

Qualified Health Plans 2026 Drug Formulary for HMOs and PPOs



THIS DOCUMENT HAS INFORMATION ABOUT THE PRESCRIPTION DRUGS WE COVER FOR QUALIFIED HEALTH PLANS.

Qualified Health Plans (QHP) are Affordable Care Act-compliant plans that cover essential health benefits and follow established limits on cost-sharing.

In addition to frequently asked questions regarding our drug formulary and prescription coverage, the actual list of covered drugs for our health plans is also included herein. This list is current as of January 2026.

If you have questions about your health plan, please call a Customer Service at the number on your ID card or log in at hap.org and send us a message.

Please note: A drug's formulary status may change prior to being updated in this document. The listing of a drug does not imply coverage for all benefits. Some dosage forms or strengths of an existing formulary drug may not be covered. Please contact us for more details.

Q&A

Q. What is the drug list?

A. The drug list, also known as a formulary, is a list of covered prescription drugs. Prescription drugs are medications you can obtain from pharmacies and administer to yourself. Our drug list is developed with a team of health care providers, including doctors and pharmacists. It contains the prescription drugs believed to be a necessary part of a quality treatment program. The prescription is then filled at an in-network pharmacy.

The status of covered drugs can change over time. For example:

- We may add new drugs to the list as they are approved by the Food and Drug Administration.
- We may remove drugs as we learn more about how safe they are and how well they work.
- We may change the tier levels of drugs on the list. Tier levels determine your copay and other out-of-pocket costs for drugs.

From time to time, we may add or remove quantity limits, the need for prior authorization or other criteria for coverage.

Q. Where can I find the drug list?

A. You can search for covered drugs on our interactive Drug Search tool or download a drug list. The Drug Search tool and the Drug list are available at hap.org/prescription-drug

Q. How do I use the interactive Drug Search tool?

A: If you are using a computer, click on the Search QHP button. Drug Search tool will display. You only need the first three letters of the drug name to search. Type the drug name in the search box, press enter. You will get a list of drugs that match your search request. Select the drug you are looking for, press enter. The display will show the full drug name, therapeutic class, drug tier status and any criteria for coverage such as quantity limits or prior authorization

Q. How do I use the drug list ?

A. The drug list is a list of covered generic and brand name drugs and is organized by categories. Each category represents the type of medical conditions that the drugs are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular Agents.” If you know what a drug is used for, look for the category name in the list. Then look under the category name for the drug.

You can also look for your drug in the Index that is at the end of the document. The Index provides an alphabetical list of all drugs included in this document.

If you are using a computer, you can search for a specific drug within the formulary, just select Ctrl-F and enter the name of the drug in the search box. The cursor will highlight the drug you are looking for.

What is included in the drug formulary?

- The name of the covered drug. Brand name drugs are capitalized (e.g., JANUVIA) and generic drugs are listed in lower-case (e.g., metformin). **When a generic drug is listed on the formulary, only the generic is covered.**
- The covered drug cost-sharing level or *Tier*. Every drug on the formulary is in one of six cost-sharing Tiers. **Refer to your Summary of Benefits and Coverage for your cost-sharing information.** The following table will translate how the six Tiers shown on the formulary are applicable to your health plan’s prescription drug benefit.

Description of Tier	Copay
Preventive – FDA approve drugs that are covered at zero cost share per the Affordable Care Act when Health Care Reform (HCR) rules are met.	Zero Cost Share
Select Generic Drugs – FDA approved drugs that contain the same active ingredient(s), identical in concentration and strength to their brand name drug. Drugs in this tier are comprised of low-cost generic drugs.	Tier 1
Generic and Select Brand Drugs – FDA approved generic and brand name drugs that meet rigorous quality, safety and cost-effectiveness guidelines, with a slightly higher out of pocket cost than Select Generic Drugs.	Tier 2
Preferred Brand – FDA approved brand name drugs that meet rigorous quality, safety and cost-effectiveness guidelines.	Tier 3
Non-Preferred Brand and Generic Drugs – FDA approved generic and brand name drugs that meet rigorous quality, safety and cost-effectiveness guidelines that are considered non-preferred by us, which may also include higher cost generics.	Tier 4
Preferred Specialty Drugs – brand, generic or biosimilar drugs approved by the FDA that are used to treat complex and/or chronic illnesses and require close supervision and monitoring. The drugs in this category include injectable/infusible and certain orally inhaled drugs that may require prior authorization. To assure safe and quality care; these drugs must be obtained by a contracted specialty pharmacy.	Tier 5
Non-Preferred Specialty Drug – brand, generic or biosimilar drugs approved by the FDA that are used to treat complex and/or chronic illnesses and require close supervision and monitoring. The drugs in this category include higher-cost injectable/infusible and certain orally inhaled drugs that may require prior authorization. To assure safe and quality care; these drugs must be obtained by a contracted specialty pharmacy.	Tier 6
Medical Drugs – These are drugs that are infused or administered in doctor’s office or facility, that are covered under your medical benefit and may be required by us to be obtained from a Specialty Pharmacy.	Tier 7

- Drug Coverage rules and limits as follows:

PA (Prior Authorization) – You or your doctor is required to get prior authorization from us before you fill your prescription for this drug. Without prior approval, we may not cover this drug.

QL (Quantity Limit) – We limit the amount of these drugs that are covered for each prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

ST (Step Therapy) – Before we will provide coverage for this drug, you must first try another drug(s) to treat your medical condition. This drug may only be covered if the other drug(s) does not work for you.

SP (Specialty Pharmacy) – This specialty drug can only be obtained from Pharmacy Advantage by calling them at (800) 456 2112.

- **HCR (Health Care Reform)** – You must meet the Health Care Reform requirements for preventive use to obtain the drug at zero cost sharing

Q. What is a *generic substitution*?

A. When an FDA approved generic drug is available, your prescription will be filled with the generic form of the medication. Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your health plan less money than a brand name drug.

Q. What are *specialty drugs*?

A. Specialty drugs are biologics or prescription drugs that require close monitoring for safety and efficacy. For this reason we contract with Pharmacy Advantage, a specialty pharmacy, from whom you can obtain specialty drugs. Specialty drugs require prior authorization and Pharmacy Advantage can help you and your doctor submit a request. You or your doctor can contact Pharmacy Advantage at (800) 456-2112.

Q. Are there any restrictions on my coverage?

A. Some covered drugs may have additional requirements or limits on coverage. The coverage requirements are listed on the drug formulary. These requirements and limits may include:

- **Prior Authorization** – Some medications on our formulary have criteria you must meet before we cover them. This means that you will need to get approval from us before you fill your prescriptions for these drugs.
- **Step Therapy** – In some cases, we require 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
- **Quantity Limits** – Certain drugs have quantity limits. A quantity limit is the maximum quantity that can be dispensed on each fill of medication or the maximum number of fills allowed for treatment of certain conditions. Specialty/injectable drugs (except insulin) and select oral drugs (e.g. opioid analgesics) are limited to a maximum 30-day supply per fill. Some specialty drugs require a 15-day supply for the first fill.

Benefit limitations

Our drug formulary applies to drugs used in an outpatient setting. It does not include medication administered in the doctor's office or while in the hospital. These are known as *medical drugs*. Note that some medical drugs are listed on this formulary because they are part of our Specialty Program. Please refer to "what are specialty drug?" section for information about these medications

The following are general drug coverage exclusions that apply to all members:

- Over-the-counter (OTC) medications and their equivalents are not covered unless specified in the formulary or on the rider
- Drug products used for cosmetic purposes are not covered
- Experimental drugs and/or any drug products used in an experimental manner are not covered
- Replacement of lost or stolen medication is not covered

Since the selected drug packages and coverage vary for each Qualified Health Plan, check your Summary of Benefits and Coverage (SBC) for your cost-sharing and exclusions.

Q. What if my drug is not on the drug formulary?

A. When your drug is not listed on the formulary it is considered *non-formulary*. You or your doctor can ask us to make an exception and cover your drug and one of HAP clinical specialists will evaluate if the medication will be covered by your plan. However, it is best to first discuss with your doctor or pharmacist if one of the formulary alternatives will work for you.

Exception approvals for standard non-formulary medications will process at the highest non specialty copayment. Exception approvals for non-formulary specialty drugs will process at the highest Specialty copayment. Non-formulary drugs when approved by plan are limited for up to 30-day supply at a time. Non-formulary specialty drugs when approved for use by the health plan can be required to be dispensed by Pharmacy Advantage.

Q. How do I request prior authorization or drug formulary exception?

A. You or your doctor can ask us to make an exception to our requirements or limits. You may also ask us to cover a drug not included on our formulary or ask us to exempt you from a formulary requirement through the exception process. Your doctor must submit a request to us indicating why formulary requirements should not apply. Your doctor may use the forms available at **hap.org/providers** to send us information when requesting either prior authorization or exception to the formulary.

Table of Contents

ANTIDOTE THERAPEUTICS.....	2
ANTI-HISTAMINE DRUGS.....	4
ANTI-INFECTION AGENTS.....	7
ANTI-NEOPLASTIC AGENTS.....	35
ANTITOXINS, IMMUNE GLOB, TOXOIDS, VACCINES.....	54
AUTONOMIC DRUGS.....	62
BLOOD DERIVATIVES.....	77
BLOOD FORMATION, COAGULATION, THROMBOSIS.....	77
CARDIOVASCULAR DRUGS.....	90
CELLULAR AND GENE THERAPY.....	117
CENTRAL NERVOUS SYSTEM AGENTS.....	118
DENTAL AGENTS.....	175
DEVICES.....	175
DIAGNOSTIC AGENTS.....	181
ELECTROLYTIC, CALORIC, AND WATER BALANCE.....	183
ENZYMES.....	192
EYE, EAR, NOSE AND THROAT (EENT) PREPS.....	195
GASTROINTESTINAL DRUGS.....	216
GOLD COMPOUNDS.....	227
HEAVY METAL ANTAGONISTS.....	227
HORMONES AND SYNTHETIC SUBSTITUTES.....	229
IMMUNOMODULATORY AGENTS (90:00).....	293
LOCAL ANESTHETICS.....	314
MISCELLANEOUS THERAPEUTIC AGENTS.....	315
NONHORMONAL CONTRACEPTIVES.....	324
OXYTOCICS.....	326
PHARMACEUTICAL AIDS.....	326
RESPIRATORY TRACT AGENTS.....	326
SKIN AND MUCOUS MEMBRANE AGENTS.....	345
SMOOTH MUSCLE RELAXANTS.....	379
VITAMINS.....	380

CURRENT AS OF 1/1/2026

DRUG NAME	DRUG TIER	NOTES
ANTIDOTE THERAPEUTICS		
Acetaminophen Antidote		
<i>acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)</i>	2	
Alcohol Deterrents (91:02)		
<i>acamprosate oral tablet, delayed release (dr/ec) 333 mg</i>	2	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	2	
Antidote Therapeutics		
<i>atropine ophthalmic (eye) drops 0.01 %, 0.025 %, 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: Atropine 1% eye drops); QL (5 ML per 30 days)
<i>atropine ophthalmic (eye) drops 1 %</i>	2	
BAQSIMI NASAL SPRAY, NON-AEROSOL 3 MG/ACTUATION	3	QL (1 kit per 1 fill)
CHEMET ORAL CAPSULE 100 MG	4	
CUPRIMINE ORAL CAPSULE 250 MG	Non-Formulary	ALT (Covered Alternatives: DEPEN); QL (4 capsules per 1 day)
GLUCAGON (HCL) EMERGENCY KIT INJECTION RECON SOLN 1 MG	4	QL (Quantity Limits Apply)
GLUCAGON EMERGENCY KIT (HUMAN) INJECTION RECON SOLN 1 MG	4	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	2	
<i>hyoscyamine sulfate sublingual tablet 0.125 mg</i>	2	
KLOXXADO NASAL SPRAY, NON-AEROSOL 8 MG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Naloxone)
<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	QL (2 doses per 90 days)
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	Non-Formulary	QL (2 doses per 90 days)
<i>penicillamine oral capsule 250 mg</i>	Non-Formulary	ALT (Covered Alternatives: Penicillamine Tablets); QL (4 capsules per 1 day)
<i>penicillamine oral tablet 250 mg</i>	2	PA; SP; QL (4 tablets per 1 day)
Antidotes (91:04)		
ANDEXXA INTRAVENOUS RECON SOLN 200 MG	BB	
Chemotherapy Antidotes/Protectants		
COSELA INTRAVENOUS RECON SOLN 300 MG	BB	PA
ELMIRON ORAL CAPSULE 100 MG	4	PA; QL (3 capsules per 1 day)
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	2	
<i>levoleucovorin calcium intravenous recon soln 50 mg</i>	BB	PA
<i>mesna oral tablet 400 mg</i>	2	QL (6 Tablets per 1 Day)
MESNEX ORAL TABLET 400 MG	Non-Formulary	ALT (Covered Alternatives: Mesna 400mg tablet)
Fluoropyrimidine Antidote		
VISTOGARD ORAL GRANULES IN PACKET 10 GRAM	Non-Formulary	SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Methemoglobinemia Antidote		
<i>methylene blue (antidote) intravenous syringe 20 mg/2 ml (10 mg/ml) 1 %</i>	BB	
Neuromuscular Blocking Agent Antidote		
<i>sugammadex in sterile water intravenous syringe 100 mg/2 ml (50 mg/ml), 150 mg/3 ml (50 mg/ml), 200 mg/4 ml (50 mg/ml), 50 mg/5 ml (10 mg/ml)</i>	BB	
<i>sugammadex intravenous syringe 100 mg/ml</i>	BB	
ANTI-HISTAMINE DRUGS		
Ethanolamine Derivatives		
<i>clemastine oral tablet 2.68 mg</i>	2	
CLEMSZA ORAL TABLET 2.68 MG	Non-Formulary	ALT (Covered Alternatives: CLEMASTINE 2.68MG); QL (3 Tablets per 1 Day)
First Gen. Antihist. Derivatives, Misc.		
<i>cyproheptadine oral syrup 2 mg/5 ml</i>	2	
<i>cyproheptadine oral tablet 4 mg</i>	2	
First Generation Antihistamines		
<i>carbinoxamine maleate oral suspension, extended rel 12 hr 4 mg/5 ml</i>	Non-Formulary	QL (40 ML per 1 Day)
CARBZAH ORAL LIQUID 4 MG/5 ML	Non-Formulary	ALT (Covered Alternatives: CARBINOXAMINE MALEATE ORAL LIQUID 4MG/5ML); QL (30 ML per 1 Day)
<i>clemastine oral tablet 2.68 mg</i>	2	
CLEMSZA ORAL TABLET 2.68 MG	Non-Formulary	ALT (Covered Alternatives: CLEMASTINE 2.68MG); QL (3 Tablets per 1 Day)
<i>cyproheptadine oral syrup 2 mg/5 ml</i>	2	
<i>cyproheptadine oral tablet 4 mg</i>	2	
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	2	
<i>hydroxyzine hcl oral tablet 10 mg, 50 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydroxyzine hcl oral tablet 25 mg</i>	2	QL (4 tablets per 1 day)
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	2	
Other Antihistamines		
<i>bepotastine besilate ophthalmic (eye) drops 1.5 %</i>	2	QL (0.2 ml per 1 day)
BEPREVE OPHTHALMIC (EYE) DROPS 1.5 %	Non-Formulary	QL (0.2 ML per 1 day)
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	2	
<i>famotidine (pf) intravenous solution 20 mg/2 ml</i>	BB	
<i>famotidine oral suspension for reconstitution 40 mg/5 ml (8 mg/ml)</i>	2	QL (5 ML per 1 day)
<i>famotidine oral tablet 20 mg</i>	1	QL (4 tablets per 1 day)
<i>famotidine oral tablet 40 mg</i>	1	QL (3 tablets per 1 day)
<i>nizatidine oral capsule 150 mg, 300 mg</i>	2	
RYALTRIS NASAL SPRAY, NON-AEROSOL 665-25 MCG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Fluticasone Nasal Spray, Flunisolide Nasal Spray, Mometasone Nasal Spray); QL (1 gram per 1 day)
Phenothiazine Derivatives		
<i>promethazine oral syrup 6.25 mg/5 ml</i>	2	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine rectal suppository 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine-dm oral syrup 6.25-15 mg/5 ml</i>	2	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG	2	
Piperazine Derivatives		
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	
Propylamine Derivatives		
<i>hydrocodone-chlorpheniramine oral suspension, extended rel 12 hr 10-8 mg/5 ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Second Generation Antihistamines		
ALLERGY AND CONGESTION RELIEF ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY RELIEF (LORATADINE) ORAL TABLET 10 MG	2	
ALLERGY RELIEF D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY RELIEF,NASAL DECONGEST ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY-CONGESTION RELIEF-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %), 205.5 mcg (0.15 %)</i>	2	QL (30 ML per 30 days)
<i>azelastine ophthalmic (eye) drops 0.05 %</i>	2	
<i>cetirizine oral solution 1 mg/ml</i>	2	
<i>cetirizine oral tablet 10 mg, 5 mg</i>	2	
CLARITIN-D 24 HOUR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	Non-Formulary	
<i>epinastine ophthalmic (eye) drops 0.05 %</i>	2	
<i>levocetirizine oral tablet 5 mg</i>	2	
LORATA-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
<i>loratadine oral solution 5 mg/5 ml</i>	2	
<i>loratadine oral tablet 10 mg</i>	2	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
QUZYTIR INTRAVENOUS SOLUTION 10 MG/ML	BB	PA
ZERVIAE OPHTHALMIC (EYE) DROPPERETTE 0.24 %	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ANTI-INFECTIVE AGENTS		
1St Generation Cephalosporin Antibiotics		
<i>cefadroxil oral capsule 500 mg</i>	2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	2	
<i>cefadroxil oral tablet 1 gram</i>	2	
<i>cefazolin in dextrose (iso-os) intravenous piggyback 3 gram/150 ml</i>	7	
<i>cefazolin in sterile water intravenous syringe 1 gram/10 ml, 2 gram/10 ml, 2 gram/20 ml</i>	BB	
<i>cefazolin injection recon soln 10 gram</i>	7	
<i>cefazolin injection recon soln 2 gram</i>	Non-Formulary	
<i>cephalexin oral capsule 250 mg, 500 mg, 750 mg</i>	2	
<i>cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>cephalexin oral tablet 500 mg</i>	2	
2Nd Generation Cephalosporin Antibiotics		
<i>cefaclor oral capsule 250 mg, 500 mg</i>	2	
<i>cefaclor oral tablet extended release 12 hr 500 mg</i>	2	
<i>cefprozil oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	2	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	2	
3Rd Generation Cephalosporin Antibiotics		
<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>cefixime oral capsule 400 mg</i>	2	QL (2 capsules per 1 day)
<i>cefixime oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	2	
<i>cefpodoxime oral suspension for reconstitution 100 mg/5 ml, 50 mg/5 ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>cefepime injection recon soln 2 gram</i>	2	
<i>ceftriaxone injection recon soln 2 gram</i>	7	
4Th Generation Cephalosporin Antibiotics		
<i>cefepime injection recon soln 2 gram</i>	7	
5Th Generation Cephalosporin Antibiotics		
TEFLARO INTRAVENOUS RECON SOLN 400 MG, 600 MG	7	
ZEVTERA INTRAVENOUS RECON SOLN 667 MG	Non-Formulary	SP; QL (4.002 ML per 1 Day)
Adamantane Antivirals		
<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	
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG, 68.5 MG	Non-Formulary	SP
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 258 MG, 322 MG/DAY(129 MG X1-193MG X1)	Non-Formulary	QL (Quantity Limits Apply)
<i>rimantadine oral tablet 100 mg</i>	2	
Allylamine Antifungals		
<i>terbinafine hcl oral tablet 250 mg</i>	2	
Amebicides		
HUMATIN ORAL CAPSULE 250 MG	4	SP
METROGEL TOPICAL GEL 1 %	Non-Formulary	QL (Quantity Limits Apply)
<i>metronidazole oral capsule 375 mg</i>	Non-Formulary	
<i>metronidazole oral tablet 125 mg</i>	Non-Formulary	ALT (Covered Alternatives: Metronidazole 250mg Tablets); QL (1 Tablets per 1 Day)
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole topical cream 0.75 %</i>	2	QL (45 GM per 30 days)
<i>metronidazole topical gel 0.75 %, 1 %</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>metronidazole topical gel with pump 1 %</i>	2	
<i>metronidazole topical lotion 0.75 %</i>	2	QL (59 GM per 30 days)
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	2	
NORITATE TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)
NUVESSA VAGINAL GEL 1.3 % (65 MG/5 GRAM)	Non-Formulary	ALT (Covered Alternatives: METRONIDAZOLE, CLINDAMYCIN PHOSPHATE)
Aminoglycoside Antibiotics		
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION 590 MG/8.4 ML	Non-Formulary	QL (Quantity Limits Apply); SP
BETHKIS INHALATION SOLUTION FOR NEBULIZATION 300 MG/4 ML	Non-Formulary	QL (Quantity Limits Apply); QL (280 ampules per 30 days)
<i>gentamicin ophthalmic (eye) drops 0.3 %</i>	1	
<i>gentamicin topical cream 0.1 %</i>	2	QL (30 GM per 30 days)
<i>gentamicin topical ointment 0.1 %</i>	2	
<i>gentamicin-sodium citrate intra-catheter syringe 1,600 mcg/5 ml-4 %, 960 mcg/3 ml-4 %</i>	BB	
HUMATIN ORAL CAPSULE 250 MG	4	SP
KITABIS PAK INHALATION SOLUTION FOR NEBULIZATION 300 MG/5 ML	Non-Formulary	SP; ALT (Covered Alternatives: TOBRAMYCIN PAK 300 MG/5 ML)
<i>neomycin oral tablet 500 mg</i>	2	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	2	QL (5 ML per 1 fill)
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	2	
TOBI INHALATION SOLUTION FOR NEBULIZATION 300 MG/5 ML	Non-Formulary	SP
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE 28 MG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: TOBRAMYCIN SULFATE)
TOBRADEX OPHTHALMIC (EYE) OINTMENT 0.3-0.1 %	3	QL (3.5 GM per 1 fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TOBRADEX ST OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.05 %	Non-Formulary	QL (Quantity Limits Apply)
<i>tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml</i>	5	PA; SP; QL (280 ampules per 30 days)
<i>tobramycin inhalation solution for nebulization 300 mg/4 ml</i>	Non-Formulary	SP; QL (280 ampules per 30 days)
<i>tobramycin ophthalmic (eye) drops 0.3 %</i>	2	QL (5 ML per 1 fill)
<i>tobramycin with nebulizer inhalation solution for nebulization 300 mg/5 ml</i>	7	PA; SP; QL (280 ampules per 30 days)
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %</i>	2	
TOBREX OPHTHALMIC (EYE) OINTMENT 0.3 %	3	QL (1 tube per 1 fill)
ZEMDRI INTRAVENOUS SOLUTION 50 MG/ML	BB	
ZYLET OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.5 %	Non-Formulary	QL (Quantity Limits Apply)
Aminomethylcyclines		
NUZYRA ORAL TABLET 150 MG	Non-Formulary	QL (Quantity Limits Apply)
SEYSARA ORAL TABLET 100 MG, 150 MG, 60 MG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE HYCLATE, CLINDAMYCIN HCL, MINOCYCLINE HCL, TETRACYCLINE HCL)
Aminopenicillin Antibiotics		
<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	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<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>	2	
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 15 gram, 3 gram</i>	7	
<i>ampicillin-sulbactam intravenous recon soln 1.5 gram, 3 gram</i>	7	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 250-62.5 MG/5 ML	Non-Formulary	
OMECLAMOX-PAK ORAL COMBO PACK 20 MG-500 MG- 500 MG (40)	Non-Formulary	QL (Quantity Limits Apply)
TALICIA ORAL CAPSULE,IR - DELAY REL,BIPHASE 10-250-12.5 MG	Non-Formulary	QL (Quantity Limits Apply)
UNASYN INJECTION RECON SOLN 1.5 GRAM, 15 GRAM, 3 GRAM	Non-Formulary	
VOQUEZNA DUAL PAK ORAL COMBO PACK 20 MG (28)- 500 MG (84)	Non-Formulary	
VOQUEZNA TRIPLE PAK ORAL COMBO PACK 20-500-500 MG	Non-Formulary	
Anthelmintics		
<i>albendazole oral tablet 200 mg</i>	2	QL (120 Tablets per 28 Day. 28 Days of Treatment per 180 Days)
EGATEN ORAL TABLET 250 MG	Non-Formulary	
EMVERM ORAL TABLET,CHEWABLE 100 MG	4	PA; QL (6 tablets per 30 days)
<i>ivermectin oral tablet 3 mg</i>	2	QL (8 tablets per 30 days)
<i>ivermectin oral tablet 6 mg</i>	Non-Formulary	QL (2 Fills per Year); ALT (Covered Alternatives: Ivermectin 3mg Tablet); QL (8 Tablets per 30 Days)
<i>praziquantel oral tablet 600 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Antifungals, Miscellaneous		
<i>griseofulvin microsize oral suspension 125 mg/5 ml</i>	2	
<i>griseofulvin microsize oral tablet 500 mg</i>	2	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	2	
<i>griseofulvin ultramicrosize oral tablet 165 mg</i>	Non-Formulary	ALT (Covered Alternatives: Griseofulvin 125mg, Griseofulvin 250mg); QL (1 Tablet per 1 Day)
Antileprosy Agents		
ACZONE TOPICAL GEL 5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
ACZONE TOPICAL GEL WITH PUMP 7.5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>dapsone topical gel 5 %</i>	2	QL (2 GM per 1 day)
<i>dapsone topical gel 7.5 %</i>	Non-Formulary	ALT (Covered Alternatives: DAPSONE 5% GEL, DAPSONE 7.5% GEL WITH PUMP); QL (1 GM per 1 Day)
<i>dapsone topical gel with pump 7.5 %</i>	2	QL (2 GM per 1 day)
Antimalarials		
AMZEEQ TOPICAL FOAM 4 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CLINDAMYCIN PHOSPHATE, ERYTHROMYCIN)
ARAKODA ORAL TABLET 100 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>atovaquone-proguanil oral tablet 250-100 mg</i>	2	QL (12 tablets per 180 days)
<i>atovaquone-proguanil oral tablet 62.5-25 mg</i>	2	QL (9 tablets per 180 days)
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	2	QL (8 tablets per 28 days)
COARTEM ORAL TABLET 20-120 MG	4	QL (24 tablets per fill, 1 fill per 180 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DARAPRIM ORAL TABLET 25 MG	Non-Formulary	SP; ALT (Covered Alternatives: HYDROXYCHLOROQUINE SULFATE, PRIMAQUINE GENERIC, MEFLOQUINE HCL); QL (1 tablet per 1 day)
DORYX MPC ORAL TABLET, DELAYED RELEASE (DR/EC) 60 MG	Non-Formulary	ALT (Covered Alternatives: Doxycycline Hyclate, Doxycycline Monohydrate); QL (1 tablet per 1 day)
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	QL (3 capsules per 1 day)
<i>doxycycline hyclate oral tablet 100 mg</i>	2	QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE, DOXYCYCLINE HYCLATE); QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE)
<i>doxycycline hyclate oral tablet 75 mg</i>	Non-Formulary	
<i>doxycycline monohydrate oral capsule 100 mg</i>	2	QL (2 capsules per 1 day)
<i>doxycycline monohydrate oral capsule 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule 50 mg</i>	2	
<i>doxycycline monohydrate oral capsule 75 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule, ir - delay rel, biphasic 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE); QL (1 Capsule per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>doxycycline monohydrate oral tablet 100 mg</i>	2	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral tablet 150 mg, 75 mg</i>	2	
<i>doxycycline monohydrate oral tablet 50 mg</i>	2	QL (3 tablets per 1 day)
<i>hydroxychloroquine oral tablet 100 mg, 400 mg</i>	Non-Formulary	ALT (Covered Alternatives: hydroxychloroquine 200mg)
<i>hydroxychloroquine oral tablet 200 mg</i>	2	QL (6 tablets per 1 day)
<i>hydroxychloroquine oral tablet 300 mg</i>	Non-Formulary	ALT (Covered Alternatives: hydroxychloroquine 200mg); QL (1 Tablets per 1 day)
KRINTAFEL ORAL TABLET 150 MG	Non-Formulary	
<i>mefloquine oral tablet 250 mg</i>	2	QL (5 tablets per fill, 1 fill per 180 days)
<i>minocycline oral capsule 100 mg, 50 mg, 75 mg</i>	2	
<i>minocycline oral tablet 100 mg, 50 mg, 75 mg</i>	2	
MONDOXYNE NL ORAL CAPSULE 100 MG	Non-Formulary	QL (2 capsules per 1 day)
MONDOXYNE NL ORAL CAPSULE 75 MG	Non-Formulary	
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>primaquine oral tablet 26.3 mg (15 mg base)</i>	2	
PYLERA ORAL CAPSULE 140-125-125 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>pyrimethamine oral tablet 25 mg</i>	Non-Formulary	SP; QL (1 tablet per 1 day)
<i>quinidine gluconate oral tablet extended release 324 mg</i>	2	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	4	
<i>quinine sulfate oral capsule 324 mg</i>	2	QL (42 capsules per 30 days)
SOVUNA ORAL TABLET 200 MG	Non-Formulary	ALT (Covered Alternatives: Hydroxychloroquine); QL (6 Tablets per 1 Day)
SOVUNA ORAL TABLET 300 MG	Non-Formulary	ALT (Covered Alternatives: HYDROXYCHLOROQUINE); QL (1 Tablets per 1 Day)
TARGADOX ORAL TABLET 50 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZILXI TOPICAL FOAM 1.5 %	Non-Formulary	QL (Quantity Limits Apply)
Antiprotozoals, Cryptosporidiosis		
ALINIA ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML	4	PA; QL (20 ml per 1 day)
ALINIA ORAL TABLET 500 MG	Non-Formulary	QL (6 tablets per 1 day)
<i>nitazoxanide oral tablet 500 mg</i>	2	QL (6 Tablets per Day. 14 Days of Treatment per 180 Days)
Antiprotozoals, Miscellaneous		
ACZONE TOPICAL GEL 5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
ACZONE TOPICAL GEL WITH PUMP 7.5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>dapsone topical gel 5 %</i>	2	QL (2 GM per 1 day)
<i>dapsone topical gel 7.5 %</i>	Non-Formulary	ALT (Covered Alternatives: DAPSONE 5% GEL, DAPSONE 7.5% GEL WITH PUMP); QL (1 GM per 1 Day)
<i>dapsone topical gel with pump 7.5 %</i>	2	QL (2 GM per 1 day)
LAMPIT ORAL TABLET 120 MG, 30 MG	Non-Formulary	
Antiprotozoals, P Jirovecii Pneumonia		
<i>atovaquone oral suspension 750 mg/5 ml</i>	2	QL (10 ML per Day, 21 Days of Treatment per 180 Days)
PENTAM INJECTION RECON SOLN 300 MG	Non-Formulary	
<i>pentamidine injection recon soln 300 mg</i>	7	QL (1 Vial per 21 Days. 21 Days of Treatment per 180 Days)
Antiprotozoals, Nitroimidazole-Derivative		
<i>tinidazole oral tablet 250 mg, 500 mg</i>	2	QL (20 tablets per 5 days)
Antiretrovirals		
SUNLENCA ORAL TABLET 300 MG	6	PA
SUNLENCA SUBCUTANEOUS SOLUTION 309 MG/ML	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Antiretrovirals, Miscellaneous		
TYBOST ORAL TABLET 150 MG	6	QL (2 tablets per 1 day)
Antituberculosis Agents		
CIPRO HC OTIC (EAR) DROPS,SUSPENSION 0.2-1 %	4	QL (10 ML per 1 fill)
<i>ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg</i>	2	
<i>ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml</i>	2	
<i>clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	2	
<i>clarithromycin oral tablet extended release 24 hr 500 mg</i>	2	
<i>cycloserine oral capsule 250 mg</i>	4	
<i>ethambutol oral tablet 100 mg, 400 mg</i>	2	
<i>isoniazid oral solution 50 mg/5 ml</i>	2	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	2	
<i>levofloxacin in d5w intravenous piggyback 250 mg/50 ml, 500 mg/100 ml, 750 mg/150 ml</i>	Non-Formulary	
<i>levofloxacin oral solution 250 mg/10 ml</i>	2	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	2	
PRIFTIN ORAL TABLET 150 MG	3	
<i>pyrazinamide oral tablet 500 mg</i>	2	QL (4 tablets per 1 day)
<i>rifabutin oral capsule 150 mg</i>	2	
<i>rifampin oral capsule 150 mg, 300 mg</i>	2	
SIRTURO ORAL TABLET 100 MG	5	QL (4 Tablets per Day. 180 Days of Treatment in 365 Days); SP
SIRTURO ORAL TABLET 20 MG	5	QL (10 Tablets per Day. 180 Days of Treatment in 365 Days); SP
Antivirals, Miscellaneous		
<i>foscarnet intravenous solution 24 mg/ml</i>	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FOSCAVIR INTRAVENOUS SOLUTION 24 MG/ML	Non-Formulary	
Azole Antifungals		
CRESEMBA INTRAVENOUS RECON SOLN 372 MG	7	QL (0.01 Vial per Day. 90 Days of Treatment per 180 Days); SP
CRESEMBA ORAL CAPSULE 186 MG	4	PA; QL (70 capsules per 1 fill)
<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>itraconazole oral capsule 100 mg</i>	2	
<i>itraconazole oral solution 10 mg/ml</i>	2	QL (300 ML per 16 days)
<i>ketoconazole oral tablet 200 mg</i>	2	
<i>ketoconazole topical cream 2 %</i>	2	QL (60 GM per 30 days)
<i>ketoconazole topical foam 2 %</i>	2	ALT (Covered Alternatives: KETOCONAZOLE); QL (60 GM per 30 days)
<i>ketoconazole topical shampoo 2 %</i>	2	QL (120 ML per 30 days)
NOXAFIL ORAL SUSP, DELAYED RELEASE FOR RECON 300 MG	Non-Formulary	ALT (Covered Alternatives: POSACONAZOLE SUSP, ITRACONAZOLE, FLUCONAZOLE, VORICONAZOLE)
NOXAFIL ORAL SUSPENSION 200 MG/5 ML (40 MG/ML)	Non-Formulary	PA; ALT (Covered Alternatives: POSACONAZOLE SUSP, ITRACONAZOLE, FLUCONAZOLE, VORICONAZOLE); QL (105 ML per 1 fill)
<i>posaconazole intravenous solution 300 mg/16.7 ml</i>	7	
<i>posaconazole oral suspension 200 mg/5 ml (40 mg/ml)</i>	2	QL (105 EA per 1 Fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>posaconazole oral tablet, delayed release (dr/ec) 100 mg</i>	Non-Formulary	ALT (Covered Alternatives: POSACONAZOLE, ITRACONAZOLE, FLUCONAZOLE, VORICONAZOLE); QL (2 tablets per 1 day)
SPORANOX ORAL CAPSULE 100 MG	Non-Formulary	
TOLSURA ORAL CAPSULE, SOLID DISPERSION 65 MG	Non-Formulary	QL (Quantity Limits Apply)
VIVJOA ORAL CAPSULE 150 MG	Non-Formulary	ALT (Covered Alternatives: FLUCONAZOLE, TERCONAZOLE, ITRACONAZOLE)
<i>voriconazole oral tablet 200 mg, 50 mg</i>	2	QL (60 tablets per 30 days)
Carbapenem Antibiotics		
<i>ertapenem injection recon soln 1 gram</i>	7	
<i>meropenem intravenous recon soln 1 gram, 2 gram, 500 mg</i>	7	
Cmv Antivirals		
LIVTENCITY ORAL TABLET 200 MG	5	PA; QL (4 Tablets per 1 Day)
PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML	Non-Formulary	QL (Quantity Limits Apply); QL (24 ML per 1 day)
PREVYMIS ORAL PELLETS IN PACKET 120 MG, 20 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Valganciclovir); QL (4 Packets per 1 Day)
PREVYMIS ORAL TABLET 240 MG, 480 MG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: VALGANCICLOVIR HCL); QL (1 Tablet per 1 day)
Coronavirus (Covid-19)		
PAXLOVID ORAL TABLETS, DOSE PACK 150 MG (10)- 100 MG (10), 300 MG (150 MG X 2)-100 MG	5	PA; QL (5 days of treatment per 180 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Cyclic Lipopeptide Antibiotics		
<i>daptomycin in 0.9 % sod chlor intravenous piggyback 350 mg/50 ml, 500 mg/50 ml</i>	7	
<i>daptomycin intravenous recon soln 350 mg, 500 mg</i>	7	QL (10 ML per 7 days)
Echinocandin Antifungals		
<i>casposfungin intravenous recon soln 50 mg</i>	7	QL (3 Vials per Day. 84 Days of Treatment in 180 Days)
<i>casposfungin intravenous recon soln 70 mg</i>	7	QL (2.15 Vials per Day. 84 Days of Treatment in 180 Days)
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	7	QL (1 Vial per Day. 42 Days of Treatment in 180 Days)
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG	7	QL (1 Vial per 1 day)
<i>micafungin in 0.9 % sodium chl intravenous piggyback 150 mg/150 ml</i>	BB	
<i>micafungin intravenous recon soln 100 mg, 50 mg</i>	7	QL (1 vial per 1 day)
Endonuclease Inhibitors		
XOFLUZA ORAL TABLET 20 MG	4	QL (2 tablets per fill, 2 fills per 365 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	4	QL (1 tablet per fill, 2 fills per 365 days); QL (1 Tablet per 1 Fill)
Erythromycin Antibiotics		
E.E.S. 400 ORAL TABLET 400 MG	Non-Formulary	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	2	QL (100 ML per 30 days)
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	2	QL (100 ML per 1 fill)
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	2	
<i>erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)</i>	2	
<i>erythromycin oral tablet, delayed release (dr/ec) 250 mg, 500 mg</i>	2	
<i>erythromycin with ethanol topical gel 2 %</i>	2	QL (60 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>erythromycin with ethanol topical solution 2 %</i>	2	QL (60 ML per 30 days)
Extended-Spectrum Penicillins		
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML, 3.375 GRAM/50 ML, 4.5 GRAM/100 ML	BB	
Glycopeptide Antibiotics		
DALVANCE INTRAVENOUS SOLUTION 500 MG	Non-Formulary	
FIRVANQ ORAL RECON SOLN 25 MG/ML, 50 MG/ML	3	QL (450mL per fill, 3 fills per year)
<i>vancomycin in 0.9 % sodium chl intravenous solution 1 gram/250 ml, 1.25 gram/250 ml, 1.75 gram/500 ml, 2 gram/500 ml, 750 mg/250 ml</i>	BB	
<i>vancomycin intravenous recon soln 1,000 mg, 1.5 gram, 10 gram, 5 gram, 500 mg, 750 mg</i>	7	
<i>vancomycin intravenous recon soln 1.25 gram</i>	Non-Formulary	
<i>vancomycin oral capsule 125 mg, 250 mg</i>	2	QL (40 capsules per 8 days)
VIBATIV INTRAVENOUS RECON SOLN 750 MG	7	QL (1 Vial per 1 day)
Glycylcycline Antibiotics		
<i>tigecycline intravenous recon soln 50 mg</i>	7	QL (0.01 Vial per 1 day)
Hcv Polymerase Inhibitor Antivirals		
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG	Non-Formulary	SP
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG	Non-Formulary	QL (Quantity Limits Apply); SP
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG	Non-Formulary	QL (Quantity Limits Apply); SP
HARVONI ORAL TABLET 45-200 MG, 90-400 MG	Non-Formulary	QL (Quantity Limits Apply); SP
<i>ledipasvir-sofosbuvir oral tablet 90-400 mg</i>	Non-Formulary	QL (Quantity Limits Apply); SP
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	Non-Formulary	SP
SOVALDI ORAL PELLETS IN PACKET 150 MG, 200 MG	Non-Formulary	QL (Quantity Limits Apply)
SOVALDI ORAL TABLET 200 MG, 400 MG	Non-Formulary	QL (Quantity Limits Apply); SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VOSEVI ORAL TABLET 400-100-100 MG	Non-Formulary	QL (Quantity Limits Apply); SP
Hcv Protease Inhibitor Antivirals		
MAVYRET ORAL PELLETS IN PACKET 50-20 MG	Non-Formulary	SP
MAVYRET ORAL TABLET 100-40 MG	2	QL (84 tablets per fill, 168 tablets in 365 days); SP
VOSEVI ORAL TABLET 400-100-100 MG	Non-Formulary	QL (Quantity Limits Apply); SP
ZEPATIER ORAL TABLET 50-100 MG	5	PA; QL (28 tablets per fill, 84 tablets per 365 days); SP
Hcv Replication Complex Inhibitors		
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG	Non-Formulary	SP
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG	Non-Formulary	QL (Quantity Limits Apply); SP
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG	Non-Formulary	QL (Quantity Limits Apply); SP
HARVONI ORAL TABLET 45-200 MG, 90-400 MG	Non-Formulary	QL (Quantity Limits Apply); SP
<i>ledipasvir-sofosbuvir oral tablet 90-400 mg</i>	Non-Formulary	QL (Quantity Limits Apply); SP
MAVYRET ORAL PELLETS IN PACKET 50-20 MG	Non-Formulary	SP
MAVYRET ORAL TABLET 100-40 MG	2	QL (84 tablets per fill, 168 tablets in 365 days); SP
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	Non-Formulary	SP
VOSEVI ORAL TABLET 400-100-100 MG	Non-Formulary	QL (Quantity Limits Apply); SP
ZEPATIER ORAL TABLET 50-100 MG	5	PA; QL (28 tablets per fill, 84 tablets per 365 days); SP
Hiv Entry And Fusion Inhibitors		
FUZEON SUBCUTANEOUS RECON SOLN 90 MG	6	PA; QL (0.01 EA per 1 day)
<i>maraviroc oral tablet 300 mg</i>	2	QL (2 tablets per 1 day)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR 600 MG	6	PA; ALT (Covered Alternatives: FUZEON); QL (2 tablets per 1 day)
SELZENTRY ORAL TABLET 150 MG, 300 MG	Non-Formulary	QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33 ML (150 MG/ML)	BB	PA
Hiv Integrase Inhibitor Antiretrovirals		
APRETUDE INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 600 MG/3 ML (200 MG/ML)	BB	PA
BIKTARVY ORAL TABLET 30-120-15 MG	5	
BIKTARVY ORAL TABLET 50-200-25 MG	5	QL (1 tablet per 1 day)
CABENUVA INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 400 MG/2 ML- 600 MG/2 ML, 600 MG/3 ML- 900 MG/3 ML	BB	PA
DOVATO ORAL TABLET 50-300 MG	5	QL (1 tablet per 1 day)
GENVOYA ORAL TABLET 150-150-200-10 MG	5	QL (1 tablet per 1 day)
ISENTRESS ORAL TABLET 400 MG	5	QL (2 tablets per 1 day)
JULUCA ORAL TABLET 50-25 MG	6	QL (1 tablet per 1 day)
STRIBILD ORAL TABLET 150-150-200-300 MG	6	QL (1 tablet per 1 day)
TIVICAY ORAL TABLET 50 MG	5	QL (2 tablets per 1 day)
TRIUMEQ ORAL TABLET 600-50-300 MG	6	QL (1 tablet per 1 day)
TRIUMEQ PD ORAL TABLET FOR SUSPENSION 60-5-30 MG	6	SP; QL (1 Tablet per 1 day)
VOCABRIA ORAL TABLET 30 MG	Non-Formulary	QL (Quantity Limits Apply)
Hiv Nucleoside Rev. Transcrip. Inhib.		
COMPLERA ORAL TABLET 200-25-300 MG	Non-Formulary	QL (1 tablet per 1 day)
DELSTRIGO ORAL TABLET 100-300-300 MG	Non-Formulary	
EDURANT ORAL TABLET 25 MG	5	QL (2 tablets per 1 day)
<i>efavirenz oral tablet 600 mg</i>	5	QL (1 tablet per 1 day)
<i>efavirenz-emtricitabin-tenofof oral tablet 600-200-300 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>efavirenz-lamivu-tenofof disop oral tablet 400-300-300 mg, 600-300-300 mg</i>	2	
<i>emtricitita-rilpivirine-tenof df oral tablet 200-25-300 mg</i>	4	QL (Quantity Limits Apply); QL (1 Tablet per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>etravirine oral tablet 100 mg, 200 mg</i>	2	
INTELENCE ORAL TABLET 100 MG, 200 MG	Non-Formulary	ALT (Covered Alternatives: ETRAVIRINE)
INTELENCE ORAL TABLET 25 MG	Non-Formulary	ALT (Covered Alternatives: ETRAVIRINE); QL (4 tablets per 1 day)
JULUCA ORAL TABLET 50-25 MG	6	QL (1 tablet per 1 day)
<i>nevirapine oral suspension 50 mg/5 ml</i>	2	QL (480 ML per 30 days)
<i>nevirapine oral tablet 200 mg</i>	5	QL (2 tablets per 1 day)
<i>nevirapine oral tablet extended release 24 hr 100 mg, 400 mg</i>	5	QL (1 tablet per 1 day)
ODEFSEY ORAL TABLET 200-25-25 MG	5	QL (1 tablet per 1 day)
PIFELTRO ORAL TABLET 100 MG	5	
SYMFI ORAL TABLET 600-300-300 MG	Non-Formulary	QL (Quantity Limits Apply)
Hiv Nucleoside, Nucleotide Rt Inhibitors		
<i>abacavir oral solution 20 mg/ml</i>	5	QL (480 ML per 30 days)
<i>abacavir oral tablet 300 mg</i>	5	QL (2 tablets per 1 day)
<i>abacavir-lamivudine oral tablet 600-300 mg</i>	5	QL (1 tablet per 1 day)
BIKTARVY ORAL TABLET 30-120-15 MG	5	
BIKTARVY ORAL TABLET 50-200-25 MG	5	QL (1 tablet per 1 day)
CIMDUO ORAL TABLET 300-300 MG	5	
COMPLERA ORAL TABLET 200-25-300 MG	Non-Formulary	QL (1 tablet per 1 day)
DELSTRIGO ORAL TABLET 100-300-300 MG	Non-Formulary	
DESCOVY ORAL TABLET 120-15 MG	5	
DESCOVY ORAL TABLET 200-25 MG	5	PA; ALT (EMTRICITABINE-TENOFV 200-300MG, EMTRICITABINE-TENOFV 100-150MG, EMTRICITABINE-TENOFV 133-200MG, EMTRICITABINE-TENOFV 167-250MG); QL (1 tablet per 1 day)
DOVATO ORAL TABLET 50-300 MG	5	QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>efavirenz-emtricitabin-tenofovir oral tablet 600-200-300 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate oral tablet 400-300-300 mg, 600-300-300 mg</i>	2	
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	5	QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	0	QL (1 tablet per 1 day)
<i>emtricitabine-rilpivirine-tenofovir disoproxil fumarate oral tablet 200-25-300 mg</i>	4	QL (Quantity Limits Apply); QL (1 Tablet per 1 Day)
EMTRIVA ORAL SOLUTION 10 MG/ML	5	QL (680 ML per 23 days)
EPIVIR ORAL TABLET 150 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
GENVOYA ORAL TABLET 150-150-200-10 MG	5	QL (1 tablet per 1 day)
<i>lamivudine oral solution 10 mg/ml</i>	2	QL (Quantity Limits Apply); QL (2 ml per 1 day)
<i>lamivudine oral tablet 100 mg</i>	2	QL (1 Tablet per 1 day)
<i>lamivudine oral tablet 150 mg, 300 mg</i>	2	QL (2 tablets per 1 day)
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	5	QL (2 tablets per 1 day)
ODEFSEY ORAL TABLET 200-25-25 MG	5	QL (1 tablet per 1 day)
STRIBILD ORAL TABLET 150-150-200-300 MG	6	QL (1 tablet per 1 day)
SYMFI ORAL TABLET 600-300-300 MG	Non-Formulary	QL (Quantity Limits Apply)
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	5	QL (1 tablet per 1 day)
TRIUMEQ ORAL TABLET 600-50-300 MG	6	QL (1 tablet per 1 day)
TRIUMEQ PD ORAL TABLET FOR SUSPENSION 60-5-30 MG	6	SP; QL (1 Tablet per 1 day)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG	Non-Formulary	
TRUVADA ORAL TABLET 200-300 MG	Non-Formulary	QL (Quantity Limits Apply)
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM)	5	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZIAGEN ORAL SOLUTION 20 MG/ML	Non-Formulary	QL (16 units per 1 day)
<i>zidovudine oral capsule 100 mg</i>	5	QL (2 capsules per 1 day)
<i>zidovudine oral syrup 10 mg/ml</i>	5	QL (1 ML per 30 days)
<i>zidovudine oral tablet 300 mg</i>	2	QL (2 tablets per 1 day)
Hiv Protease Inhibitor Antiretrovirals		
APTIVUS ORAL CAPSULE 250 MG	5	QL (4 capsules per 1 day)
<i>atazanavir oral capsule 150 mg, 200 mg, 300 mg</i>	2	QL (2 capsules per 1 day)
<i>darunavir oral tablet 600 mg, 800 mg</i>	2	QL (Quantity Limits Apply); QL (2 Tablets per 1 day)
EVOTAZ ORAL TABLET 300-150 MG	6	QL (1 tablet per 1 day)
KALETRA ORAL SOLUTION 400-100 MG/5 ML	Non-Formulary	QL (320 units per 1 fill)
KALETRA ORAL TABLET 100-25 MG, 200-50 MG	Non-Formulary	QL (2 tablets per 1 day)
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	2	QL (6 tablets per 1 day)
NORVIR ORAL TABLET 100 MG	Non-Formulary	ALT (Covered Alternatives: Ritonavir)
PREZCOBIX ORAL TABLET 800-150 MG-MG	6	QL (2 tablets per 1 day)
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	Non-Formulary	ALT (Covered Alternatives: Darunavir); QL (2 Tablets per 1 day)
REYATAZ ORAL POWDER IN PACKET 50 MG	Non-Formulary	
<i>ritonavir oral tablet 100 mg</i>	2	QL (2 tablets per 1 day)
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	
VIRACEPT ORAL TABLET 250 MG, 625 MG	4	QL (4 tablets per 1 day)
Interferon Antivirals		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA; SP; QL (4 ML per 30 days)
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	5	PA; SP; QL (2 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Lincomycin Antibiotics		
ACANYA TOPICAL GEL WITH PUMP 1.2-2.5 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
CLINDAGEL TOPICAL GEL, ONCE DAILY 1 %	Non-Formulary	QL (Quantity Limits Apply)
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	2	
CLINDAMYCIN PEDIATRIC ORAL RECON SOLN 75 MG/5 ML	2	
<i>clindamycin phosphate topical gel 1 %</i>	2	QL (60 GM per 30 days)
<i>clindamycin phosphate topical gel, once daily 1 %</i>	2	
<i>clindamycin phosphate topical lotion 1 %</i>	2	QL (60 GM per 30 days)
<i>clindamycin phosphate topical solution 1 %</i>	2	QL (4 ML per 1 day)
<i>clindamycin phosphate topical swab 1 %</i>	2	
<i>clindamycin phosphate vaginal cream 2 %</i>	2	
<i>clindamycin-benzoyl peroxide topical gel 1.2 %(1 % base) -5 %</i>	2	QL (45 GM per 30 days)
<i>clindamycin-benzoyl peroxide topical gel 1-5 %</i>	2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %</i>	2	
CLINDESSE VAGINAL CREAM,EXTENDED RELEASE 2 %	Non-Formulary	QL (Quantity Limits Apply)
ONEXTON TOPICAL GEL 1.2 %(1 % BASE) -3.75 %	Non-Formulary	
ONEXTON TOPICAL GEL WITH PUMP 1.2 %(1 % BASE) -3.75 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
VELTIN TOPICAL GEL 1.2-0.025 %	Non-Formulary	QL (Quantity Limits Apply)
ZIANA TOPICAL GEL 1.2-0.025 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, CLINDAMYCIN HCL)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Monobactam Antibiotics		
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML	5	PA; ALT (Covered Alternatives: TOBRAMYCIN SULFATE); QL (2 boxes per 1 month)
EMBLAVEO INTRAVENOUS RECON SOLN 2 GRAM	Non-Formulary	SP; ALT (Covered Alternatives: AZTREONAM Vial)
Monoclonal Antibodies (08:18)		
BEYFORTUS INTRAMUSCULAR SYRINGE 100 MG/ML, 50 MG/0.5 ML	BB	
ILARIS (PF) SUBCUTANEOUS SOLUTION 150 MG/ML	BB	PA
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5 ML	BB	PA
Natural Penicillin Antibiotics		
LENTOCILIN S INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 1.2 MILLION UNIT	BB	
<i>penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml</i>	1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	1	
Neuraminidase Inhibitor Antivirals		
<i>oseltamivir oral capsule 30 mg, 45 mg, 75 mg</i>	2	QL (10 capsules per fill ; 2 fills per 365 days)
<i>oseltamivir oral suspension for reconstitution 6 mg/ml</i>	2	QL (120 ML per fill ; 2 fills per 365 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION	4	QL (20 inhalations (5 Rotadisks) per fill, 2 fills per 365 days)
TAMIFLU ORAL CAPSULE 30 MG	Non-Formulary	QL (20 capsules per fill ; 2 fills per 365 days)
TAMIFLU ORAL CAPSULE 45 MG	Non-Formulary	QL (10 capsules per fill ; 2 fills per 365 days)
TAMIFLU ORAL CAPSULE 75 MG	Non-Formulary	QL (10 capsules per fill, 2 fills per 365 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION 6 MG/ML	Non-Formulary	QL (120 ML per fill ; 2 fills per 365 days)
Nitroimidazole Derivative, Anti-Leishmal		
IMPAVIDO ORAL CAPSULE 50 MG	4	PA; QL (3 capsules per 1 day)
Nitroimidazole Derivatives, Misc		
METROGEL TOPICAL GEL 1 %	Non-Formulary	QL (Quantity Limits Apply)
<i>metronidazole oral capsule 375 mg</i>	Non-Formulary	
<i>metronidazole oral tablet 125 mg</i>	Non-Formulary	ALT (Covered Alternatives: Metronidazole 250mg Tablets); QL (1 Tablets per 1 Day)
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole topical cream 0.75 %</i>	2	QL (45 GM per 30 days)
<i>metronidazole topical gel 0.75 %, 1 %</i>	2	
<i>metronidazole topical gel with pump 1 %</i>	2	
<i>metronidazole topical lotion 0.75 %</i>	2	QL (59 GM per 30 days)
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	2	
NORITATE TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)
NUVESSA VAGINAL GEL 1.3 % (65 MG/5 GRAM)	Non-Formulary	ALT (Covered Alternatives: METRONIDAZOLE, CLINDAMYCIN PHOSPHATE)
Nucleoside And Nucleotide Antivirals		
<i>acyclovir in 0.9 % sodium chlr intravenous piggyback 200 mg/100 ml</i>	BB	
<i>acyclovir oral capsule 200 mg</i>	2	
<i>acyclovir oral suspension 200 mg/5 ml, 200 mg/5 ml (5 ml)</i>	2	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	2	
<i>acyclovir topical ointment 5 %</i>	2	QL (30 GM per 30 days)
<i>adefovir oral tablet 10 mg</i>	5	SP; QL (1 tablet per 1 day)
BARACLUDE ORAL SOLUTION 0.05 MG/ML	5	PA; SP; QL (700 ml per 1 fill)
BARACLUDE ORAL TABLET 0.5 MG, 1 MG	Non-Formulary	SP; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
COMPLERA ORAL TABLET 200-25-300 MG	Non-Formulary	QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 120-15 MG	5	
DESCOVY ORAL TABLET 200-25 MG	5	PA; ALT (EMTRICITABINE-TENOFV 200-300MG, EMTRICITABINE-TENOFV 100-150MG, EMTRICITABINE-TENOFV 133-200MG, EMTRICITABINE-TENOFV 167-250MG); QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	5	QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	0	QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir (tdf) oral tablet 200-25-300 mg</i>	4	QL (Quantity Limits Apply); QL (1 Tablet per 1 Day)
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	5	SP; QL (1 tablet per 1 day)
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	2	
<i>ganciclovir sodium intravenous recon soln 500 mg</i>	7	
HEPSERA ORAL TABLET 10 MG	Non-Formulary	SP; QL (1 Tablet per 1 day)
LAGEVRIO (EUA) ORAL CAPSULE 200 MG	0	HCR
ODEFSEY ORAL TABLET 200-25-25 MG	5	QL (1 tablet per 1 day)
<i>ribavirin inhalation recon soln 6 gram</i>	Non-Formulary	
<i>ribavirin oral capsule 200 mg</i>	Non-Formulary	SP; QL (6 Capsules per 1 day)
<i>ribavirin oral tablet 200 mg</i>	2	SP; QL (6 Tablets per 1 day)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG	Non-Formulary	
TRUVADA ORAL TABLET 200-300 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>valacyclovir oral tablet 1 gram, 500 mg</i>	2	QL (8 tablets per 1 day)
<i>valganciclovir oral recon soln 50 mg/ml</i>	1	PA; QL (1 ML per 1 day)
<i>valganciclovir oral tablet 450 mg</i>	2	QL (2 tablets per 1 day)
VEMLIDY ORAL TABLET 25 MG	Non-Formulary	SP
XERESE TOPICAL CREAM 5-1 %	Non-Formulary	ALT (Covered Alternatives: ACYCLOVIR, HYDROCORTISONE)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZIRGAN OPHTHALMIC (EYE) GEL 0.15 %	4	QL (5 GM per 30 days)
ZOVIRAX TOPICAL CREAM 5 %	Non-Formulary	QL (Quantity Limits Apply)
Other Macrolide Antibiotics		
<i>azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	2	QL (4 ML per 1 day)
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	2	QL (8 tablets per 1 fill)
<i>clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	2	
<i>clarithromycin oral tablet extended release 24 hr 500 mg</i>	2	
DIFICID ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML	Non-Formulary	ALT (Covered Alternatives: METRONIDAZOLE, FIRVANQ)
DIFICID ORAL TABLET 200 MG	Non-Formulary	ALT (Covered Alternatives: FIDAXOMIXIN, METRONIDAZOLE, FIRVANQ); QL (20 tablets per 30 days)
<i>fidaxomicin oral tablet 200 mg</i>	4	PA; QL (20 Tablets per 30 Days)
OMECLAMOX-PAK ORAL COMBO PACK 20 MG-500 MG- 500 MG (40)	Non-Formulary	QL (Quantity Limits Apply)
VOQUEZNA TRIPLE PAK ORAL COMBO PACK 20-500-500 MG	Non-Formulary	
Oxazolidinone Antibiotics		
<i>linezolid oral suspension for reconstitution 100 mg/5 ml</i>	2	QL (1800 ML per 30 days)
<i>linezolid oral tablet 600 mg</i>	2	QL (2 tablets per 1 day)
SIVEXTRO ORAL TABLET 200 MG	Non-Formulary	QL (Quantity Limits Apply)
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	Non-Formulary	
Penicillinase-Resistant Penicillins		
<i>dicloxacillin oral capsule 250 mg, 500 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Pleuromutilins		
XENLETA ORAL TABLET 600 MG	4	PA; QL (Quantity Limits Apply); QL (10 tablets per 30 days)
Polyene Antifungals		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	Non-Formulary	
<i>amphotericin b injection recon soln 50 mg</i>	7	
KLAYESTA TOPICAL POWDER 100,000 UNIT/GRAM	2	
<i>nystatin oral suspension 100,000 unit/ml</i>	2	
<i>nystatin oral tablet 500,000 unit</i>	2	
<i>nystatin topical cream 100,000 unit/gram</i>	2	QL (30 GM per 30 days)
<i>nystatin topical ointment 100,000 unit/gram</i>	2	QL (30 GM per 30 days)
<i>nystatin topical powder 100,000 unit/gram</i>	2	
Polymyxin Antibiotics		
<i>colistin (colistimethate na) injection recon soln 150 mg</i>	6	QL (2 ML per Day. 28 Days of Treatment in 180 Days); SP
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	2	QL (5 ML per 1 fill)
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	2	
<i>neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%</i>	1	
<i>neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%</i>	2	
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit- 1 mg/ml</i>	2	
Pyrimidine Antifungals		
<i>flucytosine oral capsule 250 mg, 500 mg</i>	6	PA; QL (1 capsule per 1 day)
Quinolone Antibiotics		
BAXDELA ORAL TABLET 450 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CILOXAN OPHTHALMIC (EYE) OINTMENT 0.3 %	3	QL (3.5 GM per 1 fill)
CIPRO HC OTIC (EAR) DROPS,SUSPENSION 0.2-1 %	4	QL (10 ML per 1 fill)
<i>ciprofloxacin hcl ophthalmic (eye) drops 0.3 %</i>	2	
<i>ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg</i>	2	
<i>ciprofloxacin hcl otic (ear) dropperette 0.2 %</i>	2	QL (14 applicators per 7 days)
<i>ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml</i>	2	
<i>ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %</i>	2	QL (7.5 ML per 1 fill)
<i>levofloxacin in d5w intravenous piggyback 250 mg/50 ml, 500 mg/100 ml, 750 mg/150 ml</i>	Non-Formulary	
<i>levofloxacin oral solution 250 mg/10 ml</i>	2	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	2	
<i>moxifloxacin ophthalmic (eye) drops 0.5 %</i>	2	QL (3 ML per 1 fill)
<i>moxifloxacin ophthalmic (eye) drops, viscous 0.5 %</i>	2	QL (3 ML per 1 fill)
<i>ofloxacin ophthalmic (eye) drops 0.3 %</i>	2	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	2	
<i>ofloxacin otic (ear) drops 0.3 %</i>	2	
OTOVEL OTIC (EAR) SOLUTION 0.3-0.025 % (0.25 ML)	Non-Formulary	QL (Quantity Limits Apply)
VIGAMOX OPHTHALMIC (EYE) DROPS 0.5 %	Non-Formulary	QL (3 units per 1 day)
Rifamycin Antibiotics		
PRIFTIN ORAL TABLET 150 MG	3	
<i>rifabutin oral capsule 150 mg</i>	2	
<i>rifampin oral capsule 150 mg, 300 mg</i>	2	
TALICIA ORAL CAPSULE,IR - DELAY REL,BIPHASE 10-250-12.5 MG	Non-Formulary	QL (Quantity Limits Apply)
XIFAXAN ORAL TABLET 200 MG	5	PA; SP; QL (9 tablets per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; SP; QL (60 tablets per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Siderophore Cephalosporins		
FETROJA INTRAVENOUS RECON SOLN 1 GRAM	Non-Formulary	
Sulfonamide Antibiotics (Systemic)		
<i>sulfadiazine oral tablet 500 mg</i>	2	
<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	
<i>sulfasalazine oral tablet 500 mg</i>	2	
<i>sulfasalazine oral tablet, delayed release (dr/ec) 500 mg</i>	2	
SULFATRIM ORAL SUSPENSION 200-40 MG/5 ML	2	
Tetracycline Antibiotics		
AMZEEQ TOPICAL FOAM 4 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CLINDAMYCIN PHOSPHATE, ERYTHROMYCIN)
<i>demeclocycline oral tablet 150 mg, 300 mg</i>	2	
DORYX MPC ORAL TABLET, DELAYED RELEASE (DR/EC) 60 MG	Non-Formulary	ALT (Covered Alternatives: Doxycycline Hyclate, Doxycycline Monohydrate); QL (1 tablet per 1 day)
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	QL (3 capsules per 1 day)
<i>doxycycline hyclate oral tablet 100 mg</i>	2	QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE, DOXYCYCLINE HYCLATE); QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE)
<i>doxycycline hyclate oral tablet 75 mg</i>	Non-Formulary	
<i>doxycycline monohydrate oral capsule 100 mg</i>	2	QL (2 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>doxycycline monohydrate oral capsule 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule 50 mg</i>	2	
<i>doxycycline monohydrate oral capsule 75 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule,ir - delay rel,biphase 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE); QL (1 Capsule per 1 Day)
<i>doxycycline monohydrate oral tablet 100 mg</i>	2	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral tablet 150 mg, 75 mg</i>	2	
<i>doxycycline monohydrate oral tablet 50 mg</i>	2	QL (3 tablets per 1 day)
<i>minocycline oral capsule 100 mg, 50 mg, 75 mg</i>	2	
<i>minocycline oral tablet 100 mg, 50 mg, 75 mg</i>	2	
MONDOXYNE NL ORAL CAPSULE 100 MG	Non-Formulary	QL (2 capsules per 1 day)
MONDOXYNE NL ORAL CAPSULE 75 MG	Non-Formulary	
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG	Non-Formulary	QL (Quantity Limits Apply)
PYLERA ORAL CAPSULE 140-125-125 MG	Non-Formulary	QL (Quantity Limits Apply)
TARGADOX ORAL TABLET 50 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>tetracycline oral capsule 250 mg, 500 mg</i>	2	
<i>tetracycline oral tablet 250 mg, 500 mg</i>	Non-Formulary	ALT (Covered Alternatives: Tetracycline Capsules); QL (2 Tablets per 1 day)
ZILXI TOPICAL FOAM 1.5 %	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Triterpenoids		
BREXAFEMME ORAL TABLET 150 MG	Non-Formulary	
Urinary Anti-Infectives		
<i>fosfomycin tromethamine oral packet 3 gram</i>	2	QL (1 packet per 30 days)
<i>methenamine hippurate oral tablet 1 gram</i>	2	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	2	QL (4 capsules per 1 day)
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	2	
<i>nitrofurantoin monohyd/m-cryst oral capsule 100 mg</i>	2	QL (4 capsules per 1 day)
<i>nitrofurantoin oral suspension 25 mg/5 ml, 50 mg/5 ml</i>	Non-Formulary	ALT (Covered Alternatives: NITROFURANTOIN CAPSULES, NITROFURANTOIN MONO-MACRO CAPSULES); QL (10 ML per 1 day)
ORLYNVAH ORAL TABLET 500-500 MG	Non-Formulary	ALT (Covered Alternatives: Trimethoprim/Sulfamethoxazole , nitrofurantoin, fosfomycin); QL (2 Tablets per 1 Day)
<i>trimethoprim oral tablet 100 mg</i>	2	
ANTINEOPLASTIC AGENTS		
Antineoplastic Agents		
<i>abiraterone oral tablet 250 mg</i>	2	SP; QL (120 tablets per 30 days)
<i>abiraterone oral tablet 500 mg</i>	2	PA; SP; QL (60 tablets per 30 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG	Non-Formulary	SP; PF
AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	Non-Formulary	SP
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	6	PA; SP
ALECENSA ORAL CAPSULE 150 MG	5	PA; SP; QL (240 capsules per 30 days)
ALIQOPA INTRAVENOUS RECON SOLN 60 MG	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ALTRENO TOPICAL LOTION 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
ALUNBRIG ORAL TABLET 180 MG	5	PA; SP; QL (30 tablets per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PA; SP; QL (60 tablets per 30 days)
ALUNBRIG ORAL TABLET 90 MG	5	PA; SP; QL (90 tablets per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK 90 MG (7)- 180 MG (23)	5	PA; SP; QL (30 tablets per 30 days)
ALYMSYS INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
AMTAGVI INTRAVENOUS SUSPENSION 7.5 X 10EXP9 TO 72X 10EXP9 CELL	BB	
<i>anastrozole oral tablet 1 mg</i>	2	HCR; QL (1 tablet per 1 day)
ANKTIVA INTRAVESICAL SOLUTION 400 MCG/0.4 ML	BB	PA
ARRANON INTRAVENOUS SOLUTION 250 MG/50 ML	BB	
ATRALIN TOPICAL GEL 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (1.5 gm per 1 day)
AUGTYRO ORAL CAPSULE 40 MG	6	PA; SP; QL (8 Capsules per 1 day)
AVASTIN INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
AVASTIN INTRAVITREAL SYRINGE 1.25 MG/0.05 ML	BB	PA
AVGEMSI INTRAVENOUS SOLUTION 1 GRAM/26.3 ML (38 MG/ML), 2 GRAM/52.6 ML (38 MG/ML)	BB	
AVMAPKI-FAKZYNJA ORAL COMBO PACK 0.8-200 MG	Non-Formulary	SP; QL (66 Tablets per 28 Days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
AXTLE INTRAVENOUS RECON SOLN 100 MG, 500 MG	BB	
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	6	PA; SP; QL (1 tablet per 1 day)
BALVERSA ORAL TABLET 3 MG	6	PA; SP; QL (3 tablets per 1 day)
BALVERSA ORAL TABLET 4 MG	6	PA; SP; QL (2 tablets per 1 day)
BALVERSA ORAL TABLET 5 MG	6	PA; SP; QL (1 tablet per 1 day)
BAVENCIO INTRAVENOUS SOLUTION 20 MG/ML	BB	PA
<i>bendamustine intravenous solution 25 mg/ml</i>	BB	
BESPONSIA INTRAVENOUS RECON SOLN 0.9 MG (0.25 MG/ML INITIAL)	BB	PA
BESREMI SUBCUTANEOUS SYRINGE 500 MCG/ML	Non-Formulary	SP
<i>bevacizumab intravitreal syringe 1.25 mg/0.05 ml, 2 mg/0.08 ml, 2.5 mg/0.1 ml, 2.75 mg/0.11 ml, 3.25 mg/0.13 ml</i>	BB	PA
<i>bexarotene oral capsule 75 mg</i>	6	PA; SP; PF; QL (1 capsule per 1 day)
<i>bexarotene topical gel 1 %</i>	5	PA; SP; QL (2 GM per 1 day)
<i>bicalutamide oral tablet 50 mg</i>	2	
BIZENGRI INTRAVENOUS SOLUTION 375 MG/18.75 ML (20 MG/ML)	BB	
BLINCYTO INTRAVENOUS KIT 35 MCG	BB	PA
BOSULIF ORAL CAPSULE 100 MG	6	PA; SP; PF; QL (3 Capsules per 1 day)
BOSULIF ORAL CAPSULE 50 MG	6	PA; SP; PF; QL (1 Capsule per 1 day)
BOSULIF ORAL TABLET 100 MG	6	PA; SP; PF; QL (3 Tablets per 1 day)
BOSULIF ORAL TABLET 400 MG, 500 MG	6	PA; SP; PF; QL (1 Tablet per 1 day)
BRAFTOVI ORAL CAPSULE 75 MG	6	PA; SP
BRUKINSA ORAL CAPSULE 80 MG	6	PA; SP; QL (120 capsules per 28 days)
CABOMETYX ORAL TABLET 20 MG	5	PA; SP; QL (30 tablets per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CABOMETYX ORAL TABLET 40 MG, 60 MG	5	PA; SP
CALQUENCE (ACALABRUTINIB MAL) ORAL TABLET 100 MG	5	PA; SP
CAMCEVI (6 MONTH) SUBCUTANEOUS SYRINGE 42 MG	BB	PA
<i>capecitabine oral tablet 150 mg, 500 mg</i>	5	SP; QL (140 tablets per 1 fill)
CAPRELSA ORAL TABLET 100 MG	5	PA; SP; QL (60 tablets per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA; SP; QL (30 tablets per 30 days)
CARAC TOPICAL CREAM 0.5 %	Non-Formulary	QL (40 gm per 30 days)
CARVYKTI INTRAVENOUS SUSPENSION 0.5 X 10EXP6 TO 1 X 10EXP8 CELL	BB	PA
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)	5	PA; SP; QL (1 capsule per 1 day)
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	Non-Formulary	SP
COTELLIC ORAL TABLET 20 MG	5	PA; SP; QL (63 tablets per 30 days)
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	QL (2 capsules per 1 day)
CYRAMZA INTRAVENOUS SOLUTION 10 MG/ML	BB	PA
DANYELZA INTRAVENOUS SOLUTION 4 MG/ML	BB	PA
DANZITEN ORAL TABLET 71 MG, 95 MG	6	PA; SP; PF; QL (4 Tablets per 1 day)
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1,800 MG-30,000 UNIT/15 ML	BB	PA
DARZALEX INTRAVENOUS SOLUTION 20 MG/ML	BB	PA
<i>dasatinib oral tablet 100 mg, 140 mg, 50 mg, 80 mg</i>	6	PA; QL (Quantity Limits Apply); SP; QL (30 Tablets per 1 Fill)
<i>dasatinib oral tablet 20 mg</i>	6	PA; QL (Quantity Limits Apply); SP; QL (90 Tablets per 1 Fill)
<i>dasatinib oral tablet 70 mg</i>	6	PA; QL (Quantity Limits Apply); SP; QL (60 Tablets per 1 Fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DATROWAY INTRAVENOUS RECON SOLN 100 MG	BB	
DAURISMO ORAL TABLET 100 MG	6	PA; SP; QL (0.01 tablet per 1 day)
DAURISMO ORAL TABLET 25 MG	6	PA; SP; QL (0.01 EA per 1 day)
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	3	QL (1 capsule per 1 day)
EFUDEX TOPICAL CREAM 5 %	Non-Formulary	QL (Quantity Limits Apply)
ELAHERE INTRAVENOUS SOLUTION 5 MG/ML	BB	PA
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	BB	PA
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG	BB	PA
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG	BB	PA
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)	BB	PA
ELZONRIS INTRAVENOUS SOLUTION 1,000 MCG/ML	BB	PA
EMPLICITI INTRAVENOUS RECON SOLN 300 MG	BB	PA
ENHERTU INTRAVENOUS RECON SOLN 100 MG	BB	PA
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML, 200 MG/100 ML	BB	PA
ERIVEDGE ORAL CAPSULE 150 MG	5	PA; SP; QL (30 capsules per 30 days)
ERLEADA ORAL TABLET 240 MG, 60 MG	6	PA; SP; QL (4 tablets per 1 day)
<i>erlotinib oral tablet 100 mg, 150 mg, 25 mg</i>	2	SP; PF; QL (30 tablets per 30 days)
<i>etoposide oral capsule 50 mg</i>	5	PA; SP; QL (1 capsule per 1 day)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	5	PA; SP
<i>everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	2	QL (10 TABLET per 1 day)
EVOMELA INTRAVENOUS RECON SOLN 50 MG	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>exemestane oral tablet 25 mg</i>	2	HCR; QL (1 tablet per 1 day)
FARESTON ORAL TABLET 60 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG	5	PA; SP; QL (6 capsules per 30 days)
FENSOLVI SUBCUTANEOUS SYRINGE 45 MG	BB	PA
<i>fluorouracil topical cream 0.5 %</i>	Non-Formulary	ALT (Covered Alternatives: FLUOROURACIL, FLUOROURACIL); QL (40 gm per 30 days)
<i>fluorouracil topical cream 5 %</i>	2	
<i>fluorouracil topical solution 2 %, 5 %</i>	2	PA; QL (10 ml per 1 month)
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	6	PA; SP; QL (1 tablet per 1 day)
FRINDOVYX INTRAVENOUS SOLUTION 500 MG/ML	BB	
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG	6	PA; SP; PF; QL (21 Capsules per 28 days)
FYARRO INTRAVENOUS SUSPENSION FOR RECONSTITUTION 100 MG	BB	PA
GAVRETO ORAL CAPSULE 100 MG	6	PA; SP; QL (1 tablet per 1 day)
GAZYVA INTRAVENOUS SOLUTION 1,000 MG/40 ML	BB	PA
<i>gefitinib oral tablet 250 mg</i>	5	PA; SP; QL (30 Tablets per 1 Fill)
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA; SP; QL (30 tablets per 30 days)
GLEEVEC ORAL TABLET 100 MG	Non-Formulary	SP; QL (180 tablets per 1 fill)
GLEEVEC ORAL TABLET 400 MG	Non-Formulary	SP; QL (60 tablets per 1 fill)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	5	PA; SP; QL (1 capsule per 1 day)
GOMEKLI ORAL CAPSULE 1 MG	Non-Formulary	SP; QL (2 Capsules per 1 Day)
GOMEKLI ORAL CAPSULE 2 MG	Non-Formulary	SP; QL (4 Capsules per 1 Day)
GOMEKLI ORAL TABLET FOR SUSPENSION 1 MG	Non-Formulary	SP; QL (8 Capsules per 1 Day)
GRAFAPEX INTRAVENOUS RECON SOLN 1 GRAM, 5 GRAM	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION 600 MG-10,000 UNIT/5 ML	BB	PA
HERCEPTIN INTRAVENOUS RECON SOLN 150 MG	BB	PA
HERNEXEOS ORAL TABLET 60 MG	Non-Formulary	SP; QL (1 Tablet per 1 Day)
HERZUMA INTRAVENOUS RECON SOLN 150 MG, 420 MG	BB	PA
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG	5	PA; SP; QL (1 capsule per 1 day)
HYDREA ORAL CAPSULE 500 MG	Non-Formulary	
<i>hydroxyurea oral capsule 500 mg</i>	2	
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA; SP; QL (21 capsules per 30 days)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA; SP; QL (21 tablets per 30 days)
ICLUSIG ORAL TABLET 10 MG, 30 MG	6	PA; SP; PF; QL (1 TABLET per 1 day)
ICLUSIG ORAL TABLET 15 MG	6	PA; SP; PF; QL (60 tablets per 30 days)
ICLUSIG ORAL TABLET 45 MG	6	PA; SP; PF; QL (30 tablets per 30 days)
IDHIFA ORAL TABLET 100 MG, 50 MG	6	PA; SP; QL (30 tablets per 30 days)
<i>imatinib oral tablet 100 mg</i>	2	SP; QL (180 tablets per 30 days)
<i>imatinib oral tablet 400 mg</i>	2	SP; QL (60 tablets per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; SP; QL (4 Capsules per 1 day)
IMBRUVICA ORAL CAPSULE 70 MG	Non-Formulary	SP; ALT (Covered Alternatives: Imbruvica Suspension)
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA; SP; QL (1 ml per 1 day)
IMBRUVICA ORAL TABLET 140 MG	Non-Formulary	SP; ALT (Covered Alternatives: Imbruvica 140mg Capsule)
IMBRUVICA ORAL TABLET 280 MG	Non-Formulary	SP; ALT (Covered Alternatives: Imbruvica 140mg Capsules)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
IMBRUVICA ORAL TABLET 420 MG	5	PA; SP; ALT (Covered Alternatives: Imbruvica 140mg Capsules); QL (1 tablet per 1 day)
IMDELLTRA INTRAVENOUS RECON SOLN 1 MG, 10 MG	BB	
IMFINZI INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
IMJUDO INTRAVENOUS SOLUTION 20 MG/ML	BB	PA
IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML	BB	PA
INFUGEM INTRAVENOUS PIGGYBACK 1,300 MG/130 ML (10 MG/ML)	BB	PA
INLYTA ORAL TABLET 1 MG, 5 MG	6	PA; SP
INQOVI ORAL TABLET 35-100 MG	Non-Formulary	SP
INREBIC ORAL CAPSULE 100 MG	6	PA; SP; QL (4 tablets per 1 day)
IRESSA ORAL TABLET 250 MG	Non-Formulary	SP; QL (30 tablets per 30 days)
ISTODAX INTRAVENOUS RECON SOLN 10 MG/2 ML	BB	PA
ITOVEBI ORAL TABLET 3 MG, 9 MG	6	PA; SP; QL (1 Tablet per 1 day)
IVRA INTRAVENOUS SOLUTION 90 MG/ML	BB	
IWILFIN ORAL TABLET 192 MG	6	PA; SP; QL (4 Tablets per 1 day)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA; SP; QL (60 tablets per 30 days)
JAYPIRCA ORAL TABLET 100 MG, 50 MG	6	PA; SP; QL (4 Tablets per 1 day)
JELMYTO INTRA-PYELOCALYCEAL KIT 40 MG X 2	Non-Formulary	
JEMPERLI INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
JOBEVNE INTRAVENOUS SOLUTION 25 MG/ML	BB	
JYLAMVO ORAL SOLUTION 2 MG/ML	Non-Formulary	QL (20 ML per 30 days)
KADCYLA INTRAVENOUS RECON SOLN 100 MG, 160 MG	BB	PA
KANJINTI INTRAVENOUS RECON SOLN 150 MG, 420 MG	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
KEYTRUDA INTRAVENOUS SOLUTION 25 MG/ML	BB	
KIMMTRAK INTRAVENOUS SOLUTION 100 MCG/0.5 ML	BB	PA
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA; SP; QL (21 tablets per 30 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5	PA; SP; QL (42 tablets per 30 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5	PA; SP; QL (63 tablets per 30 days)
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	6	PA; SP; QL (2 tablets per 1 day)
KRAZATI ORAL TABLET 200 MG	6	PA; SP; QL (6 Tablets per 1 day)
KYPROLIS INTRAVENOUS RECON SOLN 60 MG	BB	PA
<i>lapatinib oral tablet 250 mg</i>	5	PA; SP; QL (180 tablets per 30 days)
LAZCLUZE ORAL TABLET 240 MG	6	PA; SP; QL (1 Tablet per 1 day)
LAZCLUZE ORAL TABLET 80 MG	6	PA; SP; QL (2 Tablets per 1 day)
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	1	PA; SP; QL (1 Capsule per 1 day)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)	6	PA; SP; QL (3 Capsules per 1 day)
<i>letrozole oral tablet 2.5 mg</i>	2	QL (1 tablet per 1 day)
LEUKERAN ORAL TABLET 2 MG	4	SP
<i>leuprolide subcutaneous kit 1 mg/0.2 ml</i>	2	PA; SP; QL (1 Kit per 28 days)
LIBTAYO INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA; SP; QL (2 Tablets per 1 day)
LOQTORZI INTRAVENOUS SOLUTION 240 MG/6 ML (40 MG/ML)	BB	PA
LORBRENA ORAL TABLET 100 MG	5	PA; SP; QL (1 tablet per 1 day)
LORBRENA ORAL TABLET 25 MG	5	PA; SP; QL (3 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LUMAKRAS ORAL TABLET 120 MG	6	PA; SP; PF; QL (8 tablets per 1 day)
LUMAKRAS ORAL TABLET 240 MG	6	PA; SP; PF; QL (8 Tablets per 1 Day)
LUMAKRAS ORAL TABLET 320 MG	6	PA; SP; PF; QL (3 tablets per 1 day)
LUNSUMIO INTRAVENOUS SOLUTION 1 MG/ML	BB	PA
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 22.5 MG	BB	PA
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	BB	PA
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT 45 MG	BB	PA
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG, 7.5 MG	BB	PA
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 30 MG	BB	PA
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (PED)	BB	PA
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA; SP; PF; QL (120 tablets per 30 days)
LYSODREN ORAL TABLET 500 MG	3	PA; SP; QL (1 tablet per 1 day)
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)	6	PA; SP; QL (5 Tablets per 1 Day)
MARGENZA INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
MATULANE ORAL CAPSULE 50 MG	3	PA; SP; QL (1 capsule per 1 day)
MAVENCLAD (10 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (4 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (5 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
MAVENCLAD (6 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (7 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (8 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (9 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)</i>	2	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	2	QL (175 ML per 30 days)
<i>megestrol oral tablet 20 mg, 40 mg</i>	2	
MEKINIST ORAL RECON SOLN 0.05 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Mekinist Tablets)
MEKINIST ORAL TABLET 0.5 MG	5	PA; SP; QL (90 tablets per 30 days)
MEKINIST ORAL TABLET 2 MG	5	PA; SP; QL (30 tablets per 30 days)
MEKTOVI ORAL TABLET 15 MG	6	SP; PF
<i>mercaptopurine oral suspension 20 mg/ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: MERCAPTOPYRINE 50MG TABLET); QL (3 ML per 1 day)
<i>mercaptopurine oral tablet 50 mg</i>	2	
<i>methotrexate sodium (pf) injection solution 25 mg/ml</i>	7	
<i>methotrexate sodium injection solution 25 mg/ml</i>	7	
<i>methotrexate sodium oral tablet 2.5 mg</i>	2	
MONJUVI INTRAVENOUS RECON SOLN 200 MG	BB	PA
MVASI INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
MYLERAN ORAL TABLET 2 MG	4	PA; SP; QL (1 tablet per 1 day)
MYLOTARG INTRAVENOUS RECON SOLN 4.5 MG (1 MG/ML INITIAL CONC)	BB	PA
<i>nelarabine intravenous solution 250 mg/50 ml</i>	BB	
NERLYNX ORAL TABLET 40 MG	Non-Formulary	SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NEXAVAR ORAL TABLET 200 MG	Non-Formulary	SP; ALT (Covered Alternatives: Sorafenib)
<i>nilotinib hcl oral capsule 150 mg, 200 mg</i>	5	PA; SP; PF; QL (112 Capsules per 1 Fill)
<i>nilotinib hcl oral capsule 50 mg</i>	5	PA; SP; PF; QL (120 Capsules per 1 Fill)
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA; SP; QL (3 capsules per 30 days)
NUBEQA ORAL TABLET 300 MG	6	PA; SP; PF; QL (4 tablets per 1 day)
ODOMZO ORAL CAPSULE 200 MG	5	PA; SP; QL (30 capsules per 30 days)
OGIVRI INTRAVENOUS RECON SOLN 150 MG, 420 MG	BB	PA
OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG	6	PA; SP; PF; QL (6 Tablets per 1 day)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION 25 MG/ML	6	PA; SP; QL (3.2 ML per 1 day)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	6	PA; SP; QL (0.58 Tablets per 1 day)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	6	PA; SP; QL (0.72 Tablet per 1 day)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	6	PA; SP; QL (0.86 Tablet per 1 day)
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	6	PA; SP; QL (1 Tablet per 1 Day)
ONTRUZANT INTRAVENOUS RECON SOLN 150 MG, 420 MG	BB	PA
ONUREG ORAL TABLET 200 MG, 300 MG	6	PA; SP; QL (1 tablet per 1 day)
OPDIVO INTRAVENOUS SOLUTION 100 MG/10 ML, 120 MG/12 ML, 240 MG/24 ML, 40 MG/4 ML	BB	
OPDUALAG INTRAVENOUS SOLUTION 240-80 MG/20 ML	BB	PA
OPZELURA TOPICAL CREAM 1.5 %	Non-Formulary	SP; ALT (Covered Alternatives: Betamethasone, Clobetasol, Tacrolimus); QL (2 GRAM per 1 day)
ORGOVYX ORAL TABLET 120 MG	6	PA; SP; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ORSERDU ORAL TABLET 345 MG	6	PA; SP; QL (1 Tablet per 1 day)
ORSERDU ORAL TABLET 86 MG	6	PA; SP; QL (3 Tablets per 1 day)
<i>paclitaxel protein-bound intravenous suspension for reconstitution 100 mg</i>	BB	
PADCEV INTRAVENOUS RECON SOLN 20 MG	BB	PA
<i>pazopanib oral tablet 200 mg</i>	5	PA; SP; QL (4 Tablets per 1 day)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA; SP; QL (4 ML per 30 days)
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	5	PA; SP; QL (2 ML per 30 days)
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	6	PA; SP; QL (14 tablets per 21 days)
PEMFEXY INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
PERJETA INTRAVENOUS SOLUTION 420 MG/14 ML (30 MG/ML)	BB	PA
PHEGO SUBCUTANEOUS SOLUTION 1,200 MG-600MG- 30000 UNIT/15ML, 600 MG-600 MG-20000 UNIT/10ML	BB	PA
PHYRAGO ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG	Non-Formulary	SP; PF; QL (1 Tablet per 1 Day)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	5	PA; QL (Quantity Limits Apply); SP
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	6	PA; SP; QL (1 capsule per 1 day)
POTELIGEO INTRAVENOUS SOLUTION 4 MG/ML	BB	PA
PURIXAN ORAL SUSPENSION 20 MG/ML	Non-Formulary	SP
QINLOCK ORAL TABLET 50 MG	6	PA; SP; QL (3 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: METHOTREXATE)
RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG	6	PA; SP; PF; QL (2 Tablets per 1 day)
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.04 %, 0.06 %, 0.08 %, 0.1 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
RETIN-A MICRO TOPICAL GEL 0.04 %, 0.1 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
RETIN-A TOPICAL CREAM 0.025 %, 0.05 %, 0.1 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (45 gm per 1 fill)
RETIN-A TOPICAL GEL 0.01 %	Non-Formulary	QL (1.5 grams per day; 45 grams per fill); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
RETIN-A TOPICAL GEL 0.025 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (1.5 gm per 1 day)
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	5	PA; SP; QL (1 capsule per 1 day)
REVUFORJ ORAL TABLET 110 MG, 160 MG	6	PA; SP; QL (2 Tablets per 1 day)
REZLIDHIA ORAL CAPSULE 150 MG	6	PA; SP; QL (2 Capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
RIABNI INTRAVENOUS SOLUTION 10 MG/ML	BB	PA
RITUXAN HYCELA SUBCUTANEOUS SOLUTION 1400 MG/11.7 ML (120 MG/ML), 1600 MG/13.4 ML (120 MG/ML)	BB	PA
RITUXAN INTRAVENOUS CONCENTRATE 10 MG/ML	BB	PA
<i>romidepsin intravenous solution 5 mg/ml</i>	BB	PA
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG	Non-Formulary	SP; QL (8 Capsules per 28 Days)
ROZLYTREK ORAL CAPSULE 100 MG	6	PA; SP; QL (1 tablet per 1 day)
ROZLYTREK ORAL CAPSULE 200 MG	6	PA; SP; QL (3 tablets per 1 day)
ROZLYTREK ORAL PELLETS IN PACKET 50 MG	Non-Formulary	SP
RUBRACA ORAL TABLET 250 MG, 300 MG	6	PA; SP; PF; QL (120 Tablets per 1 Fill)
RUXIENCE INTRAVENOUS SOLUTION 10 MG/ML	BB	PA; QL (200 ML per 1 fill)
RYBREVANT INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
RYDAPT ORAL CAPSULE 25 MG	6	PA; SP; QL (2 capsules per 1 day)
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5 ML	BB	PA
RYTELO INTRAVENOUS RECON SOLN 188 MG, 47 MG	BB	PA
SARCLISA INTRAVENOUS SOLUTION 20 MG/ML	BB	PA
SCEMBLIX ORAL TABLET 100 MG	6	PA; SP; QL (10 Tablet per 1 Day)
SCEMBLIX ORAL TABLET 20 MG, 40 MG	6	PA; SP; QL (10 tablets per 1 day)
SIKLOS ORAL TABLET 1,000 MG, 100 MG	Non-Formulary	SP
<i>sorafenib oral tablet 200 mg</i>	5	PA; SP; QL (120 tablets per 1 fill)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	Non-Formulary	SP; ALT (Covered Alternatives: DASATINIB); QL (30 tablets per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SPRYCEL ORAL TABLET 20 MG	Non-Formulary	SP; ALT (Covered Alternatives: DASATINIB); QL (90 tablets per 30 days)
SPRYCEL ORAL TABLET 70 MG	Non-Formulary	SP; ALT (Covered Alternatives: DASATINIB); QL (60 tablets per 30 days)
STIVARGA ORAL TABLET 40 MG	5	PA; SP; QL (84 tablets per 30 days)
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	5	PA; SP; QL (30 capsules per 30 days)
SUPPRELIN LA IMPLANT KIT 50 MG (65 MCG/DAY)	BB	PA; QL (Quantity Limits Apply)
SUTENT ORAL CAPSULE 12.5 MG	Non-Formulary	SP; QL (90 capsules per 30 days)
SUTENT ORAL CAPSULE 25 MG, 37.5 MG, 50 MG	Non-Formulary	SP; QL (30 capsules per 30 days)
SYLVANT INTRAVENOUS RECON SOLN 100 MG	BB	PA
TABLOID ORAL TABLET 40 MG	4	PA; SP; QL (2 tablets per 1 day)
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA; SP; QL (4 tablets per 1 day)
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA; SP; QL (120 capsules per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION 10 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tafenlar Capsules)
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA; SP; QL (30 tablets per 30 days)
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA; SP; QL (1 Capsule per 1 day)
<i>tamoxifen oral tablet 10 mg, 20 mg</i>	2	HCR; QL (1 tablet per 1 day)
TARGRETIN ORAL CAPSULE 75 MG	Non-Formulary	SP; QL (1 capsule per 1 day)
TARGRETIN TOPICAL GEL 1 %	Non-Formulary	SP; QL (2 gm per 1 day)
TASIGNA ORAL CAPSULE 150 MG, 200 MG	Non-Formulary	SP; ALT (Covered Alternatives: Nilotinib); QL (112 capsules per 30 days)
TASIGNA ORAL CAPSULE 50 MG	Non-Formulary	SP; ALT (Covered Alternatives: Nilotinib); QL (120 capsules per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TAZVERIK ORAL TABLET 200 MG	6	PA; SP; QL (8 tablets per 1 day)
TECENTRIQ HYBREZA SUBCUTANEOUS SOLUTION 1,875 MG-30,000 UNIT/15 ML	BB	PA
TECENTRIQ INTRAVENOUS SOLUTION 1,200 MG/20 ML (60 MG/ML)	BB	PA
TECVAYLI SUBCUTANEOUS SOLUTION 10 MG/ML, 90 MG/ML	BB	PA
TEMODAR INTRAVENOUS RECON SOLN 100 MG	BB	
<i>temozolomide oral capsule 100 mg, 140 mg</i>	5	SP; QL (2 Capsules per 1 day)
<i>temozolomide oral capsule 180 mg, 250 mg</i>	5	SP; QL (1 capsule per 1 day)
<i>temozolomide oral capsule 20 mg, 5 mg</i>	5	SP; QL (3 Capsules per 1 day)
TEPADINA INJECTION RECON SOLN 100 MG, 15 MG	BB	
TEPADINA INJECTION SOLUTION 200 MG	BB	
TEPMETKO ORAL TABLET 225 MG	6	PA; SP; ALT (Covered Alternatives: Tabrecta); QL (2 tablets per 1 day)
TEPYLUTE INTRAVENOUS SOLUTION 10 MG/ML	BB	
TEVIMBRA INTRAVENOUS SOLUTION 10 MG/ML	BB	PA
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA; SP; QL (1 capsule per 1 day)
TIBSOVO ORAL TABLET 250 MG	6	PA; SP; QL (2 tablets per 1 day)
TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION 50 MG	7	HCR
TIVDAK INTRAVENOUS RECON SOLN 40 MG	BB	PA
<i>toremifene oral tablet 60 mg</i>	2	PA; SP; QL (1 tablet per 1 day)
TORPENZ ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	Non-Formulary	SP; ALT (Covered Alternatives: Everolimus); QL (1 Tablet per 1 Day)
TRAZIMERA INTRAVENOUS RECON SOLN 150 MG, 420 MG	BB	PA
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>tretinoin (antineoplastic) oral capsule 10 mg</i>	2	PA; SP; QL (8 capsule per 1 day)
<i>tretinoin microspheres topical gel 0.04 %, 0.1 %</i>	Non-Formulary	
<i>tretinoin microspheres topical gel with pump 0.04 %, 0.1 %</i>	Non-Formulary	QL (50 GM per 30 days)
<i>tretinoin microspheres topical gel with pump 0.08 %</i>	Non-Formulary	
<i>tretinoin topical cream 0.025 %, 0.05 %, 0.1 %</i>	2	PA; QL (45 GM per 1 Fill)
<i>tretinoin topical gel 0.01 %, 0.025 %</i>	2	PA; QL (45 GM per 30 days)
<i>tretinoin topical gel 0.05 %</i>	Non-Formulary	QL (1.5 gm per 1 day)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	4	PA; ALT (Covered Alternatives: METHOTREXATE); QL (1 tablet per 1 day)
TRIPTODUR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG	BB	PA
TRODELVY INTRAVENOUS RECON SOLN 180 MG	BB	PA
TRUQAP ORAL TABLET 160 MG, 200 MG	6	PA; SP; QL (64 Tablets per 28 days)
TRUXIMA INTRAVENOUS SOLUTION 10 MG/ML	BB	PA; QL (200 ML per 1 fill)
TUKYSA ORAL TABLET 150 MG, 50 MG	6	PA; SP; QL (2 tablets per 1 day)
TURALIO ORAL CAPSULE 125 MG	6	PA; SP; QL (4 Capsules per 1 day)
TYKERB ORAL TABLET 250 MG	Non-Formulary	SP; ALT (Covered Alternatives: LAPATINIB); QL (180 tablets per 1 fill)
VABRINTY (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	BB	PA
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	6	PA; SP
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML), 400 MG/20 ML (20 MG/ML)	BB	PA
VENCLEXTA ORAL TABLET 10 MG, 50 MG	5	PA; SP; QL (1 tablet per 1 day)
VENCLEXTA ORAL TABLET 100 MG	5	PA; SP; QL (4 tablet per 1 day)
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK 10 MG-50 MG- 100 MG	5	PA; SP; QL (42 tablets per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	6	PA; SP; QL (60 tablets per 30 days)
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	5	PA; SP; QL (1 Capsule per 1 day)
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA; SP; QL (1 ML per 1 day)
VIVIMUSTA INTRAVENOUS SOLUTION 25 MG/ML	BB	
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	6	PA; SP; QL (1 tablet per 1 day)
VONJO ORAL CAPSULE 100 MG	6	PA; SP; QL (4 Tablets per 1 day)
VORANIGO ORAL TABLET 10 MG	6	PA; SP; QL (2 Tablets per 1 Day)
VORANIGO ORAL TABLET 40 MG	6	PA; SP; QL (1 Tablet per 1 Day)
VOTRIENT ORAL TABLET 200 MG	Non-Formulary	SP
VYLOY INTRAVENOUS RECON SOLN 100 MG	BB	PA
WELIREG ORAL TABLET 40 MG	6	PA; SP; QL (3 tablets per 1 day)
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA; SP; QL (60 capsules per 30 days)
XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG	5	PA; SP; QL (2 Pellets per 1 day)
XATMEP ORAL SOLUTION 2.5 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: METHOTREXATE)
XELODA ORAL TABLET 150 MG, 500 MG	Non-Formulary	SP; QL (140 units per 1 fill)
XOSPATA ORAL TABLET 40 MG	6	PA; SP; QL (3 tablets per 1 day)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK), 80MG TWICE WEEK (160 MG/WEEK)	6	PA; SP; QL (4 tablets per 1 day)
XROMI ORAL SOLUTION 100 MG/ML	Non-Formulary	SP; QL (10 ML per 1 Day)
XTANDI ORAL CAPSULE 40 MG	5	PA; SP; QL (120 capsules per 30 days)
XTANDI ORAL TABLET 40 MG	5	PA; SP; QL (120 tablets per 1 fill)
XTANDI ORAL TABLET 80 MG	5	PA; SP; QL (2 tablets per 1 day)
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	BB	PA
YONDELIS INTRAVENOUS RECON SOLN 1 MG	BB	PA
YONSA ORAL TABLET 125 MG	Non-Formulary	QL (Quantity Limits Apply); SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)	BB	PA
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	6	PA; SP; QL (1 Tablet per 1 day)
ZELBORAF ORAL TABLET 240 MG	5	PA; SP; QL (240 tablets per 30 days)
ZEPZELCA INTRAVENOUS RECON SOLN 4 MG	BB	PA
ZIIHERA INTRAVENOUS RECON SOLN 300 MG	BB	
ZIRABEV INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
ZOLINZA ORAL CAPSULE 100 MG	5	PA; SP
ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG	Non-Formulary	QL (1 tablet per 1 day)
ZORTRESS ORAL TABLET 1 MG	Non-Formulary	ALT (Covered Alternatives: Everolimus); QL (1 tablet per 1 day)
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA; SP; QL (60 tablets per 30 days)
ZYKADIA ORAL TABLET 150 MG	Non-Formulary	SP; QL (150 tablets per 1 fill)
ZYNLONTA INTRAVENOUS RECON SOLN 10 MG	BB	PA
ZYTIGA ORAL TABLET 250 MG	Non-Formulary	SP; QL (120 tablets per 1 fill)
ZYTIGA ORAL TABLET 500 MG	Non-Formulary	SP; QL (60 capsules per 30 days)
ANTITOXINS, IMMUNE GLOB, TOXOIDS, VACCINES		
Allergenic Extracts (Therapeutic)		
PALFORZIA (LEVEL 0) ORAL CAPSULE, SPRINKLE 1 MG	Non-Formulary	SP
PALFORZIA (LEVEL 1) ORAL CAPSULE, SPRINKLE 3 MG (1 MG X 3)	Non-Formulary	SP
PALFORZIA (LEVEL 2) ORAL CAPSULE, SPRINKLE 6 MG (1 MG X 6)	Non-Formulary	SP
PALFORZIA (LEVEL 3) ORAL CAPSULE, SPRINKLE 12 MG (1 MG X 2, 10 MG X 1)	Non-Formulary	SP
PALFORZIA (LEVEL 4) ORAL CAPSULE, SPRINKLE 20 MG	Non-Formulary	SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PALFORZIA (LEVEL 5) ORAL CAPSULE, SPRINKLE 40 MG (20 MG X 2)	Non-Formulary	SP
PALFORZIA (LEVEL 6) ORAL CAPSULE, SPRINKLE 80 MG (20 MG X 4)	Non-Formulary	SP
PALFORZIA (LEVEL 7) ORAL CAPSULE, SPRINKLE 120 MG (20 MG X 1, 100 MG X 1)	Non-Formulary	SP
PALFORZIA (LEVEL 8) ORAL CAPSULE, SPRINKLE 160 MG (20 MG X 3, 100 MG X1)	Non-Formulary	SP
PALFORZIA (LEVEL 9) ORAL CAPSULE, SPRINKLE 200 MG (100 MG X 2)	Non-Formulary	SP
PALFORZIA (LEVEL 10) ORAL CAPSULE, SPRINKLE 240 MG (20 MG X 2, 100 MG X 2)	Non-Formulary	SP
PALFORZIA (LEVEL 11 UP-DOSE) ORAL POWDER IN PACKET 300 MG	Non-Formulary	SP
PALFORZIA INITIAL (1-3 YRS) ORAL CAPSULE, SPRINKLE 0.5/1/1.5/3 MG	Non-Formulary	SP
PALFORZIA INITIAL (4-17 YRS) ORAL CAPSULE, SPRINKLE 0.5/1/1.5/3/6 MG	Non-Formulary	SP
PALFORZIA LEVEL 11 MAINTENANCE ORAL POWDER IN PACKET 300 MG	Non-Formulary	SP
Antitoxins And Immune Globulins		
ALYGLO INTRAVENOUS SOLUTION 10 %	Non-Formulary	SP
ASCENIV INTRAVENOUS SOLUTION 10 %	Non-Formulary	SP
BIVIGAM INTRAVENOUS SOLUTION 10 %	7	PA; SP; QL (0.01 ML per 1 day)
CUTAQUIG SUBCUTANEOUS SOLUTION 16.5 %	Non-Formulary	SP
CUVITRU SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %), 8 GRAM/40 ML (20 %)	7	PA; QL (Quantity Limits Apply); SP; QL (0.01 ML per 1 day)
CYTOGAM INTRAVENOUS SOLUTION 50 MG/ML	7	PA; SP; QL (0.01 ML per 1 day)
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	7	PA; QL (Quantity Limits Apply); SP; QL (1 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 %	7	PA; QL (Quantity Limits Apply); SP; QL (1 ml per 1 day)
GAMASTAN INTRAMUSCULAR SOLUTION 15-18 % RANGE	Non-Formulary	SP
GAMMAGARD LIQUID INJECTION SOLUTION 10 %	7	PA; SP; QL (1 ML per 28 days)
GAMMAGARD S-D (IGA < 1 MCG/ML) INTRAVENOUS RECON SOLN 10 GRAM, 5 GRAM	7	PA; QL (Quantity Limits Apply); SP; QL (1 vial per 30 days)
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	7	PA; QL (Quantity Limits Apply); SP; QL (1 ML per 28 days)
GAMMAKED INJECTION SOLUTION 10 GRAM/100 ML (10 %), 20 GRAM/200 ML (10 %), 5 GRAM/50 ML (10 %)	7	PA; QL (Quantity Limits Apply); SP; QL (10 ml per 30 days)
GAMMAPLEX (WITH SORBITOL) INTRAVENOUS SOLUTION 5 %	7	PA; SP; QL (1 ML per 1 day)
GAMMAPLEX INTRAVENOUS SOLUTION 10 %	Non-Formulary	SP; QL (50 ml per 30 days)
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	7	PA; QL (Quantity Limits Apply); SP; QL (1 ML per 28 days)
GAMUNEX-C INJECTION SOLUTION 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %)	7	PA; QL (Quantity Limits Apply); SP; QL (10 ml per 30 days)
HIZENTRA SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %)	7	PA; QL (Quantity Limits Apply); SP; QL (1 ML per 30 days)
HIZENTRA SUBCUTANEOUS SYRINGE 1 GRAM/5 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %)	7	PA; QL (Quantity Limits Apply); SP; QL (1 ML per 30 days)
HYQVIA SUBCUTANEOUS SOLUTION 10 GRAM /100 ML (10 %), 2.5 GRAM /25 ML (10 %), 20 GRAM /200 ML (10 %), 30 GRAM /300 ML (10 %), 5 GRAM /50 ML (10 %)	Non-Formulary	SP
OCTAGAM INTRAVENOUS SOLUTION 10 %	7	PA; QL (Quantity Limits Apply); SP; QL (0.01 ml per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
OCTAGAM INTRAVENOUS SOLUTION 5 %	7	PA; QL (Quantity Limits Apply); SP; QL (0.01 ML per 1 day)
PANZYGA INTRAVENOUS SOLUTION 10 %	Non-Formulary	SP
PRIVIGEN INTRAVENOUS SOLUTION 10 %	7	PA; QL (Quantity Limits Apply); SP; QL (0.01 ML per 1 day)
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SYRINGE 1,500 UNIT (300 MCG)	7	
XEMBIFY SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %)	7	PA; SP; QL (0.4 ML per 1 day)
ZINPLAVA INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
Toxoids		
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	7	HCR
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	7	HCR
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML	7	HCR
PEDIARIX (PF) INTRAMUSCULAR SYRINGE 10 MCG-25LF-25 MCG-10LF/0.5 ML	7	HCR
TENIVAC (PF) INTRAMUSCULAR SUSPENSION 5 LF UNIT- 2 LF UNIT/0.5ML	7	HCR
TENIVAC (PF) INTRAMUSCULAR SYRINGE 5-2 LF UNIT/0.5 ML	7	HCR
Vaccines		
ABRYSVO (PF) INTRAMUSCULAR RECON SOLN 120 MCG/0.5 ML	7	
ACTHIB (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	7	HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
AFLURIA 2025-2026 (3YR UP)(PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
AFLURIA 2025-2026 (6MO UP) INTRAMUSCULAR SUSPENSION 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
AREXVY (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 120 MCG/0.5 ML	7	HCR
AUDENZ (NATIONAL STOCKPILE) INTRAMUSCULAR EMULSION 7.5 MCG/0.5 ML	7	HCR
AUDENZ(PF)(NATIONAL STOCKPILE) INTRAMUSCULAR SYRINGE 7.5 MCG/0.5 ML	7	HCR
<i>bcg vaccine, live (pf) percutaneous suspension for reconstitution 50 mg</i>	Non-Formulary	
BEXSERO INTRAMUSCULAR SYRINGE 50-50-25 MCG/0.5 ML	7	HCR
BIOTHRAX INTRAMUSCULAR SUSPENSION 0.5 ML/DOSE	Non-Formulary	HCR
CAPVAXIVE INTRAMUSCULAR SYRINGE 0.5 ML	7	HCR
COMIRNATY 2025-2026(5-11Y)(PF) INTRAMUSCULAR SUSPENSION 10 MCG/0.3 ML	7	HCR
DENGVAXIA (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP4.5-6 CCID50/0.5 ML	Non-Formulary	
ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML	7	HCR
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML	7	HCR
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML	7	HCR
FLUAD 2025-2026 (65 YR UP)(PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML	7	HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FLUARIX 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
FLUBLOK 2025-2026 (PF) INTRAMUSCULAR SYRINGE 135 MCG (45 MCG X 3)/0.5 ML	7	HCR
FLUCELVAX 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
FLUCELVAX 2025-2026 INTRAMUSCULAR SUSPENSION 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
FLULAVAL 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
FLUMIST 2025-2026 NASAL NASAL SPRAY SYRINGE 10EXP6.5-7.5 FF UNIT/0.2 ML	7	HCR
FLUMIST HOME 2025-2026 NASAL (HOME ADMIN) NASAL SPRAY SYRINGE 10EXP6.5-7.5 FF UNIT/0.2 ML	Non-Formulary	
FLUZONE 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
FLUZONE 2025-2026 INTRAMUSCULAR SUSPENSION 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
FLUZONE HIGH-DOSE 2025-26 (PF) INTRAMUSCULAR SYRINGE 180 MCG/0.5 ML	7	HCR
FLUZONE TRIV SOUTH HEM2025(PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML	7	HCR
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION 0.5 ML	7	HCR
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE 0.5 ML	7	HCR
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML, 720 ELISA UNIT/0.5 ML	7	HCR
HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/0.5 ML	7	HCR
HIBERIX (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	7	HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN 2.5 UNIT	7	HCR
IPOL INJECTION SUSPENSION 40-8-32 UNIT/0.5 ML	7	HCR
IXIARO (PF) INTRAMUSCULAR SYRINGE 6 MCG/0.5 ML	Non-Formulary	
KINRIX (PF) INTRAMUSCULAR SYRINGE 25 LF- 58 MCG-10 LF/0.5 ML	7	HCR
MENQUADFI (PF) INTRAMUSCULAR SOLUTION 10 MCG/0.5 ML	7	HCR
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML	7	HCR
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML	7	HCR
MNEXSPIKE 2025-2026 (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.2 ML	7	HCR
NUVAXOVID 2025-2026 (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	7	HCR
PEDIARIX (PF) INTRAMUSCULAR SYRINGE 10 MCG-25LF-25 MCG-10LF/0.5 ML	7	HCR
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION 7.5 MCG/0.5 ML	7	HCR
PENBRAYA (PF) INTRAMUSCULAR KIT 5-120 MCG/0.5 ML	7	HCR
PENMENVY MEN A-B-C-W-Y (PF) INTRAMUSCULAR KIT 0.5 ML	7	
PENMENVY MENACWY COMPONENT(PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 10-5 MCG	7	
PENMENVY MENB COMPONENT (PF) INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML	7	
PENTACEL ACTHIB COMPONENT (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	7	HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PNEUMOVAX-23 INJECTION SYRINGE 25 MCG/0.5 ML	7	HCR
PREVNAR 20 (PF) INTRAMUSCULAR SYRINGE 0.5 ML	7	HCR
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2-3.3CCID50/0.5ML	7	
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3-4.3-3- 3.99 TCID50/0.5	7	HCR
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION 15 LF-48 MCG- 5 LF UNIT/0.5ML	7	HCR
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 2.5 UNIT	7	HCR
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 40 MCG/ML, 5 MCG/0.5 ML	7	HCR
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	7	HCR
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 50 MCG/0.5 ML	7	HCR; QL (1 ML per 1 fill); AG (Min 18 Years)
SPIKEVAX 2025-2026(12Y UP)(PF) INTRAMUSCULAR SYRINGE 50 MCG/0.5 ML	7	HCR
STAMARIL (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,000 UNIT/0.5 ML	Non-Formulary	
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML, 2.4 MCG/0.5 ML	Non-Formulary	
TRUMENBA INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML	7	HCR
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT- 20 MCG/ML	7	HCR
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	Non-Formulary	
TYPHIM VI INTRAMUSCULAR SYRINGE 25 MCG/0.5 ML	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 50 UNIT/ML	7	HCR
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML, 50 UNIT/ML	7	HCR
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML	7	HCR
VAXNEUVANCE (PF) INTRAMUSCULAR SYRINGE 0.5 ML	7	HCR
VIVOTIF ORAL CAPSULE, DELAYED RELEASE (DR/EC) 2 BILLION UNIT	Non-Formulary	
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10 EXP4.74 UNIT/0.5 ML	7	HCR
AUTONOMIC DRUGS		
Alpha- And Beta-Adrenergic Agonists		
ADRENALIN IN 0.9 % SOD CHLOR INTRAVENOUS SOLUTION 10 MG/250 ML (40 MCG/ML), 2 MG/250 ML (8 MCG/ML), 8 MG/250 ML (32 MCG/ML)	BB	
ALLERGY AND CONGESTION RELIEF ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY RELIEF D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY RELIEF, NASAL DECONGEST ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY-CONGESTION RELIEF-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
AUVI-Q INJECTION AUTO-INJECTOR 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML	Non-Formulary	ALT (Covered Alternatives: EPINEPHRINE 0.15 MG AUTO-INJECT, EPINEPHRINE 0.3 MG AUTO-INJECT); QL (4 Injectors per 1 Fill)
CLARITIN-D 24 HOUR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	Non-Formulary	
<i>droxidopa oral capsule 100 mg, 200 mg, 300 mg</i>	Non-Formulary	SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>ephedrine sulfate intravenous solution 5 mg/ml, 50 mg/ml</i>	BB	
<i>ephedrine sulfate intravenous syringe 25 mg/5 ml (5 mg/ml), 50 mg/10 ml (5 mg/ml)</i>	BB	
<i>ephedrine sulfate-0.9%nacl(pf) intravenous syringe 15 mg/3 ml (5 mg/ml), 25 mg/5 ml (5 mg/ml)</i>	BB	
<i>epinephrine hcl in 0.9 % nacl intravenous solution 4 mg/250 ml (16 mcg/ml)</i>	BB	
<i>epinephrine in 0.9 % sod chlor intravenous solution 8 mg/250 ml (32 mcg/ml)</i>	BB	
<i>epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	2	QL (4 pens per 30 days)
<i>epinephrine injection syringe 0.3 mg/0.3 ml</i>	BB	
EPIPEN 2-PAK INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)
EPIPEN INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)
EPIPEN JR 2-PAK INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)
EPIPEN JR INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)
GUAIFENESIN DAC ORAL SYRUP 30-10-100 MG/5 ML	2	
LORATA-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
<i>norepinephrine bitart in water intravenous solution 2 mg/ml</i>	BB	
<i>norepinephrine bitartrate-nacl intravenous solution 32 mg/250 ml (128 mcg/ml), 8 mg/250 ml (32 mcg/ml)</i>	BB	
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG	Non-Formulary	SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PRIMATENE MIST INHALATION HFA AEROSOL INHALER 0.125 MG/ACTUATION	Non-Formulary	QL (11.7 GM per 28 days)
Alpha-Adrenergic Agonists		
<i>clonidine hcl oral tablet extended release 12 hr 0.1 mg</i>	2	
<i>lofexidine oral tablet 0.18 mg</i>	Non-Formulary	SP
LUCEMYRA ORAL TABLET 0.18 MG	Non-Formulary	QL (Quantity Limits Apply); SP
<i>midodrine oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
ONYDA XR ORAL SUSPENSION,EXTEND RELEASE 24HR 0.1 MG/ML	Non-Formulary	ALT (Covered Alternatives: CLONIDINE HCL ER 0.1 MG TABLET); QL (4 ML per 1 Day)
<i>phenylephrine hcl in 0.9% nacl intravenous solution 0.8 mg/10 ml (80 mcg/ml), 1 mg/10 ml (100 mcg/ml), 10 mg/250 ml (40 mcg/ml), 100 mg/250 ml (400 mcg/ml), 20 mg/250 ml (80 mcg/ml), 200 mg/250 ml (800 mcg/ml), 25 mg/250 ml (100 mcg/ml), 300 mg/250 ml (1,200 mcg/ml), 40 mg/250 ml (160 mcg/ml), 50 mg/250 ml (200 mcg/ml), 80 mg/250 ml (320 mcg/ml)</i>	BB	
<i>phenylephrine hcl in 0.9% nacl intravenous syringe 0.4 mg/10 ml (40 mcg/ml), 0.5 mg/5 ml (100 mcg/ml), 0.8 mg/10 ml (80 mcg/ml), 1 mg/10 ml (100 mcg/ml), 1,200 mcg/10 ml (120 mcg/ml), 100 mcg/10 ml (10 mcg/ml), 20 mg/50 ml (400 mcg/ml), 400 mcg/5 ml (80 mcg/ml), 5 mg/50 ml (100 mcg/ml)</i>	BB	
<i>phenylephrine hcl ophthalmic (eye) drops 10 %, 2.5 %</i>	2	
<i>phenylephrine in sterile water intravenous syringe 1 mg/10 ml (100 mcg/ml)</i>	BB	
Antimuscarinics/Antispasmodics		
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); TD; QL (60 Blisters per 28 days)
<i>atropine intravenous syringe 0.4 mg/ml</i>	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>atropine ophthalmic (eye) drops 0.01 %, 0.025 %, 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: Atropine 1% eye drops); QL (5 ML per 30 days)
<i>atropine ophthalmic (eye) drops 1 %</i>	2	
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION	3	QL (25.8 GM per 30 days)
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (10.7 GM per 28 days)
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	2	QL (2 capsules per 1 day)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 GM per 30 days)
CUVPOSA ORAL SOLUTION 1 MG/5 ML (0.2 MG/ML)	Non-Formulary	QL (5 ML per 1 day)
<i>dicyclomine oral capsule 10 mg</i>	2	QL (8 capsules per 1 day)
<i>dicyclomine oral solution 10 mg/5 ml</i>	2	
<i>dicyclomine oral tablet 20 mg</i>	2	QL (8 tablets per 1 day)
<i>dicyclomine oral tablet 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: DICYCLOMINE 10MG CAPSULE, DICYCLOMINE 20MG TABLET); QL (2 Tablets per 1 Day)
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml</i>	2	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	2	
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400-12 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (1 Inhaler per 28 days)
<i>glycopyrrolate (pf) injection syringe 0.4 mg/2 ml (0.2 mg/ml)</i>	BB	
<i>glycopyrrolate injection solution 0.2 mg/ml</i>	Non-Formulary	ALT (Covered Alternatives: CUVPOSA)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>glycopyrrolate intravenous syringe 0.6 mg/3 ml (0.2 mg/ml)</i>	BB	
<i>glycopyrrolate oral solution 1 mg/5 ml (0.2 mg/ml)</i>	5	PA; QL (5 ml per 1 day)
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	2	
<i>hydrocodone-homatropine oral solution 5-1.5 mg/5 ml</i>	2	QL (240 ML per 30 days)
<i>hydrocodone-homatropine oral solution 5-1.5 mg/5 ml (5 ml)</i>	Non-Formulary	QL (240 ML per 30 Days)
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	2	
<i>hyoscyamine sulfate sublingual tablet 0.125 mg</i>	2	
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE 62.5 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Breo Ellipta, Combivent, Tiotropium, Wixela, Budesonide/Formoterol, Stiolto); TD; QL (30 Blisters per 28 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	2	
<i>ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml</i>	2	
<i>methscopolamine oral tablet 2.5 mg, 5 mg</i>	2	
<i>scopolamine base transdermal patch 3 day 1 mg over 3 days</i>	2	QL (4 patches per 1 fill)
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION	3	QL (60 GM per 30 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG	Non-Formulary	ALT (Covered Alternatives: Tiotropium Bromide); QL (1 inhaler per 30 days)
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION	3	QL (4 GM per 30 days)
<i>tiotropium bromide inhalation capsule, w/inhalation device 18 mcg</i>	2	QL (1 Capsule per 1 day)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	4	PA; TD
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG	4	PA; TD; QL (1 DEVICE per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: BREO ELLIPTA, SPIRIVA, ARCAPTA NEOHALER, ADVAIR DISKUS, SYMBICORT, COMBIVENT RESPIMAT, PERFOROMIST); TD; QL (1 Inahler per 28 days)
YUPELRI INHALATION SOLUTION FOR NEBULIZATION 175 MCG/3 ML	4	SP; QL (3 vials per 1 day)
Antiparkinsonian Agents		
<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	
<i>benztropine oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG, 68.5 MG	Non-Formulary	SP
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 258 MG, 322 MG/DAY(129 MG X1-193MG X1)	Non-Formulary	QL (Quantity Limits Apply)
<i>trihexyphenidyl oral elixir 0.4 mg/ml</i>	2	
<i>trihexyphenidyl oral tablet 2 mg, 5 mg</i>	2	
Botulinum Toxins		
BOTOX INJECTION RECON SOLN 100 UNIT, 200 UNIT	BB	
DAXXIFY INTRAMUSCULAR RECON SOLN 100 UNIT	BB	PA
Centrally Acting Skeletal Muscle Relaxnt		
AMRIX ORAL CAPSULE,EXTENDED RELEASE 24HR 15 MG, 30 MG	Non-Formulary	
<i>carisoprodol oral tablet 250 mg</i>	2	
<i>carisoprodol oral tablet 350 mg</i>	2	QL (4 tablets per 1 day)
<i>carisoprodol-aspirin oral tablet 200-325 mg</i>	2	QL (4 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	2	QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 250 mg, 375 mg, 750 mg</i>	Non-Formulary	ALT (Covered Alternatives: CYCLOBENZAPRINE HCL, METHOCARBAMOL, TIZANIDINE HCL); QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 500 mg</i>	2	ALT (Covered Alternatives: CYCLOBENZAPRINE HCL, METHOCARBAMOL, TIZANIDINE HCL); QL (4 Tablets per 1 day)
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	2	QL (3 tablets per 1 day)
<i>cyclobenzaprine oral tablet 7.5 mg</i>	2	
LORZONE ORAL TABLET 375 MG, 750 MG	Non-Formulary	ALT (Covered Alternatives: CYCLOBENZAPRINE HCL, METHOCARBAMOL, TIZANIDINE HCL); QL (4 tablets per 1 day)
<i>metaxalone oral tablet 400 mg, 800 mg</i>	2	
<i>metaxalone oral tablet 640 mg</i>	Non-Formulary	ALT (Covered Alternatives: METAXALONE 400MG, METAXALONE 800MG); QL (4 Tablet per 1 day)
<i>methocarbamol oral tablet 1,000 mg</i>	Non-Formulary	ALT (Covered Alternatives: Methocarbamol 500mg, Methocarbamol 750mg); QL (4 Tablets per 1 Day)
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	2	
TANLOR ORAL TABLET 1,000 MG	Non-Formulary	ALT (Covered Alternatives: Methocarbamol 500mg, Methocarbamol 750mg); QL (4 Tablets per 1 Day)
<i>tizanidine oral capsule 2 mg</i>	2	QL (10 capsules per 1 day)
<i>tizanidine oral capsule 4 mg</i>	2	QL (9 capsules per 1 day)
<i>tizanidine oral capsule 6 mg</i>	2	QL (6 capsules per 1 day)
<i>tizanidine oral tablet 2 mg</i>	2	QL (10 tablets per 1 day)
<i>tizanidine oral tablet 4 mg</i>	2	QL (9 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Direct-Acting Skeletal Muscle Relaxants		
<i>dantrolene oral capsule 100 mg, 25 mg, 50 mg</i>	2	
Gaba-Derivative Skeletal Muscle Relaxant		
<i>baclofen intrathecal solution 10,000 mcg/20ml (500 mcg/ml)</i>	BB	PA
<i>baclofen oral solution 10 mg/5 ml (2 mg/ml)</i>	Non-Formulary	SP; ALT (Covered Alternatives: Baclofen Tablets); QL (80 ML per 1 day)
<i>baclofen oral tablet 10 mg</i>	2	QL (8 tablets per 1 day)
<i>baclofen oral tablet 15 mg</i>	Non-Formulary	ALT (Covered Alternatives: Baclofen 5mg, Baclofen 10mg, Baclofen 20mg); QL (5 Tablets per 1 Day)
<i>baclofen oral tablet 20 mg</i>	2	QL (120 tablets per 30 days)
<i>baclofen oral tablet 5 mg</i>	2	
FLEQSUVY ORAL SUSPENSION 25 MG/5 ML (5 MG/ML)	Non-Formulary	ALT (Covered Alternatives: Baclofen)
OZOBAX DS ORAL SOLUTION 10 MG/5 ML (2 MG/ML)	Non-Formulary	SP; ALT (Covered Alternatives: Baclofen Tablets); QL (80 ML per 1 day)
Indirect-Acting Skeletal Muscle Relaxant		
<i>orphenadrine citrate oral tablet extended release 100 mg</i>	2	
Neuromuscular Blocking Agents		
<i>succinylcholine chloride intravenous syringe 200 mg/10 ml (20 mg/ml)</i>	BB	
Non-Sel. Beta-Adrenergic Blocking Agents		
BETIMOL OPHTHALMIC (EYE) DROPS 0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TIMOLOL MALEATE)
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Nebivolol); QL (1 tablet per 1 day)
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>carvedilol phosphate oral capsule, er multiphase 24 hr 80 mg</i>	Non-Formulary	TD
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR 10 MG, 20 MG, 40 MG, 80 MG	Non-Formulary	
COSOPT (PF) OPHTHALMIC (EYE) DROPPERETTE 2-0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DORZOLAMIDE-TIMOLOL)
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette 2-0.5 %</i>	2	
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	2	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML	Non-Formulary	SP
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	2	
<i>nebivolol oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>pindolol oral tablet 10 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>sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	2	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	2	
Non-Sel. Alpha-Adrenergic Blocking Agents		
BREKIYA SUBCUTANEOUS AUTO-INJECTOR 1 MG/ML	Non-Formulary	QL (24 mLs per 28 days); ALT (Covered Alternatives: DIHYDROERGOTAMINE 1 MG/ML AMP); QL (3 ML per 1 Day)
<i>dihydroergotamine injection solution 1 mg/ml</i>	2	PA; QL (0.1 ML per 1 day)
<i>dihydroergotamine nasal spray, non-aerosol 0.5 mg/pump act. (4 mg/ml)</i>	2	PA; QL (8 ml per 1 fill)
<i>ergoloid oral tablet 1 mg</i>	2	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	2	QL (24 tablets per 1 fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>phenoxybenzamine oral capsule 10 mg</i>	2	PA; ALT (Covered Alternatives: DOXAZOSIN MESYLATE, PRAZOSIN HCL, TERAZOSIN HCL); QL (3 capsules per 1 day)
TRUDHESA NASAL SPRAY, NON-AEROSOL 0.725 MG/PUMP ACT. (4 MG/ML)	Non-Formulary	
Parasympathomimetic (Cholinergic Agents)		
ADLARITY TRANSDERMAL PATCH WEEKLY 10 MG/24 HOUR, 5 MG/24 HOUR	Non-Formulary	ALT (Covered Alternatives: Donepezil, Donepezil ODT)
<i>cevimeline oral capsule 30 mg</i>	2	
<i>donepezil oral tablet 10 mg, 5 mg</i>	2	QL (2 tablets per 1 day)
<i>donepezil oral tablet 23 mg</i>	2	
<i>donepezil oral tablet, disintegrating 10 mg, 5 mg</i>	2	
FIRDAPSE ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
<i>galantamine oral capsule, ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg</i>	2	
<i>galantamine oral solution 4 mg/ml</i>	2	
<i>galantamine oral tablet 12 mg, 4 mg, 8 mg</i>	2	
<i>memantine-donepezil oral capsule, sprinkle, er 24hr 14-10 mg, 21-10 mg, 28-10 mg</i>	Non-Formulary	ALT (Covered Alternatives: Memantine, Donepezil, Memantine ER); QL (1 Capsule per 1 Day)
MESTINON ORAL TABLET 60 MG	Non-Formulary	QL (Quantity Limits Apply)
MESTINON TIMESPAN ORAL TABLET EXTENDED RELEASE 180 MG	Non-Formulary	QL (Quantity Limits Apply)
NAMZARIC ORAL CAPSULE, SPRINKLE, ER 24HR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	2	
<i>pilocarpine hcl ophthalmic (eye) drops 1.25 %</i>	2	PA; QL (2.5 ML per 30 Days)
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	2	
<i>pyridostigmine bromide oral syrup 60 mg/5 ml</i>	2	PA; QL (5 ML per 1 day)
<i>pyridostigmine bromide oral tablet 60 mg</i>	2	
<i>pyridostigmine bromide oral tablet extended release 180 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	2	QL (2 capsules per 1 day)
<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 patches per 30 days)
VUITY OPHTHALMIC (EYE) DROPS 1.25 %	Non-Formulary	ALT (Covered Alternatives: PILOCARPINE 1.25%); QL (2.5 ML per 30 Days)
ZUNVEYL ORAL TABLET, DELAYED RELEASE (DR/EC) 10 MG, 15 MG, 5 MG	Non-Formulary	QL (2 Tablet per 1 day)
Selective Alpha-1-Adrenergic Block.Agent		
<i>alfuzosin oral tablet extended release 24 hr 10 mg</i>	2	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr 80 mg</i>	Non-Formulary	TD
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR 10 MG, 20 MG, 40 MG, 80 MG	Non-Formulary	
<i>dutasteride-tamsulosin oral capsule, er multiphase 24 hr 0.5-0.4 mg</i>	Non-Formulary	ALT (Covered Alternatives: DUTASTERIDE, TAMSULOSIN HCL)
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	2	
RAPAFLO ORAL CAPSULE 4 MG, 8 MG	Non-Formulary	ALT (Covered Alternatives: ALFUZOSIN HCL ER, FINASTERIDE, TAMSULOSIN HCL, DUTASTERIDE); QL (2 capsules per 1 day)
<i>silodosin oral capsule 4 mg, 8 mg</i>	2	QL (2 capsules per 1 day)
<i>tamsulosin oral capsule 0.4 mg</i>	2	QL (1 capsule per 1 day)
Selective Beta-2-Adrenergic Agonists		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	Non-Formulary	ALT (Covered Alternatives: FLUTICASONE-SALMETEROL, WIXELA INHUB); QL (60 units per 1 fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
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)
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG-14 MCG/ACTUATION, 232-14 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inhaler per 28 days)
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g), Levalbuterol HFA); QL (10.7 GM per 30 Days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	2	QL (2 Inhalers 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, 5 mg/ml</i>	2	
<i>albuterol sulfate oral syrup 2 mg/5 ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	2	
<i>albuterol sulfate oral tablet extended release 12 hr 4 mg, 8 mg</i>	2	
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); TD; QL (60 Blisters per 28 days)
<i>arformoterol inhalation solution for nebulization 15 mcg/2 ml</i>	2	QL (120 units per 30 days)
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (10.7 GM per 28 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	3	QL (1 inhaler per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
BREYNA INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	2	QL (10.3 GM per 1 Fill)
BROVANA INHALATION SOLUTION FOR NEBULIZATION 15 MCG/2 ML	Non-Formulary	QL (120 ML per 30 days)
<i>budesonide-formoterol inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	2	QL (10.3 GM per 1 Fill)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 GM per 30 days)
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400-12 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (1 Inhaler per 28 days)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 200-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	3	QL (13 GM per 28 days)
<i>fluticasone furoate-vilanterol inhalation blister with device 100-25 mcg/dose, 200-25 mcg/dose</i>	Non-Formulary	QL (60 units per 1 fill)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	2	QL (1 inhaler 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 GM per 30 days)
<i>ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml</i>	2	
<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	
<i>levalbuterol tartrate inhalation hfa aerosol inhaler 45 mcg/actuation</i>	2	
PERFOROMIST INHALATION SOLUTION FOR NEBULIZATION 20 MCG/2 ML	Non-Formulary	QL (120 nebs per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PROAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 90 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g)); QL (1 Inhaler per 28 days)
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g)); QL (2 inhalers per 30 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE	3	QL (60 units per 30 days)
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION	3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (4 GM per 28 days)
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: BUDESONIDE/FORMOTEROL FUMARATE); QL (10.3 GM per 1 Fill)
<i>terbutaline oral tablet 2.5 mg, 5 mg</i>	2	
VENTOLIN HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g)); QL (36 GM per 30 days)
WIXELA INHUB INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	2	QL (60 GM per 30 days)
Selective Beta-Adrenergic Blocking Agent		
<i>acebutolol oral capsule 200 mg, 400 mg</i>	2	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	2	QL (2 tablets per 1 day)
<i>betaxolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>betaxolol oral tablet 10 mg, 20 mg</i>	2	
BETOPTIC S OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 %	4	QL (10 ML per 1 fill)
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	QL (2 tablets per 1 day)
LOPRESSOR ORAL SOLUTION 10 MG/ML	Non-Formulary	ALT (Covered Alternatives: METOPROLOL 50MG TABLET, METOPROLOL 100MG TABLET); QL (40 ML per 1 Day)
<i>metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	2	QL (1 tablet per 1 day)
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	2	
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply)
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 200 MG, 25 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: METOPROLOL SUCCINATE)
Skeletal Muscle Relaxants, Miscellaneous		
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	3	PA
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG	3	PA
Smoking Cessation Agents		
<i>bupropion hcl (smoking deter) oral tablet extended release 12 hr 150 mg</i>	2	HCR
NALTREX ORAL CAPSULE 1.5 MG, 4.5 MG	Non-Formulary	ALT (Covered Alternatives: Naltrexone, Naloxone)
<i>naltrexone oral tablet 50 mg</i>	2	
NICORETTE BUCCAL LOZENGE 2 MG	2	HCR
<i>nicotine (polacrilex) buccal gum 2 mg, 4 mg</i>	2	HCR
<i>nicotine (polacrilex) buccal lozenge 2 mg, 4 mg</i>	2	HCR
<i>nicotine (polacrilex) buccal mini lozenge 2 mg, 4 mg</i>	2	HCR
<i>nicotine transdermal patch 24 hour 14 mg/24 hr, 21 mg/24 hr, 7 mg/24 hr</i>	2	HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NICOTROL NS NASAL SPRAY, NON-AEROSOL 10 MG/ML	4	HCR
TYRVAYA NASAL SPRAY, METERED, NON-AEROSOL 0.03 MG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Cyclosporine, Xiidra (PA required))
varenicline tartrate oral tablet 0.5 mg, 1 mg	2	HCR
varenicline tartrate oral tablets, dose pack 0.5 mg (11)- 1 mg (42)	2	HCR; QL (1 pack per 365 days)
VIVITROL INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 380 MG	BB	PA

BLOOD DERIVATIVES

Blood Derivatives

ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG, 500 MG	7	PA; QL (Quantity Limits Apply); SP
GLASSIA INTRAVENOUS SOLUTION 20 MG/ML (2 %)	Non-Formulary	PA; QL (Quantity Limits Apply); SP
PROLASTIN-C INTRAVENOUS SOLUTION 1,000 MG (+-)/20 ML	7	PA; QL (Quantity Limits Apply); SP
RYPLAZIM INTRAVENOUS RECON SOLN 68.8 MG	Non-Formulary	PA; SP
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG	7	PA; SP; QL (0.01 EA per 1 day)
ZEMAIRA INTRAVENOUS RECON SOLN 4,000 MG, 5,000 MG	7	PA; SP

BLOOD FORMATION, COAGULATION, THROMBOSIS

Antianemia Drugs

ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	BB	
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 25 MCG/0.42 ML, 300 MCG/0.6 ML, 40 MCG/0.4 ML, 500 MCG/ML, 60 MCG/0.3 ML	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 150 MCG/0.3 ML, 200 MCG/0.3 ML, 30 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML	Non-Formulary	SP
REBLOZYL SUBCUTANEOUS RECON SOLN 25 MG	BB	PA
VAFSEO ORAL TABLET 150 MG, 300 MG	Non-Formulary	SP; ALT (Covered Alternatives: Jesduvroq); QL (2 Tablets per 1 Day)
Anticoagulants, Miscellaneous		
<i>gentamicin-sodium citrate intra-catheter syringe 1,600 mcg/5 ml-4 %, 960 mcg/3 ml-4 %</i>	BB	
<i>sodium citrate intra-catheter solution 4 %</i>	BB	
Antithrombin Replacements		
THROMBATE III INTRAVENOUS RECON SOLN 500 (+/-) UNIT	BB	
Blood Form.,Coag,Thrombosis Agents Misc.		
ADAKVEO INTRAVENOUS SOLUTION 10 MG/ML	BB	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG	6	PA; SP; QL (2 Tablets per 1 day)
PYRUKYND ORAL TABLETS,DOSE PACK 20 MG (7)- 5 MG (7), 50 MG (7)- 20 MG (7)	6	PA; SP; QL (2 Tablets per 1 day)
TAVALISSE ORAL TABLET 100 MG, 150 MG	6	PA; SP; QL (2 tablets per 1 day)
WAYRILZ ORAL TABLET 400 MG	Non-Formulary	SP; QL (2 Tablets per 1 Day)
Coumarin Derivatives		
<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	
Direct Factor Xa Inhibitors		
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 5 MG (74 TABS)	3	QL (74 Tablets per 30 days)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	3	QL (2 TABLETS per 1 day)
<i>rivaroxaban oral suspension for reconstitution 1 mg/ml</i>	2	QL (20 ML per 1 Day); AG (Max 18 Years)
<i>rivaroxaban oral tablet 2.5 mg</i>	2	QL (2 Tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9)	3	QL (51 tablets per fill & 1 fill per 180 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION 1 MG/ML	3	QL (20 ML per 1 day); AG (Max 18 Years)
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG	3	QL (2 tablets per 1 day)
XARELTO ORAL TABLET 2.5 MG	3	
Direct Thrombin Inhibitors		
<i>dabigatran etexilate oral capsule 110 mg, 150 mg, 75 mg</i>	2	QL (75 Capsules per 1 Fill)
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG	Non-Formulary	ALT (Covered Alternatives: DABIGATRAN ETEXILATE CAPSULES); QL (75 Capsules per 1 Fill)
PRADAXA ORAL PELLETS IN PACKET 110 MG, 150 MG, 20 MG, 30 MG, 40 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: DABIGATRAN ETEXILATE CAPSULES)
Hematopoietic Agents		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG	Non-Formulary	SP
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	BB	
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 25 MCG/0.42 ML, 300 MCG/0.6 ML, 40 MCG/0.4 ML, 500 MCG/ML, 60 MCG/0.3 ML	BB	
DOPTELET (10 TAB PACK) ORAL TABLET 20 MG	6	PA; SP; QL (3 tablets per 1 day)
DOPTELET (15 TAB PACK) ORAL TABLET 20 MG	6	PA; SP; QL (3 tablets per 1 day)
DOPTELET (30 TAB PACK) ORAL TABLET 20 MG	6	PA; SP; QL (3 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>eltrombopag olamine oral powder in packet 12.5 mg, 25 mg</i>	5	PA; SP; QL (1 Packet per 1 day)
<i>eltrombopag olamine oral tablet 12.5 mg</i>	5	PA; SP; QL (6 Tablets per 1 Day)
<i>eltrombopag olamine oral tablet 25 mg</i>	5	PA; SP; QL (3 Tablet per 1 Day)
<i>eltrombopag olamine oral tablet 50 mg, 75 mg</i>	5	PA; SP; QL (1 Tablet per 1 Day)
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	BB	
FULPHILA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	BB	PA
FYLNTRA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	BB	PA
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML	BB	
GRANIX SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	BB	
LEUKINE INJECTION RECON SOLN 250 MCG	BB	
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 150 MCG/0.3 ML, 200 MCG/0.3 ML, 30 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML	Non-Formulary	SP
MULPLETA ORAL TABLET 3 MG	5	PA; SP; QL (7 tablets per 365 days)
NEULASTA ONPRO SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR 6 MG/0.6 ML	BB	
NEULASTA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	BB	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	BB	
NEUPOGEN INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; SP; QL (4 Syringes per 1 Fill)
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	BB	
NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NPLATE SUBCUTANEOUS RECON SOLN 125 MCG, 250 MCG, 500 MCG	BB	
NYPOZI INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; SP
NYVEPRIA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	BB	
PROCRIT 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, 40,000 UNIT/ML	BB	
PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG	Non-Formulary	SP; ALT (Covered Alternatives: ELTROMBOPAG OLAMINE); QL (1 unit per 1 day)
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG	Non-Formulary	SP; ALT (Covered Alternatives: ELTROMBOPAG OLAMINE)
REBLOZYL SUBCUTANEOUS RECON SOLN 25 MG	BB	PA
RELEUKO SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	BB	
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, 40,000 UNIT/ML	BB	
ROLVEDON SUBCUTANEOUS SYRINGE 13.2 MG/0.6 ML	BB	PA
STIMUFEND SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	BB	PA
UDENYCA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	BB	
VAFSEO ORAL TABLET 150 MG, 300 MG	Non-Formulary	SP; ALT (Covered Alternatives: Jesduvroq); QL (2 Tablets per 1 Day)
XOLREMDI ORAL CAPSULE 100 MG	Non-Formulary	SP; QL (4 Capsules per 1 Day)
ZARXIO INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZIEXTENZO SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	BB	PA
Hemorrhheologic Agents		
<i>pentoxifylline oral tablet extended release 400 mg</i>	2	
Hemostatics		
ADVATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 4,000 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
ADYNOVATE INTRAVENOUS SOLUTION 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT, 750 (+/-) UNIT	Non-Formulary	QL (Quantity Limits Apply); SP
AFSTYLA INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT RANGE, 1,500 (+/-) UNIT RANGE, 2,000 (+/-) UNIT RANGE, 2,500 (+/-) UNIT RANGE, 250 (+/-) UNIT RANGE, 3,000 (+/-) UNIT RANGE, 500 (+/-) UNIT RANGE	7	PA; SP; QL (1 unit per 1 day)
ALHEMO PEN SUBCUTANEOUS PEN INJECTOR 150 MG/1.5 ML (100 MG/ML), 300 MG/3 ML (100 MG/ML), 60 MG/1.5 ML (40 MG/ML)	Non-Formulary	SP
ALPHANATE INTRAVENOUS RECON SOLN 1,000 (400 VWF) UNIT/10 ML, 1,500 (600 VWF) UNIT/10 ML, 2,000 (800 VWF) UNIT/10 ML, 250 (100 VWF) UNIT/5 ML, 500 (200 VWF) UNIT/5 ML	7	PA; SP; QL (1 unit per 1 day)
ALPHANINE SD INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
ALPROLIX INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 500 UNIT	Non-Formulary	SP; ALT (Covered Alternatives: Alphanine SD, PROFILNINE, BENEFIX)
ALTUVIIIIO INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 4000 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (0.01 Vial per 1 day)
AMICAR ORAL SOLUTION 250 MG/ML (25 %)	Non-Formulary	QL (237 units per 60 days)
<i>aminocaproic acid oral solution 250 mg/ml (25 %)</i>	2	SP; QL (237 units per 60 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>aminocaproic acid oral tablet 1,000 mg</i>	2	QL (1 tablet per 1 day)
<i>aminocaproic acid oral tablet 500 mg</i>	2	QL (100 units per 60 days)
ANDEXXA INTRAVENOUS RECON SOLN 200 MG	BB	
BENEFIX INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 500 UNIT	7	PA; SP; QL (1 unit per 1 day)
COAGADEX INTRAVENOUS RECON SOLN 250 (+/-) UNIT RANGE, 500 (+/-) UNIT RANGE	7	PA; SP
CORIFACT INTRAVENOUS RECON SOLN 1,000-1,600 UNIT	7	PA; SP; QL (0.01 EA per 1 day)
DDAVP INJECTION SOLUTION 4 MCG/ML	BB	
<i>desmopressin injection solution 4 mcg/ml</i>	BB	
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	2	QL (0.17 ML per 1 Day)
<i>desmopressin nasal spray,non-aerosol 150 mcg/spray (0.1 ml)</i>	Non-Formulary	
<i>desmopressin oral tablet 0.1 mg, 0.2 mg</i>	2	
ELOCTATE INTRAVENOUS RECON SOLN 1,000 UNIT, 1,500 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 5,000 UNIT, 500 UNIT, 6,000 UNIT, 750 UNIT	7	PA; SP; QL (1 unit per 1 day)
ESPEROCT INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 4,000 (+/-) UNIT, 500 (+/-) UNIT	Non-Formulary	QL (Quantity Limits Apply); SP
FEIBA NF INTRAVENOUS RECON SOLN 1,750-3,250 UNIT, 350-650 UNIT, 700-1,300 UNIT	7	PA; SP; QL (1 unit per 1 day)
FIBRYGA INTRAVENOUS RECON SOLN 1 GRAM (700 MG- 1,300 MG), 2 GRAM (1,400 MG- 2,600 MG)	Non-Formulary	SP
HEMGENIX INTRAVENOUS SUSPENSION 1X10EXP13 GC/ML	BB	PA
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7 ML, 30 MG/ML, 60 MG/0.4 ML	7	PA; SP; QL (1 unit per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HEMLIBRA SUBCUTANEOUS SOLUTION 12 MG/0.4 ML	7	PA; SP; QL (0.01 ML per 1 Day)
HEMLIBRA SUBCUTANEOUS SOLUTION 150 MG/ML	7	PA; SP; QL (0.01 unit per 1 day)
HEMLIBRA SUBCUTANEOUS SOLUTION 300 MG/2 ML (150 MG/ML)	7	PA; SP
HEMOFIL M HIGH INTRAVENOUS RECON SOLN 801-1,500 UNIT	7	PA; SP; QL (1 unit per 1 day)
HEMOFIL M LOW INTRAVENOUS RECON SOLN 220-400 UNIT	7	PA; SP; QL (1 unit per 1 day)
HEMOFIL M MID INTRAVENOUS RECON SOLN 401-800 UNIT	7	PA; SP; QL (1 unit per 1 day)
HEMOFIL M SUPER HIGH INTRAVENOUS RECON SOLN 1,501-2,000 UNIT	7	PA; SP; QL (1 unit per 1 day)
HUMATE-P INTRAVENOUS RECON SOLN 1,000-2,400 UNIT, 250-600 UNIT, 500-1,200 UNIT	7	PA; SP; QL (1 unit per 1 day)
HYMPAVZI PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML	Non-Formulary	SP; QL (0.29 ML per 1 Day)
IDELVION INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,500 (+/-) UNIT, 500 (+/-) UNIT	Non-Formulary	SP
IXINITY INTRAVENOUS RECON SOLN 1,000 UNIT, 1,500 UNIT, 3,000 UNIT, 500 UNIT	7	PA; SP; QL (1 unit per 1 day)
JIVI INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
JIVI INTRAVENOUS RECON SOLN 4,000 (+/-) UNIT	7	PA; SP; QL (0.01 ML per 1 Day)
KCENTRA INTRAVENOUS RECON SOLN 1,000 UNIT (800-1240 UNIT)	BB	PA; SP; QL (0.01 EA per 1 day)
KCENTRA INTRAVENOUS RECON SOLN 500 UNIT (400-620 UNIT)	BB	PA; SP; QL (0.01 vial per 1 day)
KOATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (0.01 UNITS per 1 DAY)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
KOGENATE FS INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
KOVALTRY INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
NOCDURNA (MEN) SUBLINGUAL TABLET,DISINTEGRATING 55.3 MCG	Non-Formulary	QL (Quantity Limits Apply); SP
NOCDURNA (WOMEN) SUBLINGUAL TABLET,DISINTEGRATING 27.7 MCG	Non-Formulary	QL (Quantity Limits Apply); SP
NOVOEIGHT INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
NOVOSEVEN RT INTRAVENOUS RECON SOLN 1 MG (1,000 MCG), 2 MG (2,000 MCG), 8 MG (8,000 MCG)	7	PA; SP; QL (1 unit per 1 day)
NOVOSEVEN RT INTRAVENOUS RECON SOLN 5 MG (5,000 MCG)	7	PA; SP; QL (0.01 unit per 1 day)
NUWIQ INTRAVENOUS RECON SOLN 1,500 UNIT, 1000 UNIT, 2,000 UNIT, 2,500 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 500 UNIT	7	PA; SP; QL (1 unit per 1 day)
PROFILNINE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
QFITLIA PEN SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	Non-Formulary	SP; QL (0.017 ML per 1 Day)
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2 ML	Non-Formulary	SP; QL (0.017 ML per 1 Day)
REBINYN INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT	Non-Formulary	SP
RECOMBINATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
RIASTAP INTRAVENOUS RECON SOLN 1 GRAM (900MG-1,300MG)	7	PA; SP; QL (0.01 EA per 1 day)
RIXUBIS INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 500 UNIT	7	PA; SP; QL (1 unit per 1 day)
SEVENFACT INTRAVENOUS RECON SOLN 1 MG (1,000 MCG), 5 MG (5,000 MCG)	7	PA; SP; QL (1 ML per 1 day)
<i>tranexamic acid oral tablet 650 mg</i>	2	QL (60 tablets per 30 days)
TRETTEN INTRAVENOUS RECON SOLN 2,500 UNIT	7	PA; SP; QL (0.01 EA per 1 day)
VONVENDI INTRAVENOUS RECON SOLN 1,300 (+/-) UNIT RANGE, 650 (+/-) UNIT RANGE	Non-Formulary	SP
WILATE INTRAVENOUS RECON SOLN 1,000-1,000 UNIT, 500-500 UNIT	7	PA; SP; QL (1 unit per 1 day)
XYNTHA INTRAVENOUS SOLUTION 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
XYNTHA SOLOFUSE INTRAVENOUS SYRINGE 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT	7	PA; SP; QL (1 unit per 1 day)
Heparins		
<i>aa 3% no.2 ped-d10-calcium-hep intravenous parenteral solution 3 %-10 %- 2.33 meq/250 ml</i>	BB	
<i>aa 3.5% no.2 ped-d10w-heparin intravenous parenteral solution 3.5 %-10 %- 125 unit/250 ml</i>	BB	
<i>aa2.5%no.2 ped-d10-calcium-hep intravenous parenteral solution 2.5 %-10 %- 3.75 meq/250 ml</i>	BB	
<i>aa3.5% no2 ped-d10-calcium-hep intravenous parenteral solution 3.5 %-10 %- 2.33 meq/250 ml, 3.5 %-10 %- 3.75 meq/250 ml</i>	BB	
<i>aas3%no.2ped-d5w-calc gluc-hep intravenous parenteral solution 3 %-5 %- 3.75 meq/250 ml</i>	BB	
<i>enoxaparin subcutaneous solution 300 mg/3 ml</i>	2	QL (60 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml</i>	2	QL (60 ML per 30 days)
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml</i>	2	QL (48 ML per 30 days)
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml</i>	2	QL (18 ML per 30 days)
<i>enoxaparin subcutaneous syringe 40 mg/0.4 ml</i>	2	QL (24 ML per 30 days)
<i>enoxaparin subcutaneous syringe 60 mg/0.6 ml</i>	2	QL (36 ML per 30 days)
ENOXILUV SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Enoxaparin); QL (1 Kit per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	Non-Formulary	QL (1 ML per 1 day)
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML, 7,500 ANTI-XA UNIT/0.3 ML	4	PA; QL (1 EA per 1 day)
<i>heparin (porcine) in 0.9% nacl intravenous parenteral solution 2,500 unit/500 ml (5 unit/ml)</i>	BB	
<i>heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml</i>	2	
<i>heparin, porcine (pf) injection solution 5,000 unit/0.5 ml</i>	Non-Formulary	
<i>heparin, porcine (pf) injection syringe 5,000 unit/0.5 ml</i>	Non-Formulary	
Iron Preparations		
ALTRIXA OB ORAL TABLET 15 MG IRON- 1,750 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
CITRANATAL B-CALM (FE GLUC) ORAL TABLETS, SEQUENTIAL 20 MG IRON-1 MG -25 MG/25 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>iron sucrose intravenous solution 100 mg iron/5 ml, 200 mg iron/10 ml, 50 mg iron/2.5 ml</i>	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
MATERNACEL ORAL TABLET 20 MG IRON-1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
MONOFERRIC INTRAVENOUS SOLUTION 100 MG IRON/ML	BB	PA
NEEVODHA (WITH ALGAL OIL) ORAL CAPSULE 27 MG IRON-1.13 MG-581.92 MG	Non-Formulary	QL (Quantity Limits Apply)
NEOMATERNA ORAL TABLET 20 MG IRON-1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
OB COMPLETE ONE ORAL CAPSULE 40-10-1-300 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE ORAL TABLET 50 MG IRON-1.25 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE PETITE ORAL CAPSULE 35 MG IRON-5 MG IRON-1 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE PREMIER ORAL TABLET 30-20-1 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE WITH DHA ORAL CAPSULE 30 MG IRON-10 MG IRON-1 MG	Non-Formulary	QL (Quantity Limits Apply)
PNV-DHA ORAL CAPSULE 27 MG IRON-1 MG - 300 MG	2	
PRENATABS FA ORAL TABLET 29-1 MG	1	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG	2	
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	2	HCR; AG (Max 50 Years)
PRENATAL PLUS (CALCIUM CARB) ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATAL VITAMIN PLUS LOW IRON ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATE DHA (FERR ASP GLYCIN) ORAL CAPSULE 18 MG IRON-1 MG -300 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE ELITE (IRON ASP GLYC) ORAL TABLET 20 MG IRON- 1 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PRENATE ENHANCE ORAL CAPSULE 28 MG IRON- 1 MG-400 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE ESSENTIAL(IRON-ASP-GL) ORAL CAPSULE 18 MG IRON- 1 MG-300 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE MINI (FERR ASP GLYCIN) ORAL CAPSULE 18-1-350 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE PIXIE ORAL CAPSULE 10 MG IRON- 1 MG-200 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE RESTORE ORAL CAPSULE 27 MG IRON- 1 MG-400 MG	Non-Formulary	QL (Quantity Limits Apply)
PRIMACARE ORAL CAPSULE 30-1-300 MG	Non-Formulary	QL (Quantity Limits Apply)
SE-NATAL 19 ORAL TABLET 29 MG IRON- 1 MG	2	
TRINATAL RX 1 ORAL TABLET 60 MG IRON-1 MG	1	
VITALARA ORAL TABLET 20 MG IRON- 1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
ZATEAN-PN DHA ORAL CAPSULE 27 MG IRON- 1 MG -300 MG	2	
Platelet-Aggregation Inhibitors		
ASPIRIN CHILDRENS ORAL TABLET,CHEWABLE 81 MG	2	HCR; QL (1 tablet per 1 day)
<i>aspirin oral tablet 325 mg</i>	2	HCR
<i>aspirin oral tablet,chewable 81 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg</i>	2	QL (2 capsules per 1 day)
BAYER ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG	2	HCR; QL (1 tablet per 1 day)
BRILINTA ORAL TABLET 60 MG, 90 MG	Non-Formulary	ALT (Covered Alternatives: Ticagrelor); QL (2 tablets per 1 day)
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	2	QL (6 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CHILDREN'S ASPIRIN ORAL TABLET,CHEWABLE 81 MG	2	HCR; QL (1 tablet per 1 day)
<i>cilostazol oral tablet 100 mg, 50 mg</i>	2	
<i>clopidogrel oral tablet 300 mg, 75 mg</i>	2	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	2	
EFFIENT ORAL TABLET 10 MG, 5 MG	Non-Formulary	
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	2	
<i>ticagrelor oral tablet 60 mg, 90 mg</i>	2	QL (2 Tablets per 1 Day)
ZONTIVITY ORAL TABLET 2.08 MG	4	PA; QL (1 tablet per 1 day)
Platelet-Reducing Agents		
<i>anagrelide oral capsule 0.5 mg, 1 mg</i>	2	PA; QL (4 capsules per 1 day)
Thrombolytic Agents		
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	2	QL (6 capsules per 1 day)
TNKASE INTRAVENOUS RECON SOLN 25 MG, 50 MG	BB	
Von Willebrand Factor-Related Antithromb		
CABLIVI INJECTION KIT 11 MG	6	PA; SP; QL (1 vial per 1 day)
CABLIVI INJECTION RECON SOLN 11 MG	6	PA; SP; QL (1 vial per 1 day)
CARDIOVASCULAR DRUGS		
Acl Inhibitors		
NEXLETOL ORAL TABLET 180 MG	6	PA; SP; QL (1 tablet per 1 day)
NEXLIZET ORAL TABLET 180-10 MG	6	PA; SP; QL (1 tablet per 1 day)
Alpha-Adrenergic Blocking Agents		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr 80 mg</i>	Non-Formulary	TD
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR 10 MG, 20 MG, 40 MG, 80 MG	Non-Formulary	
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	2	
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>prazosin oral capsule 1 mg, 2 mg, 5 mg</i>	2	
<i>terazosin oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	
Angiotensin II Recep Antagonist/Neprollys		
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	Non-Formulary	ALT (Covered Alternatives: SACUBITRIL/VALSARTAN); QL (2 tablets per 1 day)
ENTRESTO SPRINKLE ORAL PELLETT 15-16 MG, 6-6 MG	4	PA
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	2	TD; QL (2 Tablet per 1 day)
Angiotensin II Receptor Antagonists		
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	2	
<i>amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	2	
<i>amlodipine-valsartan-hcthiazyd oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg</i>	2	
<i>amlodipine-valsartan-hcthiazyd oral tablet 5-160-25 mg</i>	2	QL (2 tablets per 1 day)
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG	Non-Formulary	
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG	Non-Formulary	QL (1 tablet per 1 day)
BENICAR ORAL TABLET 20 MG, 40 MG, 5 MG	Non-Formulary	QL (1 tablet per 1 day)
<i>candesartan oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	2	QL (1 tablet per 1 day)
<i>candesartan-hydrochlorothiazid oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	2	QL (2 tablets per 1 day)
EDARBI ORAL TABLET 40 MG, 80 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CHLORTHALIDONE, LOSARTAN POTASSIUM, IRBESARTAN, VALSARTAN, OLMESARTAN MEDOXOMIL, CANDESARTAN CILEXETIL, TELMISARTAN)
<i>eprosartan oral tablet 600 mg</i>	2	QL (1 tablet per 1 day)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	2	QL (1 tablet per 1 day)
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	2	QL (1 tablet per 1 day)
<i>losartan oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	
<i>olmesartan oral tablet 20 mg, 40 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<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>	2	TD
<i>olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	2	QL (1 tablet per 1 day)
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	2	QL (1 tablet per 1 day)
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	2	
<i>telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	2	QL (2 tablets per 1 day)
TRIBENZOR 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	Non-Formulary	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	2	QL (1 tablet per 1 day)
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	2	QL (2 tablets per 1 day)
Angiotensin-Converting Enzyme Inhibitors		
<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>	2	QL (2 capsules per 1 day)
<i>benazepril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	2	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	2	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	2	
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>fosinopril oral tablet 10 mg, 20 mg, 40 mg</i>	2	
<i>fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg</i>	2	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>moexipril oral tablet 15 mg, 7.5 mg</i>	2	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	2	QL (2 tablets per 1 day)
<i>quinapril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	2	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	2	
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG	Non-Formulary	QL (Quantity Limits Apply)
ZESTRIL ORAL TABLET 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG	Non-Formulary	QL (Quantity Limits Apply)
Angptl3 Inhibitors (24:06)		
EVKEEZA INTRAVENOUS SOLUTION 150 MG/ML	Non-Formulary	PA; SP
Antilipemic Agents, Miscellaneous		
LEQVIO SUBCUTANEOUS SYRINGE 284 MG/1.5 ML	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>niacin oral tablet extended release 24 hr 1,000 mg, 500 mg, 750 mg</i>	2	
Beta-Adrenergic Blocking Agents		
<i>acebutolol oral capsule 200 mg, 400 mg</i>	2	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	2	QL (2 tablets per 1 day)
<i>betaxolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>betaxolol oral tablet 10 mg, 20 mg</i>	2	
BETIMOL OPHTHALMIC (EYE) DROPS 0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TIMOLOL MALEATE)
BETOPTIC S OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 %	4	QL (10 ML per 1 fill)
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	2	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	QL (2 tablets per 1 day)
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Nebivolol); QL (1 tablet per 1 day)
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr 80 mg</i>	Non-Formulary	TD
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR 10 MG, 20 MG, 40 MG, 80 MG	Non-Formulary	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML	Non-Formulary	SP
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	2	
LOPRESSOR ORAL SOLUTION 10 MG/ML	Non-Formulary	ALT (Covered Alternatives: METOPROLOL 50MG TABLET, METOPROLOL 100MG TABLET); QL (40 ML per 1 Day)
<i>metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	2	QL (1 tablet per 1 day)
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>nebivolol oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>pindolol oral tablet 10 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>sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	2	
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	2	
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 200 MG, 25 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: METOPROLOL SUCCINATE)
Bile Acid Sequestrants		
<i>cholestyramine (with sugar) oral powder 4 gram</i>	2	QL (8 GM per 1 day)
<i>cholestyramine (with sugar) oral powder in packet 4 gram</i>	2	
CHOLESTYRAMINE LIGHT ORAL POWDER 4 GRAM	1	QL (8 GM per 1 day)
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET 4 GRAM	2	QL (8 packets per 1 day)
<i>colesevelam oral powder in packet 3.75 gram</i>	2	QL (1 packet per 1 day)
<i>colesevelam oral tablet 625 mg</i>	2	QL (6 tablets per 1 day)
<i>colestipol oral packet 5 gram</i>	2	
<i>colestipol oral tablet 1 gram</i>	2	
WELCHOL ORAL POWDER IN PACKET 3.75 GRAM	Non-Formulary	QL (1 unit per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
WELCHOL ORAL TABLET 625 MG	Non-Formulary	ST (Step Therapy Required); QL (7 tablets per 1 day)
Bradykinin Receptors Antagonists		
FIRAZYR SUBCUTANEOUS SYRINGE 30 MG/3 ML	Non-Formulary	SP; QL (0.01 ml per 1 day)
<i>icatibant subcutaneous syringe 30 mg/3 ml</i>	5	PA; SP; QL (0.01 ML per 1 day)
SAJAZIR SUBCUTANEOUS SYRINGE 30 MG/3 ML	Non-Formulary	SP; QL (0.01 ml per 1 day)
Calcium-Channel Blocking Agents		
<i>amlodipine oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<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, 5-20 mg, 5-40 mg, 5-80 mg</i>	2	TD; QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin oral tablet 2.5-40 mg, 5-10 mg</i>	2	TD; ST (Step Therapy Required); QL (1 tablet per 1 day)
<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>	2	QL (2 capsules per 1 day)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	2	
<i>amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	2	
<i>amlodipine-valsartan-hcthiazyd oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg</i>	2	
<i>amlodipine-valsartan-hcthiazyd oral tablet 5-160-25 mg</i>	2	QL (2 tablets per 1 day)
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG	Non-Formulary	
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	Non-Formulary	QL (Quantity Limits Apply)
CONJUPRI ORAL TABLET 2.5 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Amlodipine, Cartia XT, Verapamil, Diltiazem, Nifedipine, Felodipine); QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	2	
<i>diltiazem in dextrose 5 % intravenous solution 125 mg/125 ml (1 mg/ml)</i>	BB	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	2	
KATERZIA ORAL SUSPENSION 1 MG/ML	Non-Formulary	
<i>levamlodipine oral tablet 2.5 mg, 5 mg</i>	Non-Formulary	ALT (Covered Alternatives: Amlodipine, Cartia XT, Verapamil, Diltiazem, Nifedipine); QL (1 tablet per 1 day)
<i>nicardipine in nacl (iso-os) intravenous piggyback 20 mg/200 ml (0.1 mg/ml)</i>	BB	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	2	
<i>nifedipine oral tablet extended release 24hr 30 mg, 60 mg</i>	2	QL (3 tablets per 1 day)
<i>nifedipine oral tablet extended release 24hr 90 mg</i>	2	
<i>nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg</i>	2	QL (3 tablets per 1 day)
<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>	2	TD
TRIBENZOR 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	Non-Formulary	
Carbonic Anhydrase Inhibitors (24:36)		
<i>acetazolamide oral capsule, extended release 500 mg</i>	2	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	2	
Cardiac Drugs, Miscellaneous		
ASPRUZYO SPRINKLE ORAL EXTEND RELEASE GRANULES,PACKET 1,000 MG, 500 MG	Non-Formulary	ALT (Covered Alternatives: Ranolazine ER)
ATTRUBY ORAL TABLET 356 MG	6	PA; SP; QL (4 Tablets per 1 day)
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG	6	PA; SP; QL (1 capsule per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>ranolazine oral tablet extended release 12 hr 1,000 mg, 500 mg</i>	2	QL (2 tablets per 1 day)
VYNDAMAX ORAL CAPSULE 61 MG	6	PA; SP; QL (1 capsule per 1 day)
VYNDAQEL ORAL CAPSULE 20 MG	6	PA; SP; QL (4 capsules per 1 day)
Cardiotonic Agents		
CORLANOR ORAL SOLUTION 5 MG/5 ML	Non-Formulary	QL (Quantity Limits Apply)
CORLANOR ORAL TABLET 5 MG, 7.5 MG	Non-Formulary	ALT (Covered Alternatives: IVABRADINE TABLETS); QL (2 tablets per 1 day)
DIGITEK ORAL TABLET 125 MCG (0.125 MG), 250 MCG (0.25 MG)	2	
<i>digoxin injection solution 250 mcg/ml (0.25 mg/ml)</i>	BB	
<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)</i>	2	
<i>ivabradine oral tablet 5 mg, 7.5 mg</i>	4	QL (2 Tablets per 1 day)
LANOXIN ORAL TABLET 125 MCG (0.125 MG), 250 MCG (0.25 MG), 62.5 MCG (0.0625 MG)	Non-Formulary	
Cardiovascular Drugs, Nsaid Anti-Infl		
<i>colchicine oral capsule 0.6 mg</i>	Non-Formulary	ALT (Covered Alternatives: Colchicine Tablets); QL (4 Capsules per 1 day)
<i>colchicine oral tablet 0.6 mg</i>	2	QL (4 tablets per 1 day)
COLCRYS ORAL TABLET 0.6 MG	Non-Formulary	ALT (Covered Alternatives: COLCHICINE, PROBENECID W/COLCHICINE, ALLOPURINOL); QL (4 tablets per 1 day)
GLOPERBA ORAL SOLUTION 0.6 MG/5 ML	Non-Formulary	QL (Quantity Limits Apply)
LODOCO ORAL TABLET 0.5 MG	Non-Formulary	QL (1 Tablet per 1 Day)
MITIGARE ORAL CAPSULE 0.6 MG	Non-Formulary	QL (Quantity Limits Apply)
Central Alpha-Agonists		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>clonidine hcl oral tablet extended release 12 hr 0.1 mg</i>	2	
<i>clonidine hcl oral tablet extended release 24 hr 0.17 mg</i>	Non-Formulary	ALT (Covered Alternatives: Clonidine Tablets); QL (1 Tablet per 1 day)
<i>clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr</i>	2	QL (4 patches per 30 days)
<i>guanfacine oral tablet 1 mg, 2 mg</i>	2	
<i>guanfacine oral tablet extended release 24 hr 1 mg, 2 mg, 3 mg, 4 mg</i>	2	QL (1 tablet per 1 day)
<i>methyldopa oral tablet 250 mg, 500 mg</i>	2	
ONYDA XR ORAL SUSPENSION,EXTEND RELEASE 24HR 0.1 MG/ML	Non-Formulary	ALT (Covered Alternatives: CLONIDINE HCL ER 0.1 MG TABLET); QL (4 ML per 1 Day)
Cholesterol Absorption Inhibitors		
<i>ezetimibe oral tablet 10 mg</i>	2	QL (1 tablet per 1 day)
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	2	QL (1 tablet per 1 day)
VYTORIN 10-10 ORAL TABLET 10-10 MG	Non-Formulary	QL (1 tablet per 1 day)
VYTORIN 10-20 ORAL TABLET 10-20 MG	Non-Formulary	QL (1 tablet per 1 day)
VYTORIN 10-40 ORAL TABLET 10-40 MG	Non-Formulary	QL (1 tablet per 1 day)
VYTORIN 10-80 ORAL TABLET 10-80 MG	Non-Formulary	QL (1 tablet per 1 day)
ZETIA ORAL TABLET 10 MG	Non-Formulary	QL (1 tablet per 1 day)
Class Ia Antiarrhythmics		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	2	
<i>quinidine gluconate oral tablet extended release 324 mg</i>	2	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	4	
Class Ib Antiarrhythmics		
DILANTIN EXTENDED ORAL CAPSULE 100 MG	3	
DILANTIN INFATABS ORAL TABLET,CHEWABLE 50 MG	Non-Formulary	QL (Quantity Limits Apply)
DILANTIN KAPSEAL ORAL CAPSULE 100 MG	3	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DILANTIN ORAL CAPSULE 30 MG	3	
<i>lidocaine (pf) injection syringe 100 mg/5 ml (2 %)</i>	BB	
<i>mexiletine oral capsule 150 mg, 200 mg, 250 mg</i>	2	QL (3 capsules per 1 day)
PHENYTEK ORAL CAPSULE 200 MG, 300 MG	3	
<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	
Class Ic Antiarrhythmics		
<i>flecainide oral tablet 100 mg, 150 mg, 50 mg</i>	2	
<i>propafenone oral capsule, extended release 12 hr 225 mg, 425 mg</i>	2	QL (2 capsules per 1 day)
<i>propafenone oral capsule, extended release 12 hr 325 mg</i>	2	
<i>propafenone oral tablet 150 mg, 225 mg, 300 mg</i>	2	
Class II Antiarrhythmics		
<i>acebutolol oral capsule 200 mg, 400 mg</i>	2	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	2	QL (2 tablets per 1 day)
<i>betaxolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>betaxolol oral tablet 10 mg, 20 mg</i>	2	
BETIMOL OPHTHALMIC (EYE) DROPS 0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TIMOLOL MALEATE)
BETOPTIC S OPHTHALMIC (EYE) DROPS, SUSPENSION 0.25 %	4	QL (10 ML per 1 fill)
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	2	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	QL (2 tablets per 1 day)
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Nebivolol); QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr 80 mg</i>	Non-Formulary	TD
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR 10 MG, 20 MG, 40 MG, 80 MG	Non-Formulary	
COSOPT (PF) OPHTHALMIC (EYE) DROPPERETTE 2-0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DORZOLAMIDE-TIMOLOL)
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette 2-0.5 %</i>	2	
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	2	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML	Non-Formulary	SP
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	2	
LOPRESSOR ORAL SOLUTION 10 MG/ML	Non-Formulary	ALT (Covered Alternatives: METOPROLOL 50MG TABLET, METOPROLOL 100MG TABLET); QL (40 ML per 1 Day)
<i>metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	2	QL (1 tablet per 1 day)
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>nebivolol oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>pindolol oral tablet 10 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	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	2	
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 200 MG, 25 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: METOPROLOL SUCCINATE)
Class Iii Antiarrhythmics		
<i>amiodarone oral tablet 100 mg, 200 mg</i>	2	
<i>amiodarone oral tablet 400 mg</i>	2	QL (1 tablet per 1 day)
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	2	QL (4 capsules per 1 day)
MULTAQ ORAL TABLET 400 MG	3	QL (2 tablets per 1 day)
PACERONE ORAL TABLET 100 MG, 200 MG	2	
<i>sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	2	
Class Iv Antiarrhythmics		
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 300 MG, 360 MG	Non-Formulary	QL (Quantity Limits Apply)
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	Non-Formulary	QL (Quantity Limits Apply)
CARTIA XT ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 300 MG	1	
CARTIA XT ORAL CAPSULE,EXTENDED RELEASE 24HR 240 MG	1	QL (1 unit per 1 day)
<i>diltiazem hcl intravenous recon soln 100 mg</i>	BB	
<i>diltiazem hcl oral capsule,ext.rel 24h degradable 180 mg</i>	2	QL (1 tablet per 1 day)
<i>diltiazem hcl oral capsule,ext.rel 24h degradable 240 mg</i>	2	QL (1 capsule per 1 day)
<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 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 300 mg, 360 mg</i>	1	
<i>diltiazem hcl oral capsule,extended release 24hr 240 mg</i>	1	QL (1 capsule per 1 day)
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	2	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem in dextrose 5 % intravenous solution 125 mg/125 ml (1 mg/ml)</i>	BB	
DILT-XR ORAL CAPSULE,EXT.REL 24H DEGRADABLE 120 MG, 180 MG, 240 MG	2	QL (1 capsule per 1 day)
<i>verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg</i>	Non-Formulary	ALT (Covered Alternatives: VERAPAMIL ER, VERAPAMIL ER, VERAPAMIL ER)
<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>	2	
Dihydropyridines		
<i>amlodipine oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<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, 5-20 mg, 5-40 mg, 5-80 mg</i>	2	TD; QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin oral tablet 2.5-40 mg, 5-10 mg</i>	2	TD; ST (Step Therapy Required); QL (1 tablet per 1 day)
<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>	2	QL (2 capsules per 1 day)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	2	
<i>amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	2	
<i>amlodipine-valsartan-hcthiazyd oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>amlodipine-valsartan-hcthiazyd oral tablet 5-160-25 mg</i>	2	QL (2 tablets per 1 day)
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG	Non-Formulary	
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	Non-Formulary	QL (Quantity Limits Apply)
CONJUPRI ORAL TABLET 2.5 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Amlodipine, Cartia XT, Verapamil, Diltiazem, Nifedipine, Felodipine); QL (1 tablet per 1 day)
CONSENSI ORAL TABLET 10-200 MG, 2.5-200 MG, 5-200 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>felodipine oral tablet extended release 24 hr 10 mg, 2.5 mg, 5 mg</i>	2	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	2	
KATERZIA ORAL SUSPENSION 1 MG/ML	Non-Formulary	
<i>levamlodipine oral tablet 2.5 mg, 5 mg</i>	Non-Formulary	ALT (Covered Alternatives: Amlodipine, Cartia XT, Verapamil, Diltiazem, Nifedipine); QL (1 tablet per 1 day)
<i>nicardipine in nacl (iso-os) intravenous piggyback 20 mg/200 ml (0.1 mg/ml)</i>	BB	
<i>nicardipine oral capsule 20 mg, 30 mg</i>	2	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	2	
<i>nifedipine oral tablet extended release 24hr 30 mg, 60 mg</i>	2	QL (3 tablets per 1 day)
<i>nifedipine oral tablet extended release 24hr 90 mg</i>	2	
<i>nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg</i>	2	QL (3 tablets per 1 day)
<i>nimodipine oral capsule 30 mg</i>	2	
<i>nimodipine oral solution 60 mg/20 ml</i>	Non-Formulary	ALT (Covered Alternatives: Nimodipine Capsule); QL (60 ML per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>nisoldipine oral tablet extended release 24 hr 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	Non-Formulary	
<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>	2	TD
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	2	
TRIBENZOR 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	Non-Formulary	
Direct Vasodilators		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG	4	ST (Step Therapy Required- Tried and failed sildenafil in the last 120 days); QL (6 kits per 30 days)
CAVERJECT INTRACAVERNOSAL RECON SOLN 20 MCG, 40 MCG	4	ST (Step Therapy Required- Tried and failed sildenafil in the last 120 days); QL (6 vials per 30 days)
CAVERJECT INTRACAVERNOSAL SYRINGE 10 MCG, 20 MCG	4	ST (Step Therapy Required- Tried and failed sildenafil in the last 120 days); QL (6 ML per 30 days)
<i>hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	
<i>isosorbide-hydralazine oral tablet 20-37.5 mg</i>	3	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	2	
Diuretics, Miscellaneous (24:36)		
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG	4	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	2	
<i>theophylline oral tablet extended release 24 hr 400 mg, 600 mg</i>	2	
Factor Xiia Inhibitors		
ANDEMBRY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 200 MG/1.2 ML	Non-Formulary	SP; QL (1.2 ML per 28 Days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Fibric Acid Derivatives		
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	2	QL (1 capsule per 1 day)
<i>fenofibrate micronized oral capsule 90 mg</i>	Non-Formulary	ALT (Covered Alternatives: fenofibrate 43mg capsule, fenofibrate 130mg capsule, fenofibrate 67mg capsule)
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	2	QL (1 tablet per 1 day)
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: FENOFIBRATE, FENOFIBRATE)
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	2	QL (1 tablet per 1 day)
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec) 135 mg, 45 mg</i>	Non-Formulary	
<i>fenofibric acid oral tablet 105 mg, 35 mg</i>	2	
<i>gemfibrozil oral tablet 600 mg</i>	2	
LIPOFEN ORAL CAPSULE 150 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: FENOFIBRATE)
Hmg-Coa Reductase Inhibitors		
<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, 5-20 mg, 5-40 mg, 5-80 mg</i>	2	TD; QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin oral tablet 2.5-40 mg, 5-10 mg</i>	2	TD; ST (Step Therapy Required); QL (1 tablet per 1 day)
ATORVALIQ ORAL SUSPENSION 20 MG/5 ML (4 MG/ML)	Non-Formulary	ALT (Covered Alternatives: Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, Simvastatin); QL (5 ML per 1 Day)
<i>atorvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	2	HCR
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	Non-Formulary	QL (Quantity Limits Apply)
EZALLOR SPRINKLE ORAL CAPSULE, SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	2	QL (1 tablet per 1 day)
FLOLIPID ORAL SUSPENSION 20 MG/5 ML (4 MG/ML), 40 MG/5 ML (8 MG/ML)	Non-Formulary	QL (Quantity Limits Apply)
<i>fluvastatin oral capsule 20 mg, 40 mg</i>	2	
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG	Non-Formulary	ALT (Covered Alternatives: SIMVASTATIN, PRAVASTATIN SODIUM, LOVASTATIN, ATORVASTATIN CALCIUM, ROSUVASTATIN CALCIUM, EZETIMIBE-SIMVASTATIN); QL (1 tablet per 1 day)
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	2	HCR
<i>pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg</i>	Non-Formulary	ALT (Covered Alternatives: SIMVASTATIN, PRAVASTATIN, LOVASTATIN, ATORVASTATIN, ROSUVASTATIN, EZETIMIBE-SIMVASTATIN); QL (1 Tablet per 1 day)
<i>pravastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	2	HCR
<i>rosuvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i>	2	HCR
VYTORIN 10-10 ORAL TABLET 10-10 MG	Non-Formulary	QL (1 tablet per 1 day)
VYTORIN 10-20 ORAL TABLET 10-20 MG	Non-Formulary	QL (1 tablet per 1 day)
VYTORIN 10-40 ORAL TABLET 10-40 MG	Non-Formulary	QL (1 tablet per 1 day)
VYTORIN 10-80 ORAL TABLET 10-80 MG	Non-Formulary	QL (1 tablet per 1 day)
ZYPITAMAG ORAL TABLET 2 MG, 4 MG	Non-Formulary	QL (Quantity Limits Apply)
Kallikrein Inhibitors (24:48:08)		
EKTERLY ORAL TABLET 300 MG	Non-Formulary	QL (6 Tablets per 30 Days); SP; QL (4 Tablets per 1 Day)
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML (1 ML)	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ORLADEYO ORAL CAPSULE 110 MG, 150 MG	Non-Formulary	SP; ALT (Covered Alternatives: TAKHZYRO, HAEGARDA)
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2 ML (150 MG/ML)	6	PA; SP; QL (2 vials per 1 month)
TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML	6	PA; SP
TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)	6	PA; SP; QL (4 ml per 30 days)
Loop Diuretics (24:36)		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
EDECIN ORAL TABLET 25 MG	Non-Formulary	QL (2 tablet per 1 day)
<i>ethacrynic acid oral tablet 25 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>furosemide injection solution 10 mg/ml</i>	7	
<i>furosemide oral solution 10 mg/ml, 40 mg/4 ml, 40 mg/5 ml (8 mg/ml)</i>	2	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>toremide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	2	
Mineralocorticoid (Aldosterone) Antagnts		
KERENDIA ORAL TABLET 10 MG, 20 MG	4	PA; ALT (Covered Alternatives: SPIRONOLACTONE); QL (1 tablet per 1 day)
KERENDIA ORAL TABLET 40 MG	4	PA; QL (1 Tablet per 1 Day)
Mtp Protein Inhibitors		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	Non-Formulary	SP
Nitrates And Nitrites		
ISORDIL TITRADOSE ORAL TABLET 5 MG	Non-Formulary	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	2	
<i>isosorbide dinitrate oral tablet 40 mg</i>	2	QL (3 TABLET per 1 day)
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg</i>	2	
<i>isosorbide-hydralazine oral tablet 20-37.5 mg</i>	3	
NITRO-BID TRANSDERMAL OINTMENT 2 %	2	QL (2 GM per 1 day)
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.3 MG/HR, 0.4 MG/HR, 0.6 MG/HR, 0.8 MG/HR	Non-Formulary	ALT (Covered Alternatives: Nitroglycerin Patches)
<i>nitroglycerin oral capsule, extended release 2.5 mg, 6.5 mg, 9 mg</i>	2	
<i>nitroglycerin rectal ointment 0.4 % (w/w)</i>	2	QL (30 GM per 84 Days)
<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	QL (1 patch per 1 day)
NITROSTAT SUBLINGUAL TABLET 0.3 MG, 0.4 MG, 0.6 MG	Non-Formulary	QL (Quantity Limits Apply)
NITRO-TIME ORAL CAPSULE, EXTENDED RELEASE 2.5 MG	2	
RECTIV RECTAL OINTMENT 0.4 % (W/W)	Non-Formulary	ALT (Covered Alternatives: Nitroglycerin Ointment); QL (30 GM per 90 days)
Omega-3-Mediated Antilipemics		
<i>icosapent ethyl oral capsule 0.5 gram, 1 gram</i>	2	ALT (Covered Alternatives: OMEGA-3 ACID ETHYL ESTERS, SIMVASTATIN, PRAVASTATIN SODIUM, LOVASTATIN, ATORVASTATIN CALCIUM); QL (4 capsules per 1 day)
<i>omega-3 acid ethyl esters oral capsule 1 gram</i>	2	QL (4 capsules per 1 day)
VASCEPA ORAL CAPSULE 0.5 GRAM, 1 GRAM	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: OMEGA-3 ACID ETHYL ESTERS, SIMVASTATIN, PRAVASTATIN SODIUM, LOVASTATIN, ATORVASTATIN CALCIUM); QL (4 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Osmotic Diuretics (24:36)		
<i>urea topical cream 20 %</i>	2	
Pcsk9 Inhibitors		
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML	5	PA; SP; QL (2 ML per 30 days)
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR 420 MG/3.5 ML	5	PA; SP; QL (3.5 ML per 30 days)
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR 140 MG/ML	5	PA; SP; QL (2 ML per 30 days)
REPATHA SYRINGE SUBCUTANEOUS SYRINGE 140 MG/ML	5	PA; SP; QL (2 ML per 30 days)
Phosphodiesterase Type 5 Inhibitors		
ADCIRCA ORAL TABLET 20 MG	Non-Formulary	SP; ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (2 Tablets per 1 day)
ALYQ ORAL TABLET 20 MG	Non-Formulary	SP; QL (2 Tablets per 1 day)
CIALIS ORAL TABLET 10 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (6 tablets per 30 days)
CIALIS ORAL TABLET 20 MG	Non-Formulary	ALT (Covered Alternatives: SILDENAFIL CITRATE)
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tadalafil, Opsumit); QL (1 Tablet per 1 Day)
REVATIO INTRAVENOUS SOLUTION 10 MG/12.5 ML	Non-Formulary	
REVATIO ORAL TABLET 20 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution 10 mg/ml</i>	Non-Formulary	SP
<i>sildenafil (pulm.hypertension) oral tablet 20 mg</i>	2	QL (1 tablet per 1 day)
<i>sildenafil oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (12 Tablets per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: SILDENAFIL CITRATE)
<i>tadalafil (pulm. hypertension) oral tablet 20 mg</i>	5	PA; SP; ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (2 Tablets per 1 day)
<i>tadalafil oral tablet 10 mg, 5 mg</i>	2	QL (12 Tablets per 30 days)
<i>tadalafil oral tablet 2.5 mg</i>	Non-Formulary	ALT (Covered Alternatives: TERAZOSIN HCL, TAMSULOSIN HCL, ALFUZOSIN HCL ER, SILODOSIN); QL (12 Tablets per 30 days)
<i>tadalafil oral tablet 20 mg</i>	Non-Formulary	
TADLIQ ORAL SUSPENSION 20 MG/5 ML (4 MG/ML)	Non-Formulary	SP
<i>varденаfil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Non-Formulary	
<i>varденаfil oral tablet, disintegrating 10 mg</i>	Non-Formulary	
VIAGRA ORAL TABLET 100 MG, 25 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (6 tablets per 1 day)
Potassium-Sparing Diuretic		
CAROSPIR ORAL SUSPENSION 25 MG/5 ML	Non-Formulary	ALT (Covered Alternatives: Spironolactone Tablets); QL (15 ML per 1 day)
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5 ml</i>	Non-Formulary	QL (15 ML per 1 day)
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolacton-hydrochlorothiaz oral tablet 25-25 mg</i>	2	
Potassium-Sparing Diuretics (Hypoten)		
<i>amiloride oral tablet 5 mg</i>	2	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
DYRENIUM ORAL CAPSULE 100 MG, 50 MG	Non-Formulary	QL (4 capsules per 1 day)
<i>triamterene oral capsule 100 mg, 50 mg</i>	2	PA; QL (4 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	2	
<i>triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg</i>	2	
Renin Inhibitors		
<i>aliskiren oral tablet 150 mg, 300 mg</i>	2	TD; QL (1 tablet per 1 day)
Renin-Angioten.-Aldost. Sys. Inhib, Misc		
FILSPARI ORAL TABLET 200 MG, 400 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
Sclerosing Agents		
ABLYSINOL INTRA-ARTERIAL SOLUTION 99 %	BB	
<i>ethyl alcohol intra-arterial solution 99 %</i>	BB	
Steroidal Mineralocorticoid Receptor Ant		
CAROSPIR ORAL SUSPENSION 25 MG/5 ML	Non-Formulary	ALT (Covered Alternatives: Spironolactone Tablets); QL (15 ML per 1 day)
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5 ml</i>	Non-Formulary	QL (15 ML per 1 day)
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>spironolacton-hydrochlorothiaz oral tablet 25-25 mg</i>	2	
Thiazide Diuretics (24:36)		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
<i>amlodipine-valsartan-hcthiazid oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg</i>	2	
<i>amlodipine-valsartan-hcthiazid oral tablet 5-160-25 mg</i>	2	QL (2 tablets per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	2	
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG	Non-Formulary	QL (1 tablet per 1 day)
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>candesartan-hydrochlorothiazid oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	2	QL (2 tablets per 1 day)
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	2	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 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	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	2	QL (1 tablet per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	
<i>metoprolol ta-hydrochlorothiazid oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	2	QL (1 tablet per 1 day)
<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>	2	TD
<i>olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	2	QL (1 tablet per 1 day)
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	2	
<i>spironolacton-hydrochlorothiazid oral tablet 25-25 mg</i>	2	
<i>telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	2	QL (2 tablets per 1 day)
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	2	
<i>triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg</i>	2	
TRIBENZOR 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	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	2	QL (2 tablets per 1 day)
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG	Non-Formulary	QL (Quantity Limits Apply)
Thiazide-Like Diuretics (24:36)		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	2	QL (2 tablets per 1 day)
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	2	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CHLORTHALIDONE, LOSARTAN POTASSIUM, IRBESARTAN, VALSARTAN, OLMESARTAN MEDOXOMIL, CANDESARTAN CILEXETIL, TELMISARTAN)
HEMICLOR ORAL TABLET 12.5 MG	Non-Formulary	ALT (Covered Alternatives: CHLORTHALIDONE 25MG, CHLORTHALIDONE 50MG); QL (1 Tablet per 1 Day)
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
Vasodilating Agents, Miscellaneous		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	6	PA; SP; QL (3 tablets per 1 day)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	2	PA; SP; QL (1 tablet per 1 day)
<i>amlodipine oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<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, 5-20 mg, 5-40 mg, 5-80 mg</i>	2	TD; QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin oral tablet 2.5-40 mg, 5-10 mg</i>	2	TD; ST (Step Therapy Required); QL (1 tablet per 1 day)
<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>	2	QL (2 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	2	
<i>amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	2	
AURLUMYN INTRAVENOUS SOLUTION 100 MCG/ML	BB	PA
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG	Non-Formulary	
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	2	PA; SP; QL (2 tablets per 1 day)
<i>bosentan oral tablet for suspension 32 mg</i>	Non-Formulary	SP; QL (120 tablets per 30 days)
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	Non-Formulary	QL (Quantity Limits Apply)
CONJUPRI ORAL TABLET 2.5 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Amlodipine, Cartia XT, Verapamil, Diltiazem, Nifedipine, Felodipine); QL (1 tablet per 1 day)
CONSENSI ORAL TABLET 10-200 MG, 2.5-200 MG, 5-200 MG	Non-Formulary	QL (Quantity Limits Apply)
FLOLAN INTRAVENOUS RECON SOLN 0.5 MG	BB	PA
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	2	
KATERZIA ORAL SUSPENSION 1 MG/ML	Non-Formulary	
LETAIRIS ORAL TABLET 10 MG, 5 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
<i>levamlodipine oral tablet 2.5 mg, 5 mg</i>	Non-Formulary	ALT (Covered Alternatives: Amlodipine, Cartia XT, Verapamil, Diltiazem, Nifedipine); QL (1 tablet per 1 day)
<i>nicardipine in nacl (iso-os) intravenous piggyback 20 mg/200 ml (0.1 mg/ml)</i>	BB	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	2	
<i>nifedipine oral tablet extended release 24hr 30 mg, 60 mg</i>	2	QL (3 tablets per 1 day)
<i>nifedipine oral tablet extended release 24hr 90 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg</i>	2	QL (3 tablets per 1 day)
OPSUMIT ORAL TABLET 10 MG	5	PA; SP; QL (1 tablet per 1 day)
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tadalafil, Opsumit); QL (1 Tablet per 1 Day)
ORENITRAM MONTH 1 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG (42)	Non-Formulary	SP
ORENITRAM MONTH 2 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG (210)	Non-Formulary	SP
ORENITRAM MONTH 3 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG(42)-1MG	Non-Formulary	SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
REMODULIN INJECTION SOLUTION 1 MG/ML, 10 MG/ML, 2.5 MG/ML, 5 MG/ML	Non-Formulary	SP
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	2	
TRACLEER ORAL TABLET 125 MG, 62.5 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
TRACLEER ORAL TABLET FOR SUSPENSION 32 MG	Non-Formulary	QL (Quantity Limits Apply); SP
<i>treprostinil sodium injection solution 1 mg/ml, 10 mg/ml, 2.5 mg/ml, 5 mg/ml</i>	7	PA; SP; QL (0.01 ml per 1 day)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG	Non-Formulary	SP; QL (2.9 ML per 1 Day)
TYVASO INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)	5	PA; SP; QL (2.9 ML per 1 day)
TYVASO INSTITUTIONAL START KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML	5	PA; SP; QL (2.9 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)	5	PA; SP; QL (2.9 ML per 1 day)
TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML	5	PA; SP; QL (2.9 ML per 1 day)
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	5	PA; SP; QL (2 tablets per 1 day)
UPTRAVI ORAL TABLETS,DOSE PACK 200 MCG (140)- 800 MCG (60)	5	PA; SP; QL (2 tablets per 1 day)
VELETRI INTRAVENOUS RECON SOLN 0.5 MG, 1.5 MG	BB	PA
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG	Non-Formulary	SP
CELLULAR AND GENE THERAPY		
Cellular Therapy		
AMTAGVI INTRAVENOUS SUSPENSION 7.5 X 10EXP9 TO 72X 10EXP9 CELL	BB	
OMISIRGE INTRAVENOUS SUSPENSION	BB	PA
Gene Therapy		
CARVYKTI INTRAVENOUS SUSPENSION 0.5 X 10EXP6 TO 1 X 10EXP8 CELL	BB	PA
CASGEVY INTRAVENOUS SUSPENSION 4 X TO 13 X 10EXP6 CELL/ML	BB	PA
HEMGENIX INTRAVENOUS SUSPENSION 1X10EXP13 GC/ML	BB	PA
IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML	BB	PA
KEBILIDI INTRACRANIAL SUSPENSION 2.8 X10EXP11 VG/0.5 ML	BB	PA
LENMELDY INTRAVENOUS SUSPENSION 2 X TO 11.8 X 10EXP6 CELL/ML	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LUXTURNA SUBRETINAL SUSPENSION 1.5 X 10EXP11 VG/0.3 ML (FNL)	BB	PA
LYFGENIA INTRAVENOUS SUSPENSION 1.7 X TO 20 X 10EXP6 CELL/ML	BB	
SKYSONA INTRAVENOUS SUSPENSION 4 X TO 30 X 10EXP6 CELL/ML	BB	PA
TECELRA INTRAVENOUS SUSPENSION 2.68X10EXP9 TO 10X10EXP9 CELL	BB	PA
VYJUVEK TOPICAL GEL 5 X 10EXP9 PFU/2.5 ML	Non-Formulary	
ZOLGENSMA INTRAVENOUS KIT 2 X 10EXP13 VG/ML	BB	PA
ZYNTEGLO INTRAVENOUS SUSPENSION 2 X TO 20 X 10EXP6 CELL/ML	BB	PA
CENTRAL NERVOUS SYSTEM AGENTS		
Adamantanes (Cns)		
<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	
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG, 68.5 MG	Non-Formulary	SP
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 258 MG, 322 MG/DAY(129 MG X1-193MG X1)	Non-Formulary	QL (Quantity Limits Apply)
Adenosine A2a Receptor Antagonists		
NOURIANZ ORAL TABLET 20 MG, 40 MG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: CARBIDOPA/LEVODOPA, CARBIDOPA-LEVODOPA ER, STALEVO, PRAMIPEXOLE DI-HCL, PRAMIPEXOLE ER, ROPINIROLE HCL)
Amphetamine Derivatives		
<i>diethylpropion oral tablet 25 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>diethylpropion oral tablet extended release 75 mg</i>	2	
LOMAIRA ORAL TABLET 8 MG	Non-Formulary	ALT (Covered Alternatives: PHENTERMINE HCL 8MG); QL (3 Tablet per 1 day)
<i>phentermine oral capsule 15 mg, 30 mg, 37.5 mg</i>	2	
<i>phentermine oral tablet 37.5 mg</i>	2	
<i>phentermine oral tablet 8 mg</i>	3	QL (3 Tablets per 1 Day)
Amphetamines		
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: DEXTROAMPHETAMINE/AMPHETAMINE ER); QL (2 capsules per 1 day)
ADZENYS XR-ODT ORAL TABLET,DISINTEGR BIPHASE 24H 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>benzphetamine oral tablet 50 mg</i>	2	
<i>dextroamphetamine sulfate oral capsule, extended release 10 mg, 15 mg, 5 mg</i>	2	QL (4 capsules per 1 day)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	2	QL (6 tablets per 1 day)
<i>dextroamphetamine sulfate oral tablet 15 mg, 2.5 mg, 20 mg, 30 mg, 7.5 mg</i>	2	
<i>dextroamphetamine-amphetamine oral capsule, er triphasic 24 hr 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER, GUANFACINE ER)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	2	QL (2 capsules per 1 day)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	2	QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DYANA VEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR 2.5 MG/ML	Non-Formulary	QL (Quantity Limits Apply)
EVEKEO ORAL TABLET 10 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: DEXTROAMPHETAMINE-AMPHETAMINE, METHYLPHENIDATE HCL, DEXTROAMPHETAMINE SULFATE, METHAMPHETAMINE HCL)
<i>lisdexamfetamine oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg</i>	2	QL (1 Capsule per 1 day)
<i>lisdexamfetamine oral tablet, chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	2	QL (1 Tablet per 1 day)
<i>methamphetamine oral tablet 5 mg</i>	2	
MYDAYIS ORAL CAPSULE, ER TRIPHASIC 24 HR 12.5 MG, 25 MG, 37.5 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG	Non-Formulary	ALT (Covered Alternatives: LISDEXAMFETAMINE DIMESYLATE Capsules); TD; QL (1 capsule per 1 day)
VYVANSE ORAL TABLET, CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG	Non-Formulary	ALT (Covered Alternatives: LISDEXAMFETAMINE DIMESYLATE Capsules); QL (1 tablet per 1 day)
XELSTRYM TRANSDERMAL PATCH 24 HOUR 13.5 MG/9 HOUR, 18 MG/9 HOUR, 4.5 MG/9 HOUR, 9 MG/9 HOUR	Non-Formulary	ALT (Covered Alternatives: Dextroamphetamine, Dextroamphetamine ER, Dextroamphetamine-Amphetamine, Dextroamphetamine-Amphetamine ER); QL (1 patch per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZENZEDI ORAL TABLET 10 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER, GUANFACINE HCL ER); QL (6 tablets per 1 day)
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	Non-Formulary	ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER, GUANFACINE HCL ER)
Amyotrophic Lateral Sclerosis(Als) Agent		
<i>edaravone intravenous solution 30 mg/100 ml, 60 mg/100 ml</i>	BB	PA
QALSODY INTRATHECAL SOLUTION 100 MG/15 ML (6.7 MG/ML)	BB	PA
RADICAVA INTRAVENOUS SOLUTION 30 MG/100 ML	Non-Formulary	PA; SP
RADICAVA ORS ORAL SUSPENSION 105 MG/5 ML	Non-Formulary	SP
RADICAVA ORS STARTER KIT SUSP ORAL SUSPENSION 105 MG/5 ML	Non-Formulary	SP
<i>riluzole oral tablet 50 mg</i>	2	QL (4 tablets per 1 day)
TEGLUTIK ORAL SUSPENSION 50 MG/10 ML	Non-Formulary	ALT (Covered Alternatives: RILUZOLE TABLET); QL (20 ML per 1 day)
TIGLUTIK ORAL SUSPENSION 50 MG/10 ML	Non-Formulary	QL (Quantity Limits Apply)
Analgesics And Antipyretics, Misc.		
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>gabapentin oral solution 250 mg/5 ml, 250 mg/5 ml (5 ml)</i>	2	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	2	
<i>gabapentin oral tablet extended release 24 hr 300 mg, 600 mg</i>	Non-Formulary	ALT (Covered Alternatives: Gabapentin, Duloxetine, Amitriptyline)
GABARONE ORAL TABLET 100 MG, 400 MG	Non-Formulary	ALT (Covered Alternatives: Gabapentin 100mg, Gabapentin 300mg, Gabapentin 400mg); QL (3 Tablets per 1 Day)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: GABAPENTIN, DULOXETINE HCL, AMITRIPTYLINE HCL)
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG, 600 MG	4	PA; ALT (Covered Alternatives: GABAPENTIN, PRAMIPEXOLE DI-HCL, ROPINIROLE HCL); QL (2 tablets per 1 day)
JOURNAVX ORAL TABLET 50 MG	Non-Formulary	QL (28 Tablets per 14 Days); ALT (Covered Alternatives: Tramadol HCL 50mg, Tramadol 100mg ER, MORPHINE SULFATE, MORPHINE SULFATE ER, Oxycodone); QL (2 Tablets per 1 Day)
Anorexigenic Agents		
CONTRAVE ORAL TABLET EXTENDED RELEASE 8-90 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PHENTERMINE HCL, DIETHYLPROPION HCL, BENZPHETAMINE HCL)
<i>phentermine-topiramate oral capsule, er multiphase 24 hr 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg</i>	2	QL (1 Capsule per 1 Day)
QSYMIA ORAL CAPSULE, ER MULTIPHASE 24 HR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG	Non-Formulary	ALT (Covered Alternatives: Phentermine-Topiramate ER Capsules); QL (1 Capsule per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Anorexigenic Agents, Miscellaneous		
<i>liraglutide (weight loss) subcutaneous pen injector 3 mg/0.5 ml (18 mg/3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: PHENTERMINE HCL, DIETHYLPROPION HCL, BENZPHETAMINE HCL)
<i>liraglutide subcutaneous pen injector 0.6 mg/0.1 ml (18 mg/3 ml)</i>	2	PA; QL (0.3 ML per 1 day)
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	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (0.08 ML per 1 day)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML)	3	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (0.06 ML per 1 day)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	3	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (0.11 ML per 1 day)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (1 tablet per 1 day)
SAXENDA SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML (18 MG/3 ML)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PHENTERMINE HCL, DIETHYLPROPION HCL, BENZPHETAMINE HCL)
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (0.5 ml per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	Non-Formulary	ALT (Covered Alternatives: Liraglutide); QL (9 ML per 30 days)
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	Non-Formulary	ALT (Covered Alternatives: Liraglutide); QL (9 ML per 30 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML	Non-Formulary	QL (2 ML per 28 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML	Non-Formulary	QL (3 ML per 28 days)
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRULICITY, LIRAGLUTIDE, LANTUS, TOUJEO SOLOSTAR); QL (0.5 ml per 1 day)
Anticholinergic Agents (Cns)		
<i>benztropine oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>trihexyphenidyl oral elixir 0.4 mg/ml</i>	2	
<i>trihexyphenidyl oral tablet 2 mg, 5 mg</i>	2	
Anticonvulsants, Miscellaneous		
<i>acetazolamide oral capsule, extended release 500 mg</i>	2	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	2	
BRIVIACT ORAL SOLUTION 10 MG/ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LEVETIRACETAM, CARBAMAZEPINE, VALPROIC ACID, DIVALPROEX SODIUM, OXCARBAZEPINE, ZONISAMIDE); TD
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	4	PA; QL (Medications with multiple dosage strengths: least number of tabs/caps used to achieve total daily dose apply); QL (2 tablets per 1 day)
<i>carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg</i>	2	QL (8 capsules per 1 day)
<i>carbamazepine oral suspension 100 mg/5 ml</i>	2	
<i>carbamazepine oral tablet 200 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg</i>	2	
<i>carbamazepine oral tablet, chewable 100 mg, 200 mg</i>	2	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	5	PA; SP; QL (60 ml per 30 days)
EPRONTIA ORAL SOLUTION 25 MG/ML	Non-Formulary	
<i>felbamate oral suspension 600 mg/5 ml</i>	2	
<i>felbamate oral tablet 400 mg, 600 mg</i>	2	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	5	PA; SP; ALT (Covered Alternatives: CLOBAZAM, TOPIRAMATE, LEVETIRACETAM); QL (360 ML per 30 days)
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	4	PA; QL (1 ML per 1 day)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	Non-Formulary	ALT (Covered Alternatives: Perampanel Tablets); QL (1 tablet per 1 day)
KEPPRA ORAL SOLUTION 100 MG/ML	Non-Formulary	
KEPPRA ORAL TABLET 1,000 MG, 250 MG, 500 MG, 750 MG	Non-Formulary	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG, 750 MG	Non-Formulary	QL (4 Tablets per 1 day)
LAMICTAL XR STARTER (BLUE) ORAL TABLET EXTENDED REL, DOSE PACK 25 MG (21) -50 MG (7)	Non-Formulary	ALT (Covered Alternatives: LAMOTRIGINE)
LAMICTAL XR STARTER (GREEN) ORAL TABLET EXTENDED REL, DOSE PACK 50 MG (14) -100MG (14) -200 MG (7)	Non-Formulary	ALT (Covered Alternatives: LAMOTRIGINE)
LAMICTAL XR STARTER (ORANGE) ORAL TABLET EXTENDED REL, DOSE PACK 25MG (14) -50 MG (14) -100MG (7)	Non-Formulary	ALT (Covered Alternatives: LAMOTRIGINE)
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	2	
<i>lamotrigine oral tablet extended release 24hr 100 mg, 200 mg, 250 mg, 300 mg</i>	2	QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>lamotrigine oral tablet extended release 24hr 25 mg, 50 mg</i>	2	QL (4 tablets per 1 day)
<i>lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>lamotrigine oral tablets,dose pack 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14)</i>	2	QL (1 Kit per 365 days)
<i>levetiracetam oral solution 100 mg/ml, 500 mg/5 ml (5 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	QL (4 tablets per 1 day)
<i>perampanel oral tablet 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	4	PA; QL (1 Tablet per 1 Day)
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG, 250 MG, 500 MG, 750 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>topiramate oral capsule, sprinkle 15 mg, 25 mg</i>	2	QL (8 capsules per 1 day)
<i>topiramate oral capsule, sprinkle 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: TOPIRAMATE IMMEDIATE RELEASE); QL (8 Capsules per 1 day)
<i>topiramate oral capsule,extended release 24hr 100 mg, 25 mg, 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: Topiramate Tablets); QL (1 Capsule per 1 day)
<i>topiramate oral capsule,sprinkle,er 24hr 100 mg, 150 mg, 200 mg, 25 mg, 50 mg</i>	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Topiramate Tablets); QL (1 Capsule per 1 day)
<i>topiramate oral solution 25 mg/ml</i>	Non-Formulary	ALT (Covered Alternatives: TOPIRAMATE 25MG TABLET); QL (16 ML per 1 Day)
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 25 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TOPIRAMATE)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Antidepressants, Miscellaneous		
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HR 174 MG, 348 MG, 522 MG	Non-Formulary	QL (Quantity Limits Apply)
AUVELITY ORAL TABLET, IR AND ER, BIPHASIC 45-105 MG	Non-Formulary	ALT (Covered Alternatives: Bupropion, Citalopram, Fluoxetine, Escitalopram, Paroxetine, Duloxetine)
<i>bupropion hcl (smoking deter) oral tablet extended release 12 hr 150 mg</i>	2	HCR
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg</i>	2	
<i>bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg</i>	2	
FORFIVO XL ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>ketamine in 0.9 % sod chloride intravenous syringe 25 mg/ml</i>	BB	
<i>ketamine in nacl, iso-osmotic intravenous solution 10 mg/ml</i>	BB	
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	Non-Formulary	QL (Quantity Limits Apply)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	6	PA; SP; QL (2 Capsules per 1 day)
ZURZUVAE ORAL CAPSULE 30 MG	6	PA; SP; QL (1 Capsule per 1 day)
Antimanic Agents		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML, 960 MG/3.2 ML	BB	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG, 400 MG	BB	SP
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 300 MG, 400 MG	BB	SP
<i>aripiprazole oral solution 1 mg/ml</i>	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
ARISTADA INITIO INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 675 MG/2.4 ML	BB	
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML, 441 MG/1.6 ML, 662 MG/2.4 ML, 882 MG/3.2 ML	BB	
<i>asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg</i>	2	PA; TD; QL (1 tablet per 1 day)
<i>carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg</i>	2	QL (8 capsules per 1 day)
<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, 200 mg</i>	2	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG	Non-Formulary	ALT (Covered Alternatives: DIVALPROEX SODIUM)
<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	
<i>divalproex oral tablet, delayed release (dr/ec) 125 mg, 250 mg, 500 mg</i>	2	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	2	
<i>lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>lamotrigine oral tablets, dose pack 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14)</i>	2	QL (1 Kit per 365 days)
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	2	
<i>lithium carbonate oral tablet 300 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>lithium carbonate oral tablet extended release 300 mg, 450 mg</i>	2	
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	2	QL (3 tablets per 1 day)
<i>olanzapine oral tablet, disintegrating 10 mg, 15 mg, 20 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Non-Formulary	ALT (Covered Alternatives: olanzapine, fluoxetine)
OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: ARIPIPRAZOLE TABLETS, ARIPIPRAZOLE SOLUTION); QL (1 Film per 1 Day)
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	2	QL (4 tablets per 1 day)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	2	QL (1 tablet per 1 day)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML, 50 MG/2 ML	BB	SP
<i>risperidone microspheres intramuscular suspension, extended rel recon 12.5 mg/2 ml, 25 mg/2 ml, 37.5 mg/2 ml, 50 mg/2 ml</i>	BB	
<i>risperidone oral solution 1 mg/ml</i>	2	
<i>risperidone oral syringe 1 mg/ml</i>	2	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	2	QL (9.34 tablets per 1 day)
<i>risperidone oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	2	QL (280 tablets per 30 days)
SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Azenapine)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HOUR, 5.7 MG/24 HOUR, 7.6 MG/24 HOUR	Non-Formulary	QL (Quantity Limits Apply)
SEROQUEL ORAL TABLET 400 MG	Non-Formulary	QL (4 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: Quetiapine); QL (1 tablet per 1 day)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML, 125 MG/0.35 ML, 150 MG/0.42 ML, 200 MG/0.56 ML, 250 MG/0.7 ML, 50 MG/0.14 ML, 75 MG/0.21 ML	BB	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml, 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)</i>	2	
<i>valproic acid oral capsule 250 mg</i>	2	
<i>ziprasidone hcl oral capsule 20 mg, 60 mg</i>	2	QL (2 capsules per 1 day)
<i>ziprasidone hcl oral capsule 40 mg, 80 mg</i>	2	QL (4 capsules per 1 day)
Antimigraine Agents, Miscellaneous		
<i>acetaminophen intravenous solution 1,000 mg/100 ml (10 mg/ml), 500 mg/50 ml (10 mg/ml), 650 mg/65 ml (10 mg/ml)</i>	BB	
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	2	QL (4500 ML per 30 days)
<i>acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml</i>	2	QL (50 ML per 1 Day)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	2	QL (10 tablets per 1 day)
BETIMOL OPHTHALMIC (EYE) DROPS 0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TIMOLOL MALEATE)
BREKIYA SUBCUTANEOUS AUTO-INJECTOR 1 MG/ML	Non-Formulary	QL (24 mLs per 28 days); ALT (Covered Alternatives: DIHYDROERGOTAMINE 1 MG/ML AMP); QL (3 ML per 1 Day)
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	Non-Formulary	ALT (Covered Alternatives: BUTALB-ACETAMIN-CAF-COD)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	2	QL (6 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>butalbital-acetaminophen oral tablet 50-300 mg, 50-325 mg</i>	2	QL (60 tablets per 30 days)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	2	QL (5 capsules per 1 day)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	2	
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	2	
COSOPT (PF) OPHTHALMIC (EYE) DROPPERETTE 2-0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DORZOLAMIDE-TIMOLOL)
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG	Non-Formulary	ALT (Covered Alternatives: DIVALPROEX SODIUM)
<i>diclofenac epolamine transdermal patch 12 hour 1.3 %</i>	Non-Formulary	
<i>diclofenac potassium oral capsule 25 mg</i>	Non-Formulary	
<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 (300 GM per 30 days)
<i>diclofenac sodium topical solution in metered-dose pump 20 mg/gram /actuation(2 %)</i>	Non-Formulary	ALT (Covered Alternatives: Diclofenac Sodium Tablets, Celecoxib, Ibuprofen, Meloxicam, Naproxen, Nabumetone)
<i>diclofenac-misoprostol oral tablet, ir, delayed rel, biphasic 75-200 mg-mcg</i>	2	
<i>dihydroergotamine injection solution 1 mg/ml</i>	2	PA; QL (0.1 ML per 1 day)
<i>dihydroergotamine nasal spray, non-aerosol 0.5 mg/pump act. (4 mg/ml)</i>	2	PA; QL (8 ml per 1 fill)
<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	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>divalproex oral tablet, delayed release (dr/ec) 125 mg, 250 mg, 500 mg</i>	2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette 2-0.5 %</i>	2	
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	2	
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	2	QL (8 tablets per 1 day)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	2	QL (24 tablets per 1 fill)
FLECTOR TRANSDERMAL PATCH 12 HOUR 1.3 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PIROXICAM, DICLOFENAC SODIUM, DICLOFENAC SODIUM, MELOXICAM, NABUMETONE, NAPROXEN, CELECOXIB)
HEMANGEOL ORAL SOLUTION 4.28 MG/ML	Non-Formulary	SP
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15 ml</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15); QL (90 ML per 1 Day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15 SOLUTION, HYDROCODONE-ACETAMIN 5-217/10 SOLUTION); QL (60 ML per 1 Day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml(15 ml)</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15 SOLUTION, HYDROCODONE-ACETAMIN 5-217/10 SOLUTION); QL (60 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	2	QL (90 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (8 tablets per 1 day)
<i>hydrocodone-acetaminophen oral tablet 2.5-325 mg</i>	2	QL (12 Tablet per 1 day)
LICART TRANSDERMAL PATCH 24 HOUR 1.3 %	Non-Formulary	QL (Quantity Limits Apply)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (8 tablets per 1 day)
<i>oxycodone-acetaminophen oral tablet 7.5-300 mg</i>	2	
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DICLOFENAC SODIUM, DICLOFENAC SODIUM, CELECOXIB, IBUPROFEN, MELOXICAM, NAPROXEN, NABUMETONE)
<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>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	2	QL (8 tablets per 1 day)
TRUDHESA NASAL SPRAY, NON-AEROSOL 0.725 MG/PUMP ACT. (4 MG/ML)	Non-Formulary	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml, 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)</i>	2	
<i>valproic acid oral capsule 250 mg</i>	2	
ZIPSOR ORAL CAPSULE 25 MG	Non-Formulary	QL (Quantity Limits Apply)
Anxiolytics, Sedatives, And Hypnotics, Misc		
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	2	
<i>hydroxyzine hcl oral tablet 10 mg, 50 mg</i>	2	
<i>hydroxyzine hcl oral tablet 25 mg</i>	2	QL (4 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<i>promethazine oral syrup 6.25 mg/5 ml</i>	2	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine rectal suppository 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine-codeine oral syrup 6.25-10 mg/5 ml</i>	2	
<i>promethazine-dm oral syrup 6.25-15 mg/5 ml</i>	2	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG	2	
Atypical Antipsychotics		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML, 960 MG/3.2 ML	BB	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG, 400 MG	BB	SP
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 300 MG, 400 MG	BB	SP
<i>aripiprazole oral solution 1 mg/ml</i>	Non-Formulary	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
ARISTADA INITIO INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 675 MG/2.4 ML	BB	
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML, 441 MG/1.6 ML, 662 MG/2.4 ML, 882 MG/3.2 ML	BB	
<i>asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg</i>	2	PA; TD; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	Non-Formulary	ALT (Covered Alternatives: Ziprasidone, Aripiprazole, Risperidone, Quetiapine, Olanzapine, Lurasidone); TD
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	QL (5 tablets per 1 day)
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	Non-Formulary	
ERZOFRI INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 351 MG/2.25 ML, 39 MG/0.25 ML, 78 MG/0.5 ML	BB	PA
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	4	PA; ALT (Covered Alternatives: ARIPIPRAZOLE, RISPERIDONE, QUETIAPINE FUMARATE, OLANZAPINE, ZIPRASIDONE HCL, PALIPERIDONE ER); QL (2 tablets per 1 day)
FANAPT TITRATION PACK A ORAL TABLETS, DOSE PACK 1MG(2)-2MG(2)- 4MG(2)-6MG(2)	Non-Formulary	ALT (Covered Alternatives: ARIPIPRAZOLE, RISPERIDONE, QUETIAPINE FUMARATE, OLANZAPINE, ZIPRASIDONE HCL, PALIPERIDONE ER); QL (2 tablets per 1 day)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML, 1,560 MG/5 ML	BB	
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 6 MG, 9 MG	Non-Formulary	QL (1 tablet per 1 day)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 39 MG/0.25 ML, 78 MG/0.5 ML	BB	PA
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML, 410 MG/1.32 ML, 546 MG/1.75 ML, 819 MG/2.63 ML	BB	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG	Non-Formulary	ALT (Covered Alternatives: Lurasidone Tablets); QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	2	QL (1 Tablet per 1 day)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	Non-Formulary	ALT (Covered Alternatives: Olanzapine)
NUPLAZID ORAL CAPSULE 34 MG	6	PA; SP; QL (2 capsules per 1 day)
NUPLAZID ORAL TABLET 10 MG	6	PA; SP; QL (2 tablets per 1 day)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	2	QL (3 tablets per 1 day)
<i>olanzapine oral tablet, disintegrating 10 mg, 15 mg, 20 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Non-Formulary	ALT (Covered Alternatives: olanzapine, fluoxetine)
OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: ARIPIPRAZOLE TABLETS, ARIPIPRAZOLE SOLUTION); QL (1 Film per 1 Day)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg</i>	2	QL (1 tablet per 1 day)
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	2	QL (4 tablets per 1 day)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	2	QL (1 tablet per 1 day)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	4	PA; ALT (Covered Alternatives: Aripiprazole, Risperidone, Quetiapine, Olanzapine, Lurasidone); TD; QL (1 tablet per 1 day)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML, 50 MG/2 ML	BB	SP
<i>risperidone microspheres intramuscular suspension, extended rel recon 12.5 mg/2 ml, 25 mg/2 ml, 37.5 mg/2 ml, 50 mg/2 ml</i>	BB	
<i>risperidone oral solution 1 mg/ml</i>	2	
<i>risperidone oral syringe 1 mg/ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	2	QL (9.34 tablets per 1 day)
<i>risperidone oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	2	QL (280 tablets per 30 days)
SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: Asenapine)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HOUR, 5.7 MG/24 HOUR, 7.6 MG/24 HOUR	Non-Formulary	QL (Quantity Limits Apply)
SEROQUEL ORAL TABLET 400 MG	Non-Formulary	QL (4 tablets per 1 day)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: Quetiapine); QL (1 tablet per 1 day)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 100 MG/0.28 ML, 125 MG/0.35 ML, 150 MG/0.42 ML, 200 MG/0.56 ML, 250 MG/0.7 ML, 50 MG/0.14 ML, 75 MG/0.21 ML	BB	
VERSACLOZ ORAL SUSPENSION 50 MG/ML	4	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	Non-Formulary	QL (Quantity Limits Apply); TD
<i>ziprasidone hcl oral capsule 20 mg, 60 mg</i>	2	QL (2 capsules per 1 day)
<i>ziprasidone hcl oral capsule 40 mg, 80 mg</i>	2	QL (4 capsules per 1 day)
Barbiturates (Anticonvulsants)		
<i>methohexital injection recon soln 500 mg</i>	BB	
MYSOLINE ORAL TABLET 250 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)</i>	2	
<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	
<i>primidone oral tablet 250 mg, 50 mg</i>	2	
Barbiturates (Anxiolytic, Sedative/Hyp)		
ASCOMP WITH CODEINE ORAL CAPSULE 30-50-325-40 MG	2	QL (6 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	Non-Formulary	ALT (Covered Alternatives: BUTALB-ACETAMIN-CAF-COD 50-325)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	2	QL (6 tablets per 1 day)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	2	QL (5 capsules per 1 day)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	2	
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	2	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	2	QL (6 capsules per 1 day)
<i>butalbital-aspirin-caffeine oral tablet 50-325-40 mg</i>	2	QL (4 tablets per 1 day)
<i>codeine-butalbital-asa-caff oral capsule 30-50-325-40 mg</i>	2	QL (6 capsules per 1 day)
<i>phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)</i>	2	
<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	
Barbiturates (General Anesthetics)		
<i>methohexital injection recon soln 500 mg</i>	BB	
Benzodiazepines (Anticonvulsants)		
ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>clobazam oral suspension 2.5 mg/ml</i>	2	QL (16 ml per 1 day)
<i>clobazam oral tablet 10 mg, 20 mg</i>	2	QL (4 tablets per 1 day)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	2	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	Non-Formulary	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml, 5 ml)</i>	Non-Formulary	ALT (Covered Alternatives: Diazepam Tablets)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	2	
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg</i>	2	QL (1 twinpack per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
NAYZILAM NASAL SPRAY, NON-AEROSOL 5 MG/SPRAY (0.1 ML)	3	QL (2 Devices per 30 days)
ONFI ORAL SUSPENSION 2.5 MG/ML	Non-Formulary	QL (16 ml per 1 day)
ONFI ORAL TABLET 10 MG, 20 MG	Non-Formulary	QL (4 tablets per 1 day)
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG	Non-Formulary	QL (Quantity Limits Apply)
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)	3	QL (2 Individual Blister Packs/Doses per 30 days)
Benzodiazepines (Anxiolytic, Sedativ/Hyp)		
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg</i>	2	
<i>alprazolam oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	
<i>amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg</i>	3	
ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	2	
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	2	QL (2 capsules per 1 day)
<i>clobazam oral suspension 2.5 mg/ml</i>	2	QL (16 ml per 1 day)
<i>clobazam oral tablet 10 mg, 20 mg</i>	2	QL (4 tablets per 1 day)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	2	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml, 5 ml)</i>	Non-Formulary	ALT (Covered Alternatives: Diazepam Tablets)
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	2	
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg</i>	2	QL (1 twinpack per 30 days)
DORAL ORAL TABLET 15 MG	Non-Formulary	ALT (Covered Alternatives: Quazepam)
<i>estazolam oral tablet 1 mg, 2 mg</i>	2	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>midazolam oral syrup 10 mg/5 ml (2 mg/ml), 2 mg/ml</i>	Non-Formulary	
NAYZILAM NASAL SPRAY, NON-AEROSOL 5 MG/SPRAY (0.1 ML)	3	QL (2 Devices per 30 days)
ONFI ORAL SUSPENSION 2.5 MG/ML	Non-Formulary	QL (16 ml per 1 day)
ONFI ORAL TABLET 10 MG, 20 MG	Non-Formulary	QL (4 tablets per 1 day)
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	2	
<i>quazepam oral tablet 15 mg</i>	Non-Formulary	ST (Step Therapy Required: Step through zolpidem, eszopiclone, zaleplon (Trial of 2 or more, 1 fill each))
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG	Non-Formulary	QL (Quantity Limits Apply)
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	2	
<i>triazolam oral tablet 0.125 mg, 0.25 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)	3	QL (2 Individual Blister Packs/Doses per 30 days)
Butyrophenones		
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	BB	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	2	
Calcitonin Gene-Related Peptide Antag.		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	6	PA; SP; QL (0.04 ML per 1 day)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	6	PA; SP; QL (0.04 ml per 1 day)
AJOVY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 225 MG/1.5 ML	5	PA; SP; QL (1.5 ML per 30 days)
AJOVY SYRINGE SUBCUTANEOUS SYRINGE 225 MG/1.5 ML	5	PA; SP; QL (1.5 ML per 30 days)
EMGALITY PEN SUBCUTANEOUS PEN INJECTOR 120 MG/ML	6	PA; SP; QL (1 ML per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X 3)	6	PA; SP; QL (1 ML per 30 days)
NURTEC ODT ORAL TABLET,DISINTEGRATING 75 MG	6	PA; SP; QL (8 tablets per 30 days)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG	Non-Formulary	SP; ALT (Covered Alternatives: Candesartan, Propranolol, Amitriptyline, Duloxetine, Divalproex, Topiramate)
UBRELVY ORAL TABLET 100 MG, 50 MG	6	PA; SP; QL (10 Tablets per 30 days)
VYEPTI INTRAVENOUS SOLUTION 100 MG/ML	Non-Formulary	PA; QL (Quantity Limits Apply); SP
ZAVZPRET NASAL SPRAY, NON-AEROSOL 10 MG/ACTUATION	Non-Formulary	SP; ALT (Covered Alternatives: Sumatriptan Nasal Spray); QL (0.2 Units per 1 day)
Catechol-O-Methyltransferase(Comt)Inhib.		
<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	QL (8 tablets per 1 day)
<i>entacapone oral tablet 200 mg</i>	2	
ONGENTYS ORAL CAPSULE 25 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>tolcapone oral tablet 100 mg</i>	2	PA; ALT (Covered Alternatives: ENTACAPONE); QL (3 tablets per 1 day)
Central Nervous System Agents, Misc.		
ADDYI ORAL TABLET 100 MG	5	PA; SP; QL (1 tablet per 1 day)
<i>carbidopa oral tablet 25 mg</i>	2	
DAYBUE ORAL SOLUTION 200 MG/ML	Non-Formulary	SP; QL (120 ML per 1 day)
<i>memantine oral capsule, sprinkle, er 24hr 14 mg, 21 mg, 28 mg, 7 mg</i>	2	TD; QL (1 Capsule per 1 day)
<i>memantine oral solution 2 mg/ml</i>	2	
<i>memantine oral tablet 10 mg</i>	2	QL (2 tablets per 1 day)
<i>memantine oral tablet 5 mg</i>	2	QL (4 Tablets per 1 day)
<i>memantine oral tablets, dose pack 5-10 mg</i>	Non-Formulary	QL (1 tablet per 365 days)
<i>memantine-donepezil oral capsule, sprinkle, er 24hr 14-10 mg, 21-10 mg, 28-10 mg</i>	Non-Formulary	ALT (Covered Alternatives: Memantine, Donepezil, Memantine ER); QL (1 Capsule per 1 Day)
NAMENDA XR ORAL CAP, SPRINKLE, ER 24HR DOSE PACK 7-14-21-28 MG	Non-Formulary	TD
NAMENDA XR ORAL CAPSULE, SPRINKLE, ER 24HR 7 MG	Non-Formulary	
NAMZARIC ORAL CAPSULE, SPRINKLE, ER 24HR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	Non-Formulary	QL (Quantity Limits Apply)
NUEDEXTA ORAL CAPSULE 20-10 MG	4	PA; QL (2 capsules per 1 day)
VEOZAH ORAL TABLET 45 MG	Non-Formulary	ALT (Covered Alternatives: Oxybutynin, Gabapentin, Paroxetine, Venlafaxine, Desvenlafaxine); TD; QL (1 Tablet per 1 day)
VYLEESI SUBCUTANEOUS AUTO-INJECTOR 1.75 MG/0.3 ML	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: ADDYI)
Cyclooxygenase-2 (Cox-2) Inhibitors		
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	2	QL (2 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CONSENSI ORAL TABLET 10-200 MG, 2.5-200 MG, 5-200 MG	Non-Formulary	QL (Quantity Limits Apply)
Dibenzoxapines		
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
Diphenylbutylperidines		
<i>pimozide oral tablet 1 mg, 2 mg</i>	2	
Dopamine Precursors		
<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	QL (8 tablets per 1 day)
<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	QL (8 tablets per 1 day)
DUOPA J-TUBE INTESTINAL PUMP SUSPENSION 4.63-20 MG/ML	BB	PA
INBRIJA INHALATION CAPSULE 42 MG	6	PA; SP; QL (120 capsules per 30 days)
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE 42 MG	6	PA; SP; QL (120 capsules per 30 days)
RYTARY ORAL CAPSULE, EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CARBIDOPA/LEVODOPA, CARBIDOPA-LEVODOPA ER, STALEVO, PRAMIPEXOLE DI-HCL, PRAMIPEXOLE ER, ROPINIROLE HCL)
VYALEV CONTIN. SUBCUTANEOUS INFUSION SOLUTION 12-240 MG/ML	BB	PA
Ergot-Deriv. Dopamine Receptor Agonists		
<i>bromocriptine oral capsule 5 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>bromocriptine oral tablet 2.5 mg</i>	2	
<i>cabergoline oral tablet 0.5 mg</i>	2	
CYCLOSET ORAL TABLET 0.8 MG	4	PA; ALT (Covered Alternatives: METFORMIN HCL, GLYBURIDE, GLIPIZIDE, JANUVIA, PIOGLITAZONE HCL, JARDIANCE, LIRAGLUTIDE); QL (1 tablet per 1 day)
Fibromyalgia Agents		
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG	Non-Formulary	
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	2	QL (3 capsules per 1 day)
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: DULOXETINE HCL, DULOXETINE HCL, DULOXETINE HCL); QL (1 capsule per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 330 MG, 82.5 MG	Non-Formulary	QL (2 tablets per 1 day)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG	Non-Formulary	QL (2 capsules per 1 day)
LYRICA ORAL SOLUTION 20 MG/ML	Non-Formulary	QL (Quantity Limits Apply)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	2	QL (2 capsules per 1 day)
<i>pregabalin oral tablet extended release 24 hr 165 mg, 330 mg, 82.5 mg</i>	Non-Formulary	QL (2 tablets per 1 day)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	4	PA; QL (2 tablets per 1 day)
SAVELLA ORAL TABLETS, DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42)	4	PA; QL (2 tablets per 1 day)
Gaba-Mediated Anticonvulsants		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG	Non-Formulary	ALT (Covered Alternatives: DIVALPROEX SODIUM)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	4	PA; QL (1 capsule per 1 day)
DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG	Non-Formulary	SP; ALT (Covered Alternatives: DIACOMIT)
<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	
<i>divalproex oral tablet, delayed release (dr/ec) 125 mg, 250 mg, 500 mg</i>	2	
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	2	
<i>gabapentin oral solution 250 mg/5 ml, 250 mg/5 ml (5 ml)</i>	2	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	2	
<i>gabapentin oral tablet extended release 24 hr 300 mg, 600 mg</i>	Non-Formulary	ALT (Covered Alternatives: Gabapentin, Duloxetine, Amitriptyline)
GABARONE ORAL TABLET 100 MG, 400 MG	Non-Formulary	ALT (Covered Alternatives: Gabapentin 100mg, Gabapentin 300mg, Gabapentin 400mg); QL (3 Tablets per 1 Day)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: GABAPENTIN, DULOXETINE HCL, AMITRIPTYLINE HCL)
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG, 600 MG	4	PA; ALT (Covered Alternatives: GABAPENTIN, PRAMIPEXOLE DI-HCL, ROPINIROLE HCL); QL (2 tablets per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 330 MG, 82.5 MG	Non-Formulary	QL (2 tablets per 1 day)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG	Non-Formulary	QL (2 capsules per 1 day)
LYRICA ORAL SOLUTION 20 MG/ML	Non-Formulary	QL (Quantity Limits Apply)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	2	QL (2 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>pregabalin oral tablet extended release 24 hr 165 mg, 330 mg, 82.5 mg</i>	Non-Formulary	QL (2 tablets per 1 day)
SABRIL ORAL POWDER IN PACKET 500 MG	Non-Formulary	QL (1 unit per 1 day)
SABRIL ORAL TABLET 500 MG	Non-Formulary	QL (6 tablets per 1 day)
<i>tiagabine oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml, 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)</i>	2	
<i>valproic acid oral capsule 250 mg</i>	2	
<i>vigabatrin oral powder in packet 500 mg</i>	5	PA; SP; QL (1 packet per 1 day)
<i>vigabatrin oral tablet 500 mg</i>	5	PA; SP; QL (6 tablets per 1 day)
VIGADRONE ORAL POWDER IN PACKET 500 MG	5	PA; SP; QL (1 packet per 1 day)
VIGADRONE ORAL TABLET 500 MG	5	PA; SP; QL (6 Tablets per 1 day)
VIGAFYDE ORAL SOLUTION 100 MG/ML	Non-Formulary	QL (5 ML per 1 day)
ZTALMY ORAL SUSPENSION 50 MG/ML	6	PA; SP; QL (36 ML per 1 DAY)
Hydantoins		
DILANTIN EXTENDED ORAL CAPSULE 100 MG	3	
DILANTIN INFATABS ORAL TABLET,CHEWABLE 50 MG	Non-Formulary	QL (Quantity Limits Apply)
DILANTIN KAPSEAL ORAL CAPSULE 100 MG	3	
DILANTIN ORAL CAPSULE 30 MG	3	
PHENYTEK ORAL CAPSULE 200 MG, 300 MG	3	
<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	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Ion Channel Inhibition Agents		
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG	4	PA; ALT (Covered Alternatives: LEVETIRACETAM, CARBAMAZEPINE, VALPROIC ACID, OXCARBAZEPINE, ZONISAMIDE); QL (1 tablet per 1 day)
BANZEL ORAL TABLET 200 MG, 400 MG	Non-Formulary	ALT (Covered Alternatives: RUFINAMIDE); QL (280 tablets per 1 fill)
<i>lacosamide oral solution 10 mg/ml</i>	Non-Formulary	ALT (Covered Alternatives: Lacosamide Tablets); QL (40 ML per 1 day)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	QL (3 Tablets per 1 Day)
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 150 MG, 200 MG	Non-Formulary	ALT (Covered Alternatives: Lacosamide); QL (3 Capsules per 1 day)
<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	QL (8 tablets per 1 day)
<i>oxcarbazepine oral tablet extended release 24 hr 150 mg, 300 mg, 600 mg</i>	Non-Formulary	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG, 600 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>rufinamide oral tablet 200 mg, 400 mg</i>	2	PA; QL (280 tablets per 1 fill)
VIMPAT ORAL SOLUTION 10 MG/ML	Non-Formulary	ALT (Covered Alternatives: Lacosamide Tablets); QL (40 ml per 1 day)
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	Non-Formulary	QL (3 tablets per 1 day)
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	4	PA; QL (1 Tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	4	PA; QL (1 Tablet per 1 day)
XCOPRI ORAL TABLET 25 MG	4	PA; QL (1 Tablet per 1 Day)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14), 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	4	PA; QL (1 Tablet per 1 day)
ZONEGRAN ORAL CAPSULE 25 MG	Non-Formulary	TD
ZONISADE ORAL SUSPENSION 100 MG/5 ML	Non-Formulary	
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	2	
Melatonin Receptor Agonists		
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML	Non-Formulary	SP; QL (5 ML per 1 day)
HETLIOZ ORAL CAPSULE 20 MG	Non-Formulary	SP; ALT (Covered Alternatives: ROZEREM, ZOLPIDEM TARTRATE, TRAZODONE HCL, ZALEPLON, ESZOPICLONE, ZOLPIDEM TARTRATE ER); QL (1 capsule per 1 day)
<i>ramelteon oral tablet 8 mg</i>	2	QL (1 tablet per 1 day)
Monoamine Oxidase B Inhibitors		
AZILECT ORAL TABLET 0.5 MG, 1 MG	Non-Formulary	QL (1 tablet per 1 day)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR	4	PA; QL (1 patch per 1 day)
<i>rasagiline oral tablet 0.5 mg, 1 mg</i>	2	QL (1 tablet per 1 day)
<i>selegiline hcl oral capsule 5 mg</i>	2	
<i>selegiline hcl oral tablet 5 mg</i>	2	
XADAGO ORAL TABLET 100 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply)
ZELAPAR ORAL TABLET,DISINTEGRATING 1.25 MG	Non-Formulary	ALT (Covered Alternatives: Selegiline Tablets, Selegiline Capsules, Emsam Patches); QL (2 Tablets per 1 day)
Monoamine Oxidase Inhibitors		
AZILECT ORAL TABLET 0.5 MG, 1 MG	Non-Formulary	QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR	4	PA; QL (1 patch per 1 day)
MARPLAN ORAL TABLET 10 MG	4	QL (6 tablets per 1 day)
<i>phenelzine oral tablet 15 mg</i>	2	
<i>rasagiline oral tablet 0.5 mg, 1 mg</i>	2	QL (1 tablet per 1 day)
<i>selegiline hcl oral capsule 5 mg</i>	2	
<i>selegiline hcl oral tablet 5 mg</i>	2	
<i>tranylcypromine oral tablet 10 mg</i>	2	
ZELAPAR ORAL TABLET,DISINTEGRATING 1.25 MG	Non-Formulary	ALT (Covered Alternatives: Selegiline Tablets, Selegiline Capsules, Emsam Patches); QL (2 Tablets per 1 day)
Nmda Antagonists		
SPRAVATO NASAL SPRAY,NON-AEROSOL 28 MG, 56 MG (28 MG X 2), 84 MG (28 MG X 3)	BB	PA
Non-Barbiturates		
<i>ketamine in 0.9 % sod chloride intravenous syringe 25 mg/ml</i>	BB	
<i>ketamine in nacl, iso-osmotic intravenous solution 10 mg/ml</i>	BB	
Non-Benzodiazepine Anxiolytics		
<i>buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	2	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	2	
Non-Benzodiazepine Hypnotics		
EDLUAR SUBLINGUAL TABLET 10 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: ZOLPIDEM TARTRATE, ZOLPIDEM TARTRATE ER, ESZOPICLONE, TRAZODONE HCL, ZALEPLON)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	2	QL (1 tablet per 1 day)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>zolpidem oral capsule 7.5 mg</i>	Non-Formulary	ALT (Covered Alternatives: Zolpidem Tablets, Zolpidem ER Tablets); QL (1 Tablets per 1 day)
<i>zolpidem oral tablet 10 mg</i>	2	QL (1 tablet per 1 day)
<i>zolpidem oral tablet 5 mg</i>	2	QL (2 tablets per 1 day)
<i>zolpidem oral tablet,ext release multiphase 12.5 mg</i>	2	
<i>zolpidem oral tablet,ext release multiphase 6.25 mg</i>	2	QL (1 tablet per 1 day)
Nonergot-Deriv.Dopamine Receptor Agonist		
APOKYN SUBCUTANEOUS CARTRIDGE 10 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Apomorphine); QL (1 ML per 1 day)
<i>apomorphine subcutaneous cartridge 10 mg/ml</i>	5	PA; SP; QL (1 ML per 1 day)
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	PA; ALT (Covered Alternatives: PRAMIPEXOLE DI-HCL, ROPINIROLE HCL, GABAPENTIN); QL (1 patch per 1 day)
ONAPGO SUBCUTANEOUS CARTRIDGE 4.9 MG/ ML	6	PA; QL (1 ML per 1 day)
<i>pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	2	
<i>pramipexole oral tablet extended release 24 hr 0.375 mg, 2.25 mg, 3 mg</i>	2	QL (1 tablet per 1 day)
<i>pramipexole oral tablet extended release 24 hr 0.75 mg, 1.5 mg, 3.75 mg, 4.5 mg</i>	2	
<i>ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	2	
<i>ropinirole oral tablet extended release 24 hr 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	2	
Non-Opioid Analgesics		
<i>acetaminophen intravenous solution 1,000 mg/100 ml (10 mg/ml), 500 mg/50 ml (10 mg/ml), 650 mg/65 ml (10 mg/ml)</i>	BB	
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	2	QL (4500 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml</i>	2	QL (50 ML per 1 Day)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	2	QL (10 tablets per 1 day)
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	Non-Formulary	ALT (Covered Alternatives: BUTALB-ACETAMIN-CAF-COD 50-325)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	2	QL (6 tablets per 1 day)
<i>butalbital-acetaminophen oral tablet 50-300 mg, 50-325 mg</i>	2	QL (60 tablets per 30 days)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	2	QL (5 capsules per 1 day)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	2	
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	2	
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	2	QL (8 tablets per 1 day)
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15 ml</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15); QL (90 ML per 1 Day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15 SOLUTION, HYDROCODONE-ACETAMIN 5-217/10 SOLUTION); QL (60 ML per 1 Day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml(15 ml)</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15 SOLUTION, HYDROCODONE-ACETAMIN 5-217/10 SOLUTION); QL (60 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	2	QL (90 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	2	
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (8 tablets per 1 day)
<i>hydrocodone-acetaminophen oral tablet 2.5-325 mg</i>	2	QL (12 Tablet per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (8 tablets per 1 day)
<i>oxycodone-acetaminophen oral tablet 7.5-300 mg</i>	2	
PRIALT INTRATHECAL SOLUTION 100 MCG/ML	BB	PA
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	2	QL (8 tablets per 1 day)
Nonsteroidal Anti-Inflamm. Agents, Misc		
DICLOSAICIN TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 %	Non-Formulary	ALT (Covered Alternatives: Diclofenac Sodium 1% gel, Diclofenac 1.5% topical solution); QL (12.9 grams per 1 day)
TOLECTIN 600 ORAL TABLET 600 MG	Non-Formulary	ALT (Covered Alternatives: TOLMETIN SODIUM Tablets, TOLMETIN SODIUM Capsules); QL (3 Tablets per 1 Day)
<i>tolmetin oral capsule 400 mg</i>	2	
Opioid Agonists (28:08)		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	2	QL (4500 ML per 30 days)
<i>acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml</i>	2	QL (50 ML per 1 Day)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	2	QL (10 tablets per 1 day)
ASCOMP WITH CODEINE ORAL CAPSULE 30-50-325-40 MG	2	QL (6 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	Non-Formulary	ALT (Covered Alternatives: BUTALB-ACETAMIN-CAF-COD 50-325)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	2	QL (6 tablets per 1 day)
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	2	QL (4 tablets per 1 day)
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	2	QL (6 tablets per 1 day)
<i>codeine-butalbital-asa-caff oral capsule 30-50-325-40 mg</i>	2	QL (6 capsules per 1 day)
<i>codeine-guaifenesin oral liquid 10-100 mg/5 ml</i>	2	
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	2	QL (8 tablets per 1 day)
<i>fentanyl (pf)-bupivacaine-nacl epidural syringe 2 mcg/ml- 0.125 %</i>	BB	
<i>fentanyl (pf)-bupivacaine-nacl injection solution 2 mcg/ml- 0.0625 %, 2 mcg/ml- 0.125 %</i>	BB	
<i>fentanyl citrate (pf) intravenous pt controlled analgesia syring 1,500 mcg/30 ml (50 mcg/ml), 2,500 mcg/50 ml (50 mcg/ml)</i>	BB	
<i>fentanyl citrate (pf) intravenous solution 50 mcg/ml</i>	BB	
<i>fentanyl citrate (pf)-0.9%nacl intravenous pt controlled analgesia syring 1,500 mcg/30 ml (50 mcg/ml)</i>	BB	
<i>fentanyl citrate (pf)-0.9%nacl intravenous solution 20 mcg/ml, 50 mcg/ml</i>	BB	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 200 mcg</i>	2	PA; QL (2 lozenges per 1 day)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour</i>	2	QL (10 patches per 30 days)
GUAIFENESIN DAC ORAL SYRUP 30-10-100 MG/5 ML	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydrocodone bitartrate oral capsule, oral only, er 12hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg</i>	2	PA; QL (2 capsules per 1 day)
<i>hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 100 mg, 120 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	Non-Formulary	
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15 ml</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15); QL (90 ML per 1 Day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15 SOLUTION, HYDROCODONE-ACETAMIN 5-217/10 SOLUTION); QL (60 ML per 1 Day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml(15 ml)</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCODONE-ACETAMN 7.5-325/15 SOLUTION, HYDROCODONE-ACETAMIN 5-217/10 SOLUTION); QL (60 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	2	QL (90 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	2	
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (8 tablets per 1 day)
<i>hydrocodone-acetaminophen oral tablet 2.5-325 mg</i>	2	QL (12 Tablet per 1 day)
<i>hydrocodone-chlorpheniramine oral suspension,extended rel 12 hr 10-8 mg/5 ml</i>	2	
<i>hydrocodone-homatropine oral solution 5-1.5 mg/5 ml</i>	2	QL (240 ML per 30 days)
<i>hydrocodone-homatropine oral solution 5-1.5 mg/5 ml (5 ml)</i>	Non-Formulary	QL (240 ML per 30 Days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 7.5-200 mg</i>	2	QL (8 tablets per 1 day)
<i>hydrocodone-ibuprofen oral tablet 5-200 mg</i>	2	QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydromorphone (pf)-0.9 % nacl intravenous pt controlled analgesia syring 30 mg/30 ml (1 mg/ml)</i>	BB	
<i>hydromorphone in 0.9 % nacl intravenous pt controlled analgesia syring 30 mg/30 ml (1 mg/ml)</i>	BB	
<i>hydromorphone oral liquid 1 mg/ml</i>	2	QL (945 ml per 1 fill)
<i>hydromorphone oral tablet 2 mg, 4 mg, 8 mg</i>	2	QL (4 tablets per 1 day)
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg</i>	2	QL (1 Tablet per 1 day)
<i>hydromorphone(pf)-nacl,iso-osm injection syringe 2 mg/10 ml (0.2 mg/ml)</i>	BB	
<i>hydromorphone(pf)-nacl,iso-osm intravenous pt controlled analgesia syring 6 mg/30 ml (0.2 mg/ml)</i>	BB	
<i>hydromorphone(pf)-nacl,iso-osm intravenous syringe 0.4 mg/2 ml (0.2 mg/ml)</i>	BB	
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: HYDROCODONE W/ACETAMINOPHEN, MORPHINE SULFATE ER, OXYCODONE HCL ER, TRAMADOL HCL, GABAPENTIN, DICLOFENAC SODIUM, CELECOXIB)
<i>levorphanol tartrate oral tablet 2 mg</i>	4	PA; QL (6 tablets per 1 day)
<i>meperidine oral tablet 50 mg</i>	2	
<i>methadone in 0.9 % sod.chlorid intravenous syringe 5 mg/5 ml</i>	BB	
<i>methadone oral concentrate 10 mg/ml</i>	2	
<i>methadone oral solution 10 mg/5 ml, 5 mg/5 ml</i>	2	QL (900 ML per 30 days)
<i>methadone oral tablet 10 mg, 5 mg</i>	2	QL (6 tablets per 1 day)
<i>morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)</i>	2	QL (450 ML per 30 days)
<i>morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	2	QL (2 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>morphine oral solution 10 mg/5 ml</i>	2	QL (20 ML per 1 day)
<i>morphine oral solution 20 mg/5 ml (4 mg/ml)</i>	2	QL (10 ML per 1 day)
<i>morphine oral tablet 15 mg, 30 mg</i>	2	QL (4 tablets per 1 day)
<i>morphine oral tablet extended release 100 mg, 200 mg</i>	2	QL (3 tablets per 1 day)
<i>morphine oral tablet extended release 15 mg, 30 mg</i>	2	QL (6 Tablets per 1 day)
<i>morphine oral tablet extended release 60 mg</i>	2	QL (4 Tablets per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG	4	PA; QL (2 tablets per 1 day)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>oxycodone oral capsule 5 mg</i>	2	QL (4 capsules per 1 day)
<i>oxycodone oral solution 5 mg/5 ml</i>	2	QL (500 ML per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	2	QL (9 Tablets per 1 day)
<i>oxycodone oral tablet, oral only 15 mg</i>	Non-Formulary	ALT (Covered Alternatives: OXYCODONE HCL (IR) 5 MG TABLET, OXYCODONE HCL (IR) 10 MG TAB, OXYCODONE HCL (IR) 15 MG TAB, OXYCODONE HCL (IR) 20 MG TAB, OXYCODONE HCL (IR) 30 MG TAB); QL (9 Tablets per 1 day)
<i>oxycodone oral tablet, oral only 30 mg, 5 mg</i>	Non-Formulary	ALT (Covered Alternatives: OXYCODONE HCL (IR) 5 MG TABLET, OXYCODONE HCL (IR) 10 MG TAB, OXYCODONE HCL (IR) 15 MG TAB, OXYCODONE HCL (IR) 20 MG TAB, OXYCODONE HCL (IR) 30 MG TAB); QL (9 Tablets per 1 Day)
<i>oxycodone oral tablet, oral only, ext. rel. 12 hr 10 mg, 20 mg, 40 mg, 80 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (8 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>oxycodone-acetaminophen oral tablet 7.5-300 mg</i>	2	
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG	Non-Formulary	ALT (Covered Alternatives: OXYCODONE HCL ER); QL (2 tablets per 1 day)
<i>oxymorphone oral tablet 10 mg, 5 mg</i>	2	QL (6 tablets per 1 day)
<i>oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg</i>	Non-Formulary	QL (2 tablets per 1 day)
<i>promethazine-codeine oral syrup 6.25-10 mg/5 ml</i>	2	
QDOLO ORAL SOLUTION 5 MG/ML	Non-Formulary	
ROXYBOND ORAL TABLET, ORAL ONLY 10 MG, 15 MG, 30 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: OXYCODONE HCL (IR) 5 MG TABLET, OXYCODONE HCL (IR) 10 MG TAB, OXYCODONE HCL (IR) 15 MG TAB, OXYCODONE HCL (IR) 20 MG TAB); QL (9 Tablet per 1 day)
<i>tramadol oral tablet 100 mg</i>	Non-Formulary	ALT (Covered Alternatives: Tramadol 50mg, Tramadol 100mg ER); QL (2 Tablets per 1 Day)
<i>tramadol oral tablet 25 mg</i>	Non-Formulary	QL (12 Tablets per 1 Day)
<i>tramadol oral tablet 50 mg</i>	2	QL (12 tablets per 1 day)
<i>tramadol oral tablet 75 mg</i>	Non-Formulary	ALT (Covered Alternatives: TRAMADOL 50MG TABLET, TRAMADOL 100MG ER TABLET); QL (12 Tablets per 1 day)
<i>tramadol oral tablet extended release 24 hr 100 mg, 200 mg, 300 mg</i>	2	QL (2 tablets per 1 day)
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	2	QL (8 tablets per 1 day)
VIRTUSSIN AC ORAL LIQUID 10-100 MG/5 ML	2	
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: MORPHINE SULFATE ER, OXYCODONE HCL ER, FENTANYL, METHADONE HCL)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Opioid Antagonists (28:10)		
KLOXXADO NASAL SPRAY, NON-AEROSOL 8 MG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Naloxone)
<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	QL (2 doses per 90 days)
NALTREX ORAL CAPSULE 1.5 MG, 4.5 MG	Non-Formulary	ALT (Covered Alternatives: Naltrexone, Naloxone)
<i>naltrexone oral tablet 50 mg</i>	2	
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	Non-Formulary	QL (2 doses per 90 days)
VIVITROL INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 380 MG	BB	PA
Opioid Partial Agonists		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG	Non-Formulary	QL (Quantity Limits Apply)
BRIXADI SUBCUTANEOUS SOLUTION, EXTENDED REL SYRINGE 128 MG/0.36 ML, 16 MG/0.32 ML, 24 MG/0.48 ML, 32 MG/0.64 ML, 64 MG/0.18 ML, 8 MG/0.16 ML, 96 MG/0.27 ML	BB	PA
<i>buprenorphine hcl sublingual tablet 2 mg, 8 mg</i>	2	
<i>buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour</i>	2	PA; ALT (Covered Alternatives: KADIAN, OXYCODONE HCL ER, BUPRENORPHINE HYDROCHLORIDE, GABAPENTIN, DULOXETINE HCL, DICLOFENAC SODIUM); QL (0.15 unit per 1 day)
<i>buprenorphine transdermal patch weekly 7.5 mcg/hour</i>	2	ALT (Covered Alternatives: KADIAN, OXYCODONE HCL ER, BUPRENORPHINE HYDROCHLORIDE, GABAPENTIN, DULOXETINE HCL, DICLOFENAC SODIUM); QL (0.15 unit per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>buprenorphine-naloxone sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	2	QL (3 films per 1 day)
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg</i>	2	QL (3 tablets per 1 day)
<i>butorphanol nasal spray, non-aerosol 10 mg/ml</i>	2	QL (5 ML per 30 days)
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HOUR, 15 MCG/HOUR, 20 MCG/HOUR, 5 MCG/HOUR, 7.5 MCG/HOUR	Non-Formulary	ALT (Covered Alternatives: KADIAN, OXYCODONE HCL ER, BUPRENORPHINE HYDROCHLORIDE, GABAPENTIN, DULOXETINE HCL, DICLOFENAC SODIUM)
<i>pentazocine-naloxone oral tablet 50-0.5 mg</i>	2	QL (6 tablets per 1 day)
SUBLOCADE SUBCUTANEOUS SOLUTION, EXTENDED REL SYRINGE 100 MG/0.5 ML, 300 MG/1.5 ML	BB	PA
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG	Non-Formulary	ALT (Covered Alternatives: BUPRENORPHINE-NALOXONE); QL (3 films per 1 day)
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG	Non-Formulary	QL (Quantity Limits Apply)
Orexin Receptor Antagonists		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	4	PA; ALT (Covered Alternatives: ZOLPIDEM TARTRATE, ZOLPIDEM TARTRATE ER, ESZOPICLONE, TRAZODONE HCL, ZALEPLON); TD; QL (1 tablet per 1 day)
DAYVIGO ORAL TABLET 10 MG, 5 MG	Non-Formulary	QL (1 Tablet per 1 day)
QUVIVIQ ORAL TABLET 25 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: Zolpidem, Zaleplon)
Phenothiazines		
<i>chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	2	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	3	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	2	
<i>prochlorperazine rectal suppository 25 mg</i>	2	
<i>thioridazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	2	
<i>trifluoperazine oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
Respiratory And Cns Stimulants		
APTENSIO XR ORAL CAP,ER SPRINKLE,BIPHASIC 40-60 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG	Non-Formulary	QL (Quantity Limits Apply)
ASCOMP WITH CODEINE ORAL CAPSULE 30-50-325-40 MG	2	QL (6 capsules per 1 day)
<i>atomoxetine oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</i>	2	
AZSTARYS ORAL CAPSULE 26.1 MG- 5.2 MG, 39.2 MG- 7.8 MG, 52.3 MG- 10.4 MG	Non-Formulary	
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	Non-Formulary	ALT (Covered Alternatives: BUTALB-ACETAMIN-CAF-COD)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	2	QL (6 tablets per 1 day)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	2	QL (5 capsules per 1 day)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	2	
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	2	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	2	QL (6 capsules per 1 day)
<i>butalbital-aspirin-caffeine oral tablet 50-325-40 mg</i>	2	QL (4 tablets per 1 day)
CAFCIT INTRAVENOUS SOLUTION 60 MG/3 ML (20 MG/ML)	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>caffeine citrate intravenous solution 60 mg/3 ml (20 mg/ml)</i>	BB	
<i>codeine-butalbital-asa-caff oral capsule 30-50-325-40 mg</i>	2	QL (6 capsules per 1 day)
COTEMPLA XR-ODT ORAL TABLET,DISINTEG ER BIPHASE 24H 17.3 MG, 25.9 MG, 8.6 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER, GUANFACINE HCL ER)
DAYTRANA TRANSDERMAL PATCH 24 HOUR 10 MG/9 HR, 15 MG/9 HR, 20 MG/9 HR, 30 MG/9 HR	Non-Formulary	ALT (Covered Alternatives: Methylphenidate Patches); ST (Step Therapy Required); QL (1 patch per 1 day)
<i>dexmethylphenidate oral capsule,er biphasic 50-50 10 mg, 15 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg</i>	2	QL (1 capsule per 1 day)
<i>dexmethylphenidate oral capsule,er biphasic 50-50 20 mg</i>	2	
<i>dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	QL (3 tablets per 1 day)
FOCALIN XR ORAL CAPSULE,ER BIPHASIC 50-50 10 MG, 15 MG, 25 MG, 30 MG, 35 MG, 40 MG, 5 MG	Non-Formulary	QL (1 capsule per 1 day)
FOCALIN XR ORAL CAPSULE,ER BIPHASIC 50-50 20 MG	Non-Formulary	
JORNAY PM ORAL CAPSULE,DEL REL,EXT REL SPRINK 100 MG, 20 MG, 40 MG, 60 MG, 80 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER, GUANFACINE HCL ER)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
METADATE CD ORAL CAPSULE, ER BIPHASIC 30-70 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG	Non-Formulary	ALT (Covered Alternatives: METHYLPHENIDATE LA, METHYLPHENIDATE HCL CD, METHYLPHENIDATE ER, METHYLPHENIDATE HCL, METADATE ER); QL (2 Tablets per 1 Day)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 30 mg</i>	2	QL (3 capsules per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 40 mg, 50 mg, 60 mg</i>	2	QL (2 capsules per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 50-50 10 mg, 60 mg</i>	2	
<i>methylphenidate hcl oral capsule, er biphasic 50-50 20 mg, 30 mg, 40 mg</i>	2	QL (2 tablets per 1 day)
<i>methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml</i>	2	QL (30 ML per 1 day)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	2	QL (3 tablets per 1 day)
<i>methylphenidate hcl oral tablet extended release 10 mg, 20 mg</i>	2	QL (2 tablets per 1 day)
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg</i>	2	QL (2 tablets per 1 day)
<i>methylphenidate hcl oral tablet extended release 24hr 45 mg, 63 mg</i>	Non-Formulary	ALT (Covered Alternatives: Methylphenidate ER, Methylphenidate ER 36mg); QL (2 tablets per 1 day)
<i>methylphenidate hcl oral tablet extended release 24hr 72 mg</i>	Non-Formulary	QL (2 tablets per 1 day)
<i>methylphenidate hcl oral tablet, chewable 10 mg, 2.5 mg, 5 mg</i>	Non-Formulary	QL (3 tablets per 1 day)
<i>methylphenidate transdermal patch 24 hour 10 mg/9 hr, 15 mg/9 hr, 20 mg/9 hr, 30 mg/9 hr</i>	2	ST (Step Therapy Required- Tried and failed methylphenidate 54mg in the last 30 days); QL (1 patch per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 150 MG, 200 MG	Non-Formulary	
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 30 MG, 40 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER, GUANFACINE HCL ER)
QUILLIVANT XR ORAL SUSPENSION,EXT REL 24HR,RECON 5 MG/ML (25 MG/5 ML)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: METHYLPHENIDATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXMETHYLPHENIDATE HCL ER, ATOMOXETINE HCL, CLONIDINE HCL ER, GUANFACINE HCL ER); TD
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 36 MG, 45 MG, 54 MG, 63 MG, 72 MG	Non-Formulary	ALT (Covered Alternatives: METHYLPHENIDATE ER); QL (2 Tablets per 1 day)
Reversible Cox-1/Cox-2 Inhibitors		
CHILDREN'S IBUPROFEN ORAL SUSPENSION 100 MG/5 ML	2	
COXANTO ORAL CAPSULE 300 MG	Non-Formulary	QL (4 Capsules per 1 Day)
<i>diclofenac epolamine transdermal patch 12 hour 1.3 %</i>	Non-Formulary	
<i>diclofenac potassium oral capsule 25 mg</i>	Non-Formulary	
<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 (300 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>diclofenac sodium topical gel 3 %</i>	2	QL (100 GM per 30 days)
<i>diclofenac sodium topical solution in metered-dose pump 20 mg/gram /actuation(2 %)</i>	Non-Formulary	ALT (Covered Alternatives: Diclofenac Sodium Tablets, Celecoxib, Ibuprofen, Meloxicam, Naproxen, Nabumetone)
<i>diclofenac-misoprostol oral tablet,ir,delayed rel,biphasic 75-200 mg-mcg</i>	2	
<i>diflunisal oral tablet 500 mg</i>	2	QL (3 tablets per 1 day)
<i>etodolac oral capsule 200 mg, 300 mg</i>	2	QL (3 capsules per 1 day)
<i>etodolac oral tablet 400 mg, 500 mg</i>	2	QL (3 tablets per 1 day)
<i>etodolac oral tablet extended release 24 hr 400 mg, 500 mg, 600 mg</i>	2	QL (1 tablet per 1 day)
<i>fenoprofen oral capsule 200 mg, 400 mg</i>	Non-Formulary	ALT (Covered Alternatives: IBUPROFEN, MEDIPROXEN, ETODOLAC, NABUMETONE)
<i>fenoprofen oral tablet 600 mg</i>	Non-Formulary	ALT (Covered Alternatives: IBUPROFEN, MEDIPROXEN, ETODOLAC, NABUMETONE)
FENOPRON ORAL CAPSULE 300 MG	Non-Formulary	ALT (Covered Alternatives: Ibuprofen, Naproxen, Etodolac); QL (4 Capsules per 1 Day)
FLECTOR TRANSDERMAL PATCH 12 HOUR 1.3 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PIROXICAM, DICLOFENAC SODIUM, DICLOFENAC SODIUM, MELOXICAM, NABUMETONE, NAPROXEN, CELECOXIB)
<i>flurbiprofen oral tablet 100 mg</i>	2	
<i>flurbiprofen sodium ophthalmic (eye) drops 0.03 %</i>	2	
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 7.5-200 mg</i>	2	QL (8 tablets per 1 day)
<i>hydrocodone-ibuprofen oral tablet 5-200 mg</i>	2	QL (1 tablet per 1 day)
<i>ibuprofen oral suspension 100 mg/5 ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>ibuprofen oral tablet 300 mg</i>	Non-Formulary	ALT (Covered Alternatives: IBUPROFEN 400MG, IBUPROFEN 600MG, IBUPROFEN 800MG)
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	2	
<i>indomethacin oral capsule 25 mg</i>	2	QL (12 capsules per 1 day)
<i>indomethacin oral capsule 50 mg</i>	2	
<i>indomethacin oral capsule, extended release 75 mg</i>	2	
<i>indomethacin rectal suppository 100 mg</i>	Non-Formulary	ALT (Covered Alternatives: Indomethacin Capsules, Indomethacin ER Capsules, Colchicine, Febuxostat, Probenacid); QL (1 suppository per 1 day)
<i>ketoprofen oral capsule 25 mg</i>	Non-Formulary	ALT (Covered Alternatives: CELECOXIB, MELOXICAM); QL (12 Capsules per 1 day)
<i>ketoprofen oral capsule 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: CELECOXIB, MELOXICAM); QL (6 Capsules per 1 day)
<i>ketoprofen oral capsule 75 mg</i>	Non-Formulary	ALT (Covered Alternatives: CELECOXIB, MELOXICAM); QL (4 Capsules per 1 day)
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	Non-Formulary	ALT (Covered Alternatives: CELECOXIB, MELOXICAM); QL (1 Capsules per 1 day)
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	2	QL (5 ML per 30 days)
<i>ketorolac injection solution 30 mg/ml</i>	2	QL (10 ML per 30 days)
<i>ketorolac injection syringe 15 mg/ml, 30 mg/ml</i>	2	QL (5 syringes per 30 days)
<i>ketorolac intramuscular solution 60 mg/2 ml</i>	2	QL (4 ML per 30 days)
<i>ketorolac intramuscular syringe 60 mg/2 ml</i>	2	QL (5 syringes per 30 days)
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	2	QL (5 ML per 1 fill)
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	2	
<i>ketorolac oral tablet 10 mg</i>	2	
LICART TRANSDERMAL PATCH 24 HOUR 1.3 %	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>meclofenamate oral capsule 100 mg, 50 mg</i>	2	
<i>mefenamic acid oral capsule 250 mg</i>	Non-Formulary	ALT (Covered Alternatives: IBUPROFEN, DICLOFENAC SODIUM, NAPROXEN SODIUM, ETODOLAC, PIROXICAM, CELECOXIB)
<i>meloxicam oral suspension 7.5 mg/5 ml</i>	Non-Formulary	ALT (Covered Alternatives: Meloxicam Tablets)
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	2	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	2	
NALFON ORAL CAPSULE 400 MG	Non-Formulary	ALT (Covered Alternatives: IBUPROFEN, NAPROXEN SODIUM, ETODOLAC, NABUMETONE)
NALFON ORAL TABLET 600 MG	Non-Formulary	ALT (Covered Alternatives: IBUPROFEN, NAPROXEN SODIUM, ETODOLAC, NABUMETONE)
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 750 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>naproxen oral suspension 125 mg/5 ml</i>	2	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	2	
<i>naproxen oral tablet, delayed release (dr/ec) 375 mg, 500 mg</i>	2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	
<i>naproxen sodium oral tablet, er multiphase 24 hr 750 mg</i>	Non-Formulary	ALT (Covered Alternatives: Naproxen Tablets, Naproxen Caplets)
<i>oxaprozin oral tablet 600 mg</i>	2	
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DICLOFENAC SODIUM, DICLOFENAC SODIUM, CELECOXIB, IBUPROFEN, MELOXICAM, NAPROXEN, NABUMETONE)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	
SPRIX NASAL SPRAY, NON-AEROSOL 15.75 MG/SPRAY	Non-Formulary	QL (Quantity Limits Apply); SP
<i>sulindac oral tablet 150 mg, 200 mg</i>	2	
VIMOVO ORAL TABLET, IR, DELAYED REL, BIPHASIC 500-20 MG	Non-Formulary	ALT (Covered Alternatives: ESOMEPRAZOLE MAGNESIUM, NAPROXEN)
ZIPSOR ORAL CAPSULE 25 MG	Non-Formulary	QL (Quantity Limits Apply)
Salicylates		
ASCOMP WITH CODEINE ORAL CAPSULE 30-50-325-40 MG	2	QL (6 capsules per 1 day)
ASPIRIN CHILDRENS ORAL TABLET, CHEWABLE 81 MG	2	HCR; QL (1 tablet per 1 day)
<i>aspirin oral tablet 325 mg</i>	2	HCR
<i>aspirin oral tablet, chewable 81 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>aspirin oral tablet, delayed release (dr/ec) 325 mg, 81 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg</i>	2	QL (2 capsules per 1 day)
BAYER ASPIRIN ORAL TABLET, DELAYED RELEASE (DR/EC) 325 MG	2	HCR; QL (1 tablet per 1 day)
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	2	QL (6 capsules per 1 day)
<i>carisoprodol-aspirin oral tablet 200-325 mg</i>	2	QL (4 tablets per 1 day)
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	2	QL (4 tablets per 1 day)
CHILDREN'S ASPIRIN ORAL TABLET, CHEWABLE 81 MG	2	HCR; QL (1 tablet per 1 day)
<i>codeine-butalbital-asa-caff oral capsule 30-50-325-40 mg</i>	2	QL (6 capsules per 1 day)
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	3	PA
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG	3	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Sel.Serotonin,Norepi Reuptake Inhibitor		
<i>desvenlafaxine oral tablet extended release 24 hr 100 mg, 50 mg</i>	Non-Formulary	
<i>desvenlafaxine succinate oral tablet extended release 24 hr 100 mg, 25 mg, 50 mg</i>	2	QL (1 tablet per 1 day)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG	Non-Formulary	
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	2	QL (3 capsules per 1 day)
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: DULOXETINE HCL, DULOXETINE HCL, DULOXETINE HCL); QL (1 capsule per 1 day)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	Non-Formulary	ALT (Covered Alternatives: VENLAFAXINE HCL, DULOXETINE HCL, CITALOPRAM HBR, ESCITALOPRAM OXALATE, FLUOXETINE HCL, FLUVOXAMINE MALEATE, PAROXETINE HCL); QL (1 capsule per 1 day)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG	4	PA; ALT (Covered Alternatives: VENLAFAXINE HCL, DULOXETINE HCL, CITALOPRAM HBR, ESCITALOPRAM OXALATE, FLUOXETINE HCL, FLUVOXAMINE MALEATE, PAROXETINE HCL); QL (1 capsule per 1 day)
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 25 MG, 50 MG	Non-Formulary	QL (1 tablet per 1 day)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	4	PA; QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42)	4	PA; QL (2 tablets per 1 day)
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	2	QL (2 capsules per 1 day)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	2	QL (5 capsules per 1 day)
<i>venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	QL (3 tablets per 1 day)
Selective Serotonin Agonists		
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	2	QL (12 tablets per 30 days)
<i>eletriptan oral tablet 20 mg, 40 mg</i>	2	QL (12 tablets per 30 days)
FROVA ORAL TABLET 2.5 MG	Non-Formulary	QL (12 tablets per 30 days)
<i>frovatriptan oral tablet 2.5 mg</i>	2	ALT (Covered Alternatives: ZOLMITRIPTAN, ALMOTRIPTAN MALATE, NARATRIPTAN HCL, RIZATRIPTAN, SUMATRIPTAN SUCCINATE); QL (12 tablets per 30 days)
<i>naratriptan oral tablet 1 mg, 2.5 mg</i>	2	QL (12 tablets per 30 days)
ONZETRA XSAIL NASAL AEROSOL POWDR BREATH ACTIVATED 11 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: SUMATRIPTAN, SUMATRIPTAN SUCCINATE, ZOLMITRIPTAN, NARATRIPTAN HCL, RIZATRIPTAN)
RELPAK ORAL TABLET 20 MG, 40 MG	Non-Formulary	QL (12 tablets per 1 fill)
REYVOW ORAL TABLET 100 MG, 50 MG	5	PA; SP; QL (8 tablets per 30 days)
<i>rizatriptan oral tablet 10 mg, 5 mg</i>	2	QL (12 tablets per 30 days)
<i>rizatriptan oral tablet,disintegrating 10 mg, 5 mg</i>	2	QL (12 tablets per 30 days)
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation, 5 mg/actuation</i>	2	QL (6 nasal sprays per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (18 tablets per 30 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml, 6 mg/0.5 ml</i>	2	QL (6 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml</i>	2	QL (6 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5 ml</i>	2	QL (6 ML per 30 days)
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	2	QL (6 ML per 30 days)
TOSYMRA NASAL SPRAY, NON-AEROSOL 10 MG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply)
ZEMBRACE SYMTOUCH SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: SUMATRIPTAN SUCCINATE, SUMATRIPTAN, SUMATRIPTAN SUCCINATE, ZOLMITRIPTAN, NARATRIPTAN HCL, RIZATRIPTAN)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	2	QL (12 tablets per 30 days)
<i>zolmitriptan oral tablet, disintegrating 2.5 mg, 5 mg</i>	Non-Formulary	
ZOMIG NASAL SPRAY, NON-AEROSOL 2.5 MG	Non-Formulary	ALT (Covered Alternatives: ZOLMITRIPTAN, ALMOTRIPTAN, NARATRIPTAN, RIZATRIPTAN)
ZOMIG NASAL SPRAY, NON-AEROSOL 5 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: ZOLMITRIPTAN, ALMOTRIPTAN, NARATRIPTAN, RIZATRIPTAN)
ZOMIG ORAL TABLET 2.5 MG, 5 MG	Non-Formulary	QL (12 tablets per 1 fill)
Selective-Serotonin Reuptake Inhibitors		
<i>citalopram oral solution 10 mg/5 ml</i>	2	
<i>citalopram oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>escitalopram oxalate oral solution 5 mg/5 ml</i>	2	QL (60 ML per 30 days)
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	2	QL (2 tablets per 1 day)
<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>fluoxetine oral tablet 10 mg, 20 mg</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>fluoxetine oral tablet 60 mg</i>	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: FLUOXETINE HCL, FLUOXETINE HCL, FLUOXETINE HCL)
<i>fluvoxamine oral capsule, extended release 24hr 100 mg, 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: Fluvoxamine Tablets)
<i>fluvoxamine oral tablet 100 mg, 25 mg, 50 mg</i>	2	
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Non-Formulary	ALT (Covered Alternatives: olanzapine, fluoxetine)
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	1	QL (1 tablet per 1 day)
<i>paroxetine hcl oral tablet extended release 24 hr 12.5 mg, 25 mg, 37.5 mg</i>	2	QL (1 tablet per 1 day)
PAXIL ORAL SUSPENSION 10 MG/5 ML	Non-Formulary	ALT (Covered Alternatives: PAROXETINE HCL, FLUOXETINE HCL)
<i>sertraline oral capsule 150 mg, 200 mg</i>	Non-Formulary	ALT (Covered Alternatives: Sertraline Tablets); QL (1 Capsule per 1 Day)
<i>sertraline oral concentrate 20 mg/ml</i>	2	
<i>sertraline oral tablet 100 mg, 25 mg, 50 mg</i>	2	
ZOLOFT ORAL CONCENTRATE 20 MG/ML	Non-Formulary	QL (Quantity Limits Apply)
ZOLOFT ORAL TABLET 100 MG, 25 MG, 50 MG	Non-Formulary	QL (Quantity Limits Apply)
Serotonin Modulators		
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	2	QL (4 tablets per 1 day)
<i>mirtazapine oral tablet 7.5 mg</i>	2	QL (2 tablets per 1 day)
<i>mirtazapine oral tablet, disintegrating 15 mg, 30 mg, 45 mg</i>	2	
<i>nefazodone oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	2	
<i>trazodone oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	2	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	4	PA; QL (Quantity Limits Apply); QL (1 Tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG	Non-Formulary	ALT (Covered Alternatives: VILAZODONE, PAROXETINE HCL, CITALOPRAM HBR, ESCITALOPRAM OXALATE, FLUOXETINE HCL, SERTRALINE HCL, DULOXETINE HCL, VENLAFAXINE HCL ER); QL (1 tablet per 1 day)
<i>vilazodone oral tablet 10 mg, 20 mg, 40 mg</i>	2	ALT (Covered Alternatives: PAROXETINE HCL, CITALOPRAM HBR, ESCITALOPRAM OXALATE, FLUOXETINE HCL, SERTRALINE HCL, DULOXETINE HCL, VENLAFAXINE HCL ER); QL (1 TABLET per 1 day)
Succinimides		
CELONTIN ORAL CAPSULE 300 MG	Non-Formulary	ALT (Covered- Alternatives: METHSUXIMIDE); QL (4 capsules per 1 day)
<i>ethosuximide oral capsule 250 mg</i>	2	QL (7 capsules per 1 day)
<i>ethosuximide oral solution 250 mg/5 ml</i>	2	
<i>methsuximide oral capsule 300 mg</i>	2	QL (4 Capsules per 1 day)
ZARONTIN ORAL SOLUTION 250 MG/5 ML	Non-Formulary	
Thioxanthenes		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
Tricyclics, Other Norepi-Ru Inhibitors		
<i>amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg</i>	3	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	2	
ANAFRANIL ORAL CAPSULE 25 MG, 50 MG, 75 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>clomipramine oral capsule 25 mg, 50 mg, 75 mg</i>	2	
<i>desipramine oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>doxepin oral concentrate 10 mg/ml</i>	2	
<i>doxepin oral tablet 3 mg, 6 mg</i>	2	ST (Step Therapy Required); QL (1 tablet per 1 day)
<i>doxepin topical cream 5 %</i>	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUCINONIDE, TACROLIMUS)
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	2	
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	2	
<i>nortriptyline oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	2	QL (4 capsules per 1 day)
<i>nortriptyline oral solution 10 mg/5 ml</i>	2	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	3	
<i>protriptyline oral tablet 10 mg, 5 mg</i>	2	
PRUDOXIN TOPICAL CREAM 5 %	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUCINONIDE, TACROLIMUS)
SILENOR ORAL TABLET 3 MG, 6 MG	Non-Formulary	ALT (Covered Alternatives: ZOLPIDEM TARTRATE, TRAZODONE HCL, ESZOPICLONE, ZALEPLON); QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>trimipramine oral capsule 100 mg, 25 mg, 50 mg</i>	2	
Vesicular Monoamine Transport2 Inhibitor		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: Tetrabenazine Tablets); QL (4 Tablets per 1 day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tetrabenazine); QL (1 Tablet per 1 day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 18 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tetrabenazine); QL (1 Tablet per 1 Day)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tetrabenazine)
INGREZZA INITIATION PK(TARDIV) ORAL CAPSULE,DOSE PACK 40 MG (7)- 80 MG (21)	6	PA; SP; ALT (Covered Alternatives: TETRABENAZINE); QL (1 pack per 1 year)
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG	6	PA; SP; ALT (Covered Alternatives: TETRABENAZINE); QL (1 capsule per 1 day)
INGREZZA SPRINKLE ORAL CAPSULE, SPRINKLE 40 MG, 60 MG, 80 MG	Non-Formulary	PA; SP; ALT (Covered Alternatives: Ingrezza Capsules, Tetrabenazine); QL (1 Capsules per 1 Day)
<i>tetrabenazine oral tablet 12.5 mg</i>	5	SP; QL (1 tablet per 1 day)
<i>tetrabenazine oral tablet 25 mg</i>	5	SP; QL (2 Tablets per 1 day)
XENAZINE ORAL TABLET 12.5 MG, 25 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
Wakefulness-Promoting Agents		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	2	QL (1 tablet per 1 day)
<i>armodafinil oral tablet 50 mg</i>	2	QL (2 Tablets per 1 day)
LUMRYZ ORAL EXTEND RELEASE GRANULES,PACKET 4.5 GRAM, 6 GRAM, 7.5 GRAM, 9 GRAM	Non-Formulary	SP; QL (1 Packet per 1 day)
<i>modafinil oral tablet 100 mg, 200 mg</i>	2	QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG, 50 MG	Non-Formulary	QL (1 tablet per 1 day)
<i>sodium oxybate oral solution 500 mg/ml</i>	2	PA; SP; QL (18 ML per 1 day)
SUNOSI ORAL TABLET 150 MG, 75 MG	4	PA; SP; QL (1 tablet per 1 day)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
XYREM ORAL SOLUTION 500 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Sodium Oxybate); QL (18 ML per 1 day)
XYWAV ORAL SOLUTION 0.5 GRAM/ML	Non-Formulary	SP; QL (18 ML per 1 day)
DENTAL AGENTS		
Nutritional Supplements		
DENTA 5000 PLUS SENSITIVE DENTAL PASTE 1.1-5 %	Non-Formulary	ALT (Covered Alternatives: DENTA 5000 PLUS CREAM, DENTAGEL GEL); QL (100 ml per 30 Days)
<i>fluoride (sodium) oral drops 0.5 mg (1.1 mg sod.fluorid)/ml</i>	2	HCR
<i>fluoride (sodium) oral tablet, chewable 0.25 mg(0.55 mg sod. fluoride), 0.5 mg (1.1 mg sodium fluorid)</i>	2	HCR
<i>sodium fluoride-pot nitrate dental paste 1.1-5 %</i>	1	
DEVICES		
Devices		
AEROCHAMBER PLUS FLOW-VU SPACER	7	QL (1 spacer per 365 days)
AEROCHAMBER PLUS Z STAT SPACER	7	QL (1 spacer per 365 days)
ASSURE PLATINUM GLUCOSE METER	Non-Formulary	ALT (Covered Alternatives: FREESTYLE PREC NEO METER, FREESTYLE LITE METER, FREESTYLE INSULINX METER)
AUTOLET LITE	Non-Formulary	QL (1 Device per 30 Days)
BINAXNOW COVID AG CARD HOME TST KIT	7	
BINAXNOW COVID-19 AG SELF TEST KIT	7	
BLULINK DIABETIC TEST BUNDLE KIT	Non-Formulary	
BLULINK GLUCOSE MONITOR SYSTEM	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
BREATHERITE MDI SPACER SPACER	7	QL (1 spacer per 365 days)
CARESTART COVID-19 AG HOME TST KIT	7	
CLEVER CHOICE CHAMBER-LRG MASK SPACER	7	QL (1 spacer per 365 days)
CLEVER CHOICE CHAMBER-MED MASK SPACER	7	QL (1 spacer per 365 days)
CLEVER CHOICE CHAMBER-SM MASK SPACER	7	QL (1 spacer per 365 days)
CLINITEST COVID-19 HOME TEST KIT	7	
COMPACT SPACE CHAMBER SPACER	7	QL (1 spacer per 365 days)
CONTOUR PLUS BLUE METER	Non-Formulary	ALT (Covered Alternatives: Freestyle Precision Neo)
COVID-19 AT-HOME TEST KIT	7	
DEXCOM G6 RECEIVER	0	ST (Step Therapy Required- Tried and failed any insulin products in the last 120 days); QL (1 Receiver per 1 Year)
DEXCOM G6 SENSOR DEVICE	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (3 Sensors per 30 days)
DEXCOM G6 TRANSMITTER DEVICE	0	ST (Step Therapy Required- Tried and failed any insulin products in the last 120 days); QL (1 transmitter per 90 days)
DEXCOM G7 RECEIVER	0	ST (Step Therapy Required- Tried and failed any insulin products in the last 120 days); QL (1 Receiver per 1 Year)
DEXCOM G7 SENSOR DEVICE	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (3 Sensors per 30 days)
EASIVENT HOLDING CHAMBER SPACER	7	QL (1 spacer per 365 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
EASY TRAK II BLOOD GLUCOSE MTR	Non-Formulary	ALT (Covered Alternatives: Freestyle Neo Meter, Freestyle Lite Meter, Freestyle Freedom Lite Meter)
EASYMAX T1 KIT	Non-Formulary	
ELLUME COVID-19 HOME TEST KIT	7	
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM	5	
FLEXICHAMBER SPACER	7	QL (1 spacer per 365 days)
FLOWFLEX COVID-19 AG HOME TEST KIT	7	
FORA TN'G ADV MOBILE MULTI MTR DEVICE	Non-Formulary	ALT (Covered Alternatives: Precision Xtra Ketone Strips)
FREESTYLE CONTROL SOLUTION	0	QL (1 bottle per 90 days)
FREESTYLE FREEDOM LITE KIT	0	QL (1 meter per 1 year)
FREESTYLE INSULINX	0	QL (1 meter per 1 year)
FREESTYLE LANCETS 28 GAUGE	0	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)
FREESTYLE LIBRE 14 DAY READER	0	ST (Step Therapy Required- Tried and failed any insulin products in the last 120 days); QL (1 reader per 1 year)
FREESTYLE LIBRE 14 DAY SENSOR KIT	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (2 sensors per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR DEVICE	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (2 Sensors per 30 Days)
FREESTYLE LIBRE 2 READER	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (1 reader per 1 year)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FREESTYLE LIBRE 2 SENSOR KIT	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (2 sensors per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR DEVICE	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (2 Sensors per 30 days)
FREESTYLE LIBRE 3 READER	0	ST (Step Therapy Required- Tried and failed any insulin products in the last 120 days); QL (1 Reader per 1 Year)
FREESTYLE LIBRE 3 SENSOR DEVICE	0	ST (Step Therapy Required- Tried and failed any insulin or 3 oral antidiabetic products in the last 120 days); QL (2 sensors per 28 days)
FREESTYLE LITE METER KIT	0	QL (1 meter per 1 year)
FREESTYLE PRECISION NEO METER	0	QL (1 meter per 1 year)
GLUCOSE KETONE CONTROL SOLN SOLUTION	0	QL (1 bottle per 90 days)
GUARDIAN 4 GLUCOSE SENSOR DEVICE	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: FREESTYLE LIBRE SENSOR, DEXCOM)
GUARDIAN 4 TRANSMITTER DEVICE	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: FREESTYLE LIBRE SENSOR, DEXCOM)
GUARDIAN LINK 3 TRANSMITTER DEVICE	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: FREESTYLE LIBRE SENSOR, DEXCOM)
GUARDIAN SENSOR 3 DEVICE	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: FREESTYLE LIBRE SENSOR, DEXCOM)
<i>heparin (porcine) in 0.9% nacl intravenous parenteral solution 2,500 unit/500 ml (5 unit/ml)</i>	BB	
IHEALTH COVID-19 AG HOME TEST KIT	7	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
IHEALTH GLUCO PLUS METER KIT	Non-Formulary	ALT (Covered Alternatives: FREESTYLE PREC NEO METER, FREESTYLE LITE METER, FREESTYLE INSULINX METER)
INDICAID COVID-19 AG HOME TEST KIT	7	
INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	2	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 0.3 ml 29 gauge x 1/2", 0.3 ml 30, 0.3 ml 31 gauge x 5/16", 0.5 ml 30 gauge x 1/2", 0.5 ml 31 gauge x 5/16", 1 ml 28 gauge, 1 ml 28 gauge x 1/2", 1 ml 29 gauge x 1/2", 1 ml 29 gauge x 7/16", 1 ml 30 gauge x 5/16, 1 ml 30 gauge x 7/16", 1 ml 31 gauge x 5/16, 1/2 ml 28 gauge, 1/2 ml 28 gauge x 1/2", 1/2 ml 29, 1/2 ml 30 gauge</i>	2	
INTELISWAB COVID-19 HOME TEST KIT	7	
<i>lancets</i>	0	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)
LITEAIRE MDI CHAMBER SPACER	7	QL (1 spacer per 365 days)
MEDISENSE GLUCOSE KETONE COMBO PACK	4	QL (1 Unit per 90 days)
NOVOFINE 32 NEEDLE 32 GAUGE X 1/4"	2	
NOVOFINE PLUS NEEDLE 32 GAUGE X 1/6"	2	
NOVOPEN ECHO SUBCUTANEOUS INSULIN PEN	Non-Formulary	
OMNIPOD 5 (G6/LIBRE 2 PLUS) SUBCUTANEOUS CARTRIDGE	4	ST (Step Therapy Required- Tried and failed 90 day treatment of an insulin product in the last 120 days); QL (10 Pods per 30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5) SUBCUTANEOUS CARTRIDGE	4	ST (Step Therapy Required- Tried and failed 90 day treatment of an insulin product in the last 120 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
OMNIPOD 5 G6-G7 PODS (GEN 5) SUBCUTANEOUS CARTRIDGE	4	ST (Step Therapy Required- Tried and failed 90 day treatment of an insulin product in the last 120 days); QL (10 Pods per 30 Days)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS) SUBCUTANEOUS CARTRIDGE	4	ST (Step Therapy Required- Tried and failed 90 day treatment of an insulin product in the last 120 days); QL (1 Kit per 2 Yearss)
OMNIPOD DASH PODS (GEN 4) SUBCUTANEOUS CARTRIDGE	4	ST (Step Therapy Required- Tried and failed 90 day treatment of an insulin product in the last 120 days); QL (10 pods per 30 days)
ON-GO COVID-19 AG AT HOME TEST KIT	7	
OPTICHAMBER DIAMOND LG MASK SPACER	7	QL (1 spacer per 365 days)
OPTICHAMBER DIAMOND VHC SPACER	7	QL (1 spacer per 365 days)
OPTICHAMBER DIAMOND-MED MSK SPACER	7	QL (1 spacer per 365 days)
OPTICHAMBER DIAMOND-SML MASK SPACER	7	QL (1 spacer per 365 days)
PEN NEEDLE NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16"	2	
<i>pen needle, diabetic needle 29 gauge x 1/2", 31 gauge x 1/4", 31 gauge x 5/16", 32 gauge x 5/32"</i>	2	
PLATINUM GLUCOSE METER KIT	Non-Formulary	ALT (Covered Alternatives: FREESTYLE PREC NEO METER, FREESTYLE LITE METER, FREESTYLE INSULINX METER)
POCKET CHAMBER SPACER	7	QL (1 spacer per 365 days)
PRECISION XTRA B-KETONE STRIP	2	QL (1 strip per 1 day)
PRECISION XTRA MONITOR	0	QL (1 meter per 1 year)
PRO COMFORT SPACER-ADULT MASK SPACER	7	QL (1 spacer per 365 days)
PRO COMFORT SPACER-CHILD MASK SPACER	7	QL (1 spacer per 365 days)
PROCHAMBER SPACER	7	QL (1 spacer per 365 days)
QUICKVUE AT-HOME COVID-19 TEST KIT	7	
RITEFLO AEROCHAMBER SPACER	7	QL (1 spacer per 365 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SALIVAMAX MUCOUS MEMBRANE POWDER IN PACKET 351 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>sodium chloride inhalation solution for nebulization 10 %, 7 %</i>	2	
<i>sodium chloride inhalation solution for nebulization 3 %</i>	7	
ULTILET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	2	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 1/2 ML 28 GAUGE X 1/2"	2	
VIVAGUARD INO CTRL SOLN-L1,2,3 SOLUTION	Non-Formulary	ALT (Covered Alternatives: FREESTYLE CONTROL SOLUTION)
VIVAGUARD INO CTRL SOLN-L1,L3 SOLUTION	Non-Formulary	ALT (Covered Alternatives: FREESTYLE CONTROL SOLUTION)
VIVAGUARD INO CTRL SOLN-L2 SOLUTION	Non-Formulary	ALT (Covered Alternatives: FREESTYLE CONTROL SOLUTION)
DIAGNOSTIC AGENTS		
Adrenocortical Insufficiency		
ACTHAR INJECTION GEL 80 UNIT/ML	Non-Formulary	QL (Quantity Limits Apply); SP
ACTHAR SELFJECT SUBCUTANEOUS PEN INJECTOR 40 UNIT/0.5 ML, 80 UNIT/ML	Non-Formulary	SP
CORTROPHIN GEL INJECTION GEL 80 UNIT/ML	Non-Formulary	SP
Cardiac Function		
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg</i>	2	QL (2 capsules per 1 day)
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Diabetes Mellitus		
ASSURE PLATINUM TEST STRIP STRIP	Non-Formulary	ALT (Covered Alternatives: FREESTYLE PREC NEO TEST STRIPS, FREESTYLE LITE TEST STRIP, FREESTYLE INSULINX TEST STRIPS)
BLULINK GLUCOSE TEST STRIP STRIP	Non-Formulary	
CONTOUR PLUS TEST STRIP STRIP	Non-Formulary	ALT (Covered Alternatives: Freestyle Precision Neo)
FREESTYLE INSULINX STRIP	2	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)
FREESTYLE INSULINX TEST STRIPS STRIP	2	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)
FREESTYLE LITE STRIPS STRIP	2	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)
FREESTYLE PRECISION NEO STRIPS STRIP	0	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)
FREESTYLE TEST STRIP	2	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PLATINUM TEST STRIP STRIP	Non-Formulary	ALT (Covered Alternatives: FREESTYLE PREC NEO TEST STRIPS, FREESTYLE LITE TEST STRIP, FREESTYLE INSULINX TEST STRIPS)
PRECISION XTRA TEST STRIP	2	QL (Long Acting Insulin/Oral Diabetes Med hx=300/90 days, Short Acting Insulin hx= <18: 720/90, 18 and older: 600/90 days. Gestational Diabetes = 5/day)
Ocular Disorders		
<i>fluorescein ophthalmic (eye) strip 1 mg</i>	BB	
Pheochromocytoma		
<i>metirosine oral capsule 250 mg</i>	Non-Formulary	SP
Pituitary Function		
METOPIRONE ORAL CAPSULE 250 MG	Non-Formulary	SP
Roentgenography And Other Imaging Agents		
<i>gadoteridol intravenous solution 279.3 mg/ml</i>	BB	
<i>iopamidol injection solution 200 mg iodine /ml (41 %)</i>	BB	
<i>iopamidol intrathecal solution 200 mg iodine /ml (41 %), 300 mg iodine /ml (61 %)</i>	BB	
<i>iopamidol intravenous solution 250 mg iodine /ml (51 %), 300 mg iodine /ml (61 %), 370 mg iodine /ml (76 %)</i>	BB	
Thyroid Function		
THYROGEN INTRAMUSCULAR RECON SOLN 0.9 MG	BB	
ELECTROLYTIC, CALORIC, AND WATER BALANCE		
Alkalinizing Agents		
<i>potassium citrate oral tablet extended release 10 meq (1,080 mg), 15 meq, 5 meq (540 mg)</i>	2	
<i>sodium citrate intra-catheter solution 4 %</i>	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>tromethamine intravenous solution 36 mg/ml (0.3 m)</i>	BB	
Ammonia Detoxicants		
BUPHENYL ORAL POWDER 0.94 GRAM/GRAM	Non-Formulary	SP; QL (3 gm per 1 day)
BUPHENYL ORAL TABLET 500 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
CARBAGLU ORAL TABLET, DISPERSIBLE 200 MG	Non-Formulary	SP
CONSTULOSE ORAL SOLUTION 10 GRAM/15 ML	2	
KRISTALOSE ORAL PACKET 10 GRAM, 20 GRAM	3	QL (1 Packet per 1 day)
<i>lactulose oral packet 10 gram</i>	Non-Formulary	ALT (Covered Alternatives: Lactulose Solution, Kristalose Packets); QL (1 Packet per 1 day)
<i>lactulose oral packet 20 gram</i>	Non-Formulary	ALT (Covered Alternatives: KRISTALOSE PACKET, LACTULOSE 10 GM/15 ML SOLUTION); QL (1 Packet per 1 Day)
<i>lactulose oral solution 10 gram/15 ml</i>	2	
LITHOSTAT ORAL TABLET 250 MG	Non-Formulary	
OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM, 4 GRAM, 5 GRAM, 6 GRAM, 6.67 GRAM	Non-Formulary	SP
PHEBURANE ORAL GRANULES 483 MG/GRAM	Non-Formulary	SP; ALT (Covered Alternatives: Sodium Phenylbutyarte 500mg Tablets, Sodium Phenylbutyarte Powder); QL (1 GM per 30 days)
RAVICTI ORAL LIQUID 1.1 GRAM/ML	Non-Formulary	SP
<i>sodium phenylbutyrate oral powder 0.94 gram/gram</i>	5	PA; SP; QL (3 GRAM per 1 day)
<i>sodium phenylbutyrate oral tablet 500 mg</i>	5	PA; SP; QL (1 tablet per 1 day)
Caloric Agents		
<i>aa 3% no.2 ped-d10-calcium-hep intravenous parenteral solution 3 %-10 %- 2.33 meq/250 ml</i>	BB	
<i>aa 3%no.2ped-d10w-calcium gluc intravenous parenteral solution 3 %-10 %- 3.75 meq/250 ml</i>	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>aa 3.5% no.2 ped-d10w-heparin intravenous parenteral solution 3.5 %-10 %- 125 unit/250 ml</i>	BB	
<i>aa2.5%no.2 ped-d10-calcium-hep intravenous parenteral solution 2.5 %-10 %- 3.75 meq/250 ml</i>	BB	
<i>aa3.5% no2 ped-d10-calcium-hep intravenous parenteral solution 3.5 %-10 %- 2.33 meq/250 ml, 3.5 %-10 %- 3.75 meq/250 ml</i>	BB	
<i>aas3%no.2ped-d5w-calc gluc-hep intravenous parenteral solution 3 %-5 %- 3.75 meq/250 ml</i>	BB	
D5 % (D-GLUCOSE)-0.9 % SODCHLR INTRAVENOUS PARENTERAL SOLUTION	BB	
<i>d5 % and 0.9 % sodium chloride intravenous parenteral solution</i>	BB	
<i>dextrose 50 % in water (d50w) intravenous parenteral solution</i>	BB	
DOJOLVI ORAL LIQUID 8.3 KCAL/ML	Non-Formulary	SP; ALT (Covered Alternatives: BETAQUIK, LIQUIGEN); QL (1 ML per 1 day)
Carbonic Anhydrase Inhibitors		
<i>acetazolamide oral capsule, extended release 500 mg</i>	2	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	2	
Diuretics, Miscellaneous		
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG	4	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	2	
<i>theophylline oral tablet extended release 24 hr 400 mg, 600 mg</i>	2	
Electrolytic,Caloric,Water Balance Misc,		
CRYSVITA SUBCUTANEOUS SOLUTION 10 MG/ML, 20 MG/ML, 30 MG/ML	BB	PA; SP; QL (0.4 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Irrigating Solutions		
<i>sodium chloride inhalation solution for nebulization 10 %, 7 %</i>	2	
<i>sodium chloride inhalation solution for nebulization 3 %</i>	7	
<i>sodium chloride injection syringe 0.9 %</i>	BB	
<i>sodium chloride irrigation solution 0.9 %</i>	2	QL (3000 ML per 30 Days)
Loop Diuretics (40:28)		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
EDECIN ORAL TABLET 25 MG	Non-Formulary	QL (2 tablet per 1 day)
<i>ethacrynic acid oral tablet 25 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>furosemide injection solution 10 mg/ml</i>	7	
<i>furosemide oral solution 10 mg/ml, 40 mg/4 ml, 40 mg/5 ml (8 mg/ml)</i>	2	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	2	
Osmotic Diuretics		
<i>urea topical cream 20 %</i>	2	
Phosphate-Removing Agents		
AURYXIA ORAL TABLET 210 MG IRON	4	PA; QL (6 tablets per 1 day)
<i>calcium acetate(phosphat bind) oral capsule 667 mg</i>	2	
<i>ferric citrate oral tablet 210 mg iron</i>	Non-Formulary	ALT (Covered Alternatives: Auryxia); QL (6 Tablets per 1 Day)
<i>lanthanum oral tablet, chewable 1,000 mg, 500 mg, 750 mg</i>	2	QL (3 tablets per 1 day)
RENVELA ORAL POWDER IN PACKET 0.8 GRAM, 2.4 GRAM	Non-Formulary	QL (105 units per 1 fill)
RENVELA ORAL TABLET 800 MG	Non-Formulary	QL (10 tablets per 1 day)
<i>sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram</i>	2	QL (3.5 packets per 1 day)
<i>sevelamer carbonate oral tablet 800 mg</i>	2	QL (10 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>sevelamer hcl oral tablet 400 mg</i>	Non-Formulary	ALT (Covered Alternatives: Sevelamer Carbonate)
<i>sevelamer hcl oral tablet 800 mg</i>	Non-Formulary	ALT (Covered Alternatives: Sevelamer Carbonate); QL (7 tablets per 1 day)
VELPHORO ORAL TABLET,CHEWABLE 500 MG	4	PA; ALT (Covered Alternatives: CALCIUM ACETATE, SEVELAMER HCL, RENAGEL, LANTHANUM CARBONATE); QL (3 tablets per 1 day)
Potassium-Removing Agents		
LOKELMA ORAL POWDER IN PACKET 10 GRAM, 5 GRAM	4	PA; QL (2 packs per 1 day)
SPS (WITH SORBITOL) ORAL SUSPENSION 15-20 GRAM/60 ML	2	
SPS (WITH SORBITOL) RECTAL ENEMA 30-40 GRAM/120 ML	2	
VELTASSA ORAL POWDER IN PACKET 1 GRAM	Non-Formulary	ALT (Covered Alternatives: Veltassa 8.4gm powder packet, Veltassa 16.8gm powder packet, Veltassa 25.2gm powder packet); QL (1 Packet per 1 Day)
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 8.4 GRAM	4	PA; QL (1 packet per 1 day)
Potassium-Sparing Diuretics		
<i>amiloride oral tablet 5 mg</i>	2	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
CAROSPIR ORAL SUSPENSION 25 MG/5 ML	Non-Formulary	ALT (Covered Alternatives: Spironolactone Tablets); QL (15 ML per 1 day)
DYRENIUM ORAL CAPSULE 100 MG, 50 MG	Non-Formulary	QL (4 capsules per 1 day)
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>spironolactone oral suspension 25 mg/5 ml</i>	Non-Formulary	QL (15 ML per 1 day)
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>spironolacton-hydrochlorothiaz oral tablet 25-25 mg</i>	2	
<i>triamterene oral capsule 100 mg, 50 mg</i>	2	PA; QL (4 capsules per 1 day)
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	2	
<i>triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg</i>	2	
Replacement Preparations		
<i>aa 3% no.2 ped-d10-calcium-hep intravenous parenteral solution 3 %-10 %- 2.33 meq/250 ml</i>	BB	
<i>aa2.5%no.2 ped-d10-calcium-hep intravenous parenteral solution 2.5 %-10 %- 3.75 meq/250 ml</i>	BB	
<i>aa3.5% no2 ped-d10-calcium-hep intravenous parenteral solution 3.5 %-10 %- 2.33 meq/250 ml, 3.5 %-10 %- 3.75 meq/250 ml</i>	BB	
<i>aas3%no.2ped-d5w-calc gluc-hep intravenous parenteral solution 3 %-5 %- 3.75 meq/250 ml</i>	BB	
<i>chromium chloride intravenous solution 4 mcg/ml</i>	BB	
EFFER-K ORAL TABLET, EFFERVESCENT 10 MEQ, 20 MEQ	3	
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON 8 ORAL TABLET EXTENDED RELEASE 8 MEQ	2	
KLOR-CON M10 ORAL TABLET,ER PARTICLES/CRYSTALS 10 MEQ	2	
KLOR-CON M15 ORAL TABLET,ER PARTICLES/CRYSTALS 15 MEQ	2	
KLOR-CON M20 ORAL TABLET,ER PARTICLES/CRYSTALS 20 MEQ	2	
KLOR-CON ORAL PACKET 20 MEQ	2	QL (1 packet per 1 day)
OB COMPLETE ONE ORAL CAPSULE 40-10-1-300 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE PREMIER ORAL TABLET 30-20-1 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PLASMA-LYTE 148 PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	BB	
<i>potassium chloride in water intravenous piggyback 20 meq/100 ml</i>	7	
<i>potassium chloride intravenous solution 2 meq/ml</i>	7	
<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>	Non-Formulary	QL (1 packet per 1 day)
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	2	
<i>potassium chloride oral tablet, er particles/crystals 10 meq, 20 meq</i>	2	
<i>potassium phos in 0.9 % nacl intravenous solution 15 mmol/250 ml, 30 mmol/500 ml</i>	BB	
PRENATABS FA ORAL TABLET 29-1 MG	1	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG	2	
PRENATAL PLUS (CALCIUM CARB) ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATAL VITAMIN PLUS LOW IRON ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATE CHEWABLE ORAL TABLET,CHEWABLE 1 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>sodium chloride 3 % hypertonic intravenous parenteral solution 3 %</i>	5	SP
<i>sodium chloride injection syringe 0.9 %</i>	BB	
TRINATAL RX 1 ORAL TABLET 60 MG IRON-1 MG	1	
Thiazide Diuretics		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>amlodipine-valsartan-hcthiazyd oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg</i>	2	
<i>amlodipine-valsartan-hcthiazyd oral tablet 5-160-25 mg</i>	2	QL (2 tablets per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	2	
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG	Non-Formulary	QL (1 tablet per 1 day)
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	QL (2 tablets per 1 day)
<i>candesartan-hydrochlorothiazid oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	2	QL (2 tablets per 1 day)
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	2	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	
<i>fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 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	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	2	QL (1 tablet per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	
<i>losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	
<i>metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	2	QL (1 tablet per 1 day)
<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>	2	TD
<i>olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	2	QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	2	
<i>spironolacton-hydrochlorothiaz oral tablet 25-25 mg</i>	2	
<i>telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	2	QL (2 tablets per 1 day)
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	2	
<i>triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg</i>	2	
TRIBENZOR 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	Non-Formulary	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	2	QL (2 tablets per 1 day)
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG	Non-Formulary	QL (Quantity Limits Apply)
Thiazide-Like Diuretics		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	2	QL (2 tablets per 1 day)
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	2	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CHLORTHALIDONE, LOSARTAN POTASSIUM, IRBESARTAN, VALSARTAN, OLMESARTAN MEDOXOMIL, CANDESARTAN CILEXETIL, TELMISARTAN)
HEMICLOR ORAL TABLET 12.5 MG	Non-Formulary	ALT (Covered Alternatives: CHLORTHALIDONE 25MG, CHLORTHALIDONE 50MG); QL (1 Tablet per 1 Day)
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
Uricosuric Agents		
<i>probenecid oral tablet 500 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>probenecid-colchicine oral tablet 500-0.5 mg</i>	2	
Vasopressin Antagonists		
JYNARQUE ORAL TABLET 15 MG, 30 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
JYNARQUE ORAL TABLETS, SEQUENTIAL 15 MG (AM)/ 15 MG (PM), 30 MG (AM)/ 15 MG (PM), 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM)	Non-Formulary	SP; QL (2 tablets per 1 day)
SAMSCA ORAL TABLET 15 MG, 30 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
<i>tolvaptan (polycys kidney dis) oral tablet 15 mg, 30 mg</i>	5	PA; SP; QL (2 Tablets per 1 Day)
<i>tolvaptan (polycys kidney dis) oral tablets, sequential 15 mg (am)/ 15 mg (pm), 30 mg (am)/ 15 mg (pm), 45 mg (am)/ 15 mg (pm), 60 mg (am)/ 30 mg (pm), 90 mg (am)/ 30 mg (pm)</i>	5	PA; SP; QL (2 Tablets per 1 Day)
<i>tolvaptan oral tablet 15 mg</i>	6	PA; SP; QL (2 tablets per 1 day)
<i>tolvaptan oral tablet 30 mg</i>	Non-Formulary	SP; QL (2 tablets per 1 day)
VAPRISOL IN 5 % DEXTROSE INTRAVENOUS SOLUTION 20 MG/100 ML	BB	PA
ENZYMES		
Enzyme Cofactors/Chaperones		
GALAFOLD ORAL CAPSULE 123 MG	6	PA; SP; QL (15 capsules per 30 days)
HARLIKU ORAL TABLET 2 MG	Non-Formulary	PA; SP; ALT (Covered Alternatives: NITISINONE); QL (2 Tablets per 1 Day)
JAVYGTOR ORAL POWDER IN PACKET 100 MG, 500 MG	Non-Formulary	SP; ALT (Covered Alternatives: SAPROPTERIN Tablets, SAPROPTERIN Powder)
JAVYGTOR ORAL TABLET,SOLUBLE 100 MG	Non-Formulary	SP; ALT (Covered Alternatives: SAPROPTERIN Tablets, SAPROPTERIN Powder)
KUVAN ORAL POWDER IN PACKET 100 MG, 500 MG	Non-Formulary	SP; ALT (Covered Alternatives: SAPROPTERIN DIHYDROCHLORIDE); QL (1 packet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
KUVAN ORAL TABLET,SOLUBLE 100 MG	Non-Formulary	SP; ALT (Covered Alternatives: SAPROPTERIN DIHYDROCHLORIDE); QL (1 EA per 1 day)
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG	Non-Formulary	SP; QL (3 Capsules per 1 Day)
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	5	PA; SP; QL (2 capsules per 1 day)
NITYR ORAL TABLET 10 MG, 2 MG, 5 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG	Non-Formulary	SP; ALT (Covered Alternatives: NITISINONE Capsules); QL (2 capsules per 1 day)
ORFADIN ORAL SUSPENSION 4 MG/ML	6	PA; SP; QL (0.01 ML per 1 day)
<i>sapropterin oral powder in packet 100 mg, 500 mg</i>	5	PA; SP; QL (1 packet per 1 day)
<i>sapropterin oral tablet,soluble 100 mg</i>	5	PA; SP; QL (1 tablet per 1 day)
SEPHIENCE ORAL POWDER IN PACKET 1,000 MG, 250 MG	Non-Formulary	SP; QL (1 Packet per 1 day)
Enzyme Inhibitors		
CERDELGA ORAL CAPSULE 84 MG	Non-Formulary	QL (Quantity Limits Apply); SP
OPFOLDA ORAL CAPSULE 65 MG	4	PA; SP; QL (4 Capsules per 1 day)
VIJOICE ORAL GRANULES IN PACKET 50 MG	Non-Formulary	SP; ALT (Covered Alternatives: Piqray); QL (1 Packet per 1 Day)
VIJOICE ORAL TABLET 125 MG, 50 MG	Non-Formulary	SP; QL (1 Tablet per 1 day)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	Non-Formulary	SP
ZOKINVY ORAL CAPSULE 50 MG, 75 MG	Non-Formulary	SP
Enzymes		
ADZYNMA INTRAVENOUS KIT 1,500 (+/-) UNIT, 500 (+/-) UNIT	BB	PA
ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5 ML	BB	PA
BRINEURA INTRAVENTRICULAR KIT 300 MG/10 ML (150MG/5ML X2)	BB	PA; SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
BRINEURA INTRAVENTRICULAR SOLUTION 150 MG/ 5 ML	BB	PA
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	BB	PA
ELAPRASE INTRAVENOUS SOLUTION 6 MG/3 ML	BB	PA
ELELYSO INTRAVENOUS RECON SOLN 200 UNIT	Non-Formulary	PA; SP
ELFABRIO INTRAVENOUS SOLUTION 2 MG/ML	BB	PA
ELITEK INTRAVENOUS RECON SOLN 1.5 MG, 7.5 MG	BB	PA
FABRAZYME INTRAVENOUS RECON SOLN 35 MG, 5 MG	Non-Formulary	PA; SP
KANUMA INTRAVENOUS SOLUTION 2 MG/ML	BB	PA
LAMZEDE INTRAVENOUS RECON SOLN 10 MG	BB	
LUMIZYME INTRAVENOUS RECON SOLN 50 MG	BB	PA
MEPSEVII INTRAVENOUS SOLUTION 2 MG/ML	BB	PA
NAGLAZYME INTRAVENOUS SOLUTION 5 MG/5 ML	BB	PA
NEXVIAZYME INTRAVENOUS RECON SOLN 100 MG	BB	PA
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 2.5 MG/0.5 ML, 20 MG/ML	6	PA; SP; QL (2 ML per 30 days)
POMBILITI INTRAVENOUS RECON SOLN 105 MG	BB	PA
PULMOZYME INHALATION SOLUTION 1 MG/ML	5	PA; SP; QL (2 ampules per 1 day)
REVCovi INTRAMUSCULAR SOLUTION 2.4 MG/1.5 ML (1.6 MG/ML)	6	PA; SP; QL (1.5 ML per 30 days)
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5 ML	BB	PA
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM	4	PA; QL (30GM per fill, 2 fills per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45 ML	Non-Formulary	SP
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML	Non-Formulary	QL (Quantity Limits Apply); SP
SUCRAID ORAL SOLUTION 8,500 UNIT/ML	Non-Formulary	SP
TNKASE INTRAVENOUS RECON SOLN 25 MG, 50 MG	BB	
VIMIZIM INTRAVENOUS SOLUTION 5 MG/5 ML (1 MG/ML)	BB	PA
VPRIV INTRAVENOUS RECON SOLN 400 UNIT	BB	PA; SP; QL (1 vial per 28 days)
XENPOZYME INTRAVENOUS RECON SOLN 20 MG	BB	PA
XIAFLEX INJECTION RECON SOLN 0.9 MG	BB	
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
Alpha-Adrenergic Agonists (Eent)		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	Non-Formulary	ALT (Covered Alternatives: Brimonidine 0.1% eye drops); QL (15 ML per 1 Fill)
<i>apraclonidine ophthalmic (eye) drops 0.5 %</i>	2	
<i>brimonidine ophthalmic (eye) drops 0.1 %</i>	2	QL (15 ML per 1 Fill)
<i>brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %</i>	2	QL (15 ML per 1 fill)
<i>brimonidine topical gel with pump 0.33 %</i>	2	PA; QL (1 GM per 1 day)
<i>brimonidine-timolol ophthalmic (eye) drops 0.2-0.5 %</i>	2	QL (10 ML per 30 days)
COMBIGAN OPHTHALMIC (EYE) DROPS 0.2-0.5 %	Non-Formulary	QL (10 ML per 30 days)
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE 1 %	4	QL (1 bottle per 1 fill)
MIRVASO TOPICAL GEL WITH PUMP 0.33 %	Non-Formulary	QL (1 GM per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION 1-0.2 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: BRIMONIDINE TARTRATE, AZOPT, DORZOLAMIDE-TIMOLOL); TD
Antiallergic Agents		
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %), 205.5 mcg (0.15 %)</i>	2	QL (30 ML per 30 days)
<i>azelastine ophthalmic (eye) drops 0.05 %</i>	2	
<i>bepotastine besilate ophthalmic (eye) drops 1.5 %</i>	2	QL (0.2 ml per 1 day)
BEPREVE OPHTHALMIC (EYE) DROPS 1.5 %	Non-Formulary	QL (0.2 ML per 1 day)
<i>cromolyn ophthalmic (eye) drops 4 %</i>	2	
DYMISTA NASAL SPRAY,NON-AEROSOL 137-50 MCG/SPRAY	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: AZELASTINE HCL, FLUTICASONE PROPIONATE, FLUNISOLIDE, TRIAMCINOLONE ACETONIDE, BUDESONIDE, MOMETASONE FUROATE)
<i>epinastine ophthalmic (eye) drops 0.05 %</i>	2	
<i>olopatadine nasal spray,non-aerosol 0.6 %</i>	2	
<i>olopatadine ophthalmic (eye) drops 0.1 %</i>	2	QL (5 ML per 1 fill)
<i>olopatadine ophthalmic (eye) drops 0.2 %</i>	2	QL (2.5 ML per 1 fill)
PATADAY ONCE DAILY RELIEF OPHTHALMIC (EYE) DROPS 0.2 %, 0.7 %	Non-Formulary	
RYALTRIS NASAL SPRAY,NON-AEROSOL 665-25 MCG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Fluticasone Nasal Spray, Flunisolide Nasal Spray, Mometasone Nasal Spray); QL (1 gram per 1 day)
ZERVIAE OPHTHALMIC (EYE) DROPPERETTE 0.24 %	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Antibacterials (52:04)		
AMZEEQ TOPICAL FOAM 4 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CLINDAMYCIN PHOSPHATE, ERYTHROMYCIN)
AZASITE OPHTHALMIC (EYE) DROPS 1 %	3	QL (2.5 ML per 30 days)
<i>bacitracin ophthalmic (eye) ointment 500 unit/gram</i>	2	
BESIVANCE OPHTHALMIC (EYE) DROPS,SUSPENSION 0.6 %	4	QL (5 ML per 30 days)
CILOXAN OPHTHALMIC (EYE) OINTMENT 0.3 %	3	QL (3.5 GM per 1 fill)
CIPRO HC OTIC (EAR) DROPS,SUSPENSION 0.2-1 %	4	QL (10 ML per 1 fill)
<i>ciprofloxacin hcl ophthalmic (eye) drops 0.3 %</i>	2	
<i>ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg</i>	2	
<i>ciprofloxacin hcl otic (ear) dropperette 0.2 %</i>	2	QL (14 applicators per 7 days)
<i>ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml</i>	2	
<i>ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %</i>	2	QL (7.5 ML per 1 fill)
DORYX MPC ORAL TABLET,DELAYED RELEASE (DR/EC) 60 MG	Non-Formulary	ALT (Covered Alternatives: Doxycycline Hyclate, Doxycycline Monohydrate); QL (1 tablet per 1 day)
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	QL (3 capsules per 1 day)
<i>doxycycline hyclate oral tablet 100 mg</i>	2	QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE, DOXYCYCLINE HYCLATE); QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 20 mg</i>	2	
<i>doxycycline hyclate oral tablet 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE)
<i>doxycycline hyclate oral tablet 75 mg</i>	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>doxycycline monohydrate oral capsule 100 mg</i>	2	QL (2 capsules per 1 day)
<i>doxycycline monohydrate oral capsule 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule 50 mg</i>	2	
<i>doxycycline monohydrate oral capsule 75 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule,ir - delay rel,biphase 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE); QL (1 Capsule per 1 Day)
<i>doxycycline monohydrate oral tablet 100 mg</i>	2	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral tablet 150 mg, 75 mg</i>	2	
<i>doxycycline monohydrate oral tablet 50 mg</i>	2	QL (3 tablets per 1 day)
E.E.S. 400 ORAL TABLET 400 MG	Non-Formulary	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	2	QL (100 ML per 30 days)
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	2	QL (100 ML per 1 fill)
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	2	
<i>erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)</i>	2	
<i>erythromycin oral tablet,delayed release (dr/ec) 250 mg, 500 mg</i>	2	
<i>erythromycin with ethanol topical gel 2 %</i>	2	QL (60 GM per 30 days)
<i>erythromycin with ethanol topical solution 2 %</i>	2	QL (60 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>gatifloxacin ophthalmic (eye) drops 0.5 %</i>	2	QL (6 ML per 30 days)
<i>gentamicin ophthalmic (eye) drops 0.3 %</i>	1	
<i>gentamicin topical cream 0.1 %</i>	2	QL (30 GM per 30 days)
<i>gentamicin topical ointment 0.1 %</i>	2	
<i>levofloxacin in d5w intravenous piggyback 250 mg/50 ml, 500 mg/100 ml, 750 mg/150 ml</i>	Non-Formulary	
<i>levofloxacin oral solution 250 mg/10 ml</i>	2	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 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>	2	
MONDOXYNE NL ORAL CAPSULE 100 MG	Non-Formulary	QL (2 capsules per 1 day)
MONDOXYNE NL ORAL CAPSULE 75 MG	Non-Formulary	
<i>moxifloxacin ophthalmic (eye) drops 0.5 %</i>	2	QL (3 ML per 1 fill)
<i>moxifloxacin ophthalmic (eye) drops, viscous 0.5 %</i>	2	QL (3 ML per 1 fill)
<i>moxifloxacin oral tablet 400 mg</i>	2	QL (1 tablet per 1 day)
<i>neomycin oral tablet 500 mg</i>	2	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	2	QL (5 ML per 1 fill)
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	2	
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml</i>	2	
<i>neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%</i>	1	
<i>neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%</i>	2	
<i>ofloxacin ophthalmic (eye) drops 0.3 %</i>	2	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	2	
<i>ofloxacin otic (ear) drops 0.3 %</i>	2	
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
OTOVEL OTIC (EAR) SOLUTION 0.3-0.025 % (0.25 ML)	Non-Formulary	QL (Quantity Limits Apply)
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit- 1 mg/ml</i>	2	
<i>sulfacetamide sodium ophthalmic (eye) drops 10 %</i>	2	
TARGADOX ORAL TABLET 50 MG	Non-Formulary	QL (Quantity Limits Apply)
TOBRADEX OPHTHALMIC (EYE) OINTMENT 0.3-0.1 %	3	QL (3.5 GM per 1 fill)
TOBRADEX ST OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.05 %	Non-Formulary	QL (Quantity Limits Apply)
<i>tobramycin ophthalmic (eye) drops 0.3 %</i>	2	QL (5 ML per 1 fill)
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %</i>	2	
TOBEX OPHTHALMIC (EYE) OINTMENT 0.3 %	3	QL (1 tube per 1 fill)
VIGAMOX OPHTHALMIC (EYE) DROPS 0.5 %	Non-Formulary	QL (3 units per 1 day)
ZILXI TOPICAL FOAM 1.5 %	Non-Formulary	QL (Quantity Limits Apply)
ZYLET OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.5 %	Non-Formulary	QL (Quantity Limits Apply)
Antifungals (Eent)		
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 %	4	PA; QL (15 ML per 30 days)
Antiglaucoma Agents, Miscellaneous		
<i>mitomycin (pf) in water ophthalmic (eye) syringe 0.2 mg/ml, 0.4 mg/ml</i>	BB	
RHOPRESSA OPHTHALMIC (EYE) DROPS 0.02 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LATANOPROST,BIMATOPROST,T RAVOPROST)
ROCKLATAN OPHTHALMIC (EYE) DROPS 0.02-0.005 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LATANOPROST, BIMATOPROST, TRAVOPROST)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Anti-Infectives, Miscellaneous (52:04)		
<i>acetic acid otic (ear) solution 2 %</i>	2	
<i>hydrocortisone-acetic acid otic (ear) drops 1-2 %</i>	2	
XDEMVI OPTHALMIC (EYE) DROPS 0.25 %	6	PA; SP; QL (10 ML per 30 days)
Anti-Inflammatory Agents (Eent)		
CEQUA OPTHALMIC (EYE) DROPPERETTE 0.09 %	Non-Formulary	QL (Quantity Limits Apply)
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<i>cyclosporine ophthalmic (eye) dropperette 0.05 %</i>	2	QL (2 Units per 1 day)
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	2	
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	
MIEBO (PF) OPTHALMIC (EYE) DROPS 100 %	Non-Formulary	ALT (Covered Alternatives: Cyclosporine); QL (0.2 ML per 1 day)
OXERVATE OPTHALMIC (EYE) DROPS 0.002 %	6	PA; SP; QL (1 vial per 1 day)
RESTASIS MULTIDOSE OPTHALMIC (EYE) DROPS 0.05 %	Non-Formulary	ALT (Covered Alternatives: Cyclosporine 0.05%); QL (5.5 ML per 24 days)
RESTASIS OPTHALMIC (EYE) DROPPERETTE 0.05 %	Non-Formulary	ALT (Covered Alternatives: Cyclosporine 0.05%); QL (2 dropperettes per 1 day)
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG	Non-Formulary	
TEPEZZA INTRAVENOUS RECON SOLN 500 MG	Non-Formulary	PA; SP
VEVYE OPTHALMIC (EYE) DROPS 0.1 %	Non-Formulary	ALT (Covered Alternatives: Cyclosporine DROPPERETTE, SINGLE-USE DROP DISPENSER)
XIIDRA OPTHALMIC (EYE) DROPPERETTE 5 %	4	PA; QL (60 units per 30 days)
Antivirals (Eent)		
<i>ganciclovir sodium intravenous recon soln 500 mg</i>	7	
<i>trifluridine ophthalmic (eye) drops 1 %</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZIRGAN OPHTHALMIC (EYE) GEL 0.15 %	4	QL (5 GM per 30 days)
Astringents (52:04)		
<i>chlorhexidine gluconate mucous membrane mouthwash 0.12 %</i>	2	
PAROEX ORAL RINSE MUCOUS MEMBRANE MOUTHWASH 0.12 %	2	
PERIOGARD MUCOUS MEMBRANE MOUTHWASH 0.12 %	2	
Beta-Adrenergic Blocking Agents (Eent)		
<i>betaxolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>betaxolol oral tablet 10 mg, 20 mg</i>	2	
BETIMOL OPHTHALMIC (EYE) DROPS 0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TIMOLOL MALEATE)
BETOPTIC S OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 %	4	QL (10 ML per 1 fill)
<i>brimonidine-timolol ophthalmic (eye) drops 0.2-0.5 %</i>	2	QL (10 ML per 30 days)
<i>carteolol ophthalmic (eye) drops 1 %</i>	2	QL (10 ML per 1 fill)
COMBIGAN OPHTHALMIC (EYE) DROPS 0.2-0.5 %	Non-Formulary	QL (10 ML per 30 days)
COSOPT (PF) OPHTHALMIC (EYE) DROPPERETTE 2-0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DORZOLAMIDE-TIMOLOL)
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette 2-0.5 %</i>	2	
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	2	
ISTALOL OPHTHALMIC (EYE) DROPS, ONCE DAILY 0.5 %	Non-Formulary	QL (Quantity Limits Apply)
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	2	QL (10 ML per 1 fill)
<i>timolol maleate (pf) ophthalmic (eye) dropperette 0.5 %</i>	Non-Formulary	QL (2 Dropperettes per 1 day)
<i>timolol maleate ophthalmic (eye) drops 0.25 %</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>timolol maleate ophthalmic (eye) drops 0.5 %</i>	2	
<i>timolol maleate ophthalmic (eye) drops, once daily 0.5 %</i>	2	ALT (Covered Alternatives: Timolol Maleate)
<i>timolol maleate ophthalmic (eye) gel forming solution 0.25 %, 0.5 %</i>	2	
TIMOPTIC OCUDOSE (PF) OPHTHALMIC (EYE) DROPPERETTE 0.25 %	Non-Formulary	QL (Quantity Limits Apply)
TIMOPTIC OCUDOSE (PF) OPHTHALMIC (EYE) DROPPERETTE 0.5 %	Non-Formulary	ALT (Covered Alternatives: Timolol Maleate)
Carbonic Anhydrase Inhibitors (Eent)		
<i>acetazolamide oral capsule, extended release 500 mg</i>	2	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	2	
AZOPT OPHTHALMIC (EYE) DROPS,SUSPENSION 1 %	Non-Formulary	QL (10 ML per 1 fill)
<i>brinzolamide ophthalmic (eye) drops,suspension 1 %</i>	2	QL (10 ML per 1 fill)
COSOPT (PF) OPHTHALMIC (EYE) DROPPERETTE 2-0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DORZOLAMIDE-TIMOLOL)
<i>dorzolamide (pf) ophthalmic (eye) drops 2 %</i>	Non-Formulary	
<i>dorzolamide ophthalmic (eye) drops 2 %</i>	2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette 2-0.5 %</i>	2	
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	2	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	2	
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION 1-0.2 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: BRIMONIDINE TARTRATE, AZOPT, DORZOLAMIDE-TIMOLOL); TD

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Corticosteroids (Eent)		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	Non-Formulary	ALT (Covered Alternatives: FLUTICASONE-SALMETEROL, WIXELA INHUB); QL (60 units per 1 fill)
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)
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG-14 MCG/ACTUATION, 232-14 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inhaler per 28 days)
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g), Levalbuterol HFA); QL (10.7 GM per 30 Days)
ALA-SCALP TOPICAL LOTION 2 %	Non-Formulary	QL (1 ml per 1 day)
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE)
ALREX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.2 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Loteprednol etabonate); QL (0.4 ML per 1 day)
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION, 80 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (6.1 GM per 28 days)
ARMONAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG/ACTUATION, 232 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inaler per 28 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (30 Blisters per 28 days)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	4	QL (13 GM per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	4	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	3	QL (1 inhaler per 30 days)
BREYNA INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	2	QL (10.3 GM per 1 Fill)
<i>budesonide-formoterol inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	2	QL (10.3 GM per 1 Fill)
CAPEX TOPICAL SHAMPOO 0.01 %	4	PA; ALT (Covered Alternatives: CLOBETASOL PROPIONATE, FLUCINOLONE ACETONIDE, FLUCINOLONE ACETONIDE); QL (120 ml per 1 month)
CIPRO HC OTIC (EAR) DROPS,SUSPENSION 0.2-1 %	4	QL (10 ML per 1 fill)
<i>ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %</i>	2	QL (7.5 ML per 1 fill)
DEXAMETHASONE INTENSOL ORAL DROPS 1 MG/ML	3	QL (30 ML per 1 fill)
<i>dexamethasone oral elixir 0.5 mg/5 ml</i>	2	
<i>dexamethasone oral solution 0.5 mg/5 ml</i>	2	QL (300 ML per 30 days)
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	2	
<i>dexamethasone sodium phos (pf) injection solution 4 mg/ml</i>	BB	
<i>dexamethasone sodium phos (pf) injection syringe 10 mg/ml</i>	BB	
<i>dexamethasone sodium phosphate injection solution 4 mg/ml</i>	7	
<i>dexamethasone sodium phosphate ophthalmic (eye) drops 0.1 %</i>	2	QL (10 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>difluprednate ophthalmic (eye) drops 0.05 %</i>	2	QL (5 ML per 1 fill)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 200-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	3	QL (13 GM per 28 days)
DUREZOL OPHTHALMIC (EYE) DROPS 0.05 %	Non-Formulary	QL (5 ML per 1 fill)
DYMISTA NASAL SPRAY, NON-AEROSOL 137-50 MCG/SPRAY	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: AZELASTINE HCL, FLUTICASONE PROPIONATE, FLUNISOLIDE, TRIAMCINOLONE ACETONIDE, BUDESONIDE, MOMETASONE FUROATE)
EYSUVIS OPHTHALMIC (EYE) DROPS, SUSPENSION 0.25 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: ALREX, LOTEPREDNOL ETABONATE)
FLAREX OPHTHALMIC (EYE) DROPS, SUSPENSION 0.1 %	4	QL (5 ML per 1 fill)
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	2	
<i>fluocinolone acetonide oil otic (ear) drops 0.01 %</i>	2	QL (20 ML per 1 fill)
<i>fluocinolone topical cream 0.01 %</i>	2	QL (60 GM per 30 days)
<i>fluocinolone topical cream 0.025 %</i>	2	
<i>fluocinolone topical oil 0.01 %</i>	2	QL (120 ML per 30 days)
<i>fluocinolone topical solution 0.01 %</i>	2	QL (60 ML per 30 days)
<i>fluorometholone ophthalmic (eye) drops, suspension 0.1 %</i>	2	
<i>fluticasone furoate inhalation blister with device 100 mcg/actuation, 200 mcg/actuation, 50 mcg/actuation</i>	Non-Formulary	QL (1 Box per 30 Days)
<i>fluticasone furoate-vilanterol inhalation blister with device 100-25 mcg/dose, 200-25 mcg/dose</i>	Non-Formulary	QL (60 units per 1 fill)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation, 220 mcg/actuation, 44 mcg/actuation</i>	3	ALT (Covered Alternatives: Pulmicort Flexhaler, QVAR, Alvesco, Asmanex); QL (1 Inhaler per 30 days); AG (Max 4 Years)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>fluticasone propionate nasal spray,suspension 50 mcg/actuation</i>	2	QL (1 bottle per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	2	QL (1 inhaler 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 GM per 30 days)
<i>hydrocortisone acetate topical cream with perineal applicator 2.5 %</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE 2.5% CREAM, HYDROCORTISONE 2.5% OINTMENT, HYDROCORTISONE 1% CREAM, HYDROCORTISONE 1% OINTMENT); QL (1 Tube per 30 Days)
<i>hydrocortisone butyrate topical ointment 0.1 %</i>	Non-Formulary	QL (45 gm per 30 days)
<i>hydrocortisone butyrate topical solution 0.1 %</i>	2	QL (45 ML per 30 days)
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>hydrocortisone sod succinate injection recon soln 100 mg</i>	7	
<i>hydrocortisone topical cream 1 %</i>	2	QL (1 gm per 1 day)
<i>hydrocortisone topical cream 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical cream with perineal applicator 1 %</i>	2	QL (28.5 GM per 30 days)
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical lotion 2.5 %</i>	2	QL (60 GM per 30 days)
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical solution 2.5 %</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE 2.5% CREAM, HYDROCORTISONE 2.5% LOTION, HYDROCORTISONE 2.5% OINTMENT); QL (1 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydrocortisone valerate topical cream 0.2 %</i>	2	QL (60 GM per 30 days)
<i>hydrocortisone valerate topical ointment 0.2 %</i>	Non-Formulary	QL (2 gm per 1 day)
INVELTYS OPHTHALMIC (EYE) DROPS,SUSPENSION 1 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LOTEMAX)
KENALOG INJECTION SUSPENSION 10 MG/ML	7	
KENALOG INJECTION SUSPENSION 40 MG/ML	Non-Formulary	
KENALOG TOPICAL AEROSOL 0.147 MG/GRAM	Non-Formulary	QL (100 gm per 30 days)
KHINDIVI ORAL SOLUTION 1 MG/ML	Non-Formulary	ALT (Covered Alternatives: Hydrocortisone 5mg tablet)
LOTEMAX OPHTHALMIC (EYE) DROPS,GEL 0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LOTEMAX)
LOTEMAX OPHTHALMIC (EYE) OINTMENT 0.5 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LOTEMAX)
LOTEMAX SM OPHTHALMIC (EYE) DROPS,GEL 0.38 %	Non-Formulary	QL (Quantity Limits Apply)
<i>loteprednol etabonate ophthalmic (eye) drops,gel 0.5 %</i>	2	QL (0.17 ml per 1 day)
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.2 %</i>	2	QL (0.4 ML per 1 day)
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.5 %</i>	2	QL (0.5 ml per 1 day)
MAXIDEX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 %	4	QL (5 ML per 1 fill)
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE TOPICAL CREAM, HYDROCORTISONE TOPICAL OINMENT); QL (1 Tube per 30 Days)
<i>mometasone nasal spray,non-aerosol 50 mcg/actuation</i>	2	QL (17 GM per 30 days)
<i>mometasone topical cream 0.1 %</i>	2	QL (45 GM per 30 days)
<i>mometasone topical ointment 0.1 %</i>	2	QL (45 GM per 30 days)
<i>mometasone topical solution 0.1 %</i>	2	QL (45 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	2	QL (5 ML per 1 fill)
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	2	
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml</i>	2	
<i>nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%</i>	2	QL (1.4 GM per 1 day)
<i>nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%</i>	2	QL (1.4 GM per 1 day)
OTOVEL OTIC (EAR) SOLUTION 0.3-0.025 % (0.25 ML)	Non-Formulary	QL (Quantity Limits Apply)
OZURDEX INTRAVITREAL IMPLANT 0.7 MG	Non-Formulary	
PRED MILD OPHTHALMIC (EYE) DROPS,SUSPENSION 0.12 %	4	QL (5 ML per 1 fill)
<i>prednisolone acetate ophthalmic (eye) drops,suspension 1 %</i>	2	
<i>prednisolone oral solution 15 mg/5 ml</i>	2	QL (450 ML per 30 days)
<i>prednisolone sodium phosphate ophthalmic (eye) drops 1 %</i>	2	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml</i>	2	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 15 mg/5 ml (5 ml), 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	2	QL (16 ML per 1 day)
<i>prednisolone sodium phosphate oral tablet,disintegrating 10 mg, 15 mg, 30 mg</i>	Non-Formulary	
PROCTO-MED HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)
PROCTOSOL HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)
PROCTOZONE-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION, 80 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); TD
RYALTRIS NASAL SPRAY, NON-AEROSOL 665-25 MCG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Fluticasone Nasal Spray, Flunisolide Nasal Spray, Mometasone Nasal Spray); QL (1 gram per 1 day)
SCALACORT DK TOPICAL COMBO PACK 2-2-2 %	Non-Formulary	
SCALACORT TOPICAL LOTION 2 %	Non-Formulary	QL (1 ml per 1 day)
SINUVA SINUS IMPLANT 1,350 MCG	BB	PA
SOLU-CORTEF ACT-O-VIAL (PF) INJECTION RECON SOLN 1,000 MG/8 ML, 100 MG/2 ML	7	
SOLU-CORTEF INJECTION RECON SOLN 100 MG	Non-Formulary	
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: BUDESONIDE/FORMOTEROL FUMARATE); QL (10.3 GM per 1 Fill)
TOBRADEX OPHTHALMIC (EYE) OINTMENT 0.3-0.1 %	3	QL (3.5 GM per 1 fill)
TOBRADEX ST OPHTHALMIC (EYE) DROPS, SUSPENSION 0.3-0.05 %	Non-Formulary	QL (Quantity Limits Apply)
<i>tobramycin-dexamethasone ophthalmic (eye) drops, suspension 0.3-0.1 %</i>	2	
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	4	PA; TD
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG	4	PA; TD; QL (1 DEVICE per 30 days)
<i>triamcinolone acetate-0.9% nacl injection suspension 50 mg/ml</i>	7	
<i>triamcinolone acetonide dental paste 0.1 %</i>	2	QL (5 GM per 1 fill)
<i>triamcinolone acetonide injection suspension 40 mg/ml</i>	7	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>triamcinolone acetonide topical aerosol 0.147 mg/gram</i>	Non-Formulary	QL (100 gm per 30 days)
<i>triamcinolone acetonide topical cream 0.025 %, 0.5 %</i>	2	QL (80 GM per 30 days)
<i>triamcinolone acetonide topical cream 0.1 %</i>	2	QL (90 GM per 30 days)
<i>triamcinolone acetonide topical lotion 0.025 %, 0.1 %</i>	2	QL (60 GM per 30 days)
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %</i>	2	QL (80 GM per 30 days)
<i>triamcinolone acetonide topical ointment 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE)
<i>triamcinolone acetonide topical ointment 0.5 %</i>	2	QL (15 GM per 30 days)
TRIANEX TOPICAL OINTMENT 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, FLUCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE)
VERIPRED 20 ORAL SOLUTION 20 MG/5 ML (4 MG/ML)	Non-Formulary	QL (16 units per 1 day)
WIXELA INHUB INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	2	QL (60 GM per 30 days)
XHANCE NASAL AEROSOL BREATH ACTIVATED 93 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply)
ZYLET OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.5 %	Non-Formulary	QL (Quantity Limits Apply)
Eent Drugs, Miscellaneous		
BYOOVIZ INTRAVITREAL SOLUTION 0.5 MG/0.05 ML	BB	
<i>cromolyn ophthalmic (eye) drops 4 %</i>	2	
DEBACTEROL MUCOUS MEMBRANE SOLUTION 30-50 %	4	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %), 42 mcg (0.06 %)</i>	2	
PHOTREXA CROSS-LINKING KIT OPHTHALMIC (EYE) COMBO, DROPS AND DROPS VISCOUS 0.146 % -0.146 %	BB	
TYRVAYA NASAL SPRAY, METERED, NON-AEROSOL 0.03 MG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Cyclosporine, Xiidra (PA required))
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	2	HCR
<i>varenicline tartrate oral tablets,dose pack 0.5 mg (11)- 1 mg (42)</i>	2	HCR; QL (1 pack per 365 days)
Eent Nonsteroidal Anti-Inflam. Agents		
ACUVAIL (PF) OPHTHALMIC (EYE) DROPPERETTE 0.45 %	4	QL (30 ML per 1 fill)
<i>bromfenac ophthalmic (eye) drops 0.07 %, 0.075 %</i>	2	QL (10 ML per 365 days)
<i>bromfenac ophthalmic (eye) drops 0.09 %</i>	2	QL (3.4 ML per 1 fill)
BROMSITE OPHTHALMIC (EYE) DROPS 0.075 %	Non-Formulary	ALT (Covered Alternatives: Bromfenac 0.075%); QL (10 ML per 365 days)
<i>cyclopent-tropic-phen-ketr-wat ophthalmic (eye) drops 1 %-1 %-2.5 %- 0.5 %</i>	BB	
<i>diclofenac sodium ophthalmic (eye) drops 0.1 %</i>	2	
<i>flurbiprofen oral tablet 100 mg</i>	2	
<i>flurbiprofen sodium ophthalmic (eye) drops 0.03 %</i>	2	
ILEVRO OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3 %	4	QL (3 ML per 1 fill)
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	2	QL (5 ML per 30 days)
<i>ketorolac injection solution 30 mg/ml</i>	2	QL (10 ML per 30 days)
<i>ketorolac injection syringe 15 mg/ml, 30 mg/ml</i>	2	QL (5 syringes per 30 days)
<i>ketorolac intramuscular solution 60 mg/2 ml</i>	2	QL (4 ML per 30 days)
<i>ketorolac intramuscular syringe 60 mg/2 ml</i>	2	QL (5 syringes per 30 days)
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	2	QL (5 ML per 1 fill)
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>ketorolac oral tablet 10 mg</i>	2	
NEVANAC OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 %	4	QL (3 ML per 1 fill)
PROLENSA OPHTHALMIC (EYE) DROPS 0.07 %	3	
SPRIX NASAL SPRAY,NON-AEROSOL 15.75 MG/SPRAY	Non-Formulary	QL (Quantity Limits Apply); SP
Local Anesthetics (Eent)		
<i>lidocaine hcl mucous membrane jelly in applicator 2 %</i>	2	QL (1 GM per 1 day)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	2	QL (1.6 ML per 1 day)
LIDOCAINE VISCOUS MUCOUS MEMBRANE SOLUTION 2 %	2	
<i>proparacaine ophthalmic (eye) drops 0.5 %</i>	2	
<i>tetracaine hcl (pf) ophthalmic (eye) drops 0.5 %</i>	2	
<i>tetracaine hcl ophthalmic (eye) drops 0.5 %</i>	2	
Macular Degeneration Agents		
CYSTADROPS OPHTHALMIC (EYE) DROPS 0.37 %	6	PA; SP; QL (5 ML per 30 days)
CYSTARAN OPHTHALMIC (EYE) DROPS 0.44 %	6	PA; SP; QL (15 ML per 1 fill)
IZERVAY (PF) INTRAVITREAL SOLUTION 2 MG/0.1 ML	BB	
SYFOVRE (PF) INTRAVITREAL SOLUTION 15 MG /0.1 ML	BB	
Miotics		
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	2	
<i>pilocarpine hcl ophthalmic (eye) drops 1.25 %</i>	2	PA; QL (2.5 ML per 30 Days)
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	2	
VIZZ OPHTHALMIC (EYE) DROPPERETTE 1.44 %	Non-Formulary	ALT (Covered Alternatives: PILOCARPINE 1.25%); QL (10 ML per 30 Days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VUITY OPHTHALMIC (EYE) DROPS 1.25 %	Non-Formulary	ALT (Covered Alternatives: PILOCARPINE 1.25%); QL (2.5 ML per 30 Days)
Mydriatics		
<i>atropine ophthalmic (eye) drops 0.01 %, 0.025 %, 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: Atropine 1% eye drops); QL (5 ML per 30 days)
<i>atropine ophthalmic (eye) drops 1 %</i>	2	
<i>cyclopentolate ophthalmic (eye) drops 1 %</i>	2	
<i>cyclopent-tropic-phen-ketr-wat ophthalmic (eye) drops 1 %-1 %-2.5 %- 0.5 %</i>	BB	
MYDCOMBI OPHTHALMIC (EYE) CARTRIDGE 2.5-1 %	Non-Formulary	QL (0.05 ML per 1 Day)
<i>phenylephrine hcl ophthalmic (eye) drops 10 %, 2.5 %</i>	2	
<i>tropicamide ophthalmic (eye) drops 0.5 %, 1 %</i>	2	
Osmotic Agents		
<i>urea topical cream 20 %</i>	2	
Prostaglandin Analogs		
<i>bimatoprost ophthalmic (eye) drops 0.03 %</i>	2	TD; QL (7.5 ML per 30 days)
DURYSTA INTRACAMERAL IMPLANT 10 MCG	BB	PA
IDOSE TR INTRACAMERAL IMPLANT 75 MCG	BB	PA
IYUZEH (PF) OPHTHALMIC (EYE) DROPPERETTE 0.005 %	Non-Formulary	ALT (Covered Alternatives: Latanoprost, Travoprost); QL (1 Dropperette per 1 Day)
<i>latanoprost ophthalmic (eye) drops 0.005 %</i>	2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	3	ST (Step Therapy Required- Tried and failed latanoprost in the last 120 days); QL (2.5 ML per 25 days)
ROCKLATAN OPHTHALMIC (EYE) DROPS 0.02-0.005 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LATANOPROST, BIMATOPROST, TRAVOPROST)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>tafluprost (pf) ophthalmic (eye) dropperette 0.0015 %</i>	3	ST (Step Therapy Required- Tried and failed 30 day trial of Latanoprost); QL (1 dropperette per 1 day)
<i>travoprost ophthalmic (eye) drops 0.004 %</i>	2	QL (5 ML per 30 days)
VYZULTA OPHTHALMIC (EYE) DROPS 0.024 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LATANOPROST, BIMATOPROST, TRAVOPROST)
ZIOPTAN (PF) OPHTHALMIC (EYE) DROPPERETTE 0.0015 %	Non-Formulary	ALT (Covered Alternatives: LATANOPROST, BIMATOPROST, TRAVOPROST); QL (1 Dropperette per 1 day)
Rho Kinase Inhibitors		
RHOPRESSA OPHTHALMIC (EYE) DROPS 0.02 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LATANOPROST, BIMATOPROST, TRAVOPROST)
ROCKLATAN OPHTHALMIC (EYE) DROPS 0.02-0.005 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LATANOPROST, BIMATOPROST, TRAVOPROST)
Vascular Endothelial Growth Factor Antag		
AVASTIN INTRAVITREAL SYRINGE 1.25 MG/0.05 ML	BB	PA
BEOVU INTRAVITREAL SYRINGE 6 MG/0.05 ML	BB	PA
<i>bevacizumab intravitreal syringe 1.25 mg/0.05 ml, 2 mg/0.08 ml, 2.5 mg/0.1 ml, 2.75 mg/0.11 ml, 3.25 mg/0.13 ml</i>	BB	PA
CIMERLI INTRAVITREAL SOLUTION 0.3 MG/0.05 ML, 0.5 MG/0.05 ML	BB	PA
EYLEA INTRAVITREAL SYRINGE 2 MG/0.05 ML	BB	PA
LUCENTIS INTRAVITREAL SOLUTION 0.5 MG/0.05 ML	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PAVBLU INTRAVITREAL SOLUTION 2 MG/0.05 ML	BB	PA
PAVBLU INTRAVITREAL SYRINGE 2 MG/0.05 ML	BB	PA
SUSVIMO INTRAVITREAL SOLUTION 10 MG/0.1 ML	BB	PA
VABYSMO INTRAVITREAL SOLUTION 6 MG/0.05 ML	BB	PA
VABYSMO INTRAVITREAL SYRINGE 6 MG/0.05 ML	BB	PA
Vasoconstrictors		
<i>cyclopent-tropic-phen-ketr-wat ophthalmic (eye) drops 1 %-1 %-2.5 %- 0.5 %</i>	BB	
<i>phenylephrine hcl ophthalmic (eye) drops 10 %, 2.5 %</i>	2	
UPNEEQ (PF) OPHTHALMIC (EYE) DROPPERETTE 0.1 %	Non-Formulary	
GASTROINTESTINAL DRUGS		
5-Ht3 Receptor Antagonists		
AKYNZEO (FOSNETUPITANT) INTRAVENOUS RECON SOLN 235-0.25 MG	BB	PA
AKYNZEO (NETUPITANT) ORAL CAPSULE 300-0.5 MG	4	PA; ALT (Covered Alternatives: ONDANSETRON HCL, GRANISETRON HCL); QL (1 fill per 1 month)
<i>granisetron hcl oral tablet 1 mg</i>	2	QL (10 tablets per 30 days)
<i>ondansetron hcl (pf) injection solution 4 mg/2 ml</i>	7	
<i>ondansetron hcl (pf) injection syringe 4 mg/2 ml</i>	7	
<i>ondansetron hcl intravenous solution 2 mg/ml</i>	7	
<i>ondansetron hcl oral solution 4 mg/5 ml</i>	2	QL (15 ML per 1 day)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>ondansetron oral tablet, disintegrating 16 mg</i>	Non-Formulary	ALT (Covered Alternatives: ONDANSETRON ODT 4 MG TABLET, ONDANSETRON ODT 8 MG TABLET)
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	2	
<i>palonosetron intravenous solution 0.25 mg/2 ml</i>	BB	PA
POSFREA INTRAVENOUS SOLUTION 0.25 MG/5 ML	BB	PA
SANCUSO TRANSDERMAL PATCH WEEKLY 3.1 MG/24 HOUR	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: GRANISETRON HCL, ONDANSETRON HCL, OLANZAPINE, DEXAMETHASONE, APREPITANT)
Antidiarrhea Agents		
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml</i>	2	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	2	
<i>loperamide oral capsule 2 mg</i>	2	QL (2 capsules per 1 day)
MYTESI ORAL TABLET, DELAYED RELEASE (DR/EC) 125 MG	4	PA; QL (2 Tablets per 1 Day)
VIBERZI ORAL TABLET 100 MG, 75 MG	Non-Formulary	QL (Quantity Limits Apply)
XERMELO ORAL TABLET 250 MG	6	PA; SP; QL (90 tablets per 30 days)
Antiemetics, Miscellaneous		
DICLEGIS ORAL TABLET, DELAYED RELEASE (DR/EC) 10-10 MG	Non-Formulary	QL (4 tablets per 1 day)
<i>doxylamine-pyridoxine (vit b6) oral tablet, delayed release (dr/ec) 10-10 mg</i>	2	QL (6 Fills per 365 Days); TD; QL (4 tablets per 1 day)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	2	QL (3 tablets per 1 day)
<i>olanzapine oral tablet, disintegrating 10 mg, 15 mg, 20 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Non-Formulary	ALT (Covered Alternatives: olanzapine, fluoxetine)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>scopolamine base transdermal patch 3 day 1 mg over 3 days</i>	2	QL (4 patches per 1 fill)
Antihistamines (Gi Drugs)		
DICLEGIS ORAL TABLET,DELAYED RELEASE (DR/EC) 10-10 MG	Non-Formulary	QL (4 tablets per 1 day)
<i>doxylamine-pyridoxine (vit b6) oral tablet, delayed release (dr/ec) 10-10 mg</i>	2	QL (6 Fills per 365 Days); TD; QL (4 tablets per 1 day)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	2	
<i>prochlorperazine rectal suppository 25 mg</i>	2	
<i>trimethobenzamide oral capsule 300 mg</i>	2	QL (2 capsules per 1 day)
Anti-Inflammatory Agents (Gi Drugs)		
<i>alosetron oral tablet 0.5 mg, 1 mg</i>	2	PA; QL (1 tablet per 1 day)
<i>balsalazide oral capsule 750 mg</i>	2	
CANASA RECTAL SUPPOSITORY 1,000 MG	Non-Formulary	QL (1 unit per 1 day)
DIPENTUM ORAL CAPSULE 250 MG	4	
LIALDA ORAL TABLET,DELAYED RELEASE (DR/EC) 1.2 GRAM	Non-Formulary	QL (4 tablets per 1 day)
<i>mesalamine oral capsule (with del rel tablets) 400 mg</i>	2	QL (12 capsules per 1 day)
<i>mesalamine oral capsule, extended release 500 mg</i>	2	QL (8 capsules per 1 day)
<i>mesalamine oral capsule, extended release 24hr 0.375 gram</i>	2	QL (4 capsules per 1 day)
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	2	QL (4 tablets per 1 day)
<i>mesalamine oral tablet, delayed release (dr/ec) 800 mg</i>	2	QL (6 tablets per 1 day)
<i>mesalamine rectal enema 4 gram/60 ml</i>	2	QL (60 ML per 1 day)
<i>mesalamine rectal suppository 1,000 mg</i>	2	QL (1 suppository per 1 day)
<i>mesalamine with cleansing wipe rectal enema kit 4 gram/60 ml</i>	2	QL (4 kits per 28 days)
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	4	QL (8 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	Non-Formulary	QL (8 capsules per 1 day)
<i>sulfasalazine oral tablet 500 mg</i>	2	
<i>sulfasalazine oral tablet, delayed release (dr/ec) 500 mg</i>	2	
Antulcer Agents And Acid Suppress., Misc		
TALICIA ORAL CAPSULE, IR - DELAY REL, BIPHASE 10-250-12.5 MG	Non-Formulary	QL (Quantity Limits Apply)
Antulcer Agents And Acid Suppressants		
<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	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 250-62.5 MG/5 ML	Non-Formulary	
<i>clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	2	
<i>clarithromycin oral tablet extended release 24 hr 500 mg</i>	2	
METROGEL TOPICAL GEL 1 %	Non-Formulary	QL (Quantity Limits Apply)
<i>metronidazole oral capsule 375 mg</i>	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>metronidazole oral tablet 125 mg</i>	Non-Formulary	ALT (Covered Alternatives: Metronidazole 250mg Tablets); QL (1 Tablets per 1 Day)
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole topical cream 0.75 %</i>	2	QL (45 GM per 30 days)
<i>metronidazole topical gel 0.75 %, 1 %</i>	2	
<i>metronidazole topical gel with pump 1 %</i>	2	
<i>metronidazole topical lotion 0.75 %</i>	2	QL (59 GM per 30 days)
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	2	
NORITATE TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)
NUVESSA VAGINAL GEL 1.3 % (65 MG/5 GRAM)	Non-Formulary	ALT (Covered Alternatives: METRONIDAZOLE, CLINDAMYCIN PHOSPHATE)
PYLERA ORAL CAPSULE 140-125-125 MG	Non-Formulary	QL (Quantity Limits Apply)
Cathartics And Laxatives		
GAVILYTE-G ORAL RECON SOLN 236-22.74-6.74 -5.86 GRAM	2	HCR; QL (2 fills per 365 days)
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	2	HCR; QL (2 fills per 365 days)
<i>peg3350-sod sul-nacl-kcl-asb-c oral powder in packet 100-7.5-2.691 gram</i>	2	HCR; QL (2 fills per 365 days)
<i>peg-electrolyte soln oral recon soln 420 gram</i>	2	HCR; QL (2 fills per 365 days)
PLENVU ORAL POWDER IN PACKET, SEQUENTIAL 140-9-5.2 GRAM	Non-Formulary	QL (Quantity Limits Apply)
<i>polyethylene glycol 3350 oral powder 17 gram/dose</i>	2	HCR; QL (2 fills per 365 days); AG (Min 50 Years and Max 75 Years)
<i>polyethylene glycol 3350 oral powder in packet 17 gram</i>	2	HCR
<i>sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram</i>	2	QL (2 fills per 365 days)
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM	Non-Formulary	QL (2 fills per 365 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SUTAB ORAL TABLET 1.479-0.188- 0.225 GRAM	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PEG 3350-ELECTROLYTE)
Chloride Channel Activators		
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG	Non-Formulary	ALT (Covered Alternatives: Lubiprostone); QL (2 capsules per 1 day)
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	2	QL (2 tablets per 1 day)
Cholelitholytic Agents		
BYLVAY ORAL CAPSULE 1,200 MCG, 400 MCG	Non-Formulary	SP
BYLVAY ORAL PELLETT 200 MCG, 600 MCG	Non-Formulary	SP
CHENODAL ORAL TABLET 250 MG	Non-Formulary	SP
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	Non-Formulary	SP; QL (2 capsules per 1 day)
CTEXLI ORAL TABLET 250 MG	Non-Formulary	SP; QL (3 Tablet per 1 day)
IQIRVO ORAL TABLET 80 MG	Non-Formulary	SP; QL (1 Tablet per 1 Day)
LIVDELZI ORAL CAPSULE 10 MG	Non-Formulary	SP; QL (1 Capsule per 1 Day)
LIVMARLI ORAL SOLUTION 19 MG/ML	Non-Formulary	SP
LIVMARLI ORAL SOLUTION 9.5 MG/ML	Non-Formulary	SP; QL (3 ML per 1 day)
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG, 30 MG	Non-Formulary	SP
OICALIVA ORAL TABLET 10 MG, 5 MG	6	PA; SP; QL (30 tablets per 30 days)
<i>ursodiol oral capsule 300 mg</i>	2	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	2	
Digestants		
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	QL (8 capsules per 1 day)
GATTEX 30-VIAL SUBCUTANEOUS KIT 5 MG	6	PA; SP; QL (0.01 unit per 1 day)
GATTEX ONE-VIAL SUBCUTANEOUS KIT 5 MG	6	PA; SP; QL (1 kit per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600-8,800- 15,200 UNIT, 21,000-54,700- 83,900 UNIT, 37,000-97,300-149,900 UNIT, 4,200-14,200- 24,600 UNIT	4	QL (8 capsules per 1 day)
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 16,000-57,500- 60,500 UNIT, 24,000-86,250- 90,750 UNIT, 4,000-14,375- 15,125 UNIT, 8,000-28,750- 30,250 UNIT	4	QL (8 capsules per 1 day)
VIOKACE ORAL TABLET 10,440-39,150- 39,150 UNIT, 20,880-78,300- 78,300 UNIT	Non-Formulary	QL (Quantity Limits Apply)
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	QL (8 capsules per 1 day)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 60,000-189,600- 252,600 UNIT	3	QL (8 Capsules per 1 Day)
Dopamine Receptor Antagonists		
<i>promethazine oral syrup 6.25 mg/5 ml</i>	2	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine rectal suppository 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine-codeine oral syrup 6.25-10 mg/5 ml</i>	2	
<i>promethazine-dm oral syrup 6.25-15 mg/5 ml</i>	2	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG	2	
Gi Drugs, Miscellaneous		
ALLI ORAL CAPSULE 60 MG	2	ALT (Covered Alternatives: PHENTERMINE HCL, DIETHYLPROPION HCL, BENZPHETAMINE HCL); QL (6 Capsules per 1 day)
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	2	QL (2 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
IBSRELA ORAL TABLET 50 MG	Non-Formulary	SP; ALT (Covered Alternatives: polyethylene glycol 3350 powder, lactulose, lubiprostone, Linzess); QL (2 Tablets per 1 Day)
<i>orlistat oral capsule 120 mg</i>	4	PA
SYNDROS ORAL SOLUTION 5 MG/ML	Non-Formulary	QL (Quantity Limits Apply)
XENICAL ORAL CAPSULE 120 MG	Non-Formulary	QL (3 capsules per 1 day)
Guanylate Cyclase C (Gcc) Recept Agonist		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	4	PA; ALT (Covered Alternatives: Lubiprostone); TD; QL (1 capsule per 1 day)
TRULANCE ORAL TABLET 3 MG	Non-Formulary	QL (Quantity Limits Apply)
Histamine H2-Antagonists		
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	2	
<i>famotidine (pf) intravenous solution 20 mg/2 ml</i>	BB	
<i>famotidine oral suspension for reconstitution 40 mg/5 ml (8 mg/ml)</i>	2	QL (5 ML per 1 day)
<i>famotidine oral tablet 20 mg</i>	1	QL (4 tablets per 1 day)
<i>famotidine oral tablet 40 mg</i>	1	QL (3 tablets per 1 day)
<i>nizatidine oral capsule 150 mg, 300 mg</i>	2	
Immunomodulatory Agents (56:44)		
OMVOH INTRAVENOUS SOLUTION 300 MG/15 ML (20 MG/ML)	BB	PA
OMVOH PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 300MG/3ML(100MG /ML-200 MG/2ML)	Non-Formulary	SP; QL (2 ML per 28 days)
OMVOH SUBCUTANEOUS SYRINGE 100 MG/ML	Non-Formulary	SP; QL (2 ML per 28 days)
OMVOH SUBCUTANEOUS SYRINGE 300MG/3ML(100MG /ML-200 MG/2ML)	Non-Formulary	SP; QL (2 ML per 23 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VELSIPITY ORAL TABLET 2 MG	Non-Formulary	SP; ALT (Covered Alternatives: Sulfasalazine, Mesalamine, Balsalazide Disodium); QL (1 Tablet per 1 day)
Lipotropic Agents		
<i>scopolamine base transdermal patch 3 day 1 mg over 3 days</i>	2	QL (4 patches per 1 fill)
Neurokinin-1 Receptor Antagonists		
AKYNZEO (FOSNETUPITANT) INTRAVENOUS RECON SOLN 235-0.25 MG	BB	PA
AKYNZEO (NETUPITANT) ORAL CAPSULE 300-0.5 MG	4	PA; ALT (Covered Alternatives: ONDANSETRON HCL, GRANISETRON HCL); QL (1 fill per 1 month)
<i>aprepitant oral capsule 125 mg</i>	2	QL (1 Capsules per 1 Fill)
<i>aprepitant oral capsule 40 mg, 80 mg</i>	2	QL (2 Capsules per 1 Fill)
<i>aprepitant oral capsule, dose pack 125 mg (1)- 80 mg (2)</i>	2	QL (1 Capsule per 1 Day)
CINVANTI INTRAVENOUS EMULSION 130 MG/18 ML (7.2 MG/ML)	BB	PA
EMEND ORAL CAPSULE 80 MG	Non-Formulary	QL (2 capsules per 1 day)
VARUBI ORAL TABLET 90 MG	4	PA; QL (4 tablets per 28 days)
Opioid Antagonists (56:18)		
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	4	PA; QL (1 tablet per 1 day)
RELISTOR ORAL TABLET 150 MG	Non-Formulary	QL (Quantity Limits Apply); SP
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6 ML	Non-Formulary	QL (Quantity Limits Apply); SP
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML	Non-Formulary	QL (Quantity Limits Apply); SP
SYMPROIC ORAL TABLET 0.2 MG	4	PA; QL (1 tablet per 1 day)
Potassium-Competitive Acid Blockers		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<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	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 250-62.5 MG/5 ML	Non-Formulary	
<i>clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	2	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	2	
<i>clarithromycin oral tablet extended release 24 hr 500 mg</i>	2	
VOQUEZNA DUAL PAK ORAL COMBO PACK 20 MG (28)- 500 MG (84)	Non-Formulary	
VOQUEZNA ORAL TABLET 10 MG, 20 MG	Non-Formulary	
VOQUEZNA TRIPLE PAK ORAL COMBO PACK 20-500-500 MG	Non-Formulary	
Prokinetic Agents		
<i>metoclopramide hcl oral solution 5 mg/5 ml</i>	2	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	2	QL (4 tablets per 1 day)
MOTEGRITY ORAL TABLET 1 MG, 2 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>prucalopride oral tablet 1 mg, 2 mg</i>	Non-Formulary	ALT (Covered Alternatives: LUBIPROSTONE, LACTULOSE); QL (1 Tablet per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Prostaglandins		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	2	
Protectants		
CARAFATE ORAL SUSPENSION 100 MG/ML	Non-Formulary	QL (Quantity Limits Apply)
<i>sucralfate oral suspension 100 mg/ml</i>	2	
<i>sucralfate oral tablet 1 gram</i>	2	QL (4 tablets per 1 day)
Proton-Pump Inhibitors		
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 30 MG, 60 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: LANSOPRAZOLE, PANTOPRAZOLE SODIUM, RABEPRAZOLE SODIUM, ESOMEPRAZOLE MAGNESIUM)
<i>dexlansoprazole oral capsule,biphase delayed releas 30 mg, 60 mg</i>	Non-Formulary	ALT (Covered Alternatives: Lansoprazole, Pantoprazole, Rabeprazole, Esomeprazole, Omeprazole); QL (1 capsule per 1 day)
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg</i>	1	QL (1 capsule per 1 day)
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg</i>	1	QL (2 capsules per 1 day)
<i>esomeprazole magnesium oral granules dr for susp in packet 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg</i>	Non-Formulary	ALT (Covered Alternatives: FIRST-OMEPRAZOLE 2 MG/ML SUSP, FIRST-LANSOPRAZOLE 3 MG/ML); QL (1 Packet per 1 Day)
KONVOMEPRAL ORAL SUSPENSION FOR RECONSTITUTION 2-84 MG/ML	Non-Formulary	ALT (Covered Alternatives: Omeprazole, Esomeprazole, Lansoprazole, Pantoprazole); QL (10 ML per 1 Day)
<i>lansoprazole oral capsule,delayed release(dr/ec) 15 mg, 30 mg</i>	2	QL (2 capsules per 1 day)
<i>lansoprazole oral tablet,disintegrat, delay rel 15 mg, 30 mg</i>	Non-Formulary	ALT (Covered Alternatives: LANSOPRAZOLE, OMEPRAZOLE, PANTOPRAZOLE SODIUM)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 40 MG, 5 MG	Non-Formulary	QL (Quantity Limits Apply)
OMECLAMOX-PAK ORAL COMBO PACK 20 MG-500 MG- 500 MG (40)	Non-Formulary	QL (Quantity Limits Apply)
<i>omeprazole oral capsule, delayed release (dr/ec) 10 mg, 20 mg, 40 mg</i>	2	QL (2 capsules per 1 day)
<i>pantoprazole in 0.9% sod chlor intravenous piggyback 40 mg/100 ml (0.4 mg/ml), 40 mg/50 ml (0.8 mg/ml), 80 mg/100 ml (0.8 mg/ml)</i>	BB	
<i>pantoprazole oral tablet, delayed release (dr/ec) 20 mg</i>	2	QL (4 tablets per 1 day)
<i>pantoprazole oral tablet, delayed release (dr/ec) 40 mg</i>	2	QL (2 tablets per 1 day)
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON 10 MG, 2.5 MG	Non-Formulary	ALT (Covered Alternatives: OMEPRAZOLE, PANTOPRAZOLE SODIUM)
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>rabeprazole oral tablet, delayed release (dr/ec) 20 mg</i>	2	QL (2 tablets per 1 day)
TALICIA ORAL CAPSULE, IR - DELAY REL, BIPHASE 10-250-12.5 MG	Non-Formulary	QL (Quantity Limits Apply)
VIMOVO ORAL TABLET, IR, DELAYED REL, BIPHASIC 500-20 MG	Non-Formulary	ALT (Covered Alternatives: ESOMEPRAZOLE MAGNESIUM, NAPROXEN)
GOLD COMPOUNDS		
Gold Compounds		
RIDAURA ORAL CAPSULE 3 MG	Non-Formulary	SP; QL (1 capsule per 1 day)
HEAVY METAL ANTAGONISTS		
Heavy Metal Antagonists		
CHEMET ORAL CAPSULE 100 MG	4	
CUPRIMINE ORAL CAPSULE 250 MG	Non-Formulary	ALT (Covered Alternatives: DEPEN); QL (4 capsules per 1 day)
CUVRIOR ORAL TABLET 300 MG	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>deferasirox oral granules in packet 180 mg, 360 mg, 90 mg</i>	5	PA; SP
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	2	PA; SP
<i>deferasirox oral tablet, dispersible 125 mg, 250 mg, 500 mg</i>	2	PA; SP
<i>deferiprone oral tablet 1,000 mg</i>	5	PA; SP; ALT (Covered Alternatives: Deferasirox (PA)); QL (3 tablets per 1 day)
<i>deferiprone oral tablet 500 mg</i>	5	PA; SP; QL (3 tablets per 1 day)
EXJADE ORAL TABLET, DISPERSIBLE 125 MG, 250 MG, 500 MG	Non-Formulary	SP
FERRIPROX (2 TIMES A DAY) ORAL TABLET, MODIFIED RELEASE 1,000 MG	Non-Formulary	SP; ALT (Covered Alternatives: Deferasirox (PA)); QL (3 TABLET per 1 day)
FERRIPROX ORAL SOLUTION 100 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: EXJADE)
FERRIPROX ORAL TABLET 1,000 MG	Non-Formulary	SP; ALT (Covered Alternatives: Deferasirox (PA)); QL (3 TABLET per 1 day)
FERRIPROX ORAL TABLET 500 MG	Non-Formulary	SP; ALT (Covered Alternatives: EXJADE); QL (3 tablets per 1 day)
GALZIN ORAL CAPSULE 25 MG (ZINC), 50 MG (ZINC)	Non-Formulary	SP; QL (3 Capsules per 1 Day)
JADENU ORAL TABLET 180 MG, 360 MG, 90 MG	Non-Formulary	SP
JADENU SPRINKLE ORAL GRANULES IN PACKET 180 MG, 360 MG, 90 MG	Non-Formulary	SP; ALT (Covered Alternatives: DEFERASIROX)
<i>penicillamine oral capsule 250 mg</i>	Non-Formulary	ALT (Covered Alternatives: Penicillamine Tablets); QL (4 capsules per 1 day)
<i>penicillamine oral tablet 250 mg</i>	2	PA; SP; QL (4 tablets per 1 day)
SYPRINE ORAL CAPSULE 250 MG	Non-Formulary	SP; QL (1 capsule per 1 day)
<i>trientine oral capsule 250 mg</i>	6	PA; SP; QL (1 capsule per 1 day)
<i>trientine oral capsule 500 mg</i>	Non-Formulary	SP; ALT (Covered Alternatives: trientine 250mg capsule)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HORMONES AND SYNTHETIC SUBSTITUTES		
Adrenals		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	Non-Formulary	ALT (Covered Alternatives: FLUTICASONE-SALMETEROL, WIXELA INHUB); QL (60 units per 1 fill)
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)
AGAMREE ORAL SUSPENSION 40 MG/ML	Non-Formulary	SP; QL (7.5 ML per 1 Day)
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG-14 MCG/ACTUATION, 232-14 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inhaler per 28 days)
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g), Levalbuterol HFA); QL (10.7 GM per 30 Days)
ALA-SCALP TOPICAL LOTION 2 %	Non-Formulary	QL (1 ml per 1 day)
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE)
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION, 80 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (6.1 GM per 28 days)
ARMONAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG/ACTUATION, 232 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inaler per 28 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (30 Blisters per 28 days)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	4	QL (13 GM per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	4	QL (1 inhaler per 30 days)
<i>betamethasone dipropionate topical cream 0.05 %</i>	2	QL (60 GM per 30 days)
<i>betamethasone dipropionate topical lotion 0.05 %</i>	2	QL (60 GM per 30 days)
<i>betamethasone dipropionate topical ointment 0.05 %</i>	2	QL (60 GM per 30 days)
<i>betamethasone valerate topical cream 0.1 %</i>	1	QL (60 GM per 30 days)
<i>betamethasone valerate topical foam 0.12 %</i>	Non-Formulary	
<i>betamethasone valerate topical lotion 0.1 %</i>	2	
<i>betamethasone valerate topical ointment 0.1 %</i>	2	
<i>betamethasone, augmented topical cream 0.05 %</i>	2	QL (60 GM per 1 day)
<i>betamethasone, augmented topical gel 0.05 %</i>	2	QL (15 GM per 30 days)
<i>betamethasone, augmented topical lotion 0.05 %</i>	2	QL (60 GM per 1 day)
<i>betamethasone, augmented topical ointment 0.05 %</i>	2	QL (60 GM per 1 fill)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	3	QL (1 inhaler per 30 days)
BREYNA INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	2	QL (10.3 GM per 1 Fill)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml</i>	2	QL (120 ML per 30 days)
<i>budesonide oral capsule, delayed, extend. release 3 mg</i>	2	QL (3 capsules per 1 day)
<i>budesonide oral tablet, delayed and ext. release 9 mg</i>	2	QL (1 Tablet per Day. 8 Weeks of Treatment per 180 Days)
<i>budesonide-formoterol inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	2	QL (10.3 GM per 1 Fill)
<i>deflazacort oral suspension 22.75 mg/ml</i>	Non-Formulary	SP
<i>deflazacort oral tablet 18 mg, 30 mg, 36 mg, 6 mg</i>	6	PA; SP; QL (2 Tablets per 1 day)
DEXAMETHASONE INTENSOL ORAL DROPS 1 MG/ML	3	QL (30 ML per 1 fill)
<i>dexamethasone oral elixir 0.5 mg/5 ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>dexamethasone oral solution 0.5 mg/5 ml</i>	2	QL (300 ML per 30 days)
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	2	
<i>dexamethasone sodium phos (pf) injection solution 4 mg/ml</i>	BB	
<i>dexamethasone sodium phos (pf) injection syringe 10 mg/ml</i>	BB	
<i>dexamethasone sodium phosphate injection solution 4 mg/ml</i>	7	
<i>dexamethasone sodium phosphate ophthalmic (eye) drops 0.1 %</i>	2	QL (10 ML per 30 days)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 200-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	3	QL (13 GM per 28 days)
DYMISTA NASAL SPRAY, NON-AEROSOL 137-50 MCG/SPRAY	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: AZELASTINE HCL, FLUTICASONE PROPIONATE, FLUNISOLIDE, TRIAMCINOLONE ACETONIDE, BUDESONIDE, MOMETASONE FUROATE)
EMFLAZA ORAL SUSPENSION 22.75 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: PREDNISONE, METHYLPREDNISOLONE)
EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG	Non-Formulary	SP; ALT (Covered Alternatives: Deflazacort Tablets); QL (2 tablets per 1 day)
EOHILIA ORAL SUSPENSION IN PACKET 2 MG/10 ML	Non-Formulary	SP; ALT (Covered Alternatives: BUDESONIDE AMPUL FOR NEBULIZATION (ML)); QL (20 ML per 1 Day)
<i>fludrocortisone oral tablet 0.1 mg</i>	2	
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	2	
<i>fluticasone furoate inhalation blister with device 100 mcg/actuation, 200 mcg/actuation, 50 mcg/actuation</i>	Non-Formulary	QL (1 Box per 30 Days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>fluticasone furoate-vilanterol inhalation blister with device 100-25 mcg/dose, 200-25 mcg/dose</i>	Non-Formulary	QL (60 units per 1 fill)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation, 220 mcg/actuation, 44 mcg/actuation</i>	3	ALT (Covered Alternatives: Pulmicort Flexhaler, QVAR, Alvesco, Asmanex); QL (1 Inhaler per 30 days); AG (Max 4 Years)
<i>fluticasone propionate nasal spray,suspension 50 mcg/actuation</i>	2	QL (1 bottle per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	2	QL (1 inhaler 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 GM per 30 days)
<i>hydrocortisone acetate topical cream with perineal applicator 2.5 %</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE 2.5% CREAM, HYDROCORTISONE 2.5% OINTMENT, HYDROCORTISONE 1% CREAM, HYDROCORTISONE 1% OINTMENT); QL (1 Tube per 30 Days)
<i>hydrocortisone butyrate topical ointment 0.1 %</i>	Non-Formulary	QL (45 gm per 30 days)
<i>hydrocortisone butyrate topical solution 0.1 %</i>	2	QL (45 ML per 30 days)
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>hydrocortisone sod succinate injection recon soln 100 mg</i>	7	
<i>hydrocortisone topical cream 1 %</i>	2	QL (1 gm per 1 day)
<i>hydrocortisone topical cream 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical cream with perineal applicator 1 %</i>	2	QL (28.5 GM per 30 days)
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical lotion 2.5 %</i>	2	QL (60 GM per 30 days)
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	2	QL (30 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydrocortisone topical solution 2.5 %</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE 2.5% CREAM, HYDROCORTISONE 2.5% LOTION, HYDROCORTISONE 2.5% OINTMENT); QL (1 ML per 1 day)
<i>hydrocortisone valerate topical cream 0.2 %</i>	2	QL (60 GM per 30 days)
<i>hydrocortisone valerate topical ointment 0.2 %</i>	Non-Formulary	QL (2 gm per 1 day)
<i>hydrocortisone-acetic acid otic (ear) drops 1-2 %</i>	2	
INTRAROSA VAGINAL INSERT 6.5 MG	4	PA; QL (1 applicator per 1 day)
ISTURISA ORAL TABLET 1 MG, 5 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
JAYTHARI ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
KENALOG INJECTION SUSPENSION 10 MG/ML	7	
KENALOG INJECTION SUSPENSION 40 MG/ML	Non-Formulary	
KENALOG TOPICAL AEROSOL 0.147 MG/GRAM	Non-Formulary	QL (100 gm per 30 days)
KHINDIVI ORAL SOLUTION 1 MG/ML	Non-Formulary	ALT (Covered Alternatives: Hydrocortisone 5mg tablet)
MAXIDEX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 %	4	QL (5 ML per 1 fill)
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG	Non-Formulary	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	2	
<i>methylprednisolone oral tablets,dose pack 4 mg</i>	2	
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE TOPICAL CREAM, HYDROCORTISONE TOPICAL OINMENT); QL (1 Tube per 30 Days)
<i>mometasone nasal spray,non-aerosol 50 mcg/actuation</i>	2	QL (17 GM per 30 days)
<i>mometasone topical cream 0.1 %</i>	2	QL (45 GM per 30 days)
<i>mometasone topical ointment 0.1 %</i>	2	QL (45 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>mometasone topical solution 0.1 %</i>	2	QL (45 ML per 30 days)
<i>nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%</i>	2	QL (1.4 GM per 1 day)
<i>nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%</i>	2	QL (1.4 GM per 1 day)
ORTIKOS ORAL CAPSULE, EXTENDED RELEASE 6 MG, 9 MG	Non-Formulary	QL (Quantity Limits Apply)
OZURDEX INTRAVITREAL IMPLANT 0.7 MG	Non-Formulary	
PRED MILD OPHTHALMIC (EYE) DROPS,SUSPENSION 0.12 %	4	QL (5 ML per 1 fill)
<i>prednisolone acetate ophthalmic (eye) drops,suspension 1 %</i>	2	
<i>prednisolone oral solution 15 mg/5 ml</i>	2	QL (450 ML per 30 days)
<i>prednisolone sodium phosphate ophthalmic (eye) drops 1 %</i>	2	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml</i>	2	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 15 mg/5 ml (5 ml), 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	2	QL (16 ML per 1 day)
<i>prednisolone sodium phosphate oral tablet,disintegrating 10 mg, 15 mg, 30 mg</i>	Non-Formulary	
PREDNISONO INTENSOL ORAL CONCENTRATE 5 MG/ML	3	QL (1 ML per 1 day)
<i>prednisone oral solution 5 mg/5 ml</i>	2	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	2	
<i>prednisone oral tablets,dose pack 10 mg, 5 mg</i>	2	
PROCTO-MED HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)
PROCTOSOL HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PROCTOZONE-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION, 90 MCG/ACTUATION	3	QL (1 inhaler per 30 days)
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML, 1 MG/2 ML	Non-Formulary	ALT (Covered Alternatives: BUDESONIDE); QL (4 ml per 1 day)
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION, 80 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); TD
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION, 80 MCG/ACTUATION	3	
RAYOS ORAL TABLET,DELAYED RELEASE (DR/EC) 1 MG, 2 MG, 5 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PREDNISONE, CORTISONE ACETATE, DEXAMETHASONE, METHYLPREDNISOLONE, FLUDROCORTISONE ACETATE, PREDNISOLONE)
RECORLEV ORAL TABLET 150 MG	Non-Formulary	SP
RYALTRIS NASAL SPRAY, NON-AEROSOL 665-25 MCG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Fluticasone Nasal Spray, Flunisolide Nasal Spray, Mometasone Nasal Spray); QL (1 gram per 1 day)
SCALACORT DK TOPICAL COMBO PACK 2-2-2 %	Non-Formulary	
SCALACORT TOPICAL LOTION 2 %	Non-Formulary	QL (1 ml per 1 day)
SERNIVO TOPICAL SPRAY WITH PUMP 0.05 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, FLUOCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE, FLUOCINONIDE, HYDROCORTISONE)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SINUVA SINUS IMPLANT 1,350 MCG	BB	PA
SOLU-CORTEF ACT-O-VIAL (PF) INJECTION RECON SOLN 1,000 MG/8 ML, 100 MG/2 ML	7	
SOLU-CORTEF INJECTION RECON SOLN 100 MG	Non-Formulary	
SOLU-MEDROL (PF) INJECTION RECON SOLN 125 MG/2 ML	7	
SOLU-MEDROL INTRAVENOUS RECON SOLN 500 MG	Non-Formulary	
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: BUDESONIDE/FORMOTEROL FUMARATE); QL (10.3 GM per 1 Fill)
TARPEYO ORAL CAPSULE, DELAYED RELEASE(DR/EC) 4 MG	Non-Formulary	SP
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	4	PA; TD
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG	4	PA; TD; QL (1 DEVICE per 30 days)
<i>triamcinolone aceton-0.9% nacl injection suspension 50 mg/ml</i>	7	
<i>triamcinolone acetonide dental paste 0.1 %</i>	2	QL (5 GM per 1 fill)
<i>triamcinolone acetonide injection suspension 40 mg/ml</i>	7	
<i>triamcinolone acetonide topical aerosol 0.147 mg/gram</i>	Non-Formulary	QL (100 gm per 30 days)
<i>triamcinolone acetonide topical cream 0.025 %, 0.5 %</i>	2	QL (80 GM per 30 days)
<i>triamcinolone acetonide topical cream 0.1 %</i>	2	QL (90 GM per 30 days)
<i>triamcinolone acetonide topical lotion 0.025 %, 0.1 %</i>	2	QL (60 GM per 30 days)
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %</i>	2	QL (80 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>triamcinolone acetonide topical ointment 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE)
<i>triamcinolone acetonide topical ointment 0.5 %</i>	2	QL (15 GM per 30 days)
TRIANEX TOPICAL OINTMENT 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, FLUCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE)
UCERIS RECTAL FOAM 2 MG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply)
VERIPRED 20 ORAL SOLUTION 20 MG/5 ML (4 MG/ML)	Non-Formulary	QL (16 units per 1 day)
WIXELA INHUB INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	2	QL (60 GM per 30 days)
XHANCE NASAL AEROSOL BREATH ACTIVATED 93 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply)
ZILRETTA INTRA-ARTICULAR SUSPENSION,EXTENDED REL RECON 32 MG	BB	PA
Alpha-Glucosidase Inhibitors		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	2	
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	2	
Androgens		
AVEED INTRAMUSCULAR SOLUTION 750 MG/3 ML (250 MG/ML)	BB	PA
AZMIRO INTRAMUSCULAR SYRINGE 200 MG/ML	BB	
COVARYX H.S. ORAL TABLET 0.625-1.25 MG	Non-Formulary	
COVARYX ORAL TABLET 1.25-2.5 MG	Non-Formulary	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	2	
EEMT HS ORAL TABLET 0.625-1.25 MG	Non-Formulary	
EEMT ORAL TABLET 1.25-2.5 MG	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>estrogens-methyltestosterone oral tablet 0.625-1.25 mg, 1.25-2.5 mg</i>	Non-Formulary	
JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG	Non-Formulary	QL (Quantity Limits Apply)
KYZATREX ORAL CAPSULE 100 MG, 150 MG, 200 MG	Non-Formulary	
<i>methyltestosterone oral capsule 10 mg</i>	2	PA; QL (2 capsules per 1 day)
TESTIM TRANSDERMAL GEL 50 MG/5 GRAM (1 %)	Non-Formulary	QL (5 gm per 1 day)
TESTOPEL IMPLANT PELLETT 75 MG	BB	PA
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	2	QL (10 ML per 28 days)
<i>testosterone enanthate intramuscular oil 200 mg/ml</i>	2	
<i>testosterone transdermal gel 50 mg/5 gram (1 %)</i>	2	QL (5 GM per 1 day)
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation</i>	2	PA; QL (120 GM per 30 days)
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	2	QL (5 GM per 1 day)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	2	QL (10 GM per 1 day)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram)</i>	2	QL (75 GM per 1 Fill)
<i>testosterone transdermal gel in packet 1 % (50 mg/5 gram)</i>	2	PA; QL (5 GM per 1 day)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	2	PA; QL (60 packets per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	2	QL (60 packets per 30 days)
UNDECATREX ORAL CAPSULE 200 MG	Non-Formulary	ALT (Covered Alternatives: Testosterone Cypionate Vial); QL (2 Capsules per 1 Day)
VOGELXO TRANSDERMAL GEL 50 MG/5 GRAM (1 %)	Non-Formulary	QL (5 gm per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP 12.5 MG/ 1.25 GRAM (1 %)	Non-Formulary	QL (5 units per 1 day)
VOGELXO TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	Non-Formulary	QL (5 gm per 1 day)
XYOSTED SUBCUTANEOUS AUTO-INJECTOR 100 MG/0.5 ML, 50 MG/0.5 ML, 75 MG/0.5 ML	Non-Formulary	QL (Quantity Limits Apply)
Antidiabetic Agents, Miscellaneous		
<i>colesevelam oral powder in packet 3.75 gram</i>	2	QL (1 packet per 1 day)
<i>colesevelam oral tablet 625 mg</i>	2	QL (6 tablets per 1 day)
KORLYM ORAL TABLET 300 MG	Non-Formulary	SP; QL (1 Tablet per 1 day)
<i>mifepristone oral tablet 300 mg</i>	Non-Formulary	SP; QL (1 Tablet per 1 day)
WELCHOL ORAL POWDER IN PACKET 3.75 GRAM	Non-Formulary	QL (1 unit per 1 day)
WELCHOL ORAL TABLET 625 MG	Non-Formulary	ST (Step Therapy Required); QL (7 tablets per 1 day)
Antiestrogens		
<i>anastrozole oral tablet 1 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>exemestane oral tablet 25 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>letrozole oral tablet 2.5 mg</i>	2	QL (1 tablet per 1 day)
Antigonadotropins		
AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ALTAVERA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
AMETHYST (28) ORAL TABLET 90-20 MCG (28)	2	HCR; QL (1 tablet per 1 day)
ARANELLE (28) ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUBRA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
AUROVELA 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AVEED INTRAMUSCULAR SOLUTION 750 MG/3 ML (250 MG/ML)	BB	PA
AVIANE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AYUNA ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
AZMIRO INTRAMUSCULAR SYRINGE 200 MG/ML	BB	
BALZIVA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
BRIELLYN ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
CAMILA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
CETROTIDE SUBCUTANEOUS KIT 0.25 MG	Non-Formulary	SP; ALT (Covered Alternatives: Ganirelix); QL (1 Kit per 1 day)
CHATEAL EQ (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
CRYSSELLE (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	2	
DASETTA 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
DASETTA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
DEBLITANE ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
DOLISHALE ORAL TABLET 90-20 MCG (28)	4	HCR
ELINEST ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ELURYNG VAGINAL RING 0.12-0.015 MG/24 HR	2	HCR; QL (1 ring per 30 days)
EMZAHH ORAL TABLET 0.35 MG	2	
ENILLORING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	
ENPRESSE ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)
ERRIN ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	2	HCR; QL (1 ring per 30 days)
FALMINA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
FYREMADEL SUBCUTANEOUS SYRINGE 250 MCG/0.5 ML	Non-Formulary	ALT (Covered Alternatives: Ganirelix); QL (7 Syringes per 28 days)
<i>ganirelix subcutaneous syringe 250 mcg/0.5 ml</i>	5	PA; SP; QL (10 Syringes per 28 days)
HAILEY ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
HALOETTE VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	
HEATHER ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
ICLEVIA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	4	HCR
INCASSIA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
INTROVALE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 Tablets per 1 Day)
JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG	Non-Formulary	QL (Quantity Limits Apply)
JENCYCLA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
JOLESSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
JUNEL 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
JUNEL 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
KURVELO (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
KYZATREX ORAL CAPSULE 100 MG, 150 MG, 200 MG	Non-Formulary	
LARIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LARIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LEENA 28 ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LESSINA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LEVONEST (28) ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg (28)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2	HCR; QL (1 tablet per 1 day)
LEVORA-28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
LOW-OGESTREL (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LUTERA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LYLEQ ORAL TABLET 0.35 MG	4	HCR
LYZA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
MARLISSA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
MELEYA ORAL TABLET 0.35 MG	2	HCR
<i>methyltestosterone oral capsule 10 mg</i>	2	PA; QL (2 capsules per 1 day)
MICROGESTIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MICROGESTIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MYFEMBREE ORAL TABLET 40-1-0.5 MG	6	PA; QL (1 tablet per month, 24 months max); SP
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NEXPLANON SUBDERMAL IMPLANT 68 MG	1	PA; HCR
NORA-BE ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
<i>norelgestromin-ethin.estradiol transdermal patch weekly 150-35 mcg/24 hr</i>	4	HCR
<i>norethindrone (contraceptive) oral tablet 0.35 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG (21)	2	HCR; QL (1 tablet per 1 day)
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NORTREL 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
NUVARING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	ALT (Covered Alternatives: ETONOGESTREL-ETHINYL ESTRADIOL, ELURYNG); HCR; QL (1 unit per 1 fill)
NYLIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	4	HCR
NYLIA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG-35 MCG	4	HCR
ORGOVYX ORAL TABLET 120 MG	6	PA; SP; QL (1 tablet per 1 day)
ORIAHNN ORAL CAPSULE, SEQUENTIAL 300-1-0.5MG(AM) /300 MG(PM)	Non-Formulary	QL (Quantity Limits Apply)
ORLISSA ORAL TABLET 150 MG, 200 MG	6	PA; SP; QL (1 tablets per 1 day)
ORQUIDEA ORAL TABLET 0.35 MG	2	HCR; QL (1 Tablet per 1 day)
PHILITH ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
PORTIA 28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
SETLAKIN ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
SHAROBEL ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
SLYND ORAL TABLET 4 MG (28)	4	QL (Quantity Limits Apply); HCR
SRONYX ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
TESTIM TRANSDERMAL GEL 50 MG/5 GRAM (1 %)	Non-Formulary	QL (5 gm per 1 day)
TESTOPEL IMPLANT PELLETT 75 MG	BB	PA
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	2	QL (10 ML per 28 days)
<i>testosterone enanthate intramuscular oil 200 mg/ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>testosterone transdermal gel 50 mg/5 gram (1 %)</i>	2	QL (5 GM per 1 day)
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation</i>	2	PA; QL (120 GM per 30 days)
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	2	QL (5 GM per 1 day)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	2	QL (10 GM per 1 day)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram)</i>	2	QL (75 GM per 1 Fill)
<i>testosterone transdermal gel in packet 1 % (50 mg/5 gram)</i>	2	PA; QL (5 GM per 1 day)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	2	PA; QL (60 packets per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	2	QL (60 packets per 30 days)
TULANA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
TURQOZ (28) ORAL TABLET 0.3-30 MG-MCG	4	HCR
TYBLUME ORAL TABLET,CHEWABLE 0.1 MG-20 MCG	4	HCR
UNDECATREX ORAL CAPSULE 200 MG	Non-Formulary	ALT (Covered Alternatives: Testosterone Cypionate Vial); QL (2 Capsules per 1 Day)
VIENVA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
VOGELXO TRANSDERMAL GEL 50 MG/5 GRAM (1 %)	Non-Formulary	QL (5 gm per 1 day)
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP 12.5 MG/ 1.25 GRAM (1 %)	Non-Formulary	QL (5 units per 1 day)
VOGELXO TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	Non-Formulary	QL (5 gm per 1 day)
VYFEMLA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
WERA (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	2	HCR; QL (3 patches per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
XYOSTED SUBCUTANEOUS AUTO-INJECTOR 100 MG/0.5 ML, 50 MG/0.5 ML, 75 MG/0.5 ML	Non-Formulary	QL (Quantity Limits Apply)
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	4	HCR
Antiparathyroid Agents		
<i>calcitonin (salmon) nasal spray, non-aerosol 200 unit/actuation</i>	2	PA; QL (3.7 ml per 1 month)
<i>cinacalcet oral tablet 30 mg, 60 mg, 90 mg</i>	2	QL (4 tablets per 1 day)
SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG	Non-Formulary	QL (4 tablets per 1 day)
Antithyroid Agents		
<i>methimazole oral tablet 10 mg, 5 mg</i>	2	
<i>propylthiouracil oral tablet 50 mg</i>	2	
Biguanides		
<i>dapaglifloz propaned-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg</i>	Non-Formulary	ALT (Covered Alternatives: Xigduo XR); QL (1 Tablet per 1 Day)
<i>dapaglifloz propaned-metformin oral tablet, ir - er, biphasic 24hr 5-1,000 mg</i>	Non-Formulary	ALT (Covered Alternatives: Xigduo XR); QL (2 Tablets per 1 Day)
<i>glipizide-metformin oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	2	QL (4 tablets per 1 day)
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	2	
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG	Non-Formulary	ALT (Covered Alternatives: SYNJARDY, JARDIANCE); TD; QL (2 tablets per 1 day)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG	Non-Formulary	QL (Quantity Limits Apply); TD
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG	3	QL (2 tablets per 1 day)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	3	QL (1 Tablet per 1 day)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	3	QL (2 Tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG	Non-Formulary	QL (Quantity Limits Apply); TD
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	Non-Formulary	QL (Quantity Limits Apply); TD
KAZANO ORAL TABLET 12.5-1,000 MG, 12.5-500 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: JANUVIA, JANUMET, JANUMET XR)
<i>metformin oral solution 500 mg/5 ml</i>	Non-Formulary	ALT (Covered Alternatives: Metformin Tablets); QL (20 ML per 1 day)
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	1	
<i>metformin oral tablet 750 mg</i>	Non-Formulary	ALT (Covered Alternatives: Metformin 500mg, Metformin 1000mg); QL (4 Tablets per 1 Day)
<i>metformin oral tablet extended release 24 hr 500 mg, 750 mg</i>	2	QL (4 tablets per 1 day)
<i>metformin oral tablet extended release 24hr 1,000 mg, 500 mg</i>	Non-Formulary	ALT (Covered Alternatives: METFORMIN HCL ER, GLUCOPHAGE XR)
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg, 500 mg</i>	Non-Formulary	ALT (Covered Alternatives: METFORMIN HCL ER, GLUCOPHAGE XR)
<i>pioglitazone-metformin oral tablet 15-500 mg, 15-850 mg</i>	2	QL (4 tablets per 1 day)
RIOMET ORAL SOLUTION 500 MG/5 ML	Non-Formulary	QL (Quantity Limits Apply)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg</i>	Non-Formulary	TD; QL (2 Tablets per 1 day)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg</i>	Non-Formulary	TD; QL (1 Tablet per 1 day)
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 7.5-1,000 MG, 7.5-500 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>sitagliptin-metformin oral tablet, er multiphase 24 hr 100-1,000 mg</i>	Non-Formulary	QL (1 Tablet per 1 Day)
<i>sitagliptin-metformin oral tablet, er multiphase 24 hr 50-1,000 mg, 50-500 mg</i>	Non-Formulary	QL (2 Tablets per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG	3	QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	QL (1 tablet per 1 day)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	QL (2 tablets per 1 day)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 12.5-2.5-1,000 MG, 25-5-1,000 MG, 5-2.5-1,000 MG	Non-Formulary	QL (Quantity Limits Apply)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 2.5-1,000 MG, 5-500 MG	3	ALT (Covered Alternatives: JARDIANCE, SYNJARDY, JANUVIA, METFORMIN HCL); QL (1 tablets per 1 day)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	ALT (Covered Alternatives: JARDIANCE, SYNJARDY, JANUVIA, METFORMIN HCL); QL (2 tablets per 1 day)
Contraceptives		
AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AFTER PILL ORAL TABLET 1.5 MG	4	HCR; QL (2 Tablets per 1 Fill)
AFTERA ORAL TABLET 1.5 MG	Non-Formulary	ALT (Covered Alternatives: LEVONORGESTREL); HCR
ALTAVERA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
AMETHIA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7)	2	HCR; QL (1 tablet per 1 day)
AMETHYST (28) ORAL TABLET 90-20 MCG (28)	2	HCR; QL (1 tablet per 1 day)
ANNOVERA VAGINAL RING 0.15-0.013 MG/24 HOUR	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: ETONOGESTREL-ETHINYL ESTRADIOL, ELURYNG); HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
APRI ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
ARANELLE (28) ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ASHLYNA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7)	2	HCR; QL (1 tablet per 1 day)
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUBRA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 24 FE ORAL TABLET 1 MG-20 MCG (24)/75 MG (4)	2	HCR; QL (1 tablet per 1 day)
AUROVELA FE 1.5/30 (28) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
AUROVELA FE 1-20 (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
AVERI ORAL TABLET 0.15 MG-0.03 MG (21)/36.5 MG(7)	2	HCR
AVIANE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AYUNA ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
AZURETTE (28) ORAL TABLET 0.15-0.02 MGX21 /0.01 MG X 5	2	HCR; QL (1 tablet per 1 day)
BALCOLTRA ORAL TABLET 0.1 MG-0.02 MG (21)/IRON (7)	Non-Formulary	QL (Quantity Limits Apply); HCR
BALZIVA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
BEYAZ ORAL TABLET 3-0.02-0.451 MG (24) (4)	Non-Formulary	QL (Quantity Limits Apply); HCR
BLISOVI 24 FE ORAL TABLET 1 MG-20 MCG (24)/75 MG (4)	2	HCR; QL (1 tablet per 1 day)
BLISOVI FE 1.5/30 (28) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
BLISOVI FE 1/20 (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
BRIELLYN ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
CAMILA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
CAMRESE LO ORAL TABLETS,DOSE PACK,3 MONTH 0.1 MG-20 MCG (84)/10 MCG (7)	2	HCR; QL (1 tablet per 1 day)
CAMRESE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7)	2	HCR; QL (1 tablet per 1 day)
CAZIAN (28) ORAL TABLET 0.1/.125/.15-25 MG-MCG	2	HCR; QL (1 tablet per 1 day)
CHARLOTTE 24 FE ORAL TABLET,CHEWABLE 1 MG-20 MCG(24) /75 MG (4)	4	HCR
CHATEAL EQ (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
CRYSELLE (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
CYRED EQ ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
CYRED ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
DASETTA 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
DASETTA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
DAYSEE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7)	2	HCR; QL (1 tablet per 1 day)
DEBLITANE ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
<i>desog-e.estradiol/e.estradiol oral tablet 0.15-0.02 mgx21 /0.01 mg x 5</i>	2	HCR; QL (1 tablet per 1 day)
DOLISHALE ORAL TABLET 90-20 MCG (28)	4	HCR
<i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4), 3-0.03-0.451 mg (21) (7)</i>	2	HCR
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	2	HCR; QL (1 tablet per 1 day)
ECONTRA EZ ORAL TABLET 1.5 MG	2	QL (1 pack per fill and 3 fills per 365 days); HCR
ECONTRA ONE-STEP ORAL TABLET 1.5 MG	2	HCR
ELINEST ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ELLA ORAL TABLET 30 MG	4	QL (1 pack per fill and 3 fills per 365 days); HCR
ELURYNG VAGINAL RING 0.12-0.015 MG/24 HR	2	HCR; QL (1 ring per 30 days)
EMZAHH ORAL TABLET 0.35 MG	2	
ENILLORING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	
ENPRESSE ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)
ENSKYCE ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
ERRIN ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
ESTARYLLA ORAL TABLET 0.25-0.035 MG	2	HCR; QL (1 tablet per 1 day)
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg</i>	2	HCR; QL (1 tablet per 1 day)
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	2	HCR
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	2	HCR; QL (1 ring per 30 days)
FALMINA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
FEIRZA ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 Tablet per 1 day)
FINZALA ORAL TABLET,CHEWABLE 1 MG-20 MCG(24) /75 MG (4)	4	HCR
GALBRIELA ORAL TABLET,CHEWABLE 0.8MG-25MCG(24) AND 75 MG (4)	2	HCR
GEMMILY ORAL CAPSULE 1 MG-20 MCG (24)/75 MG (4)	4	HCR
HAILEY 24 FE ORAL TABLET 1 MG-20 MCG (24)/75 MG (4)	2	HCR; QL (1 tablet per 1 day)
HAILEY FE 1.5/30 (28) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
HAILEY FE 1/20 (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR
HAILEY ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
HALOETTE VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HEATHER ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
ICLEVIA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	4	HCR
INCASSIA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
INTROVALE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 Tablets per 1 Day)
ISIBLOOM ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
JAIMIESS ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7)	4	HCR
JASMIEL (28) ORAL TABLET 3-0.02 MG	2	HCR; QL (1 tablet per 1 day)
JENCYCLA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
JOLESSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
JOYEAUX ORAL TABLET 0.1 MG-0.02 MG (21)/IRON (7)	4	HCR
JULEBER ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
JUNEL 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
JUNEL 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
JUNEL FE 1.5/30 (28) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
JUNEL FE 1/20 (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
JUNEL FE 24 ORAL TABLET 1 MG-20 MCG (24)/75 MG (4)	2	HCR; QL (1 tablet per 1 day)
KAITLIB FE ORAL TABLET,CHEWABLE 0.8MG-25MCG(24) AND 75 MG (4)	2	HCR; QL (1 tablet per 1 day)
KALLIGA ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
KARIVA (28) ORAL TABLET 0.15-0.02 MGX21 /0.01 MG X 5	2	HCR; QL (1 tablet per 1 day)
KELNOR 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
KURVELO (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)</i>	2	HCR; QL (1 tablet per 1 day)
LARIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LARIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LARIN 24 FE ORAL TABLET 1 MG-20 MCG (24)/75 MG (4)	2	HCR; QL (1 tablet per 1 day)
LARIN FE 1.5/30 (28) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
LARIN FE 1/20 (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
LEENA 28 ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LESSINA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LEVONEST (28) ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)
<i>levonorgest-eth.estradiol-iron oral tablet 0.1 mg-0.02 mg (21)/iron (7)</i>	4	HCR
<i>levonorgestrel oral tablet 1.5 mg</i>	2	HCR
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg (28)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2	HCR; QL (1 tablet per 1 day)
LEVORA-28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG (24)/10 MCG (2)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: JUNEL FE, LARIN FE, TARINA FE, MICROGESTIN FE); HCR
LOJAIMIESS ORAL TABLETS,DOSE PACK,3 MONTH 0.1 MG-20 MCG (84)/10 MCG (7)	4	HCR
LORYNA (28) ORAL TABLET 3-0.02 MG	2	HCR; QL (1 tablet per 1 day)
LOW-OGESTREL (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LO-ZUMANDIMINE (28) ORAL TABLET 3-0.02 MG	2	HCR; QL (1 tablet per 1 day)
LUTERA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LYLEQ ORAL TABLET 0.35 MG	4	HCR
LYZA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
MARLISSA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
MELEYA ORAL TABLET 0.35 MG	2	HCR
MERZEE ORAL CAPSULE 1 MG-20 MCG (24)/75 MG (4)	4	HCR
MICROGESTIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MICROGESTIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MICROGESTIN FE 1.5/30 (28) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
MICROGESTIN FE 1/20 (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
MILI ORAL TABLET 0.25-0.035 MG	2	HCR; QL (1 tablet per 1 day)
MONO-LINYAH ORAL TABLET 0.25-0.035 MG	2	HCR; QL (1 tablet per 1 day)
MY CHOICE ORAL TABLET 1.5 MG	2	HCR
MY WAY ORAL TABLET 1.5 MG	2	QL (1 pack per fill ; 3 fills per 365 days); HCR
NATAZIA ORAL TABLET 3 MG/2 MG-2 MG/ 2 MG-3 MG/1 MG	Non-Formulary	QL (Quantity Limits Apply); HCR; TD
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NEW DAY ORAL TABLET 1.5 MG	2	HCR
NEXPLANON SUBDERMAL IMPLANT 68 MG	1	PA; HCR
NEXTSTELLIS ORAL TABLET 3 MG- 14.2 MG (28)	Non-Formulary	ALT (Covered Alternatives: DROSPIRENONE-ETHINYL ESTRADIOL, NIKKI, ZARAH, LORYNA, SYEDA); HCR
NIKKI (28) ORAL TABLET 3-0.02 MG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NORA-BE ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
<i>norelgestromin-ethin.estradiol transdermal patch weekly 150-35 mcg/24 hr</i>	4	HCR
<i>noreth-ethinyl estradiol-iron oral tablet,chewable 0.8mg-25mcg(24) and 75 mg (4)</i>	2	HCR; QL (1 tablet per 1 day)
<i>norethindrone (contraceptive) oral tablet 0.35 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	2	HCR; QL (1 tablet per 1 day)
<i>norethindrone-e.estradiol-iron oral capsule 1 mg-20 mcg (24)/75 mg (4)</i>	4	HCR
<i>norethindrone-e.estradiol-iron oral tablet 1.5 mg-30 mcg (21)/75 mg (7)</i>	2	HCR; QL (1 tablet per 1 day)
<i>norethindrone-e.estradiol-iron oral tablet,chewable 1 mg-20 mcg(24) /75 mg (4)</i>	2	HCR
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-0.025 mg</i>	2	HCR
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-0.035mg (28), 0.25-0.035 mg</i>	2	HCR; QL (1 tablet per 1 day)
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG (21)	2	HCR; QL (1 tablet per 1 day)
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NORTREL 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
NUVARING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	ALT (Covered Alternatives: ETONOGESTREL-ETHINYL ESTRADIOL, ELURYNG); HCR; QL (1 unit per 1 fill)
NYLIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	4	HCR
NYLIA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG-35 MCG	4	HCR
OCELLA ORAL TABLET 3-0.03 MG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
OPCICON ONE-STEP ORAL TABLET 1.5 MG	2	QL (1 pack per fill and 3 fills per 365 days); HCR
OPTION-2 ORAL TABLET 1.5 MG	2	HCR
ORQUIDEA ORAL TABLET 0.35 MG	2	HCR; QL (1 Tablet per 1 day)
PHILITH ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
PIMTREA (28) ORAL TABLET 0.15-0.02 MGX21 /0.01 MG X 5	2	HCR; QL (1 tablet per 1 day)
PORTIA 28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
RECLIPSEN (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
RIVELSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-20 MCG/ 0.15 MG-25 MCG	2	HCR; QL (1 tablet per 1 day)
ROSYRAH ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-20 MCG/ 0.15 MG-25 MCG	2	HCR; QL (1 Tablet per 1 Day)
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (21) (7)	Non-Formulary	QL (Quantity Limits Apply); HCR
SETLAKIN ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
SHAROBEL ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
SIMLIYA (28) ORAL TABLET 0.15-0.02 MGX21 /0.01 MG X 5	2	HCR; QL (1 tablet per 1 day)
SIMPESSE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7)	2	HCR; QL (1 tablet per 1 day)
SLYND ORAL TABLET 4 MG (28)	4	QL (Quantity Limits Apply); HCR
SPRINTEC (28) ORAL TABLET 0.25-0.035 MG	2	HCR; QL (1 tablet per 1 day)
SRONYX ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
SYEDA ORAL TABLET 3-0.03 MG	2	HCR; QL (1 tablet per 1 day)
TAKE ACTION ORAL TABLET 1.5 MG	Non-Formulary	ALT (Covered Alternatives: LEVONORGESTREL); HCR
TARINA FE 1/20 (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)
TARINA FE 1-20 EQ (28) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TAYTULLA ORAL CAPSULE 1 MG-20 MCG (24)/75 MG (4)	Non-Formulary	QL (Quantity Limits Apply); HCR
TILIA FE ORAL TABLET 1-20(5)/1-30(7) /1MG-35MCG (9)	2	HCR; QL (1 tablet per 1 day)
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-0.035MG (28)	2	HCR; QL (1 tablet per 1 day)
TRI-LEGEST FE ORAL TABLET 1-20(5)/1-30(7) /1MG-35MCG (9)	2	HCR; QL (1 tablet per 1 day)
TRI-LINYAH ORAL TABLET 0.18/0.215/0.25 MG-0.035MG (28)	2	HCR; QL (1 tablet per 1 day)
TRI-LO-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-0.025 MG	2	HCR
TRI-LO-MARZIA ORAL TABLET 0.18/0.215/0.25 MG-0.025 MG	2	HCR
TRI-LO-MILI ORAL TABLET 0.18/0.215/0.25 MG-0.025 MG	2	HCR
TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-0.025 MG	2	HCR
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-0.035MG (28)	2	HCR; QL (1 tablet per 1 day)
TRI-SPRINTEC (28) ORAL TABLET 0.18/0.215/0.25 MG-0.035MG (28)	2	HCR; QL (1 tablet per 1 day)
TRI-VYLIBRA LO ORAL TABLET 0.18/0.215/0.25 MG-0.025 MG	2	HCR
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-0.035MG (28)	2	HCR; QL (1 tablet per 1 day)
TULANA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
TURQOZ (28) ORAL TABLET 0.3-30 MG-MCG	4	HCR
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24 HR	4	HCR
TYBLUME ORAL TABLET,CHEWABLE 0.1 MG-20 MCG	4	HCR
VELIVET TRIPHASIC REGIMEN (28) ORAL TABLET 0.1/.125/.15-25 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VIENVA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
VIORELE (28) ORAL TABLET 0.15-0.02 MGX21 /0.01 MG X 5	2	HCR; QL (1 tablet per 1 day)
VOLNEA (28) ORAL TABLET 0.15-0.02 MGX21 /0.01 MG X 5	4	HCR
VYFEMLA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
VYLIBRA ORAL TABLET 0.25-0.035 MG	2	HCR; QL (1 tablet per 1 day)
WERA (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
WYMZYA FE ORAL TABLET,CHEWABLE 0.4MG-35MCG(21) AND 75 MG (7)	2	HCR; QL (1 tablet per 1 day)
XARAH FE ORAL TABLET 1-20(5)/1-30(7) /1MG-35MCG (9)	2	HCR; QL (1 Tablet per 1 day)
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	2	HCR; QL (3 patches per 28 days)
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	4	HCR
ZARAH ORAL TABLET 3-0.03 MG	2	HCR; QL (1 tablet per 1 day)
ZUMANDIMINE (28) ORAL TABLET 3-0.03 MG	2	HCR; QL (1 tablet per 1 day)
Dipeptidyl Peptidase-4(Dpp-4) Inhibitors		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: JARDIANCE, JANUVIA); TD
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG	3	QL (2 tablets per 1 day)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	3	QL (1 Tablet per 1 day)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	3	QL (2 Tablets per 1 day)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	QL (1 tablet per 1 day)
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG	Non-Formulary	QL (Quantity Limits Apply); TD
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	Non-Formulary	QL (Quantity Limits Apply); TD

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
KAZANO ORAL TABLET 12.5-1,000 MG, 12.5-500 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: JANUVIA, JANUMET, JANUMET XR)
NESINA ORAL TABLET 12.5 MG, 25 MG	Non-Formulary	ALT (Covered Alternatives: JANUVIA, JANUMET); QL (1 tablet per 1 day)
OSENI ORAL TABLET 12.5-30 MG, 25-45 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>saxagliptin oral tablet 2.5 mg, 5 mg</i>	2	PA; TD; QL (1 Tablet per 1 Day)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg</i>	Non-Formulary	TD; QL (2 Tablets per 1 day)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg</i>	Non-Formulary	TD; QL (1 Tablet per 1 day)
<i>sitagliptin oral tablet 100 mg, 25 mg, 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: Januvia); QL (1 Tablet per 1 day)
<i>sitagliptin-metformin oral tablet, er multiphase 24 hr 100-1,000 mg</i>	Non-Formulary	QL (1 Tablet per 1 Day)
<i>sitagliptin-metformin oral tablet, er multiphase 24 hr 50-1,000 mg, 50-500 mg</i>	Non-Formulary	QL (2 Tablets per 1 Day)
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG	Non-Formulary	QL (Quantity Limits Apply)
TRADJENTA ORAL TABLET 5 MG	4	PA; TD; QL (1 tablet per 1 day)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 12.5-2.5-1,000 MG, 25-5-1,000 MG, 5-2.5-1,000 MG	Non-Formulary	QL (Quantity Limits Apply)
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: Januvia); QL (1 Tablet per 1 Day)
Estrogen Agonist-Antagonists		
CLOMID ORAL TABLET 50 MG	3	QL (30 tablets per 30 dayss)
<i>clomiphene citrate oral tablet 50 mg</i>	2	QL (30 tablets per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DUAVEE ORAL TABLET 0.45-20 MG	4	PA; ALT (Covered Alternatives: ESTRADIOL, RALOXIFENE HCL, ALENDRONATE SODIUM, IBANDRONATE SODIUM, CITALOPRAM HBR, ESCITALOPRAM OXALATE, FLUOXETINE HCL); QL (1 tablet per 1 day)
FARESTON ORAL TABLET 60 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
OSPHENA ORAL TABLET 60 MG	4	PA; QL (1 tablet per 1 day)
<i>raloxifene oral tablet 60 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>tamoxifen oral tablet 10 mg, 20 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>toremifene oral tablet 60 mg</i>	2	PA; SP; QL (1 tablet per 1 day)
Estrogens		
ABIGALE LO ORAL TABLET 0.5-0.1 MG	2	HCR
ABIGALE ORAL TABLET 1-0.5 MG	2	HCR
AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ALTAVERA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
AMETHYST (28) ORAL TABLET 90-20 MCG (28)	2	HCR; QL (1 tablet per 1 day)
ARANELLE (28) ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUBRA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AVIANE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AYUNA ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
BALZIVA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
BIJUVA ORAL CAPSULE 0.5-100 MG	Non-Formulary	QL (1 Capsule per 1 day)
BIJUVA ORAL CAPSULE 1-100 MG	Non-Formulary	QL (Quantity Limits Apply); QL (1 Capsule per 1 day)
BRIELLYN ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
CHATEAL EQ (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/24 HR	Non-Formulary	QL (Quantity Limits Apply)
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.14 MG/24 HR, 0.05-0.25 MG/24 HR	4	QL (8 patches per 28 days)
COVARYX H.S. ORAL TABLET 0.625-1.25 MG	Non-Formulary	
COVARYX ORAL TABLET 1.25-2.5 MG	Non-Formulary	
CRYSELLE (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
DASETTA 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
DASETTA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
DIVIGEL TRANSDERMAL GEL IN PACKET 0.25 MG/0.25 GRAM (0.1 %), 0.5 MG/0.5 GRAM (0.1 %), 0.75 MG/0.75 GRAM (0.1%), 1 MG/GRAM (0.1 %), 1.25 MG/1.25 GRAM (0.1 %)	Non-Formulary	QL (1 Packet per 1 day)
DOLISHALE ORAL TABLET 90-20 MCG (28)	4	HCR
DUAVEE ORAL TABLET 0.45-20 MG	4	PA; ALT (Covered Alternatives: ESTRADIOL, RALOXIFENE HCL, ALENDRONATE SODIUM, IBANDRONATE SODIUM, CITALOPRAM HBR, ESCITALOPRAM OXALATE, FLUOXETINE HCL); QL (1 tablet per 1 day)
EEMT HS ORAL TABLET 0.625-1.25 MG	Non-Formulary	
EEMT ORAL TABLET 1.25-2.5 MG	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ELESTRIN TRANSDERMAL GEL IN METERED-DOSE PUMP 0.87 GRAM/ACTUATION	4	QL (1 GM per 30 days)
ELINEST ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ELURYNG VAGINAL RING 0.12-0.015 MG/24 HR	2	HCR; QL (1 ring per 30 days)
ENILLORING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	
ENPRESSE ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>estradiol transdermal gel in metered-dose pump 1.25 gram/actuation</i>	2	QL (50 GM per 30 Days)
<i>estradiol transdermal gel in packet 0.25 mg/0.25 gram (0.1 %), 0.5 mg/0.5 gram (0.1 %), 0.75 mg/0.75 gram (0.1%), 1 mg/gram (0.1 %), 1.25 mg/1.25 gram (0.1 %)</i>	2	QL (30 packets per 30 days)
<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>	2	QL (8 patches per 30 days)
<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>	2	QL (4 patches per 30 days)
<i>estradiol vaginal cream 0.01 % (0.1 mg/gram)</i>	2	QL (42.5 GM per 1 fill)
<i>estradiol vaginal tablet 10 mcg</i>	2	QL (0.29 Tablets per 1 day)
<i>estradiol valerate intramuscular oil 20 mg/ml</i>	2	QL (5 ML per 28 days)
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	2	
ESTRING VAGINAL RING 2 MG (7.5 MCG /24 HOUR)	4	QL (1 ring per 90 days)
ESTROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 1.25 GRAM/ACTUATION	Non-Formulary	ALT (Covered Alternatives: ESTRADIOL 0.06% 1.25G GEL PUMP); QL (50 GM per 30 days)
<i>estrogens-methyltestosterone oral tablet 0.625-1.25 mg, 1.25-2.5 mg</i>	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	2	HCR; QL (1 ring per 30 days)
EVAMIST TRANSDERMAL SPRAY, NON-AEROSOL 1.53 MG/SPRAY (1.7%)	Non-Formulary	QL (Quantity Limits Apply)
FALMINA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
FEMRING VAGINAL RING 0.05 MG/24 HR, 0.1 MG/24 HR	4	QL (1 ring per 84 days)
HAILEY ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
HALOETTE VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	
ICLEVIA ORAL TABLETS, DOSE PACK, 3 MONTH 0.15 MG-30 MCG (91)	4	HCR
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: Femring)
IMVEXXY STARTER PACK VAGINAL INSERT, DOSE PACK 10 MCG, 4 MCG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: Femring)
INTROVALE ORAL TABLETS, DOSE PACK, 3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 Tablets per 1 Day)
JINTELI ORAL TABLET 1-5 MG-MCG	2	
JOLESSA ORAL TABLETS, DOSE PACK, 3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
JUNEL 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
JUNEL 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
KURVELO (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
LARIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LARIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LEENA 28 ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LESSINA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LEVONEST (28) ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg (28)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2	HCR; QL (1 tablet per 1 day)
LEVORA-28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
LOW-OGESTREL (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LUTERA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MARLISSA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	3	QL (1 tablet per 1 day)
MENEST ORAL TABLET 2.5 MG	3	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24 HR	4	QL (4 patches per 28 days)
MICROGESTIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MICROGESTIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MIMVEY ORAL TABLET 1-0.5 MG	2	
MYFEMBREE ORAL TABLET 40-1-0.5 MG	6	PA; SP; QL (1 TABLET per 1 day)
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
<i>norelgestromin-ethin.estradiol transdermal patch weekly 150-35 mcg/24 hr</i>	4	HCR
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	2	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	2	HCR; QL (1 tablet per 1 day)
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG (21)	2	HCR; QL (1 tablet per 1 day)
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NORTREL 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
NUVARING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	ALT (Covered Alternatives: ETONOGESTREL-ETHINYL ESTRADIOL, ELURYNG); HCR; QL (1 unit per 1 fill)
NYLIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	4	HCR
NYLIA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG-35 MCG	4	HCR
ORIAHNN ORAL CAPSULE, SEQUENTIAL 300-1-0.5MG(AM) /300 MG(PM)	Non-Formulary	QL (Quantity Limits Apply)
PHILITH ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
PORTIA 28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	3	QL (1 tablet per 1 day)
PREMARIN VAGINAL CREAM 0.625 MG/GRAM	3	QL (30 GM per 30 days)
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14)	3	QL (1 tablet per 1 day)
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	QL (1 tablet per 1 day)
SETLAKIN ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
SRONYX ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
TURQOZ (28) ORAL TABLET 0.3-30 MG-MCG	4	HCR
TYBLUME ORAL TABLET,CHEWABLE 0.1 MG-20 MCG	4	HCR
VAGIFEM VAGINAL TABLET 10 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Estradiol 10mcg Vaginal Insert Tablets); QL (0.29 Tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VIENVA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
VYFEMLA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
WERA (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	2	HCR; QL (3 patches per 28 days)
YUVAFEM VAGINAL TABLET 10 MCG	2	
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	4	HCR
Glycogenolytic Agents		
BAQSIMI NASAL SPRAY, NON-AEROSOL 3 MG/ACTUATION	3	QL (1 kit per 1 fill)
GLUCAGON (HCL) EMERGENCY KIT INJECTION RECON SOLN 1 MG	4	QL (Quantity Limits Apply)
GLUCAGON EMERGENCY KIT (HUMAN) INJECTION RECON SOLN 1 MG	4	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Glucagon, Glucagen, Baqsimi, Zegalogue)
ZEGALOGUE AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 0.6 MG/0.6 ML	4	QL (1.2 ML per 1 fill)
ZEGALOGUE SYRINGE SUBCUTANEOUS SYRINGE 0.6 MG/0.6 ML	4	QL (1.2 ML per 1 fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Gonadotropins		
CAMCEVI (6 MONTH) SUBCUTANEOUS SYRINGE 42 MG	BB	PA
<i>chorionic gonadotropin, human injection recon soln 6,000 unit</i>	2	PA; QL (3 Vials per 28 days)
<i>chorionic gonadotropin, human intramuscular recon soln 10,000 unit</i>	5	PA; SP; QL (3 Vials per 28 days)
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	BB	PA
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG	BB	PA
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG	BB	PA
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)	BB	PA
FENSOLVI SUBCUTANEOUS SYRINGE 45 MG	BB	PA
FOLLISTIM AQ SUBCUTANEOUS CARTRIDGE 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML	Non-Formulary	QL (Quantity Limits Apply); SP; QL (5 Cartridges per 28 days)
GONAL-F RFF REDI-JECT SUBCUTANEOUS PEN INJECTOR 300 UNIT/0.48 ML, 450 UNIT/0.72 ML, 900 UNIT/1.44 ML	5	PA; SP; QL (5 Syringes per 28 days)
GONAL-F RFF SUBCUTANEOUS RECON SOLN 75 UNIT	5	PA; SP; QL (5 Vials per 28 days)
GONAL-F SUBCUTANEOUS RECON SOLN 1,050 UNIT	5	PA; SP; QL (3 Vials per 28 days)
GONAL-F SUBCUTANEOUS RECON SOLN 450 UNIT	5	PA; SP; QL (5 Vials per 28 days)
<i>leuprolide subcutaneous kit 1 mg/0.2 ml</i>	2	PA; SP; QL (1 Kit per 28 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 22.5 MG	BB	PA
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT 45 MG	BB	PA
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG, 7.5 MG	BB	PA
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 30 MG	BB	PA
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (PED)	BB	PA
MENOPUR SUBCUTANEOUS RECON SOLN 75 UNIT	5	PA; SP; QL (25 Vials per 28 days)
NOVAREL INTRAMUSCULAR RECON SOLN 5,000 UNIT	Non-Formulary	SP; QL (3 Vials per 28 days)
OVIDREL SUBCUTANEOUS SYRINGE 250 MCG/0.5 ML	4	PA; SP; QL (1 Syringe per 28 days)
PREGNYL INTRAMUSCULAR RECON SOLN 10,000 UNIT	Non-Formulary	SP; QL (3 Vials per 28 days)
SUPPRELIN LA IMPLANT KIT 50 MG (65 MCG/DAY)	BB	PA; QL (Quantity Limits Apply)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	BB	PA
TRIPTODUR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG	BB	PA
VABRINTY (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	BB	PA
Incretin Mimetics		
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRULICITY, LIRAGLUTIDE); QL (0.13 ml per 1 day)
<i>exenatide subcutaneous pen injector 10 mcg/dose(250 mcg/ml) 2.4 ml, 5 mcg/dose (250 mcg/ml) 1.2 ml</i>	Non-Formulary	QL (1 Fill per 30 Days); ALT (Covered Alternatives: LIRAGLUTIDE); QL (0.04 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>liraglutide (weight loss) subcutaneous pen injector 3 mg/0.5 ml (18 mg/3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: PHENTERMINE HCL, DIETHYLPROPION HCL, BENZPHETAMINE HCL)
<i>liraglutide subcutaneous pen injector 0.6 mg/0.1 ml (18 mg/3 ml)</i>	2	PA; QL (0.3 ML per 1 day)
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	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (0.08 ML per 1 day)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML)	3	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (0.06 ML per 1 day)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	3	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (0.11 ML per 1 day)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (1 tablet per 1 day)
SAXENDA SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML (18 MG/3 ML)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PHENTERMINE HCL, DIETHYLPROPION HCL, BENZPHETAMINE HCL)
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (0.5 ml per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
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	QL (2 ML / 30 Days); ST (Step Therapy Required- Medical diagnosis of Type 2 diabetes and tried and failed 90 days treatment of metformin in the last 120 days); QL (0.08 ml per 1 day)
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	Non-Formulary	ALT (Covered Alternatives: Liraglutide); QL (9 ML per 30 days)
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	Non-Formulary	ALT (Covered Alternatives: Liraglutide); QL (9 ML per 30 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML	Non-Formulary	QL (2 ML per 28 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML	Non-Formulary	QL (3 ML per 28 days)
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRULICITY, LIRAGLUTIDE, LANTUS, TOUJEO SOLOSTAR); QL (0.5 ml per 1 day)
ZEPBOUND 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	Non-Formulary	QL (0.08 ML per 1 day)
ZEPBOUND SUBCUTANEOUS SOLUTION 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	Non-Formulary	QL (0.08 ML per 1 Day)
Insulins		
APIDRA SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	4	PA; QL (1 ml per 1 day)
APIDRA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	4	PA; QL (1 ml per 1 day)
BASAGLAR KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); TD; QL (1 ml per 1 day)
BASAGLAR TEMPO PEN(U-100)INSLN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (1 ml per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)
FIASP PUMPCART SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (1.6 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (50-50)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70-30, LANTUS, TOUJEO SOLOSTAR); QL (15 ML per 30 days)
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (75-25)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70-30, LANTUS, TOUJEO SOLOSTAR); TD; QL (0.5 ml per 1 day)
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (75-25)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70-30, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HUMALOG TEMPO PEN(U-100)INSULN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML	4	PA; ALT (Covered Alternatives: Novolog, Novolin); QL (1 ML per 1 day)
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	4	PA; ALT (Covered Alternatives: NOVOLIN 70-30, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMULIN N NPH INSULIN KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	4	PA; ALT (Covered Alternatives: NOVOLIN N, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMULIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN N, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ML per 1 day)
HUMULIN R REGULAR U-100 INSULN INJECTION SOLUTION 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ML per 1 day)
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION 500 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (42 ML per 1 Fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML)	4	PA; TD; QL (42 ML per 1 Fill)
<i>insulin degludec subcutaneous insulin pen 100 unit/ml (3 ml), 200 unit/ml (3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); QL (1 ml per 1 day)
<i>insulin degludec subcutaneous solution 100 unit/ml</i>	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); QL (1 ml per 1 day)
<i>insulin glargine u-300 conc subcutaneous insulin pen 300 unit/ml (1.5 ml), 300 unit/ml (3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (0.3 ML per 1 day)
<i>insulin glargine-yfgn subcutaneous insulin pen 100 unit/ml (3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
<i>insulin lispro protamin-lispro subcutaneous insulin pen 100 unit/ml (75-25)</i>	Non-Formulary	TD; QL (1 ml per 1 day)
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	2	QL (60 ML per 30 days)
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	QL (60 ML per 30 days)
LYUMJEV KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)
LYUMJEV KWIKPEN U-200 INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)
LYUMJEV TEMPO PEN(U-100)INSULN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LYUMJEV U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	3	QL (2 ML per 1 day)
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (1 ML per 1 day)
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	QL (2 ML per 1 day)
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (1 ML per 1 day)
NOVOLIN R REGULAR U100 INSULIN INJECTION SOLUTION 100 UNIT/ML	3	QL (2 ML per 1 day)
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (1 ML per 1 day)
NOVOLOG MIX 70-30 U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	3	QL (1 ML per 1 day)
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	QL (1 ML per 1 day)
REZVOGLAR KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
SEMGLEE(INSULIN GLARGINE-YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SEMGLEE(INSULIN GLARG-YFGN)PEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (0.5 ml per 1 day)
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML)	3	QL (9 ML per 30 days)
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML)	3	QL (9 ML per 30 days)
TRESIBA FLEXTOUCH U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
TRESIBA FLEXTOUCH U-200 SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
TRESIBA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRULICITY, LIRAGLUTIDE, LANTUS, TOUJEO SOLOSTAR); QL (0.5 ml per 1 day)
Intermediate-Acting Insulins		
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (50-50)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70- 30, LANTUS, TOUJEO SOLOSTAR); QL (15 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (75-25)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70- 30, LANTUS, TOUJEO SOLOSTAR); TD; QL (0.5 ml per 1 day)
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (75-25)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70- 30, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	4	PA; ALT (Covered Alternatives: NOVOLIN 70-30, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMULIN N NPH INSULIN KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	4	PA; ALT (Covered Alternatives: NOVOLIN N, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMULIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN N, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ML per 1 day)
<i>insulin lispro protamin-lispro subcutaneous insulin pen 100 unit/ml (75-25)</i>	Non-Formulary	TD; QL (1 ml per 1 day)
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	3	QL (2 ML per 1 day)
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (1 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	QL (2 ML per 1 day)
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
Leptins		
MYALEPT SUBCUTANEOUS RECON SOLN 5 MG/ML (FINAL CONC.)	6	PA; SP; QL (0.1 ML per 1 day)
Long-Acting Insulins		
BASAGLAR KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); TD; QL (1 ml per 1 day)
BASAGLAR TEMPO PEN(U-100)INSLN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (1 ml per 1 day)
<i>insulin degludec subcutaneous insulin pen 100 unit/ml (3 ml), 200 unit/ml (3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); QL (1 ml per 1 day)
<i>insulin degludec subcutaneous solution 100 unit/ml</i>	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); QL (1 ml per 1 day)
<i>insulin glargine u-300 conc subcutaneous insulin pen 300 unit/ml (1.5 ml), 300 unit/ml (3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (0.3 ML per 1 day)
<i>insulin glargine-yfgn subcutaneous insulin pen 100 unit/ml (3 ml)</i>	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	2	QL (60 ML per 30 days)
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	QL (60 ML per 30 days)
REZVOGLAR KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
SEMGLEE(INSULIN GLARGINE-YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
SEMGLEE(INSULIN GLARG-YFGN)PEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max)
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Lantus Solostar, Toujeo Solostar Lantus Vial, Toujeo Solostar Max); QL (0.5 ml per 1 day)
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML)	3	QL (9 ML per 30 days)
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML)	3	QL (9 ML per 30 days)
TRESIBA FLEXTOUCH U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
TRESIBA FLEXTOUCH U-200 SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TRESIBA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRULICITY, LIRAGLUTIDE, LANTUS, TOUJEO SOLOSTAR); QL (0.5 ml per 1 day)
Meglitinides		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	2	
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	QL (8 tablets per 1 day)
Melanocortin Receptor Antagonists		
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML	Non-Formulary	SP; QL (2 ML per 1 day)
SCENESSE SUBCUTANEOUS IMPLANT 16 MG	BB	PA
Parathyroid Agents		
BONSITY SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (560MCG/2.24ML)	Non-Formulary	SP; ALT (Covered Alternatives: TERIPARATIDE); QL (0.09 ML per 1 Day)
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (560MCG/2.24ML)	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: TERIPARATIDE); QL (0.08 ML per 1 day)
<i>teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)</i>	5	PA; SP; QL (0.09 ML per 1 day)
TYMLOS SUBCUTANEOUS PEN INJECTOR 80 MCG (3,120 MCG/1.56 ML)	Non-Formulary	SP; ALT (Covered Alternatives: TERIPARATIDE); QL (1 pen per 30 days)
YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML, 294 MCG/0.98 ML, 420 MCG/1.4 ML	Non-Formulary	SP; QL (0.1 ML per 1 Day)
Pituitary		
ACTHAR INJECTION GEL 80 UNIT/ML	Non-Formulary	QL (Quantity Limits Apply); SP
ACTHAR SELFJECT SUBCUTANEOUS PEN INJECTOR 40 UNIT/0.5 ML, 80 UNIT/ML	Non-Formulary	SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CORTROPHIN GEL INJECTION GEL 80 UNIT/ML	Non-Formulary	SP
DDAVP INJECTION SOLUTION 4 MCG/ML	BB	
<i>desmopressin injection solution 4 mcg/ml</i>	BB	
<i>desmopressin nasal spray with pump 10 mcg/spray (0.1 ml)</i>	2	QL (0.17 ML per 1 Day)
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	2	QL (0.17 ML per 1 Day)
<i>desmopressin nasal spray,non-aerosol 150 mcg/spray (0.1 ml)</i>	Non-Formulary	
<i>desmopressin oral tablet 0.1 mg, 0.2 mg</i>	2	
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML, 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	5	PA; QL (Quantity Limits Apply); SP
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML), 5 MG/ML (15 UNIT/ML)	5	PA; QL (Quantity Limits Apply); SP
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT), 6 MG (18 UNIT)	Non-Formulary	QL (Quantity Limits Apply); SP
HUMATROPE INJECTION RECON SOLN 5 (15 UNIT) MG	Non-Formulary	QL (Quantity Limits Apply); SP
NGENLA SUBCUTANEOUS PEN INJECTOR 24 MG/1.2 ML (20 MG/ML), 60 MG/1.2 ML (50 MG/ML)	Non-Formulary	SP
NOCDURNA (MEN) SUBLINGUAL TABLET,DISINTEGRATING 55.3 MCG	Non-Formulary	QL (Quantity Limits Apply); SP
NOCDURNA (WOMEN) SUBLINGUAL TABLET,DISINTEGRATING 27.7 MCG	Non-Formulary	QL (Quantity Limits Apply); SP
NORDITROPIN FLEXPPO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	5	PA; QL (Quantity Limits Apply); SP
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML)	5	PA; SP; QL (0.4 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 20 MG/2 ML (10 MG/ML)	5	PA; SP; QL (0.02 ML per 1 day)
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 5 MG/2 ML (2.5 MG/ML)	5	PA; SP; QL (0.3 ML per 1 day)
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	Non-Formulary	QL (Quantity Limits Apply); SP
OMNITROPE SUBCUTANEOUS RECON SOLN 5.8 MG	Non-Formulary	QL (Quantity Limits Apply); SP
SAIZEN SAIZENPREP SUBCUTANEOUS CARTRIDGE 8.8 MG/1.51 ML (FINAL CONC.)	Non-Formulary	SP
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	Non-Formulary	SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG	Non-Formulary	
SOGROYA SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	Non-Formulary	SP; ALT (Covered Alternatives: Nutropin AQ); QL (0.22 ML per 1 day)
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG, 5 MG	Non-Formulary	QL (Quantity Limits Apply); SP
Progestins		
ABIGALE LO ORAL TABLET 0.5-0.1 MG	2	HCR
ABIGALE ORAL TABLET 1-0.5 MG	2	HCR
AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ALTAVERA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ALYACEN 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
AMETHYST (28) ORAL TABLET 90-20 MCG (28)	2	HCR; QL (1 tablet per 1 day)
ARANELLE (28) ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
AUBRA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AUROVELA 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AVIANE ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
AYUNA ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
BALZIVA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
BIJUVA ORAL CAPSULE 0.5-100 MG	Non-Formulary	QL (1 Capsule per 1 day)
BIJUVA ORAL CAPSULE 1-100 MG	Non-Formulary	QL (Quantity Limits Apply); QL (1 Capsule per 1 day)
BRIELLYN ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
CAMILA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
CHATEAL EQ (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.14 MG/24 HR, 0.05-0.25 MG/24 HR	4	QL (8 patches per 28 days)
CRINONE VAGINAL GEL 4 %, 8 %	4	PA; SP; QL (60 GM per 30 days)
CRYSELLE (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
DASETTA 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
DASETTA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
DEBLITANE ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	Non-Formulary	ALT (Covered Alternatives: MEDROXYPROGESTERONE ACETATE); HCR
DEPO-PROVERA INTRAMUSCULAR SYRINGE 150 MG/ML	Non-Formulary	ALT (Covered Alternatives: MEDROXYPROGESTERONE ACETATE); HCR
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE 104 MG/0.65 ML	7	HCR
DOLISHALE ORAL TABLET 90-20 MCG (28)	4	HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ELINEST ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
ELURYNG VAGINAL RING 0.12-0.015 MG/24 HR	2	HCR; QL (1 ring per 30 days)
EMZAHH ORAL TABLET 0.35 MG	2	
ENDOMETRIN VAGINAL INSERT 100 MG	4	SP; QL (90 inserts per 30 days)
ENILLORING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	
ENPRESSE ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)
ERRIN ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	2	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	2	HCR; QL (1 ring per 30 days)
FALMINA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
HAILEY ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
HALOETTE VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	
HEATHER ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
ICLEVIA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	4	HCR
INCASSIA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
INTROVALE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 Tablets per 1 Day)
JENCYCLA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
JINTELI ORAL TABLET 1-5 MG-MCG	2	
JOLESSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
JUNEL 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
JUNEL 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
KURVELO (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LARIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LARIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LEENA 28 ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LESSINA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LEVONEST (28) ORAL TABLET 50-30 (6)/75-40 (5)/125-30(10)	2	HCR; QL (1 tablet per 1 day)
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg (28)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	2	HCR; QL (1 tablet per 1 day)
<i>levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	2	HCR; QL (1 tablet per 1 day)
LEVORA-28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
LOW-OGESTREL (28) ORAL TABLET 0.3-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LUTERA (28) ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
LYLEQ ORAL TABLET 0.35 MG	4	HCR
LYZA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
MARLISSA (28) ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
<i>medroxyprogesterone intramuscular suspension 150 mg/ml</i>	7	HCR
<i>medroxyprogesterone intramuscular syringe 150 mg/ml</i>	7	HCR
<i>medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 800 mg/20 ml (20 ml)</i>	2	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	2	QL (175 ML per 30 days)
<i>megestrol oral tablet 20 mg, 40 mg</i>	2	
MELEYA ORAL TABLET 0.35 MG	2	HCR
MICROGESTIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	HCR; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
MICROGESTIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
MIMVEY ORAL TABLET 1-0.5 MG	2	
MYFEMBREE ORAL TABLET 40-1-0.5 MG	6	PA; QL (1 tablet per month, 24 months max); SP
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NEXPLANON SUBDERMAL IMPLANT 68 MG	1	PA; HCR
NORA-BE ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
<i>norelgestromin-ethin.estradiol transdermal patch weekly 150-35 mcg/24 hr</i>	4	HCR
<i>norethindrone (contraceptive) oral tablet 0.35 mg</i>	2	HCR; QL (1 tablet per 1 day)
<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>	2	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	2	HCR; QL (1 tablet per 1 day)
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG (21)	2	HCR; QL (1 tablet per 1 day)
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
NORTREL 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	2	HCR; QL (1 tablet per 1 day)
NUVARING VAGINAL RING 0.12-0.015 MG/24 HR	Non-Formulary	ALT (Covered Alternatives: ETONOGESTREL-ETHINYL ESTRADIOL, ELURYNG); HCR; QL (1 unit per 1 fill)
NYLIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	4	HCR
NYLIA 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG-35 MCG	4	HCR
ORIAHNN ORAL CAPSULE, SEQUENTIAL 300-1-0.5MG(AM) /300 MG(PM)	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ORQUIDEA ORAL TABLET 0.35 MG	2	HCR; QL (1 Tablet per 1 day)
PHILITH ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
PORTIA 28 ORAL TABLET 0.15-0.03 MG	2	HCR; QL (1 tablet per 1 day)
<i>progesterone intramuscular oil 50 mg/ml</i>	7	
<i>progesterone micronized oral capsule 100 mg, 200 mg</i>	2	
SETLAKIN ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91)	2	HCR; QL (1 tablet per 1 day)
SHAROBEL ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
SLYND ORAL TABLET 4 MG (28)	4	QL (Quantity Limits Apply); HCR
SRONYX ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
TULANA ORAL TABLET 0.35 MG	2	HCR; QL (1 tablet per 1 day)
TURQOZ (28) ORAL TABLET 0.3-30 MG-MCG	4	HCR
TYBLUME ORAL TABLET,CHEWABLE 0.1 MG-20 MCG	4	HCR
VIENVA ORAL TABLET 0.1-20 MG-MCG	2	HCR; QL (1 tablet per 1 day)
VYFEMLA (28) ORAL TABLET 0.4-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
WERA (28) ORAL TABLET 0.5-35 MG-MCG	2	HCR; QL (1 tablet per 1 day)
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	2	HCR; QL (3 patches per 28 days)
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR	4	HCR
Rapid-Acting Insulins		
APIDRA SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	4	PA; QL (1 ml per 1 day)
APIDRA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	4	PA; QL (1 ml per 1 day)
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FIASP PUMPCART SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (1.6 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog); QL (1 ML per 1 day)
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (50-50)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70-30, LANTUS, TOUJEO SOLOSTAR); QL (15 ML per 30 days)
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (75-25)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70-30, LANTUS, TOUJEO SOLOSTAR); TD; QL (0.5 ml per 1 day)
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (75-25)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG MIX 70-30, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMALOG TEMPO PEN(U-100)INSULN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML	4	PA; ALT (Covered Alternatives: Novolog, Novolin); QL (1 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
<i>insulin lispro protamin-lispro subcutaneous insulin pen 100 unit/ml (75-25)</i>	Non-Formulary	TD; QL (1 ml per 1 day)
LYUMJEV KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)
LYUMJEV KWIKPEN U-200 INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)
LYUMJEV TEMPO PEN(U-100)INSULN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)
LYUMJEV U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	Non-Formulary	ALT (Covered Alternatives: Novolog, Novolin); QL (1 ml per 1 day)
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (1 ML per 1 day)
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	3	QL (1 ML per 1 day)
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	QL (1 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Short-Acting Insulins		
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ml per 1 day)
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	4	PA; ALT (Covered Alternatives: NOVOLIN 70-30, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (15 ML per 30 days)
HUMULIN R REGULAR U-100 INSULIN INJECTION SOLUTION 100 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (1 ML per 1 day)
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION 500 UNIT/ML	4	PA; ALT (Covered Alternatives: NOVOLIN R, NOVOLOG, LANTUS, TOUJEO SOLOSTAR); TD; QL (42 ML per 1 Fill)
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML)	4	PA; TD; QL (42 ML per 1 Fill)
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	3	QL (2 ML per 1 day)
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	QL (1 ML per 1 day)
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (1 ML per 1 day)
NOVOLIN R REGULAR U100 INSULIN INJECTION SOLUTION 100 UNIT/ML	3	QL (2 ML per 1 day)
Sodium-Gluc Cotransport 2 (SglT2) Inhib		
BRENZAVVY ORAL TABLET 20 MG	Non-Formulary	ALT (Covered Alternatives: JARDIANCE, SYNJARDY, FARXIGA, XIGDUO XR, SYNJARDY XR); QL (1 Tablet per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>dapaglifloz propaned-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg</i>	Non-Formulary	ALT (Covered Alternatives: Xigduo XR); QL (1 Tablet per 1 Day)
<i>dapaglifloz propaned-metformin oral tablet, ir - er, biphasic 24hr 5-1,000 mg</i>	Non-Formulary	ALT (Covered Alternatives: Xigduo XR); QL (2 Tablets per 1 Day)
<i>dapagliflozin propanediol oral tablet 10 mg, 5 mg</i>	Non-Formulary	ALT (Covered Alternatives: Farxiga); QL (1 Tablet per 1 Day)
FARXIGA ORAL TABLET 10 MG, 5 MG	3	ALT (Covered Alternatives: JARDIANCE); QL (1 tablet per 1 day)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: JARDIANCE, JANUVIA); TD
INPEFA ORAL TABLET 200 MG	Non-Formulary	ALT (Covered Alternatives: Fraxiga, Jardiance, Synjardy, Xigduo XR, Synjardy XR); QL (1 Tablet per 1 day)
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG	Non-Formulary	ALT (Covered Alternatives: SYNJARDY, JARDIANCE); TD; QL (2 tablets per 1 day)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG	Non-Formulary	QL (Quantity Limits Apply); TD
INVOKANA ORAL TABLET 100 MG, 300 MG	Non-Formulary	ALT (Covered Alternatives: JARDIANCE, SYNJARDY); TD; QL (1 tablet per 1 day)
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	QL (1 tablet per 1 day)
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 7.5-1,000 MG, 7.5-500 MG	Non-Formulary	QL (Quantity Limits Apply)
STEGLATRO ORAL TABLET 15 MG, 5 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: JARDIANCE)
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG	Non-Formulary	QL (Quantity Limits Apply)
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG	3	QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	QL (1 tablet per 1 day)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	QL (2 tablets per 1 day)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 12.5-2.5-1,000 MG, 25-5-1,000 MG, 5-2.5-1,000 MG	Non-Formulary	QL (Quantity Limits Apply)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 2.5-1,000 MG, 5-500 MG	3	ALT (Covered Alternatives: JARDIANCE, SYNJARDY, JANUVIA, METFORMIN HCL); QL (1 tablets per 1 day)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	ALT (Covered Alternatives: JARDIANCE, SYNJARDY, JANUVIA, METFORMIN HCL); QL (2 tablets per 1 day)
Somatostatin Agonists		
<i>lanreotide subcutaneous syringe 120 mg/0.5 ml</i>	BB	PA
MYCAPSSA ORAL CAPSULE, DELAYED RELEASE(DR/EC) 20 MG	Non-Formulary	SP; ALT (Covered Alternatives: SANDOSTATIN LAR DEPOT)
<i>octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml</i>	2	QL (2 ML per 1 day)
<i>octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml), 500 mcg/ml (1 ml)</i>	2	QL (2 ML per 1 day)
<i>octreotide, microspheres intramuscular suspension, extended rel recon 20 mg, 30 mg</i>	BB	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 10 MG	BB	PA
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 20 MG	BB	PA
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 60 MG	BB	
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML (1 ML), 0.6 MG/ML (1 ML)	5	PA; SP; QL (0.01 ml per 1 day)
SIGNIFOR SUBCUTANEOUS SOLUTION 0.9 MG/ML (1 ML)	5	PA; SP; QL (0.01 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML	BB	PA
Somatotropin Agonists		
EGRIFTA SV SUBCUTANEOUS RECON SOLN 2 MG	Non-Formulary	SP
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG	Non-Formulary	SP; QL (1 Kit per 28 Days)
INCRELEX SUBCUTANEOUS SOLUTION 10 MG/ML	6	PA; SP; QL (0.01 ML per 1 day)
Somatotropin Antagonists		
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG	5	PA; SP; ALT (Covered Alternatives: OCTREOTIDE ACETATE); QL (0.01 vial per 1 day)
SOMAVERT SUBCUTANEOUS RECON SOLN 30 MG	5	PA; SP; ALT (Covered Alternatives: OCTREOTIDE ACETATE); QL (0.01 ML per 1 day)
Sulfonylureas		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>glimepiride oral tablet 3 mg</i>	Non-Formulary	ALT (Covered Alternatives: GLIMEPIRIDE 1 MG, GLIMEPIRIDE 2 MG, GLIMEPIRIDE 4 MG)
<i>glipizide oral tablet 10 mg, 5 mg</i>	1	
<i>glipizide oral tablet 2.5 mg</i>	Non-Formulary	ALT (Covered Alternatives: Glipizide 5mg, Glipizide 10mg)
<i>glipizide oral tablet extended release 24hr 10 mg, 2.5 mg, 5 mg</i>	1	
<i>glipizide-metformin oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	2	QL (4 tablets per 1 day)
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Thiazolidinediones		
OSENI ORAL TABLET 12.5-30 MG, 25-45 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>pioglitazone oral tablet 15 mg, 30 mg, 45 mg</i>	1	QL (1 tablet per 1 day)
<i>pioglitazone-metformin oral tablet 15-500 mg, 15-850 mg</i>	2	QL (4 tablets per 1 day)
Thyroid Agents		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG	3	QL (1 tablet per 1 day)
ERMEZA ORAL SOLUTION 30 MCG/ML	Non-Formulary	ALT (Covered Alternatives: Levothyroxine); QL (2.6 ml per 1 day)
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	Non-Formulary	QL (2 tablets per 1 day)
LEVO-T 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	Non-Formulary	
<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>	2	QL (2 tablets per 1 day)
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	3	QL (2 tablets per 1 day)
<i>liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg</i>	2	
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	2	QL (1 tablet per 1 day)
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG	6	PA; SP; QL (1 Tablet per 1 Day)
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	QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG	4	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 50 MCG/ML, 75 MCG/ML, 88 MCG/ML	4	QL (Quantity Limits Apply)
TIROSINT-SOL ORAL SOLUTION 37.5 MCG/ML, 44 MCG/ML, 62.5 MCG/ML	4	
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	3	QL (2 tablets per 1 day)
IMMUNOMODULATORY AGENTS (90:00)		
Amino Acid Polymers		
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	Non-Formulary	SP; QL (30 ml per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	Non-Formulary	SP; QL (12 ml per 30 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	2	SP; QL (30 ML per 30 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	2	SP; QL (12 ML per 30 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	2	SP; QL (30 ML per 30 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	2	SP; QL (12 ML per 30 days)
Antimetabolites		
AUBAGIO ORAL TABLET 14 MG, 7 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
MAVENCLAD (10 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (4 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
MAVENCLAD (5 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (6 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (7 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (8 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
MAVENCLAD (9 TABLET PACK) ORAL TABLET 10 MG	6	PA; SP; QL (1 tablet per 1 day)
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	2	SP; QL (1 tablet per 1 day)
Antimetabolites, Immunosupp Therapy Misc		
AZASAN ORAL TABLET 100 MG, 75 MG	Non-Formulary	
<i>azathioprine oral tablet 100 mg</i>	Non-Formulary	
<i>azathioprine oral tablet 50 mg</i>	2	
<i>mycophenolate mofetil oral capsule 250 mg</i>	2	QL (8 capsules per 1 day)
<i>mycophenolate mofetil oral suspension for reconstitution 200 mg/ml</i>	2	
<i>mycophenolate mofetil oral tablet 500 mg</i>	2	QL (8 tablets per 1 day)
<i>mycophenolate sodium oral tablet, delayed release (dr/ec) 180 mg, 360 mg</i>	2	
MYHIBBIN ORAL SUSPENSION 200 MG/ML	Non-Formulary	QL (15 ML per 1 Day)
Bone-Modifying Agents		
EVENITY SUBCUTANEOUS SYRINGE 105 MG/1.17 ML, 210MG/2.34ML (105MG/1.17MLX2)	BB	PA
JUBBONTI SUBCUTANEOUS SYRINGE 60 MG/ML	BB	PA
PROLIA SUBCUTANEOUS SYRINGE 60 MG/ML	7	PA; QL (Quantity Limits Apply); SP
WYOST SUBCUTANEOUS SOLUTION 120 MG/1.7 ML (70 MG/ML)	BB	PA
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7 ML (70 MG/ML)	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Calcineurin Inhibitors, Misc (90:28)		
CEQUA OPHTHALMIC (EYE) DROPPERETTE 0.09 %	Non-Formulary	QL (Quantity Limits Apply)
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<i>cyclosporine ophthalmic (eye) dropperette 0.05 %</i>	2	QL (2 Units per 1 day)
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	2	
ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG	Non-Formulary	
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	
RESTASIS MULTIDOSE OPHTHALMIC (EYE) DROPS 0.05 %	Non-Formulary	ALT (Covered Alternatives: Cyclosporine 0.05%); QL (5.5 ML per 24 days)
RESTASIS OPHTHALMIC (EYE) DROPPERETTE 0.05 %	Non-Formulary	ALT (Covered Alternatives: Cyclosporine 0.05%); QL (2 dropperettes per 1 day)
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG	Non-Formulary	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	2	
<i>tacrolimus topical ointment 0.03 %, 0.1 %</i>	2	QL (100 GM per 30 days)
VEVYE OPHTHALMIC (EYE) DROPS 0.1 %	Non-Formulary	ALT (Covered Alternatives: Cyclosporine DROPPERETTE, SINGLE-USE DROP DISPENSER)
Complement Inhibitor Agents (90:20)		
EMPAVELI SUBCUTANEOUS SOLUTION 1,080 MG/20 ML	Non-Formulary	SP; ALT (Covered Alternatives: Tavneos)
ENJAYMO INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
FABHALTA ORAL CAPSULE 200 MG	Non-Formulary	SP; QL (2 Capsules per 1 Day)
IZERVAY (PF) INTRAVITREAL SOLUTION 2 MG/0.1 ML	BB	
PIASKY INJECTION SOLUTION 340 MG/2 ML	BB	PA
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30 ML	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SYFOVRE (PF) INTRAVITREAL SOLUTION 15 MG /0.1 ML	BB	
TAVNEOS ORAL CAPSULE 10 MG	6	PA; SP; QL (6 Capsules per 1 Day)
Complement Inhibitors (90:08)		
ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML	6	PA; SP; QL (0.416 ML per 1 day)
ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML	6	PA; SP; QL (0.574 ML per 1 day)
ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML	6	PA; SP; QL (0.81 ML per 1 day)
Disease-Modifying Antirheumat Drugs Misc		
ENTYVIO INTRAVENOUS RECON SOLN 300 MG	7	PA; QL (Quantity Limits Apply); SP
ENTYVIO PEN SUBCUTANEOUS PEN INJECTOR 108 MG/0.68 ML	6	PA; SP
ORENCIA (WITH MALTOSE) INTRAVENOUS RECON SOLN 250 MG	7	PA; QL (Quantity Limits Apply); SP
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR 125 MG/ML	6	PA; SP; QL (0.15 ML per 1 day)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	6	PA; SP; QL (0.15 ml per 1 day)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML, 87.5 MG/0.7 ML	6	PA; SP; QL (0.15 ML per 1 day)
Disease-Modifying Antirheumatic Drugs		
<i>hydroxychloroquine oral tablet 100 mg, 400 mg</i>	Non-Formulary	ALT (Covered Alternatives: hydroxychloroquine 200mg)
<i>hydroxychloroquine oral tablet 200 mg</i>	2	QL (6 tablets per 1 day)
<i>hydroxychloroquine oral tablet 300 mg</i>	Non-Formulary	ALT (Covered Alternatives: hydroxychloroquine 200mg); QL (1 Tablets per 1 day)
JYLAMVO ORAL SOLUTION 2 MG/ML	Non-Formulary	QL (20 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LEFLUNICLO KIT,GEL AND TABLET 20 MG- 1 %	Non-Formulary	ALT (Covered Alternatives: LEFLUNOMIDE TABLET, Diclofenac Gel); QL (1 kit per 30 days)
<i>methotrexate sodium (pf) injection solution 25 mg/ml</i>	7	
<i>methotrexate sodium injection solution 25 mg/ml</i>	7	
<i>methotrexate sodium oral tablet 2.5 mg</i>	2	
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: METHOTREXATE)
RIABNI INTRAVENOUS SOLUTION 10 MG/ML	BB	PA
RIDAURA ORAL CAPSULE 3 MG	Non-Formulary	SP; QL (1 capsule per 1 day)
RITUXAN HYCELA SUBCUTANEOUS SOLUTION 1400 MG/11.7 ML (120 MG/ML), 1600 MG/13.4 ML (120 MG/ML)	BB	PA
RITUXAN INTRAVENOUS CONCENTRATE 10 MG/ML	BB	PA
RUXIENCE INTRAVENOUS SOLUTION 10 MG/ML	BB	PA; QL (200 ML per 1 fill)
SOVUNA ORAL TABLET 200 MG	Non-Formulary	ALT (Covered Alternatives: Hydroxychloroquine); QL (6 Tablets per 1 Day)
SOVUNA ORAL TABLET 300 MG	Non-Formulary	ALT (Covered Alternatives: HYDROXYCHLOROQUINE); QL (1 Tablets per 1 Day)
<i>sulfasalazine oral tablet 500 mg</i>	2	
<i>sulfasalazine oral tablet,delayed release (dr/ec) 500 mg</i>	2	
TREMFYA INTRAVENOUS SOLUTION 200 MG/20 ML (10 MG/ML)	BB	PA
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML	6	PA; SP; QL (0.02 ML per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	6	PA; SP; QL (0.072 ML per 1 Day)
TREMFYA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	6	PA; QL (Maintenance dosing- 0.02ml/day; Loading/Induction dose PLA required (0.04ml/day x 8 weeks)); SP
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML	6	PA; QL (Maintenance dosing- 0.02ml/day; Loading/Induction dose PLA required (0.04ml/day x 8 weeks)); SP
TREMFYA SUBCUTANEOUS SYRINGE 200 MG/2 ML	6	PA; SP; QL (0.072 ML per 1 Day)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	4	PA; ALT (Covered Alternatives: METHOTREXATE); QL (1 tablet per 1 day)
TRUXIMA INTRAVENOUS SOLUTION 10 MG/ML	BB	PA; QL (200 ML per 1 fill)
XATMEP ORAL SOLUTION 2.5 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: METHOTREXATE)
Fumarates		
BAFIERTAM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 95 MG	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: GILENYA, TECFIDERA)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg</i>	2	SP; QL (2 capsules per 1 day)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG	Non-Formulary	SP; ALT (Covered Alternatives: DIMETHYL FUMARATE); QL (2 capsules per 1 day)
VUMERITY ORAL CAPSULE,DELAYED RELEASE(DR/EC) 231 MG	Non-Formulary	QL (Quantity Limits Apply); SP
Igg1 Monoclonal Antibodies		
BENLYSTA INTRAVENOUS RECON SOLN 120 MG, 400 MG	BB	PA
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR 200 MG/ML	6	PA; SP; QL (4 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
BENLYSTA SUBCUTANEOUS SYRINGE 200 MG/ML	6	PA; SP; QL (4 ML per 30 days)
SAPHNELO INTRAVENOUS SOLUTION 300 MG/2 ML (150 MG/ML)	Non-Formulary	PA; SP
Immunomodulatory Agents (90:00)		
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG	Non-Formulary	SP; PF
AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	Non-Formulary	SP
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	QL (2 capsules per 1 day)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	5	PA; SP
<i>everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	2	QL (10 TABLET per 1 day)
FRINDOVYX INTRAVENOUS SOLUTION 500 MG/ML	BB	
<i>mercaptopurine oral suspension 20 mg/ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: MERCAPTOPYRINE 50MG TABLET); QL (3 ML per 1 day)
<i>mercaptopurine oral tablet 50 mg</i>	2	
PURIXAN ORAL SUSPENSION 20 MG/ML	Non-Formulary	SP
TORPENZ ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	Non-Formulary	SP; ALT (Covered Alternatives: Everolimus); QL (1 Tablet per 1 Day)
ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG	Non-Formulary	QL (1 tablet per 1 day)
ZORTRESS ORAL TABLET 1 MG	Non-Formulary	ALT (Covered Alternatives: Everolimus); QL (1 tablet per 1 day)
Interferon Gamma Inhibitor Agents, Misc		
GAMIFANT INTRAVENOUS SOLUTION 5 MG/ML	BB	
Interferons		
AVONEX INTRAMUSCULAR PEN INJECTOR 30 MCG/0.5 ML	5	PA; SP; QL (4 pens per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML	5	PA; SP; QL (4 pens per 30 days)
AVONEX INTRAMUSCULAR SYRINGE 30 MCG/0.5 ML	5	PA; SP; QL (4 syringes per 30 days)
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML	5	PA; SP; QL (4 syringes per 30 days)
BETASERON SUBCUTANEOUS KIT 0.3 MG	Non-Formulary	SP; QL (14 kits per 30 days)
BETASERON SUBCUTANEOUS RECON SOLN 0.3 MG	Non-Formulary	
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA; SP; QL (4 ML per 30 days)
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	5	PA; SP; QL (2 ML per 30 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA; SP; QL (0.04 ML per 1 day)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	5	PA; SP; QL (0.04 ml per 1 day)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA; SP; QL (1 kit per 30 days)
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 22 MCG/0.5 ML, 44 MCG/0.5 ML	5	PA; SP; QL (6 syringes per 30 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	5	PA; SP; QL (6 ML per 30 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	5	PA; SP; QL (5 ML per 30 days)
REBIF TITRATION PACK SUBCUTANEOUS SYRINGE 8.8MCG/0.2ML-22 MCG/0.5ML (6)	5	PA; SP; QL (5 ML per 30 days)
Interleukin Inhibitor Agents, Misc		
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	5	PA; SP; QL (2 ML per 1 Fill)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	5	PA; SP; QL (1 ML per 1 Fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG	BB	PA
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA; SP; QL (2 ML per 1 Fill)
XOLAIR SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; SP
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; SP; QL (1 ML per 1 Fill)
Interleukin-Mediated Agents, Misc		
ACTEMRA ACTPEN SUBCUTANEOUS PEN INJECTOR 162 MG/0.9 ML	6	PA; SP; QL (0.13 ML per 1 day)
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML), 400 MG/20 ML (20 MG/ML), 80 MG/4 ML (20 MG/ML)	7	PA; QL (Quantity Limits Apply); SP
ACTEMRA SUBCUTANEOUS SYRINGE 162 MG/0.9 ML	6	PA; SP; QL (0.13 ML per 1 day)
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE 150 MG/ML	6	PA; SP; QL (2 syringes per 30 days)
COSENTYX INTRAVENOUS SOLUTION 25 MG/ML	BB	PA
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR 150 MG/ML	6	PA; SP; QL (2 pens per 30 days)
COSENTYX PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML	Non-Formulary	SP; QL (0.08 vial per 1 day)
COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML	Non-Formulary	SP; QL (0.08 vial per 1 day)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	6	PA; SP; QL (0.02 ML per 1 day)
COSENTYX UNOREADY PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	6	SP
IMULDOSA INTRAVENOUS SOLUTION 130 MG/26 ML	Non-Formulary	SP
IMULDOSA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
IMULDOSA SUBCUTANEOUS SYRINGE 90 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
KEVZARA SUBCUTANEOUS PEN INJECTOR 150 MG/1.14 ML, 200 MG/1.14 ML	Non-Formulary	SP; QL (2 pens per 30 days)
KEVZARA SUBCUTANEOUS SYRINGE 150 MG/1.14 ML, 200 MG/1.14 ML	Non-Formulary	SP; QL (2 pens per 30 days)
KINERET SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	6	PA; SP; QL (19 ML per 30 days)
OTULFI INTRAVENOUS SOLUTION 130 MG/26 ML	BB	
OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	Non-Formulary	QL (Covered Alternatives: Yesintek); SP; QL (0.01 ML per 1 day)
OTULFI SUBCUTANEOUS SYRINGE 90 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 45 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 Day)
PYZCHIVA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 90 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 Day)
PYZCHIVA INTRAVENOUS SOLUTION 130 MG/26 ML	Non-Formulary	SP
PYZCHIVA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
PYZCHIVA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	Non-Formulary	SP; QL (0.01 ML per 1 day)
PYZCHIVA SUBCUTANEOUS SYRINGE 90 MG/ML	Non-Formulary	SP; QL (0.02 ML per 1 day)
SELARSDI INTRAVENOUS SOLUTION 130 MG/26 ML	Non-Formulary	SP
SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
SELARSDI SUBCUTANEOUS SYRINGE 90 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
STELARA INTRAVENOUS SOLUTION 130 MG/26 ML	Non-Formulary	QL (Quantity Limits Apply); SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	Non-Formulary	PA; QL (Maintenance dosing-0.01ml/day; Loading/Induction dose PLA required (0.02ml/day x 8 weeks)); SP; ALT (Covered Alternatives: Yesintek)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	Non-Formulary	PA; QL (Maintenance dosing-0.01ml/day; Loading/Induction dose PLA required (0.02ml/day x 8 weeks)); SP; ALT (Covered Alternatives: Yesintek)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	Non-Formulary	PA; QL (Maintenance dosing-0.02ml/day; Loading/Induction dose PLA required (0.04ml/day x 8 weeks)); SP; ALT (Covered Alternatives: Yesintek)
STEQEYMA I.V. INTRAVENOUS SOLUTION 130 MG/26 ML	BB	
STEQEYMA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
STEQEYMA SUBCUTANEOUS SYRINGE 90 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
TALTZ AUTOINJECTOR (2 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: Hadlima, Renflexis, Inflectra)
TALTZ AUTOINJECTOR (3 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: Hadlima, Renflexis, Inflectra)
TALTZ AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: Hadlima, Renflexis, Inflectra)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML, 40 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima, Renflexis, Inflectra)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: Hadlima, Renflexis, Inflectra)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TYENNE AUTOINJECTOR SUBCUTANEOUS PEN INJECTOR 162 MG/0.9 ML	6	PA; SP
TYENNE INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML), 400 MG/20 ML (20 MG/ML), 80 MG/4 ML (20 MG/ML)	Non-Formulary	PA; SP
TYENNE SUBCUTANEOUS SYRINGE 162 MG/0.9 ML	6	PA; SP
<i>ustekinumab intravenous solution 130 mg/26 ml</i>	BB	
<i>ustekinumab subcutaneous solution 45 mg/0.5 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
<i>ustekinumab subcutaneous syringe 45 mg/0.5 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
<i>ustekinumab subcutaneous syringe 90 mg/ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
<i>ustekinumab-aekn subcutaneous syringe 45 mg/0.5 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
<i>ustekinumab-aekn subcutaneous syringe 90 mg/ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
<i>ustekinumab-ttwe intravenous solution 130 mg/26 ml</i>	BB	
<i>ustekinumab-ttwe subcutaneous syringe 45 mg/0.5 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
<i>ustekinumab-ttwe subcutaneous syringe 90 mg/ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
WEZLANA I.V. INTRAVENOUS SOLUTION 130 MG/26 ML	BB	
WEZLANA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
WEZLANA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.01 ML per 1 day)
WEZLANA SUBCUTANEOUS SYRINGE 90 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Yesintek); QL (0.02 ML per 1 day)
YESINTEK INTRAVENOUS SOLUTION 130 MG/26 ML	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	5	PA; SP; QL (0.018 ML per 1 day)
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5	PA; SP; QL (0.018 ML per 1 day)
YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; SP; QL (0.036 ML per 1 day)
Janus Kinase Inhibitors, Miscellaneous		
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG	Non-Formulary	SP; ALT (Covered Alternatives: Dupixent)
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG	Non-Formulary	SP
RINVOQ LQ ORAL SOLUTION 1 MG/ML	Non-Formulary	SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
XELJANZ ORAL SOLUTION 1 MG/ML	6	PA; SP; QL (10 ML per 1 day)
XELJANZ ORAL TABLET 10 MG, 5 MG	6	PA; SP; QL (60 tablets per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG, 22 MG	6	PA; SP; QL (30 tablets per 30 days)
Monocarboxylic Acid Amide Agents		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	2	
Monoclonal Antibodies (90:04)		
BRIUMVI INTRAVENOUS SOLUTION 25 MG/ML	Non-Formulary	SP
KESIMPTA PEN SUBCUTANEOUS PEN INJECTOR 20 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Glatiramer, Dimethyl Fumarate, Teriflunomide, Fingolimod); QL (1 pen per 30 days)
LEMTRADA INTRAVENOUS SOLUTION 12 MG/1.2 ML	BB	PA
OCREVUS INTRAVENOUS SOLUTION 30 MG/ML	BB	PA
TYSABRI INTRAVENOUS SOLUTION 300 MG/15 ML	6	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Monoclonal Antibodies (90:10)		
KISUNLA INTRAVENOUS SOLUTION 17.5 MG/ML	BB	PA
LEQEMBI INTRAVENOUS SOLUTION 100 MG/ML	BB	PA
Monoclonal Antibodies (90:12)		
ENSPRYNG SUBCUTANEOUS SYRINGE 120 MG/ML	5	PA; SP; QL (1 ML per 30 days)
UPLIZNA INTRAVENOUS SOLUTION 10 MG/ML	Non-Formulary	PA; SP
Mtor Inhibitors, Miscellaneous		
HYFTOR TOPICAL GEL 0.2 %	Non-Formulary	
<i>sirolimus oral solution 1 mg/ml</i>	2	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
Neonatal Fc Receptor Blockers		
IMAAVY INTRAVENOUS SOLUTION 185 MG/ML	BB	PA
RYSTIGGO SUBCUTANEOUS SOLUTION 140 MG/ML	BB	PA
VYVGART HYTRULO SUBCUTANEOUS SOLUTION 1,008 MG-11,200 UNIT/5.6 ML	Non-Formulary	PA; SP
VYVGART HYTRULO SUBCUTANEOUS SYRINGE 1,000 MG-10,000 UNIT/5 ML	Non-Formulary	PA; SP
VYVGART INTRAVENOUS SOLUTION 20 MG/ML	Non-Formulary	PA; SP
Phosphodiesterase-4 Inhibitors, Misc		
OTEZLA ORAL TABLET 20 MG	6	PA; SP; QL (2 Tablets per 1 day)
OTEZLA ORAL TABLET 30 MG	6	PA; SP; QL (2 tablets per 1 day)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG(19)	6	PA; SP; QL (1 Kit per 1 Year)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	6	PA; SP; QL (1 kit per 1 year)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Sphingosine 1-Phosphate (S1p) Agents		
<i>fingolimod oral capsule 0.5 mg</i>	2	SP; QL (1 capsule per 1 day)
GILENYA ORAL CAPSULE 0.25 MG	Non-Formulary	SP; ALT (Covered Alternatives: Fingolimod); QL (1 capsule per 1 day)
GILENYA ORAL CAPSULE 0.5 MG	Non-Formulary	SP; ALT (Covered Alternatives: Fingolimod); QL (1 Capsule per 1 day)
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG	6	PA; SP; QL (1 tablet per 1 day)
MAYZENT STARTER(FOR 1MG MAINT) ORAL TABLETS,DOSE PACK 0.25 MG (7 TABS)	6	PA; SP; QL (1 tablet per 1 day)
MAYZENT STARTER(FOR 2MG MAINT) ORAL TABLETS,DOSE PACK 0.25 MG (12 TABS)	6	PA; SP; QL (1 tablet per 1 day)
PONVORY 14-DAY STARTER PACK ORAL TABLETS,DOSE PACK 2 MG (2) - 10 MG (3)	Non-Formulary	SP; QL (1 tablet per 1 day)
PONVORY ORAL TABLET 20 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
TASCENSO ODT ORAL TABLET,DISINTEGRATING 0.25 MG, 0.5 MG	Non-Formulary	ALT (Covered Alternatives: Fingolimod); QL (1 tablet per 1 day)
ZEPOSIA ORAL CAPSULE 0.92 MG	Non-Formulary	SP; ALT (Covered Alternatives: FINGOLIMOD, DIMETHYL FUMARATE, SULFASALAZINE, MESALAMINE, BALSALAZIDE DISODIUM); QL (1 Capsule per 1 day)
ZEPOSIA STARTER KIT (28-DAY) ORAL CAPSULE,DOSE PACK 0.23 MG-0.46 MG -0.92 MG (21)	Non-Formulary	SP; ALT (Covered Alternatives: FINGOLIMOD, DIMETHYL FUMARATE, SULFASALAZINE, MESALAMINE, BALSALAZIDE DISODIUM); QL (1 kit per 30 days)
ZEPOSIA STARTER PACK (7-DAY) ORAL CAPSULE,DOSE PACK 0.23 MG (4)- 0.46 MG (3)	Non-Formulary	SP; ALT (Covered Alternatives: FINGOLIMOD, DIMETHYL FUMARATE, SULFASALAZINE, MESALAMINE, BALSALAZIDE DISODIUM); QL (1 kit per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
T-Cell Blockers (90:24)		
LUPKYNIS ORAL CAPSULE 7.9 MG	Non-Formulary	SP; ALT (Covered Alternatives: Mycophenolate, Everolimus, Tacrolimus, Cyclosporine); QL (6 Capsules per 1 day)
Tumor Necrosis Factor Inhibitors, Misc		
ABRILADA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP
ABRILADA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML, 40 MG/0.8 ML	Non-Formulary	SP
<i>adalimumab-aacf subcutaneous pen injector kit 40 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-aacf subcutaneous syringe 40 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-aacf subcutaneous syringe kit 40 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (1 Kit per 28 days)
ADALIMUMAB-AACF(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (1 Kit per 28 days)
ADALIMUMAB-AACF(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (1 Kit per 28 days)
<i>adalimumab-aaty subcutaneous auto-injector, kit 40 mg/0.4 ml, 80 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-aaty subcutaneous syringe kit 20 mg/0.2 ml, 40 mg/0.4 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes/Pens per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>adalimumab-adaz subcutaneous pen injector 80 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 Days)
<i>adalimumab-adaz subcutaneous syringe 20 mg/0.2 ml, 40 mg/0.4 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.4 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 Days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 40 mg/0.4 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 Days)
ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 Days)
ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 Days)
ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-fkjp subcutaneous pen injector kit 40 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>adalimumab-fkjp subcutaneous syringe kit 20 mg/0.4 ml, 40 mg/0.8 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-ryvk subcutaneous auto-injector, kit 40 mg/0.4 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
<i>adalimumab-ryvk subcutaneous syringe kit 40 mg/0.4 ml</i>	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 Days)
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML	Non-Formulary	SP; QL (2 Syringes per 28 days)
AMJEVITA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Humira); QL (2 Syringes per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Humira); QL (2 Syringes per 28 days)
AMJEVITA(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML, 40 MG/0.4 ML	Non-Formulary	SP; QL (2 Syringes per 28 days)
AVSOLA INTRAVENOUS RECON SOLN 100 MG	Non-Formulary	PA; QL (Quantity Limits Apply); SP
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS)	6	PA; SP; QL (1 kit per 30 days)
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	6	PA; SP; QL (6 syringes per 365 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	6	PA; SP; QL (2 syringes per 30 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (6 Kits per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CYLTEZO(CF) PEN PSORIASIS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (4 Kits per 28 days)
CYLTEZO(CF) PEN PSORIASIS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
CYLTEZO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
CYLTEZO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML)	5	PA; SP; QL (0.15 ML per 1 day)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML	5	PA; SP; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	5	PA; SP; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	5	PA; SP; QL (0.15 ML per 1 day)
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML)	5	PA; SP; QL (0.15 ML per 1 day)
HADLIMA PUSHTOUCH SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	5	PA; SP; QL (4.8 ML per 28 days)
HADLIMA SUBCUTANEOUS SYRINGE 40 MG/0.8 ML	5	PA; SP; QL (4.8 ML per 28 days)
HADLIMA(CF) PUSHTOUCH SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML	5	PA; SP; QL (2.4 ML per 28 days)
HADLIMA(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	5	PA; SP; QL (2.4 ML per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HULIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP
HULIO(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML, 40 MG/0.8 ML	Non-Formulary	SP
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima)
HYRIMOZ PEN CROHN'S-UC STARTER SUBCUTANEOUS PEN INJECTOR 80 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringe/Pen per 28 days)
HYRIMOZ PEN PSORIASIS STARTER SUBCUTANEOUS PEN INJECTOR 80MG/0.8ML(X1)- 40 MG/0.4ML(X2)	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringe/Pen per 28 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML, 80 MG/0.8 ML- 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringe/Pen per 28 days)
HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringe/Pen per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringe/Pen per 28 days)
INFLECTRA INTRAVENOUS RECON SOLN 100 MG	BB	PA; SP; QL (8 Vials per 1 Fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>infliximab intravenous recon soln 100 mg</i>	BB	PA; SP; QL (8 Vials per 1 Fill)
REMICADE INTRAVENOUS RECON SOLN 100 MG	Non-Formulary	PA; QL (Quantity Limits Apply); SP
RENFLXIS INTRAVENOUS RECON SOLN 100 MG	BB	PA; SP; QL (8 Vials per 1 Fill)
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML, 80 MG/0.8 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML	7	PA; QL (Quantity Limits Apply); SP
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML	6	PA; SP; QL (0.02 ML per 1 day)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML	6	PA; SP; QL (0.02 ml per 1 day)
YUFLYMA(CF) AI CROHN'S-UC-HS SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	Non-Formulary	SP; QL (2 Syringes per 28 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML	Non-Formulary	SP; QL (2 Syringes per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	Non-Formulary	SP; ALT (Covered Alternatives: Hadlima); QL (2 Syringes per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	Non-Formulary	SP; QL (2 Syringes per 28 days)
YUSIMRY(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.8 ML	Non-Formulary	SP
ZYMFENTRA SUBCUTANEOUS PEN INJECTOR KIT 120 MG/ML	BB	
ZYMFENTRA SUBCUTANEOUS SYRINGE KIT 120 MG/ML	BB	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
LOCAL ANESTHETICS		
Local Anesthetics		
<i>bupivacaine-lidocaine-sod chl</i> r injection syringe 0.375 %-2 % (10 ml)	BB	
<i>fentanyl (pf)-bupivacaine-nacl epidural syringe</i> 2 mcg/ml- 0.125 %	BB	
<i>fentanyl (pf)-bupivacaine-nacl injection solution</i> 2 mcg/ml- 0.0625 %, 2 mcg/ml- 0.125 %	BB	
<i>lidocaine (pf) injection syringe</i> 100 mg/5 ml (2 %)	BB	
<i>lidocaine hcl laryngotracheal solution</i> 4 %	2	
<i>lidocaine hcl-hydrocortison ac rectal kit</i> 3-2.5 % (7 gram)	Non-Formulary	ALT (Covered Alternatives: lidocaine-HC rectal cream 3-05%); QL (1 Tube per 30 Days)
<i>lidocaine topical adhesive patch,medicated</i> 5 %	2	QL (3 Patches per 1 day)
<i>lidocaine topical ointment</i> 5 %	2	QL (39 gm per 1 fill)
<i>lidocaine-prilocaine topical cream</i> 2.5-2.5 %	2	QL (1 GM per 1 day)
LIDOCAN III TOPICAL ADHESIVE PATCH,MEDICATED 5 %	Non-Formulary	ALT (Covered Alternatives: LIDOCAINE 5% PATCH); QL (1 Patch per 1 Day)
LIDOCAN IV TOPICAL ADHESIVE PATCH,MEDICATED 5 %	Non-Formulary	ALT (Covered Alternatives: LIDOCAINE 5% PATCH); QL (1 Patch per 1 Day)
LIDOCAN V TOPICAL ADHESIVE PATCH,MEDICATED 5 %	Non-Formulary	ALT (Covered Alternatives: LIDOCAINE 5% PATCH); QL (1 Patch per 1 Day)
LIVIXIL PAK TOPICAL KIT 2.5-2.5 %	Non-Formulary	
<i>ropivacaine (pf) injection solution</i> 7.5 mg/ml (0.75 %)	BB	
<i>ropivacaine(pf)-0.9 % sodchlor injection solution</i> 0.2 % (2 mg/ml)	BB	
<i>tetracaine hcl ophthalmic (eye) drops</i> 0.5 %	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
MISCELLANEOUS THERAPEUTIC AGENTS		
5-Alpha-Reductase Inhibitors (92:04)		
<i>dutasteride oral capsule 0.5 mg</i>	2	QL (1 capsule per 1 day)
<i>dutasteride-tamsulosin oral capsule, er multiphase 24 hr 0.5-0.4 mg</i>	Non-Formulary	ALT (Covered Alternatives: DUTASTERIDE, TAMSULOSIN HCL)
<i>finasteride oral tablet 5 mg</i>	2	QL (2 tablets per 1 day)
Antigout Agents		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	2	
<i>allopurinol oral tablet 200 mg</i>	Non-Formulary	ALT (Covered Alternatives: Allopurinol 100mg, Allopurinol 300mg)
<i>colchicine oral capsule 0.6 mg</i>	Non-Formulary	ALT (Covered Alternatives: Colchicine Tablets); QL (4 Capsules per 1 day)
<i>colchicine oral tablet 0.6 mg</i>	2	QL (4 tablets per 1 day)
COLCRYS ORAL TABLET 0.6 MG	Non-Formulary	ALT (Covered Alternatives: COLCHICINE, PROBENECID W/COLCHICINE, ALLOPURINOL); QL (4 tablets per 1 day)
<i>febuxostat oral tablet 40 mg</i>	2	QL (3 Tablets per 1 day)
<i>febuxostat oral tablet 80 mg</i>	2	TD; QL (1 tablet per 1 day)
GLOPERBA ORAL SOLUTION 0.6 MG/5 ML	Non-Formulary	QL (Quantity Limits Apply)
<i>indomethacin oral capsule 25 mg</i>	2	QL (12 capsules per 1 day)
<i>indomethacin oral capsule 50 mg</i>	2	
<i>indomethacin oral capsule, extended release 75 mg</i>	2	
<i>indomethacin rectal suppository 100 mg</i>	Non-Formulary	ALT (Covered Alternatives: Indomethacin Capsules, Indomethacin ER Capsules, Colchicine, Febuxostat, Probenacid); QL (1 suppository per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
KRYSTEXXA INTRAVENOUS SOLUTION 8 MG/ML	BB	PA
LODOCO ORAL TABLET 0.5 MG	Non-Formulary	QL (1 Tablet per 1 Day)
MITIGARE ORAL CAPSULE 0.6 MG	Non-Formulary	QL (Quantity Limits Apply)
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 750 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>naproxen oral suspension 125 mg/5 ml</i>	2	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	2	
<i>naproxen oral tablet, delayed release (dr/ec) 375 mg, 500 mg</i>	2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	
<i>naproxen sodium oral tablet, er multiphase 24 hr 750 mg</i>	Non-Formulary	ALT (Covered Alternatives: Naproxen Tablets, Naproxen Caplets)
<i>probenecid oral tablet 500 mg</i>	2	
<i>probenecid-colchicine oral tablet 500-0.5 mg</i>	2	
ULORIC ORAL TABLET 40 MG, 80 MG	Non-Formulary	ST (Step Therapy Required); QL (1 tablet per 1 day)
VIMOVO ORAL TABLET, IR, DELAYED REL, BIPHASIC 500-20 MG	Non-Formulary	ALT (Covered Alternatives: ESOMEPRAZOLE MAGNESIUM, NAPROXEN)
Antisense Oligonucleotides		
AMONDYS-45 INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
EVRYSDI ORAL RECON SOLN 0.75 MG/ML	6	PA; SP; ALT (Covered Alternatives: SPINRAZA); QL (1 ML per 1 day)
EVRYSDI ORAL TABLET 5 MG	6	PA; SP; QL (1 Tablet per 1 day)
LUMRYZ ORAL EXTEND RELEASE GRANULES, PACKET 4.5 GRAM, 6 GRAM, 7.5 GRAM, 9 GRAM	Non-Formulary	SP; QL (1 Packet per 1 day)
<i>sodium oxybate oral solution 500 mg/ml</i>	2	PA; SP; QL (18 ML per 1 day)
SPINRAZA (PF) INTRATHECAL SOLUTION 12 MG/5 ML	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VILTEPSO INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
VYONDYS-53 INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
WAINUA SUBCUTANEOUS AUTO-INJECTOR 45 MG/0.8 ML	5	PA; SP; QL (0.8 ML per 30 days)
XYREM ORAL SOLUTION 500 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Sodium Oxybate); QL (18 ML per 1 day)
XYWAV ORAL SOLUTION 0.5 GRAM/ML	Non-Formulary	SP; QL (18 ML per 1 day)
Bone Anabolic Agents		
BONSITY SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (560MCG/2.24ML)	Non-Formulary	SP; ALT (Covered Alternatives: TERIPARATIDE); QL (0.09 ML per 1 Day)
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (560MCG/2.24ML)	Non-Formulary	QL (Quantity Limits Apply); SP; ALT (Covered Alternatives: TERIPARATIDE); QL (0.08 ML per 1 day)
TYMLOS SUBCUTANEOUS PEN INJECTOR 80 MCG (3,120 MCG/1.56 ML)	Non-Formulary	SP; ALT (Covered Alternatives: TERIPARATIDE); QL (1 pen per 30 days)
Bone Resorption Inhibitors		
ABIGALE LO ORAL TABLET 0.5-0.1 MG	2	HCR
ABIGALE ORAL TABLET 1-0.5 MG	2	HCR
<i>alendronate oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	2	
BINOSTO ORAL TABLET, EFFERVESCENT 70 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>calcitonin (salmon) nasal spray, non-aerosol 200 unit/actuation</i>	2	PA; QL (3.7 ml per 1 month)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/24 HR	Non-Formulary	QL (Quantity Limits Apply)
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.14 MG/24 HR, 0.05-0.25 MG/24 HR	4	QL (8 patches per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DIVIGEL TRANSDERMAL GEL IN PACKET 0.25 MG/0.25 GRAM (0.1 %), 0.5 MG/0.5 GRAM (0.1 %), 0.75 MG/0.75 GRAM (0.1%), 1 MG/GRAM (0.1 %), 1.25 MG/1.25 GRAM (0.1 %)	Non-Formulary	QL (1 Packet per 1 day)
ELESTRIN TRANSDERMAL GEL IN METERED-DOSE PUMP 0.87 GRAM/ACTUATION	4	QL (1 GM per 30 days)
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>estradiol transdermal gel in metered-dose pump 1.25 gram/actuation</i>	2	QL (50 GM per 30 Days)
<i>estradiol transdermal gel in packet 0.25 mg/0.25 gram (0.1 %), 0.5 mg/0.5 gram (0.1 %), 0.75 mg/0.75 gram (0.1%), 1 mg/gram (0.1 %), 1.25 mg/1.25 gram (0.1 %)</i>	2	QL (30 packets per 30 days)
<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>	2	QL (8 patches per 30 days)
<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>	2	QL (4 patches per 30 days)
<i>estradiol vaginal cream 0.01 % (0.1 mg/gram)</i>	2	QL (42.5 GM per 1 fill)
<i>estradiol vaginal tablet 10 mcg</i>	2	QL (0.29 Tablets per 1 day)
<i>estradiol valerate intramuscular oil 20 mg/ml</i>	2	QL (5 ML per 28 days)
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	2	
ESTRING VAGINAL RING 2 MG (7.5 MCG /24 HOUR)	4	QL (1 ring per 90 days)
ESTROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 1.25 GRAM/ACTUATION	Non-Formulary	ALT (Covered Alternatives: ESTRADIOL 0.06% 1.25G GEL PUMP); QL (50 GM per 30 days)
EVAMIST TRANSDERMAL SPRAY, NON-AEROSOL 1.53 MG/SPRAY (1.7%)	Non-Formulary	QL (Quantity Limits Apply)
FEMRING VAGINAL RING 0.05 MG/24 HR, 0.1 MG/24 HR	4	QL (1 ring per 84 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FOSAMAX PLUS D ORAL TABLET 70 MG- 2,800 UNIT, 70 MG- 5,600 UNIT	4	ST (Step Therapy Required- Tried and failed 90 days treatment of alendronate or ibandronate); QL (4 tablets per 28 days)
<i>ibandronate oral tablet 150 mg</i>	2	QL (1 tablet per 30 days)
JINTELI ORAL TABLET 1-5 MG-MCG	2	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24 HR	4	QL (4 patches per 28 days)
MIMVEY ORAL TABLET 1-0.5 MG	2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	2	
<i>raloxifene oral tablet 60 mg</i>	2	HCR; QL (1 tablet per 1 day)
<i>risedronate oral tablet 150 mg</i>	2	QL (1 tablet per 28 days)
<i>risedronate oral tablet 30 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>risedronate oral tablet 35 mg</i>	2	QL (4 tablets per 28 days)
VAGIFEM VAGINAL TABLET 10 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Estradiol 10mcg Vaginal Insert Tablets); QL (0.29 Tablets per 1 day)
YUVAFEM VAGINAL TABLET 10 MCG	2	
Bradykinin Receptor Antagonists		
FIRAZYR SUBCUTANEOUS SYRINGE 30 MG/3 ML	Non-Formulary	SP; QL (0.01 ml per 1 day)
<i>icatibant subcutaneous syringe 30 mg/3 ml</i>	5	PA; SP; QL (0.01 ML per 1 day)
SAJAZIR SUBCUTANEOUS SYRINGE 30 MG/3 ML	Non-Formulary	SP; QL (0.01 ml per 1 day)
Carbonic Anhydrase Inhibitors (Misc.)		
KEVEYIS ORAL TABLET 50 MG	Non-Formulary	SP
Cariostatic Agents		
DENTA 5000 PLUS SENSITIVE DENTAL PASTE 1.1-5 %	Non-Formulary	ALT (Covered Alternatives: DENTA 5000 PLUS CREAM, DENTAGEL GEL); QL (100 ml per 30 Days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>fluoride (sodium) oral drops 0.5 mg (1.1 mg sod.fluorid)/ml</i>	2	HCR
<i>fluoride (sodium) oral tablet, chewable 0.25 mg(0.55 mg sod. fluoride), 0.5 mg (1.1 mg sodium fluorid)</i>	2	HCR
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.5 MG	2	HCR
<i>sodium fluoride-pot nitrate dental paste 1.1-5 %</i>	1	
Complement Inhibitors		
VOYDEYA ORAL TABLET 100 MG	Non-Formulary	SP; QL (6 Tablets per 1 day)
VOYDEYA ORAL TABLET 150 MG (50 MG X 1-100 MG X 1)	Non-Formulary	SP
Complement Inhibitors (92:32)		
BERINERT INTRAVENOUS KIT 500 UNIT (10 ML)	BB	PA; SP
BERINERT INTRAVENOUS RECON SOLN 500 UNIT (10 ML)	BB	PA; SP
CINRYZE INTRAVENOUS RECON SOLN 500 UNIT (5 ML)	BB	PA; SP; QL (0.01 EA per 1 day)
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT	6	PA; SP; QL (0.01 unit per 1 day)
HAEGARDA SUBCUTANEOUS RECON SOLN 3,000 UNIT	6	PA; SP; QL (0.01 EA per 1 day)
RUCONEST INTRAVENOUS RECON SOLN 2,100 UNIT	BB	PA; QL (Quantity Limits Apply)
VEOPOZ INJECTION SOLUTION 200 MG/ML	BB	PA
Iga Nephropathy		
FILSPARI ORAL TABLET 200 MG, 400 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
VANRAFIA ORAL TABLET 0.75 MG	Non-Formulary	SP; QL (1 Tablet per 1 Day)
Immunomodulatory Agents		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5 ML	5	PA; SP; QL (1.5 ML per 1 Fill)
<i>hydroxychloroquine oral tablet 100 mg, 400 mg</i>	Non-Formulary	ALT (Covered Alternatives: hydroxychloroquine 200mg)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydroxychloroquine oral tablet 200 mg</i>	2	QL (6 tablets per 1 day)
<i>hydroxychloroquine oral tablet 300 mg</i>	Non-Formulary	ALT (Covered Alternatives: hydroxychloroquine 200mg); QL (1 Tablets per 1 day)
JOENJA ORAL TABLET 70 MG	Non-Formulary	SP; QL (2 Tablets per 1 day)
LEFLUNICLO KIT,GEL AND TABLET 20 MG- 1 %	Non-Formulary	ALT (Covered Alternatives: LEFLUNOMIDE TABLET, Diclofenac Gel); QL (1 kit per 30 days)
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	1	PA; SP; QL (1 Capsule per 1 day)
OCREVUS ZUNOVO SUBCUTANEOUS SOLUTION 920 MG-23,000 UNIT/23 ML	BB	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	6	PA; SP; QL (1 capsule per 1 day)
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	5	PA; SP; QL (1 capsule per 1 day)
RIDAURA ORAL CAPSULE 3 MG	Non-Formulary	SP; QL (1 capsule per 1 day)
SOVUNA ORAL TABLET 200 MG	Non-Formulary	ALT (Covered Alternatives: Hydroxychloroquine); QL (6 Tablets per 1 Day)
SOVUNA ORAL TABLET 300 MG	Non-Formulary	ALT (Covered Alternatives: HYDROXYCHLOROQUINE); QL (1 Tablets per 1 Day)
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA; SP; QL (1 capsule per 1 day)
VELSIPITY ORAL TABLET 2 MG	Non-Formulary	SP; ALT (Covered Alternatives: Sulfasalazine, Mesalamine, Balsalazide Disodium); QL (1 Tablet per 1 day)
Other Miscellaneous Therapeutic Agents		
AMVUTTRA SUBCUTANEOUS SYRINGE 25 MG/0.5 ML	BB	PA
CYSTADANE ORAL POWDER 1 GRAM/SCOOP	Non-Formulary	SP
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	4	PA; SP; QL (1 capsule per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DUVYZAT ORAL SUSPENSION 8.86 MG/ML	6	PA; SP; QL (6 ML per 1 day)
ENDARI ORAL POWDER IN PACKET 5 GRAM	Non-Formulary	QL (Quantity Limits Apply); SP
EVOTAZ ORAL TABLET 300-150 MG	6	QL (1 tablet per 1 day)
EVRYSDI ORAL RECON SOLN 0.75 MG/ML	6	PA; SP; ALT (Covered Alternatives: SPINRAZA); QL (1 ML per 1 day)
EVRYSDI ORAL TABLET 5 MG	6	PA; SP; QL (1 Tablet per 1 day)
GIVLAARI SUBCUTANEOUS SOLUTION 189 MG/ML	BB	PA
<i>glutamine (sickle cell) oral powder in packet 5 gram</i>	Non-Formulary	SP
<i>levocarnitine (with sugar) oral solution 100 mg/ml</i>	2	
<i>levocarnitine oral tablet 330 mg</i>	2	
NIKTIMVO INTRAVENOUS SOLUTION 50 MG/ML	BB	PA
NULIBRY INTRAVENOUS RECON SOLN 9.5 MG	Non-Formulary	SP
ONPATTRO INTRAVENOUS SOLUTION 2 MG/ML	BB	PA
OXLUMO SUBCUTANEOUS SOLUTION 94.5 MG/0.5 ML	BB	PA
PREZCOBIX ORAL TABLET 800-150 MG-MG	6	QL (2 tablets per 1 day)
PROCYSBI ORAL CAPSULE, DELAYED REL SPRINKLE 25 MG, 75 MG	Non-Formulary	SP; QL (1 capsule per 1 day)
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET 300 MG, 75 MG	Non-Formulary	SP
REZUROCK ORAL TABLET 200 MG	Non-Formulary	SP
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5 ML (160 MG/ML)	Non-Formulary	
RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML, 160 MG/ML	Non-Formulary	
SKYCLARYS ORAL CAPSULE 50 MG	6	PA; SP; QL (3 capsules per 1 day)
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG	Non-Formulary	SP; QL (2 Capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
THIOLA EC ORAL TABLET,DELAYED RELEASE (DR/EC) 100 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tiopronin 100mg Tablets); QL (10 Tablets per 1 day)
THIOLA EC ORAL TABLET,DELAYED RELEASE (DR/EC) 300 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tiopronin 100mg); QL (4 Tablets per 1 day)
THIOLA ORAL TABLET 100 MG	Non-Formulary	SP; ALT (Covered Alternatives: tiopronin)
<i>tiopronin oral tablet 100 mg</i>	2	PA; SP; QL (20 TABLET per 1 day)
<i>tiopronin oral tablet, delayed release (dr/ec) 100 mg</i>	Non-Formulary	SP; ALT (Covered Alternatives: Tiopronin 100mg Tablets); QL (10 Tablets per 1 Day)
<i>tiopronin oral tablet, delayed release (dr/ec) 300 mg</i>	Non-Formulary	SP; ALT (Covered Alternatives: Tiopronin 100mg); QL (4 Tablets per 1 Day)
VENXXIVA ORAL TABLET,DELAYED RELEASE (DR/EC) 100 MG	Non-Formulary	SP; QL (10 Tablets per 1 Day)
VENXXIVA ORAL TABLET,DELAYED RELEASE (DR/EC) 300 MG	Non-Formulary	SP; QL (4 Tablets per 1 Day)
VOXZOGO SUBCUTANEOUS RECON SOLN 0.4 MG, 0.56 MG, 1.2 MG	5	PA; SP
XPHOZAH ORAL TABLET 20 MG, 30 MG	Non-Formulary	SP; QL (2 Tablets per 1 Day)
Protective Agents		
<i>adapalene topical cream 0.1 %</i>	2	PA; QL (45 GM per 30 days); AG (Max 30 Years)
<i>adapalene topical gel 0.1 %, 0.3 %</i>	2	PA; QL (45 GM per 30 days); AG (Max 30 Years)
<i>adapalene topical gel with pump 0.3 %</i>	2	PA; QL (45 GM per 30 days); AG (Max 30 Years)
<i>adapalene topical lotion 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Adapalene (Gel & Cream)); AG (Max 30 Years)
<i>adapalene topical solution 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Adapalene (Gel & Cream)); AG (Max 30 Years)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>adapalene topical swab 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Adapalene (Gel & Cream)); AG (Max 30 Years)
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HR 10 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
<i>dalfampridine oral tablet extended release 12 hr 10 mg</i>	2	SP; QL (2 tablets per 1 day)
DIFFERIN TOPICAL LOTION 0.1 %	Non-Formulary	QL (Quantity Limits Apply)
SCENESSE SUBCUTANEOUS IMPLANT 16 MG	BB	PA

NONHORMONAL CONTRACEPTIVES

Nonhormonal Contraceptives

AIMSCO LATEX CONDOM DEVICE	0	HCR; QL (12 condoms per 30 days)
DUREX AIR CONDOM DEVICE	4	HCR
DUREX AVANTI BARE REAL FEEL	0	HCR; QL (10 condom per 30 days)
DUREX EXTRA SENSITIVE CONDOM DEVICE	4	HCR
DUREX TROPICAL CONDOM DEVICE	4	HCR
FANTASY CONDOM DEVICE	0	HCR; QL (12 condoms per 30 days)
FC2 FEMALE CONDOM	0	HCR
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM	5	
KIMONO LUBRICATED CONDOMS DEVICE	4	HCR
KIMONO MICROTHIN AQUA LUBE CON DEVICE	0	HCR; QL (12 condoms per 30 days)
KIMONO MICROTHIN CONDOMS DEVICE	4	HCR; QL (12 condoms per 30 days)
KIMONO MICROTHIN LARGE CONDOMS DEVICE	0	HCR; QL (12 condoms per 30 days)
KIMONO TEXTURED CONDOMS DEVICE	0	HCR; QL (12 condoms per 30 days)
KIMONO THIN LUBRICATED CONDOMS DEVICE	4	HCR
PHEXXI VAGINAL GEL 1.8-1-0.4 %	4	HCR
TROJAN BARESKIN DEVICE	4	HCR
TROJAN EXTENDED PLEASURE DEVICE	4	HCR

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TROJAN MAGNUM CONDOMS DEVICE	4	HCR
TROJAN PLEASURE PACK DEVICE	4	HCR
TROJAN ULTRA RIBBED CONDOM DEVICE	4	HCR
TROJAN ULTRA THIN DEVICE	4	HCR
TROJAN ULTRA THIN SPERMICIDAL DEVICE	4	HCR
TROJAN VERY THIN LUB CONDOMS DEVICE	4	HCR
TROJAN-ENZ (NON-LUB) CONDOMS DEVICE	4	HCR
TROJAN-ENZ LUBRICATED CONDOMS DEVICE	4	HCR
TROJAN-ENZ/SPERMICIDAL CONDOMS DEVICE	4	HCR
TRUE COVER CONDOM DEVICE	4	HCR
TRUSTEX LATEX CONDOM DEVICE	0	HCR; QL (12 condoms per 30 days)
TRUSTEX LUBRICATED CONDOMS DEVICE	0	HCR; QL (12 condoms per 30 days)
TRUSTEX NON-LUB CONDOMS DEVICE	4	HCR
TRUSTEX-RIA LUB/SPERMICIDE DEVICE	0	HCR; QL (12 condoms per 30 days)
TRUSTEX-RIA LUBRICATED CONDOMS DEVICE	0	HCR
TRUSTEX-RIA NON-LUB CONDOMS DEVICE	4	HCR
VAGINAL CONTRACEPTIVE FILM VAGINAL FILM 28 %	4	QL (9 Film per 30 days)
VCF CONTRACEPTIVE GEL VAGINAL GEL 4 %	4	HCR
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 60 MM	0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 65 MM	5	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 70 MM	5	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 75 MM	5	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 80 MM	5	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 85 MM	5	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 90 MM	5	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 95 MM	5	
OXYTOCICS		
Oxytocics		
<i>oxytocin in 0.9 % sod chloride intravenous solution 10 unit/500 ml, 15 unit/250 ml, 20 unit/1000 ml, 30 unit/500 ml, 40 unit/1000 ml</i>	BB	
<i>oxytocin in lactated ringers intravenous solution 10 unit/500 ml, 15 unit/250 ml, 20 unit/1,000 ml, 30 unit/500 ml</i>	BB	
PHARMACEUTICAL AIDS		
Pharmaceutical Aids		
DILUENT FOR REMODULIN INTRAVENOUS SOLUTION	Non-Formulary	SP
<i>diluent for treprostinil (gly) intravenous solution</i>	7	SP
TEGADERM FRAME STYLE TOPICAL BANDAGE 2 3/8 X 2 3/4 "	7	ST (Step Therapy Required- Use of Freestyle Libre in the last 180 days); QL (20 patches per 30 days)
TEGADERM TRANSPARENT DRESSING TOPICAL BANDAGE 2 3/8 X 2 3/4 "	7	ST (Step Therapy Required- Use of Freestyle Libre in the last 180 days); QL (20 patches per 30 Days)
RESPIRATORY TRACT AGENTS		
Alpha And Beta Adrenergic Agonist(Respr)		
ADRENALIN IN 0.9 % SOD CHLOR INTRAVENOUS SOLUTION 10 MG/250 ML (40 MCG/ML), 2 MG/250 ML (8 MCG/ML), 8 MG/250 ML (32 MCG/ML)	BB	
ALLERGY AND CONGESTION RELIEF ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ALLERGY RELIEF D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY RELIEF,NASAL DECONGEST ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY-CONGESTION RELIEF-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
AUVI-Q INJECTION AUTO-INJECTOR 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML	Non-Formulary	ALT (Covered Alternatives: EPINEPHRINE 0.15 MG AUTO-INJECT, EPINEPHRINE 0.3 MG AUTO-INJECT); QL (4 Injectors per 1 Fill)
CLARITIN-D 24 HOUR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	Non-Formulary	
<i>ephedrine sulfate intravenous solution 5 mg/ml, 50 mg/ml</i>	BB	
<i>ephedrine sulfate intravenous syringe 25 mg/5 ml (5 mg/ml), 50 mg/10 ml (5 mg/ml)</i>	BB	
<i>ephedrine sulfate-0.9%nacl(pf) intravenous syringe 15 mg/3 ml (5 mg/ml), 25 mg/5 ml (5 mg/ml)</i>	BB	
<i>epinephrine hcl in 0.9 % nacl intravenous solution 4 mg/250 ml (16 mcg/ml)</i>	BB	
<i>epinephrine in 0.9 % sod chlor intravenous solution 8 mg/250 ml (32 mcg/ml)</i>	BB	
<i>epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	2	QL (4 pens per 30 days)
<i>epinephrine injection syringe 0.3 mg/0.3 ml</i>	BB	
EPIPEN 2-PAK INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)
EPIPEN INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)
EPIPEN JR 2-PAK INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)
EPIPEN JR INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML	Non-Formulary	QL (4 units per 1 fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
GUAIFENESIN DAC ORAL SYRUP 30-10-100 MG/5 ML	2	
LORATA-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
PRIMATENE MIST INHALATION HFA AEROSOL INHALER 0.125 MG/ACTUATION	Non-Formulary	QL (11.7 GM per 28 days)
Anticholinergic Agents (Respir. Tract)		
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); TD; QL (60 Blisters per 28 days)
<i>atropine ophthalmic (eye) drops 0.01 %, 0.025 %, 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: Atropine 1% eye drops); QL (5 ML per 30 days)
<i>atropine ophthalmic (eye) drops 1 %</i>	2	
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION	3	QL (25.8 GM per 30 days)
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (10.7 GM per 28 days)
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER 160-9-4.8 MCG/ACTUATION	4	PA; TD; QL (10.7 GM per 30 days)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 GM per 30 days)
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400-12 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (1 Inhaler per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	2	
<i>hyoscyamine sulfate sublingual tablet 0.125 mg</i>	2	
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE 62.5 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Breo Ellipta, Combivent, Tiotropium, Wixela, Budesonide/Formoterol, Stiolto); TD; QL (30 Blisters per 28 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	2	
<i>ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml</i>	2	
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION	3	QL (60 GM per 30 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG	Non-Formulary	ALT (Covered Alternatives: Tiotropium Bromide); QL (1 inhaler per 30 days)
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION	3	QL (4 GM per 30 days)
<i>tiotropium bromide inhalation capsule, w/inhalation device 18 mcg</i>	2	QL (1 Capsule per 1 day)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	4	PA; TD
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG	4	PA; TD; QL (1 DEVICE per 30 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: BREO ELLIPTA, SPIRIVA, ARCAPTA NEOHALER, ADVAIR DISKUS, SYMBICORT, COMBIVENT RESPIMAT, PERFOROMIST); TD; QL (1 Inahler per 28 days)
YUPELRI INHALATION SOLUTION FOR NEBULIZATION 175 MCG/3 ML	4	SP; QL (3 vials per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Antifibrotic Agents		
ESBRIET ORAL CAPSULE 267 MG	Non-Formulary	ALT (Covered Alternatives: Pirfenidone Capsules, Pirfenidone Tablets)
ESBRIET ORAL TABLET 267 MG, 801 MG	Non-Formulary	ALT (Covered Alternatives: Pirfenidone Capsules, Pirfenidone Tablets)
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA; SP; QL (60 capsules per 30 days)
<i>pirfenidone oral capsule 267 mg</i>	Non-Formulary	ALT (Covered Alternatives: PIRFENIDONE 267 TABLETS); QL (6 Capsules per 1 Day)
<i>pirfenidone oral tablet 267 mg</i>	5	SP; QL (6 Tablets per 1 day)
<i>pirfenidone oral tablet 534 mg</i>	Non-Formulary	SP; ALT (Covered Alternatives: Pirfenidone 267mg, Pirfenidone 801mg); QL (3 Tablets per 1 day)
<i>pirfenidone oral tablet 801 mg</i>	5	SP; QL (3 Tablets per 1 day)
Antitussives		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	2	QL (4500 ML per 30 days)
<i>acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml</i>	2	QL (50 ML per 1 Day)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	2	QL (10 tablets per 1 day)
<i>benzonatate oral capsule 100 mg</i>	2	QL (6 capsules per 1 day)
<i>benzonatate oral capsule 200 mg</i>	2	QL (3 capsules per 1 day)
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	Non-Formulary	ALT (Covered Alternatives: BUTALB-ACETAMIN-CAF-COD 50-325)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	2	QL (6 tablets per 1 day)
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	2	QL (6 tablets per 1 day)
<i>codeine-guaifenesin oral liquid 10-100 mg/5 ml</i>	2	
GUAIFENESIN DAC ORAL SYRUP 30-10-100 MG/5 ML	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydrocodone-chlorpheniramine oral suspension, extended rel 12 hr 10-8 mg/5 ml</i>	2	
<i>hydrocodone-homatropine oral solution 5-1.5 mg/5 ml</i>	2	QL (240 ML per 30 days)
<i>hydrocodone-homatropine oral solution 5-1.5 mg/5 ml (5 ml)</i>	Non-Formulary	QL (240 ML per 30 Days)
NUEDEXTA ORAL CAPSULE 20-10 MG	4	PA; QL (2 capsules per 1 day)
<i>promethazine-codeine oral syrup 6.25-10 mg/5 ml</i>	2	
<i>promethazine-dm oral syrup 6.25-15 mg/5 ml</i>	2	
VIRTUSSIN AC ORAL LIQUID 10-100 MG/5 ML	2	
Corticosteroids (Respiratory Tract)		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	Non-Formulary	ALT (Covered Alternatives: FLUTICASONE-SALMETEROL, WIXELA INHUB); QL (60 units per 1 fill)
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)
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG-14 MCG/ACTUATION, 232-14 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inhaler per 28 days)
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g), Levalbuterol HFA); QL (10.7 GM per 30 Days)
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION, 80 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (6.1 GM per 28 days)
ARMONAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG/ACTUATION, 232 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inaler per 28 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (30 Blisters per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	4	QL (13 GM per 28 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	4	QL (1 inhaler per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	3	QL (1 inhaler per 30 days)
BREYNA INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	2	QL (10.3 GM per 1 Fill)
<i>budesonide-formoterol inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	2	QL (10.3 GM per 1 Fill)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 200-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	3	QL (13 GM per 28 days)
DYMISTA NASAL SPRAY, NON-AEROSOL 137-50 MCG/SPRAY	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: AZELASTINE HCL, FLUTICASONE PROPIONATE, FLUNISOLIDE, TRIAMCINOLONE ACETONIDE, BUDESONIDE, MOMETASONE FUROATE)
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	2	
<i>fluticasone furoate inhalation blister with device 100 mcg/actuation, 200 mcg/actuation, 50 mcg/actuation</i>	Non-Formulary	QL (1 Box per 30 Days)
<i>fluticasone furoate-vilanterol inhalation blister with device 100-25 mcg/dose, 200-25 mcg/dose</i>	Non-Formulary	QL (60 units per 1 fill)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation, 220 mcg/actuation, 44 mcg/actuation</i>	3	ALT (Covered Alternatives: Pulmicort Flexhaler, QVAR, Alvesco, Asmanex); QL (1 Inhaler per 30 days); AG (Max 4 Years)
<i>fluticasone propionate nasal spray, suspension 50 mcg/actuation</i>	2	QL (1 bottle per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	2	QL (1 inhaler 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 GM per 30 days)
KENALOG INJECTION SUSPENSION 10 MG/ML	7	
KENALOG INJECTION SUSPENSION 40 MG/ML	Non-Formulary	
KENALOG TOPICAL AEROSOL 0.147 MG/GRAM	Non-Formulary	QL (100 gm per 30 days)
<i>mometasone topical cream 0.1 %</i>	2	QL (45 GM per 30 days)
<i>mometasone topical ointment 0.1 %</i>	2	QL (45 GM per 30 days)
<i>mometasone topical solution 0.1 %</i>	2	QL (45 ML per 30 days)
<i>nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%</i>	2	QL (1.4 GM per 1 day)
<i>nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%</i>	2	QL (1.4 GM per 1 day)
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION, 80 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); TD
RYALTRIS NASAL SPRAY, NON-AEROSOL 665-25 MCG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Fluticasone Nasal Spray, Flunisolide Nasal Spray, Mometasone Nasal Spray); QL (1 gram per 1 day)
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: BUDESONIDE/FORMOTEROL FUMARATE); QL (10.3 GM per 1 Fill)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	4	PA; TD
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG	4	PA; TD; QL (1 DEVICE per 30 days)
<i>triamcinolone acetate-0.9% nacl injection suspension 50 mg/ml</i>	7	
<i>triamcinolone acetonide dental paste 0.1 %</i>	2	QL (5 GM per 1 fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>triamcinolone acetonide injection suspension 40 mg/ml</i>	7	
<i>triamcinolone acetonide topical aerosol 0.147 mg/gram</i>	Non-Formulary	QL (100 gm per 30 days)
<i>triamcinolone acetonide topical cream 0.025 %, 0.5 %</i>	2	QL (80 GM per 30 days)
<i>triamcinolone acetonide topical cream 0.1 %</i>	2	QL (90 GM per 30 days)
<i>triamcinolone acetonide topical lotion 0.025 %, 0.1 %</i>	2	QL (60 GM per 30 days)
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %</i>	2	QL (80 GM per 30 days)
<i>triamcinolone acetonide topical ointment 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE)
<i>triamcinolone acetonide topical ointment 0.5 %</i>	2	QL (15 GM per 30 days)
TRIANEX TOPICAL OINTMENT 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, FLUOCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE)
WIXELA INHUB INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	2	QL (60 GM per 30 days)
XHANCE NASAL AEROSOL BREATH ACTIVATED 93 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply)
Cystic Fibrosis (Cftr) Correctors		
ALYFTREK ORAL TABLET 10-50-125 MG	6	PA; SP; QL (2 Tablets per 1 day)
ALYFTREK ORAL TABLET 4-20-50 MG	6	PA; SP; QL (3 Tablets per 1 day)
ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG	Non-Formulary	SP; QL (4 packets per 1 day)
ORKAMBI ORAL GRANULES IN PACKET 75-94 MG	Non-Formulary	SP; ALT (Covered Alternatives: Orkambi Tablets); QL (4 packets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; SP; QL (4 Tablets per 1 day)
SYMDEKO ORAL TABLETS, SEQUENTIAL 100-150 MG (D)/ 150 MG (N), 50-75 MG (D)/ 75 MG (N)	5	PA; SP; QL (2 tablets per 1 day)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL 100-50-75MG (D) /75 MG (N), 80-40-60 MG (D) /59.5 MG (N)	6	PA; SP; QL (3 Packets per 1 day)
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N), 50-25-37.5 MG (D)/75 MG (N)	6	PA; SP; QL (3 tablets per 1 day)
Cystic Fibrosis (Cftr) Potentiators		
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG	5	PA; SP; QL (2 Packets per 1 day)
KALYDECO ORAL TABLET 150 MG	5	PA; SP; QL (2 Tablets per 1 day)
ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG	Non-Formulary	SP; QL (4 packets per 1 day)
ORKAMBI ORAL GRANULES IN PACKET 75-94 MG	Non-Formulary	SP; ALT (Covered Alternatives: Orkambi Tablets); QL (4 packets per 1 day)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; SP; QL (4 Tablets per 1 day)
SYMDEKO ORAL TABLETS, SEQUENTIAL 100-150 MG (D)/ 150 MG (N), 50-75 MG (D)/ 75 MG (N)	5	PA; SP; QL (2 tablets per 1 day)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL 100-50-75MG (D) /75 MG (N), 80-40-60 MG (D) /59.5 MG (N)	6	PA; SP; QL (3 Packets per 1 day)
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N), 50-25-37.5 MG (D)/75 MG (N)	6	PA; SP; QL (3 tablets per 1 day)
Dual Phosphodiesterase Inhibitor (48:34)		
OHTUVAYRE INHALATION SUSPENSION FOR NEBULIZATION 3 MG/2.5 ML	Non-Formulary	SP; QL (5 ML per 1 Day)
Expectorants		
<i>codeine-guaifenesin oral liquid 10-100 mg/5 ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
GUAIFENESIN DAC ORAL SYRUP 30-10-100 MG/5 ML	2	
VIRTUSSIN AC ORAL LIQUID 10-100 MG/5 ML	2	
First Generation Antihist.(Respir Tract)		
<i>carbinoxamine maleate oral suspension,extended rel 12 hr 4 mg/5 ml</i>	Non-Formulary	QL (40 ML per 1 Day)
CARBZAH ORAL LIQUID 4 MG/5 ML	Non-Formulary	ALT (Covered Alternatives: CARBINOXAMINE MALEATE ORAL LIQUID 4MG/5ML); QL (30 ML per 1 Day)
<i>clemastine oral tablet 2.68 mg</i>	2	
CLEMSZA ORAL TABLET 2.68 MG	Non-Formulary	ALT (Covered Alternatives: CLEMASTINE 2.68MG); QL (3 Tablets per 1 Day)
<i>cyproheptadine oral syrup 2 mg/5 ml</i>	2	
<i>cyproheptadine oral tablet 4 mg</i>	2	
DICLEGIS ORAL TABLET,DELAYED RELEASE (DR/EC) 10-10 MG	Non-Formulary	QL (4 tablets per 1 day)
<i>doxylamine-pyridoxine (vit b6) oral tablet,delayed release (dr/ec) 10-10 mg</i>	2	QL (6 Fills per 365 Days); TD; QL (4 tablets per 1 day)
<i>hydrocodone-chlorpheniramine oral suspension,extended rel 12 hr 10-8 mg/5 ml</i>	2	
<i>promethazine oral syrup 6.25 mg/5 ml</i>	2	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine-codeine oral syrup 6.25-10 mg/5 ml</i>	2	
<i>promethazine-dm oral syrup 6.25-15 mg/5 ml</i>	2	
Interleukin Antagonists		
ARCALYST SUBCUTANEOUS RECON SOLN 220 MG	6	PA; SP; QL (0.01 EA per 1 day)
CINQAIR INTRAVENOUS SOLUTION 10 MG/ML	7	PA; QL (Quantity Limits Apply); SP; QL (0.01 ML per 1 day)
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR 30 MG/ML	6	PA; SP; QL (1 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	BB	PA
ILARIS (PF) SUBCUTANEOUS SOLUTION 150 MG/ML	BB	PA
NUCALA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	6	PA; SP; QL (1 ML per 30 days)
NUCALA SUBCUTANEOUS RECON SOLN 100 MG	BB	PA
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML	6	PA; SP; QL (1 ML per 30 days)
TEZSPIRE SUBCUTANEOUS PEN INJECTOR 210 MG/1.91 ML (110 MG/ML)	Non-Formulary	SP; ALT (Covered Alternatives: Icatibant, Nucala, Takhzyro, Fasenra, Haegarda); QL (0.07 ML per 1 day)
TEZSPIRE SUBCUTANEOUS SYRINGE 210 MG/1.91 ML (110 MG/ML)	Non-Formulary	PA; SP
Leukotriene Modifiers		
<i>montelukast oral granules in packet 4 mg</i>	2	QL (1 packet per 1 day)
<i>montelukast oral tablet 10 mg</i>	2	QL (1 tablet per 1 day)
<i>montelukast oral tablet, chewable 4 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	2	
<i>zileuton oral tablet, er multiphase 12 hr 600 mg</i>	2	PA; QL (4 tablets per 1 day)
Mast-Cell Stabilizers		
<i>cromolyn ophthalmic (eye) drops 4 %</i>	2	
<i>cromolyn oral concentrate 100 mg/5 ml</i>	2	
Mucolytic Agents		
<i>acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)</i>	2	
PULMOZYME INHALATION SOLUTION 1 MG/ML	5	PA; SP; QL (2 ampules per 1 day)
Phosphodiesterase Type 4 Inhibitors		
DALIRESP ORAL TABLET 250 MCG, 500 MCG	Non-Formulary	QL (1 tablet per 1 day)
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	2	QL (1 tablet per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZORYVE TOPICAL CREAM 0.15 %	Non-Formulary	ALT (Covered Alternatives: TAZAROTENE, CALCIPOTRIENE); QL (2 GM per 1 Day)
ZORYVE TOPICAL CREAM 0.3 %	Non-Formulary	ALT (Covered Alternatives: Tazarotene, Calcipotriene); QL (2 GM per 1 day)
ZORYVE TOPICAL FOAM 0.3 %	Non-Formulary	ALT (Covered Alternatives: TAZAROTENE, CALCIPOTRIENE); QL (2 GM per 1 day)
Phosphodiesterase-5 Inhibitors (Respir)		
ADCIRCA ORAL TABLET 20 MG	Non-Formulary	SP; ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (2 Tablets per 1 day)
ALYQ ORAL TABLET 20 MG	Non-Formulary	SP; QL (2 Tablets per 1 day)
CIALIS ORAL TABLET 10 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (6 tablets per 30 days)
CIALIS ORAL TABLET 20 MG	Non-Formulary	ALT (Covered Alternatives: SILDENAFIL CITRATE)
REVATIO INTRAVENOUS SOLUTION 10 MG/12.5 ML	Non-Formulary	
REVATIO ORAL TABLET 20 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution 10 mg/ml</i>	Non-Formulary	SP
<i>sildenafil (pulm.hypertension) oral tablet 20 mg</i>	2	QL (1 tablet per 1 day)
<i>sildenafil oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (12 Tablets per 30 days)
<i>tadalafil (pulm. hypertension) oral tablet 20 mg</i>	5	PA; SP; ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (2 Tablets per 1 day)
<i>tadalafil oral tablet 10 mg, 5 mg</i>	2	QL (12 Tablets per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>tadalafil oral tablet 2.5 mg</i>	Non-Formulary	ALT (Covered Alternatives: TERAZOSIN HCL, TAMSULOSIN HCL, ALFUZOSIN HCL ER, SILODOSIN); QL (12 Tablets per 30 days)
<i>tadalafil oral tablet 20 mg</i>	Non-Formulary	
VIAGRA ORAL TABLET 100 MG, 25 MG, 50 MG	Non-Formulary	ALT (Covered Alternatives: SILDENAFIL CITRATE); QL (6 tablets per 1 day)
Prostacyclin & Prostacyclin Derivatives		
VENTAVIS INHALATION SOLUTION FOR NEBULIZATION 10 MCG/ML, 20 MCG/ML	5	PA; SP; QL (9 ml per 1 day)
Respiratory Tract Agents, Miscellaneous		
BRONCHITOL INHALATION CAPSULE, W/INHALATION DEVICE 40 MG	Non-Formulary	ALT (Covered Alternatives: PULMOZYME)
WINREVAIR SUBCUTANEOUS KIT 120 MG (60 MG X 2), 45 MG, 60 MG, 90 MG (45 MG X 2)	6	PA; SP; ALT (Covered Alternatives: Sildenafil); QL (2 vials per 21 days)
Second Generation Antihist(Respir Tract)		
ALLERGY AND CONGESTION RELIEF ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY RELIEF (LORATADINE) ORAL TABLET 10 MG	2	
ALLERGY RELIEF D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY RELIEF,NASAL DECONGEST ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
ALLERGY-CONGESTION RELIEF-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
<i>cetirizine oral solution 1 mg/ml</i>	2	
<i>cetirizine oral tablet 10 mg, 5 mg</i>	2	
CLARITIN-D 24 HOUR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DYMISTA NASAL SPRAY, NON-AEROSOL 137-50 MCG/SPRAY	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: AZELASTINE HCL, FLUTICASONE PROPIONATE, FLUNISOLIDE, TRIAMCINOLONE ACETONIDE, BUDESONIDE, MOMETASONE FUROATE)
<i>levocetirizine oral tablet 5 mg</i>	2	
LORATA-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
<i>loratadine oral solution 5 mg/5 ml</i>	2	
<i>loratadine oral tablet 10 mg</i>	2	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG	1	
QUZYTIR INTRAVENOUS SOLUTION 10 MG/ML	BB	PA
ZERVIAE OPHTHALMIC (EYE) DROPPERETTE 0.24 %	Non-Formulary	QL (Quantity Limits Apply)
Select.Beta-2-Adrenergic Agonist(Respir)		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	Non-Formulary	ALT (Covered Alternatives: FLUTICASONE-SALMETEROL, WIXELA INHUB); QL (60 units per 1 fill)
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)
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG-14 MCG/ACTUATION, 232-14 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inhaler per 28 days)
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g), Levalbuterol HFA); QL (10.7 GM per 30 Days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	2	QL (2 Inhalers per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<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, 5 mg/ml</i>	2	
<i>albuterol sulfate oral syrup 2 mg/5 ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	2	
<i>albuterol sulfate oral tablet extended release 12 hr 4 mg, 8 mg</i>	2	
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); TD; QL (60 Blisters per 28 days)
<i>arformoterol inhalation solution for nebulization 15 mcg/2 ml</i>	2	QL (120 units per 30 days)
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (10.7 GM per 28 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	3	QL (1 inhaler per 30 days)
BREYNA INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	2	QL (10.3 GM per 1 Fill)
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER 160-9-4.8 MCG/ACTUATION	4	PA; TD; QL (10.7 GM per 30 days)
BROVANA INHALATION SOLUTION FOR NEBULIZATION 15 MCG/2 ML	Non-Formulary	QL (120 ML per 30 days)
<i>budesonide-formoterol inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	2	QL (10.3 GM per 1 Fill)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400-12 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (1 Inhaler per 28 days)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 200-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	3	QL (13 GM per 28 days)
<i>fluticasone furoate-vilanterol inhalation blister with device 100-25 mcg/dose, 200-25 mcg/dose</i>	Non-Formulary	QL (60 units per 1 fill)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	2	QL (1 inhaler 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 GM per 30 days)
<i>ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml</i>	2	
<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	
<i>levalbuterol tartrate inhalation hfa aerosol inhaler 45 mcg/actuation</i>	2	
PERFOROMIST INHALATION SOLUTION FOR NEBULIZATION 20 MCG/2 ML	Non-Formulary	QL (120 nebs per 30 days)
PROAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 90 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g)); QL (1 Inhaler per 28 days)
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g)); QL (2 inahlers per 30 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE	3	QL (60 units per 30 days)
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION	3	QL (4 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
STRIVERDI RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (4 GM per 28 days)
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: BUDESONIDE/FORMOTEROL FUMARATE); QL (10.3 GM per 1 Fill)
<i>terbutaline oral tablet 2.5 mg, 5 mg</i>	2	
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	4	PA; TD
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG	4	PA; TD; QL (1 DEVICE per 30 days)
VENTOLIN HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g)); QL (36 GM per 30 days)
WIXELA INHUB INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	2	QL (60 GM per 30 days)
Vasodilating Agents (Respiratory Tract)		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	6	PA; SP; QL (3 tablets per 1 day)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	2	PA; SP; QL (1 tablet per 1 day)
AURLUMYN INTRAVENOUS SOLUTION 100 MCG/ML	BB	PA
<i>bosentan oral tablet 62.5 mg</i>	2	PA; SP; QL (2 tablets per 1 day)
<i>bosentan oral tablet for suspension 32 mg</i>	Non-Formulary	SP; QL (120 tablets per 30 days)
FLOLAN INTRAVENOUS RECON SOLN 0.5 MG	BB	PA
LETAIRIS ORAL TABLET 10 MG, 5 MG	Non-Formulary	SP; QL (1 tablet per 1 day)
OPSUMIT ORAL TABLET 10 MG	5	PA; SP; QL (1 tablet per 1 day)
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG	Non-Formulary	SP; ALT (Covered Alternatives: Tadalafil, Opsumit); QL (1 Tablet per 1 Day)
ORENITRAM MONTH 1 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG (42)	Non-Formulary	SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ORENITRAM MONTH 2 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG (210)	Non-Formulary	SP
ORENITRAM MONTH 3 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG(42)-1MG	Non-Formulary	SP
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
REMODULIN INJECTION SOLUTION 1 MG/ML, 10 MG/ML, 2.5 MG/ML, 5 MG/ML	Non-Formulary	SP
TADLIQ ORAL SUSPENSION 20 MG/5 ML (4 MG/ML)	Non-Formulary	SP
TRACLEER ORAL TABLET 125 MG, 62.5 MG	Non-Formulary	SP; QL (2 tablets per 1 day)
TRACLEER ORAL TABLET FOR SUSPENSION 32 MG	Non-Formulary	QL (Quantity Limits Apply); SP
<i>treprostinil sodium injection solution 1 mg/ml, 10 mg/ml, 2.5 mg/ml, 5 mg/ml</i>	7	PA; SP; QL (0.01 ml per 1 day)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG	Non-Formulary	SP; QL (2.9 ML per 1 Day)
TYVASO INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)	5	PA; SP; QL (2.9 ML per 1 day)
TYVASO INSTITUTIONAL START KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML	5	PA; SP; QL (2.9 ML per 1 day)
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)	5	PA; SP; QL (2.9 ML per 1 day)
TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML	5	PA; SP; QL (2.9 ML per 1 day)
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	5	PA; SP; QL (2 tablets per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
UPTRAVI ORAL TABLETS,DOSE PACK 200 MCG (140)- 800 MCG (60)	5	PA; SP; QL (2 tablets per 1 day)
VELETRI INTRAVENOUS RECON SOLN 0.5 MG, 1.5 MG	BB	PA
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG	Non-Formulary	SP
Xanthine Derivatives		
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG	4	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	2	
<i>theophylline oral tablet extended release 24 hr 400 mg, 600 mg</i>	2	
SKIN AND MUCOUS MEMBRANE AGENTS		
Adrenergic Agonists		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	Non-Formulary	ALT (Covered Alternatives: Brimonidine 0.1% eye drops); QL (15 ML per 1 Fill)
<i>brimonidine ophthalmic (eye) drops 0.1 %</i>	2	QL (15 ML per 1 Fill)
<i>brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %</i>	2	QL (15 ML per 1 fill)
<i>brimonidine topical gel with pump 0.33 %</i>	2	PA; QL (1 GM per 1 day)
MIRVASO TOPICAL GEL WITH PUMP 0.33 %	Non-Formulary	QL (1 GM per 1 day)
UPNEEQ (PF) OPHTHALMIC (EYE) DROPPERETTE 0.1 %	Non-Formulary	
Allylamines (Skin And Mucous Membrane)		
<i>naftifine topical cream 2 %</i>	2	QL (45 GM per 1 Fill)
<i>naftifine topical gel 2 %</i>	2	QL (45 GM per 1 Fill)
NAFTIN TOPICAL GEL 2 %	Non-Formulary	ALT (Covered Alternatives: Naftifine); QL (45 GM per 1 Fill)
<i>terbinafine hcl oral tablet 250 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Antibacterials (84:04)		
ACANYA TOPICAL GEL WITH PUMP 1.2-2.5 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
ACZONE TOPICAL GEL 5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
ACZONE TOPICAL GEL WITH PUMP 7.5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
ALTABAX TOPICAL OINTMENT 1 %	4	PA; QL (15 GM per 1 fill)
AMZEEQ TOPICAL FOAM 4 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CLINDAMYCIN PHOSPHATE, ERYTHROMYCIN)
<i>azelaic acid topical gel 15 %</i>	2	QL (50 gm per 1 fill)
AZELEX TOPICAL CREAM 20 %	4	PA; QL (1 GM per 1 day)
CABTREO TOPICAL GEL 0.15-3.1-1.2 %	Non-Formulary	ALT (Covered Alternatives: CLINDAMYCIN-BENZOYL PEROXIDE, ADAPALENE/BENZOYL PEROXIDE, ADAPALENE); QL (50 GM per 30 Days)
CLINDAGEL TOPICAL GEL, ONCE DAILY 1 %	Non-Formulary	QL (Quantity Limits Apply)
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	2	
CLINDAMYCIN PEDIATRIC ORAL RECON SOLN 75 MG/5 ML	2	
<i>clindamycin phosphate topical gel 1 %</i>	2	QL (60 GM per 30 days)
<i>clindamycin phosphate topical gel, once daily 1 %</i>	2	
<i>clindamycin phosphate topical lotion 1 %</i>	2	QL (60 GM per 30 days)
<i>clindamycin phosphate topical solution 1 %</i>	2	QL (4 ML per 1 day)
<i>clindamycin phosphate topical swab 1 %</i>	2	
<i>clindamycin phosphate vaginal cream 2 %</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>clindamycin-benzoyl peroxide topical gel 1.2 %(1 % base) -5 %</i>	2	QL (45 GM per 30 days)
<i>clindamycin-benzoyl peroxide topical gel 1-5 %</i>	2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %</i>	2	
CLINDESSE VAGINAL CREAM,EXTENDED RELEASE 2 %	Non-Formulary	QL (Quantity Limits Apply)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>dapsone topical gel 5 %</i>	2	QL (2 GM per 1 day)
<i>dapsone topical gel 7.5 %</i>	Non-Formulary	ALT (Covered Alternatives: DAPSONE 5% GEL, DAPSONE 7.5% GEL WITH PUMP); QL (1 GM per 1 Day)
<i>dapsone topical gel with pump 7.5 %</i>	2	QL (2 GM per 1 day)
DORYX MPC ORAL TABLET,DELAYED RELEASE (DR/EC) 60 MG	Non-Formulary	ALT (Covered Alternatives: Doxycycline Hyclate, Doxycycline Monohydrate); QL (1 tablet per 1 day)
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	QL (3 capsules per 1 day)
<i>doxycycline hyclate oral tablet 100 mg</i>	2	QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE, DOXYCYCLINE HYCLATE); QL (3 tablets per 1 day)
<i>doxycycline hyclate oral tablet 50 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE)
<i>doxycycline hyclate oral tablet 75 mg</i>	Non-Formulary	
<i>doxycycline monohydrate oral capsule 100 mg</i>	2	QL (2 capsules per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>doxycycline monohydrate oral capsule 150 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE, DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule 50 mg</i>	2	
<i>doxycycline monohydrate oral capsule 75 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE MONOHYDRATE)
<i>doxycycline monohydrate oral capsule,ir - delay rel,biphase 40 mg</i>	Non-Formulary	ALT (Covered Alternatives: DOXYCYCLINE HYCLATE); QL (1 Capsule per 1 Day)
<i>doxycycline monohydrate oral tablet 100 mg</i>	2	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral tablet 150 mg, 75 mg</i>	2	
<i>doxycycline monohydrate oral tablet 50 mg</i>	2	QL (3 tablets per 1 day)
E.E.S. 400 ORAL TABLET 400 MG	Non-Formulary	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	2	QL (100 ML per 30 days)
<i>erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml</i>	2	QL (100 ML per 1 fill)
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	2	
<i>erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)</i>	2	
<i>erythromycin oral tablet, delayed release (dr/ec) 250 mg, 500 mg</i>	2	
<i>erythromycin with ethanol topical gel 2 %</i>	2	QL (60 GM per 30 days)
<i>erythromycin with ethanol topical solution 2 %</i>	2	QL (60 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FINACEA TOPICAL FOAM 15 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: AZELAIC ACID)
<i>gentamicin ophthalmic (eye) drops 0.3 %</i>	1	
<i>gentamicin topical cream 0.1 %</i>	2	QL (30 GM per 30 days)
<i>gentamicin topical ointment 0.1 %</i>	2	
<i>levofloxacin in d5w intravenous piggyback 250 mg/50 ml, 500 mg/100 ml, 750 mg/150 ml</i>	Non-Formulary	
<i>levofloxacin oral solution 250 mg/10 ml</i>	2	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	2	
<i>mafenide acetate topical packet 50 gram</i>	Non-Formulary	
METROGEL TOPICAL GEL 1 %	Non-Formulary	QL (Quantity Limits Apply)
<i>metronidazole oral capsule 375 mg</i>	Non-Formulary	
<i>metronidazole oral tablet 125 mg</i>	Non-Formulary	ALT (Covered Alternatives: Metronidazole 250mg Tablets); QL (1 Tablets per 1 Day)
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>metronidazole topical cream 0.75 %</i>	2	QL (45 GM per 30 days)
<i>metronidazole topical gel 0.75 %, 1 %</i>	2	
<i>metronidazole topical gel with pump 1 %</i>	2	
<i>metronidazole topical lotion 0.75 %</i>	2	QL (59 GM per 30 days)
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</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>	2	
MONDOXYNE NL ORAL CAPSULE 100 MG	Non-Formulary	QL (2 capsules per 1 day)
MONDOXYNE NL ORAL CAPSULE 75 MG	Non-Formulary	
<i>moxifloxacin oral tablet 400 mg</i>	2	QL (1 tablet per 1 day)
<i>mupirocin calcium topical cream 2 %</i>	Non-Formulary	ALT (Covered Alternatives: Mupirocin Ointment); QL (30 GM per 30 days)
<i>mupirocin topical ointment 2 %</i>	2	QL (44 GM per 30 days)
<i>neomycin oral tablet 500 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	2	QL (5 ML per 1 fill)
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	2	
<i>neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%</i>	1	
<i>neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%</i>	2	
NORITATE TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)
NUVESSA VAGINAL GEL 1.3 % (65 MG/5 GRAM)	Non-Formulary	ALT (Covered Alternatives: METRONIDAZOLE, CLINDAMYCIN PHOSPHATE)
ONEXTON TOPICAL GEL 1.2 %(1 % BASE) -3.75 %	Non-Formulary	
ONEXTON TOPICAL GEL WITH PUMP 1.2 %(1 % BASE) -3.75 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit- 1 mg/ml</i>	2	
PYLERA ORAL CAPSULE 140-125-125 MG	Non-Formulary	QL (Quantity Limits Apply)
SULFAMYLON TOPICAL CREAM 85 MG/G	4	
SULFAMYLON TOPICAL PACKET 50 GRAM	Non-Formulary	ALT (Covered Alternatives: SILVER SULFADIAZINE)
TARGADOX ORAL TABLET 50 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>tetracycline oral capsule 250 mg, 500 mg</i>	2	
<i>tetracycline oral tablet 250 mg, 500 mg</i>	Non-Formulary	ALT (Covered Alternatives: Tetracycline Capsules); QL (2 Tablets per 1 day)
VELTIN TOPICAL GEL 1.2-0.025 %	Non-Formulary	QL (Quantity Limits Apply)
XEPI TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ZIANA TOPICAL GEL 1.2-0.025 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, CLINDAMYCIN HCL)
ZILXI TOPICAL FOAM 1.5 %	Non-Formulary	QL (Quantity Limits Apply)
Anti-Inflammatory Agents, Misc (Skin)		
WINLEVI TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)
Antiproliferants		
<i>bexarotene oral capsule 75 mg</i>	6	PA; SP; PF; QL (1 capsule per 1 day)
<i>bexarotene topical gel 1 %</i>	5	PA; SP; QL (2 GM per 1 day)
CARAC TOPICAL CREAM 0.5 %	Non-Formulary	QL (40 gm per 30 days)
EFUDEX TOPICAL CREAM 5 %	Non-Formulary	QL (Quantity Limits Apply)
<i>fluorouracil topical cream 0.5 %</i>	Non-Formulary	ALT (Covered Alternatives: FLUOROURACIL, FLUOROURACIL); QL (40 gm per 30 days)
<i>fluorouracil topical cream 5 %</i>	2	
<i>fluorouracil topical solution 2 %, 5 %</i>	2	PA; QL (10 ml per 1 month)
<i>imiquimod topical cream in packet 3.75 %</i>	2	
<i>imiquimod topical cream in packet 5 %</i>	2	QL (1 GM per 30 days)
PANRETIN TOPICAL GEL 0.1 %	4	
TARGRETIN ORAL CAPSULE 75 MG	Non-Formulary	SP; QL (1 capsule per 1 day)
TARGRETIN TOPICAL GEL 1 %	Non-Formulary	SP; QL (2 gm per 1 day)
VALCHLOR TOPICAL GEL 0.016 %	5	PA; SP; QL (60 GM per 1 fill)
Antipruritics And Local Anesthetics		
<i>doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>doxepin oral concentrate 10 mg/ml</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>doxepin topical cream 5 %</i>	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUCINONIDE, TACROLIMUS)
DYCLOPRO TOPICAL SOLUTION 0.5 %	Non-Formulary	QL (30 ML per 30 Days)
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	1	QL (60 gm per 30 days)
<i>hydrocortisone-pramoxine rectal cream 2.5-1 %, 2.5-1 % (4g)</i>	2	QL (60 gm per 30 days)
<i>hydrocortisone-pramoxine topical cream 2.5-1 %</i>	2	QL (60 GM per 30 days)
KORSUVA INTRAVENOUS SOLUTION 50 MCG/ML	BB	PA
<i>lidocaine (pf) injection syringe 100 mg/5 ml (2 %)</i>	BB	
<i>lidocaine hcl laryngotracheal solution 4 %</i>	2	
<i>lidocaine hcl-hydrocortison ac rectal kit 3-2.5 % (7 gram)</i>	Non-Formulary	ALT (Covered Alternatives: lidocaine-HC rectal cream 3-05%); QL (1 Tube per 30 Days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	2	QL (3 Patches per 1 day)
<i>lidocaine topical ointment 5 %</i>	2	QL (39 gm per 1 fill)
<i>lidocaine-prilocaine topical cream 2.5-2.5 %</i>	2	QL (1 GM per 1 day)
LIDOCAN III TOPICAL ADHESIVE PATCH,MEDICATED 5 %	Non-Formulary	ALT (Covered Alternatives: LIDOCAINE 5% PATCH); QL (1 Patch per 1 Day)
LIDOCAN IV TOPICAL ADHESIVE PATCH,MEDICATED 5 %	Non-Formulary	ALT (Covered Alternatives: LIDOCAINE 5% PATCH); QL (1 Patch per 1 Day)
LIDOCAN V TOPICAL ADHESIVE PATCH,MEDICATED 5 %	Non-Formulary	ALT (Covered Alternatives: LIDOCAINE 5% PATCH); QL (1 Patch per 1 Day)
LIVIXIL PAK TOPICAL KIT 2.5-2.5 %	Non-Formulary	
<i>phenazopyridine oral tablet 100 mg, 200 mg</i>	2	
PRAMOSONE TOPICAL LOTION 1-1 %, 2.5-1 %	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PROCTOFOAM HC RECTAL FOAM 1-1 %	Non-Formulary	QL (Quantity Limits Apply)
PRUDOXIN TOPICAL CREAM 5 %	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUOCINONIDE, TACROLIMUS)
Antivirals (Skin And Mucous Membrane)		
<i>acyclovir in 0.9 % sodium chl r intravenous piggyback 200 mg/100 ml</i>	BB	
<i>acyclovir oral capsule 200 mg</i>	2	
<i>acyclovir oral suspension 200 mg/5 ml, 200 mg/5 ml (5 ml)</i>	2	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	2	
<i>acyclovir topical ointment 5 %</i>	2	QL (30 GM per 30 days)
DENAVIR TOPICAL CREAM 1 %	Non-Formulary	ALT (Covered Alternatives: Penciclovir); QL (5 gm per 28 days)
<i>penciclovir topical cream 1 %</i>	2	PA; QL (5 gm per 28 days)
XERESE TOPICAL CREAM 5-1 %	Non-Formulary	ALT (Covered Alternatives: ACYCLOVIR, HYDROCORTISONE)
YCANTH TOPICAL SOLUTION WITH APPLICATOR 0.7 %	BB	PA
ZELSUVMI TOPICAL GEL 10.3 %	Non-Formulary	SP; QL (31 GM per 30 Days)
ZOVIRAX TOPICAL CREAM 5 %	Non-Formulary	QL (Quantity Limits Apply)
Astringents (84:12)		
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Stiolto, fluticasone/salmeterol, budesonide/formoterol, Breo Ellipta; tiotropium); QL (10.7 GM per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CUVPOSA ORAL SOLUTION 1 MG/5 ML (0.2 MG/ML)	Non-Formulary	QL (5 ML per 1 day)
<i>glycopyrrolate (pf) injection syringe 0.4 mg/2 ml (0.2 mg/ml)</i>	BB	
<i>glycopyrrolate injection solution 0.2 mg/ml</i>	Non-Formulary	ALT (Covered Alternatives: CUVPOSA)
<i>glycopyrrolate intravenous syringe 0.6 mg/3 ml (0.2 mg/ml)</i>	BB	
<i>glycopyrrolate oral solution 1 mg/5 ml (0.2 mg/ml)</i>	5	PA; QL (5 ml per 1 day)
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	2	
QBREXZA TOPICAL TOWELETTE 2.4 %	6	PA; SP; QL (1 packet per 1 day)
SOFDRA TOPICAL GEL WITH PUMP 12.45 % (72 MG /ACTUATION)	Non-Formulary	SP
Astringents, Anti-Infective		
<i>chlorhexidine gluconate mucous membrane mouthwash 0.12 %</i>	2	
PAROEX ORAL RINSE MUCOUS MEMBRANE MOUTHWASH 0.12 %	2	
PERIOGARD MUCOUS MEMBRANE MOUTHWASH 0.12 %	2	
<i>selenium sulfide topical lotion 2.5 %</i>	2	QL (120 GM per 30 days)
<i>silver sulfadiazine topical cream 1 %</i>	2	QL (50 GM per 30 days)
SSD TOPICAL CREAM 1 %	2	QL (50 GM per 30 days)
Azoles (Skin And Mucous Membrane)		
<i>clotrimazole mucous membrane troche 10 mg</i>	2	
<i>clotrimazole topical cream 1 %</i>	2	QL (60 GM per 30 days)
<i>clotrimazole-betamethasone topical cream 1-0.05 %</i>	2	QL (60 GM per 1 fill)
<i>clotrimazole-betamethasone topical lotion 1-0.05 %</i>	2	QL (1 GM per 1 day)
<i>econazole nitrate topical cream 1 %</i>	2	QL (85 GM per 30 days)
ERTACZO TOPICAL CREAM 2 %	Non-Formulary	QL (Quantity Limits Apply)
EXELDERM TOPICAL SOLUTION 1 %	4	PA; QL (30 ml per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
GYNAZOLE-1 VAGINAL CREAM 2 %	3	PA; QL (Quantity Limits Apply); ALT (Covered Alternatives: MICONAZOLE 3, TERCONAZOLE)
JUBLIA TOPICAL SOLUTION WITH APPLICATOR 10 %	3	PA; QL (Quantity Limits Apply); ALT (Covered Alternatives: ITRACONAZOLE, TERBINAFINE, CICLOPIROX); QL (4 ML per 30 days)
<i>ketoconazole oral tablet 200 mg</i>	2	
<i>ketoconazole topical cream 2 %</i>	2	QL (60 GM per 30 days)
<i>ketoconazole topical foam 2 %</i>	2	ALT (Covered Alternatives: KETOCONAZOLE); QL (60 GM per 30 days)
<i>ketoconazole topical shampoo 2 %</i>	2	QL (120 ML per 30 days)
LUZU TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)
MICONAZOLE-3 VAGINAL SUPPOSITORY 200 MG	2	
<i>oxiconazole topical cream 1 %</i>	2	PA; ALT (Covered Alternatives: CLOTRIMAZOLE)
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	2	
<i>terconazole vaginal suppository 80 mg</i>	2	
Basic Lotions And Liniments		
<i>ammonium lactate topical lotion 12 %</i>	2	
Basic Ointments And Protectants		
<i>ammonium lactate topical cream 12 %</i>	2	QL (140 GM per 30 days)
<i>calcipotriene scalp solution 0.005 %</i>	2	QL (60 ML per 30 days)
<i>calcipotriene topical cream 0.005 %</i>	2	QL (60 GM per 30 days)
<i>calcipotriene topical ointment 0.005 %</i>	2	QL (60 GM per 30 days)
<i>calcipotriene-betamethasone topical ointment 0.005-0.064 %</i>	Non-Formulary	
<i>calcipotriene-betamethasone topical suspension 0.005-0.064 %</i>	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ENSTILAR TOPICAL FOAM 0.005-0.064 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CALCIPOTRIENE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE, DESONIDE, ALCLOMETASONE DIPROPIONATE, HALOBETASOL PROPIONATE, FLUOCINOLONE ACETONIDE)
NITRO-BID TRANSDERMAL OINTMENT 2 %	2	QL (2 GM per 1 day)
<i>nitroglycerin rectal ointment 0.4 % (w/w)</i>	2	QL (30 GM per 84 Days)
RECTIV RECTAL OINTMENT 0.4 % (W/W)	Non-Formulary	ALT (Covered Alternatives: Nitroglycerin Ointment); QL (30 GM per 90 days)
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM	4	PA; QL (30GM per fill, 2 fills per 30 days)
SORILUX TOPICAL FOAM 0.005 %	Non-Formulary	QL (Quantity Limits Apply)
STRATAMARK TOPICAL GEL	Non-Formulary	QL (Quantity Limits Apply)
STRATATRIZ TOPICAL GEL	Non-Formulary	QL (Quantity Limits Apply)
TACLONEX TOPICAL SUSPENSION 0.005-0.064 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CALCIPOTRIENE-BETAMETHASONE DP)
VTAMA TOPICAL CREAM 1 %	Non-Formulary	ALT (Covered Alternatives: Tazarotene, Calcipotriene)
Cell Stimulants And Proliferants		
ALTRENO TOPICAL LOTION 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ATRALIN TOPICAL GEL 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (1.5 gm per 1 day)
<i>finasteride oral tablet 5 mg</i>	2	QL (2 tablets per 1 day)
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	2	
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.04 %, 0.06 %, 0.08 %, 0.1 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
RETIN-A MICRO TOPICAL GEL 0.04 %, 0.1 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
RETIN-A TOPICAL CREAM 0.025 %, 0.05 %, 0.1 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (45 gm per 1 fill)
RETIN-A TOPICAL GEL 0.01 %	Non-Formulary	QL (1.5 grams per day; 45 grams per fill); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
RETIN-A TOPICAL GEL 0.025 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (1.5 gm per 1 day)
<i>tretinoin microspheres topical gel 0.04 %, 0.1 %</i>	Non-Formulary	
<i>tretinoin microspheres topical gel with pump 0.04 %, 0.1 %</i>	Non-Formulary	QL (50 GM per 30 days)
<i>tretinoin microspheres topical gel with pump 0.08 %</i>	Non-Formulary	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>tretinoin topical cream 0.025 %, 0.05 %, 0.1 %</i>	2	PA; QL (45 GM per 1 Fill)
<i>tretinoin topical gel 0.01 %, 0.025 %</i>	2	PA; QL (45 GM per 30 days)
<i>tretinoin topical gel 0.05 %</i>	Non-Formulary	QL (1.5 gm per 1 day)
VELTIN TOPICAL GEL 1.2-0.025 %	Non-Formulary	QL (Quantity Limits Apply)
ZIANA TOPICAL GEL 1.2-0.025 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, CLINDAMYCIN HCL)
Corticosteroids (Skin, Mucous Membrane)		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	Non-Formulary	ALT (Covered Alternatives: FLUTICASONE-SALMETEROL, WIXELA INHUB); QL (60 units per 1 fill)
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)
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG-14 MCG/ACTUATION, 232-14 MCG/ACTUATION	Non-Formulary	QL (Quantity Limits Apply); QL (1 Inhaler per 28 days)
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: Albuterol HFA (package size 8.5g & 6.7g), Levalbuterol HFA); QL (10.7 GM per 30 Days)
ALA-SCALP TOPICAL LOTION 2 %	Non-Formulary	QL (1 ml per 1 day)
<i>alclometasone topical cream 0.05 %</i>	2	QL (45 GM per 30 days)
<i>alclometasone topical ointment 0.05 %</i>	2	QL (45 GM per 30 days)
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE)
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	2	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG	Non-Formulary	
APEXICON E TOPICAL CREAM 0.05 %	Non-Formulary	ALT (Covered Alternatives: Diflorasone); QL (1 gram per 1 day)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION	4	QL (13 GM per 28 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	4	QL (1 inhaler per 30 days)
<i>betamethasone dipropionate topical cream 0.05 %</i>	2	QL (60 GM per 30 days)
<i>betamethasone dipropionate topical lotion 0.05 %</i>	2	QL (60 GM per 30 days)
<i>betamethasone dipropionate topical ointment 0.05 %</i>	2	QL (60 GM per 30 days)
<i>betamethasone valerate topical cream 0.1 %</i>	1	QL (60 GM per 30 days)
<i>betamethasone valerate topical foam 0.12 %</i>	Non-Formulary	
<i>betamethasone valerate topical lotion 0.1 %</i>	2	
<i>betamethasone valerate topical ointment 0.1 %</i>	2	
<i>betamethasone, augmented topical cream 0.05 %</i>	2	QL (60 GM per 1 day)
<i>betamethasone, augmented topical gel 0.05 %</i>	2	QL (15 GM per 30 days)
<i>betamethasone, augmented topical lotion 0.05 %</i>	2	QL (60 GM per 1 day)
<i>betamethasone, augmented topical ointment 0.05 %</i>	2	QL (60 GM per 1 fill)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	3	QL (1 inhaler per 30 days)
BREYNA INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	2	QL (10.3 GM per 1 Fill)
BRYHALI TOPICAL LOTION 0.01 %	Non-Formulary	QL (Quantity Limits Apply)
<i>budesonide-formoterol inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	2	QL (10.3 GM per 1 Fill)
CAPEX TOPICAL SHAMPOO 0.01 %	4	PA; ALT (Covered Alternatives: CLOBETASOL PROPIONATE, FLUOCINOLONE ACETONIDE, FLUOCINOLONE ACETONIDE); QL (120 ml per 1 month)
<i>clobetasol scalp solution 0.05 %</i>	2	QL (60 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>clobetasol topical cream 0.025 %</i>	Non-Formulary	ALT (Covered Alternatives: CLOBETASOL 0.05% OINTMENT, CLOBETASOL 0.05% CREAM, CLOBETASOL 0.05% SOLUTION); QL (2 GM per 1 day)
<i>clobetasol topical cream 0.05 %</i>	2	QL (60 GM per 30 days)
<i>clobetasol topical lotion 0.05 %</i>	2	QL (60 GM per 30 days)
<i>clobetasol topical ointment 0.05 %</i>	2	QL (60 GM per 30 days)
<i>clobetasol topical shampoo 0.05 %</i>	2	QL (118 ML per 30 days)
<i>clobetasol topical spray,non-aerosol 0.05 %</i>	2	ALT (Covered Alternatives: FLUOCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE, FLUOCINONIDE, HYDROCORTISONE, MOMETASONE FUROATE); QL (4.2 ML per 1 day)
<i>clobetasol-emollient topical cream 0.05 %</i>	2	QL (45 GM per 30 days)
CLOBEX TOPICAL LOTION 0.05 %	Non-Formulary	QL (2 ml per 1 day)
CLOBEX TOPICAL SHAMPOO 0.05 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: FLUOCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE, FLUOCINONIDE, HYDROCORTISONE, MOMETASONE FUROATE)
CLOBEX TOPICAL SPRAY, NON-AEROSOL 0.05 %	Non-Formulary	QL (4.2 ml per 1 day)
<i>clocortolone pivalate topical cream 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Betamethasone Valerate, Clobetasol, Desonide); QL (1.5 GM per 1 day)
<i>clotrimazole-betamethasone topical cream 1-0.05 %</i>	2	QL (60 GM per 1 fill)
<i>clotrimazole-betamethasone topical lotion 1-0.05 %</i>	2	QL (1 GM per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CORDRAN TAPE LARGE ROLL TOPICAL TAPE 4 MCG/CM2	Non-Formulary	
CORTIFOAM RECTAL FOAM 10 % (80 MG)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: HYDROCORTISONE, HYDROCORTISONE ACETATE)
<i>desonide topical cream 0.05 %</i>	2	QL (60 GM per 30 days)
<i>desonide topical lotion 0.05 %</i>	2	QL (60 GM per 30 days)
<i>desonide topical ointment 0.05 %</i>	2	QL (60 GM per 30 days)
<i>desoximetasone topical cream 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUOCINONIDE)
<i>desoximetasone topical cream 0.25 %</i>	2	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUOCINONIDE); QL (15 GM per 30 days)
<i>desoximetasone topical ointment 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUOCINONIDE)
<i>diflorasone topical cream 0.05 %</i>	2	PA; QL (1 GM per 1 day)
<i>diflorasone topical ointment 0.05 %</i>	2	QL (15 GM per 1 fill)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 200-5 MCG/ACTUATION, 50-5 MCG/ACTUATION	3	QL (13 GM per 28 days)
DUOBRII TOPICAL LOTION 0.01-0.045 %	Non-Formulary	QL (Quantity Limits Apply); SP
<i>fluocinolone and shower cap scalp oil 0.01 %</i>	2	QL (120 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>fluocinolone topical cream 0.01 %</i>	2	QL (60 GM per 30 days)
<i>fluocinolone topical cream 0.025 %</i>	2	
<i>fluocinolone topical oil 0.01 %</i>	2	QL (120 ML per 30 days)
<i>fluocinolone topical solution 0.01 %</i>	2	QL (60 ML per 30 days)
<i>fluocinonide topical cream 0.05 %, 0.1 %</i>	2	QL (60 GM per 1 fill)
<i>fluocinonide topical gel 0.05 %</i>	2	QL (60 GM per 30 days)
<i>fluocinonide topical ointment 0.05 %</i>	2	QL (60 GM per 30 days)
<i>fluocinonide topical solution 0.05 %</i>	2	QL (60 ML per 30 days)
<i>fluocinonide-emollient topical cream 0.05 %</i>	2	QL (60 GM per 30 days)
<i>flurandrenolide topical cream 0.05 %</i>	2	PA; QL (60 GM per 30 days)
<i>fluticasone furoate-vilanterol inhalation blister with device 100-25 mcg/dose, 200-25 mcg/dose</i>	Non-Formulary	QL (60 units per 1 fill)
<i>fluticasone propionate topical cream 0.05 %</i>	2	QL (60 GM per 30 days)
<i>fluticasone propionate topical lotion 0.05 %</i>	2	QL (60 GM per 30 days)
<i>fluticasone propionate topical ointment 0.005 %</i>	2	QL (60 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	2	QL (1 inhaler 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 GM per 30 days)
<i>halcinonide topical cream 0.1 %</i>	2	PA; QL (2 GM per 1 day)
<i>halobetasol propionate topical cream 0.05 %</i>	2	QL (50 GM per 30 days)
<i>halobetasol propionate topical foam 0.05 %</i>	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: HALOBETASOL PROPIONATE Ointment, HALOBETASOL PROPIONATE Cream); QL (50 GM per 30 days)
<i>halobetasol propionate topical ointment 0.05 %</i>	2	QL (50 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
HALOG TOPICAL CREAM 0.1 %	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUOCINONIDE); QL (60 gm per 30 days)
HALOG TOPICAL OINTMENT 0.1 %	Non-Formulary	QL (Quantity Limits Apply)
HALOG TOPICAL SOLUTION 0.1 %	Non-Formulary	QL (Quantity Limits Apply)
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG	2	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	2	
<i>hydrocortisone acetate topical cream with perineal applicator 2.5 %</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE 2.5% CREAM, HYDROCORTISONE 2.5% OINTMENT, HYDROCORTISONE 1% CREAM, HYDROCORTISONE 1% OINTMENT); QL (1 Tube per 30 Days)
<i>hydrocortisone butyrate topical ointment 0.1 %</i>	Non-Formulary	QL (45 gm per 30 days)
<i>hydrocortisone butyrate topical solution 0.1 %</i>	2	QL (45 ML per 30 days)
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>hydrocortisone rectal enema 100 mg/60 ml</i>	2	
<i>hydrocortisone sod succinate injection recon soln 100 mg</i>	7	
<i>hydrocortisone topical cream 1 %</i>	2	QL (1 gm per 1 day)
<i>hydrocortisone topical cream 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical cream with perineal applicator 1 %</i>	2	QL (28.5 GM per 30 days)
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical lotion 2.5 %</i>	2	QL (60 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	2	QL (30 GM per 30 days)
<i>hydrocortisone topical solution 2.5 %</i>	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE 2.5% CREAM, HYDROCORTISONE 2.5% LOTION, HYDROCORTISONE 2.5% OINTMENT); QL (1 ML per 1 day)
<i>hydrocortisone valerate topical cream 0.2 %</i>	2	QL (60 GM per 30 days)
<i>hydrocortisone valerate topical ointment 0.2 %</i>	Non-Formulary	QL (2 gm per 1 day)
<i>hydrocortisone-acetic acid otic (ear) drops 1-2 %</i>	2	
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	1	QL (60 gm per 30 days)
<i>hydrocortisone-pramoxine rectal cream 2.5-1 %, 2.5-1 % (4g)</i>	2	QL (60 gm per 30 days)
<i>hydrocortisone-pramoxine topical cream 2.5-1 %</i>	2	QL (60 GM per 30 days)
KENALOG INJECTION SUSPENSION 10 MG/ML	7	
KENALOG INJECTION SUSPENSION 40 MG/ML	Non-Formulary	
KENALOG TOPICAL AEROSOL 0.147 MG/GRAM	Non-Formulary	QL (100 gm per 30 days)
KHINDIVI ORAL SOLUTION 1 MG/ML	Non-Formulary	ALT (Covered Alternatives: Hydrocortisone 5mg tablet)
LEXETTE TOPICAL FOAM 0.05 %	Non-Formulary	ALT (Covered Alternatives: HALOBETASOL 0.05% CREAM, HALOBETASOL 0.05% OINTMENT); QL (50 GM per 30 Days)
<i>lidocaine hcl-hydrocortison ac rectal kit 3-2.5 % (7 gram)</i>	Non-Formulary	ALT (Covered Alternatives: lidocaine-HC rectal cream 3-05%); QL (1 Tube per 30 Days)
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	Non-Formulary	ALT (Covered Alternatives: HYDROCORTISONE TOPICAL CREAM, HYDROCORTISONE TOPICAL OINMENT); QL (1 Tube per 30 Days)
<i>mometasone nasal spray,non-aerosol 50 mcg/actuation</i>	2	QL (17 GM per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>mometasone topical cream 0.1 %</i>	2	QL (45 GM per 30 days)
<i>mometasone topical ointment 0.1 %</i>	2	QL (45 GM per 30 days)
<i>mometasone topical solution 0.1 %</i>	2	QL (45 ML per 30 days)
<i>nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%</i>	2	QL (1.4 GM per 1 day)
<i>nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%</i>	2	QL (1.4 GM per 1 day)
PRAMOSONE TOPICAL LOTION 1-1 %, 2.5-1 %	Non-Formulary	QL (Quantity Limits Apply)
<i>prednicarbate topical cream 0.1 %</i>	2	QL (60 GM per 30 days)
PROCTOCORT RECTAL SUPPOSITORY 30 MG	Non-Formulary	
PROCTOFOAM HC RECTAL FOAM 1-1 %	Non-Formulary	QL (Quantity Limits Apply)
PROCTO-MED HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)
PROCTOSOL HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)
PROCTOZONE-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	2	QL (30 GM per 30 days)
RYALTRIS NASAL SPRAY, NON-AEROSOL 665-25 MCG/SPRAY	Non-Formulary	ALT (Covered Alternatives: Fluticasone Nasal Spray, Flunisolide Nasal Spray, Mometasone Nasal Spray); QL (1 gram per 1 day)
SCALACORT DK TOPICAL COMBO PACK 2-2-2 %	Non-Formulary	
SCALACORT TOPICAL LOTION 2 %	Non-Formulary	QL (1 ml per 1 day)
SERNIVO TOPICAL SPRAY WITH PUMP 0.05 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, FLUCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE, FLUCINONIDE, HYDROCORTISONE)
SINUVA SINUS IMPLANT 1,350 MCG	BB	PA

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SOLU-CORTEF ACT-O-VIAL (PF) INJECTION RECON SOLN 1,000 MG/8 ML, 100 MG/2 ML	7	
SOLU-CORTEF INJECTION RECON SOLN 100 MG	Non-Formulary	
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	Non-Formulary	ALT (Covered Alternatives: BUDESONIDE/FORMOTEROL FUMARATE); QL (10.3 GM per 1 Fill)
TOPICORT TOPICAL CREAM 0.05 %	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUOCINONIDE)
TOPICORT TOPICAL CREAM 0.25 %	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE FLUOCINONIDE)
TOPICORT TOPICAL GEL 0.05 %	Non-Formulary	
TOPICORT TOPICAL OINTMENT 0.05 %	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE ACETONIDE, FLUOCINONIDE)
TOPICORT TOPICAL OINTMENT 0.25 %	Non-Formulary	ALT (Covered Alternatives: BETAMETHASONE DIPROPIONATE, TRIAMCINOLONE FLUOCINONIDE)
TOPICORT TOPICAL SPRAY, NON-AEROSOL 0.25 %	Non-Formulary	
<i>triamcinolone acetonide 0.9% nacl injection suspension 50 mg/ml</i>	7	
<i>triamcinolone acetonide dental paste 0.1 %</i>	2	QL (5 GM per 1 fill)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>triamcinolone acetonide injection suspension 40 mg/ml</i>	7	
<i>triamcinolone acetonide topical aerosol 0.147 mg/gram</i>	Non-Formulary	QL (100 gm per 30 days)
<i>triamcinolone acetonide topical cream 0.025 %, 0.5 %</i>	2	QL (80 GM per 30 days)
<i>triamcinolone acetonide topical cream 0.1 %</i>	2	QL (90 GM per 30 days)
<i>triamcinolone acetonide topical lotion 0.025 %, 0.1 %</i>	2	QL (60 GM per 30 days)
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %</i>	2	QL (80 GM per 30 days)
<i>triamcinolone acetonide topical ointment 0.05 %</i>	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE)
<i>triamcinolone acetonide topical ointment 0.5 %</i>	2	QL (15 GM per 30 days)
TRIANEX TOPICAL OINTMENT 0.05 %	Non-Formulary	ALT (Covered Alternatives: TRIAMCINOLONE ACETONIDE, FLUCINOLONE ACETONIDE, BETAMETHASONE DIPROPIONATE, CLOBETASOL PROPIONATE)
ULTRAVATE TOPICAL LOTION 0.05 %	Non-Formulary	QL (Quantity Limits Apply)
WIXELA INHUB INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	2	QL (60 GM per 30 days)
XERESE TOPICAL CREAM 5-1 %	Non-Formulary	ALT (Covered Alternatives: ACYCLOVIR, HYDROCORTISONE)
Hydroxypyridones (Skin, Mucous Membrane)		
<i>ciclopirox topical cream 0.77 %</i>	2	QL (30 GM per 30 days)
<i>ciclopirox topical gel 0.77 %</i>	2	QL (45 GM per 30 days)
<i>ciclopirox topical shampoo 1 %</i>	2	QL (120 ML per 30 days)
<i>ciclopirox topical solution 8 %</i>	2	QL (6.6 ML per 30 days)
<i>ciclopirox topical suspension 0.77 %</i>	2	QL (60 ML per 30 days)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Immunomodulatory Agents (84:06)		
ADBRY SUBCUTANEOUS AUTO-INJECTOR 300 MG/2 ML	6	PA; SP; QL (4 ML per 30 Days)
ADBRY SUBCUTANEOUS SYRINGE 150 MG/ML	6	PA; SP; QL (4 ML per 30 days)
BIMZELX AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 160 MG/ML	Non-Formulary	SP; QL (2 ML per 56 days)
BIMZELX SUBCUTANEOUS SYRINGE 160 MG/ML	Non-Formulary	SP; QL (2 ML per 56 days)
EBGLYSS PEN SUBCUTANEOUS PEN INJECTOR 250 MG/2 ML	Non-Formulary	SP; ALT (Covered Alternatives: Betamethasone Ointment, Clobetasol Ointment); QL (0.072 ML per 1 Day)
ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG	Non-Formulary	
HYFTOR TOPICAL GEL 0.2 %	Non-Formulary	
ILUMYA SUBCUTANEOUS SYRINGE 100 MG/ML	6	PA; SP; QL (1 ML per 90 days)
NEMLUVIO SUBCUTANEOUS PEN INJECTOR 30 MG	Non-Formulary	SP; ALT (Covered Alternative: Betamethasone, Clobetasol, Halobetasol, Methotrexate, Cyclosporine); QL (1 pen per 28 days)
<i>pimecrolimus topical cream 1 %</i>	2	QL (1 GM per 1 day)
SILIQ SUBCUTANEOUS SYRINGE 210 MG/1.5 ML	6	PA; QL (Quantity Limits Apply); SP
<i>sirolimus oral solution 1 mg/ml</i>	2	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
SKYRIZI INTRAVENOUS SOLUTION 60 MG/ML	BB	PA
SKYRIZI SUBCUTANEOUS PEN INJECTOR 150 MG/ML	Non-Formulary	QL (Maintenance dosing - 0.02 mL/day; Loading/induction dose PLA required (0.04 mL/day x 4 weeks)); SP; QL (0.02 ML per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	Non-Formulary	QL (Maintenance dosing - 0.02 mL/day; Loading/induction dose PLA required (0.04 mL/day x 4 weeks)); SP; QL (0.02 ML per 1 day)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)	Non-Formulary	SP; QL (0.012 ML per 1 day)
SPEVIGO INTRAVENOUS SOLUTION 60 MG/ML	Non-Formulary	PA; SP; ALT (Covered Alternatives: Cyclosporine, Methotrexate, Tacrolimus, Infliximab, Hadlima); QL (2 ML per 28 days)
SPEVIGO SUBCUTANEOUS SYRINGE 150 MG/ML	Non-Formulary	SP; ALT (Covered Alternatives: Cyclosporine, Methotrexate, Tacrolimus, Infliximab, Hadlima); QL (2 ML per 28 days)
SPEVIGO SUBCUTANEOUS SYRINGE 300 MG/2 ML	Non-Formulary	SP; ALT (Covered Alternatives: Cyclosporine, Methotrexate, Tacrolimus, Infliximab, Hadlima); QL (2 ML per 28 Days)
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	2	
<i>tacrolimus topical ointment 0.03 %, 0.1 %</i>	2	QL (100 GM per 30 days)
TREMFYA INTRAVENOUS SOLUTION 200 MG/20 ML (10 MG/ML)	BB	PA
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML	6	PA; SP; QL (0.02 ML per 1 Day)
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	6	PA; SP; QL (0.072 ML per 1 Day)
TREMFYA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	6	PA; QL (Maintenance dosing- 0.02ml/day; Loading/Induction dose PLA required (0.04ml/day x 8 weeks)); SP
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML	6	PA; QL (Maintenance dosing- 0.02ml/day; Loading/Induction dose PLA required (0.04ml/day x 8 weeks)); SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TREMFYA SUBCUTANEOUS SYRINGE 200 MG/2 ML	6	PA; SP; QL (0.072 ML per 1 Day)
Janus Kinase Inhibitors (84:06)		
ANZUPGO TOPICAL CREAM 2 %	Non-Formulary	SP; ALT (Covered Alternatives: BETAMETHASONE, CLOBETASOL, TACROLIMUS OINTMENT); QL (1 Tube per 30 Days)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG	Non-Formulary	SP; ALT (Covered Alternatives: Dupixent)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA; SP; QL (60 tablets per 30 days)
LITFULO ORAL CAPSULE 50 MG	Non-Formulary	SP; ALT (Covered Alternatives: Betamethasone, Clobetasol, Triamcinolone); QL (1 Capsule per 1 day)
OPZELURA TOPICAL CREAM 1.5 %	Non-Formulary	SP; ALT (Covered Alternatives: Betamethasone, Clobetasol, Tacrolimus); QL (2 GRAM per 1 day)
SOTYKTU ORAL TABLET 6 MG	Non-Formulary	SP; ALT (Covered Alternatives: Acitretin, Methoxsalen)
Keratolytic Agents		
ABSORICA LD ORAL CAPSULE 16 MG, 24 MG, 32 MG, 8 MG	Non-Formulary	QL (Quantity Limits Apply)
ABSORICA ORAL CAPSULE 25 MG, 35 MG	Non-Formulary	QL (Quantity Limits Apply)
ACANYA TOPICAL GEL WITH PUMP 1.2-2.5 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	2	QL (2 capsules per 1 day)
<i>adapalene topical cream 0.1 %</i>	2	PA; QL (45 GM per 30 days); AG (Max 30 Years)
<i>adapalene topical gel 0.1 %, 0.3 %</i>	2	PA; QL (45 GM per 30 days); AG (Max 30 Years)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>adapalene topical gel with pump 0.3 %</i>	2	PA; QL (45 GM per 30 days); AG (Max 30 Years)
<i>adapalene topical lotion 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Adapalene (Gel & Cream)); AG (Max 30 Years)
<i>adapalene topical solution 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Adapalene (Gel & Cream)); AG (Max 30 Years)
<i>adapalene topical swab 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Adapalene (Gel & Cream)); AG (Max 30 Years)
AKLIEF TOPICAL CREAM 0.005 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Tretinoin 0.025% Cream, Tretinoin 0.05% Cream, Tretinoin 0.1% Cream, Tretinoin 0.01% Gel, Tretinoin 0.025% Gel)
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	2	QL (2 capsules per 1 day)
ARAZLO TOPICAL LOTION 0.045 %	Non-Formulary	QL (Quantity Limits Apply)
AVAR TOPICAL CLEANSER 10-5 % (W/W)	2	
BP 10-1 TOPICAL CLEANSER 10-1 %	2	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	QL (2 capsules per 1 day)
<i>clindamycin-benzoyl peroxide topical gel 1.2 % (1 % base) -5 %</i>	2	QL (45 GM per 30 days)
<i>clindamycin-benzoyl peroxide topical gel 1-5 %</i>	2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %</i>	2	
CONDYLOX TOPICAL GEL 0.5 %	Non-Formulary	QL (3.5 GM per 30 Days)
DIFFERIN TOPICAL LOTION 0.1 %	Non-Formulary	QL (Quantity Limits Apply)
DUOBRII TOPICAL LOTION 0.01-0.045 %	Non-Formulary	QL (Quantity Limits Apply); SP

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FABIOR TOPICAL FOAM 0.1 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TAZAROTENE, ADAPALENE, SODIUM SULFACETAMIDE/SULFUR, CLINDAMYCIN PHOSPHATE)
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	2	QL (2 capsules per 1 day)
<i>isotretinoin oral capsule 25 mg, 35 mg</i>	Non-Formulary	ALT (Covered Alternatives: Isotretinoin 10mg, Isotretinoin 20mg, Isotretinoin 30mg, Isotretinoin 40mg)
METDRAY TOPICAL GEL 17-2 %	Non-Formulary	ALT (Covered Alternatives: SALICYLIC ACID CREAM, SALICYLIC ACID FOAM, SALICYLIC ACID gel, SALICYLIC ACID lotion); QL (1 pump per 30 days)
ONEXTON TOPICAL GEL 1.2 %(1 % BASE) -3.75 %	Non-Formulary	
ONEXTON TOPICAL GEL WITH PUMP 1.2 %(1 % BASE) -3.75 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
<i>podofilox topical gel 0.5 %</i>	Non-Formulary	QL (3.5 GM per 30 Days)
<i>podofilox topical solution 0.5 %</i>	2	QL (3.5 ML per 30 days)
SALICATE TOPICAL LIQUID 10 %	Non-Formulary	QL (30 ML per 30 days)
<i>salicylic acid topical cream 6 %</i>	2	
<i>salicylic acid topical cream,extended release 6 %</i>	2	
<i>salicylic acid topical film forming liquid w/appl 27.5 %</i>	2	QL (10 ml per 30 days)
<i>salicylic acid topical foam 6 %</i>	Non-Formulary	
<i>salicylic acid topical gel 6 %</i>	Non-Formulary	
<i>salicylic acid topical lotion 6 %</i>	2	
<i>salicylic acid topical lotion,extended release 6 %</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
<i>salicylic acid topical ointment 3 %</i>	Non-Formulary	ALT (Covered Alternatives: Salicylic Acid 6%)
<i>salicylic acid-ceramides no.1 topical kit,cleanser and cream er 6 %</i>	Non-Formulary	ALT (Covered Alternatives: SALICYLIC ACID, SALICYLIC ACID, SALICYLIC ACID, SALICYLIC ACID, SALICYLIC ACID)
SALYCIM TOPICAL CREAM 6 %	Non-Formulary	ALT (Covered Alternatives: SALICYLIC ACID CREAM, SALICYLIC ACID LOTION, SALICYLIC ACID GEL); QL (454 GM per 30 Days)
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	2	
<i>sulfacetamide sodium-sulfur topical cleanser 9-4 %</i>	2	QL (454 ML per 30 days)
SUMAXIN TOPICAL CLEANSER 9-4 %	Non-Formulary	ALT (Covered Alternatives: SOD SULFACET-SULFUR 10-5% CLSR, SOD SULFACE-SULFUR 9-4.5% WASH); QL (454 GM per 30 Days)
<i>tazarotene topical cream 0.05 %</i>	2	PA; ALT (Covered Alternatives: Tazarotene 0.1% cream); QL (1 GM per 1 day)
<i>tazarotene topical cream 0.1 %</i>	2	TD; QL (1 GM per 1 day)
<i>tazarotene topical foam 0.1 %</i>	Non-Formulary	ALT (Covered Alternatives: Tazarotene 0.1% cream)
<i>tazarotene topical gel 0.05 %, 0.1 %</i>	2	PA; ALT (Covered Alternatives: Tazarotene 0.1% cream); QL (1 GM per 1 day)
TAZORAC TOPICAL CREAM 0.05 %	Non-Formulary	ALT (Covered Alternatives: Tazarotene 0.1% cream); QL (1 GM per 1 day)
TAZORAC TOPICAL CREAM 0.1 %	Non-Formulary	ALT (Covered Alternatives: Tazarotene 0.1% cream); QL (1 gm per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
TAZORAC TOPICAL GEL 0.05 %, 0.1 %	Non-Formulary	ALT (Covered Alternatives: Tazarotene 0.1% cream); QL (1 GM per 1 day)
<i>urea topical cream 20 %</i>	2	
VEREGEN TOPICAL OINTMENT 15 %	4	PA; QL (60 GM per 1 fill)
ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	2	QL (2 capsules per 1 day)
Local Anti-Infectives, Miscellaneous		
AVAR TOPICAL CLEANSER 10-5 % (W/W)	2	
BP 10-1 TOPICAL CLEANSER 10-1 %	2	
FEM PH VAGINAL GEL 0.9-0.025 %	2	
OVACE PLUS SHAMPOO TOPICAL SHAMPOO 10 %	Non-Formulary	ALT (Covered Alternatives: SODIUM SULFACETAMIDE, TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
OVACE PLUS TOPICAL CLEANSER 10 %	Non-Formulary	ALT (Covered Alternatives: SODIUM SULFACETAMIDE, TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
OVACE PLUS TOPICAL CREAM 10 %	Non-Formulary	ALT (Covered Alternatives: SODIUM SULFACETAMIDE, TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
OVACE PLUS TOPICAL LOTION 9.8 %	Non-Formulary	ALT (Covered Alternatives: SODIUM SULFACETAMIDE, TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
OVACE PLUS WASH TOPICAL CLEANSER, GEL 10 %	Non-Formulary	ALT (Covered Alternatives: SODIUM SULFACETAMIDE, TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE)
<i>sulfacetamide sodium (acne) topical suspension 10 %</i>	2	QL (118 ML per 30 days)
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	2	
<i>sulfacetamide sodium-sulfur topical cleanser 9-4 %</i>	2	QL (454 ML per 30 days)
SUMAXIN TOPICAL CLEANSER 9-4 %	Non-Formulary	ALT (Covered Alternatives: SOD SULFACET-SULFUR 10-5% CLSR, SOD SULFACE-SULFUR 9-4.5% WASH); QL (454 GM per 30 Days)
ULESFIA TOPICAL LOTION 5 %	4	PA; QL (227 ml per 1 fill)
Nonsteroidal Anti-Inflammat.Agents(Skin)		
<i>diclofenac epolamine transdermal patch 12 hour 1.3 %</i>	Non-Formulary	
<i>diclofenac potassium oral capsule 25 mg</i>	Non-Formulary	
<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 (300 GM per 30 days)
<i>diclofenac sodium topical gel 3 %</i>	2	QL (100 GM per 30 days)
<i>diclofenac-misoprostol oral tablet, ir, delayed rel, biphasic 75-200 mg-mcg</i>	2	
DICLOSAICIN TOPICAL COMBO PACK, SOLUTION AND CREAM 1.5-0.025 %	Non-Formulary	ALT (Covered Alternatives: Diclofenac Sodium 1% gel, Diclofenac 1.5% topical solution); QL (12.9 grams per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
FLECTOR TRANSDERMAL PATCH 12 HOUR 1.3 %	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: PIROXICAM, DICLOFENAC SODIUM, DICLOFENAC SODIUM, MELOXICAM, NABUMETONE, NAPROXEN, CELECOXIB)
LICART TRANSDERMAL PATCH 24 HOUR 1.3 %	Non-Formulary	QL (Quantity Limits Apply)
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %)	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: DICLOFENAC SODIUM, DICLOFENAC SODIUM, CELECOXIB, IBUPROFEN, MELOXICAM, NAPROXEN, NABUMETONE)
ZIPSOR ORAL CAPSULE 25 MG	Non-Formulary	QL (Quantity Limits Apply)
Oxaboroles		
<i>tavaborole topical solution with applicator 5 %</i>	2	QL (10 ML per 30 days)
Phosphodiesterase-4 Inhibitors (84:06)		
DALIRESP ORAL TABLET 250 MCG, 500 MCG	Non-Formulary	QL (1 tablet per 1 day)
EUCRISA TOPICAL OINTMENT 2 %	6	PA; SP; QL (60 GM per 30 days)
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	2	QL (1 tablet per 1 day)
ZORYVE TOPICAL CREAM 0.15 %	Non-Formulary	ALT (Covered Alternatives: TAZAROTENE, CALCIPOTRIENE); QL (2 GM per 1 Day)
ZORYVE TOPICAL CREAM 0.3 %	Non-Formulary	ALT (Covered Alternatives: Tazarotene, Calcipotriene); QL (2 GM per 1 day)
ZORYVE TOPICAL FOAM 0.3 %	Non-Formulary	ALT (Covered Alternatives: TAZAROTENE, CALCIPOTRIENE); QL (2 GM per 1 day)
Pigmenting Agents		
<i>methoxsalen oral capsule, liqd-filled, rapid rel 10 mg</i>	2	PA; QL (1 CAPSULE per 1 day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Polyenes (Skin And Mucous Membrane)		
KLAYESTA TOPICAL POWDER 100,000 UNIT/GRAM	2	
<i>nystatin oral suspension 100,000 unit/ml</i>	2	
<i>nystatin oral tablet 500,000 unit</i>	2	
<i>nystatin topical cream 100,000 unit/gram</i>	2	QL (30 GM per 30 days)
<i>nystatin topical ointment 100,000 unit/gram</i>	2	QL (30 GM per 30 days)
<i>nystatin topical powder 100,000 unit/gram</i>	2	
Scabicides And Pediculicides		
CROTAN TOPICAL LOTION 10 %	Non-Formulary	QL (454 GM per 1 Fill)
EURAX TOPICAL CREAM 10 %	Non-Formulary	PA; ALT (Covered Alternatives: Pruradik 10% Lotion); QL (2 GRAM per 1 day)
EURAX TOPICAL LOTION 10 %	Non-Formulary	PA; ALT (Covered Alternatives: Pruradik 10% Lotion); QL (454 GM per 1 fill)
<i>ivermectin topical lotion 0.5 %</i>	2	PA; QL (45 ML per 1 month)
<i>malathion topical lotion 0.5 %</i>	2	QL (59 GM per 30 days)
<i>permethrin topical cream 5 %</i>	2	QL (60 GM per 7 days)
PRURADIK TOPICAL LOTION 10 %	4	PA; QL (237 GM per 30 Days)
<i>spinosad topical suspension 0.9 %</i>	2	QL (120 ML per 30 days)
ULESFIA TOPICAL LOTION 5 %	4	PA; QL (227 ml per 1 fill)
Skin And Mucous Membrane Agents, Misc.		
ACZONE TOPICAL GEL 5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
ACZONE TOPICAL GEL WITH PUMP 7.5 %	Non-Formulary	ALT (Covered Alternatives: Dapsone); QL (2.1 GM per 1 day)
<i>adapalene-benzoyl peroxide topical gel with pump 0.1-2.5 %</i>	2	PA; QL (45 GM per 30 days); AG (Max 30 Years)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
CABTREO TOPICAL GEL 0.15-3.1-1.2 %	Non-Formulary	ALT (Covered Alternatives: CLINDAMYCIN-BENZOYL PEROXIDE, ADAPALENE/BENZOYL PEROXIDE, ADAPALENE); QL (50 GM per 30 Days)
<i>calcitriol topical ointment 3 mcg/gram</i>	2	QL (100 GM per 30 days)
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>dapsone topical gel 5 %</i>	2	QL (2 GM per 1 day)
<i>dapsone topical gel 7.5 %</i>	Non-Formulary	ALT (Covered Alternatives: DAPSONE 5% GEL, DAPSONE 7.5% GEL WITH PUMP); QL (1 GM per 1 Day)
<i>dapsone topical gel with pump 7.5 %</i>	2	QL (2 GM per 1 day)
DEBACTEROL MUCOUS MEMBRANE SOLUTION 30-50 %	4	
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML	6	PA; SP
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	6	PA; SP; QL (0.09 ML per 1 day)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	6	PA; SP; QL (0.15 ml per 1 day)
EPIDUO FORTE TOPICAL GEL WITH PUMP 0.3-2.5 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (45 gm per 30 days)
EPIDUO TOPICAL GEL WITH PUMP 0.1-2.5 %	Non-Formulary	ALT (Covered Alternatives: TRETINOIN, ADAPALENE, BENZOYL PEROXIDE, CLINDAMYCIN-BENZOYL PEROXIDE); QL (45 gm per 30 days)
FILSUEVZ TOPICAL GEL 10 %	Non-Formulary	SP; QL (0.8 GM per 1 Day)
<i>ivermectin topical cream 1 %</i>	Non-Formulary	QL (2 Fills per Year); ALT (Covered Alternatives: Ivermectin 3mg Tablet)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
QUTENZA TOPICAL KIT 8 %	BB	PA
SOOLANTRA TOPICAL CREAM 1 %	Non-Formulary	QL (Quantity Limits Apply)
VYJUVEK TOPICAL GEL 5 X 10EXP9 PFU/2.5 ML	Non-Formulary	
Sunscreen Agents		
SCENESSE SUBCUTANEOUS IMPLANT 16 MG	BB	PA
SMOOTH MUSCLE RELAXANTS		
Antimuscarinics		
<i>darifenacin oral tablet extended release 24 hr 15 mg, 7.5 mg</i>	2	QL (1 tablet per 1 day)
<i>fesoterodine oral tablet extended release 24 hr 4 mg, 8 mg</i>	Non-Formulary	ALT (Covered Alternatives: Mybetriq); TD
<i>oxybutynin chloride oral syrup 5 mg/5 ml</i>	1	
<i>oxybutynin chloride oral tablet 5 mg</i>	2	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg, 5 mg</i>	2	QL (3 tablets per 1 day)
<i>solifenacin oral tablet 10 mg, 5 mg</i>	2	QL (1 tablet per 1 day)
<i>tolterodine oral capsule,extended release 24hr 2 mg, 4 mg</i>	2	QL (1 capsule per 1 day)
<i>tolterodine oral tablet 1 mg</i>	2	
<i>tolterodine oral tablet 2 mg</i>	2	QL (2 tablets per 1 day)
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR 4 MG, 8 MG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: Fesoterodine); TD
<i>trospium oral capsule,extended release 24hr 60 mg</i>	2	QL (1 capsule per 1 day)
<i>trospium oral tablet 20 mg</i>	1	
Respiratory Smooth Muscle Relaxants		
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG	4	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	2	
<i>theophylline oral tablet extended release 24 hr 400 mg, 600 mg</i>	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
Selective Beta-3-Adrenergic Agonists		
GEMTESA ORAL TABLET 75 MG	Non-Formulary	
<i>mirabegron oral tablet extended release 24 hr 25 mg, 50 mg</i>	2	ST (Step Therapy Required- Tried and failed 30 day trial of tolterodine er, oxybutynin er and solifenacin); QL (1 Tablet per 1 Day)
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON 8 MG/ML	4	TD; ST (Step Therapy Required- Tried and failed 30 day trial of tolterodine er, oxybutynin er and solifenacin)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 25 MG	Non-Formulary	ALT (Covered Alternatives: Mirabegron); ST (Step Therapy Required- Tried and failed 30 day trial of tolterodine er, oxybutynin er and solifenacin); QL (1 tablet per 1 day)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 50 MG	Non-Formulary	ALT (Covered Alternatives: Mirabegron); TD; ST (Step Therapy Required- Tried and failed 30 day trial of tolterodine er, oxybutynin er and solifenacin); QL (1 tablet per 1 day)
VITAMINS		
Multivitamin Preparations		
ALTRIXA OB ORAL TABLET 15 MG IRON- 1,750 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
CITRANATAL B-CALM (FE GLUC) ORAL TABLETS, SEQUENTIAL 20 MG IRON-1 MG -25 MG/25 MG	Non-Formulary	QL (Quantity Limits Apply)
MATERNACEL ORAL TABLET 20 MG IRON-1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.5 MG	2	HCR
NEEVODHA (WITH ALGAL OIL) ORAL CAPSULE 27 MG IRON-1.13 MG-581.92 MG	Non-Formulary	QL (Quantity Limits Apply)
NEOMATERNA ORAL TABLET 20 MG IRON-1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
OB COMPLETE ONE ORAL CAPSULE 40-10-1-300 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE ORAL TABLET 50 MG IRON-1.25 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE PETITE ORAL CAPSULE 35 MG IRON-5 MG IRON-1 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE PREMIER ORAL TABLET 30-20-1 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE WITH DHA ORAL CAPSULE 30 MG IRON-10 MG IRON-1 MG	Non-Formulary	QL (Quantity Limits Apply)
PNV-DHA ORAL CAPSULE 27 MG IRON-1 MG -300 MG	2	
PRENATABS FA ORAL TABLET 29-1 MG	1	
PRENATABS RX ORAL TABLET 29 MG IRON-1 MG	2	
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	2	HCR; AG (Max 50 Years)
PRENATAL PLUS (CALCIUM CARB) ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATAL VITAMIN PLUS LOW IRON ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATE CHEWABLE ORAL TABLET,CHEWABLE 1 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE DHA (FERR ASP GLYCIN) ORAL CAPSULE 18 MG IRON-1 MG -300 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE ELITE (IRON ASP GLYC) ORAL TABLET 20 MG IRON- 1 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE ENHANCE ORAL CAPSULE 28 MG IRON- 1 MG-400 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE ESSENTIAL(IRON-ASP-GL) ORAL CAPSULE 18 MG IRON- 1 MG-300 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE MINI (FERR ASP GLYCIN) ORAL CAPSULE 18-1-350 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PRENATE PIXIE ORAL CAPSULE 10 MG IRON- 1 MG-200 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE RESTORE ORAL CAPSULE 27 MG IRON- 1 MG-400 MG	Non-Formulary	QL (Quantity Limits Apply)
PRIMACARE ORAL CAPSULE 30-1-300 MG	Non-Formulary	QL (Quantity Limits Apply)
TRINATAL RX 1 ORAL TABLET 60 MG IRON-1 MG	1	
VITALARA ORAL TABLET 20 MG IRON- 1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
ZATEAN-PN DHA ORAL CAPSULE 27 MG IRON- 1 MG -300 MG	2	
Vitamin B Complex		
ALTRIXA OB ORAL TABLET 15 MG IRON- 1,750 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
CITRANATAL B-CALM (FE GLUC) ORAL TABLETS, SEQUENTIAL 20 MG IRON-1 MG -25 MG/25 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>cyanocobalamin (vitamin b-12) injection solution 1,000 mcg/ml</i>	2	
<i>cyanocobalamin (vitamin b-12) nasal spray,non-aerosol 500 mcg/spray</i>	2	PA; QL (0.14 ML per 1 day)
DICLEGIS ORAL TABLET,DELAYED RELEASE (DR/EC) 10-10 MG	Non-Formulary	QL (4 tablets per 1 day)
<i>doxylamine-pyridoxine (vit b6) oral tablet,delayed release (dr/ec) 10-10 mg</i>	2	QL (6 Fills per 365 Days); TD; QL (4 tablets per 1 day)
<i>folic acid oral tablet 1 mg</i>	1	QL (1 tablet per 1 day)
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	2	HCR; AG (Max 50 Years)
MATERNACEL ORAL TABLET 20 MG IRON- 1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
NASCOBAL NASAL SPRAY,NON-AEROSOL 500 MCG/SPRAY	Non-Formulary	
NEEVODHA (WITH ALGAL OIL) ORAL CAPSULE 27 MG IRON-1.13 MG-581.92 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
NEOMATERNA ORAL TABLET 20 MG IRON-1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
<i>niacin oral tablet extended release 24 hr 1,000 mg, 500 mg, 750 mg</i>	2	
OB COMPLETE ONE ORAL CAPSULE 40-10-1-300 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE ORAL TABLET 50 MG IRON-1.25 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE PETITE ORAL CAPSULE 35 MG IRON-5 MG IRON-1 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE PREMIER ORAL TABLET 30-20-1 MG	Non-Formulary	QL (Quantity Limits Apply)
OB COMPLETE WITH DHA ORAL CAPSULE 30 MG IRON-10 MG IRON-1 MG	Non-Formulary	QL (Quantity Limits Apply)
PNV-DHA ORAL CAPSULE 27 MG IRON-1 MG - 300 MG	2	
PRENATABS FA ORAL TABLET 29-1 MG	1	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG	2	
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG	2	HCR; AG (Max 50 Years)
PRENATAL PLUS (CALCIUM CARB) ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATAL VITAMIN PLUS LOW IRON ORAL TABLET 27 MG IRON- 1 MG	1	
PRENATE CHEWABLE ORAL TABLET,CHEWABLE 1 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE DHA (FERR ASP GLYCIN) ORAL CAPSULE 18 MG IRON-1 MG -300 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE ELITE (IRON ASP GLYC) ORAL TABLET 20 MG IRON- 1 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE ENHANCE ORAL CAPSULE 28 MG IRON- 1 MG-400 MG	Non-Formulary	QL (Quantity Limits Apply)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
PRENATE ESSENTIAL(IRON-ASP-GL) ORAL CAPSULE 18 MG IRON- 1 MG-300 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE MINI (FERR ASP GLYCIN) ORAL CAPSULE 18-1-350 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE PIXIE ORAL CAPSULE 10 MG IRON- 1 MG-200 MG	Non-Formulary	QL (Quantity Limits Apply)
PRENATE RESTORE ORAL CAPSULE 27 MG IRON- 1 MG-400 MG	Non-Formulary	QL (Quantity Limits Apply)
PRIMACARE ORAL CAPSULE 30-1-300 MG	Non-Formulary	QL (Quantity Limits Apply)
<i>thiamine in 0.9 % sod chloride intravenous solution 500 mg/100 ml</i>	BB	
TRINATAL RX 1 ORAL TABLET 60 MG IRON-1 MG	1	
VITALARA ORAL TABLET 20 MG IRON- 1,670 MCG DFE	Non-Formulary	QL (1 Tablet per 1 Day)
ZATEAN-PN DHA ORAL CAPSULE 27 MG IRON- 1 MG -300 MG	2	
Vitamin D		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	2	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	2	
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	2	
FOSAMAX PLUS D ORAL TABLET 70 MG- 2,800 UNIT, 70 MG- 5,600 UNIT	4	ST (Step Therapy Required- Tried and failed 90 days treatment of alendronate or ibandronate); QL (4 tablets per 28 days)
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	2	PA; QL (2 capsules per 1 day)
RAYALDEE ORAL CAPSULE,EXTENDED RELEASE 24 HR 30 MCG	Non-Formulary	QL (Quantity Limits Apply); ALT (Covered Alternatives: CALCITRIOL, VITAMIN D2, VITAMIN D3, DOXERCALCIFEROL, PARICALCITOL)

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

DRUG NAME	DRUG TIER	NOTES
VITAMIN D2 ORAL CAPSULE 1,250 MCG (50,000 UNIT)	2	

Tier 1= Select Generic, Tier 2= Generic and Select Brand, Tier 3= Preferred Brand,

Tier 4= Non-Preferred Brand and Generic, Tier 5= Preferred Specialty, Tier 6= Non-Preferred Specialty

Tier 7= Medical Coinsurance

BB= Buy and Bill Only

PA = Prior Authorization

QL = Quantity Limits

SP = This drug can only be obtained at Pharmacy Advantage: (800) 456-2112; up to 30 day supply at a time.

ST = Step Therapy Required

HCR = Health Care Reform rules apply

TD= FOR NEW TO HAP MEMBERS ONLY: One 30 day fill in the first 90 days of enrolling with HAP.

PF= Partial Fill Program

AG= Age Restriction

Index

- aa 3% no.2 ped-d10-calcium-hep* 86, 184, 188
aa 3%no.2ped-d10w-calcium gluc. 184
aa 3.5% no.2 ped-d10w-heparin 86, 185
aa2.5%no.2 ped-d10-calcium-hep 86, 185, 188
aa3.5% no2 ped-d10-calcium-hep 86, 185, 188
aas3%no.2ped-d5w-calc gluc-hep 86, 185, 188
abacavir 23
abacavir-lamivudine 23
ABELCET 31
ABIGALE 259, 280, 317
ABIGALE LO 259, 280, 317
ABILIFY ASIMTUFII 127, 134
ABILIFY MAINTENA 127, 134
abiraterone 35
ABLYSINOL 112
ABRILADA(CF) 308
ABRILADA(CF) PEN 308
ABRYSVO (PF) 57
ABSORICA 370
ABSORICA LD 370
acamprosate 2
ACANYA 26, 346, 370
acarbose 237
acebutolol 75, 94, 100
acetaminophen 130, 150
acetaminophen-codeine 130, 150, 151, 152, 330
acetazolamide 97, 124, 185, 203
acetic acid 201
acetylcysteine 2, 337
acitretin 370
ACTEMRA 301
ACTEMRA ACTPEN 301
ACTHAR 181, 278
ACTHAR SELFJECT 181, 278
ACTHIB (PF) 57
ACTIMMUNE 320
ACUVAIL (PF) 212
acyclovir 28, 353
*acyclovir in 0.9 % sodium chl*r 28, 353
ACZONE 12, 15, 346, 377
ADACEL(TDAP
ADOLESN/ADULT)(PF) 57
ADAKVEO 78
adalimumab-aacf 308
ADALIMUMAB-AACF(CF) PEN
CROHNS 308
ADALIMUMAB-AACF(CF) PEN
PS-UV 308
adalimumab-aaty 308
adalimumab-adaz 308, 309
adalimumab-adbm 309
ADALIMUMAB-ADBM(CF) PEN
CROHNS 309
ADALIMUMAB-ADBM(CF) PEN
PS-UV 309
adalimumab-fkjp 309, 310
adalimumab-ryvk 310
adapalene 323, 324, 370, 371
adapalene-benzoyl peroxide 377
ADBRY 368
ADCIRCA 110, 338
ADDERALL XR 119
ADDYI 142
adefovir 28
ADEMPAS 114, 343
ADLARITY 71
ADRENALIN IN 0.9 % SOD
CHLOR 62, 326
ADVAIR DISKUS
..... 72, 204, 229, 331, 340, 358
ADVAIR HFA
..... 73, 204, 229, 331, 340, 358
ADVATE 82
ADYNOVATE 82
ADZENYS XR-ODT 119
ADZYNMA 193
AEROCHAMBER PLUS FLOW-
VU 175
AEROCHAMBER PLUS Z STAT 175
AFINITOR 35, 299
AFINITOR DISPERZ 35, 299
AFIRMELLE 239, 247, 259, 280
AFLURIA 2025-2026 (3YR
UP)(PF) 58
AFLURIA 2025-2026 (6MO UP) 58
AFSTYLA 82
AFTER PILL 247
AFTERA 247
AGAMREE 229
AIMOVIG AUTOINJECTOR 141
AIMSCO LATEX CONDOM 324
AIRDUO DIGIHALER
..... 73, 204, 229, 331, 340, 358
AIRSUPRA
..... 73, 204, 229, 331, 340, 358
AJOVY AUTOINJECTOR 141
AJOVY SYRINGE 141
AKEEGA 35
AKLIEF 371
AKYNZEO (FOSNETUPITANT)
..... 216, 224
AKYNZEO (NETUPITANT) 216, 224
ALA-SCALP 204, 229, 358
albendazole 11
albuterol sulfate 73, 340, 341
alclometasone 358
ALDURAZYME 193
ALECENSA 35
alendronate 317
alfuzosin 72
ALHEMO PEN 82
ALINIA 15
ALIQOPA 35
aliskiren 112
ALKINDI SPRINKLE... 204, 229, 358
ALLERGY AND CONGESTION
RELIEF 6, 62, 326, 339
ALLERGY RELIEF
(LORATADINE) 6, 339
ALLERGY RELIEF D-24HR
..... 6, 62, 327, 339
ALLERGY RELIEF,NASAL
DECONGEST 6, 62, 327, 339
ALLERGY-CONGESTION
RELIEF-D 6, 62, 327, 339
ALLI 222
allopurinol 315
almotriptan malate 169
alosetron 218
ALPHAGAN P 195, 345
ALPHANATE 82
ALPHANINE SD 82
alprazolam 139
ALPROLIX 82
ALREX 204
ALTABAX 346
ALTAVERA (28).. 239, 247, 259, 280
ALTRENO 36, 356
ALTRIXA OB 87, 380, 382
ALTUVIIO 82
ALUNBRIG 36
ALVAIZ 79
ALVESCO 204, 229, 331
ALYACEN 1/35 (28)
..... 239, 247, 259, 280
ALYACEN 7/7/7 (28)
..... 239, 247, 259, 280
ALYFTREK 334
ALYGLO 55
ALYMSYS 36
ALYQ 110, 338
amantadine hcl 8, 67, 118
ambrisentan 114, 343
AMETHIA 247
AMETHYST (28).. 239, 247, 259, 280
AMICAR 82
amiloride 111, 187
amiloride-hydrochlorothiazide
..... 111, 112, 187, 189
aminocaproic acid 82, 83
amiodarone 102
AMITIZA 221

<i>amitriptyline</i>	172	ARANELLE (28)...	239, 248, 259, 280	AUROVELA 1.5/30 (21)	.....	240, 248, 259, 281
<i>amitriptyline-chlordiazepoxide</i>	.....	ARANESP (IN POLYSORBATE)	.....	AUROVELA 1/20 (21)	.....	240, 248, 259, 281
.....	139, 172	ARAZLO.....	371	AUROVELA 24 FE.....	.....	248
AMJEVITA(CF).....	310	ARCALYST.....	336	AUROVELA FE 1.5/30 (28).....	.....	248
AMJEVITA(CF)	.....	AREXVY (PF).....	58	AUROVELA FE 1-20 (28).....	.....	248
AUTOINJECTOR.....	310	<i>arformoterol</i>	73, 341	AURYXIA.....	.....	186
<i>amlodipine</i>	96, 103, 114	ARIKAYCE.....	9	AUSTEDO.....	.....	174
<i>amlodipine-atorvastatin</i>	.....	<i>aripiprazole</i>	127, 128, 134	AUSTEDO XR.....	.....	174
.....	96, 103, 106, 114	ARISTADA.....	128, 134	AUSTEDO XR TITRATION	.....	.....
<i>amlodipine-benazepril</i>	92, 96, 103, 114	ARISTADA INITIO.....	128, 134	KT(WK1-4).....	.....	174
<i>amlodipine-olmesartan</i>	.....	<i>armodafinil</i>	174	AUTOLET LITE.....	.....	175
.....	91, 96, 103, 115	ARMONAIR DIGIHALER	.....	AUVELITY.....	.....	127
<i>amlodipine-valsartan</i>	91, 96, 103, 115	.....	204, 229, 331	AUVI-Q.....	.....	62, 327
<i>amlodipine-valsartan-hctiazid</i>	.....	ARMOUR THYROID.....	292	AVAR.....	.....	371, 374
.....	91, 96, 103, 104, 112, 190	ARNUIITY ELLIPTA... ..	204, 229, 331	AVASTIN.....	.....	36, 215
<i>ammonium lactate</i>	355	ARRANON.....	36	AVEED.....	.....	237, 240
AMNESTEEM.....	371	ASCENIV.....	55	AVERI.....	.....	248
AMONDYS-45.....	316	ASCOMP WITH CODEINE	.....	AVGEMSI.....	.....	36
<i>amoxapine</i>	172	.....	137, 152, 160, 167	AVIANE.....	.....	240, 248, 259, 281
<i>amoxicillin</i>	10, 219, 224, 225	<i>asenapine maleate</i>	128, 134	AVMAPKI-FAKZYNJA.....	.....	36
<i>amoxicillin-pot clavulanate</i>	.....	ASHLYNA.....	248	AVONEX.....	.....	299, 300
.....	10, 11, 219, 225	ASMANEX HFA... ..	204, 229, 332, 358	AVSOLA.....	.....	310
<i>amphotericin b</i>	31	ASMANEX TWISTHALER	.....	AXTLE.....	.....	37
<i>ampicillin</i>	11	.....	205, 230, 332, 359	AYUNA.....	.....	240, 248, 259, 281
<i>ampicillin-sulbactam</i>	11	<i>aspirin</i>	89, 167	AYVAKIT.....	.....	37
AMPYRA.....	324	ASPIRIN CHILDRENS.....	89, 167	AZASAN.....	.....	294
AMRIX.....	67	<i>aspirin-dipyridamole</i>	89, 167, 181	AZASITE.....	.....	197
AMTAGVI.....	36, 117	ASPRUZYO SPRINKLE.....	97	<i>azathioprine</i>.....	.....	294
AMVUTTRA.....	321	ASSURE PLATINUM GLUCOSE	.....	<i>azelaic acid</i>.....	.....	346
AMZEEQ.....	12, 33, 197, 346	METER.....	175	<i>azelastine</i>.....	.....	6, 196
ANAFRANIL.....	172	ASSURE PLATINUM TEST	.....	AZELEX.....	.....	346
<i>anagrelide</i>	90	STRIP.....	182	AZILECT.....	.....	148
<i>anastrozole</i>	36, 239	<i>atazanavir</i>	25	<i>azithromycin</i>.....	.....	30
ANDEMBRY AUTOINJECTOR..	105	<i>atenolol</i>	75, 94, 100	AZMIRO.....	.....	237, 240
ANDEXXA.....	3, 83	<i>atenolol-chlorthalidone</i>	.....	AZOPT.....	.....	203
ANKTIVA.....	36	.....	75, 94, 100, 114, 191	AZOR.....	.....	91, 96, 104, 115
ANNOVERA.....	247	ATIVAN.....	138, 139	AZSTARYS.....	.....	160
ANORO ELLIPTA... ..	64, 73, 328, 341	<i>atomoxetine</i>	160	AZURETTE (28).....	.....	248
ANUCORT-HC.....	358	ATORVALIQ.....	106	<i>bacitracin</i>.....	.....	197
ANUSOL-HC.....	358	<i>atorvastatin</i>	106	<i>baclofen</i>.....	.....	69
ANZUPGO.....	370	<i>atovaquone</i>	15	BAFIERTAM.....	.....	298
APEXICON E.....	358	<i>atovaquone-proguanil</i>	12	BALCOLTRA.....	.....	248
APIDRA SOLOSTAR U-100	.....	ATRALIN.....	36, 357	<i>balsalazide</i>.....	.....	218
INSULIN.....	269, 285	<i>atropine</i>	2, 64, 65, 214, 328	BALVERSA.....	.....	37
APIDRA U-100 INSULIN.....	269, 285	ATROVENT HFA.....	65, 328	BALZIVA (28).....	.....	240, 248, 260, 281
APLENZIN.....	127	ATTRUBY.....	97	BANZEL.....	.....	147
APOKYN.....	150	AUBAGIO.....	293	BAQSIMI.....	.....	2, 265
<i>apomorphine</i>	150	AUBRA.....	239, 248, 259, 281	BARACLUDGE.....	.....	28
<i>apraclonidine</i>	195	AUBRA EQ.....	239, 248, 259, 280	BASAGLAR KWIKPEN U-100	.....	.....
<i>aprepitant</i>	224	AUDENZ (NATIONAL	.....	INSULIN.....	.....	269, 276
APRETUDE.....	22	STOCKPILE).....	58	BASAGLAR TEMPO PEN(U-	.....	.....
APRI.....	248	AUDENZ(PF)(NATIONAL	.....	100)INSLN.....	.....	269, 276
APTENSIO XR.....	160	STOCKPILE).....	58	BAVENCIO.....	.....	37
APTIOM.....	147	AUGMENTIN.....	11, 219, 225	BAXDELA.....	.....	31
APTIVUS.....	25	AUGTYRO.....	36	BAYER ASPIRIN.....	.....	89, 167
ARAKODA.....	12	AURLUMYN.....	115, 343			
ARALAST NP.....	77					

<i>bcg vaccine, live (pf)</i>	58	BLULINK DIABETIC TEST	BUTRANS	159
BELBUCA.....	158	BUNDLE.....	BYDUREON BCISE.....	267
BELSOMRA.....	159	BLULINK GLUCOSE MONITOR	BYLVAY	221
<i>benazepril</i>	92	SYSTEM.....	BYOOVIZ.....	211
<i>benazepril-hydrochlorothiazide</i>		BLULINK GLUCOSE TEST	BYSTOLIC.....	69, 94, 100
.....	93, 112, 190	STRIP.....	CABENUVA.....	22
<i>bendamustine</i>	37	BONSITY	<i>cabergoline</i>	144
BENEFIX.....	83	278, 317	CABLIVI.....	90
BENICAR.....	91	BOOSTRIX TDAP.....	CABOMETYX.....	37, 38
BENICAR HCT.....	91, 112, 190	<i>bosentan</i>	CABTREEO.....	346, 378
BENLYSTA.....	298, 299	115, 343	CADUET.....	96, 104, 106, 115
<i>benzonatate</i>	330	BOSULIF.....	CAFCIT.....	160
<i>benzphetamine</i>	119	37	<i>caffeine citrate</i>	161
<i>benztropine</i>	67, 124	BRAFTOVI.....	<i>calcipotriene</i>	355
BEOVU.....	215	BREATHERITE MDI SPACER... 176	<i>calcipotriene-betamethasone</i>	355
<i>bepotastine besilate</i>	5, 196	BREKIYA.....	<i>calcitonin (salmon)</i>	245, 317
BEPREVE.....	5, 196	BRENZAVVY.....	<i>calcitriol</i>	378, 384
BERINERT.....	320	BREO ELLIPTA	<i>calcium acetate(phosphat bind)</i>	186
BESIVANCE.....	197	.....	CALQUENCE	
BESPONSA.....	37	73, 205, 230, 332, 341, 359	(ACALABRUTINIB MAL).....	38
BESREMI.....	37	BREXAFEMME.....	CAMCEVI (6 MONTH).....	38, 266
<i>betamethasone dipropionate</i> ..	230, 359	35	CAMILA.....	240, 249, 281
<i>betamethasone valerate</i>	230, 359	BREYNA. 74, 205, 230, 332, 341, 359	CAMRESE.....	249
<i>betamethasone, augmented</i>	230, 359	BREZTRI AEROSPHERE....	CAMRESE LO.....	249
BETASERON.....	300	328, 341	CAMZYOS.....	97
<i>betaxolol</i>	75, 94, 100, 202	BRIELLYN.....	CANASA.....	218
BETHKIS.....	9	240, 249, 260, 281	<i>candesartan</i>	91
BETIMOL.....	69, 94, 100, 130, 202	BRILINTA.....	<i>candesartan-hydrochlorothiazide</i>	
BETOPTIC S.....	75, 94, 100, 202	89	.....	91, 113, 190
<i>bevacizumab</i>	37, 215	<i>brimonidine</i>	<i>capecitabine</i>	38
BEVESPI AEROSPHERE		195, 345	CAPEX.....	205, 359
.....	65, 73, 328, 341, 353	<i>brimonidine-timolol</i>	CAPLYTA.....	135
<i>bexarotene</i>	37, 351	195, 202	CAPRELSA.....	38
BEXSERO.....	58	BRINEURA.....	<i>captopril</i>	93
BEYAZ.....	248	193, 194	<i>captopril-hydrochlorothiazide</i>	
BEYFORTUS.....	27	<i>brinzolamide</i>.....	.....	93, 113, 190
<i>bicalutamide</i>	37	203	CAPVAXIVE.....	58
BIJUVA.....	260, 281	BRIUMVI.....	CARAC.....	38, 351
BIKTARVY.....	22, 23	305	CARAFATE.....	226
<i>bimatoprost</i>	214	BRIVIACT.....	CARBAGLU.....	184
BIMZELX.....	368	124	<i>carbamazepine</i>	124, 125, 128
BIMZELX AUTOINJECTOR.....	368	BRIXADI.....	<i>carbidopa</i>	142
BINAXNOW COVD AG CARD		158	<i>carbidopa-levodopa</i>	143
HOME TST.....	175	<i>bromfenac</i>	<i>carbidopa-levodopa-entacapone</i>	
BINAXNOW COVID-19 AG		212	.....	141, 143
SELF TEST.....	175	<i>bromocriptine</i>	<i>carbinoxamine maleate</i>	4, 336
BINOSTO.....	317	143, 144	CARBZAH.....	4, 336
BIOTHRAX.....	58	BROMSITE.....	CARDIZEM CD.....	102
<i>bisoprolol fumarate</i>	75, 94, 100	212	CARDIZEM LA.....	102
<i>bisoprolol-hydrochlorothiazide</i>		BRONCHITOL.....	CARESTART COVID-19 AG	
.....	76, 94, 100, 112, 190	339	HOME TST.....	176
BIVIGAM.....	55	BROVANA.....	<i>carisoprodol</i>	67
BIZENGRI.....	37	74, 341	<i>carisoprodol-aspirin</i>	67, 167
BLINCYTO.....	37	BRUKINSA.....	<i>carisoprodol-aspirin-codeine</i>	
BLISOVI 24 FE.....	248	37	.....	68, 153, 167
BLISOVI FE 1.5/30 (28).....	248	BRYHALI.....	CAROSPIR.....	111, 112, 187
BLISOVI FE 1/20 (28).....	248	359	<i>carteolol</i>	202
		<i>budesonide</i>		
		230		
		<i>budesonide-formoterol</i>		
			
		74, 205, 230, 332, 341, 359		
		<i>bumetanide</i>		
		108, 186		
		BUPHENYL.....		
		184		
		<i>bupivacaine-lidocaine-sod chlr</i>		
		314		
		<i>buprenorphine</i>		
		158		
		<i>buprenorphine hcl</i>		
		158		
		<i>buprenorphine-naloxone</i>		
		159		
		<i>bupropion hcl</i>		
		127		
		<i>bupropion hcl (smoking deter)</i> . 76, 127		
		<i>buspirone</i>		
		149		
		<i>butalbital-acetaminop-caff-cod</i>		
			
		130, 138, 151, 153, 160, 330		
		<i>butalbital-acetaminophen</i>		
		131, 151		
		<i>butalbital-acetaminophen-caff</i>		
			
		131, 138, 151, 160		
		<i>butalbital-aspirin-caffeine</i>		
			
		89, 90, 138, 160, 167		
		<i>butorphanol</i>		
		159		

CARTIA XT.....	102	CIMERLI.....	215	COARTEM.....	12
<i>carvedilol</i>	69, 72, 90, 94, 101	<i>cimetidine</i>	5, 223	<i>codeine sulfate</i>	153, 330
<i>carvedilol phosphate</i>	70, 72, 90, 94, 101	CIMZIA.....	310	<i>codeine-butalbital-asa-caff</i>	138, 153, 161, 167
CARVYKTI.....	38, 117	CIMZIA POWDER FOR RECONST.....	310	<i>codeine-guaifenesin</i>	153, 330, 335
CASGEVY.....	117	CIMZIA STARTER KIT.....	310	<i>colchicine</i>	98, 315
<i>caspofungin</i>	19	<i>cinacalcet</i>	245	COLCRYS.....	98, 315
CAVERJECT.....	105	CINQAIR.....	336	<i>colesevelam</i>	95, 239
CAVERJECT IMPULSE.....	105	CINRYZE.....	320	<i>colestipol</i>	95
CAYSTON.....	27	CINVANTI.....	224	<i>colistin (colistimethate na)</i>	31
CAZANT (28).....	249	CIPRO HC.....	16, 32, 197, 205	COMBIGAN.....	195, 202
<i>ceftazidime</i>	7	<i>ciprofloxacin</i>	16, 32, 197	COMBIPATCH.....	260, 281, 317
<i>cefadroxil</i>	7	<i>ciprofloxacin hcl</i>	16, 32, 197	COMBIVENT RESPIMAT	65, 74, 328, 341
<i>cefazolin</i>	7	<i>ciprofloxacin-dexamethasone</i>	32, 197, 205	COMETRIQ.....	38
<i>cefazolin in dextrose (iso-os)</i>	7	<i>citalopram</i>	170	COMIRNATY 2025-2026(5- 11Y)(PF).....	58
<i>cefazolin in sterile water</i>	7	CITRANATAL B-CALM (FE GLUC).....	87, 380, 382	COMPACT SPACE CHAMBER..	176
<i>cefdinir</i>	7	CLARAVIS.....	371	COMPLERA.....	22, 23, 29
<i>cefepime</i>	8	<i>clarithromycin</i>	16, 30, 219, 225	CONDYLOX.....	371
<i>cefixime</i>	7	CLARITIN-D 24 HOUR	6, 62, 327, 339	CONJUPRI.....	96, 104, 115
<i>cefipodoxime</i>	7, 8	<i>clemastine</i>	4, 336	CONSENSI.....	104, 115, 143
<i>cefprozil</i>	7	CLEMSZA.....	4, 336	CONSTULOSE.....	184
<i>ceftriaxone</i>	8	CLEVER CHOICE CHAMBER- LRG MASK.....	176	CONTOUR PLUS BLUE METER	176
<i>cefuroxime axetil</i>	7	CLEVER CHOICE CHAMBER- MED MASK.....	176	CONTOUR PLUS TEST STRIP...	182
<i>celecoxib</i>	142	CLEVER CHOICE CHAMBER- SM MASK.....	176	CONTRAVE.....	122
CELONTIN.....	172	CLIMARA PRO.....	260, 317	COPAXONE.....	293
<i>cephalexin</i>	7	CLINDAGEL.....	26, 346	COPIKTRA.....	38
CEQUA.....	201, 295	<i>clindamycin hcl</i>	26, 346	CORDRAN TAPE LARGE ROLL	361
CERDELGA.....	193	<i>clindamycin phosphate</i>	26, 346	COREG CR.....	70, 72, 90, 94, 101
CEREZYME.....	194	<i>clindamycin-benzoyl peroxide</i>	26, 347, 371	CORIFACT.....	83
<i>cetirizine</i>	6, 339	CLINDESSE.....	26, 347	CORLANOR.....	98
CETROTIDE.....	240	CLINITEST COVID-19 HOME TEST.....	176	CORTIFOAM.....	361
<i>cevimeline</i>	71	<i>clobazam</i>	138, 139	CORTROPHIN GEL.....	181, 279
CHARLOTTE 24 FE.....	249	<i>clobetasol</i>	359, 360	COSELA.....	3
CHATEAL EQ (28)	240, 249, 260, 281	<i>clobetasol-emollient</i>	360	COSENTYX.....	301
CHEMET.....	2, 227	CLOBEX.....	360	COSENTYX (2 SYRINGES).....	301
CHENODAL.....	221	<i>clocortolone pivalate</i>	360	COSENTYX PEN.....	301
CHILDREN'S ASPIRIN.....	90, 167	CLOMID.....	258	COSENTYX (2 SYRINGES).....	301
CHILDREN'S IBUPROFEN.....	163	<i>clomiphene citrate</i>	258	COSENTYX PEN.....	301
<i>chlordiazepoxide hcl</i>	139	<i>clomipramine</i>	173	COSENTYX UNOREADY PEN..	301
<i>chlordiazepoxide-clidinium</i>	65, 139	<i>clonazepam</i>	138, 139	COSOPT (PF)..	70, 101, 131, 202, 203
<i>chlorhexidine gluconate</i>	202, 354	<i>clonidine</i>	99	COTELLIC.....	38
<i>chloroquine phosphate</i>	12	<i>clonidine hcl</i>	64, 98, 99	COTEMPLA XR-ODT.....	161
<i>chlorpromazine</i>	159	<i>clopidogrel</i>	90	COVARYX.....	237, 260
<i>chlorthalidone</i>	114, 191	<i>clorazepate dipotassium</i>	138, 139	COVARYX H.S.....	237, 260
<i>chlorzoxazone</i>	68	CLOTIMAZOLE.....	354	COVID-19 AT-HOME TEST.....	176
CHOLBAM.....	221	<i>clotrimazole</i>	354	COXANTO.....	163
<i>cholestyramine (with sugar)</i>	95	<i>clotrimazole-betamethasone</i> ..	354, 360	CREON.....	221
CHOLESTYRAMINE LIGHT.....	95	<i>clozapine</i>	135	CRESEMBA.....	17
<i>chorionic gonadotropin, human</i>	266	COAGADEX.....	83	CRINONE.....	281
<i>chromium chloride</i>	188			<i>cromolyn</i>	196, 211, 337
CIALIS.....	110, 338			CROTAN.....	377
CIBINQO.....	305, 370			CRYSSELLE (28)....	240, 249, 260, 281
<i>ciclopirox</i>	367			CRYSVITA.....	185
<i>cilostazol</i>	90			CTEXTLI.....	221
CILOXAN.....	32, 197			CUPRIMINE.....	2, 227
CIMDUO.....	23			CUTAQUIG.....	55

CUVITRU.....	55	DAXXIFY.....	67	<i>diethylpropion</i>	118, 119
CUVPOSA.....	65, 354	DAYBUE.....	142	DIFFERIN.....	324, 371
CUVRIOR.....	227	DAYSEE.....	249	DIFICID.....	30
<i>cyanocobalamin (vitamin b-12)</i>	382	DAYTRANA.....	161	<i>diflorasone</i>	361
<i>cyclobenzaprine</i>	68	DAYVIGO.....	159	<i>diflunisal</i>	164
<i>cyclopentolate</i>	214	DDAVP.....	83, 279	<i>difluprednate</i>	206
<i>cyclopent-tropic-phen-ketr-wat</i>		DEBACTEROL.....	211, 378	DIGITEK.....	98
.....	212, 214, 216	DEBLITANE.....	240, 249, 281	<i>digoxin</i>	98
<i>cyclophosphamide</i>	38, 299	<i>deferasirox</i>	228	<i>dihydroergotamine</i>	70, 131
<i>cycloserine</i>	16	<i>deferiprone</i>	228	DILANTIN.....	100, 146
CYCLOSET.....	144	<i>deflazacort</i>	230	DILANTIN EXTENDED.....	99, 146
<i>cyclosporine</i>	201, 295	DELSTRIGO.....	22, 23	DILANTIN INFATABS.....	99, 146
<i>cyclosporine modified</i>	201, 295	<i>demeclocycline</i>	33	DILANTIN KAPSEAL.....	99, 146
CYLTEZO(CF).....	311	DENAVIR.....	353	<i>diltiazem hcl</i>	97, 102, 103
CYLTEZO(CF) PEN.....	311	DENG VAXIA (PF).....	58	<i>diltiazem in dextrose 5 %</i>	97, 103
CYLTEZO(CF) PEN CROHN'S-		DENTA 5000 PLUS SENSITIVE		DILT-XR.....	103
UC-HS.....	310	.....	175, 319	DILUENT FOR REMODULIN.....	326
CYLTEZO(CF) PEN PSORIASIS-		DEPAKOTE ER.....	128, 131, 144	<i>diluent for treprostinil (gly)</i>	326
UV.....	311	DEPO-PROVERA.....	281	<i>dimethyl fumarate</i>	298
<i>cyproheptadine</i>	4, 336	DEPO-SUBQ PROVERA.....	104, 281	DIPENTUM.....	218
CYRAMZA.....	38	DESCOVY.....	23, 29	<i>diphenoxylate-atropine</i>	65, 217
CYRED.....	249	<i>desipramine</i>	173	<i>dipyridamole</i>	90, 181
CYRED EQ.....	249	<i>desmopressin</i>	83, 279	<i>disopyramide phosphate</i>	99
CYSTADANE.....	321	<i>desog-e.estradiol/e.estradiol</i>	249	<i>disulfiram</i>	2
CYSTADROPS.....	213	<i>desonide</i>	361	<i>divalproex</i>	128, 131, 132, 145
CYSTAGON.....	321	<i>desoximetasone</i>	361	DIVIGEL.....	260, 318
CYSTARAN.....	213	<i>desvenlafaxine</i>	168	<i>dofetilide</i>	102
CYTOGAM.....	55	<i>desvenlafaxine succinate</i>	168	DOJOLVI.....	185
D5 % (D-GLUCOSE)-0.9 %		<i>dexamethasone</i>	205, 230, 231	DOLISHALE.....	240, 249, 260, 281
SODCHLR.....	185	DEXAMETHASONE INTENSOL		<i>donepezil</i>	71
<i>d5 % and 0.9 % sodium chloride</i> ...	185	.....	205, 230	DOPTELET (10 TAB PACK).....	79
<i>dabigatran etexilate</i>	79	<i>dexamethasone sodium phos (pf)</i>		DOPTELET (15 TAB PACK).....	79
<i>dalfampridine</i>	324	.....	205, 231	DOPTELET (30 TAB PACK).....	79
DALIRESP.....	337, 376	<i>dexamethasone sodium phosphate</i>		DORAL.....	140
DALVANCE.....	20	.....	205, 231	DORYX MPC.....	13, 33, 197, 347
<i>danazol</i>	237, 240	DEXCOM G6 RECEIVER.....	176	<i>dorzolamide</i>	203
<i>dantrolene</i>	69	DEXCOM G6 SENSOR.....	176	<i>dorzolamide (pf)</i>	203
DANYELZA.....	38	DEXCOM G6 TRANSMITTER... ..	176	<i>dorzolamide-timolol</i>	
DANZITEN.....	38	DEXCOM G7 RECEIVER.....	176	.....	70, 101, 132, 202, 203
<i>dapaglifloz propaned-metformin</i>		DEXCOM G7 SENSOR.....	176	<i>dorzolamide-timolol (pf)</i>	
.....	245, 289	DEXILANT.....	226	.....	70, 101, 132, 202, 203
<i>dapagliflozin propanediol</i>	289	<i>dexlansoprazole</i>	226	DOVATO.....	22, 23
<i>dapsone</i>	12, 15, 347, 378	<i>dexmethylphenidate</i>	161	<i>doxazosin</i>	90
<i>daptomycin</i>	19	<i>dextroamphetamine sulfate</i>	119	<i>doxepin</i>	173, 351, 352
<i>daptomycin in 0.9 % sod chlor</i>	19	<i>dextroamphetamine-amphetamine</i>	119	<i>doxercalciferol</i>	384
DARAPRIM.....	13	<i>dextrose 50 % in water (d50w)</i>	185	<i>doxycycline hyclate</i>	13, 33, 197, 347
<i>darifenacin</i>	379	DIACOMIT.....	145	<i>doxycycline monohydrate</i>	
<i>darunavir</i>	25	<i>diazepam</i>	138, 139, 140	.....	13, 14, 33, 34, 198, 347, 348
DARZALEX.....	38	DICLEGIS.....	217, 218, 336, 382	<i>doxylamine-pyridoxine (vit b6)</i>	
DARZALEX FASPRO.....	38	<i>diclofenac epolamine</i>	131, 163, 375	.....	217, 218, 336, 382
<i>dasatinib</i>	38	<i>diclofenac potassium</i>	131, 163, 375	DRIZALMA SPRINKLE.....	144, 168
DASETTA 1/35 (28)		<i>diclofenac sodium</i>		<i>dronabinol</i>	222
.....	240, 249, 260, 281	.....	131, 163, 164, 212, 375	<i>drospirenone-e.estradiol-lm.fa</i>	249
DASETTA 7/7/7 (28)		<i>diclofenac-misoprostol</i>	131, 164, 375	<i>drospirenone-ethinyl estradiol</i>	249
.....	240, 249, 260, 281	DICLOSAICIN.....	152, 375	DROXIA.....	39
DATROWAY.....	39	<i>dicloxacillin</i>	30	<i>droxidopa</i>	62
DAURISMO.....	39	<i>diclomine</i>	65		

DUAKLIR PRESSAIR	ELFABRIO	ENVARCUS XR
..... 65, 74, 328, 342	..... 194	..... 295, 368
DUAVEE	ELIGARD	EOHILIA
..... 259, 260	..... 39, 266	..... 231
DULERA	ELIGARD (3 MONTH)	EPCLUSA
..... 74, 206, 231, 332, 342, 361	..... 39, 266	..... 20, 21
<i>duloxetine</i>	ELIGARD (4 MONTH)	<i>ephedrine sulfate</i>
..... 144, 168	..... 39, 266	..... 63, 327
DUOBRII	ELIGARD (6 MONTH)	<i>ephedrine sulfate-0.9%nacl(pf)</i>
..... 361, 371	..... 39, 266	..... 63, 327
DUOPA	ELINEST	EPIDIOLEX
..... 143	..... 240, 249, 261, 282	..... 125
DUPIXENT PEN	ELIQUIS	EPIDUO
..... 378	..... 78	..... 378
DUPIXENT SYRINGE	ELIQUIS DVT-PE TREAT 30D	EPIDUO FORTE
..... 378	START	..... 378
DUREX AIR CONDOM	..... 78	<i>epinastine</i>
..... 324	ELITEK	..... 6, 196
DUREX AVANTI BARE REAL	..... 194	<i>epinephrine</i>
FEEL	ELLA	..... 63, 327
..... 324	..... 250	<i>epinephrine hcl in 0.9 % nacl.</i>
DUREX EXTRA SENSITIVE	ELLUME COVID-19 HOME	..... 63, 327
CONDOM	TEST	..... 63, 327
..... 324	..... 177	EIPEN
DUREX TROPICAL CONDOM	ELMIRON	..... 63, 327
..... 324	..... 3	EIPEN 2-PAK
DUREZOL	ELOCTATE	..... 63, 327
..... 206	..... 83	EIPEN JR
DURYSTA	<i>eltrombopag olamine</i>	..... 63, 327
..... 214	..... 80	EIPEN JR 2-PAK
<i>dutasteride</i>	ELURYNG	..... 63, 327
..... 315	..... 240, 250, 261, 282	EPIVIR
<i>dutasteride-tamsulosin</i>	ELZONRIS	..... 24
..... 72, 315	..... 39	<i>eplerenone</i>
DUVYZAT	EMBLAVEO	..... 111, 112, 187
..... 322	..... 27	EPOGEN
DYANAVEL XR	EMEND	..... 80
..... 120	..... 224	EPRONTIA
DYCLOPRO	EMFLAZA	..... 125
..... 352	..... 231	<i>eprosartan</i>
DYMISTA	EMGALITY PEN	..... 92
..... 196, 206, 231, 332, 340	..... 141	ERAXIS(WATER DILUENT)
DYRENIUM	EMGALITY SYRINGE	..... 19
..... 111, 187	..... 141	ERBITUX
E.E.S. 400	EMPAVELI	..... 39
..... 19, 198, 348	..... 295	<i>ergocalciferol (vitamin d2)</i>
EASIVENT HOLDING	EMPLICITI	..... 384
CHAMBER	..... 39	<i>ergoloid</i>
..... 176	EMSAM	..... 70
EASY TRAK II BLOOD	..... 148, 149	<i>ergotamine-caffeine</i>
GLUCOSE MTR	<i>emtricitabine-tenofovir (tdf)</i>	..... 70, 132
..... 177	..... 24, 29	ERIVEDGE
EASYMAX TI	<i>emtricitabine-tenofovir df</i>	..... 39
..... 177	..... 22, 24, 29	ERLEADA
EBGLYSS PEN	EMTRIVA	..... 39
..... 368	..... 24	<i>erlotinib</i>
<i>econazole nitrate</i>	EMVERM	..... 39
..... 354	..... 11	ERMEZA
ECONTRA EZ	EMZAHH	..... 292
..... 249	..... 240, 250, 282	ERRIN
ECONTRA ONE-STEP	<i>enalapril maleate</i>	..... 240, 250, 282
..... 249	..... 93	ERTACZO
<i>edaravone</i>	..... 93, 113, 190	..... 354
..... 121	ENBREL	<i>ertapenem</i>
EDARBI	..... 311	..... 18
..... 91	ENBREL MINI	<i>erythromycin</i>
EDARBYCLOR	..... 311	..... 19, 198, 348
..... 92, 114, 191	ENBREL SURECLICK	<i>erythromycin ethylsuccinate</i>
EDECIN	..... 311	..... 19, 198, 348
..... 108, 186	ENDARI	<i>erythromycin with ethanol</i>
EDLUAR	..... 322	..... 19, 20, 198, 348
..... 149	ENDOCET	ERZOFRI
EDURANT	..... 132, 151, 153	..... 135
..... 22	ENDOMETRIN	ESBRIET
EEMT	..... 282	..... 330
..... 237, 260	ENGERIX-B (PF)	<i>escitalopram oxalate</i>
EEMT HS	..... 58	..... 170
..... 237, 260	ENGERIX-B PEDIATRIC (PF)	<i>esomeprazole magnesium</i>
<i>efavirenz</i>	..... 58	..... 226
..... 22	ENHERTU	ESPEROCT
<i>efavirenz-emtricitabin-tenofov</i>	..... 39	..... 83
..... 22, 24	ENILLORING	ESTARYLLA
<i>efavirenz-lamivu-tenofov disop</i>	..... 240, 250, 261, 282	..... 250
..... 22, 24	ENJAYMO	<i>estazolam</i>
EFFER-K	..... 295	..... 140
..... 188	<i>enoxaparin</i>	<i>estradiol</i>
EFFIENT	..... 86, 87	..... 261, 318
..... 90	ENOXILUV	<i>estradiol valerate</i>
EFUDEX	..... 87	..... 261, 318
..... 39, 351	ENPRESSE	<i>estradiol-norethindrone acet</i>
EGATEN	..... 240, 250, 261, 282	..... 261, 282, 318
..... 11	ENSKYCE	ESTRING
EGRIFTA SV	..... 250	..... 261, 318
..... 291	ENSPRYNG	ESTROGEL
EGRIFTA WR	..... 306	..... 261, 318
..... 291	ENSTILAR	<i>estrogens-methyltestosterone</i>
EKTERLY	..... 356	..... 238, 261
..... 107	<i>entacapone</i>	<i>eszopiclone</i>
ELAHERE	..... 141	..... 149
..... 39	<i>entecavir</i>	<i>ethacrynic acid</i>
ELAPRASE	..... 29	..... 108, 186
..... 194	ENTRESTO	<i>ethambutol</i>
ELELYSO	..... 91	..... 16
..... 194	ENTRESTO SPRINKLE	<i>ethosuximide</i>
ELESTRIN	..... 91	..... 172
..... 261, 318	ENTYVIO	<i>ethyl alcohol</i>
<i>eletriptan</i>	..... 296	..... 112
..... 169	ENTYVIO PEN	
	..... 296	

<i>ethynodiol diac-eth estradiol</i>	250	<i>fenoprofen</i>	164	<i>fluocinolone acetonide oil</i>	206
<i>etodolac</i>	164	FENOPRON.....	164	<i>fluocinolone and shower cap</i>	361
<i>etonogestrel-ethinyl estradiol</i>	241, 250, 262, 282	FENSOLVI.....	40, 266	<i>fluocinonide</i>	362
<i>etoposide</i>	39	<i>fentanyl</i>	153	<i>fluocinonide-emollient</i>	362
<i>etravirine</i>	23	<i>fentanyl (pf)-bupivacaine-nacl</i>	153, 314	<i>fluorescein</i>	183
EUCRISA.....	376	<i>fentanyl citrate</i>	153	<i>fluoride (sodium)</i>	175, 320
EURAX.....	377	<i>fentanyl citrate (pf)</i>	153	<i>fluorometholone</i>	206
EUTHYROX.....	292	<i>fentanyl citrate (pf)-0.9%nacl</i>	153	<i>fluorouracil</i>	40, 351
EVAMIST.....	262, 318	<i>ferric citrate</i>	186	<i>fluoxetine</i>	170, 171
EVEKEO.....	120	FERRIPROX.....	228	<i>fluphenazine hcl</i>	159
EVENITY.....	294	FERRIPROX (2 TIMES A DAY).....	228	<i>flurandrenolide</i>	362
<i>everolimus (antineoplastic)</i>	39, 299	<i>fesoterodine</i>	379	<i>flurbiprofen</i>	164, 212
<i>everolimus (immunosuppressive)</i>	39, 299	FETROJA.....	33	<i>flurbiprofen sodium</i>	164, 212
EVKEEZA.....	93	FETZIMA.....	168	<i>fluticasone furoate</i>	206, 231, 332
EVOMELA.....	39	FIASP FLEXTOUCH U-100	270, 285	<i>fluticasone furoate-vilanterol</i>	74, 206, 232, 332, 342, 362
EVOTAZ.....	25, 322	INSULIN.....	270, 285	<i>fluticasone propionate</i>	206, 207, 232, 332, 362
EVRYSDI.....	316, 322	FIASP PENFILL U-100 INSULIN	270, 285	<i>fluticasone propion-salmeterol</i>	74, 207, 232, 333, 342, 362
EXELDERM.....	354	FIASP PUMPCART.....	270, 286	<i>fluvastatin</i>	107
<i>exemestane</i>	40, 239	FIASP U-100 INSULIN.....	270, 286	<i>flvoxamine</i>	171
<i>exenatide</i>	267	FIBRYGA.....	83	FLUZONE 2025-2026.....	59
EXJADE.....	228	<i>fidaxomicin</i>	30	FLUZONE 2025-2026 (PF).....	59
EYLEA.....	215	FILSPARI.....	112, 320	FLUZONE HIGH-DOSE 2025-26 (PF).....	59
EYSUVIS.....	206	FILSUVEZ.....	378	FLUZONE TRIV SOUTH HEM2025(PF).....	59
EZALLOR SPRINKLE.....	106	FINACEA.....	349	FOCALIN XR.....	161
<i>ezetimibe</i>	99	<i>finasteride</i>	315, 357	<i>folic acid</i>	382
<i>ezetimibe-simvastatin</i>	99, 107	<i>ingolimod</i>	307	FOLLISTIM AQ.....	266
FABHALTA.....	295	FINTEPLA.....	125	FORA TN'G ADV MOBILE MULTI MTR.....	177
FABIOR.....	372	FINZALA.....	250	FORFIVO XL.....	127
FABRAZYME.....	194	FIRAZYR.....	96, 319	FORTEO.....	278, 317
FALMINA (28).....	241, 250, 262, 282	FIRDAPSE.....	71	FOSAMAX PLUS D.....	319, 384
<i>famciclovir</i>	29	FIRVANQ.....	20	<i>foscarnet</i>	16
<i>famotidine</i>	5, 223	FLAREX.....	206	FOSCAVIR.....	17
<i>famotidine (pf)</i>	5, 223	FLEBOGAMMA DIF.....	55, 56	<i>fosfomycin tromethamine</i>	35
FANAPT.....	135	<i>flecainide</i>	100	<i>fosinopril</i>	93
FANAPT TITRATION PACK A..	135	FLECTOR.....	132, 164, 376	<i>fosinopril-hydrochlorothiazide</i>	93, 113, 190
FANTASY CONDOM.....	324	FLEQSUVY.....	69	FOTIVDA.....	40
FARESTON.....	40, 259	FLEXICHAMBER.....	177	FRAGMIN.....	87
FARXIGA.....	289	FLOLAN.....	115, 343	FREESTYLE CONTROL.....	177
FARYDAK.....	40	FLOLIPID.....	107	FREESTYLE FREEDOM LITE....	177
FASENRA.....	337	FLOWFLEX COVID-19 AG HOME TEST.....	177	FREESTYLE INSULINX.....	177, 182
FASENRA PEN.....	336	FLUAD 2025-2026 (65 YR UP)(PF).....	58	FREESTYLE INSULINX TEST STRIPS.....	182
FC2 FEMALE CONDOM.....	324	FLUARIX 2025-2026 (PF).....	59	FREESTYLE LANCETS.....	177
<i>febuxostat</i>	315	FLUBLOK 2025-2026 (PF).....	59	READER.....	177
FEIBA NF.....	83	FLUCELVAX 2025-2026.....	59	FREESTYLE LIBRE 14 DAY READER.....	177
FEIRZA.....	250	FLUCELVAX 2025-2026 (PF).....	59	FREESTYLE LIBRE 14 DAY SENSOR.....	177
<i>felbamate</i>	125	<i>fluconazole</i>	17	FREESTYLE LIBRE 2 PLUS SENSOR.....	177
<i>felodipine</i>	104	<i>flucytosine</i>	31	FREESTYLE LIBRE 2 READER..	177
FEM PH.....	374	<i>fludrocortisone</i>	231		
FEMCAP.....	177, 324	FLULAVAL 2025-2026 (PF).....	59		
FEMRING.....	262, 318	FLUMIST 2025-2026.....	59		
<i>fenofibrate</i>	106	FLUMIST HOME 2025-2026.....	59		
<i>fenofibrate micronized</i>	106	<i>flunisolide</i>	206, 231, 332		
<i>fenofibrate nanocrystallized</i>	106	<i>fluocinolone</i>	206, 362		
<i>fenofibric acid</i>	106				
<i>fenofibric acid (choline)</i>	106				

FREESTYLE LIBRE 2 SENSOR..178	<i>gentamicin-sodium citrate</i>.....9, 78	HADLIMA(CF) PUSHTOUCH.... 311
FREESTYLE LIBRE 3 PLUS	GENVOYA.....22, 24	HAEGARDA..... 320
SENSOR..... 178	GILENYA.....307	HAILEY.....241, 250, 262, 282
FREESTYLE LIBRE 3 READER..178	GILOTRIF..... 40	HAILEY 24 FE..... 250
FREESTYLE LIBRE 3 SENSOR..178	GIVLAARI..... 322	HAILEY FE 1.5/30 (28)..... 250
FREESTYLE LITE METER..... 178	GLASSIA.....77	HAILEY FE 1/20 (28)..... 250
FREESTYLE LITE STRIPS.....182	<i>glatiramer</i>.....293	<i>halcinonide</i>.....362
FREESTYLE PRECISION NEO	GLATOPA.....293	<i>halobetasol propionate</i> 362
METER..... 178	GLEEVEC..... 40	HALOETTE.....241, 250, 262, 282
FREESTYLE PRECISION NEO	GLEOSTINE.....40	HALOG.....363
STRIPS.....182	<i>glimepiride</i> 291	<i>haloperidol</i> 141
FREESTYLE TEST..... 182	<i>glipizide</i> 291	<i>haloperidol decanoate</i>.....140
FRINDOVYX..... 40, 299	<i>glipizide-metformin</i> 245, 291	<i>haloperidol lactate</i> 140
FROVA..... 169	GLOPERBA.....98, 315	HARLIKU.....192
<i>frovatriptan</i> 169	GLUCAGON (HCL)	HARVONI..... 20, 21
FRUZAQLA..... 40	EMERGENCY KIT..... 2, 265	HAVRIX (PF)..... 59
FULPHILA..... 80	GLUCAGON EMERGENCY KIT	HEATHER..... 241, 251, 282
<i>furosemide</i> 108, 186	(HUMAN).....2, 265	HEMANGEOL..... 70, 94, 101, 132
FUZEON.....21	GLUCOSE KETONE CONTROL	HEMGENIX..... 83, 117
FYARRO..... 40	SOLN..... 178	HEMICLOR..... 114, 191
FYCOMPA..... 125	<i>glutamine (sickle cell)</i>.....322	HEMLIBRA.....83, 84
FYLNETRA.....80	<i>glyburide</i> 291	HEMMOREX-HC..... 363
FYREMADEL..... 241	<i>glyburide micronized</i>.....291	HEMOFIL M HIGH..... 84
<i>gabapentin</i> 121, 122, 145	<i>glyburide-metformin</i>.....245, 291	HEMOFIL M LOW..... 84
GABARONE..... 122, 145	<i>glycopyrrolate</i> 65, 66, 354	HEMOFIL M MID.....84
<i>gadoteridol</i> 183	<i>glycopyrrolate (pf)</i> 65, 354	HEMOFIL M SUPER HIGH..... 84
GALAFOLD..... 192	GLYXAMBI..... 257, 289	<i>heparin (porcine)</i> 87
<i>galantamine</i>.....71	GOCOVRI..... 8, 67, 118	<i>heparin (porcine) in 0.9% nacl</i> 87, 178
GALBRIELA..... 250	GOMEKLI..... 40	<i>heparin, porcine (pf)</i> 87
GALZIN.....228	GONAL-F.....266	HEPLISAV-B (PF)..... 59
GAMASTAN.....56	GONAL-F RFF.....266	HEPSERA.....29
GAMIFANT.....299	GONAL-F RFF REDI-JECT..... 266	HERCEPTIN.....41
GAMMAGARD LIQUID.....56	GRAFAPEX.....40	HERCEPTIN HYLECTA.....41
GAMMAGARD S-D (IGA < 1	GRALISE..... 122, 145	HERNEXEOS.....41
MCG/ML)..... 56	<i>granisetron hcl</i> 216	HERZUMA.....41
GAMMAKED.....56	GRANIX..... 80	HETLIOZ.....148
GAMMAPLEX.....56	<i>griseofulvin microsize</i> 12	HETLIOZ LQ..... 148
GAMMAPLEX (WITH	<i>griseofulvin ultramicrosize</i> 12	HIBERIX (PF)..... 59
SORBITOL).....56	GUAIFENESIN DAC	HIZENTRA.....56
GAMUNEX-C..... 56	.....63, 153, 328, 330, 336	HORIZANT..... 122, 145
<i>ganciclovir sodium</i> 29, 201	<i>guanfacine</i>.....99	HULIO(CF).....312
<i>ganirelix</i> 241	GUARDIAN 4 GLUCOSE	HULIO(CF) PEN..... 312
GARDASIL 9 (PF)..... 59	SENSOR..... 178	HUMALOG JUNIOR KWIKPEN
<i>gatifloxacin</i>.....199	GUARDIAN 4 TRANSMITTER.. 178	U-100..... 270, 286
GATTEX 30-VIAL.....221	GUARDIAN LINK 3	HUMALOG KWIKPEN INSULIN
GATTEX ONE-VIAL.....221	TRANSMITTER.....178	.....270, 286
GAVILYTE-G..... 220	GUARDIAN SENSOR 3..... 178	HUMALOG MIX 50-50
GAVRETO.....40	GVOKE HYPOPEN 1-PACK... 2, 265	KWIKPEN..... 270, 274, 286
GAZYVA.....40	GVOKE HYPOPEN 2-PACK... 2, 265	HUMALOG MIX 75-25
<i>gefitinib</i> 40	GVOKE PFS 1-PACK SYRINGE	KWIKPEN..... 270, 275, 286
<i>gemfibrozil</i> 106	.....2, 265	HUMALOG MIX 75-25(U-
GEMMILY.....250	GVOKE PFS 2-PACK SYRINGE	100)INSULN.....270, 275, 286
GEMTESA.....380	.....3, 265	HUMALOG TEMPO PEN(U-
GENGRAF.....201, 295	GYNAZOLE-1.....355	100)INSULN.....271, 286
GENOTROPIN.....279	HADLIMA.....311	HUMALOG U-100 INSULIN
GENOTROPIN MINIQUICK..... 279	HADLIMA PUSHTOUCH.....311	.....271, 287
<i>gentamicin</i>.....9, 199, 349	HADLIMA(CF)..... 311	HUMATE-P..... 84

HUMATIN.....	8, 9	HYRIMOZ PEN CROHN'S-UC		INGREZZA INITIATION	
HUMATROPE.....	279	STARTER.....	312	PK(TARDIV).....	174
HUMIRA.....	312	HYRIMOZ PEN PSORIASIS		INGREZZA SPRINKLE.....	174
HUMIRA PEN.....	312	STARTER.....	312	INLYTA.....	42
HUMIRA(CF).....	312	HYRIMOZ(CF).....	312	INPEFA.....	289
HUMIRA(CF) PEN.....	312	HYRIMOZ(CF) PEDI CROHN		INQOVI.....	42
HUMIRA(CF) PEN CROHNS-		STARTER.....	312	INREBIC.....	42
UC-HS.....	312	HYRIMOZ(CF) PEN.....	312	<i>insulin degludec</i>	272, 276
HUMIRA(CF) PEN PSOR-UV-		HYSINGLA ER.....	155	<i>insulin glargine u-300 conc...</i>	272, 276
ADOL HS.....	312	<i>ibandronate</i>	319	<i>insulin glargine-yfgn</i>	272, 276, 277
HUMULIN 70/30 U-100 INSULIN		IBRANCE.....	41	<i>insulin lispro protamin-lispro</i>	
.....	271, 275, 288	IBSRELA.....	223	.....	272, 275, 287
HUMULIN 70/30 U-100		<i>ibuprofen</i>	164, 165	INSULIN SYRINGE.....	179
KWIKPEN.....	271, 275, 288	<i>icatibant</i>	96, 319	<i>insulin syringe-needle u-100</i>	179
HUMULIN N NPH INSULIN		ICLEVIA.....	241, 251, 262, 282	INTELENCE.....	23
KWIKPEN.....	271, 275	ICLUSIG.....	41	INTELISWAB COVID-19 HOME	
HUMULIN N NPH U-100		<i>icosapent ethyl</i>	109	TEST.....	179
INSULIN.....	271, 275	IDELVION.....	84	INTRAROSA.....	233
HUMULIN R REGULAR U-100		IDHIFA.....	41	INTROVALE.....	241, 251, 262, 282
INSULN.....	271, 288	IDOSE TR.....	214	INVEGA.....	135
HUMULIN R U-500 (CONC)		IHEALTH COVID-19 AG HOME		INVEGA HAFYERA.....	135
INSULIN.....	271, 288	TEST.....	178	INVEGA SUSTENNA.....	135
HUMULIN R U-500 (CONC)		IHEALTH GLUCO PLUS METER		INVEGA TRINZA.....	135
KWIKPEN.....	272, 288	.....	179	INVELTYS.....	208
HYCANTIN.....	41	ILARIS (PF).....	27, 337	INVOKAMET.....	245, 289
<i>hydralazine</i>	105	ILEVRO.....	212	INVOKAMET XR.....	245, 289
HYDREA.....	41	ILUMYA.....	368	INVOKANA.....	289
<i>hydrochlorothiazide</i>	113, 190	IMAAVY.....	306	<i>iopamidol</i>	183
<i>hydrocodone bitartrate</i>	154	<i>imatinib</i>	41	IOPIDINE.....	195
<i>hydrocodone-acetaminophen</i>		IMBRUVICA.....	41, 42	IPOL.....	60
.....	132, 133, 151, 152, 154	IMCIVREE.....	278	<i>ipratropium bromide</i>	66, 212, 329
<i>hydrocodone-chlorpheniramine</i>		IMDELLTRA.....	42	<i>ipratropium-albuterol</i>	66, 74, 329, 342
.....	5, 154, 331, 336	IMFINZI.....	42	IQIRVO.....	221
<i>hydrocodone-homatropine</i>		<i>imipramine hcl</i>	173	<i>irbesartan</i>	92
.....	66, 154, 331	<i>imipramine pamoate</i>	173	<i>irbesartan-hydrochlorothiazide</i>	
<i>hydrocodone-ibuprofen</i>	154, 164	<i>imiquimod</i>	351	.....	92, 113, 190
<i>hydrocortisone</i>	207, 232, 233, 363, 364	IMJUDO.....	42	IRESSA.....	42
<i>hydrocortisone acetate</i> ...	207, 232, 363	IMLYGIC.....	42, 117	<i>iron sucrose</i>	87
<i>hydrocortisone butyrate</i>	207, 232, 363	IMOVAX RABIES VACCINE		ISENTRESS.....	22
<i>hydrocortisone sod succinate</i>		(PF).....	60	ISIBLOOM.....	251
.....	207, 232, 363	IMPAVIDO.....	28	<i>isoniazid</i>	16
<i>hydrocortisone valerate</i>	208, 233, 364	IMULDOSA.....	301, 302	ISORDIL TITRADOSE.....	108
<i>hydrocortisone-acetic acid</i>		IMVEXXY MAINTENANCE		<i>isosorbide dinitrate</i>	108
.....	201, 233, 364	PACK.....	262	<i>isosorbide mononitrate</i>	108, 109
<i>hydrocortisone-pramoxine</i>	352, 364	IMVEXXY STARTER PACK.....	262	<i>isosorbide-hydralazine</i>	105, 109
<i>hydromorphone</i>	155	INBRIJA.....	143	<i>isotretinoin</i>	372
<i>hydromorphone (pf)-0.9 % nacl</i>	155	INCASSIA.....	241, 251, 282	<i>isradipine</i>	97, 104, 115
<i>hydromorphone in 0.9 % nacl</i>	155	INCRELEX.....	291	ISTALOL.....	202
<i>hydromorphone(pf)-nacl,iso-osm</i> ...	155	INCRUSE ELLIPTA.....	66, 329	ISTODAX.....	42
<i>hydroxychloroquine</i>	14, 296, 320, 321	<i>indapamide</i>	114, 191	ISTURISA.....	233
<i>hydroxyurea</i>	41	INDICAID COVID-19 AG HOME		ITOVEBI.....	42
<i>hydroxyzine hcl</i>	4, 5, 133	TEST.....	179	<i>itraconazole</i>	17
<i>hydroxyzine pamoate</i>	5, 134	<i>indomethacin</i>	165, 315	<i>ivabradine</i>	98
HYFTOR.....	306, 368	INFLECTRA.....	312	<i>ivermectin</i>	11, 377, 378
HYMPAVZI PEN.....	84	<i>infliximab</i>	313	IVRA.....	42
<i>hyoscyamine sulfate</i>	3, 66, 329	INFUGEM.....	42	IWILFIN.....	42
HYQVIA.....	56	INGREZZA.....	174	IXIARO (PF).....	60

IXINITY	84	KEPPRA XR	125	<i>lactulose</i>	184
IYUZEH (PF)	214	KERENDIA	108	LAGEVRIO (EUA)	29
IZERVAY (PF)	213, 295	KESIMPTA PEN	305	LAMICTAL XR STARTER	
JADENU	228	<i>ketamine in 0.9 % sod chloride</i>		(BLUE)	125
JADENU SPRINKLE	228	.....	127, 149	LAMICTAL XR STARTER	
JAIMIESS	251	<i>ketamine in nacl, iso-osmotic</i>	127, 149	(GREEN)	125
JAKAFI	42, 370	<i>ketoconazole</i>	17, 355	LAMICTAL XR STARTER	
JANUMET	245, 257	<i>ketoprofen</i>	165	(ORANGE)	125
JANUMET XR	245, 257	<i>ketorolac</i>	165, 212, 213	<i>lamivudine</i>	24
JANUVIA	257	KEVEYIS	319	<i>lamivudine-zidovudine</i>	24
JARDIANCE	289	KEVZARA	302	<i>lamotrigine</i>	125, 126, 128
JASMIEL (28)	251	KEYTRUDA	43	LAMPIT	15
JATENZO	238, 241	KHINDIVI	208, 233, 364	LAMZEDE	194
JAVYGTOR	192	KIMMTRAK	43	<i>lancets</i>	179
JAYPIRCA	42	KIMONO LUBRICATED		LANOXIN	98
JAYTHARI	233	CONDOMS	324	<i>lanreotide</i>	290
JELMYTO	42	KIMONO MICROTHIN AQUA		<i>lansoprazole</i>	226
JEMPERLI	42	LUBE CON	324	<i>lanthanum</i>	186
JENCYCLA	241, 251, 282	KIMONO MICROTHIN		LANTUS SOLOSTAR U-100	
JENTADUETO	246, 257	CONDOMS	324	INSULIN	272, 277
JENTADUETO XR	246, 257	KIMONO MICROTHIN LARGE		LANTUS U-100 INSULIN ...	272, 277
JINTELI	262, 282, 319	CONDOMS	324	<i>lapatinib</i>	43
JIVI	84	KIMONO TEXTURED		LARIN 1.5/30 (21)	241, 252, 262, 283
JOBEVNE	42	CONDOMS	324	LARIN 1/20 (21)	241, 252, 262, 283
JOENJA	321	KIMONO THIN LUBRICATED		LARIN 24 FE	252
JOLESSA	241, 251, 262, 282	CONDOMS	324	LARIN FE 1.5/30 (28)	252
JORNAY PM	161	KINERET	302	LARIN FE 1/20 (28)	252
JOURNAVX	122	KINRIX (PF)	60	<i>latanoprost</i>	214
JOYEAUX	251	KISQALI	43	LATUDA	135
JUBBONTI	294	KISUNLA	306	LAZCLUZE	43
JUBLIA	355	KITABIS PAK	9	<i>ledipasvir-sofosbuvir</i>	20, 21
JULEBER	251	KLAYESTA	31, 377	LEENA 28	241, 252, 262, 283
JULUCA	22, 23	KLOR-CON	188	LEFLUNICLO	297, 321
JUNEL 1.5/30 (21)	241, 251, 262, 282	KLOR-CON 10	188	<i>leflunomide</i>	305
JUNEL 1/20 (21)	241, 251, 262, 282	KLOR-CON 8	188	LEMTRADA	305
JUNEL FE 1.5/30 (28)	251	KLOR-CON M10	188	<i>lenalidomide</i>	43, 321
JUNEL FE 1/20 (28)	251	KLOR-CON M15	188	LENMELDY	117
JUNEL FE 24	251	KLOR-CON M20	188	LENTOCILIN S	27
JUXTAPID	108	KLOXXADO	3, 158	LENVIMA	43
JYLAMVO	42, 296	KOATE	84	LEQEMBI	306
JYNARQUE	192	KOGENATE FS	85	LEQVIO	93
KADCYLA	42	KONVOMEPEP	226	LESSINA	241, 252, 262, 283
KAITLIB FE	251	KORLYM	239	LETAIRIS	115, 343
KALBITOR	107	KORSUVA	352	<i>letrozole</i>	43, 239
KALETRA	25	KOSELUGO	43	<i>leucovorin calcium</i>	3
KALLIGA	251	KOVALTRY	85	LEUKERAN	43
KALYDECO	335	KRAZATI	43	LEUKINE	80
KANJINTI	42	KRINTAFEL	14	<i>leuprolide</i>	43, 266
KANUMA	194	KRISTALOSE	184	<i>levabuterol hcl</i>	74, 342
KARIVA (28)	251	KRYSTEXXA	316	<i>levabuterol tartrate</i>	74, 342
KATERZIA	97, 104, 115	KURVELO (28)	241, 251, 262, 282	<i>levamlodipine</i>	97, 104, 115
KAZANO	246, 258	KUVAN	192, 193	<i>levetiracetam</i>	126
KCENTRA	84	KYPROLIS	43	<i>levobunolol</i>	202
KEBILIDI	117	KYZATREX	238, 241	<i>levocarnitine</i>	322
KELNOR 1/35 (28)	251	<i>l norgest/e.estradiol-e.estradiol</i>	252	<i>levocarnitine (with sugar)</i>	322
KENALOG	208, 233, 333, 364	<i>labetalol</i>	70, 72, 90, 94, 101	<i>levocetirizine</i>	6, 340
KEPPRA	125	<i>lacosamide</i>	147	<i>levofloxacin</i>	16, 32, 199, 349

<i>levofloxacin in d5w</i>	16, 32, 199, 349	LOQTORZI.....	43	LYZA.....	242, 253, 283
<i>levoleucovorin calcium</i>	3	LORATA-D.....	6, 63, 328, 340	<i>mafenide acetate</i>	349
LEVONEST (28) ...	242, 252, 262, 283	<i>loratadine</i>	6, 340	<i>malathion</i>	377
<i>levonorgest-eth.estradiol-iron</i>	252	LORATADINE-D.....	6, 63, 328, 340	<i>maraviroc</i>	21
<i>levonorgestrel</i>	252	<i>lorazepam</i>	139, 140	MARGENZA.....	44
<i>levonorgestrel-ethinyl estrad</i>	242, 252, 263, 283	LORBRENA.....	43	MARLISSA (28)....	242, 253, 263, 283
<i>levonorg-eth estrad triphasic</i>	242, 252, 263, 283	LORYNA (28).....	252	MARPLAN.....	149
LEVORA-28.....	242, 252, 263, 283	LORZONE.....	68	MATERNACEL.....	88, 380, 382
<i>levorphanol tartrate</i>	155	<i>losartan</i>	92	MATULANE.....	44
LEVO-T.....	292	<i>losartan-hydrochlorothiazide</i>	92, 113, 190	MAVENCLAD (10 TABLET PACK).....	44, 293
<i>levothyroxine</i>	292	LOTEMAX.....	208	MAVENCLAD (4 TABLET PACK).....	44, 293
LEVOXYL.....	292	LOTEMAX SM.....	208	MAVENCLAD (5 TABLET PACK).....	44, 294
LEXETTE.....	364	<i>loteprednol etabonate</i>	208	MAVENCLAD (6 TABLET PACK).....	45, 294
LIALDA.....	218	<i>lovastatin</i>	107	MAVENCLAD (7 TABLET PACK).....	45, 294
LIBTAYO.....	43	LOW-OGESTREL (28)	242, 252, 263, 283	MAVENCLAD (8 TABLET PACK).....	45, 294
LICART.....	133, 165, 376	<i>loxapine succinate</i>	143	MAVENCLAD (9 TABLET PACK).....	45, 294
<i>lidocaine</i>	314, 352	LO-ZUMANDIMINE (28).....	253	MAVYRET.....	21
<i>lidocaine (pf)</i>	100, 314, 352	<i>lubiprostone</i>	221	MAXIDEX.....	208, 233
<i>lidocaine hcl</i>	213, 314, 352	LUCEMYRA.....	64	MAYZENT.....	307
<i>lidocaine hcl-hydrocortison ac</i>	314, 352, 364	LUCENTIS.....	215	MAYZENT STARTER(FOR 1MG MAINT).....	307
LIDOCAINE VISCOUS.....	213	LUMAKRAS.....	44	MAYZENT STARTER(FOR 2MG MAINT).....	307
<i>lidocaine-prilocaine</i>	314, 352	LUMIGAN.....	214	<i>meclizine</i>	5, 218
LIDOCAN III.....	314, 352	LUMIZYME.....	194	<i>meclofenamate</i>	166
LIDOCAN IV.....	314, 352	LUMRYZ.....	174, 316	MEDISENSE GLUCOSE KETONE.....	179
LIDOCAN V.....	314, 352	LUNSUMIO.....	44	MEDROL.....	233
<i>linezolid</i>	30	LUPKYNIS.....	308	<i>medroxyprogesterone</i>	283
LINZESS.....	223	LUPRON DEPOT.....	44, 267	<i>mefenamic acid</i>	166
<i>liothyronine</i>	292	LUPRON DEPOT (3 MONTH)	44, 266	<i>mefloquine</i>	14
LIPOFEN.....	106	LUPRON DEPOT (4 MONTH)	44, 266	<i>megestrol</i>	45, 283
<i>liraglutide</i>	123, 268	LUPRON DEPOT (6 MONTH)	44, 267	MEKINIST.....	45
<i>liraglutide (weight loss)</i>	123, 268	LUPRON DEPOT-PED.....	44, 267	MEKTOVI.....	45
<i>lisdexamfetamine</i>	120	LUPRON DEPOT-PED (3 MONTH).....	44, 267	MELEYA.....	242, 253, 283
<i>lisinopril</i>	93	<i>lurasidone</i>	136	<i>meloxicam</i>	166
<i>lisinopril-hydrochlorothiazide</i>	93, 113, 190	LUTERA (28).....	242, 253, 263, 283	<i>memantine</i>	142
LITEAIRE MDI CHAMBER.....	179	LUXTURNA.....	118	<i>memantine-donepezil</i>	71, 142
LITFULO.....	370	LUZU.....	355	MENEST.....	263
<i>lithium carbonate</i>	128, 129	LYBALVI.....	136	MENOPUR.....	267
LITHOSTAT.....	184	LYFGENIA.....	118	MENOSTAR.....	263, 319
LIVALO.....	107	LYLEQ.....	242, 253, 283	MENQUADFI (PF).....	60
LIVDELZI.....	221	LYNPARZA.....	44	MENVEO A-C-Y-W-135-DIP (PF).....	60
LIVIXIL PAK.....	314, 352	LYRICA.....	144, 145	<i>meperidine</i>	155
LIVMARLI.....	221	LYRICA CR.....	144, 145	<i>meprobamate</i>	149
LIVTENCITY.....	18	LYSODREN.....	44	MEPSEVII.....	194
LO LOESTRIN FE.....	252	LYTGOBI.....	44	<i>mercaptopurine</i>	45, 299
LODOCO.....	98, 316	LYUMJEV KWIKPEN U-100 INSULIN.....	272, 287	<i>meropenem</i>	18
<i>lofexidine</i>	64	LYUMJEV KWIKPEN U-200 INSULIN.....	272, 287	MERZEE.....	253
LOJAIMIESS.....	252	LYUMJEV TEMPO PEN(U- 100)INSULN.....	272, 287		
LOKELMA.....	187	LYUMJEV U-100 INSULIN.....	273, 287		
LOMAIRA.....	119				
LONSURF.....	43				
<i>loperamide</i>	217				
<i>lopinavir-ritonavir</i>	25				
LOPRESSOR.....	76, 94, 101				

<i>mesalamine</i>	218	<i>minocycline</i>	14, 34, 199, 349	NALTREX.....	76, 158
<i>mesalamine with cleansing wipe</i>	218	<i>minoxidil</i>	105, 357	<i>naltrexone</i>	76, 158
<i>mesna</i>	3	MIPLYFFA.....	193	NAMENDA XR.....	142
MESNEX.....	3	<i>mirabegron</i>	380	NAMZARIC.....	71, 142
MESTINON.....	71	MIRCERA.....	78, 80	NAPRELAN CR.....	166, 316
MESTINON TIMESPAN.....	71	<i>mirtazapine</i>	171	<i>naproxen</i>	166, 316
METADATE CD.....	162	MIRVASO.....	195, 345	<i>naproxen sodium</i>	166, 316
<i>metaxalone</i>	68	<i>misoprostol</i>	226	<i>naratriptan</i>	169
METDRAY.....	372	MITIGARE.....	98, 316	NARCAN.....	3, 158
<i>metformin</i>	246	<i>mitomycin (pf) in water</i>	200	NASCOBAL.....	382
<i>methadone</i>	155	M-M-R II (PF).....	60	NATACYN.....	200
<i>methadone in 0.9 % sod.chlorid</i>	155	MNEXSPIKE 2025-2026 (PF).....	60	NATAZIA.....	253
<i>methamphetamine</i>	120	<i>modafinil</i>	174	<i>nateglinide</i>	278
<i>methazolamide</i>	203	<i>moexipril</i>	93	NAYZILAM.....	139, 140
<i>methenamine hippurate</i>	35	<i>mometasone</i>	208, 233, 234, 333, 364, 365	<i>neбиволол</i>	70, 95, 101
<i>methimazole</i>	245	MONDOXYNE NL... 14, 34, 199, 349		NECON 0.5/35 (28)	242, 253, 263, 284
<i>methocarbamol</i>	68	MONJUVI.....	45	NEEVODHA (WITH ALGAL OIL).....	88, 380, 382
<i>methohexital</i>	137, 138	MONOFERRIC.....	88	<i>nefazodone</i>	171
<i>methotrexate sodium</i>	45, 297	MONO-LINYAH.....	253	<i>nelarabine</i>	45
<i>methotrexate sodium (pf)</i>	45, 297	montelukast.....	337	NEMLUVIO.....	368
<i>methoxsalen</i>	376	<i>morphine</i>	155, 156	NEOMATERNA.....	88, 380, 383
<i>methscopolamine</i>	66	<i>morphine concentrate</i>	155	<i>neomycin</i>	9, 199, 349
<i>methsuximide</i>	172	MOTEGRITY.....	225	<i>neomycin-polymyxin b-dexameth</i>	9, 31, 199, 209, 350
<i>methyl dopa</i>	99	MOTPOLY XR.....	147	<i>neomycin-polymyxin-hc</i>	31, 199, 209, 350
<i>methylene blue (antidote)</i>	4	MOUNJARO.....	123, 268	NERLYNX.....	45
<i>methylphenidate</i>	162	MOVANTIK.....	224	NESINA.....	258
<i>methylphenidate hcl</i>	162	<i>moxifloxacin</i>	32, 199, 349	NEULASTA.....	80
<i>methylprednisolone</i>	233	MULPLETA.....	80	NEULASTA ONPRO.....	80
<i>methyltestosterone</i>	238, 242	MULTAQ.....	102	NEUPOGEN.....	80
<i>metoclopramide hcl</i>	225	MULTI-VITAMIN WITH FLUORIDE.....	320, 380	NEUPRO.....	150
<i>metolazone</i>	114, 191	<i>mupirocin</i>	349	NEVANAC.....	213
METOPIRONE.....	183	<i>mupirocin calcium</i>	349	<i>nevirapine</i>	23
<i>metoprolol succinate</i>	76, 94, 101	MVASI.....	45	NEW DAY.....	253
<i>metoprolol ta-hydrochlorothiaz</i>	76, 95, 101, 113, 190	MY CHOICE.....	253	NEXAVAR.....	46
<i>metoprolol tartrate</i>	76, 95, 101	MY WAY.....	253	NEXIUM PACKET.....	227
METROGEL.....	8, 28, 219, 349	MYALEPT.....	276	NEXLETOL.....	90
<i>metronidazole</i> ...8, 9, 28, 219, 220, 349		MYCAPSSA.....	290	NEXLIZET.....	90
<i>metyrosine</i>	183	<i>mycophenolate mofetil</i>	294	NEXPLANON.....	242, 253, 284
<i>mexiletine</i>	100	<i>mycophenolate sodium</i>	294	NEXTSTELLIS.....	253
<i>micafungin</i>	19	MYDAYIS.....	120	NEXVIAZYME.....	194
<i>micafungin in 0.9 % sodium chl</i>	19	MYDCOMBI.....	214	NGENLA.....	279
MICONAZOLE-3.....	355	MYFEMBREE.....	242, 263, 284	<i>niacin</i>	94, 383
MICORT-HC.....	208, 233, 364	MYHIBBIN.....	294	<i>nicardipine</i>	104
MICROGESTIN 1.5/30 (21)	242, 253, 263, 283	MYLERAN.....	45	<i>nicardipine in nacl (iso-os)</i>	97, 104, 115
MICROGESTIN 1/20 (21)	242, 253, 263, 284	MYLOTARG.....	45	NICORETTE.....	76
MICROGESTIN FE 1.5/30 (28)....	253	MYRBETRIQ.....	380	<i>nicotine</i>	76
MICROGESTIN FE 1/20 (28).....	253	MYSOLINE.....	137	<i>nicotine (polacrilex)</i>	76
<i>midazolam</i>	140	MYTESI.....	217	NICOTROL NS.....	77
<i>midodrine</i>	64	<i>nabumetone</i>	166	<i>nifedipine</i>	97, 104, 115, 116
MIEBO (PF).....	201	<i>nadolol</i>	76, 95, 101	NIKKI (28).....	253
<i>mifepristone</i>	239	<i>naftifine</i>	345	NIKTIMVO.....	322
<i>miglitol</i>	237	NAFTIN.....	345	<i>nilotinib hcl</i>	46
MILI.....	253	NAGLAZYME.....	194		
MIMVEY.....	263, 284, 319	NALFON.....	166		
		<i>naloxone</i>	3, 158		

<i>nimodipine</i>	104	NOVOLIN R REGULAR U100		<i>ofloxacin</i>	32, 199
NINLARO.....	46	INSULIN.....	273, 288	OGIVRI.....	46
<i>nisoldipine</i>	105	NOVOLOG FLEXPEN U-100		OGSIVEO.....	46
<i>nitazoxanide</i>	15	INSULIN.....	273, 287	OHTUVAYRE.....	335
<i>nitisinone</i>	193	NOVOLOG MIX 70-30 U-100		OJEMDA.....	46
NITRO-BID.....	109, 356	INSULIN.....	273, 276, 287	OJJAARA.....	46
NITRO-DUR.....	109	NOVOLOG MIX 70-30FLEXPEN		<i>olanzapine</i>	129, 136, 217
<i>nitrofurantoin</i>	35	U-100.....	273, 276, 287	<i>olanzapine-fluoxetine</i>	
<i>nitrofurantoin macrocrystal</i>	35	NOVOLOG PENFILL U-100		.....	129, 136, 171, 217
<i>nitrofurantoin monohyd/m-cryst</i>	35	INSULIN.....	273, 287	<i>olmesartan</i>	92
<i>nitroglycerin</i>	109, 356	NOVOLOG U-100 INSULIN		<i>olmesartan-amlodipin-hcthiazyd</i>	
NITROSTAT.....	109	ASPART.....	273, 287	.....	92, 97, 105, 113, 190
NITRO-TIME.....	109	NOVOPEN ECHO.....	179	<i>olmesartan-hydrochlorothiazide</i>	
NITYR.....	193	NOVOSEVEN RT.....	85	.....	92, 113, 190
NIVESTYM.....	80	NOXAFIL.....	17	<i>olopatadine</i>	196
<i>nizatidine</i>	5, 223	NP THYROID.....	292	OLPRUVA.....	184
NOC DURNA (MEN).....	85, 279	NPLATE.....	81	OLUMIANT.....	305
NOC DURNA (WOMEN).....	85, 279	NUBEQA.....	46	OMECLAMOX-PAK.....	11, 30, 227
NORA-BE.....	242, 254, 284	NUCALA.....	337	<i>omega-3 acid ethyl esters</i>	109
NORDITROPIN FLEXPRO.....	279	NUCYNTA.....	156	<i>omeprazole</i>	227
<i>norelgestromin-ethin.estradiol</i>		NUCYNTA ER.....	156	OMISIRGE.....	117
.....	242, 254, 263, 284	NUEDEXTA.....	142, 331	OMNIPOD 5 (G6/LIBRE 2 PLUS)	
<i>norepinephrine bitart in water</i>	63	NULIBRY.....	322	.....	179
<i>norepinephrine bitartrate-nacl</i>	63	NUPLAZID.....	136	OMNIPOD 5 G6-G7 INTRO	
<i>noreth-ethinyl estradiol-iron</i>	254	NURTEC ODT.....	141	KT(GEN5).....	179
<i>norethindrone (contraceptive)</i>		NUTROPIN AQ NUSPIN.....	279, 280	OMNIPOD 5 G6-G7 PODS (GEN	
.....	242, 254, 284	NUVARING.....	243, 254, 264, 284	5).....	180
<i>norethindrone acetate</i>	284	NUVAXOVID 2025-2026 (PF).....	60	OMNIPOD 5	
<i>norethindrone ac-eth estradiol</i>		NUVESSA.....	9, 28, 220, 350	INTRO(G6/LIBRE2PLUS).....	180
.....	242, 254, 263, 284, 319	NUVIGIL.....	175	OMNIPOD DASH PODS (GEN 4)	
<i>norethindrone-e.estradiol-iron</i>	254	NUWIQ.....	85	.....	180
<i>norgestimate-ethinyl estradiol</i>	254	NUZYRA.....	10	OMNITROPE.....	280
NORITATE.....	9, 28, 220, 350	NYLIA 1/35 (28).....	243, 254, 264, 284	OMVOH.....	223
NORTHERA.....	63	NYLIA 7/7/7 (28).....	243, 254, 264, 284	OMVOH PEN.....	223
NORTREL 0.5/35 (28)		NYPOZI.....	81	ONAPGO.....	150
.....	243, 254, 263, 284	<i>nystatin</i>	31, 377	<i>ondansetron</i>	217
NORTREL 1/35 (21)		<i>nystatin-triamcinolone</i>		<i>ondansetron hcl</i>	216
.....	243, 254, 264, 284	.....	209, 234, 333, 365	<i>ondansetron hcl (pf)</i>	216
NORTREL 1/35 (28)		NYVEPRIA.....	81	ONEXTON.....	26, 350, 372
.....	243, 254, 264, 284	OB COMPLETE.....	88, 381, 383	ONFI.....	139, 140
NORTREL 7/7/7 (28)		OB COMPLETE ONE		ONGENTYS.....	141
.....	243, 254, 264, 284	.....	88, 188, 381, 383	ON-GO COVID-19 AG AT	
<i>nortriptyline</i>	173	OB COMPLETE PETITE.....	88, 381, 383	HOME TEST.....	180
NORVIR.....	25	OB COMPLETE PREMIER		ONPATTRO.....	322
NOURIANZ.....	118	.....	88, 188, 381, 383	ONTRUZANT.....	46
NOVAREL.....	267	OB COMPLETE WITH DHA		ONUREG.....	46
NOVOEIGHT.....	85	.....	88, 381, 383	ONYDA XR.....	64, 99
NOVOFINE 32.....	179	OALIVA.....	221	ONZETRA XSAIL.....	169
NOVOFINE PLUS.....	179	OCELLA.....	254	OPCICON ONE-STEP.....	255
NOVOLIN 70/30 U-100 INSULIN		OCREVUS.....	305	OPDIVO.....	46
.....	273, 275, 288	OCREVUS ZUNOVO.....	321	OPDUALAG.....	46
NOVOLIN 70-30 FLEXPEN U-		OCTAGAM.....	56, 57	OPFOLDA.....	193
100.....	273, 275, 288	<i>octreotide acetate</i>	290	OPIPZA.....	129, 136
NOVOLIN N FLEXPEN.....	273, 275	<i>octreotide,microspheres</i>	290	OPSUMIT.....	116, 343
NOVOLIN N NPH U-100		ODEFSEY.....	23, 24, 29	OPSYNVI.....	110, 116, 343
INSULIN.....	273, 276	ODOMZO.....	46	OPTICHAMBER DIAMOND LG	
NOVOLIN R FLEXPEN.....	273, 288	OFEV.....	330	MASK.....	180

OPTICHAMBER DIAMOND VHC.....	180	<i>oxymorphone</i>	157	PENMENVY MEN A-B-C-W-Y (PF).....	60
OPTICHAMBER DIAMOND-MED MSK.....	180	<i>oxytocin in 0.9 % sod chloride</i>	326	PENMENVY MENACWY COMPONENT(PF).....	60
OPTICHAMBER DIAMOND-SML MASK.....	180	<i>oxytocin in lactated ringers</i>	326	PENMENVY MENB COMPONENT (PF).....	60
OPTION-2.....	255	OZEMPIC.....	123, 268	PENNSAID.....	133, 166, 376
OPZELURA.....	46, 370	OZOBAX DS.....	69	PENTACEL ACTHIB COMPONENT (PF).....	60
ORACEA.....	14, 34, 199, 350	OZURDEX.....	209, 234	PENTAM.....	15
ORENCIA.....	296	PACERONE.....	102	<i>pentamidine</i>	15
ORENCIA (WITH MALTOSE)....	296	<i>paclitaxel protein-bound</i>	47	PENTASA.....	218, 219
ORENCIA CLICKJECT.....	296	PADCEV.....	47	<i>pentazocine-naloxone</i>	159
ORENITRAM.....	116, 344	PALFORZIA (LEVEL 0).....	54	<i>pentoxifylline</i>	82
ORENITRAM MONTH 1 TITRATION KT.....	116, 343	PALFORZIA (LEVEL 1).....	54	<i>perampanel</i>	126
ORENITRAM MONTH 2 TITRATION KT.....	116, 344	PALFORZIA (LEVEL 2).....	54	PERFOROMIST.....	74, 342
ORENITRAM MONTH 3 TITRATION KT.....	116, 344	PALFORZIA (LEVEL 3).....	54	<i>perindopril erbumine</i>	93
ORFADIN.....	193	PALFORZIA (LEVEL 4).....	54	PERIOGARD.....	202, 354
ORGOVYX.....	46, 243	PALFORZIA (LEVEL 5).....	55	PERJETA.....	47
ORIAHNN.....	243, 264, 284	PALFORZIA (LEVEL 6).....	55	<i>permethrin</i>	377
ORILISSA.....	243	PALFORZIA (LEVEL 7).....	55	<i>perphenazine</i>	160
ORKAMBI.....	334, 335	PALFORZIA (LEVEL 8).....	55	<i>perphenazine-amitriptyline</i>	160, 173
ORLADEYO.....	108	PALFORZIA (LEVEL 9).....	55	PERTZYE.....	222
<i>orlistat</i>	223	PALFORZIA (LEVEL 10).....	55	PHEBURANE.....	184
ORLYNVAH.....	35	PALFORZIA (LEVEL 11 UP-DOSE).....	55	<i>phenazopyridine</i>	352
<i>orphenadrine citrate</i>	69	PALFORZIA INITIAL (1-3 YRS)..	55	<i>phenelzine</i>	149
<i>orphenadrine-asa-caffeine</i>	76, 167	PALFORZIA INITIAL (4-17 YRS)	55	<i>phenobarbital</i>	137, 138
ORPHENGESIC FORTE.....	76, 167	PALFORZIA LEVEL 11 MAINTENANCE.....	55	<i>phenoxybenzamine</i>	71
ORQUIDEA.....	243, 255, 285	<i>paliperidone</i>	136	<i>phentermine</i>	119
ORSERDU.....	47	<i>palonosetron</i>	217	<i>phentermine-topiramate</i>	122
ORTIKOS.....	234	PALYNZIQ.....	194	<i>phenylephrine hcl</i>	64, 214, 216
<i>oseltamivir</i>	27	PANCREAZE.....	222	<i>phenylephrine hcl in 0.9% nacl</i>	64
OSENI.....	258, 292	PANRETIN.....	351	<i>phenylephrine in sterile water</i>	64
OSMOLEX ER.....	8, 67, 118	<i>pantoprazole</i>	227	PHENYTEK.....	100, 146
OSPHENA.....	259	<i>pantoprazole in 0.9% sod chlor</i>	227	<i>phenytoin</i>	100, 146
OTEZLA.....	306	PANZYGA.....	57	<i>phenytoin sodium extended</i>	100, 146
OTEZLA STARTER.....	306	<i>paricalcitol</i>	384	PHESGO.....	47
OTOVEL.....	32, 200, 209	PAROEX ORAL RINSE.....	202, 354	PHEXXI.....	324
OTULFI.....	302	<i>paroxetine hcl</i>	171	PHILITH.....	243, 255, 264, 285
OVACE PLUS.....	374	PATADAY ONCE DAILY RELIEF.....	196	PHOTREXA CROSS-LINKING KIT.....	212
OVACE PLUS SHAMPOO.....	374	PAVBLU.....	216	PHYRAGO.....	47
OVACE PLUS WASH.....	375	PAXIL.....	171	PIASKY.....	295
OVIDREL.....	267	PAXLOVID.....	18	PIFELTRO.....	23
<i>oxaprozin</i>	166	<i>pazopanib</i>	47	<i>pilocarpine hcl</i>	71, 213
<i>oxazepam</i>	140	PEDIARIX (PF).....	57, 60	<i>pimecrolimus</i>	368
<i>oxcarbazepine</i>	147	PEDVAX HIB (PF).....	60	<i>pimozide</i>	143
OXERVATE.....	201	<i>peg 3350-electrolytes</i>	220	PIMTREA (28).....	255
<i>oxiconazole</i>	355	<i>peg3350-sod sul-nacl-kcl-asb-c</i>	220	<i>pindolol</i>	70, 95, 101
OXLUMO.....	322	PEGASYS.....	25, 47, 300	<i>pioglitazone</i>	292
OXTELLAR XR.....	147	<i>peg-electrolyte soln</i>	220	<i>pioglitazone-metformin</i>	246, 292
<i>oxybutynin chloride</i>	379	PEMAZYRE.....	47	PIQRAY.....	47
<i>oxycodone</i>	156	PEMFEXY.....	47	<i>pirfenidone</i>	330
<i>oxycodone-acetaminophen</i>	133, 152, 156, 157	PEN NEEDLE.....	180	<i>piroxicam</i>	167
OXYCONTIN.....	157	<i>pen needle, diabetic</i>	180	<i>pitavastatin calcium</i>	107
		PENBRAYA (PF).....	60	PLASMA-LYTE 148 PH 7.4.....	189
		<i>penciclovir</i>	353	PLATINUM GLUCOSE METER.....	180
		<i>penicillamine</i>	3, 228		
		<i>penicillin v potassium</i>	27		

PLATINUM TEST STRIP	183	PRENATE DHA (FERR ASP GLYCIN).....	88, 381, 383	<i>propranolol</i>	70, 95, 101, 133
PLEGRIDY	300	PRENATE ELITE (IRON ASP GLYC).....	88, 381, 383	<i>propylthiouracil</i>	245
PLENVU	220	PRENATE ENHANCE....	89, 381, 383	PROQUAD (PF).....	61
PNEUMOVAX-23.....	61	PRENATE ESSENTIAL(IRON- ASP-GL).....	89, 381, 384	PROTONIX.....	227
PNV-DHA.....	88, 381, 383	PRENATE MINI (FERR ASP GLYCIN).....	89, 381, 384	<i>protriptyline</i>	173
POCKET CHAMBER.....	180	PRENATE PIXIE.....	89, 382, 384	<i>prucalopride</i>	225
<i>podofilox</i>	372	PRENATE RESTORE....	89, 382, 384	PRUDOXIN.....	173, 353
<i>polyethylene glycol 3350</i>	220	PREVNAR 20 (PF).....	61	PRURADIK.....	377
<i>polymyxin b sulf-trimethoprim</i>	31, 200, 350	PREVYMIS.....	18	PULMICORT.....	235
POMALYST.....	47, 321	PREZCOBIX.....	25, 322	PULMICORT FLEXHALER.....	235
POMBILITI.....	194	PREZISTA.....	25	PULMOZYME.....	194, 337
PONVORY.....	307	PRIALT.....	152	PURIXAN.....	47, 299
PONVORY 14-DAY STARTER PACK.....	307	PRIFTIN.....	16, 32	PYLERA.....	14, 34, 220, 350
PORTIA 28.....	243, 255, 264, 285	PRIOSEC.....	227	<i>pyrazinamide</i>	16
<i>posaconazole</i>	17, 18	PRIMACARE.....	89, 382, 384	<i>pyridostigmine bromide</i>	71
POSFREA.....	217	<i>primaquine</i>	14	<i>pyrimethamine</i>	14
<i>potassium chloride</i>	189	PRIMATENE MIST.....	64, 328	PYRUKYND.....	78
<i>potassium chloride in water</i>	189	<i>primidone</i>	137	PYZCHIVA.....	302
<i>potassium citrate</i>	183	PRIORIX (PF).....	61	PYZCHIVA AUTOINJECTOR....	302
<i>potassium phos in 0.9 % nacl</i>	189	PRISTIQ.....	168	QALSODY.....	121
POTELIGEO.....	47	PRIVIGEN.....	57	QBREXZA.....	354
PRADAXA.....	79	PRO COMFORT SPACER- ADULT MASK.....	180	QDOLO.....	157
PRALUENT PEN.....	110	PRO COMFORT SPACER- CHILD MASK.....	180	QELBREE.....	163
<i>pramipexole</i>	150	PROAIR DIGIHALER.....	75, 342	QFITLIA.....	85
PRAMOSONE.....	352, 365	PROAIR RESPICLICK.....	75, 342	QFITLIA PEN.....	85
<i>prasugrel hcl</i>	90	<i>probenecid</i>	191, 316	QINLOCK.....	47
<i>pravastatin</i>	107	<i>probenecid-colchicine</i>	192, 316	QNASL.....	210, 235, 333
<i>praziquantel</i>	11	PROCHAMBER.....	180	QSYMIA.....	122
<i>prazosin</i>	91	<i>prochlorperazine</i>	160, 218	QUADRACEL (PF).....	61
PRECISION XTRA B-KETONE..	180	<i>prochlorperazine maleate</i>	160, 218	<i>quazepam</i>	140
PRECISION XTRA MONITOR...	180	PROCRIT.....	81	<i>quetiapine</i>	129, 136
PRECISION XTRA TEST.....	183	PROCTOCORT.....	365	QUICKVUE AT-HOME COVID- 19 TEST.....	180
PRED MILD.....	209, 234	PROCTOFOAM HC.....	353, 365	QUILLICHEW ER.....	163
<i>prednicarbate</i>	365	PROCTO-MED HC.....	209, 234, 365	QUILLIVANT XR.....	163
<i>prednisolone</i>	209, 234	PROCTOSOL HC.....	209, 234, 365	<i>quinapril</i>	93
<i>prednisolone acetate</i>	209, 234	PROCTOZONE-HC.....	209, 235, 365	<i>quinapril-hydrochlorothiazide</i>	93, 113, 191
<i>prednisolone sodium phosphate</i>	209, 234	PROCYSBI.....	322	<i>quinidine gluconate</i>	14, 99
<i>prednisone</i>	234	PROFILNINE.....	85	<i>quinidine sulfate</i>	14, 99
PREDNISONE INTENSOL.....	234	<i>progesterone</i>	285	<i>quinine sulfate</i>	14
<i>pregabalin</i>	144, 145, 146	<i>progesterone micronized</i>	285	QULIPTA.....	141
PREGNYL.....	267	PROLASTIN-C.....	77	QUTENZA.....	379
PREMARIN.....	264	PROLIA.....	294	QUVIVIQ.....	159
PREMPHASE.....	264	PROMACTA.....	81	QUZYTIR.....	6, 340
PREMPRO.....	264	<i>promethazine</i>	5, 134, 222, 336	QVAR REDIHALER.....	235
PRENATABS FA....	88, 189, 381, 383	<i>promethazine-codeine</i>	134, 157, 222, 331, 336	RABAVERT (PF).....	61
PRENATABS RX....	88, 189, 381, 383	<i>promethazine-dm</i>	5, 134, 222, 331, 336	<i>rabeprazole</i>	227
PRENATAL.....	88, 381, 383	PROMETHEGAN.....	5, 134, 222	RADICAVA.....	121
PRENATAL PLUS (CALCIUM CARB).....	88, 189, 381, 383	<i>propafenone</i>	100	RADICAVA ORS.....	121
PRENATAL VITAMIN PLUS LOW IRON.....	88, 189, 381, 383	<i>proparacaine</i>	213	RADICAVA ORS STARTER KIT SUSP.....	121
PRENATE CHEWABLE	189, 381, 383			<i>raloxifene</i>	259, 319

<i>rasagiline</i>	148, 149	<i>rimantadine</i>	8	SANDIMMUNE.....	201, 295
RASUVO (PF).....	48, 297	RINVOQ.....	305	SANDOSTATIN LAR DEPOT.....	290
RAVICTI.....	184	RINVOQ LQ.....	305	SANTYL.....	194, 356
RAYALDEE.....	384	RIOMET.....	246	SAPHNELO.....	299
RAYOS.....	235	<i>risedronate</i>	319	SAPHRIS.....	129, 137
REBIF (WITH ALBUMIN).....	300	RISPERDAL CONSTA.....	129, 136	<i>sapropterin</i>	193
REBIF REBIDOSE.....	300	<i>risperidone</i>	129, 136, 137	SARCLISA.....	49
REBIF TITRATION PACK.....	300	<i>risperidone microspheres</i>	129, 136	SAVELLA.....	144, 168, 169
REBINYN.....	85	RITEFLO AEROCHAMBER.....	180	<i>saxagliptin</i>	258
REBLOZYL.....	78, 81	<i>ritonavir</i>	25	<i>saxagliptin-metformin</i>	246, 258
RECLIPSEN (28).....	255	RITUXAN.....	49, 297	SAXENDA.....	123, 268
RECOMBINATE.....	85	RITUXAN HYCELA.....	49, 297	SCALACORT.....	210, 235, 365
RECOMBIVAX HB (PF).....	61	<i>rivaroxaban</i>	78	SCALACORT DK.....	210, 235, 365
RECORLEV.....	235	<i>rivastigmine</i>	72	SCSEMBLIX.....	49
RECTIV.....	109, 356	<i>rivastigmine tartrate</i>	72	SCENESSE.....	278, 324, 379
RELENZA DISKHALER.....	27	RIVELSA.....	255	<i>scopolamine base</i>	66, 218, 224
RELEUKO.....	81	RIVFLOZA.....	322	SECUADO.....	129, 137
RELEXXII.....	163	RIXUBIS.....	86	SEGLUROMET.....	246, 289
RELISTOR.....	224	<i>rizatriptan</i>	169	SELARSDI.....	302
RELPAK.....	169	ROCKLATAN.....	200, 214, 215	<i>selegiline hcl</i>	148, 149
REMICADE.....	313	<i>roflumilast</i>	337, 376	<i>selenium sulfide</i>	354
REMODULIN.....	116, 344	ROLVEDON.....	81	SELZENTRY.....	21
RENFLEXIS.....	313	<i>romidepsin</i>	49	SEMGLEE(INSULIN	
REVELA.....	186	ROMVIMZA.....	49	GLARGINE-YFGN).....	273, 277
<i>repaglinide</i>	278	<i>ropinirole</i>	150	SEMGLEE(INSULIN GLARG-	
REPATHA PUSHTRONEX.....	110	<i>ropivacaine (pf)</i>	314	YFGN)PEN.....	274, 277
REPATHA SURECLICK.....	110	<i>ropivacaine(pf)-0.9 % sodchlor</i>	314	SE-NATAL 19.....	89
REPATHA SYRINGE.....	110	<i>rosuvastatin</i>	107	SENSIPAR.....	245
RESTASIS.....	201, 295	ROSYRAH.....	255	SEPHIENCE.....	193
RESTASIS MULTIDOSE.....	201, 295	ROXYBOND.....	157	SEREVENT DISKUS.....	75, 342
RESTORIL.....	140	ROZLYTREK.....	49	SERNIVO.....	235, 365
RETACRIT.....	81	RUBRACA.....	49	SEROQUEL.....	129, 137
RETEVMO.....	48	RUCONEST.....	320	SEROQUEL XR.....	130, 137
RETIN-A.....	48, 357	<i>rufinamide</i>	147	SEROSTIM.....	280
RETIN-A MICRO.....	48, 357	RUKOBIA.....	21	<i>sertraline</i>	171
RETIN-A MICRO PUMP.....	48, 357	RUXIENCE.....	49, 297	SETLAKIN.....	243, 255, 264, 285
REVATIO.....	110, 338	RYALTRIS 5, 196, 210, 235, 333, 365		<i>sevelamer carbonate</i>	186
REVCIVI.....	194	RYBELSUS.....	123, 268	<i>sevelamer hcl</i>	187
REVLIMID.....	48, 321	RYBREVANT.....	49	SEVENFACT.....	86
REVUFORJ.....	48	RYDAPT.....	49	SEYSARA.....	10
REXULTI.....	136	RYLAZE.....	49, 194	SHAROBEL.....	243, 255, 285
REYATAZ.....	25	RYPLAZIM.....	77	SHINGRIX (PF).....	61
REYVOW.....	169	RYSTIGGO.....	306	SIGNIFOR.....	290
REZDIFFRA.....	292	RYTARY.....	143	SIGNIFOR LAR.....	290
REZLIDHIA.....	48	RYTELO.....	49	SIKLOS.....	49
REZUROCK.....	322	SABRIL.....	146	<i>sildenafil</i>	110, 338
REZVOGLAR KWIKPEN....	273, 277	<i>sacubitril-valsartan</i>	91	<i>sildenafil (pulm.hypertension)</i>	110, 338
RHOGAM ULTRA-FILTERED		SAFYRAL.....	255	SILENOR.....	173
PLUS.....	57	SAIZEN SAIZENPREP.....	280	SILIQ.....	368
RHOPRESSA.....	200, 215	SAJAZIR.....	96, 319	<i>silodosin</i>	72
RIABNI.....	49, 297	SALICATE.....	372	<i>silver sulfadiazine</i>	354
RIASTAP.....	86	<i>salicylic acid</i>	372, 373	SIMBRINZA.....	196, 203
<i>ribavirin</i>	29	<i>salicylic acid-ceramides no.1</i>	373	SIMLANDI(CF).....	313
RIDAURA.....	227, 297, 321	SALIVAMAX.....	181	SIMLANDI(CF)	
<i>rifabutin</i>	16, 32	SALYCIM.....	373	AUTOINJECTOR.....	313
<i>rifampin</i>	16, 32	SAMSCA.....	192	SIMLIYA (28).....	255
<i>riluzole</i>	121	SANCUSO.....	217	SIMPESSE.....	255

SIMPONI.....	313	SPRIX.....	167, 213	SYMTUZA.....	24, 25
SIMPONI ARIA.....	313	SPRYCEL.....	49, 50	SYNAGIS.....	27
<i>simvastatin</i>	107	SPS (WITH SORBITOL).....	187	SYNDROS.....	223
SINUVA.....	210, 236, 365	SRONYX.....	243, 255, 264, 285	SYNJARDY.....	247, 289
<i>sirolimus</i>	306, 368	SSD.....	354	SYNJARDY XR.....	247, 290
SIRTURO.....	16	STAMARIL (PF).....	61	SYNTHROID.....	292
<i>sitagliptin</i>	258	STEGLATRO.....	289	SYPRINE.....	228
<i>sitagliptin-metformin</i>	246, 258	STEGLUJAN.....	258, 289	TABLOID.....	50
SIVEXTRO.....	30	STELARA.....	302, 303	TABRECTA.....	50
SKYCLARYS.....	322	STENDRA.....	111	TACLONEX.....	356
SKYRIZI.....	368, 369	STEQEYMA.....	303	<i>tacrolimus</i>	295, 369
SKYSONA.....	118	STEQEYMA I.V.....	303	<i>tadalafil</i>	111, 338, 339
SKYTROFA.....	280	STIMUFEND.....	81	<i>tadalafil (pulm. hypertension)</i>	111, 338
SLYND.....	243, 255, 285	STIOLTO RESPIMAT		TADLIQ.....	111, 344
<i>sodium chloride</i>	181, 186, 189	.....	66, 75, 329, 342	TAFINLAR.....	50
<i>sodium chloride 3 % hypertonic</i>	189	STIVARGA.....	50	<i>tafluprost (pf)</i>	215
<i>sodium citrate</i>	78, 183	STRATAMARK.....	356	TAGRISSE.....	50
<i>sodium fluoride-pot nitrate</i>	175, 320	STRATATRIZ.....	356	TAKE ACTION.....	255
<i>sodium oxybate</i>	175, 316	STRENSIQ.....	195	TAKHZYRO.....	108
<i>sodium phenylbutyrate</i>	184	STRIBILD.....	22, 24	TALICIA.....	11, 32, 219, 227
<i>sodium,potassium,mag sulfates</i>	220	STRIVERDI RESPIMAT.....	75, 343	TALTZ AUTOINJECTOR.....	303
SOFDRA.....	354	SUBLOCADE.....	159	TALTZ AUTOINJECTOR (2	
<i>sofosbuvir-velpatasvir</i>	20, 21	SUBOXONE.....	159	PACK).....	303
SOGROYA.....	280	<i>succinylcholine chloride</i>	69	TALTZ AUTOINJECTOR (3	
SOHONOS.....	322	SUCRAID.....	195	PACK).....	303
<i>solifenacin</i>	379	<i>sucralfate</i>	226	TALTZ SYRINGE.....	303
SOLQUA 100/33..	123, 268, 274, 277	<i>sugammadex</i>	4	TALZENNA.....	50
SOLIRIS.....	295	<i>sugammadex in sterile water</i>	4	TAMIFLU.....	27, 28
SOLU-CORTEF.....	210, 236, 366	<i>sulfacetamide sodium</i>	200	<i>tamoxifen</i>	50, 259
SOLU-CORTEF ACT-O-VIAL		<i>sulfacetamide sodium (acne)</i>	375	<i>tamsulosin</i>	72
(PF).....	210, 236, 366	<i>sulfacetamide sodium-sulfur</i> ..	373, 375	TANLOR.....	68
SOLU-MEDROL.....	236	<i>sulfadiazine</i>	33	TARGADOX.....	14, 34, 200, 350
SOLU-MEDROL (PF).....	236	<i>sulfamethoxazole-trimethoprim</i>	33	TARGRETIN.....	50, 351
SOMATULINE DEPOT.....	291	SULFAMYLON.....	350	TARINA FE 1/20 (28).....	255
SOMAVERT.....	291	<i>sulfasalazine</i>	33, 219, 297	TARINA FE 1-20 EQ (28).....	255
SOOLANTRA.....	379	SULFATRIM.....	33	TARPEYO.....	236
<i>sorafenib</i>	49	<i>sulindac</i>	167	TASCENSO ODT.....	307
SORILUX.....	356	<i>sumatriptan</i>	169	TASIGNA.....	50
<i>sotalol</i>	70, 95, 102	<i>sumatriptan succinate</i>	169, 170	<i>tavorole</i>	376
SOTYKTU.....	370	SUMAXIN.....	373, 375	TAVALISSE.....	78
SOVALDI.....	20	<i>sunitinib malate</i>	50	TAVNEOS.....	296
SOVUNA.....	14, 297, 321	SUNLENCA.....	15	TAYTULLA.....	256
SPEVIGO.....	369	SUNOSI.....	175	<i>tazarotene</i>	373
SPIKEVAX 2025-2026(12Y		SUPPRELIN LA.....	50, 267	TAZORAC.....	373, 374
UP)(PF).....	61	SUPREP BOWEL PREP KIT.....	220	TAZVERIK.....	51
<i>spinosad</i>	377	SUSVIMO.....	216	TECELRA.....	118
SPINRAZA (PF).....	316	SUTAB.....	221	TECENTRIQ.....	51
SPIRIVA RESPIMAT.....	66, 329	SUTENT.....	50	TECENTRIQ HYBREZA.....	51
SPIRIVA WITH HANDIHALER		SYEDA.....	255	TECFIDERA.....	298
.....	66, 329	SYFOVRE (PF).....	213, 296	TECVAYLI.....	51
<i>spironolactone</i>	111, 112, 187	SYLVANT.....	50	TEFLARO.....	8
<i>spironolacton-hydrochlorothiaz</i>		SYMBICORT		TEGADERM FRAME STYLE....	326
.....	111, 112, 113, 188, 191	.....	75, 210, 236, 333, 343, 366	TEGADERM TRANSPARENT	
SPORANOX.....	18	SYMDEKO.....	335	DRESSING.....	326
SPRAVATO.....	149	SYMFI.....	23, 24	TEGLUTIK.....	121
SPRINTEC (28).....	255	SYMPAZAN.....	139, 140	<i>telmisartan</i>	92
SPRITAM.....	126	SYMPROIC.....	224	<i>telmisartan-amlodipine</i>	92, 105

<i>telmisartan-hydrochlorothiazid</i>	TIVICAY	22	TREXALL	52, 298
..... 92, 113, 191	<i>tizanidine</i>	68	<i>triamcinolone aceton-0.9% nacl</i>	..... 210, 236, 333, 366
<i>temazepam</i>	TNKASE	90, 195	<i>triamcinolone acetonide</i>	210, 211, 236, 237, 333, 334, 366, 367
TEMODAR	TOBI	9	<i>triamterene</i>	111, 188
<i>temozolomide</i>	TOBI PODHALER	9	<i>triamterene-hydrochlorothiazid</i>	..... 112, 113, 188, 191
TENIVAC (PF)	TOBRADEX	9, 200, 210	TRIANEX	211, 237, 334, 367
<i>tenofovir disoproxil fumarate</i>	TOBRADEX ST	10, 200, 210	<i>triazolam</i>	140
TENORMIN	<i>tobramycin</i>	10, 200	TRIBENZOR	92, 97, 105, 113, 191
TEPADINA	<i>tobramycin in 0.225 % nacl</i>	10	<i>trientine</i>	228
TEPEZZA	<i>tobramycin with nebulizer</i>	10	TRI-ESTARYLLA	256
TEPMETKO	<i>tobramycin-dexamethasone</i>	..... 10, 200, 210	<i>trifluoperazine</i>	160
TEPYLUTE	TOBREX	10, 200	<i>trifluridine</i>	201
<i>terazosin</i>	<i>tolcapone</i>	142	<i>trihexyphenidyl</i>	67, 124
<i>terbinafine hcl</i>	TOLECTIN 600	152	TRIJARDY XR	247, 258, 290
<i>terbutaline</i>	<i>tolmetin</i>	152	TRIKAFTA	335
<i>terconazole</i>	TOLSURA	18	TRI-LEGEST FE	256
<i>teriflunomide</i>	<i>tolterodine</i>	379	TRI-LINYAH	256
<i>teriparatide</i>	<i>tolvaptan</i>	192	TRI-LO-ESTARYLLA	256
TESTIM	<i>tolvaptan (polycys kidney dis)</i>	192	TRI-LO-MARZIA	256
TESTOPEL	TOPICORT	366	TRI-LO-MILI	256
<i>testosterone</i>	<i>topiramate</i>	126	TRI-LO-SPRINTEC	256
<i>testosterone cypionate</i>	TOPROL XL	76, 95, 102	<i>trimethobenzamide</i>	218
<i>testosterone enanthate</i>	<i>toremifene</i>	51, 259	<i>trimethoprim</i>	35
<i>tetrabenazine</i>	TORPENZ	51, 299	TRI-MILI	256
<i>tetracaine hcl</i>	<i>torseamide</i>	108, 186	<i>trimipramine</i>	174
<i>tetracaine hcl (pf)</i>	TOSYMRA	170	TRINATAL RX 1 ...	89, 189, 382, 384
<i>tetracycline</i>	TOUJEO MAX U-300		TRINTELLIX	171
TEVIMBRA	SOLOSTAR	274, 277	TRIPTODUR	52, 267
TEZSPIRE	TOUJEO SOLOSTAR U-300		TRI-SPRINTEC (28)	256
THALOMID	INSULIN	274, 277	TRIUMEQ	22, 24
THEO-24	TOVIAZ	379	TRIUMEQ PD	22, 24
<i>theophylline</i>	TRACLEER	116, 344	TRI-VYLIBRA	256
<i>thiamine in 0.9 % sod chloride</i>	TRADJENTA	258	TRI-VYLIBRA LO	256
THIOLA	<i>tramadol</i>	157	TRODELVY	52
THIOLA EC	<i>tramadol-acetaminophen</i>	133, 152, 157	TROGARZO	22
<i>thioridazine</i>	<i>trandolapril</i>	93	TROJAN BARESKIN	324
<i>thiothixene</i>	<i>tranexamic acid</i>	86	TROJAN EXTENDED	
THROMBATE III	<i>transylcypromine</i>	149	PLEASURE	324
THYROGEN	<i>travoprost</i>	215	TROJAN MAGNUM CONDOMS	325
<i>tiagabine</i>	TRAZIMERA	51	TROJAN PLEASURE PACK	325
TIBSOVO	<i>trazodone</i>	171	TROJAN ULTRA RIBBED	
<i>ticagrelor</i>	TRELEGY ELLIPTA		CONDOM	325
TICE BCG .....	..... 66, 210, 236, 329, 333, 343		TROJAN ULTRA THIN	325
TICOVAC	TRELSTAR	51, 267	TROJAN ULTRA THIN	
<i>tigecycline</i>	TREMFYA	297, 298, 369, 370	SPERMICIDAL	325
TIGLUTIK	TREMFYA PEN	297, 298, 369	TROJAN VERY THIN LUB	
TILIA FE	<i>treprostinil sodium</i>	116, 344	CONDOMS	325
<i>timolol maleate</i>	TRESIBA FLEXTOUCH U-100		TROJAN-ENZ (NON-LUB)	
..... 70, 95, 102, 116, 133, 202, 203	..... 274, 277		CONDOMS	325
<i>timolol maleate (pf)</i>	TRESIBA FLEXTOUCH U-200		TROJAN-ENZ LUBRICATED	
TIMOPTIC OCUDOSE (PF) .....	..... 274, 277		CONDOMS	325
<i>tinidazole</i>	TRESIBA U-100 INSULIN ..	274, 278	TROJAN-ENZ/SPERMICIDAL	
<i>tiopronin</i>	<i>tretinoin</i>	52, 358	CONDOMS	325
<i>tiotropium bromide</i>	<i>tretinoin (antineoplastic)</i>	52	TROJAN-ENZ/SPERMICIDAL	
TIROSINT	<i>tretinoin microspheres</i>	52, 357	CONDOMS	325
TIROSINT-SOL	TRETTEN	86	TROKENDI XR	126
TIVDAK				

<i>tromethamine</i>	184	UPNEEQ (PF).....	216, 345	VERSACLOZ.....	137
<i>tropicamide</i>	214	UPTRAVI.....	117, 344, 345	VERZENIO.....	53
<i>trosipium</i>	379	<i>urea</i>	110, 186, 214, 374	VEVYE.....	201, 295
TRUDHESA.....	71, 133	<i>ursodiol</i>	221	VIAGRA.....	111, 339
TRUE COVER CONDOM.....	325	<i>ustekinumab</i>	304	VIBATIV.....	20
TRULANCE.....	223	<i>ustekinumab-aekn</i>	304	VIBERZI.....	217
TRULICITY.....	269	<i>ustekinumab-ttwe</i>	304	VICTOZA 2-PAK.....	124, 269
TRUMENBA.....	61	UZEDY.....	130, 137	VICTOZA 3-PAK.....	124, 269
TRUQAP.....	52	VABRINTY (3 MONTH).....	52, 267	VIENVA.....	244, 257, 265, 285
TRUSTEX LATEX CONDOM.....	325	VABYSMO.....	216	<i>vigabatrin</i>	146
TRUSTEX LUBRICATED		VAFSEO.....	78, 81	VIGADRONE.....	146
CONDOMS.....	325	VAGIFEM.....	264, 319	VIGAFYDE.....	146
TRUSTEX NON-LUB		VAGINAL CONTRACEPTIVE		VIGAMOX.....	32, 200
CONDOMS.....	325	FILM.....	325	VIIBRYD.....	172
TRUSTEX-RIA		<i>valacyclovir</i>	29	VIJOICE.....	193
LUB/SPERMICIDE.....	325	VALCHLOR.....	351	<i>vilazodone</i>	172
TRUSTEX-RIA LUBRICATED		<i>valganciclovir</i>	29	VILTEPSO.....	317
CONDOMS.....	325	<i>valproic acid</i>	130, 133, 146	VIMIZIM.....	195
TRUSTEX-RIA NON-LUB		<i>valproic acid (as sodium salt)</i>		VIMOVO.....	167, 227, 316
CONDOMS.....	325	.....	130, 133, 146	VIMPAT.....	147
TRUVADA.....	24, 29	<i>valsartan</i>	92	VIOKACE.....	222
TRUXIMA.....	52, 298	<i>valsartan-hydrochlorothiazide</i>		VIORELE (28).....	257
TUDORZA PRESSAIR.....	67, 329	.....	92, 114, 191	VIRACEPT.....	25
TUKYSA.....	52	VALTOCO.....	139, 140	VIREAD.....	24
TULANA.....	244, 256, 285	<i>vancomycin</i>	20	VIRTUSSIN AC.....	157, 331, 336
TURALIO.....	52	<i>vancomycin in 0.9 % sodium chl</i>	20	VISTOGARD.....	3
TURQOZ (28).....	244, 256, 264, 285	VANFLYTA.....	52	VITALARA.....	89, 382, 384
TWINRIX (PF).....	61	VANRAFIA.....	320	VITAMIN D2.....	385
TWIRLA.....	256	VAPRISOL IN 5 % DEXTROSE.....	192	VITRAKVI.....	53
TYBLUME.....	244, 256, 264, 285	VAQTA (PF).....	62	VIVAGUARD INO CTRL SOLN-	
TYBOST.....	16	<i>varденаfil</i>	111	L1,2,3.....	181
TYENNE.....	304	<i>varenciline tartrate</i>	77, 212	VIVAGUARD INO CTRL SOLN-	
TYENNE AUTOINJECTOR.....	304	VARIVAX (PF).....	62	L1,L3.....	181
TYKERB.....	52	VARUBI.....	224	VIVAGUARD INO CTRL SOLN-	
TYMLOS.....	278, 317	VASCEPA.....	109	L2.....	181
TYPHIM VI.....	61	VAXNEUVANCE (PF).....	62	VIVIMUSTA.....	53
TYRVAYA.....	77, 212	VCF CONTRACEPTIVE GEL.....	325	VIVITROL.....	77, 158
TYSABRI.....	305	VECTIBIX.....	52	VIVJOA.....	18
TYVASO.....	116, 344	VELETRI.....	117, 345	VIVOTIF.....	62
TYVASO DPI.....	116, 344	VELIVET TRIPHASIC		VIZIMPRO.....	53
TYVASO INSTITUTIONAL		REGIMEN (28).....	256	VIZZ.....	213
START KIT.....	116, 344	VELPHORO.....	187	VOCABRIA.....	22
TYVASO REFILL KIT.....	117, 344	VELSIPITY.....	224, 321	VOGELXO.....	238, 239, 244
TYVASO STARTER KIT.....	117, 344	VELTASSA.....	187	VOLNEA (28).....	257
UBRELVY.....	141	VELTIN.....	26, 350, 358	VONJO.....	53
UCERIS.....	237	VEMLIDY.....	29	VONVENDI.....	86
UDENYCA.....	81	VENCLEXTA.....	52	VOQUEZNA.....	225
ULESFIA.....	375, 377	VENCLEXTA STARTING PACK.....	52	VOQUEZNA DUAL PAK.....	11, 225
ULORIC.....	316	<i>venlafaxine</i>	169	VOQUEZNA TRIPLE PAK	
ULTILET INSULIN SYRINGE.....	181	VENTAVIS.....	339	.....	11, 30, 225
ULTRA COMFORT INSULIN		VENTOLIN HFA.....	75, 343	VORANIGO.....	53
SYRINGE.....	181	VENXXIVA.....	323	<i>voriconazole</i>	18
ULTRAVATE.....	367	VEOPOZ.....	320	VOSEVI.....	21
UNASYN.....	11	VEOZAH.....	142	VOTRIENT.....	53
UNDECATREX.....	238, 244	<i>verapamil</i>	103	VOXZOGO.....	323
UNITHROID.....	293	VEREGEN.....	374	VOYDEYA.....	320
UPLIZNA.....	306	VERIPRED 20.....	211, 237	VPRIV.....	195

VRAYLAR.....	137	XCOPRI MAINTENANCE PACK	147	<i>zaleplon</i>	149
VTAMA.....	356	.....	147	ZALTRAP.....	54
VUITY.....	72, 214	XCOPRI TITRATION PACK.....	148	ZARAH.....	257
VUMERITY.....	298	XDEMVEY.....	201	ZARONTIN.....	172
VYALEV.....	143	XELJANZ.....	305	ZARXIO.....	81
VYEPTI.....	141	XELJANZ XR.....	305	ZATEAN-PN DHA.....	89, 382, 384
VYFEMLA (28).....	244, 257, 265, 285	XELODA.....	53	ZAVZPRET.....	141
VYJUVEK.....	118, 379	XELSTRYM.....	120	ZEGALOGUE AUTOINJECTOR.....	265
VYLEESI.....	142	XEMBIFY.....	57	ZEGALOGUE SYRINGE.....	265
VYLIBRA.....	257	XENAZINE.....	174	ZEJULA.....	54
VYLOY.....	53	XENICAL.....	223	ZELAPAR.....	148, 149
VYNDAMAX.....	98	XENLETA.....	31	ZELBORAF.....	54
VYNDAQEL.....	98	XENPOZYME.....	195	ZELSUVMI.....	353
VYONDYS-53.....	317	XEPI.....	350	ZEMAIRA.....	77
VYTORIN 10-10.....	99, 107	XERESE.....	29, 353, 367	ZEMBRACE SYMTOUCH.....	170
VYTORIN 10-20.....	99, 107	XERMELO.....	217	ZEMDRI.....	10
VYTORIN 10-40.....	99, 107	XGEVA.....	294	ZENATANE.....	374
VYTORIN 10-80.....	99, 107	XHANCE.....	211, 237, 334	ZENPEP.....	222
VYVANSE.....	120	XIAFLEX.....	195	ZENZEDI.....	121
VYVGART.....	306	XIFAXAN.....	32	ZEPATIER.....	21
VYVGART HYTRULO.....	306	XIGDUO XR.....	247, 290	ZEPBOUND.....	269
VYZULTA.....	215	XIIDRA.....	201	ZEPOSIA.....	307
WAINUA.....	317	XOFLUZA.....	19	ZEPOSIA STARTER KIT (28-	
WAKIX.....	175	XOLAIR.....	300, 301	DAY).....	307
<i>warfarin</i>	78	XOLREMDI.....	81	ZEPOSIA STARTER PACK (7-	
WAYRILZ.....	78	XOSPATA.....	53	DAY).....	307
WEGOVY.....	124, 269	XPHOZAH.....	323	ZEPZELCA.....	54
WELCHOL.....	95, 96, 239	XPOVIO.....	53	ZERViate.....	6, 196, 340
WELIREG.....	53	XROMI.....	53	ZESTORETIC.....	93, 114, 191
WELLBUTRIN XL.....	127	XTAMPZA ER.....	157	ZESTRIL.....	93
WERA (28).....	244, 257, 265, 285	XTANDI.....	53	ZETIA.....	99
WEZLANA.....	304	XULANE.....	244, 257, 265, 285	ZEVTERA.....	8
WEZLANA I.V.....	304	XULTOPHY 100/3.6		ZIAGEN.....	25
WIDE-SEAL DIAPHRAGM 60.....	325	.....	124, 269, 274, 278	ZIANA.....	26, 351, 358
WIDE-SEAL DIAPHRAGM 65.....	325	XYNTHA.....	86	<i>zidovudine</i>	25
WIDE-SEAL DIAPHRAGM 70.....	325	XYNTHA SOLOFUSE.....	86	ZIEXTENZO.....	82
WIDE-SEAL DIAPHRAGM 75.....	325	XYOSTED.....	239, 245	ZIIHERA.....	54
WIDE-SEAL DIAPHRAGM 80.....	325	XYREM.....	175, 317	ZILBRYSQ.....	296
WIDE-SEAL DIAPHRAGM 85.....	326	XYWAV.....	175, 317	<i>zileuton</i>	337
WIDE-SEAL DIAPHRAGM 90.....	326	YCANTH.....	353	ZILRETTA.....	237
WIDE-SEAL DIAPHRAGM 95.....	326	YERVOY.....	53	ZILXI.....	15, 34, 200, 351
WILATE.....	86	YESINTEK.....	304, 305	ZINPLAVA.....	57
WINLEVI.....	351	YF-VAX (PF).....	62	ZIOPTAN (PF).....	215
WINREVAIR.....	339	YONDELIS.....	53	<i>ziprasidone hcl</i>	130, 137
WIXELA INHUB		YONSA.....	53	ZIPSOR.....	133, 167, 376
.....	75, 211, 237, 334, 343, 367	YORVIPATH.....	278	ZIRABEV.....	54
WYMZYA FE.....	257	YUFLYMA(CF).....	313	ZIRGAN.....	30, 202
WYOST.....	294	YUFLYMA(CF) AI CROHN'S-		ZITUVIO.....	258
XADAGO.....	148	UC-HS.....	313	ZOKINVY.....	193
XALKORI.....	53	YUFLYMA(CF)		ZOLGENSMA.....	118
XARAH FE.....	257	AUTOINJECTOR.....	313	ZOLINZA.....	54
XARELTO.....	79	YUPELRI.....	67, 329	<i>zolmitriptan</i>	170
XARELTO DVT-PE TREAT 30D		YUSIMRY(CF) PEN.....	313	ZOLOFT.....	171
START.....	79	YUTREPIA.....	117, 345	<i>zolpidem</i>	150
XATMEP.....	53, 298	YUVAFEM.....	265, 319	ZOMACTON.....	280
XCOPRI.....	148	ZAFEMY.....	245, 257, 265, 285	ZOMIG.....	170
		<i>zafirlukast</i>	337	ZONEGRAN.....	148

ZONISADE.....	148
<i>zonisamide</i>	148
ZONTIVITY	90
ZORTRESS.....	54, 299
ZORYVE.....	338, 376
ZOSYN IN DEXTROSE (ISO- OSM).....	20
ZOVIRAX.....	30, 353
ZTALMY.....	146
ZUBSOLV.....	159
ZUMANDIMINE (28).....	257
ZUNVEYL.....	72
ZURZUVAE.....	127
ZYDELIG.....	54
ZYKADIA.....	54
ZYLET.....	10, 200, 211
ZYMFENTRA.....	313
ZYNLONTA.....	54
ZYNTEGLO.....	118
ZYPITAMAG.....	107
ZYTIGA.....	54
ZYVOX.....	30