits: Please see page VI for details.
- **LA** stands for Limited Access medication. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at the telephone number or website for your plan listed on the inside front and back covers of this formulary, between October 1 and March 31, representatives are available seven days a week, 8 a.m. to 8 p.m., between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
- **ST** stands for Step Therapy: Please see page VI for details.
- **^** stands for Drug may be available for up to a 30-day supply only.

Drug tier copayment/coinsurance amounts

Prescription drugs are grouped into one of six tiers. To find out which tier your drug is in, look in the Drug Tier column of the formulary that begins on page 1. For more detailed information about your out-of-pocket costs for prescriptions, including any deductible that may apply, please refer to your Evidence of Coverage and other plan materials.

- **Tier 1 (Preferred Generic)** includes preferred generic drugs and may include some brand drugs.
 - **Preferred** Copayment: \$0
 - **Standard** Copayment: \$5
- **Tier 2 (Generic)** includes generic drugs and may include some brand drugs.
 - **Preferred** Copayment: \$0
 - **Standard** Copayment: \$10
- **Tier 3 (Preferred Brand)** includes preferred brand drugs and may include some generic drugs.

You won't pay more than \$35 for a one-month supply of each covered insulin product on this tier. If the tier cost-sharing is lower than \$35, you will pay the lower cost for your insulin.

- **Preferred** Coinsurance range: 18% - 25%
- **Standard** Coinsurance: 25%
- **Tier 4 (Non-Preferred Drug)** includes non-preferred brand and non-preferred generic drugs.

You won't pay more than \$35 for a one-month supply of each covered insulin product on this tier. If the tier cost-sharing is lower than \$35, you will pay the lower cost for your insulin.

- **Preferred** Coinsurance range: 32% - 50%
- **Standard** Coinsurance range: 32% - 50%

- **Tier 5 (Specialty Tier)** includes high-cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.
 - **Preferred** Coinsurance range: 28% - 33%
 - **Standard** Coinsurance range: 28% - 33%
- **Tier 6 (Select Care Drugs)** includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).
 - **Preferred** Copayment: \$0
 - **Standard** Copayment: \$0

Consult your Evidence of Coverage or Summary of Benefits for your applicable co-pays/coinsurance and amounts.

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Drug Name	Drug Tier	Requirements / Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	4	B/D
<i>amphotericin b injection recon soln 50 mg</i>	2	B/D
<i>caspofungin intravenous recon soln 50 mg, 70 mg</i>	4	
<i>clotrimazole mucous membrane troche 10 mg</i>	2	
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG	5^	PA
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	4	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	2	
<i>fluconazole oral suspension for reconstitution 10 mg/ml, 40 mg/ml</i>	2	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	5^	PA
<i>griseofulvin microsize oral suspension 125 mg/5 ml</i>	4	
<i>griseofulvin microsize oral tablet 500 mg</i>	4	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	4	
<i>itraconazole oral capsule 100 mg</i>	4	PA; QL (120 EA per 30 days)
<i>ketoconazole oral tablet 200 mg</i>	2	PA
<i>micafungin intravenous recon soln 100 mg, 50 mg</i>	4	
<i>nystatin oral suspension 100,000 unit/ml</i>	2	
<i>nystatin oral tablet 500,000 unit</i>	2	
<i>posaconazole oral tablet, delayed release (dr/ec) 100 mg</i>	5^	PA; QL (96 EA per 30 days)
<i>terbinafine hcl oral tablet 250 mg</i>	1	
<i>voriconazole intravenous recon soln 200 mg</i>	5^	PA
<i>voriconazole oral suspension for reconstitution 200 mg/5 ml (40 mg/ml)</i>	5^	PA
<i>voriconazole oral tablet 200 mg</i>	4	PA; QL (120 EA per 30 days)
<i>voriconazole oral tablet 50 mg</i>	4	PA; QL (480 EA per 30 days)
ANTIVIRALS		
<i>abacavir oral solution 20 mg/ml</i>	2	
<i>abacavir oral tablet 300 mg</i>	2	
<i>abacavir-lamivudine oral tablet 600-300 mg</i>	2	
<i>acyclovir oral capsule 200 mg</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements / Limits
<i>acyclovir oral suspension 200 mg/5 ml</i>	4	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	1	
<i>acyclovir sodium intravenous solution 50 mg/ml</i>	4	B/D
<i>adefovir oral tablet 10 mg</i>	4	
<i>amantadine hcl oral capsule 100 mg</i>	2	
<i>amantadine hcl oral solution 50 mg/5 ml</i>	2	
<i>amantadine hcl oral tablet 100 mg</i>	2	
APTIVUS ORAL CAPSULE 250 MG	5^	
<i>atazanavir oral capsule 150 mg, 200 mg, 300 mg</i>	2	
BARACLUDGE ORAL SOLUTION 0.05 MG/ML	5^	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5^	
CIMDUO ORAL TABLET 300-300 MG	5^	
COMPLERA ORAL TABLET 200-25-300 MG	5^	
<i>darunavir oral tablet 600 mg</i>	5^	QL (60 EA per 30 days)
<i>darunavir oral tablet 800 mg</i>	5^	QL (30 EA per 30 days)
DELSTRIGO ORAL TABLET 100-300-300 MG	5^	
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	5^	QL (30 EA per 30 days)
DOVATO ORAL TABLET 50-300 MG	5^	
EDURANT ORAL TABLET 25 MG	5^	
<i>efavirenz oral tablet 600 mg</i>	2	
<i>efavirenz-emtricitabin-tenofovir oral tablet 600-200-300 mg</i>	5^	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate oral tablet 400-300-300 mg, 600-300-300 mg</i>	5^	
<i>emtricitabine oral capsule 200 mg</i>	2	
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	5^	QL (30 EA per 30 days)
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	4	QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	4	
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	2	
<i>etravirine oral tablet 100 mg, 200 mg</i>	5^	
EVOTAZ ORAL TABLET 300-150 MG	5^	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	2	
<i>fosamprenavir oral tablet 700 mg</i>	4	
FUZEON SUBCUTANEOUS RECON SOLN 90 MG	5^	
GENVOYA ORAL TABLET 150-150-200-10 MG	5^	

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Drug Name	Drug Tier	Requirements / Limits
INTELENCE ORAL TABLET 25 MG	3	
ISENTRESS HD ORAL TABLET 600 MG	5^	
ISENTRESS ORAL POWDER IN PACKET 100 MG	5^	
ISENTRESS ORAL TABLET 400 MG	5^	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	5^	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	4	
JULUCA ORAL TABLET 50-25 MG	5^	
<i>lamivudine oral solution 10 mg/ml</i>	2	
<i>lamivudine oral tablet 100 mg, 150 mg, 300 mg</i>	2	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	2	
LEDIPASVIR-SOFOSBUVIR ORAL TABLET 90-400 MG	5^	PA; QL (28 EA per 28 days)
LEXIVA ORAL SUSPENSION 50 MG/ML	4	
LIVTENCITY ORAL TABLET 200 MG	5^	PA; LA; QL (120 EA per 30 days)
<i>lopinavir-ritonavir oral solution 400-100 mg/5 ml</i>	2	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	2	
<i>maraviroc oral tablet 150 mg, 300 mg</i>	5^	
<i>nevirapine oral suspension 50 mg/5 ml</i>	2	
<i>nevirapine oral tablet 200 mg</i>	2	
<i>nevirapine oral tablet extended release 24 hr 400 mg</i>	2	
NORVIR ORAL POWDER IN PACKET 100 MG	3	
ODEFSEY ORAL TABLET 200-25-25 MG	5^	
<i>oseltamivir oral capsule 30 mg</i>	2	QL (168 EA per 365 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	2	QL (84 EA per 365 days)
<i>oseltamivir oral suspension for reconstitution 6 mg/ml</i>	2	QL (1080 ML per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	3	\$0 Cost Sharing; QL (20 EA per 90 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	3	\$0 Cost Sharing; QL (30 EA per 90 days)
PIFELTRO ORAL TABLET 100 MG	5^	
PREVMIS ORAL TABLET 240 MG, 480 MG	5^	PA; QL (30 EA per 30 days)
PREZCOBIX ORAL TABLET 800-150 MG-MG	5^	
PREZISTA ORAL SUSPENSION 100 MG/ML	5^	QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	4	QL (240 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	4	QL (480 EA per 30 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION	4	QL (120 EA per 365 days)

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Drug Name	Drug Tier	Requirements / Limits
REYATAZ ORAL POWDER IN PACKET 50 MG	5 [^]	
<i>ribavirin oral capsule 200 mg</i>	2	
<i>ribavirin oral tablet 200 mg</i>	2	
<i>rimantadine oral tablet 100 mg</i>	4	
<i>ritonavir oral tablet 100 mg</i>	2	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR 600 MG	5 [^]	
SELZENTRY ORAL SOLUTION 20 MG/ML	5 [^]	
SELZENTRY ORAL TABLET 25 MG	4	
SELZENTRY ORAL TABLET 75 MG	5 [^]	
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	5 [^]	PA; QL (28 EA per 28 days)
STRIBILD ORAL TABLET 150-150-200-300 MG	5 [^]	
SUNLENCA ORAL TABLET 300 MG, 300 MG (4-TABLET PACK)	5 [^]	
SYM TUZA ORAL TABLET 800-150-200-10 MG	5 [^]	
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	2	
TIVICAY ORAL TABLET 10 MG	3	
TIVICAY ORAL TABLET 25 MG, 50 MG	5 [^]	
TIVICAY PD ORAL TABLET FOR SUSPENSION 5 MG	5 [^]	
TRIUMEQ ORAL TABLET 600-50-300 MG	5 [^]	
TRIUMEQ PD ORAL TABLET FOR SUSPENSION 60-5-30 MG	4	
TRIZIVIR ORAL TABLET 300-150-300 MG	5 [^]	
<i>valacyclovir oral tablet 1 gram, 500 mg</i>	2	
<i>valganciclovir oral recon soln 50 mg/ml</i>	5 [^]	
<i>valganciclovir oral tablet 450 mg</i>	3	
VEMLIDY ORAL TABLET 25 MG	5 [^]	
VIRACEPT ORAL TABLET 250 MG, 625 MG	5 [^]	
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM)	5 [^]	
VIREAD ORAL TABLET 150 MG, 250 MG	5 [^]	
VIREAD ORAL TABLET 200 MG	3	
<i>zidovudine oral capsule 100 mg</i>	2	
<i>zidovudine oral syrup 10 mg/ml</i>	2	
<i>zidovudine oral tablet 300 mg</i>	2	
CEPHALOSPORINS		
<i>cefaclor oral capsule 250 mg, 500 mg</i>	2	
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>cefadroxil oral capsule 500 mg</i>	1	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml</i>	4	
<i>cefadroxil oral suspension for reconstitution 500 mg/5 ml</i>	2	
<i>cefazolin injection recon soln 1 gram, 10 gram</i>	4	
<i>cefazolin injection recon soln 500 mg</i>	2	
<i>cefdinir oral capsule 300 mg</i>	2	
<i>cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>cefepime injection recon soln 1 gram, 2 gram</i>	4	
<i>cefixime oral capsule 400 mg</i>	2	
<i>cefixime oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	4	
<i>cefoxitin intravenous recon soln 1 gram, 10 gram, 2 gram</i>	2	
<i>cefpodoxime oral suspension for reconstitution 100 mg/5 ml</i>	4	
<i>cefpodoxime oral suspension for reconstitution 50 mg/5 ml</i>	2	
<i>cefpodoxime oral tablet 100 mg, 200 mg</i>	4	
<i>cefprozil oral suspension for reconstitution 125 mg/5 ml</i>	2	
<i>cefprozil oral suspension for reconstitution 250 mg/5 ml</i>	4	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	2	
<i>ceftazidime injection recon soln 1 gram, 6 gram</i>	4	
<i>ceftazidime injection recon soln 2 gram</i>	2	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram</i>	4	
<i>ceftriaxone injection recon soln 250 mg, 500 mg</i>	2	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	2	
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	2	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	1	
<i>cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>tazicef injection recon soln 1 gram, 6 gram</i>	2	
<i>tazicef injection recon soln 2 gram</i>	4	
TEFLARO INTRAVENOUS RECON SOLN 400 MG, 600 MG	5^	
ERYTHROMYCINS / OTHER MACROLIDES		
<i>azithromycin intravenous recon soln 500 mg</i>	4	
<i>azithromycin oral packet 1 gram</i>	4	

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Drug Name	Drug Tier	Requirements / Limits
<i>azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	2	
<i>azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg</i>	1	
<i>clarithromycin oral suspension for reconstitution 125 mg/5 ml</i>	2	
<i>clarithromycin oral suspension for reconstitution 250 mg/5 ml</i>	4	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	2	
<i>clarithromycin oral tablet extended release 24 hr 500 mg</i>	2	
DIFICID ORAL TABLET 200 MG	5^	QL (20 EA per 10 days)
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	2	
<i>erythrocin (as stearate) oral tablet 250 mg</i>	2	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	3	
<i>erythromycin oral capsule, delayed release (dr/ec) 250 mg</i>	4	
<i>erythromycin oral tablet 250 mg, 500 mg</i>	4	
<i>erythromycin oral tablet, delayed release (dr/ec) 250 mg, 333 mg, 500 mg</i>	2	
MISCELLANEOUS ANTIINFECTIVES		
<i>albendazole oral tablet 200 mg</i>	5^	
<i>amikacin injection solution 500 mg/2 ml</i>	4	
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION 590 MG/8.4 ML	5^	PA; LA
<i>atovaquone oral suspension 750 mg/5 ml</i>	2	
<i>atovaquone-proguanil oral tablet 250-100 mg</i>	4	
<i>atovaquone-proguanil oral tablet 62.5-25 mg</i>	2	
<i>aztreonam injection recon soln 1 gram, 2 gram</i>	4	
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML	5^	PA; LA; QL (84 ML per 56 days)
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	4	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	1	
<i>clindamycin in 5 % dextrose intravenous piggyback 300 mg/50 ml, 900 mg/50 ml</i>	2	
<i>clindamycin in 5 % dextrose intravenous piggyback 600 mg/50 ml</i>	4	
<i>clindamycin phosphate injection solution 150 mg/ml</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
COARTEM ORAL TABLET 20-120 MG	4	
<i>colistin (colistimethate na) injection recon soln 150 mg</i>	5^	QL (30 EA per 10 days)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>daptomycin intravenous recon soln 500 mg</i>	5^	
EMVERM ORAL TABLET,CHEWABLE 100 MG	5^	
<i>ertapenem injection recon soln 1 gram</i>	4	QL (14 EA per 14 days)
<i>ethambutol oral tablet 100 mg, 400 mg</i>	2	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	2	
<i>gentamicin injection solution 40 mg/ml</i>	2	
<i>hydroxychloroquine oral tablet 200 mg</i>	1	
<i>imipenem-cilastatin intravenous recon soln 250 mg</i>	2	
<i>imipenem-cilastatin intravenous recon soln 500 mg</i>	4	
<i>isoniazid oral solution 50 mg/5 ml</i>	2	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	1	
<i>ivermectin oral tablet 3 mg</i>	3	PA; QL (20 EA per 30 days)
<i>linezolid in dextrose 5% intravenous piggyback 600 mg/300 ml</i>	4	
<i>linezolid oral suspension for reconstitution 100 mg/5 ml</i>	5^	QL (1800 ML per 30 days)
<i>linezolid oral tablet 600 mg</i>	4	QL (60 EA per 30 days)
<i>mefloquine oral tablet 250 mg</i>	2	
<i>meropenem intravenous recon soln 1 gram</i>	3	QL (30 EA per 10 days)
<i>meropenem intravenous recon soln 500 mg</i>	3	QL (10 EA per 10 days)
<i>metronidazole in nacl (iso-os) intravenous piggyback 500 mg/100 ml</i>	2	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>neomycin oral tablet 500 mg</i>	2	
<i>nitazoxanide oral tablet 500 mg</i>	5^	QL (12 EA per 30 days)
<i>pentamidine inhalation recon soln 300 mg</i>	2	B/D; QL (1 EA per 28 days)
<i>pentamidine injection recon soln 300 mg</i>	2	
<i>praziquantel oral tablet 600 mg</i>	4	
PRIFTIN ORAL TABLET 150 MG	4	
PRIMAQUINE ORAL TABLET 26.3 MG (15 MG BASE)	4	
<i>pyrazinamide oral tablet 500 mg</i>	2	
<i>pyrimethamine oral tablet 25 mg</i>	5^	PA

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Drug Name	Drug Tier	Requirements / Limits
<i>quinine sulfate oral capsule 324 mg</i>	4	PA
<i>rifabutin oral capsule 150 mg</i>	2	
<i>rifampin intravenous recon soln 600 mg</i>	2	
<i>rifampin oral capsule 150 mg, 300 mg</i>	2	
SIRTURO ORAL TABLET 100 MG, 20 MG	5^	PA; LA
STREPTOMYCIN INTRAMUSCULAR RECON SOLN 1 GRAM	5^	QL (60 EA per 30 days)
<i>tigecycline intravenous recon soln 50 mg</i>	5^	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	2	
<i>tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml</i>	5^	PA; QL (280 ML per 28 days)
<i>tobramycin sulfate injection solution 10 mg/ml, 40 mg/ml</i>	2	
TRECTOR ORAL TABLET 250 MG	4	
<i>vancomycin intravenous recon soln 1,000 mg</i>	4	QL (20 EA per 10 days)
<i>vancomycin intravenous recon soln 10 gram</i>	4	QL (2 EA per 10 days)
<i>vancomycin intravenous recon soln 500 mg</i>	2	QL (10 EA per 10 days)
<i>vancomycin intravenous recon soln 750 mg</i>	4	QL (27 EA per 10 days)
<i>vancomycin oral capsule 125 mg</i>	4	QL (40 EA per 10 days)
<i>vancomycin oral capsule 250 mg</i>	4	QL (80 EA per 10 days)
XIFAXAN ORAL TABLET 550 MG	5^	PA; QL (90 EA per 30 days)
PENICILLINS		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	
<i>amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml</i>	1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	2	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 250-62.5 mg/5 ml, 400-57 mg/5 ml, 600-42.9 mg/5 ml</i>	2	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	2	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr 1,000-62.5 mg</i>	2	
<i>amoxicillin-pot clavulanate oral tablet, chewable 200-28.5 mg, 400-57 mg</i>	2	
<i>ampicillin oral capsule 500 mg</i>	1	
<i>ampicillin sodium injection recon soln 1 gram</i>	4	

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Drug Name	Drug Tier	Requirements / Limits
<i>ampicillin sodium injection recon soln 10 gram, 125 mg</i>	2	
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 15 gram, 3 gram</i>	2	
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 2,400,000 UNIT/4 ML, 600,000 UNIT/ML	4	
<i>dicloxacillin oral capsule 250 mg, 500 mg</i>	2	
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	2	
<i>nafcillin injection recon soln 10 gram</i>	5^	
<i>oxacillin injection recon soln 1 gram</i>	2	
<i>oxacillin injection recon soln 10 gram, 2 gram</i>	4	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	4	
<i>penicillin g potassium injection recon soln 20 million unit</i>	4	
<i>penicillin g sodium injection recon soln 5 million unit</i>	2	
<i>penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	1	
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	4	
QUINOLONES		
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	2	
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	2	
<i>levofloxacin oral solution 250 mg/10 ml</i>	4	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>moxifloxacin oral tablet 400 mg</i>	2	
<i>moxifloxacin-sod.chloride(iso) intravenous piggyback 400 mg/250 ml</i>	2	
SULFA'S / RELATED AGENTS		
<i>sulfadiazine oral tablet 500 mg</i>	4	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml</i>	2	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
TETRACYCLINES		
<i>demeclocycline oral tablet 150 mg, 300 mg</i>	4	
<i>doxy-100 intravenous recon soln 100 mg</i>	2	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	2	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	2	
<i>minocycline oral capsule 100 mg, 50 mg, 75 mg</i>	2	
<i>minocycline oral tablet 100 mg, 50 mg, 75 mg</i>	4	
<i>tetracycline oral capsule 250 mg, 500 mg</i>	4	
URINARY TRACT AGENTS		
<i>methenamine hippurate oral tablet 1 gram</i>	4	
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	4	
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	2	
<i>nitrofurantoin monohyd/m-cryst oral capsule 100 mg</i>	4	
<i>trimethoprim oral tablet 100 mg</i>	2	
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	2	
MESNEX ORAL TABLET 400 MG	5^	
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7 ML (70 MG/ML)	5^	B/D
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
<i>abiraterone oral tablet 250 mg</i>	5^	PA-NS; QL (120 EA per 30 days)
<i>abiraterone oral tablet 500 mg</i>	5^	PA-NS; QL (60 EA per 30 days)
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
ALECENSA ORAL CAPSULE 150 MG	5^	PA-NS; LA; QL (240 EA per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK 90 MG (7)- 180 MG (23)	5^	PA-NS; LA; QL (30 EA per 180 days)
<i>anastrozole oral tablet 1 mg</i>	1	
AUGTYRO ORAL CAPSULE 40 MG	5^	PA-NS; QL (240 EA per 30 days)
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	5^	PA-NS; LA; QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>azathioprine oral tablet 50 mg</i>	2	B/D
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	5^	PA-NS; LA
<i>bexarotene oral capsule 75 mg</i>	5^	PA-NS
<i>bexarotene topical gel 1 %</i>	5^	PA-NS; QL (60 GM per 30 days)
<i>bicalutamide oral tablet 50 mg</i>	2	
BOSULIF ORAL CAPSULE 100 MG	5^	PA-NS; QL (180 EA per 30 days)
BOSULIF ORAL CAPSULE 50 MG	5^	PA-NS; QL (330 EA per 30 days)
BOSULIF ORAL TABLET 100 MG	5^	PA-NS; QL (90 EA per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	5^	PA-NS; QL (30 EA per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
BRUKINSA ORAL CAPSULE 80 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
CALQUENCE (ACALABRUTINIB MAL) ORAL TABLET 100 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
CALQUENCE ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 100 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	5^	PA-NS; LA; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	5^	PA-NS; LA; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	5^	PA-NS; LA; QL (84 EA per 28 days)
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
COTELLIC ORAL TABLET 20 MG	5^	PA-NS; LA; QL (63 EA per 28 days)
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	B/D
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG, 50 MG	4	B/D
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	2	B/D
<i>cyclosporine modified oral solution 100 mg/ml</i>	2	B/D
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	2	B/D
DAURISMO ORAL TABLET 100 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
DAURISMO ORAL TABLET 25 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	3	
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	3	PA-NS
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG	3	PA-NS
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG	3	PA-NS
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)	3	PA-NS

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements / Limits
ENVARBUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG	3	B/D
ERIVEDGE ORAL CAPSULE 150 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
ERLEADA ORAL TABLET 240 MG	5^	PA-NS; QL (30 EA per 30 days)
ERLEADA ORAL TABLET 60 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
<i>erlotinib oral tablet 100 mg, 150 mg</i>	5^	PA-NS; QL (30 EA per 30 days)
<i>erlotinib oral tablet 25 mg</i>	5^	PA-NS; QL (90 EA per 30 days)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	5^	PA-NS; QL (30 EA per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg</i>	5^	PA-NS; QL (150 EA per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	5^	PA-NS; QL (90 EA per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 5 mg</i>	5^	PA-NS; QL (60 EA per 30 days)
<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	3	B/D
<i>everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	5^	B/D
<i>exemestane oral tablet 25 mg</i>	2	
EXKIVITY ORAL CAPSULE 40 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5^	PA-NS
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	4	PA-NS
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	5^	PA-NS; QL (84 EA per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	5^	PA-NS; QL (21 EA per 28 days)
GAVRETO ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
<i>gefitinib oral tablet 250 mg</i>	5^	PA-NS; QL (30 EA per 30 days)
<i>gengraf oral capsule 100 mg, 25 mg</i>	2	B/D
<i>gengraf oral solution 100 mg/ml</i>	2	B/D
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
GLEOSTINE ORAL CAPSULE 10 MG	4	
GLEOSTINE ORAL CAPSULE 100 MG, 40 MG	5^	
<i>hydroxyurea oral capsule 500 mg</i>	2	
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	5^	PA-NS; LA; QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements / Limits
IDHIFA ORAL TABLET 100 MG, 50 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
<i>imatinib oral tablet 100 mg</i>	5^	PA-NS; QL (180 EA per 30 days)
<i>imatinib oral tablet 400 mg</i>	5^	PA-NS; QL (60 EA per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5^	PA-NS; LA; QL (324 ML per 30 days)
IMBRUVICA ORAL TABLET 420 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
INLYTA ORAL TABLET 1 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
INLYTA ORAL TABLET 5 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
INQOVI ORAL TABLET 35-100 MG	5^	PA-NS; LA; QL (5 EA per 28 days)
INREBIC ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
IWILFIN ORAL TABLET 192 MG	5^	PA-NS; LA; QL (240 EA per 30 days)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
JAYPIRCA ORAL TABLET 100 MG	5^	PA-NS; QL (60 EA per 30 days)
JAYPIRCA ORAL TABLET 50 MG	5^	PA-NS; QL (30 EA per 30 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	5^	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	5^	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	5^	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5^	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5^	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5^	PA-NS; QL (63 EA per 28 days)
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	5^	PA
KRAZATI ORAL TABLET 200 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>lapatinib oral tablet 250 mg</i>	5^	PA-NS; QL (180 EA per 30 days)
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	5^	PA-NS; LA; QL (28 EA per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X2), 24 MG/DAY(10 MG X 2-4 MG X 1)	5^	PA-NS; LA; QL (90 EA per 30 days)
LENVIMA ORAL CAPSULE 14 MG/DAY(10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	5^	PA-NS; LA; QL (60 EA per 30 days)
<i>letrozole oral tablet 2.5 mg</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
LEUKERAN ORAL TABLET 2 MG	5^	
<i>leuprolide subcutaneous kit 1 mg/0.2 ml</i>	4	PA-NS
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5^	PA-NS; LA
LORBRENA ORAL TABLET 100 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
LORBRENA ORAL TABLET 25 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
LUMAKRAS ORAL TABLET 120 MG	5^	PA-NS; LA; QL (240 EA per 30 days)
LUMAKRAS ORAL TABLET 320 MG	5^	PA-NS; QL (90 EA per 30 days)
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG, 7.5 MG	5^	PA-NS
LYNPARZA ORAL TABLET 100 MG, 150 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
LYSODREN ORAL TABLET 500 MG	5^	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	5^	PA-NS; QL (84 EA per 28 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	5^	PA-NS; QL (112 EA per 28 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	5^	PA-NS; QL (140 EA per 28 days)
MATULANE ORAL CAPSULE 50 MG	5^	LA
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i>	4	PA
<i>megestrol oral tablet 20 mg, 40 mg</i>	4	
MEKINIST ORAL RECON SOLN 0.05 MG/ML	5^	PA-NS; QL (1200 ML per 30 days)
MEKINIST ORAL TABLET 0.5 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
MEKINIST ORAL TABLET 2 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
MEKTOVI ORAL TABLET 15 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>mercaptopurine oral tablet 50 mg</i>	2	
<i>methotrexate sodium (pf) injection solution 25 mg/ml</i>	2	B/D
<i>methotrexate sodium injection solution 25 mg/ml</i>	2	B/D
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	
<i>mycophenolate mofetil oral capsule 250 mg</i>	2	B/D
<i>mycophenolate mofetil oral suspension for reconstitution 200 mg/ml</i>	5^	B/D
<i>mycophenolate mofetil oral tablet 500 mg</i>	2	B/D
<i>mycophenolate sodium oral tablet, delayed release (dr/ec) 180 mg, 360 mg</i>	2	B/D
<i>mycophenolic acid dr 180 mg tb</i>	2	B/D; mycophenolate sodium = mycophenolic acid
<i>mycophenolic acid dr 360 mg tb</i>	2	B/D; mycophenolate sodium = mycophenolic acid

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Drug Name	Drug Tier	Requirements / Limits
NERLYNX ORAL TABLET 40 MG	5^	PA-NS; LA
<i>nilutamide oral tablet 150 mg</i>	5^	
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5^	PA-NS; QL (3 EA per 28 days)
NUBEQA ORAL TABLET 300 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	5^	PA
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	PA
ODOMZO ORAL CAPSULE 200 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION 25 MG/ML	5^	PA-NS; QL (96 ML per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	5^	PA-NS; QL (20 EA per 28 days)
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	5^	PA-NS; QL (30 EA per 30 days)
ONUREG ORAL TABLET 200 MG, 300 MG	5^	PA-NS; LA; QL (14 EA per 28 days)
ORGOVYX ORAL TABLET 120 MG	5^	PA-NS; LA; QL (30 EA per 28 days)
ORSERDU ORAL TABLET 345 MG	5^	PA-NS; QL (30 EA per 30 days)
ORSERDU ORAL TABLET 86 MG	5^	PA-NS; QL (90 EA per 30 days)
<i>pazopanib oral tablet 200 mg</i>	5^	PA-NS; QL (120 EA per 30 days)
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5^	PA-NS; LA; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	5^	PA-NS; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	5^	PA-NS; QL (56 EA per 28 days)
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG	4	B/D
PURIXAN ORAL SUSPENSION 20 MG/ML	5^	
QINLOCK ORAL TABLET 50 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
RETEVMO ORAL CAPSULE 40 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
RETEVMO ORAL CAPSULE 80 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
REZLIDHIA ORAL CAPSULE 150 MG	5^	PA-NS; QL (60 EA per 30 days)
REZUROCK ORAL TABLET 200 MG	5^	PA; LA; QL (30 EA per 30 days)
ROZLYTREK ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (150 EA per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
ROZLYTREK ORAL PELLETS IN PACKET 50 MG	5^	PA-NS; QL (336 EA per 28 days)
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
RYDAPT ORAL CAPSULE 25 MG	5^	PA-NS; QL (224 EA per 28 days)

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Drug Name	Drug Tier	Requirements / Limits
SANDIMMUNE ORAL SOLUTION 100 MG/ML	4	B/D
SCEMBLIX ORAL TABLET 100 MG	5^	PA-NS; QL (120 EA per 30 days)
SCEMBLIX ORAL TABLET 20 MG	5^	PA-NS; QL (60 EA per 30 days)
SCEMBLIX ORAL TABLET 40 MG	5^	PA-NS; QL (300 EA per 30 days)
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML (1 ML), 0.6 MG/ML (1 ML), 0.9 MG/ML (1 ML)	5^	PA; LA
<i>sirolimus oral solution 1 mg/ml</i>	5^	B/D
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	B/D
SOLTAMOX ORAL SOLUTION 20 MG/10 ML	5^	
<i>sorafenib oral tablet 200 mg</i>	5^	PA-NS; QL (120 EA per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	5^	PA-NS; QL (30 EA per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	5^	PA-NS; QL (60 EA per 30 days)
STIVARGA ORAL TABLET 40 MG	5^	PA-NS; LA; QL (84 EA per 28 days)
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	5^	PA-NS; QL (28 EA per 28 days)
TABLOID ORAL TABLET 40 MG	4	
TABRECTA ORAL TABLET 150 MG, 200 MG	5^	PA-NS
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	2	B/D
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION 10 MG	5^	PA-NS; QL (840 EA per 28 days)
TAGRISO ORAL TABLET 40 MG, 80 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
TALZENNA ORAL CAPSULE 0.1 MG, 0.35 MG	5^	PA-NS; QL (30 EA per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
<i>tamoxifen oral tablet 10 mg, 20 mg</i>	2	
TASIGNA ORAL CAPSULE 150 MG, 200 MG	5^	PA-NS; QL (112 EA per 28 days)
TASIGNA ORAL CAPSULE 50 MG	5^	PA-NS; QL (120 EA per 30 days)
TAZVERIK ORAL TABLET 200 MG	5^	PA-NS; LA
TEPMETKO ORAL TABLET 225 MG	5^	PA-NS; LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	5^	PA-NS; LA; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	5^	PA-NS; LA; QL (56 EA per 28 days)
TIBSOVO ORAL TABLET 250 MG	5^	PA-NS; LA
<i>toremifene oral tablet 60 mg</i>	5^	
<i>tretinoin (antineoplastic) oral capsule 10 mg</i>	5^	
TRUQAP ORAL TABLET 160 MG, 200 MG	5^	PA-NS; QL (64 EA per 28 days)

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Drug Name	Drug Tier	Requirements / Limits
TUKYSA ORAL TABLET 150 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
TUKYSA ORAL TABLET 50 MG	5^	PA-NS; LA; QL (300 EA per 30 days)
TURALIO ORAL CAPSULE 125 MG	5^	PA; LA; QL (120 EA per 30 days)
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	5^	PA-NS; QL (56 EA per 28 days)
VENCLEXTA ORAL TABLET 10 MG	3	PA-NS; LA; QL (14 EA per 7 days)
VENCLEXTA ORAL TABLET 100 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
VENCLEXTA ORAL TABLET 50 MG	5^	PA-NS; LA; QL (7 EA per 7 days)
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK 10 MG-50 MG- 100 MG	5^	PA-NS; LA; QL (42 EA per 180 days)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
VITRAKVI ORAL SOLUTION 20 MG/ML	5^	PA-NS; LA; QL (300 ML per 30 days)
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
VONJO ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
WELIREG ORAL TABLET 40 MG	5^	PA-NS; LA
XALKORI ORAL CAPSULE 200 MG, 250 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
XALKORI ORAL PELLETT 150 MG	5^	PA-NS; QL (180 EA per 30 days)
XALKORI ORAL PELLETT 20 MG, 50 MG	5^	PA-NS; QL (120 EA per 30 days)
XATMEP ORAL SOLUTION 2.5 MG/ML	3	
XERMELO ORAL TABLET 250 MG	5^	PA; LA; QL (84 EA per 28 days)
XOSPATA ORAL TABLET 40 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)	5^	PA-NS; LA; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	5^	PA-NS; LA; QL (4 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	5^	PA-NS; LA; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	5^	PA-NS; LA; QL (32 EA per 28 days)
XTANDI ORAL CAPSULE 40 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
XTANDI ORAL TABLET 40 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
XTANDI ORAL TABLET 80 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
ZEJULA ORAL TABLET 100 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
ZEJULA ORAL TABLET 200 MG, 300 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
ZELBORAF ORAL TABLET 240 MG	5^	PA-NS; LA; QL (240 EA per 30 days)
ZOLINZA ORAL CAPSULE 100 MG	5^	PA-NS; QL (120 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
ZYDELIG ORAL TABLET 100 MG, 150 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
ZYKADIA ORAL TABLET 150 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG, 400 MG	5^	QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	5^	QL (60 EA per 30 days)
BRIVIACT ORAL SOLUTION 10 MG/ML	5^	QL (600 ML per 30 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	5^	QL (60 EA per 30 days)
<i>carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg</i>	2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	2	
<i>carbamazepine oral tablet 200 mg</i>	2	
<i>carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg</i>	2	
<i>carbamazepine oral tablet, chewable 100 mg</i>	2	
<i>clobazam oral suspension 2.5 mg/ml</i>	4	PA-NS; QL (480 ML per 30 days)
<i>clobazam oral tablet 10 mg, 20 mg</i>	4	PA-NS; QL (60 EA per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	QL (300 EA per 30 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	2	QL (300 EA per 30 days)
DIACOMIT ORAL CAPSULE 250 MG	5^	PA-NS; LA; QL (360 EA per 30 days)
DIACOMIT ORAL CAPSULE 500 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	5^	PA-NS; LA; QL (360 EA per 30 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg</i>	4	
DILANTIN EXTENDED ORAL CAPSULE 100 MG	4	
DILANTIN INFATABS ORAL TABLET, CHEWABLE 50 MG	4	
DILANTIN ORAL CAPSULE 30 MG	4	
DILANTIN-125 ORAL SUSPENSION 125 MG/5 ML	4	
<i>divalproex oral capsule, delayed rel sprinkle 125 mg</i>	2	
<i>divalproex oral tablet extended release 24 hr 250 mg, 500 mg</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>divalproex oral tablet, delayed release (dr/ec) 125 mg, 250 mg, 500 mg</i>	2	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	5^	PA-NS; LA
<i>epitol oral tablet 200 mg</i>	2	
EPRONTIA ORAL SOLUTION 25 MG/ML	3	PA-NS
<i>ethosuximide oral capsule 250 mg</i>	2	
<i>ethosuximide oral solution 250 mg/5 ml</i>	2	
<i>felbamate oral suspension 600 mg/5 ml</i>	4	
<i>felbamate oral tablet 400 mg, 600 mg</i>	2	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	5^	PA-NS; LA; QL (360 ML per 30 days)
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	5^	QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	5^	QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG	4	QL (60 EA per 30 days)
<i>gabapentin oral capsule 100 mg, 400 mg</i>	1	QL (270 EA per 30 days)
<i>gabapentin oral capsule 300 mg</i>	1	QL (360 EA per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	2	QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	2	QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	2	QL (120 EA per 30 days)
<i>gabapentin oral tablet extended release 24 hr 300 mg</i>	4	PA; QL (180 EA per 30 days)
<i>gabapentin oral tablet extended release 24 hr 600 mg</i>	4	PA; QL (90 EA per 30 days)
<i>lacosamide oral solution 10 mg/ml</i>	2	QL (1200 ML per 30 days)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg</i>	2	QL (60 EA per 30 days)
<i>lacosamide oral tablet 50 mg</i>	2	QL (120 EA per 30 days)
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>lamotrigine oral tablet extended release 24hr 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	2	
<i>lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg</i>	2	
<i>lamotrigine oral tablet, disintegrating 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>levetiracetam oral solution 100 mg/ml</i>	2	
<i>levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg</i>	2	
<i>levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg</i>	2	
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG	5^	PA-NS; QL (10 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements / Limits
<i>methsuximide oral capsule 300 mg</i>	4	
NAYZILAM NASAL SPRAY, NON-AEROSOL 5 MG/SPRAY (0.1 ML)	4	PA-NS; QL (10 EA per 30 days)
<i>oxcarbazepine oral suspension 300 mg/5 ml (60 mg/ml)</i>	2	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	2	
<i>phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)</i>	4	PA-NS
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	2	PA-NS
<i>phenytoin oral suspension 125 mg/5 ml</i>	2	
<i>phenytoin oral tablet, chewable 50 mg</i>	2	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	2	
<i>pregabalin oral capsule 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	QL (120 EA per 30 days)
<i>pregabalin oral capsule 200 mg</i>	2	QL (90 EA per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	2	QL (60 EA per 30 days)
<i>pregabalin oral solution 20 mg/ml</i>	2	QL (900 ML per 30 days)
PRIMIDONE ORAL TABLET 125 MG	4	
<i>primidone oral tablet 250 mg, 50 mg</i>	1	
<i>roweepra oral tablet 500 mg</i>	2	
<i>rufinamide oral suspension 40 mg/ml</i>	5^	PA-NS; QL (2400 ML per 30 days)
<i>rufinamide oral tablet 200 mg</i>	2	PA-NS; QL (480 EA per 30 days)
<i>rufinamide oral tablet 400 mg</i>	5^	PA-NS; QL (240 EA per 30 days)
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG, 250 MG, 500 MG, 750 MG	3	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG	5^	PA-NS; QL (60 EA per 30 days)
<i>tiagabine oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	2	
<i>topiramate oral capsule, sprinkle 15 mg, 25 mg</i>	2	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	2	
<i>valproic acid oral capsule 250 mg</i>	2	
VALTOCO NASAL SPRAY, NON-AEROSOL 10 MG/SPRAY (0.1 ML), 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2), 5 MG/SPRAY (0.1 ML)	5^	PA-NS; QL (10 EA per 30 days)
<i>vigabatrin oral powder in packet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>vigabatrin oral tablet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>vigadrone oral powder in packet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>vigadrone oral tablet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>vigpoder oral powder in packet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	5^	QL (56 EA per 28 days)
XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG	5^	QL (30 EA per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	5^	QL (60 EA per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	4	QL (28 EA per 180 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5^	QL (28 EA per 180 days)
ZONISADE ORAL SUSPENSION 100 MG/5 ML	5^	PA-NS
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	2	
ZTALMY ORAL SUSPENSION 50 MG/ML	5^	PA-NS; QL (1100 ML per 30 days)
ANTIPARKINSONISM AGENTS		
<i>benztropine oral tablet 0.5 mg, 1 mg, 2 mg</i>	4	PA
<i>bromocriptine oral capsule 5 mg</i>	2	
<i>bromocriptine oral tablet 2.5 mg</i>	2	
<i>carbidopa oral tablet 25 mg</i>	2	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	2	
<i>carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg</i>	2	
<i>carbidopa-levodopa oral tablet,disintegrating 10-100 mg, 25-100 mg, 25-250 mg</i>	2	
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	2	
<i>entacapone oral tablet 200 mg</i>	2	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR	4	
<i>pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	1	
<i>pramipexole oral tablet extended release 24 hr 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>rasagiline oral tablet 0.5 mg, 1 mg</i>	2	
<i>ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	1	
<i>ropinirole oral tablet extended release 24 hr 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	2	
<i>selegiline hcl oral capsule 5 mg</i>	2	
<i>selegiline hcl oral tablet 5 mg</i>	2	
<i>trihexyphenidyl oral tablet 2 mg, 5 mg</i>	3	PA
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML, 70 MG/ML	3	PA; QL (1 ML per 30 days)
<i>dihydroergotamine nasal spray,non-aerosol 0.5 mg/pump act. (4 mg/ml)</i>	5^	PA; QL (8 ML per 28 days)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	2	QL (40 EA per 28 days)
<i>naratriptan oral tablet 1 mg, 2.5 mg</i>	2	QL (18 EA per 28 days)
NURTEC ODT ORAL TABLET,DISINTEGRATING 75 MG	5^	PA; QL (16 EA per 30 days)
<i>rizatriptan oral tablet 10 mg, 5 mg</i>	2	QL (18 EA per 30 days)
<i>rizatriptan oral tablet,disintegrating 10 mg, 5 mg</i>	2	QL (18 EA per 30 days)
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation, 5 mg/actuation</i>	2	QL (18 EA per 28 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	2	QL (8 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml</i>	2	QL (8 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5 ml</i>	2	QL (8 ML per 28 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	2	QL (18 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg, 5 mg</i>	2	QL (18 EA per 28 days)
MISCELLANEOUS NEUROLOGICAL THERAPY		
AUSTEDO ORAL TABLET 12 MG, 9 MG	5^	PA; LA; QL (120 EA per 30 days)
AUSTEDO ORAL TABLET 6 MG	5^	PA; LA; QL (60 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	5^	PA; QL (120 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 24 MG	5^	PA; QL (60 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 30 MG, 36 MG, 42 MG, 48 MG	5^	PA; QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	5^	PA; QL (90 EA per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 6 MG (14)-12 MG (14)-24 MG (14)	5^	PA; QL (42 EA per 28 days)
<i>dalfampridine oral tablet extended release 12 hr 10 mg</i>	2	PA; QL (60 EA per 30 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg</i>	5^	PA; QL (14 EA per 7 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	5^	PA; QL (120 EA per 180 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 240 mg</i>	5^	PA; QL (60 EA per 30 days)
<i>donepezil oral tablet 10 mg, 5 mg</i>	1	
<i>donepezil oral tablet 23 mg</i>	4	QL (30 EA per 30 days)
<i>donepezil oral tablet, disintegrating 10 mg, 5 mg</i>	1	
<i> fingolimod oral capsule 0.5 mg</i>	5^	PA; QL (30 EA per 30 days)
<i>galantamine oral capsule, ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg</i>	2	QL (30 EA per 30 days)
<i>galantamine oral solution 4 mg/ml</i>	2	
<i>galantamine oral tablet 12 mg, 4 mg, 8 mg</i>	2	QL (60 EA per 30 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	5^	PA; QL (30 ML per 30 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	5^	PA; QL (12 ML per 28 days)
<i>glatopa subcutaneous syringe 20 mg/ml</i>	5^	PA; QL (30 ML per 30 days)
<i>glatopa subcutaneous syringe 40 mg/ml</i>	5^	PA; QL (12 ML per 28 days)
<i>memantine oral capsule, sprinkle, er 24hr 14 mg, 21 mg, 28 mg, 7 mg</i>	2	PA
<i>memantine oral solution 2 mg/ml</i>	2	PA
<i>memantine oral tablet 10 mg, 5 mg</i>	2	PA
NAMZARIC ORAL CAP, SPRINKLE, ER 24HR DOSE PACK 7/14/21/28 MG-10 MG	3	
NAMZARIC ORAL CAPSULE, SPRINKLE, ER 24HR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	3	
NUEDEXTA ORAL CAPSULE 20-10 MG	5^	PA; QL (60 EA per 30 days)
RADICAVA ORS STARTER KIT SUSP ORAL SUSPENSION 105 MG/5 ML	5^	PA
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	2	QL (60 EA per 30 days)
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24 hour, 4.6 mg/24 hour, 9.5 mg/24 hour</i>	2	QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	5^	PA; QL (30 EA per 30 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	5^	PA; QL (90 EA per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	5^	PA; QL (120 EA per 30 days)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	4	PA
<i>dantrolene oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<i>pyridostigmine bromide oral tablet 60 mg</i>	2	
<i>tizanidine oral tablet 2 mg, 4 mg</i>	2	
NARCOTIC ANALGESICS		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	2	QL (2700 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	2	QL (360 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	2	QL (180 EA per 30 days)
<i>buprenorphine hcl sublingual tablet 2 mg, 8 mg</i>	2	PA; QL (90 EA per 30 days)
<i>endocet oral tablet 10-325 mg</i>	2	QL (180 EA per 30 days)
<i>endocet oral tablet 2.5-325 mg, 5-325 mg</i>	2	QL (360 EA per 30 days)
<i>endocet oral tablet 7.5-325 mg</i>	2	QL (240 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg</i>	5^	PA; QL (120 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	4	PA; QL (120 EA 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>	4	PA; QL (10 EA per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	4	QL (2700 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg</i>	4	QL (180 EA per 30 days)
<i>hydrocodone-acetaminophen oral tablet 5-325 mg</i>	4	QL (240 EA per 30 days)
<i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i>	4	QL (150 EA per 30 days)
<i>hydromorphone oral liquid 1 mg/ml</i>	2	QL (600 ML per 30 days)
<i>hydromorphone oral tablet 2 mg, 4 mg, 8 mg</i>	2	QL (180 EA per 30 days)
<i>methadone oral solution 10 mg/5 ml, 5 mg/5 ml</i>	2	PA; QL (450 ML per 30 days)
<i>methadone oral tablet 10 mg, 5 mg</i>	2	PA; QL (90 EA per 30 days)
<i>morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)</i>	2	QL (180 ML per 30 days)
<i>morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)</i>	2	QL (900 ML per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>morphine oral tablet 15 mg, 30 mg</i>	2	QL (180 EA per 30 days)
<i>morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg</i>	2	PA; QL (90 EA per 30 days)
<i>oxycodone oral capsule 5 mg</i>	2	QL (180 EA per 30 days)
<i>oxycodone oral concentrate 20 mg/ml</i>	2	QL (180 ML per 30 days)
<i>oxycodone oral solution 5 mg/5 ml</i>	2	QL (900 ML per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	2	QL (180 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	2	QL (180 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg</i>	2	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 7.5-325 mg</i>	2	QL (240 EA per 30 days)
NON-NARCOTIC ANALGESICS		
<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	2	QL (60 EA per 30 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	2	QL (90 EA per 30 days)
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg</i>	2	QL (90 EA per 30 days)
<i>butorphanol nasal spray,non-aerosol 10 mg/ml</i>	2	QL (10 ML per 28 days)
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	2	QL (60 EA per 30 days)
<i>celecoxib oral capsule 400 mg</i>	2	QL (30 EA per 30 days)
<i>diclofenac potassium oral tablet 50 mg</i>	2	
<i>diclofenac sodium oral tablet extended release 24 hr 100 mg</i>	2	
<i>diclofenac sodium oral tablet, delayed release (dr/ec) 25 mg, 50 mg, 75 mg</i>	2	
<i>diclofenac sodium topical gel 1 %</i>	2	QL (1000 GM per 28 days)
<i>diclofenac sodium topical solution in metered-dose pump 20 mg/gram /actuation(2 %)</i>	4	QL (224 GM per 28 days)
<i>diclofenac-misoprostol oral tablet,ir, delayed rel,biphasic 50-200 mg-mcg, 75-200 mg-mcg</i>	2	
<i>diflunisal oral tablet 500 mg</i>	2	
<i>etodolac oral capsule 200 mg, 300 mg</i>	2	
<i>etodolac oral tablet 400 mg, 500 mg</i>	2	
<i>etodolac oral tablet extended release 24 hr 400 mg, 500 mg, 600 mg</i>	2	
<i>flurbiprofen oral tablet 100 mg</i>	2	
<i>ibu oral tablet 600 mg, 800 mg</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>ibuprofen oral suspension 100 mg/5 ml</i>	2	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
<i>meloxicam oral tablet 15 mg</i>	1	QL (30 EA per 30 days)
<i>meloxicam oral tablet 7.5 mg</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	
<i>naloxone injection solution 0.4 mg/ml</i>	2	
<i>naloxone injection syringe 0.4 mg/ml, 1 mg/ml</i>	2	
<i>naloxone nasal spray,non-aerosol 4 mg/actuation</i>	2	
<i>naltrexone oral tablet 50 mg</i>	2	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet,delayed release (dr/ec) 375 mg</i>	2	QL (120 EA per 30 days)
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	
<i>oxaprozin oral tablet 600 mg</i>	2	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	
<i>sulindac oral tablet 150 mg, 200 mg</i>	2	
<i>tramadol oral tablet 50 mg</i>	2	QL (240 EA per 30 days)
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	2	QL (240 EA per 30 days)
VIVITROL INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 380 MG	5^	
PSYCHOTHERAPEUTIC DRUGS		
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	QL (150 EA per 30 days)
<i>amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	4	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	4	
<i>aripiprazole oral solution 1 mg/ml</i>	4	QL (900 ML per 30 days)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	4	QL (30 EA per 30 days)
<i>aripiprazole oral tablet,disintegrating 10 mg, 15 mg</i>	4	QL (60 EA per 30 days)
ARISTADA INITIO INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 675 MG/2.4 ML	5^	QL (4.8 ML per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	5^	QL (3.9 ML per 56 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	5^	QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	5^	QL (2.4 ML per 28 days)

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Drug Name	Drug Tier	Requirements / Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	5^	QL (3.2 ML per 28 days)
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	2	PA; QL (30 EA per 30 days)
<i>armodafinil oral tablet 50 mg</i>	2	PA; QL (60 EA per 30 days)
<i>asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg</i>	2	QL (60 EA per 30 days)
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	2	QL (60 EA per 30 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	2	QL (30 EA per 30 days)
AUVELITY ORAL TABLET, IR AND ER, BIPHASIC 45-105 MG	5^	ST; QL (60 EA per 30 days)
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	3	QL (30 EA per 30 days)
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	2	QL (90 EA per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	2	QL (30 EA per 30 days)
<i>bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg</i>	2	QL (60 EA per 30 days)
<i>bupirone oral tablet 10 mg, 15 mg, 5 mg</i>	1	
<i>bupirone oral tablet 30 mg, 7.5 mg</i>	2	
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	5^	QL (30 EA per 30 days)
<i>chlorpromazine oral concentrate 100 mg/ml, 30 mg/ml</i>	4	
<i>chlorpromazine oral tablet 10 mg, 50 mg</i>	2	
<i>chlorpromazine oral tablet 100 mg, 200 mg, 25 mg</i>	4	
<i>citalopram oral solution 10 mg/5 ml</i>	2	
<i>citalopram oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>clomipramine oral capsule 25 mg, 50 mg, 75 mg</i>	4	PA-NS
<i>clorazepate dipotassium oral tablet 15 mg</i>	4	PA-NS; QL (180 EA per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	4	PA-NS; QL (90 EA per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	4	PA-NS; QL (360 EA per 30 days)
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>clozapine oral tablet,disintegrating 100 mg</i>	4	QL (270 EA per 30 days)
<i>clozapine oral tablet,disintegrating 12.5 mg, 25 mg</i>	4	
<i>clozapine oral tablet,disintegrating 150 mg</i>	4	QL (180 EA per 30 days)
<i>clozapine oral tablet,disintegrating 200 mg</i>	4	QL (120 EA per 30 days)
<i>desipramine oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	4	
<i>desvenlafaxine succinate oral tablet extended release 24 hr 100 mg, 25 mg, 50 mg</i>	2	QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	QL (60 EA per 30 days)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	2	QL (60 EA per 30 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	2	QL (90 EA per 30 days)
<i>diazepam intensol oral concentrate 5 mg/ml</i>	2	PA-NS; QL (240 ML per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	PA-NS; QL (1200 ML per 30 days)
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	2	PA-NS; QL (120 EA per 30 days)
<i>doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	4	
<i>doxepin oral concentrate 10 mg/ml</i>	4	
<i>doxepin oral tablet 3 mg, 6 mg</i>	4	QL (30 EA per 30 days)
<i>duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 40 mg, 60 mg</i>	2	QL (60 EA per 30 days)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR	5^	QL (30 EA per 30 days)
<i>escitalopram oxalate oral solution 5 mg/5 ml</i>	2	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5^	ST; QL (60 EA per 30 days)
FANAPT ORAL TABLETS,DOSE PACK 1MG(2)-2MG(2)-4MG(2)-6MG(2)	4	ST; QL (8 EA per 180 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	3	QL (28 EA per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG	3	QL (30 EA per 30 days)
<i>fluoxetine oral capsule 10 mg, 20 mg, 40 mg</i>	1	
<i>fluoxetine oral solution 20 mg/5 ml (4 mg/ml)</i>	2	
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	2	
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	2	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	2	
<i>fluphenazine hcl oral elixir 2.5 mg/5 ml</i>	2	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	2	
<i>fluvoxamine oral tablet 100 mg, 25 mg, 50 mg</i>	2	
<i>guanfacine oral tablet extended release 24 hr 1 mg, 2 mg, 4 mg</i>	4	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements / Limits
<i>guanfacine oral tablet extended release 24 hr 3 mg</i>	4	QL (60 EA per 30 days)
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml (1 ml), 50 mg/ml, 50 mg/ml(1ml)</i>	2	
<i>haloperidol lactate injection solution 5 mg/ml</i>	2	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	2	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	2	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	2	
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	5^	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	5^	QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5^	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5^	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5^	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5^	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	5^	QL (0.88 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	5^	QL (1.32 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5^	QL (1.75 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	5^	QL (2.63 ML per 90 days)
<i>lisdexamfetamine oral capsule 10 mg, 20 mg, 30 mg</i>	4	QL (60 EA per 30 days)
<i>lisdexamfetamine oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	4	QL (30 EA per 30 days)
<i>lisdexamfetamine oral tablet, chewable 10 mg, 20 mg, 30 mg</i>	4	QL (60 EA per 30 days)
<i>lisdexamfetamine oral tablet, chewable 40 mg, 50 mg, 60 mg</i>	4	QL (30 EA per 30 days)
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	1	
<i>lithium carbonate oral tablet 300 mg</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>lithium carbonate oral tablet extended release 300 mg, 450 mg</i>	2	
<i>lithium citrate oral solution 8 meq/5 ml</i>	2	
<i>lorazepam intensol oral concentrate 2 mg/ml</i>	2	QL (150 ML per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	QL (150 EA per 30 days)
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	4	QL (30 EA per 30 days)
<i>lurasidone oral tablet 80 mg</i>	4	QL (60 EA per 30 days)
MARPLAN ORAL TABLET 10 MG	4	
<i>methylphenidate hcl oral solution 10 mg/5 ml</i>	2	QL (900 ML per 30 days)
<i>methylphenidate hcl oral solution 5 mg/5 ml</i>	2	QL (1800 ML per 30 days)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	2	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet extended release 10 mg, 20 mg</i>	2	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet, chewable 10 mg, 2.5 mg, 5 mg</i>	2	QL (180 EA per 30 days)
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	1	
<i>mirtazapine oral tablet, disintegrating 15 mg, 30 mg, 45 mg</i>	2	
<i>modafinil oral tablet 100 mg</i>	2	PA; QL (30 EA per 30 days)
<i>modafinil oral tablet 200 mg</i>	2	PA; QL (60 EA per 30 days)
<i>molindone oral tablet 10 mg, 25 mg, 5 mg</i>	2	
<i>nefazodone oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	2	
<i>nortriptyline oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>nortriptyline oral solution 10 mg/5 ml</i>	4	
NUPLAZID ORAL CAPSULE 34 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 10 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
<i>olanzapine intramuscular recon soln 10 mg</i>	2	QL (3 EA per 1 day)
<i>olanzapine oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	QL (60 EA per 30 days)
<i>olanzapine oral tablet 15 mg, 20 mg, 7.5 mg</i>	2	QL (30 EA per 30 days)
<i>olanzapine oral tablet, disintegrating 10 mg</i>	4	QL (60 EA per 30 days)
<i>olanzapine oral tablet, disintegrating 15 mg, 20 mg, 5 mg</i>	4	QL (30 EA per 30 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	4	QL (30 EA per 30 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	4	QL (60 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>paroxetine hcl oral suspension 10 mg/5 ml</i>	4	QL (900 ML per 30 days)
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	2	QL (30 EA per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	2	QL (60 EA per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr 12.5 mg, 25 mg, 37.5 mg</i>	4	QL (60 EA per 30 days)
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	2	
<i>phenelzine oral tablet 15 mg</i>	2	
<i>pimozide oral tablet 1 mg, 2 mg</i>	2	
<i>protriptyline oral tablet 10 mg, 5 mg</i>	4	
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	2	
QUETIAPINE ORAL TABLET 150 MG	2	
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	2	QL (30 EA per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	2	QL (60 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5^	QL (30 EA per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	5^	QL (2 EA per 28 days)
<i>risperidone oral solution 1 mg/ml</i>	2	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg</i>	2	QL (90 EA per 30 days)
<i>risperidone oral tablet,disintegrating 1 mg, 2 mg, 3 mg</i>	2	QL (60 EA per 30 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	2	QL (120 EA per 30 days)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HOUR, 5.7 MG/24 HOUR, 7.6 MG/24 HOUR	5^	QL (30 EA per 30 days)
<i>sertraline oral concentrate 20 mg/ml</i>	2	
<i>sertraline oral tablet 100 mg, 25 mg, 50 mg</i>	1	
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	5^	PA; LA; QL (540 ML per 30 days)
<i>temazepam oral capsule 15 mg</i>	4	PA; QL (60 EA per 30 days)
<i>temazepam oral capsule 30 mg, 7.5 mg</i>	4	PA; QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>thioridazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	2	
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
<i>tranylcypromine oral tablet 10 mg</i>	2	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	1	
<i>trifluoperazine oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
<i>trimipramine oral capsule 100 mg, 25 mg, 50 mg</i>	4	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	3	QL (30 EA per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg, 75 mg</i>	1	
<i>venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	
VERSACLOZ ORAL SUSPENSION 50 MG/ML	5^	PA-NS; QL (600 ML per 30 days)
<i>vilazodone oral tablet 10 mg, 20 mg, 40 mg</i>	2	QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	5^	QL (30 EA per 30 days)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	2	QL (60 EA per 30 days)
<i>ziprasidone mesylate intramuscular recon soln 20 mg/ml (final conc.)</i>	2	
<i>zolpidem oral tablet 10 mg, 5 mg</i>	2	QL (30 EA per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	5^	PA-NS; QL (28 EA per 365 days)
ZURZUVAE ORAL CAPSULE 30 MG	5^	PA-NS; QL (14 EA per 365 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	4	PA-NS; QL (2 EA per 28 days)
CARDIOVASCULAR, HYPERTENSION / LIPIDS		
ANTIARRHYTHMIC AGENTS		
<i>amiodarone oral tablet 100 mg, 400 mg</i>	2	
<i>amiodarone oral tablet 200 mg</i>	1	
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	4	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	2	
<i>flecainide oral tablet 100 mg, 150 mg, 50 mg</i>	2	
<i>mexiletine oral capsule 150 mg, 200 mg, 250 mg</i>	4	
MULTAQ ORAL TABLET 400 MG	4	
<i>pacerone oral tablet 100 mg, 400 mg</i>	2	
<i>pacerone oral tablet 200 mg</i>	1	
<i>propafenone oral capsule,extended release 12 hr 225 mg, 325 mg, 425 mg</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>propafenone oral tablet 150 mg, 225 mg, 300 mg</i>	2	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	2	
<i>sotalol af oral tablet 120 mg, 160 mg, 80 mg</i>	2	
<i>sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
ANTIHYPERTENSIVE THERAPY		
<i>acebutolol oral capsule 200 mg, 400 mg</i>	2	
<i>aliskiren oral tablet 150 mg, 300 mg</i>	2	
<i>amiloride oral tablet 5 mg</i>	1	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
<i>amlodipine oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	6	
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	6	QL (30 EA per 30 days)
<i>amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	6	QL (30 EA per 30 days)
<i>amlodipine-valsartan-hcthiazyd oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	6	QL (30 EA per 30 days)
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
<i>benazepril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	6	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	6	
<i>betaxolol oral tablet 10 mg, 20 mg</i>	2	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	
<i>bumetanide injection solution 0.25 mg/ml</i>	2	
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>candesartan oral tablet 16 mg, 4 mg, 8 mg</i>	6	QL (60 EA per 30 days)
<i>candesartan oral tablet 32 mg</i>	6	QL (30 EA per 30 days)
<i>candesartan-hydrochlorothiazid oral tablet 16-12.5 mg</i>	6	QL (60 EA per 30 days)
<i>candesartan-hydrochlorothiazid oral tablet 32-12.5 mg, 32-25 mg</i>	6	QL (30 EA per 30 days)
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	6	

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Drug Name	Drug Tier	Requirements / Limits
<i>cartia xt oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr</i>	2	
<i>diltiazem hcl oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg</i>	2	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	2	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	
<i>diltiazem hcl oral tablet extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>dilt-xr oral capsule,ext.rel 24h degradable 120 mg, 180 mg, 240 mg</i>	2	
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
EDARBI ORAL TABLET 40 MG, 80 MG	3	QL (30 EA per 30 days)
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	3	QL (30 EA per 30 days)
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	6	
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	6	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>felodipine oral tablet extended release 24 hr 10 mg, 2.5 mg, 5 mg</i>	2	
<i>fosinopril oral tablet 10 mg, 20 mg, 40 mg</i>	6	
<i>fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg</i>	6	
<i>furosemide injection solution 10 mg/ml</i>	2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>guanfacine oral tablet 1 mg, 2 mg</i>	4	
<i>hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	2	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	6	QL (30 EA per 30 days)
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg</i>	6	QL (60 EA per 30 days)
<i>irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg</i>	6	QL (30 EA per 30 days)
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	2	
KERENDIA ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	2	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	6	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	6	
<i>losartan oral tablet 100 mg</i>	6	QL (30 EA per 30 days)
<i>losartan oral tablet 25 mg, 50 mg</i>	6	QL (60 EA per 30 days)
<i>losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg</i>	6	QL (30 EA per 30 days)
<i>losartan-hydrochlorothiazide oral tablet 50-12.5 mg</i>	6	QL (60 EA per 30 days)
<i>matzim la oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
<i>metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	2	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	
<i>metyrosine oral capsule 250 mg</i>	5^	PA
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	2	
<i>moexipril oral tablet 15 mg, 7.5 mg</i>	6	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>nebivolol oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>nebivolol oral tablet 20 mg</i>	2	QL (60 EA per 30 days)
<i>nicardipine oral capsule 20 mg, 30 mg</i>	2	
<i>nifedipine oral tablet extended release 24hr 30 mg, 60 mg, 90 mg</i>	2	
<i>nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg</i>	2	
<i>nimodipine oral capsule 30 mg</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>olmesartan oral tablet 20 mg, 40 mg</i>	6	QL (30 EA per 30 days)
<i>olmesartan oral tablet 5 mg</i>	6	QL (60 EA per 30 days)
<i>olmesartan-amlodipin-hcthiazyd oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	6	QL (30 EA per 30 days)
<i>olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	6	QL (30 EA per 30 days)
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	6	
<i>pindolol oral tablet 10 mg, 5 mg</i>	2	
<i>prazosin oral capsule 1 mg, 2 mg, 5 mg</i>	2	
<i>propranolol oral capsule,extended release 24 hr 120 mg, 160 mg, 60 mg, 80 mg</i>	2	
<i>propranolol oral solution 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml)</i>	2	
<i>propranolol oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	2	
<i>quinapril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	6	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	6	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolacton-hydrochlorothiaz oral tablet 25-25 mg</i>	2	
<i>taztia xt oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	6	QL (30 EA per 30 days)
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	6	QL (30 EA per 30 days)
<i>telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-25 mg</i>	6	QL (30 EA per 30 days)
<i>telmisartan-hydrochlorothiazid oral tablet 80-12.5 mg</i>	6	QL (60 EA per 30 days)
<i>terazosin oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
<i>tiadylt er oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	6	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg</i>	1	
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	6	QL (60 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>valsartan oral tablet 320 mg</i>	6	QL (30 EA per 30 days)
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	6	QL (30 EA per 30 days)
<i>verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg</i>	2	
<i>verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg, 360 mg</i>	2	
<i>verapamil oral tablet 120 mg, 40 mg, 80 mg</i>	1	
<i>verapamil oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	
COAGULATION THERAPY		
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg</i>	2	
BRILINTA ORAL TABLET 60 MG, 90 MG	3	
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	
<i>clopidogrel oral tablet 75 mg</i>	1	
<i>dabigatran etexilate oral capsule 110 mg, 150 mg, 75 mg</i>	2	QL (60 EA per 30 days)
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	4	
DOPTELET (10 TAB PACK) ORAL TABLET 20 MG	5^	PA; LA
DOPTELET (15 TAB PACK) ORAL TABLET 20 MG	5^	PA; LA
DOPTELET (30 TAB PACK) ORAL TABLET 20 MG	5^	PA; LA
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 5 MG (74 TABS)	3	QL (74 EA per 180 days)
ELIQUIS ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (74 EA per 30 days)
<i>enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	4	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	5^	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	2	
<i>heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml</i>	2	
<i>jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
<i>pentoxifylline oral tablet extended release 400 mg</i>	1	
<i>prasugrel oral tablet 10 mg, 5 mg</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements / Limits
PROMACTA ORAL POWDER IN PACKET 12.5 MG	5^	PA; LA; QL (360 EA per 30 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	5^	PA; LA; QL (180 EA per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	5^	PA; LA; QL (30 EA per 30 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	5^	PA; LA; QL (60 EA per 30 days)
<i>warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9)	3	QL (51 EA per 180 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION 1 MG/ML	3	QL (775 ML per 28 days)
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (60 EA per 30 days)
LIPID/CHOLESTEROL LOWERING AGENTS		
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	6	QL (30 EA per 30 days)
<i>atorvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	6	QL (30 EA per 30 days)
<i>cholestyramine (with sugar) oral powder in packet 4 gram</i>	2	
<i>cholestyramine light oral powder in packet 4 gram</i>	2	
<i>colesevelam oral powder in packet 3.75 gram</i>	2	
<i>colesevelam oral tablet 625 mg</i>	2	
<i>colestipol oral packet 5 gram</i>	2	
<i>colestipol oral tablet 1 gram</i>	2	
<i>ezetimibe oral tablet 10 mg</i>	1	
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	6	QL (30 EA per 30 days)
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	2	
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	2	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	2	
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec) 135 mg, 45 mg</i>	2	
<i>fluvastatin oral capsule 20 mg, 40 mg</i>	6	QL (60 EA per 30 days)
<i>fluvastatin oral tablet extended release 24 hr 80 mg</i>	6	QL (30 EA per 30 days)
<i>gemfibrozil oral tablet 600 mg</i>	1	
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	6	QL (60 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>niacin oral tablet extended release 24 hr 1,000 mg, 500 mg, 750 mg</i>	2	
<i>pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg</i>	4	QL (30 EA per 30 days)
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML	3	PA
<i>pravastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	6	QL (30 EA per 30 days)
<i>prevalite oral powder in packet 4 gram</i>	2	
<i>rosuvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	6	QL (30 EA per 30 days)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i>	6	QL (30 EA per 30 days)
VASCEPA ORAL CAPSULE 0.5 GRAM, 1 GRAM	4	
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CORLANOR ORAL SOLUTION 5 MG/5 ML	3	QL (450 ML per 30 days)
CORLANOR ORAL TABLET 5 MG, 7.5 MG	3	QL (60 EA per 30 days)
<i>digoxin oral solution 50 mcg/ml (0.05 mg/ml)</i>	2	
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg), 62.5 mcg (0.0625 mg)</i>	2	QL (60 EA per 30 days)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	3	QL (60 EA per 30 days)
<i>ranolazine oral tablet extended release 12 hr 1,000 mg, 500 mg</i>	4	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	3	QL (30 EA per 30 days)
VYNDAQEL ORAL CAPSULE 20 MG	5^	PA
NITRATES		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	2	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	1	
<i>isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg</i>	1	
<i>nitro-bid transdermal ointment 2 %</i>	4	
<i>nitroglycerin sublingual tablet 0.3 mg, 0.4 mg, 0.6 mg</i>	2	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	2	
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	4	
<i>calcipotriene scalp solution 0.005 %</i>	4	QL (120 ML per 30 days)
<i>calcipotriene topical ointment 0.005 %</i>	4	QL (120 GM per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE 150 MG/ML	5^	PA; QL (10 ML per 28 days)
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR 150 MG/ML	5^	PA; QL (10 ML per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5^	PA; QL (2.5 ML per 28 days)
COSENTYX UNOREADY PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML (150 MG/ML)	5^	PA; QL (10 ML per 28 days)
<i>selenium sulfide topical lotion 2.5 %</i>	2	
SKYRIZI SUBCUTANEOUS PEN INJECTOR 150 MG/ML	5^	PA; QL (6 ML per 365 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	5^	PA; QL (6 ML per 365 days)
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	5^	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5^	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	5^	PA; QL (1 ML per 28 days)
TREMFYA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	5^	PA; QL (2 ML per 28 days)
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML	5^	PA; QL (2 ML per 28 days)
MISCELLANEOUS DERMATOLOGICALS		
<i>ammonium lactate topical cream 12 %</i>	2	
<i>ammonium lactate topical lotion 12 %</i>	2	
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	5^	PA; QL (4.56 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5^	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	5^	PA; QL (1.34 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5^	PA; QL (4.56 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5^	PA; QL (8 ML per 28 days)
<i>fluorouracil topical cream 5 %</i>	2	QL (40 GM per 30 days)
<i>fluorouracil topical solution 2 %, 5 %</i>	2	QL (10 ML per 30 days)
<i>imiquimod topical cream in packet 5 %</i>	2	QL (24 EA per 28 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	4	QL (50 ML per 30 days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	4	PA; QL (90 EA per 30 days)
<i>lidocaine topical ointment 5 %</i>	2	QL (50 GM per 30 days)
<i>lidocaine viscous mucous membrane solution 2 %</i>	2	
<i>lidocaine-prilocaine topical cream 2.5-2.5 %</i>	2	QL (30 GM per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>lidocan iii topical adhesive patch,medicated 5 %</i>	4	PA; QL (90 EA per 30 days)
PANRETIN TOPICAL GEL 0.1 %	5^	PA-NS; QL (60 GM per 30 days)
<i>pimecrolimus topical cream 1 %</i>	4	QL (100 GM per 30 days)
<i>podofilox topical solution 0.5 %</i>	4	QL (7 ML per 28 days)
REGRANEX TOPICAL GEL 0.01 %	5^	QL (15 GM per 30 days)
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM	4	QL (180 GM per 30 days)
<i>silver sulfadiazine topical cream 1 %</i>	2	
<i>ssd topical cream 1 %</i>	2	
<i>tacrolimus topical ointment 0.03 %, 0.1 %</i>	4	QL (100 GM per 30 days)
<i>tridacaine topical adhesive patch,medicated 5 %</i>	4	PA; QL (90 EA per 30 days)
VALCHLOR TOPICAL GEL 0.016 %	5^	PA-NS; LA; QL (60 GM per 30 days)
THERAPY FOR ACNE		
<i>acutane oral capsule 10 mg, 20 mg, 40 mg</i>	2	
<i>amnesteem oral capsule 10 mg, 20 mg, 40 mg</i>	2	
<i>azelaic acid topical gel 15 %</i>	4	QL (50 GM per 30 days)
<i>claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
<i>clindamycin phosphate topical gel 1 %</i>	4	QL (75 GM per 30 days)
<i>clindamycin phosphate topical gel, once daily 1 %</i>	4	QL (75 ML per 30 days)
<i>clindamycin phosphate topical lotion 1 %</i>	4	QL (60 ML per 30 days)
<i>clindamycin phosphate topical solution 1 %</i>	2	QL (60 ML per 30 days)
<i>ery pads topical swab 2 %</i>	4	QL (60 EA per 30 days)
<i>erythromycin with ethanol topical solution 2 %</i>	2	QL (60 ML per 30 days)
<i>isotretinoin oral capsule 10 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg</i>	4	
<i>metronidazole topical cream 0.75 %</i>	4	QL (45 GM per 30 days)
<i>metronidazole topical gel 0.75 %</i>	4	QL (45 GM per 30 days)
<i>metronidazole topical lotion 0.75 %</i>	4	QL (59 ML per 30 days)
<i>tazarotene topical cream 0.1 %</i>	3	PA; QL (60 GM per 30 days)
<i>tazarotene topical gel 0.05 %, 0.1 %</i>	4	PA
<i>tretinoin topical cream 0.025 %, 0.05 %, 0.1 %</i>	4	PA; QL (45 GM per 30 days)
<i>tretinoin topical gel 0.01 %, 0.025 %, 0.05 %</i>	4	PA; QL (45 GM per 30 days)
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
TOPICAL ANTIBACTERIALS		
<i>gentamicin topical cream 0.1 %</i>	2	QL (30 GM per 30 days)
<i>gentamicin topical ointment 0.1 %</i>	4	QL (30 GM per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>mupirocin topical ointment 2 %</i>	1	QL (44 GM per 30 days)
<i>sulfacetamide sodium (acne) topical suspension 10 %</i>	4	
TOPICAL ANTIFUNGALS		
<i>ciclopirox topical cream 0.77 %</i>	2	QL (90 GM per 28 days)
<i>ciclopirox topical gel 0.77 %</i>	2	QL (100 GM per 28 days)
<i>ciclopirox topical suspension 0.77 %</i>	4	QL (60 ML per 28 days)
<i>clotrimazole topical cream 1 %</i>	2	QL (45 GM per 28 days)
<i>clotrimazole topical solution 1 %</i>	2	QL (30 ML per 28 days)
<i>clotrimazole-betamethasone topical cream 1-0.05 %</i>	2	QL (45 GM per 28 days)
<i>clotrimazole-betamethasone topical lotion 1-0.05 %</i>	4	QL (60 ML per 28 days)
<i>ketconazole topical cream 2 %</i>	2	QL (60 GM per 28 days)
<i>ketconazole topical shampoo 2 %</i>	1	QL (120 ML per 28 days)
<i>naftifine topical cream 1 %</i>	4	QL (90 GM per 28 days)
<i>naftifine topical cream 2 %</i>	4	QL (60 GM per 28 days)
<i>naftifine topical gel 2 %</i>	4	QL (60 GM per 28 days)
<i>nyamyc topical powder 100,000 unit/gram</i>	2	QL (120 GM per 30 days)
<i>nystatin topical cream 100,000 unit/gram</i>	2	QL (30 GM per 28 days)
<i>nystatin topical ointment 100,000 unit/gram</i>	2	QL (30 GM per 28 days)
<i>nystatin topical powder 100,000 unit/gram</i>	2	QL (120 GM per 30 days)
<i>nystop topical powder 100,000 unit/gram</i>	2	QL (120 GM per 30 days)
TOPICAL CORTICOSTEROIDS		
<i>ala-cort topical cream 1 %, 2.5 %</i>	1	
<i>alclometasone topical cream 0.05 %</i>	4	QL (120 GM per 30 days)
<i>alclometasone topical ointment 0.05 %</i>	4	QL (120 GM per 30 days)
<i>betamethasone dipropionate topical cream 0.05 %</i>	2	QL (135 GM per 30 days)
<i>betamethasone dipropionate topical lotion 0.05 %</i>	2	QL (120 ML per 30 days)
<i>betamethasone dipropionate topical ointment 0.05 %</i>	4	QL (135 GM per 30 days)
<i>betamethasone valerate topical cream 0.1 %</i>	2	QL (135 GM per 30 days)
<i>betamethasone valerate topical lotion 0.1 %</i>	4	QL (120 ML per 30 days)
<i>betamethasone valerate topical ointment 0.1 %</i>	2	QL (135 GM per 30 days)
<i>betamethasone, augmented topical cream 0.05 %</i>	2	QL (150 GM per 30 days)
<i>betamethasone, augmented topical gel 0.05 %</i>	2	QL (150 GM per 30 days)
<i>betamethasone, augmented topical lotion 0.05 %</i>	2	QL (120 ML per 30 days)
<i>betamethasone, augmented topical ointment 0.05 %</i>	2	QL (150 GM per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>clobetasol scalp solution 0.05 %</i>	2	QL (100 ML per 28 days)
<i>clobetasol topical cream 0.05 %</i>	2	QL (120 GM per 28 days)
<i>clobetasol topical gel 0.05 %</i>	4	QL (60 GM per 28 days)
<i>clobetasol topical ointment 0.05 %</i>	2	QL (120 GM per 28 days)
<i>clobetasol topical shampoo 0.05 %</i>	4	QL (118 ML per 28 days)
<i>clobetasol-emollient topical cream 0.05 %</i>	4	QL (120 GM per 28 days)
<i>clodan topical shampoo 0.05 %</i>	4	QL (118 ML per 28 days)
<i>desonide topical cream 0.05 %</i>	2	QL (120 GM per 30 days)
<i>desonide topical lotion 0.05 %</i>	4	QL (118 ML per 30 days)
<i>desonide topical ointment 0.05 %</i>	2	QL (120 GM per 30 days)
<i>fluocinolone and shower cap scalp oil 0.01 %</i>	2	QL (118.28 ML per 30 days)
<i>fluocinolone topical cream 0.01 %, 0.025 %</i>	4	QL (120 GM per 30 days)
<i>fluocinolone topical ointment 0.025 %</i>	4	QL (120 GM per 30 days)
<i>fluocinolone topical solution 0.01 %</i>	2	QL (120 ML per 30 days)
<i>fluocinonide topical cream 0.05 %</i>	4	QL (120 GM per 30 days)
<i>fluocinonide topical gel 0.05 %</i>	4	QL (120 GM per 30 days)
<i>fluocinonide topical ointment 0.05 %</i>	2	QL (120 GM per 30 days)
<i>fluocinonide topical solution 0.05 %</i>	2	QL (120 ML per 30 days)
<i>fluocinonide-emollient topical cream 0.05 %</i>	4	QL (120 GM per 30 days)
<i>fluticasone propionate topical cream 0.05 %</i>	2	
<i>halobetasol propionate topical cream 0.05 %</i>	2	QL (100 GM per 30 days)
<i>halobetasol propionate topical ointment 0.05 %</i>	4	QL (100 GM per 30 days)
<i>hydrocortisone topical cream 1 %</i>	1	
<i>hydrocortisone topical lotion 2.5 %</i>	2	
<i>hydrocortisone topical ointment 2.5 %</i>	2	
<i>mometasone topical cream 0.1 %</i>	2	
<i>mometasone topical ointment 0.1 %</i>	2	
<i>mometasone topical solution 0.1 %</i>	2	
<i>triamcinolone acetonide topical cream 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triamcinolone acetonide topical lotion 0.025 %, 0.1 %</i>	2	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triderm topical cream 0.5 %</i>	2	
TOPICAL SCABICIDES / PEDICULICIDES		
<i>malathion topical lotion 0.5 %</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>permethrin topical cream 5 %</i>	2	QL (60 GM per 30 days)
DIAGNOSTICS / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
<i>acamprosate oral tablet, delayed release (dr/ec) 333 mg</i>	2	
<i>anagrelide oral capsule 0.5 mg, 1 mg</i>	2	
<i>carglumic acid oral tablet, dispersible 200 mg</i>	5^	PA; LA
<i>cevimeline oral capsule 30 mg</i>	2	
CHEMET ORAL CAPSULE 100 MG	4	
CLINIMIX 4.25%/D5W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %	4	B/D
<i>d10 %-0.45 % sodium chloride intravenous parenteral solution</i>	2	
<i>d2.5 %-0.45 % sodium chloride intravenous parenteral solution</i>	4	
<i>d5 % and 0.9 % sodium chloride intravenous parenteral solution</i>	2	
<i>d5 %-0.45 % sodium chloride intravenous parenteral solution</i>	2	
<i>deferasirox oral granules in packet 180 mg, 360 mg, 90 mg</i>	5^	PA
<i>deferasirox oral tablet 180 mg, 360 mg</i>	4	PA
<i>deferasirox oral tablet 90 mg</i>	2	PA
<i>deferasirox oral tablet, dispersible 125 mg</i>	4	PA
<i>deferasirox oral tablet, dispersible 250 mg, 500 mg</i>	5^	PA
<i>dextrose 10 % and 0.2 % nacl intravenous parenteral solution</i>	4	
<i>dextrose 10 % in water (d10w) intravenous parenteral solution 10 %</i>	2	
<i>dextrose 5 % in water (d5w) intravenous piggyback 5 %</i>	2	
<i>dextrose 5%-0.2 % sod chloride intravenous parenteral solution</i>	2	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	2	
<i>droxidopa oral capsule 100 mg</i>	5^	PA; QL (90 EA per 30 days)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	5^	PA; QL (180 EA per 30 days)
ENDARI ORAL POWDER IN PACKET 5 GRAM	5^	PA; LA
INCRELEX SUBCUTANEOUS SOLUTION 10 MG/ML	5^	PA; LA
<i>levocarnitine (with sugar) oral solution 100 mg/ml</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>levocarnitine oral tablet 330 mg</i>	2	
LOKELMA ORAL POWDER IN PACKET 10 GRAM, 5 GRAM	3	
<i>midodrine oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	5^	PA
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	2	
PROLASTIN-C INTRAVENOUS SOLUTION 1,000 MG (+-)/20 ML	5^	PA; LA
<i>riluzole oral tablet 50 mg</i>	2	
<i>risedronate oral tablet 30 mg</i>	2	QL (30 EA per 30 days)
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	2	
<i>sodium chloride irrigation solution 0.9 %</i>	2	
<i>sodium phenylbutyrate oral powder 0.94 gram/gram</i>	5^	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	5^	PA
<i>sodium polystyrene sulfonate oral powder</i>	2	
<i>sps (with sorbitol) oral suspension 15-20 gram/60 ml</i>	2	
<i>trientine oral capsule 250 mg</i>	5^	PA
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deter) oral tablet extended release 12 hr 150 mg</i>	2	
NICOTROL INHALATION CARTRIDGE 10 MG	4	
NICOTROL NS NASAL SPRAY, NON-AEROSOL 10 MG/ML	3	
<i>varenicline oral tablet 0.5 mg, 1 mg, 1 mg (56 pack)</i>	2	
<i>varenicline oral tablets, dose pack 0.5 mg (11)- 1 mg (42)</i>	2	
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
<i>azelastine nasal spray, non-aerosol 137 mcg (0.1 %)</i>	2	QL (60 ML per 30 days)
<i>chlorhexidine gluconate mucous membrane mouthwash 0.12 %</i>	1	
<i>ipratropium bromide nasal spray, non-aerosol 21 mcg (0.03 %)</i>	2	QL (30 ML per 30 days)
<i>ipratropium bromide nasal spray, non-aerosol 42 mcg (0.06 %)</i>	2	QL (45 ML per 30 days)
<i>kourzeq dental paste 0.1 %</i>	3	
<i>olopatadine nasal spray, non-aerosol 0.6 %</i>	2	
<i>perio gard mucous membrane mouthwash 0.12 %</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements / Limits
<i>triamcinolone acetonide dental paste 0.1 %</i>	4	
MISCELLANEOUS OTIC PREPARATIONS		
<i>acetic acid otic (ear) solution 2 %</i>	2	
<i>flac otic oil otic (ear) drops 0.01 %</i>	2	
<i>fluocinolone acetonide oil otic (ear) drops 0.01 %</i>	2	
<i>ofloxacin otic (ear) drops 0.3 %</i>	2	
OTIC STEROID / ANTIBIOTIC		
<i>ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %</i>	4	QL (7.5 ML per 7 days)
<i>neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%</i>	2	
<i>neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%</i>	2	
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
<i>dexamethasone oral solution 0.5 mg/5 ml</i>	2	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	2	
<i>fludrocortisone oral tablet 0.1 mg</i>	2	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	2	B/D
<i>methylprednisolone oral tablets,dose pack 4 mg</i>	2	
<i>prednisolone oral solution 15 mg/5 ml</i>	2	
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	2	
<i>prednisone intensol oral concentrate 5 mg/ml</i>	4	
<i>prednisone oral solution 5 mg/5 ml</i>	4	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	1	
<i>prednisone oral tablets,dose pack 10 mg, 10 mg (48 pack), 5 mg, 5 mg (48 pack)</i>	2	
ANTITHYROID AGENTS		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	
<i>propylthiouracil oral tablet 50 mg</i>	2	
DIABETES THERAPY		
<i>acarbose oral tablet 100 mg</i>	6	QL (90 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>acarbose oral tablet 25 mg</i>	6	QL (360 EA per 30 days)
<i>acarbose oral tablet 50 mg</i>	6	QL (180 EA per 30 days)
<i>alcohol pads topical pads, medicated</i>	2	
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85 ML	3	PA; QL (3.4 ML per 28 days)
<i>diazoxide oral suspension 50 mg/ml</i>	5^	
FARXIGA ORAL TABLET 10 MG, 5 MG	3	QL (30 EA per 30 days)
<i>glimepiride oral tablet 1 mg</i>	6	QL (240 EA per 30 days)
<i>glimepiride oral tablet 2 mg</i>	6	QL (120 EA per 30 days)
<i>glimepiride oral tablet 4 mg</i>	6	QL (60 EA per 30 days)
<i>glipizide oral tablet 10 mg</i>	6	QL (120 EA per 30 days)
<i>glipizide oral tablet 5 mg</i>	6	QL (240 EA per 30 days)
<i>glipizide oral tablet extended release 24hr 10 mg</i>	6	QL (60 EA per 30 days)
<i>glipizide oral tablet extended release 24hr 2.5 mg</i>	6	QL (240 EA per 30 days)
<i>glipizide oral tablet extended release 24hr 5 mg</i>	6	QL (120 EA per 30 days)
<i>glipizide-metformin oral tablet 2.5-250 mg</i>	6	QL (240 EA per 30 days)
<i>glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	6	QL (120 EA per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	3	QL (30 EA per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML	3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	3	
GVOKE SUBCUTANEOUS SOLUTION 1 MG/0.2 ML	3	
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION 500 UNIT/ML	3	
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML)	3	
INSULIN ASP PRT-INSULIN ASPART SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	
INSULIN ASP PRT-INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	3	
INSULIN ASPART U-100 SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	3	
INSULIN ASPART U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	
INSULIN ASPART U-100 SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	

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Drug Name	Drug Tier	Requirements / Limits
INSULIN DEGLUDEC SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML), 200 UNIT/ML (3 ML)	3	
INSULIN DEGLUDEC SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
INSULIN GLARGINE U-300 CONC SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML), 300 UNIT/ML (3 ML)	3	
INSULIN GLARGINE-YFGN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG	4	QL (60 EA per 30 days)
INVOKAMET ORAL TABLET 50-500 MG	4	QL (120 EA per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG	4	QL (60 EA per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 50-500 MG	4	QL (120 EA per 30 days)
INVOKANA ORAL TABLET 100 MG	4	QL (60 EA per 30 days)
INVOKANA ORAL TABLET 300 MG	4	QL (30 EA per 30 days)
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	QL (30 EA per 30 days)
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	QL (30 EA per 30 days)
<i>metformin oral tablet 1,000 mg</i>	6	QL (75 EA per 30 days)
<i>metformin oral tablet 500 mg</i>	6	QL (150 EA per 30 days)
<i>metformin oral tablet 850 mg</i>	6	QL (90 EA per 30 days)
<i>metformin oral tablet extended release 24 hr 500 mg</i>	6	Generic for Glucophage XR; QL (120 EA per 30 days)
<i>metformin oral tablet extended release 24 hr 750 mg</i>	6	Generic for Glucophage XR; QL (60 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
MOUNJARO SUBCUTANEOUS PEN INJECTOR 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML	3	PA; QL (2 ML per 28 days)
<i>nateglinide oral tablet 120 mg</i>	6	QL (90 EA per 30 days)
<i>nateglinide oral tablet 60 mg</i>	6	QL (180 EA per 30 days)
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	3	(brand RELION not covered)
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	(brand RELION not covered)
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	(brand RELION not covered)
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	(brand RELION not covered)
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	(brand RELION not covered)
NOVOLIN R REGULAR U100 INSULIN INJECTION SOLUTION 100 UNIT/ML	3	(brand RELION not covered)
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)	3	PA; QL (3 ML per 28 days)
<i>pioglitazone oral tablet 15 mg, 30 mg, 45 mg</i>	6	QL (30 EA per 30 days)
<i>pioglitazone-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	6	QL (30 EA per 30 days)
<i>pioglitazone-metformin oral tablet 15-500 mg, 15-850 mg</i>	6	QL (90 EA per 30 days)
<i>repaglinide oral tablet 0.5 mg</i>	6	QL (960 EA per 30 days)
<i>repaglinide oral tablet 1 mg</i>	6	QL (480 EA per 30 days)
<i>repaglinide oral tablet 2 mg</i>	6	QL (240 EA per 30 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	PA; QL (30 EA per 30 days)
<i>saxagliptin oral tablet 2.5 mg, 5 mg</i>	3	
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML	3	QL (15 ML per 25 days)
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG	3	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	QL (30 EA per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	QL (60 EA per 30 days)
TRADJENTA ORAL TABLET 5 MG	3	QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	3	QL (30 EA per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	3	QL (60 EA per 30 days)
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML	3	PA; QL (2 ML per 28 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	3	QL (60 EA per 30 days)
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML)	3	QL (15 ML per 30 days)
MISCELLANEOUS HORMONES		
<i>cabergoline oral tablet 0.5 mg</i>	2	
<i>calcitonin (salmon) nasal spray,non-aerosol 200 unit/actuation</i>	2	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	2	
<i>calcitriol oral solution 1 mcg/ml</i>	2	
<i>cinacalcet oral tablet 30 mg</i>	2	QL (60 EA per 30 days)
<i>cinacalcet oral tablet 60 mg</i>	4	QL (60 EA per 30 days)
<i>cinacalcet oral tablet 90 mg</i>	5^	QL (120 EA per 30 days)
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	2	
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	2	
<i>desmopressin oral tablet 0.1 mg, 0.2 mg</i>	2	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	2	
KORLYM ORAL TABLET 300 MG	5^	PA; LA
<i>mifepristone oral tablet 300 mg</i>	5^	PA
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	2	
<i>sapropterin oral powder in packet 100 mg, 500 mg</i>	5^	PA
<i>sapropterin oral tablet,soluble 100 mg</i>	5^	PA
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5^	PA; LA
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	2	
<i>testosterone enanthate intramuscular oil 200 mg/ml</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	2	PA; QL (300 GM per 30 days)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	2	PA; QL (150 GM per 30 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	2	PA; QL (300 GM per 30 days)
<i>tolvaptan oral tablet 15 mg, 30 mg</i>	5^	PA
THYROID HORMONES		
<i>euthyrox oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>levothyroxine oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg</i>	2	
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
<i>dicyclomine oral capsule 10 mg</i>	4	
<i>dicyclomine oral solution 10 mg/5 ml</i>	4	
<i>dicyclomine oral tablet 20 mg</i>	4	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml</i>	4	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	4	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	2	
<i>loperamide oral capsule 2 mg</i>	2	
MISCELLANEOUS GASTROINTESTINAL AGENTS		
<i>alosetron oral tablet 0.5 mg</i>	4	PA; QL (60 EA per 30 days)
<i>alosetron oral tablet 1 mg</i>	5^	PA; QL (60 EA per 30 days)
<i>aprepitant oral capsule 125 mg, 40 mg, 80 mg</i>	2	B/D

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Drug Name	Drug Tier	Requirements / Limits
<i>aprepitant oral capsule,dose pack 125 mg (1)- 80 mg (2)</i>	2	B/D
<i>balsalazide oral capsule 750 mg</i>	2	
<i>betaine oral powder 1 gram/scoop</i>	5^	LA
<i>budesonide oral capsule,delayed,extend.release 3 mg</i>	2	
<i>budesonide oral tablet,delayed and ext.release 9 mg</i>	5^	PA; QL (30 EA per 30 days)
<i>compro rectal suppository 25 mg</i>	2	
<i>constulose oral solution 10 gram/15 ml</i>	2	
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT	3	
<i>cromolyn oral concentrate 100 mg/5 ml</i>	2	
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	2	B/D; QL (60 EA per 30 days)
<i>enulose oral solution 10 gram/15 ml</i>	2	
GATTEX 30-VIAL SUBCUTANEOUS KIT 5 MG	5^	PA; LA
<i>gavilyte-c oral recon soln 240-22.72-6.72 -5.84 gram</i>	1	
<i>gavilyte-g oral recon soln 236-22.74-6.74 -5.86 gram</i>	1	
<i>generlac oral solution 10 gram/15 ml</i>	2	
<i>granisetron hcl oral tablet 1 mg</i>	2	B/D
<i>hydrocortisone rectal enema 100 mg/60 ml</i>	2	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	1	
<i>lactulose oral solution 10 gram/15 ml</i>	2	
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	3	QL (30 EA per 30 days)
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	4	QL (60 EA per 30 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	
<i>mesalamine oral capsule (with del rel tablets) 400 mg</i>	2	
<i>mesalamine oral capsule,extended release 24hr 0.375 gram</i>	2	
<i>mesalamine oral tablet,delayed release (dr/ec) 1.2 gram</i>	2	
<i>mesalamine oral tablet,delayed release (dr/ec) 800 mg</i>	4	
<i>mesalamine rectal enema 4 gram/60 ml</i>	2	
<i>mesalamine rectal suppository 1,000 mg</i>	2	
<i>metoclopramide hcl oral solution 5 mg/5 ml</i>	2	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	3	QL (30 EA per 30 days)
<i>nitroglycerin rectal ointment 0.4 % (w/w)</i>	4	QL (30 GM per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
OCALIVA ORAL TABLET 10 MG, 5 MG	5^	PA; LA; QL (30 EA per 30 days)
<i>ondansetron hcl oral solution 4 mg/5 ml</i>	2	
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	2	
<i>ondansetron oral tablet,disintegrating 4 mg, 8 mg</i>	2	
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	1	
<i>peg-electrolyte soln oral recon soln 420 gram</i>	1	
PLENVU ORAL POWDER IN PACKET, SEQUENTIAL 140-9-5.2 GRAM	4	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	2	
<i>prochlorperazine rectal suppository 25 mg</i>	2	
<i>procto-med hc topical cream with perineal applicator 2.5 %</i>	2	
<i>proctosol hc topical cream with perineal applicator 2.5 %</i>	2	
<i>proctozone-hc topical cream with perineal applicator 2.5 %</i>	2	
RECTIV RECTAL OINTMENT 0.4 % (W/W)	4	QL (30 GM per 30 days)
<i>scopolamine base transdermal patch 3 day 1 mg over 3 days</i>	4	PA; QL (10 EA per 30 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	5^	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	5^	PA; QL (2.4 ML per 56 days)
<i>sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram, 17.5-3.13-1.6 gram 2 pack (480ml)</i>	2	
SUCRAID ORAL SOLUTION 8,500 UNIT/ML	5^	PA
<i>sulfasalazine oral tablet 500 mg</i>	2	
<i>sulfasalazine oral tablet,delayed release (dr/ec) 500 mg</i>	2	
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM	4	
<i>ursodiol oral capsule 300 mg</i>	3	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	4	
VOWST ORAL CAPSULE	5^	PA; LA
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	3	

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Drug Name	Drug Tier	Requirements / Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 60,000-189,600- 252,600 UNIT	4	
ULCER THERAPY		
<i>dexlansoprazole oral capsule,biphase delayed releas 30 mg, 60 mg</i>	2	QL (30 EA per 30 days)
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg, 40 mg</i>	2	QL (60 EA per 30 days)
<i>famotidine oral suspension for reconstitution 40 mg/5 ml (8 mg/ml)</i>	2	
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	
<i>lansoprazole oral capsule,delayed release(dr/ec) 15 mg, 30 mg</i>	2	QL (60 EA per 30 days)
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	2	
<i>nizatidine oral capsule 150 mg, 300 mg</i>	2	
<i>omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg, 40 mg</i>	1	QL (60 EA per 30 days)
<i>pantoprazole oral tablet,delayed release (dr/ec) 20 mg, 40 mg</i>	1	QL (60 EA per 30 days)
<i>rabeprazole oral tablet,delayed release (dr/ec) 20 mg</i>	2	QL (60 EA per 30 days)
<i>sucralfate oral suspension 100 mg/ml</i>	4	
<i>sucralfate oral tablet 1 gram</i>	2	
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5 ML	5^	PA; LA
ARCALYST SUBCUTANEOUS RECON SOLN 220 MG	5^	PA; LA
BESREMI SUBCUTANEOUS SYRINGE 500 MCG/ML	5^	PA-NS; LA
BETASERON SUBCUTANEOUS KIT 0.3 MG	5^	PA; QL (14 EA per 28 days)
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	5^	PA
NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5^	PA
NYVEPRIA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5^	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	5^	PA
OMNITROPE SUBCUTANEOUS RECON SOLN 5.8 MG	5^	PA
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5^	PA; QL (4 ML per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	5^	PA; QL (2 ML per 28 days)

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Drug Name	Drug Tier	Requirements / Limits
RETACRIT 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	3	PA
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	5^	PA
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ABRYSVO (PF) INTRAMUSCULAR RECON SOLN 120 MCG/0.5 ML	6	NM; IRA \$0 for age 19 and older
ACTHIB (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	6	NM
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	6	NM
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	6	NM
AREXVY (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 120 MCG/0.5 ML	6	NM; IRA \$0 for age 60 and older only
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTION 50 MG	6	NM
BEXSERO INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML	6	NM
BIVIGAM INTRAVENOUS SOLUTION 10 %	5^	PA; NM; LA
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION 2.5-8-5 LF-MCG-LF/0.5ML	6	NM
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML	6	NM
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULAR SUSPENSION 15-10-5 LF-MCG-LF/0.5ML	6	NM
ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML	6	B/D; NM
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML	6	B/D; NM
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML	6	B/D; NM
GAMMAGARD LIQUID INJECTION SOLUTION 10 %	5^	PA; NM
GAMMAGARD S-D (IGA < 1 MCG/ML) INTRAVENOUS RECON SOLN 10 GRAM, 5 GRAM	5^	PA; NM
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	5^	PA; NM
GAMMAPLEX (WITH SORBITOL) INTRAVENOUS SOLUTION 5 %	5^	PA; NM; LA
GAMMAPLEX INTRAVENOUS SOLUTION 10 %, 10 % (100 ML), 10 % (200 ML)	5^	PA; NM; LA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	5^	PA; NM

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Drug Name	Drug Tier	Requirements / Limits
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION 0.5 ML	6	NM
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE 0.5 ML	6	NM
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML, 720 ELISA UNIT/0.5 ML	6	NM
HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/0.5 ML	6	B/D; NM
HIBERIX (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	6	NM
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN 2.5 UNIT	6	NM
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE 25-58-10 LF-MCG-LF/0.5ML	6	NM
IPOL INJECTION SUSPENSION 40-8-32 UNIT/0.5 ML	6	NM
IXCHIQ (PF) INTRAMUSCULAR RECON SOLN 1,000 TCID50/0.5 ML	6	NM
IXIARO (PF) INTRAMUSCULAR SYRINGE 6 MCG/0.5 ML	6	NM
JYNNEOS (PF) SUBCUTANEOUS SUSPENSION 0.5X TO 3.95X 10EXP8 UNIT/0.5	6	NM
KINRIX (PF) INTRAMUSCULAR SYRINGE 25 LF-58 MCG-10 LF/0.5 ML	6	NM
MENACTRA (PF) INTRAMUSCULAR SOLUTION 4 MCG/0.5 ML	6	NM
MENQUADFI (PF) INTRAMUSCULAR SOLUTION 10 MCG/0.5 ML	6	NM
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML	6	NM
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML	6	NM
OCTAGAM INTRAVENOUS SOLUTION 10 %, 5 %	5^	PA; NM
PANZYGA INTRAVENOUS SOLUTION 10 %, 10 % (100 ML), 10 % (200 ML), 10 % (25 ML), 10 % (300 ML), 10 % (50 ML)	5^	PA; NM
PEDIARIX (PF) INTRAMUSCULAR SYRINGE 10 MCG-25LF-25 MCG-10LF/0.5 ML	6	NM
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION 7.5 MCG/0.5 ML	6	NM
PENBRAYA (PF) INTRAMUSCULAR KIT 5-120 MCG/0.5 ML	6	NM
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU - 10 MCG/0.5ML	6	NM

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Drug Name	Drug Tier	Requirements / Limits
PREHEVBRIO (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML	6	B/D; NM
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML	6	NM
PRIVIGEN INTRAVENOUS SOLUTION 10 %	5^	PA; NM
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3-4.3-3- 3.99 TCID50/0.5	6	NM
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION 15 LF-48 MCG- 5 LF UNIT/0.5ML, 15 LF-48 MCG- 5 LF UNIT/0.5ML (58 UNT/ML)	6	NM
QUADRACEL (PF) INTRAMUSCULAR SYRINGE 15 LF-48 MCG- 5 LF UNIT/0.5ML	6	NM
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 2.5 UNIT	6	NM
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML	6	B/D; NM
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	6	B/D; NM
ROTARIX ORAL SUSPENSION 10EXP6 CCID50 /1.5 ML	6	NM
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION 10EXP6 CCID50/ML	6	NM
ROTATEQ VACCINE ORAL SOLUTION 2 ML	6	NM
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 50 MCG/0.5 ML	6	NM; A third dose may be considered in post-transplant members (PA required).; QL (2 EA per 999 days)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF UNIT/0.5 ML	6	NM
TENIVAC (PF) INTRAMUSCULAR SUSPENSION 5 LF UNIT- 2 LF UNIT/0.5ML	6	NM
TENIVAC (PF) INTRAMUSCULAR SYRINGE 5-2 LF UNIT/0.5 ML	6	NM
TETANUS,DIPHThERIA TOX PED(PF) INTRAMUSCULAR SUSPENSION 5-25 LF UNIT/0.5 ML	6	B/D; NM
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML, 2.4 MCG/0.5 ML	6	NM
TRUMENBA INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML	6	NM
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT- 20 MCG/ML	6	NM
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	6	NM

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Drug Name	Drug Tier	Requirements / Limits
TYPHIM VI INTRAMUSCULAR SYRINGE 25 MCG/0.5 ML	6	NM
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 50 UNIT/ML	6	NM
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML, 50 UNIT/ML	6	NM
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML	6	NM
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10 EXP4.74 UNIT/0.5 ML, 10 EXP4.74 UNIT/0.5 ML(2.5 ML IN 1 VIAL)	6	NM
MISCELLANEOUS SUPPLIES		
MISCELLANEOUS SUPPLIES		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	2	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	3	
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE	2	BD Preferred
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	2	BD Preferred
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	
<i>colchicine oral capsule 0.6 mg</i>	4	QL (120 EA per 30 days)
<i>colchicine oral tablet 0.6 mg</i>	4	QL (120 EA per 30 days)
<i>febuxostat oral tablet 40 mg, 80 mg</i>	2	
<i>probenecid oral tablet 500 mg</i>	2	
<i>probenecid-colchicine oral tablet 500-0.5 mg</i>	2	
OSTEOPOROSIS THERAPY		
<i>alendronate oral solution 70 mg/75 ml</i>	2	QL (300 ML per 28 days)
<i>alendronate oral tablet 10 mg</i>	1	QL (30 EA per 30 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	QL (4 EA per 28 days)
<i>ibandronate oral tablet 150 mg</i>	1	QL (1 EA per 30 days)
PROLIA SUBCUTANEOUS SYRINGE 60 MG/ML	4	QL (1 ML per 180 days)
<i>raloxifene oral tablet 60 mg</i>	2	
<i>risedronate oral tablet 150 mg</i>	2	QL (1 EA per 30 days)
<i>risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)</i>	2	QL (4 EA per 28 days)
<i>risedronate oral tablet 5 mg</i>	2	QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
<i>risedronate oral tablet, delayed release (dr/ec) 35 mg</i>	2	QL (4 EA per 28 days)
TERIPARATIDE SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (620MCG/2.48ML)	5^	PA; Only Teriparatide NDC 47781065289 is covered; QL (2.48 ML per 28 days)
OTHER RHEUMATOLOGICALS		
ACTEMRA ACTPEN SUBCUTANEOUS PEN INJECTOR 162 MG/0.9 ML	5^	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS SYRINGE 162 MG/0.9 ML	5^	PA; QL (3.6 ML per 28 days)
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR 200 MG/ML	5^	PA; LA; QL (8 ML per 28 days)
BENLYSTA SUBCUTANEOUS SYRINGE 200 MG/ML	5^	PA; LA; QL (8 ML per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5^	PA; QL (6 EA per 180 days)
CYLTEZO(CF) PEN PSORIASIS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5^	PA; QL (4 EA per 180 days)
CYLTEZO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5^	PA; QL (4 EA per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	5^	PA; QL (2 EA per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5^	PA; QL (4 EA per 28 days)
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML)	5^	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML	5^	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)	5^	PA; QL (8 ML per 28 days)
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML)	5^	PA; QL (8 ML per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (6 EA per 180 days)
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (6 EA per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (6 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (3 EA per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (4 EA per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (3 EA per 180 days)

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Drug Name	Drug Tier	Requirements / Limits
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (6 EA per 28 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (4 EA per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (2 EA per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5^	PA; Only Humira NDCs starting 00074 are covered; QL (6 EA per 28 days)
<i>leflunomide oral tablet 10 mg, 20 mg</i>	2	QL (30 EA per 30 days)
OTEZLA ORAL TABLET 30 MG	5^	PA; QL (60 EA per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	5^	PA; QL (55 EA per 180 days)
<i>penicillamine oral tablet 250 mg</i>	5^	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	5^	PA; QL (30 EA per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	5^	PA; QL (84 EA per 180 days)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	3	QL (60 EA per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42)	3	QL (55 EA per 180 days)
YUFLYMA(CF) AI CROHN'S-UC-HS SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	5^	PA; QL (3 EA per 180 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	5^	PA; QL (4 EA per 28 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	5^	PA; QL (2 EA per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	5^	PA; QL (2 EA per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5^	PA; QL (4 EA per 28 days)
OBSTETRICS / GYNECOLOGY		
<i>ESTROGENS / PROGESTINS</i>		
<i>camila oral tablet 0.35 mg</i>	2	
<i>deblitane oral tablet 0.35 mg</i>	2	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE 104 MG/0.65 ML	3	
<i>dotti transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	4	
<i>errin oral tablet 0.35 mg</i>	2	
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	4	
<i>estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	4	
<i>estradiol vaginal cream 0.01 % (0.1 mg/gram)</i>	2	
<i>estradiol vaginal tablet 10 mcg</i>	2	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	2	
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	4	
<i>fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	4	
<i>heather oral tablet 0.35 mg</i>	2	
<i>incassia oral tablet 0.35 mg</i>	2	
<i>jinteli oral tablet 1-5 mg-mcg</i>	4	
<i>lyleq oral tablet 0.35 mg</i>	2	
<i>lyllana transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	4	
<i>lyza oral tablet 0.35 mg</i>	2	
<i>medroxyprogesterone intramuscular suspension 150 mg/ml</i>	2	
<i>medroxyprogesterone intramuscular syringe 150 mg/ml</i>	2	
<i>medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>mimvey oral tablet 1-0.5 mg</i>	4	
<i>nora-be oral tablet 0.35 mg</i>	2	
<i>norethindrone (contraceptive) oral tablet 0.35 mg</i>	2	
<i>norethindrone acetate oral tablet 5 mg</i>	2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	4	
PREMARIN VAGINAL CREAM 0.625 MG/GRAM	3	
<i>progesterone micronized oral capsule 100 mg, 200 mg</i>	2	
<i>sharobel oral tablet 0.35 mg</i>	2	
<i>yuvafem vaginal tablet 10 mcg</i>	2	
MISCELLANEOUS OB/GYN		
<i>clindamycin phosphate vaginal cream 2 %</i>	4	
<i>eluryng vaginal ring 0.12-0.015 mg/24 hr</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	2	
LILETTA INTRAUTERINE INTRAUTERINE DEVICE 20.4 MCG/24 HR (8 YRS) 52 MG	3	
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	2	
NEXPLANON SUBDERMAL IMPLANT 68 MG	3	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	2	
<i>terconazole vaginal suppository 80 mg</i>	4	
<i>tranexamic acid oral tablet 650 mg</i>	2	
<i>xulane transdermal patch weekly 150-35 mcg/24 hr</i>	2	
<i>zafemy transdermal patch weekly 150-35 mcg/24 hr</i>	2	
ORAL CONTRACEPTIVES / RELATED AGENTS		
<i>altavera (28) oral tablet 0.15-0.03 mg</i>	2	
<i>alyacen 1/35 (28) oral tablet 1-35 mg-mcg</i>	2	
<i>apri oral tablet 0.15-0.03 mg</i>	2	
<i>aranelle (28) oral tablet 0.5/1/0.5-35 mg-mcg</i>	2	
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	2	
<i>aviane oral tablet 0.1-20 mg-mcg</i>	2	
<i>blisovi fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)</i>	2	
<i>cryselle (28) oral tablet 0.3-30 mg-mcg</i>	2	
<i>cyred eq oral tablet 0.15-0.03 mg</i>	2	
<i>desog-e.estradiol/e.estradiol oral tablet 0.15-0.02 mgx21 /0.01 mg x 5</i>	2	
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.03 mg</i>	2	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	2	
<i>enpresse oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2	
<i>enskyce oral tablet 0.15-0.03 mg</i>	2	
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	2	
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	2	
<i>falmina (28) oral tablet 0.1-20 mg-mcg</i>	2	
<i>introvale oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	2	
<i>isibloom oral tablet 0.15-0.03 mg</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>jasmiel (28) oral tablet 3-0.02 mg</i>	2	
<i>juleber oral tablet 0.15-0.03 mg</i>	2	
<i>junel fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)</i>	2	
<i>junel fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	2	
<i>kariva (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5</i>	2	
<i>kelnor 1/35 (28) oral tablet 1-35 mg-mcg</i>	2	
<i>kelnor 1/50 (28) oral tablet 1-50 mg-mcg</i>	2	
<i>kurvelo (28) oral tablet 0.15-0.03 mg</i>	2	
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-20 mcg/0.15 mg-25 mcg, 0.15 mg-30 mcg (84)/10 mcg (7)</i>	2	
<i>larin 1.5/30 (21) oral tablet 1.5-30 mg-mcg</i>	2	
<i>larin 1/20 (21) oral tablet 1-20 mg-mcg</i>	2	
<i>larin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)</i>	2	
<i>larin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	2	
<i>lessina oral tablet 0.1-20 mg-mcg</i>	2	
<i>levonest (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2	
<i>levonorgestrel-ethinyl estradiol oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg (28)</i>	2	
<i>levonorgestrel-ethinyl estradiol oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	2	
<i>levonorg-eth estradiol triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2	
<i>levora-28 oral tablet 0.15-0.03 mg</i>	2	
<i>loryna (28) oral tablet 3-0.02 mg</i>	2	
<i>low-ogestrel (28) oral tablet 0.3-30 mg-mcg</i>	2	
<i>lutera (28) oral tablet 0.1-20 mg-mcg</i>	2	
<i>marlissa (28) oral tablet 0.15-0.03 mg</i>	2	
<i>microgestin 1.5/30 (21) oral tablet 1.5-30 mg-mcg</i>	2	
<i>microgestin 1/20 (21) oral tablet 1-20 mg-mcg</i>	2	
<i>microgestin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)</i>	2	
<i>microgestin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	2	

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Drug Name	Drug Tier Requirements / Limits
<i>mili oral tablet 0.25-35 mg-mcg</i>	2
<i>nikki (28) oral tablet 3-0.02 mg</i>	2
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	2
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1-20(5)/1-30(7) /1mg-35mcg (9)</i>	2
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg (28), 0.25-35 mg-mcg</i>	2
<i>nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	2
<i>nortrel 1/35 (21) oral tablet 1-35 mg-mcg (21)</i>	2
<i>nortrel 1/35 (28) oral tablet 1-35 mg-mcg</i>	2
<i>nortrel 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg</i>	2
<i>pimtrea (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5</i>	2
<i>portia 28 oral tablet 0.15-0.03 mg</i>	2
<i>reclipsen (28) oral tablet 0.15-0.03 mg</i>	2
<i>setlakin oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	2
<i>sprintec (28) oral tablet 0.25-35 mg-mcg</i>	2
<i>sronyx oral tablet 0.1-20 mg-mcg</i>	2
<i>syeda oral tablet 3-0.03 mg</i>	2
<i>tarina 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)</i>	2
<i>tarina fe 1-20 eq (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	2
<i>tilia fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)</i>	2
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg (28)</i>	2
<i>tri-legest fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)</i>	2
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	2
<i>tri-sprintec (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)</i>	2
<i>trivora (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2
<i>turqoz (28) oral tablet 0.3-30 mg-mcg</i>	2
<i>velivet triphasic regimen (28) oral tablet 0.1/.125/.15-25 mg-mcg</i>	2
<i>vestura (28) oral tablet 3-0.02 mg</i>	2
<i>vienva oral tablet 0.1-20 mg-mcg</i>	2
<i>zovia 1-35 (28) oral tablet 1-35 mg-mcg</i>	2

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Drug Name	Drug Tier	Requirements / Limits
OPHTHALMOLOGY		
ANTIBIOTICS		
<i>bacitracin ophthalmic (eye) ointment 500 unit/gram</i>	2	
<i>bacitracin-polymyxin b ophthalmic (eye) ointment 500-10,000 unit/gram</i>	1	
<i>ciprofloxacin hcl ophthalmic (eye) drops 0.3 %</i>	1	
<i>erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)</i>	1	
<i>gatifloxacin ophthalmic (eye) drops 0.5 %</i>	2	
<i>gentamicin ophthalmic (eye) drops 0.3 %</i>	1	
<i>moxifloxacin ophthalmic (eye) drops 0.5 %</i>	2	
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 %	4	
<i>neomycin-bacitracin-polymyxin ophthalmic (eye) ointment 3.5-400-10,000 mg-unit-unit/g</i>	2	
<i>neomycin-polymyxin-gramicidin ophthalmic (eye) drops 1.75 mg-10,000 unit-0.025mg/ml</i>	2	
<i>ofloxacin ophthalmic (eye) drops 0.3 %</i>	2	
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit- 1 mg/ml</i>	1	
<i>tobramycin ophthalmic (eye) drops 0.3 %</i>	1	
ANTIVIRALS		
<i>trifluridine ophthalmic (eye) drops 1 %</i>	2	
ZIRGAN OPHTHALMIC (EYE) GEL 0.15 %	4	
BETA-BLOCKERS		
<i>betaxolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>carteolol ophthalmic (eye) drops 1 %</i>	2	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %</i>	1	
<i>timolol maleate ophthalmic (eye) gel forming solution 0.25 %, 0.5 %</i>	2	
MISCELLANEOUS OPHTHALMOLOGICS		
<i>atropine ophthalmic (eye) drops 1 %</i>	2	
<i>azelastine ophthalmic (eye) drops 0.05 %</i>	2	
<i>cromolyn ophthalmic (eye) drops 4 %</i>	1	
<i>cyclosporine ophthalmic (eye) dropperette 0.05 %</i>	3	QL (60 EA per 30 days)
CYSTARAN OPHTHALMIC (EYE) DROPS 0.44 %	5^	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	2	
<i>sulfacetamide sodium ophthalmic (eye) drops 10 %</i>	2	
<i>sulfacetamide sodium ophthalmic (eye) ointment 10 %</i>	2	
<i>sulfacetamide-prednisolone ophthalmic (eye) drops 10 %-0.23 % (0.25 %)</i>	2	
XDEMVI OPTHALMIC (EYE) DROPS 0.25 %	5^	PA; QL (10 ML per 42 days)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
<i>bromfenac ophthalmic (eye) drops 0.075 %, 0.09 %</i>	4	
<i>diclofenac sodium ophthalmic (eye) drops 0.1 %</i>	2	
<i>flurbiprofen sodium ophthalmic (eye) drops 0.03 %</i>	2	
<i>ketorolac ophthalmic (eye) drops 0.4 %, 0.5 %</i>	2	
PROLENSA OPTHALMIC (EYE) DROPS 0.07 %	3	
ORAL DRUGS FOR GLAUCOMA		
<i>acetazolamide oral capsule, extended release 500 mg</i>	2	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	2	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	2	
OTHER GLAUCOMA DRUGS		
<i>brinzolamide ophthalmic (eye) drops,suspension 1 %</i>	2	
COMBIGAN OPTHALMIC (EYE) DROPS 0.2-0.5 %	3	
<i>dorzolamide ophthalmic (eye) drops 2 %</i>	1	
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	1	
<i>latanoprost ophthalmic (eye) drops 0.005 %</i>	1	
LUMIGAN OPTHALMIC (EYE) DROPS 0.01 %	3	
RHOPRESSA OPTHALMIC (EYE) DROPS 0.02 %	3	
ROCKLATAN OPTHALMIC (EYE) DROPS 0.02-0.005 %	3	
<i>travoprost ophthalmic (eye) drops 0.004 %</i>	2	
STEROID-ANTIBIOTIC COMBINATIONS		
<i>neomycin-bacitracin-poly-hc ophthalmic (eye) ointment 3.5-400-10,000 mg-unit/g-1%</i>	2	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	2	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	1	
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
TOBRADEX OPHTHALMIC (EYE) OINTMENT 0.3-0.1 %	3	
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %</i>	4	
STEROIDS		
<i>dexamethasone sodium phosphate ophthalmic (eye) drops 0.1 %</i>	4	
<i>difluprednate ophthalmic (eye) drops 0.05 %</i>	4	
<i>fluorometholone ophthalmic (eye) drops,suspension 0.1 %</i>	2	
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.2 %</i>	4	
<i>prednisolone acetate ophthalmic (eye) drops,suspension 1 %</i>	2	
<i>prednisolone sodium phosphate ophthalmic (eye) drops 1 %</i>	4	
SYMPATHOMIMETICS		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	3	
<i>apraclonidine ophthalmic (eye) drops 0.5 %</i>	4	
<i>brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %</i>	1	
RESPIRATORY AND ALLERGY		
ANTI-HISTAMINE / ANTI-ALLERGENIC AGENTS		
<i>cetirizine oral solution 1 mg/ml</i>	1	
<i>cyproheptadine oral tablet 4 mg</i>	4	PA
<i>desloratadine oral tablet 5 mg</i>	2	
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	2	QL (4 EA per 30 days)
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	4	PA
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	4	PA
<i>levocetirizine oral solution 2.5 mg/5 ml</i>	2	
<i>levocetirizine oral tablet 5 mg</i>	2	
<i>promethazine oral syrup 6.25 mg/5 ml</i>	4	PA
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	4	PA
PULMONARY AGENTS		
<i>acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)</i>	2	B/D
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5^	PA; LA; QL (90 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION	3	QL (12 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	2	8.5 gm inhaler; QL (17 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	2	6.7 gm inhaler; QL (13.4 GM per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	2	B/D
<i>albuterol sulfate oral syrup 2 mg/5 ml</i>	2	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	2	
<i>alyq oral tablet 20 mg</i>	5^	PA; QL (60 EA per 30 days)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	5^	PA; LA; QL (30 EA per 30 days)
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	3	QL (60 EA per 30 days)
<i>arformoterol inhalation solution for nebulization 15 mcg/2 ml</i>	4	B/D; QL (120 ML per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	3	QL (30 EA per 30 days)
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION	4	QL (25.8 GM per 30 days)
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG	3	QL (10.7 GM per 30 days)
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	5^	PA; LA; QL (60 EA per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE, 50-25 MCG/DOSE	3	QL (60 EA per 30 days)
<i>breynga inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	3	QL (30.9 GM per 30 days)
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER 160-9-4.8 MCG/ACTUATION	3	Retail Inhalation Canister (10.7g inhaler containing 120 inhalations); QL (10.7 GM per 30 days)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	4	B/D
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 GM per 30 days)
<i>cromolyn inhalation solution for nebulization 20 mg/2 ml</i>	3	B/D

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Drug Name	Drug Tier	Requirements / Limits
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR 30 MG/ML	5^	PA; LA; QL (1 ML per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	5^	PA; QL (0.5 ML per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	5^	PA; LA; QL (1 ML per 28 days)
<i>flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)</i>	2	QL (50 ML per 30 days)
<i>fluticasone propionate nasal spray,suspension 50 mcg/actuation</i>	2	QL (16 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose</i>	2	QL (60 EA per 30 days)
<i>formoterol fumarate inhalation solution for nebulization 20 mcg/2 ml</i>	4	B/D; QL (120 ML per 30 days)
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT	5^	PA; LA; QL (30 EA per 30 days)
HAEGARDA SUBCUTANEOUS RECON SOLN 3,000 UNIT	5^	PA; LA; QL (20 EA per 30 days)
<i>icatibant subcutaneous syringe 30 mg/3 ml</i>	5^	PA; QL (27 ML per 30 days)
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE 62.5 MCG/ACTUATION	3	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	2	B/D
<i>ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml</i>	2	B/D
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 5.8 MG	5^	PA; QL (56 EA per 28 days)
KALYDECO ORAL GRANULES IN PACKET 25 MG, 50 MG, 75 MG	5^	PA; LA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET 150 MG	5^	PA; LA; QL (56 EA per 28 days)
<i>levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml</i>	2	B/D
<i>mometasone nasal spray,non-aerosol 50 mcg/actuation</i>	2	QL (34 GM per 30 days)
<i>montelukast oral granules in packet 4 mg</i>	2	
<i>montelukast oral tablet 10 mg</i>	1	
<i>montelukast oral tablet,chewable 4 mg, 5 mg</i>	2	
OFEV ORAL CAPSULE 100 MG, 150 MG	5^	PA; LA; QL (60 EA per 30 days)
OPSUMIT ORAL TABLET 10 MG	5^	PA; LA; QL (30 EA per 30 days)
ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG, 75-94 MG	5^	PA; LA; QL (56 EA per 28 days)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5^	PA; LA; QL (112 EA per 28 days)
<i>pirfenidone oral capsule 267 mg</i>	5^	PA; QL (270 EA per 30 days)
<i>pirfenidone oral tablet 267 mg</i>	5^	PA; QL (270 EA per 30 days)
<i>pirfenidone oral tablet 801 mg</i>	5^	PA; QL (90 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
PULMOZYME INHALATION SOLUTION 1 MG/ML	5^	B/D
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	2	QL (30 EA per 30 days)
<i>sajazir subcutaneous syringe 30 mg/3 ml</i>	5^	PA; LA; QL (27 ML per 30 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE	3	QL (60 EA per 30 days)
<i>sildenafil (pulm.hypertension) oral tablet 20 mg</i>	2	PA; generic for Revatio; QL (90 EA per 30 days)
SYMDEKO ORAL TABLETS, SEQUENTIAL 100-150 MG (D)/ 150 MG (N), 50-75 MG (D)/ 75 MG (N)	5^	PA; LA; QL (56 EA per 28 days)
<i>tadalafil (pulm. hypertension) oral tablet 20 mg</i>	5^	PA; generic for Adcirca; QL (60 EA per 30 days)
<i>terbutaline oral tablet 2.5 mg, 5 mg</i>	2	
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG	4	
<i>theophylline oral solution 80 mg/15 ml</i>	2	
<i>theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg, 450 mg</i>	2	
<i>theophylline oral tablet extended release 24 hr 400 mg, 600 mg</i>	2	
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG, 200-62.5-25 MCG	3	QL (60 EA per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL 100-50-75MG (D) /75 MG (N), 80-40-60 MG (D) /59.5 MG (N)	5^	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N), 50-25-37.5 MG (D)/75 MG (N)	5^	PA; LA; QL (84 EA per 28 days)
VENTOLIN HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION	3	QL (36 GM per 30 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	5^	PA; QL (8 ML per 28 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	5^	PA; QL (1 ML per 28 days)
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG	5^	PA; LA; QL (8 EA per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML	5^	PA; LA; QL (8 ML per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 300 MG/2 ML	5^	PA; QL (8 ML per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5^	PA; LA; QL (1 ML per 28 days)
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON 8 MG/ML	3	QL (300 ML per 28 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 25 MG, 50 MG	3	QL (30 EA per 30 days)
<i>oxybutynin chloride oral syrup 5 mg/5 ml</i>	2	
<i>oxybutynin chloride oral tablet 5 mg</i>	2	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg</i>	2	QL (60 EA per 30 days)
<i>oxybutynin chloride oral tablet extended release 24hr 5 mg</i>	2	QL (30 EA per 30 days)
<i>solifenacin oral tablet 10 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>tolterodine oral capsule,extended release 24hr 2 mg, 4 mg</i>	2	QL (30 EA per 30 days)
<i>tolterodine oral tablet 1 mg, 2 mg</i>	2	QL (60 EA per 30 days)
<i>trospium oral capsule,extended release 24hr 60 mg</i>	2	QL (30 EA per 30 days)
<i>trospium oral tablet 20 mg</i>	2	QL (60 EA per 30 days)
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
<i>alfuzosin oral tablet extended release 24 hr 10 mg</i>	1	
<i>dutasteride oral capsule 0.5 mg</i>	2	QL (30 EA per 30 days)
<i>dutasteride-tamsulosin oral capsule, er multiphase 24 hr 0.5-0.4 mg</i>	2	QL (30 EA per 30 days)
<i>finasteride oral tablet 5 mg</i>	1	
<i>tamsulosin oral capsule 0.4 mg</i>	1	
MISCELLANEOUS UROLOGICALS		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
CYTAGON ORAL CAPSULE 150 MG, 50 MG	4	PA; LA
ELMIRON ORAL CAPSULE 100 MG	4	
<i>potassium citrate oral tablet extended release 10 meq (1,080 mg), 15 meq, 5 meq (540 mg)</i>	2	
<i>sildenafil oral tablet 100 mg, 25 mg, 50 mg</i>	1	NT; QL (6 EA per 30 days)
<i>tadalafil oral tablet 2.5 mg</i>	4	PA; QL (60 EA per 30 days)
<i>tadalafil oral tablet 5 mg</i>	4	PA; QL (30 EA per 30 days)
<i>vardefafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	NT; QL (6 EA per 30 days)

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Drug Name	Drug Tier	Requirements / Limits
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
<i>klor-con 10 oral tablet extended release 10 meq</i>	1	
<i>klor-con 8 oral tablet extended release 8 meq</i>	1	
<i>klor-con m10 oral tablet,er particles/crystals 10 meq</i>	1	
<i>klor-con m15 oral tablet,er particles/crystals 15 meq</i>	2	
<i>klor-con m20 oral tablet,er particles/crystals 20 meq</i>	1	
<i>klor-con oral packet 20 meq</i>	2	
<i>magnesium sulfate injection solution 500 mg/ml (50 %)</i>	4	
<i>magnesium sulfate injection syringe 500 mg/ml (50 %)</i>	4	
<i>potassium chlorid-d5-0.45%nacl intravenous parenteral solution 10 meq/l, 20 meq/l, 30 meq/l, 40 meq/l</i>	2	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	2	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l</i>	2	
<i>potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml)</i>	2	
<i>potassium chloride oral capsule, extended release 10 meq, 8 meq</i>	2	
<i>potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml</i>	2	
<i>potassium chloride oral packet 20 meq</i>	2	
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	1	
<i>potassium chloride oral tablet,er particles/crystals 10 meq, 20 meq</i>	1	
<i>potassium chloride oral tablet,er particles/crystals 15 meq</i>	2	
<i>potassium chloride-0.45 % nacl intravenous parenteral solution 20 meq/l</i>	2	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	2	
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 20 meq/l</i>	2	
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 40 meq/l</i>	4	
<i>sodium chloride 0.45 % intravenous parenteral solution 0.45 %</i>	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>sodium chloride 3 % hypertonic intravenous parenteral solution 3 %</i>	2	
<i>sodium chloride 5 % hypertonic intravenous parenteral solution 5 %</i>	2	
MISCELLANEOUS NUTRITION PRODUCTS		
CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION 5 %	4	B/D
CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %	4	B/D
CLINIMIX 5%-D20W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 5 %	4	B/D
<i>electrolyte-148 intravenous parenteral solution</i>	2	
<i>intralipid intravenous emulsion 20 %</i>	4	B/D
ISOLYTE S PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	4	
ISOLYTE-P IN 5 % DEXTROSE INTRAVENOUS PARENTERAL SOLUTION 5 %	4	
PLASMA-LYTE A INTRAVENOUS PARENTERAL SOLUTION	4	
PLENAMINE INTRAVENOUS PARENTERAL SOLUTION 15 %	4	B/D
<i>premasol 10 % intravenous parenteral solution 10 %</i>	4	B/D
<i>travasol 10 % intravenous parenteral solution 10 %</i>	4	B/D
TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %	4	B/D
VITAMINS / HEMATINICS		
<i>cyanocobalamin (vitamin b-12) injection solution</i>	1	NT
<i>dodex injection solution 1,000 mcg/ml</i>	1	NT
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	1	NT
<i>fluoride (sodium) oral tablet 1 mg (2.2 mg sod. fluoride)</i>	2	
<i>folic acid oral tablet 1 mg</i>	1	NT
<i>prenatal vitamin plus low iron oral tablet 27 mg iron- 1 mg</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

Health Net Life Insurance Company is contracted with Medicare for PPO plans. “Wellcare by Health Net” is issued by Health Net Life Insurance Company.

“Wellcare” is issued by WellCare Health Insurance Company of Washington, Inc.

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French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan **1-877-374-4056 (TTY: 711)**. Yon moun ki pale Kreyol Ayisyen ka ede w. Se yon sèvis ki gratis.

Polish: Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod numer **1-877-374-4056 (TTY: 711)**. Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

Japanese: 弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、**1-877-374-4056 (TTY: 711)** にお電話ください。日本語の通訳担当者が対応します。これは無料のサービスです。

Hawaiian: Loa‘a iā mākou nā lawelawe unuhi ‘ōlelo manuahi e pane i nā nīnau āu e pili ana i kā mākou papahana olakino a lā‘au paha. No ka loa‘a ‘ana o ka unuhi ‘ōlelo e kelepona iā mākou ma **1-877-374-4056 (TTY: 711)**. Hiki i kekahi kanaka ‘ōlelo Hawai‘i ke kōkua iā ‘oe. He lawelawe manuahi kēia.

Ilocano: Adda iti libre a serbisyo ti panagpatarus mi tapno masungbatan ti anyaman a saludsod mo maipanggep iti plano ti salun-at wenno agas mi. Tapno makaala ti maysa nga agipatpatarus pakiawagan dakami laeng iti **1-877-374-4056 (TTY: 711)**. Mabalín nga makatulóng kenka ti maysa nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

Samoan: E iai matou auaunaga faamatala upu e tali atu i soo se fesili e te ono fesili ai e uiga ia matou fuafuaga tau soifua maloloina poo fualaa. Ina ia maua se tagata faamatala upu na’o le vili mai a matou i le **1-877-374-4056 (TTY: 711)**. E mafai ona fesoasoani atu ia te oe se tasi e tautala i le gagana Samoan. E leai se totogi o lenei auaunaga.

Ukrainian: Ми безкоштовно надаємо послуги перекладачів, щоб ви могли отримати відповіді на будь-які запитання щодо нашого плану медичного обслуговування чи забезпечення лікарськими засобами. Щоб отримати допомогу перекладача, просто зателефонуйте нам за номером **1-877-374-4056 (TTY: 711)**. Спеціаліст, який володіє українською, допоможе вам. Ця послуга безкоштовна.

Lao: ພວກເຮົາມີບໍລິການຄົນພາສາພຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບແຜນສຸຂະພາບ ຫຼື ຢາຂອງພວກເຮົາ. ເພື່ອຂໍຄືນແປພາສາ ພຽງແຕ່ໂທຫາພວກເຮົາໄດ້ທີ່ເບີ 1-877-374-4056 (TTY: 711). ມີຄົນທີ່ເວົ້າພາສາລາວສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນບໍລິການພຣີ.

Cambodian: យើងមានសេវាកម្មប្រែប្រួលមាត់ដោយឥតគិតថ្លៃសម្រាប់ឆ្លើយរាល់សំណួរដែលអ្នកមានអំពីគម្រោងឱសថបូគម្រោងសុខភាពរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ គ្រាន់តែទូរសព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-877-374-4056 (TTY: 711)។ មនុស្សម្នាក់ដែលនិយាយភាសាខ្មែរបានអាចជួយអ្នកបាន។ នេះជាសេវាកម្មឥតគិតថ្លៃ។

Hmong: Peb muaj cov kev pab cuam kws txhais lus pab dawb los teb cov nqe lus nug twg uas koj yuav muaj hais txog peb lub phiaj xwm duav roos kev noj qab haus huv thiab tshuaj. Yog xav tau ib tug kws txhais lus ces tsuas hu rau peb tau ntawm 1-877-374-4056 (TTY: 711). Ib tug neeg twg uas hais tau lus Hmoob yuav pab tau koj. Qhov no yog kev pab cuam pab dawb xwb.

Thai: เรามีบริการล่ามแปลภาษาให้ฟรีเพื่อตอบคำถามใดๆ ที่คุณอาจมีเกี่ยวกับแผนด้านสุขภาพหรือยาของเรา หากต้องการล่ามแปลภาษา โปรดติดต่อเราที่หมายเลข 1-877-374-4056 (TTY: 711) คนที่พูดภาษาไทยได้สามารถช่วยคุณได้ บริการนี้ไม่มีค่าใช้จ่าย

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Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il 1-844-428-2224 (TTY: 711). Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte nos através do número 1-844-428-2224 (TTY: 711). Um falante de português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan 1-844-428-2224 (TTY: 711). Yon moun ki pale Kreyol Ayisyen ka ede w. Se yon sèvis ki gratis.

Polish: Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod numer 1-844-428-2224 (TTY: 711). Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

Japanese: 弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、1-844-428-2224 (TTY : 711) にお電話ください。日本語の通訳担当者が対応します。これは無料のサービスです。

Bengali: আমাদের স্বাস্থ্য বা ড্রাগ বিষয়ক পরিকল্পনা সম্পর্কে আপনার সম্ভাব্য যে কোন প্রশ্নের উত্তর দেওয়ার জন্য আমাদের কাছে বিনামূল্যে ইন্টারপ্রেটার পরিষেবা রয়েছে। একজন ইন্টারপ্রেটার পেতে, খালি আমাদের 1-844-428-2224 (TTY: 711) নম্বরে কল করুন। বাংলা বলতে পারে এমন কেউ আপনাকে সাহায্য করতে পারে। এই পরিষেবাটির জন্য কোনও খরচ নেই।

Nepali: हाम्रा स्वास्थ्य वा औषधिसम्बन्धी प्लानहरूको सम्बन्धमा तपाईंसँग हुन सक्ने जुनसुकै प्रश्नको जवाफ दिन हामीसँग निःशुल्क दोभासे सेवाहरू छन्। कुनै दोभासेको सेवा प्राप्त गर्न तपाईंले 1-844-428-2224 (TTY: 711) मा हामीलाई कल मात्र गरे पुग्छ। नेपाली भाषा बोल्ने कुनै व्यक्तिले तपाईंलाई मद्दत गर्नुहुने छ। यो एक निःशुल्क सेवा हो।

Swahili: Tuna huduma za mkalimani zisizolipiwa wa kujibu maswali yoyote ambayo unaweza kuwa nayo kuhusu mpango wetu wa afya au dawa. Ili kupata mkalimani, tupigie tu simu kupitia 1-844-428-2224 (TTY: 711). Mtu anayezungumza Kiswahili anaweza kukusaidia. Huduma hii ni ya bila malipo.

Tamil: எங்கள் உடல்நலம் அல்லது மருந்துத் திட்டம் பற்றி உங்களுக்கு ஏதேனும் கேள்விகள் இருந்தால் பதிலளிப்பதற்காக இலவச மொழிபெயர்ப்பாளர் சேவைகளை வழங்குகிறோம். ஒரு மொழிபெயர்ப்பாளரை அணுக, 1-844-428-2224 (TTY: 711) என்ற எண்ணில் எங்களை அழைக்கவும். தமிழ் பேசத் தெரிந்த ஒருவர் உங்களுக்கு உதவுவார். இது ஒரு இலவச சேவையாகும்.

ATTENTION: If you need help in your language, call 1-877-374-4056 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-877-374-4056 (TTY: 711). These services are free.

انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على 1-877-374-4056 (TTY: 711). تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على 1-877-374-4056 (TTY: 711). هذه الخدمات مجانية.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ցանկանում եք օգնություն ստանալ ձեր լեզվով, զանգահարեք 1-877-374-4056 (TTY՝ 711): Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, օրինակ՝ բրայլյան գրատեսակով և խոշոր տառաչափով փաստաթղթեր: Չանզանահարեք 1-877-374-4056 (TTY՝ 711): Այս ծառայություններն անվճար են:

注意：如果您需要以您的语言提供的帮助，请致电 1-877-374-4056 (TTY: 711)。此外，还为残疾人提供辅助和相关服务，如盲文文件和大字体文件。请致电 1-877-374-4056 (TTY: 711)。这些服务均免费提供。

注意：如果您需要以您母語提供的協助，請致電 1-877-374-4056 (TTY: 711)。我們也為殘疾人士提供輔助和服務，例如點字和大字體印刷的文件。請致電 1-877-374-4056 (TTY: 711)。這些服務均為免費。

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-877-374-4056 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਵਰਗੀਆਂ ਅਸਮਰੱਥਾ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਉਪਲਬਧ ਹਨ। 1-877-374-4056 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਮੁਫਤ ਸੇਵਾਵਾਂ ਹਨ।

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो 1-877-374-4056 (TTY: 711) पर कॉल करें. विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं. 1-877-374-4056 (TTY: 711) पर कॉल करें. ये सेवाएं निःशुल्क हैं.

THOV MUAB SIAB RAU: Yog tias koj xav tau kev pab ua koj hom lus, ces hu rau 1-877-374-4056 (TTY: 711). Tsis tas i ntawd, peb tseem muaj cov neeg pab thiab cov kev pab cuam rau cov neeg uas muaj cov kev xiam oob qhab, xws li cov ntaub ntawv ua ntawv su rau neeg dig muag thiab ntawv luam loj. Hu rau 1-877-374-4056 (TTY: 711). Cov kev pab cuam no pab dawb xwb.

注意：言語のヘルプが必要な場合は 1-877-374-4056 (TTY : 711) までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。1-877-374-4056 (TTY : 711) にお電話ください。これらのサービスは無料です。

주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 1-877-374-4056(TTY: 711)번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. 1-877-374-4056(TTY: 711)번으로 연락해 주십시오. 이러한 서비스는 무료입니다.

ຂໍ້ຄວນເອົາໃຈໃສ່: ຫາກທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ 1-877-374-4056 (TTY: 711). ນອກຈາກນີ້ ຍັງມີຄວາມຊ່ວຍເຫຼືອສໍາລັບຜູ້ພິການ ເຊັ່ນ: ເອກະສານເປັນອັກສອນນູນ ແລະ ຕົວພິມໃຫຍ່ອີກດ້ວຍ. ໃຫ້ໂທຫາ 1-877-374-4056 (TTY: 711). ບໍລິການເຫຼົ່ານີ້ຟຣີ.

LIOUH EIX: Oix se nongc zuqc meih nyei wac jouh mienh bong zouc, cingv mboqv 1-877-374-4056 (TTY: 711). Hac haih weic waic fangx mienh zoux sic taengx qaqv, hnavg mangh wenh souh nzangc caux domh nzangc yenx benx nyei souh nzangc. Mboqv 1-877-374-4056 (TTY: 711). Naiv deix bong taengx meih se mv siou zinh.

ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-877-374-4056 (TTY: 711) ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្នាបសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ 1-877-374-4056 (TTY: 711)។ សេវាទាំងនេះមិនគិតថ្លៃនោះទេ។

توجه: اگر به زبان خودتان نیاز به کمک دارید با شماره 1-877-374-4056 (TTY: 711) تماس بگیرید. پشتیبانی و خدمات برای افراد دارای معلولیت، مانند اسناد با خط بریل و چاپ درشت، نیز موجود است. با شماره 1-877-374-4056 (TTY: 711) تماس بگیرید. این خدمات رایگان است.

ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру 1-877-374-4056 (TTY: 711). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру 1-877-374-4056 (TTY: 711). Эти услуги предоставляются бесплатно.

ATENCIÓN: Si necesita ayuda en su idioma llame al 1-877-374-4056 (TTY: 711). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al 1-877-374-4056 (TTY: 711). Estos servicios son gratuitos.

ATENSYON: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa 1-877-374-4056 (TTY: 711). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa 1-877-374-4056 (TTY: 711). Libre ang mga serbisyong ito.

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ โปรดโทร 1-877-374-4056 (TTY: 711) นอกจากนี้ ยังมีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารที่เป็นอักษรเบรลล์และเอกสารที่ใช้ตัวอักษรขนาดใหญ่ โปรดโทร 1-877-374-4056 (TTY: 711) บริการเหล่านี้ไม่มีค่าใช้จ่าย

УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером 1-877-374-4056 (TTY: 711). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером 1-877-374-4056 (TTY: 711). Ці послуги безкоштовні.

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số 1-877-374-4056 (TTY: 711). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và bản in cỡ chữ lớn cũng được cung cấp. Gọi số 1-877-374-4056 (TTY: 711). Các dịch vụ này miễn phí.

ATTENTION: If you need help in your language, call 1-844-428-2224 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-844-428-2224 (TTY: 711). These services are free.

انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على 1-844-428-2224 (TTY: 711). تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على 1-844-428-2224 (TTY: 711). هذه الخدمات مجانية.

ՈՒՇԱԴԴՈՒԹՅՈՒՆ. Եթե ցանկանում եք օգնություն ստանալ ձեր լեզվով, զանգահարեք 1-844-428-2224 (TTY` 711): Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, օրինակ՝ բրայլյան գրատեսակով և խոշոր տառաչափով փաստաթղթեր: Չանզանահարեք 1-844-428-2224 (TTY` 711): Այս ծառայություններն անվճար են:

注意：如果您需要以您的语言提供的帮助，请致电 1-844-428-2224 (TTY：711)。此外，还为残疾人提供辅助和相关服务，如盲文文件和大字体文件。请致电 1-844-428-2224 (TTY：711)。这些服务均免费提供。

注意：如果您需要以您母語提供的協助，請致電 1-844-428-2224 (TTY：711)。我們也為殘疾人士提供輔助和服務，例如點字和大字體印刷的文件。請致電 1-844-428-2224 (TTY：711)。這些服務均為免費。

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-844-428-2224 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਵਰਗੀਆਂ ਅਸਮਰੱਥਾ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਉਪਲਬਧ ਹਨ। 1-844-428-2224 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਮੁਫਤ ਸੇਵਾਵਾਂ ਹਨ।

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो 1-844-428-2224 (TTY: 711) पर कॉल करें। विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं। 1-844-428-2224 (TTY: 711) पर कॉल करें। ये सेवाएं निःशुल्क हैं।

THOV MUAB SIAB RAU: Yog tias koj xav tau kev pab ua koj hom lus, ces hu rau 1-844-428-2224 (TTY: 711). Tsis tas i ntawd, peb tseem muaj cov neeg pab thiab cov kev pab cuam rau cov neeg uas muaj cov kev xiam oob qhab, xws li cov ntaub ntawv ua ntawv su rau neeg dig muag thiab ntawv luam loj. Hu rau 1-844-428-2224 (TTY: 711). Cov kev pab cuam no pab dawb xwb.

注意：言語のヘルプが必要な場合は 1-844-428-2224 (TTY : 711) までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。1-844-428-2224 (TTY : 711) にお電話ください。これらのサービスは無料です。

주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 1-844-428-2224(TTY: 711)번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. 1-844-428-2224(TTY: 711)번으로 연락해 주십시오. 이러한 서비스는 무료입니다.

ຂໍ້ຄວນເອົາໃຈໃສ່: ຫາກທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ 1-844-428-2224 (TTY: 711). ນອກຈາກນີ້ ຍັງມີຄວາມຊ່ວຍເຫຼືອສໍາລັບຜູ້ພິການ ເຊັ່ນ: ເອກະສານເປັນອັກສອນນູນ ແລະ ຕົວພິມໃຫຍ່ອີກດ້ວຍ. ໃຫ້ໂທຫາ 1-844-428-2224 (TTY: 711). ບໍລິການເຫຼົ່ານີ້ຟຣີ.

LIOUH EIX: Oix se nongc zuqc meih nyei wac jouh mienh bong zouc, cingv mboqv 1-844-428-2224 (TTY: 711). Hac haih weic waic fangx mienh zoux sic taengx qaqv, hnavg mangh wenh souh nzangc caux domh nzangc yenx benx nyei souh nzangc. Mboqv 1-844-428-2224 (TTY: 711). Naiv deix bong taengx meih se mv siou zinh.

ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-844-428-2224 (TTY: 711) ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្នាបសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ 1-844-428-2224 (TTY: 711)។ សេវាទាំងនេះមិនគិតថ្លៃនោះទេ។

توجه: اگر به زبان خودتان نیاز به کمک دارید با شماره 1-844-428-2224 (TTY: 711) تماس بگیرید. پشتیبانی و خدمات برای افراد دارای معلولیت، مانند اسناد با خط بریل و چاپ درشت، نیز موجود است. با شماره 1-844-428-2224 (TTY: 711) تماس بگیرید. این خدمات رایگان است.

ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру 1-844-428-2224 (TTY: 711). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру 1-844-428-2224 (TTY: 711). Эти услуги предоставляются бесплатно.

ATENCIÓN: Si necesita ayuda en su idioma llame al 1-844-428-2224 (TTY: 711). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al 1-844-428-2224 (TTY: 711). Estos servicios son gratuitos.

ATENSYON: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa 1-844-428-2224 (TTY: 711). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa 1-844-428-2224 (TTY: 711). Libre ang mga serbisyong ito.

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ โปรดโทร 1-844-428-2224 (TTY: 711) นอกจากนี้ ยังมีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารที่เป็นอักษรเบรลล์และเอกสารที่ใช้ตัวอักษรขนาดใหญ่ โปรดโทร 1-844-428-2224 (TTY: 711) บริการเหล่านี้ไม่มีค่าใช้จ่าย

УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером 1-844-428-2224 (TTY: 711). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером 1-844-428-2224 (TTY: 711). Ці послуги безкоштовні.

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số 1-844-428-2224 (TTY: 711). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và bản in cỡ chữ lớn cũng được cung cấp. Gọi số 1-844-428-2224 (TTY: 711). Các dịch vụ này miễn phí.

Arkansas

Wellcare Giveback Dividend (HMO-POS)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Giveback (HMO-POS)

1-800-977-7522 (TTY: 711)

wellcare.com/allwellAR

Arizona

Wellcare Simple Open (PPO)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Giveback (HMO),

Wellcare Simple (HMO),

Wellcare Simple Value (HMO)

1-800-977-7522 (TTY: 711)

wellcare.com/allwellAZ

California

Wellcare Giveback (HMO),

Wellcare Simple (HMO)

1-866-999-3945 (TTY: 711)

wellcare.com/medicare

Wellcare Premium Ultra (HMO),

Wellcare Simple Focus (HMO),

Wellcare Simple Ruby (HMO),

Wellcare Simple Focus (HMO)

1-800-275-4737 (TTY: 711)

wellcare.com/healthnetCA

Connecticut

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Florida

HMO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Georgia

HMO-POS, PPO

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Hawaii

HMO

1-877-457-7621 (TTY: 711)

wellcare.com/ohana

Illinois

Wellcare Giveback Open (PPO),

Wellcare Simple (HMO-POS)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Simple Exclusive (HMO)

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Kansas

Wellcare Giveback (HMO-POS)

1-800-977-7522 (TTY: 711)

wellcare.com/allwellKS

Wellcare Complete - Giveback (HMO-POS)

1-800-977-7522 (TTY: 711)

wellcarecomplete.com

Kentucky

HMO-POS

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Louisiana

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Maine

HMO-POS, PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Michigan

HMO-POS, PPO

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Mississippi

HMO-POS

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Missouri

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

HMO-POS

1-800-977-7522 (TTY: 711)

wellcare.com/allwellMO

Nevada

HMO-POS

1-800-977-7522 (TTY: 711)

wellcare.com/allwellNV

New York

PPO

1-833-444-9088 (TTY: 711)

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North Carolina

PPO

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Ohio

HMO-POS

1-800-977-7522 (TTY: 711)

wellcare.com/allwellOH

Oregon

PPO

1-844-582-5177 (TTY: 711)

wellcare.com/healthnetOR

South Carolina

HMO-POS, PPO

1-866-892-8340 (TTY: 711)

wellcare.com/medicare

Tennessee

HMO-POS

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Texas

Wellcare Giveback (HMO) H0174017000,
Wellcare Giveback (HMO) H0174018000,
Wellcare Giveback (HMO) H0174019000,
Wellcare Giveback (HMO) H0174020000,
Wellcare Giveback (HMO) H0174021000,
Wellcare Mutual of Omaha Simple Secure Open
(PPO) H7323011000,
Wellcare Mutual of Omaha Simple Secure Open
(PPO) H7323012000,
Wellcare Simple (HMO) H0174002000,
Wellcare Simple (HMO) H0174010000,
Wellcare Simple (HMO) H0174014000

1-833-444-9088 (TTY: 711)

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Wellcare Giveback (HMO) H5294019000

1-800-977-7522 (TTY: 711)

wellcare.com/allwellTX

Washington

Wellcare Mutual of Omaha Premium Enhanced
Open (PPO),

Wellcare Mutual of Omaha Simple Open (PPO)

1-833-444-9088 (TTY: 711)

wellcare.com/medicare

Wellcare Giveback Open (PPO)

1-844-582-5177 (TTY: 711)

wellcare.com/healthnetOR



This formulary was updated on 09/01/2024.

For more recent information or other questions, please contact us, Wellcare Member Services at the telephone number or website for your plan listed on the inside front and back covers of this formulary, between October 1 and March 31, representatives are available seven days a week, 8 a.m. to 8 p.m., between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

09/01/2024

Medicare_{Rx}
Prescription Drug Coverage